



# Shetland Major Emergency Procedure

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<b>Responsible officer</b>	<b>Director of Public Health</b>
<b>Approved by</b>	<b>NHS Shetland Senior Management Team 2<sup>nd</sup> July 2014</b>

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**Contents**

**Amendment List Record ..... 4**

**Distribution List .....5**

**Part A Overview**

Introduction  
Preface  
Aim  
Legislation  
Definitions  
Background  
Associated Plans and Documentation  
Business / Service Continuity  
Risk Registers  
Audits  
Requests for Medical or Nursing Assistance at Incidents  
Voluntary Organisations' Aid  
Supplies

**Part B Message/Reporting System**

App B-1 Major Emergency - Information Flow  
App B-2 Event Log

**Part C Alerting and Activation**

App C-1 Receipt of Alert  
App C-2 Sample of Accident Information Form  
App C-3 Stages of Alert

**Part D Hospital Control Centre**

App D-1 Floor Plan of Hospital Control Centre

**Part E Hospital Evacuation Scheme**

**Part F Casualty Treatment & Reception**

App F-1 Sample 'Information on Emergency Patients for A&E Dept'.  
App F-2 Ground Floor Plan - Accident & Emergency  
App F-3 Sample 'Major Incident Casualty Card'  
App F-4 Movement Plan - Major Incident Casualty Card

**Part G Finance**

**Part H Media & Other Enquiries**

App H-1 Press Conferences

**Part I Exercises/Testing**

**Part J Social Care Services to Casualties, Survivors and Next-of-Kin**

**Part K Transport**

**Part L NHS 24**

**Part M Police Liaison, Mortuary Services & VIP Visits**

**Part N Post-Incident Requirements**

**Part O Chemical & Biological Hazards**

**Part P Radiation Incidents**

App P-1 Decontamination  
App P-2 Sample of 'Patient Report Form'  
App P-3 Sample of 'Patient Decontamination Record'

**Part Q Action Lists**

App Q-1 Duty Consultant Physicians / Hospital Medical Controller  
App Q-2 Chief Executive / Senior Manager on-call  
App Q-3 Medical Incident Officer  
App Q-4 Director of Public Health / Public Health Consultant on call  
App Q-5 Duty Consultant Surgeons  
App Q-6 Duty Consultant Anaesthetists  
App Q-7 Duty House Officers (Surgical and Medical)  
App Q-8 Chief Nurse, Acute Services  
App Q-9 Senior Nurse on Duty (GBH)  
App Q-10 Receptionist / Telephonist, Gilbert Bain Hospital  
App Q-11 Receptionist, NHS Shetland Board HQ  
App Q-12 Receptionist, Lerwick Health Centre  
App Q-13 Medical Records Officer  
App Q-14 Hospital Control Centre Clerical Unit  
App Q-15 Nurse in Charge of each Ward  
App Q-16 Duty Porter  
App Q-17 Medical Registration Team  
App Q-18 Duty Laboratory Biomedical Scientist

**Part Q – Action Lists - continued**

- App Q-19 Physiotherapist & Occupational Therapist
- App Q-20 Duty Radiographer
- App Q-21 Chief Nurse, Health & Social Care Directorate
- App Q-22 Shetland District, British Red Cross
- App Q-23 Pharmacist
- App Q-24 Executive Manager / Chief Social Work Officer, SIC
- App Q-25 Social Work Liaison Officer, SIC
- App Q-26 Head of Estates & Facilities
- App Q-27 Senior Manager on call
- App Q-28 Facilities Manager

**Part R – Mutual Aid**

- App R-1 Mutual Aid – North of Scotland Planning Group
- App R-2 Mutual Aid – Highlands & Islands Strategic Coordinating Group

**Part S – Counter Terrorism**

- App S-1 Bomb Threat Checklist
- App S-2 Firearm and Weapon Attacks

**Amendment List Record**

Amendment List		Amended By	Date Amendment Inserted	Next Amendment Due
No	Date			
1	01/2002	Individual amendments	2002	
2	05/2002	Individual amendments	2002	
3	05/2003	Individual amendments	2003	
4	08/2004	Individual amendments	2004	
5	09/2004	Individual amendments	2004	
6	12/2007	Complete re-issue	2008	
7	03/2011	Complete re-issue		mid 2011
8	06/2014	Complete re-issue		mid 2017
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**Distribution List**

Copy	Holder	Action Lists
01	Chairman, Shetland NHS Board, NHS Shetland	
02	Vice Chairman, NHS Shetland	
03	Board Chief Executive, NHS Shetland	App Q-2, Q-27
04	Director of Public Health (DPH) (Reserve HMC) NHS Shetland	App Q-2, Q-4, Q-27
05	Director of Health & Social Care, NHS Shetland (Deputy Chief Executive)	App Q-2, Q-27
06	Consultant PH Medicine (on-call for NHS Shetland Public Health)	App Q-4
07	Director of Nursing and Acute Services	App Q-2, Q-27
08	Community Health Partnership – Copy 1, Breiwick House	
09	Community Health Partnership – Copy 2, Breiwick House	
10	Director of Human Resources and Support Services	App Q-2, Q-27
11	Lead Clinical Pharmacist	App Q-23
12	A & E Department, GBH	App Q-8, Q-9, Q-15
13	Nurse in Charge of Out Patients	App Q-8, Q-9, Q-15
14	Director of Finance NHS Shetland	App Q-2, Q-27
15	Medical Director	App Q-2, Q-27
16	On-call Out-of-Hours GP	App Q-3
17	Chief Administrative Dental Officer (CADO), NHS Shetland	
18	Consultant Psychiatrist, NHS Shetland	
19	Receptionist, NHS Shetland	App Q-11
20	Receptionist/Telephonist, GBH	App Q-10
21	Duty Junior Doctor - Surgical	App Q-7
22	Duty Junior Doctor - Medical	App Q-7
23	General Practitioners: Bixter	App Q-3
24	Brae	App Q-3
25	Hillswick	App Q-3
26	Levenwick	App Q-3
27	Scalloway	App Q-3
28	Unst	App Q-3
29	Walls	App Q-3
30	Whalsay	App Q-3
31	Yell	App Q-3
32	Lerwick	App Q-3
33	Chief Nurse, Health & Social Care Directorate	App Q-2, Q-21, Q-27
34	Receptionist, LHC	App Q-12

35	Head of Estates & Facilities	App Q-26
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Copy	Holder	Action Lists
36	Chief Nurse, Acute Services	App Q-8, Q-9
37	NHS Scotland Resilience, Edinburgh	
38	Transport & Purchasing Manager, GBH	
39	Nurse in Charge, Ward 1, GBH	App Q-8, Q-9, Q-15
40	Emergency Medical Dispatch Centre, SAS, Inverness	
41	Nurse in Charge, Ward 3, GBH	App Q-8, Q-9, Q-15
42	Nurse in Charge, Maternity, GBH	App Q-8, Q-9, Q-15
43	Nurse in Charge, Theatre, GBH	App Q-8, Q-9, Q-15
44	Nurse in Charge – Ronas Ward	App Q-8, Q-9, Q-15
45	Medical Records Officer, GBH	App Q-13, Q-17
46	Hospital Control, GBH	App Q-14
47	Consultant General Surgeon (1), GBH	App Q-5
48	Consultant General Surgeon (2), GBH	App Q-5
49	Consultant General Surgeon (3), GBH	App Q-5
50	Consultant Physician (1) / (HMC), GBH	App Q-1
51	Consultant Physician (2) / (HMC), GBH	App Q-1
52	Consultant Physician (3) / (HMC), GBH	App Q-1
53	Consultant Anaesthetist (1), GBH	App Q-6
54	Consultant Anaesthetist (2), GBH	App Q-6
55	Consultant Anaesthetist (3), GBH	App Q-6
56	Laboratory, GBH	App Q-18
57	Occupational Therapy Dept, GBH	App Q-19
58	Physiotherapy Dept, GBH	App Q-19
59	Medical Imaging Dept, GBH	App Q-20
60	Facilities Manager, GBH	App Q-28
61	Portering Manager, GBH	App Q-16
62	Hotel Services Manager, GBH	
63	SMT Manager On-call, Brevik Reception	App Q-2, Q-27
64	Chief Executive, SIC	
65	Executive Manager - Governance & Law, SIC	
66	Emergency Planning & Resilience, SIC	
67		
68	Executive Manager / Senior Social Work Officer, SIC	App Q-24, Q-25
69	Social Work Liaison Officer, Children's Services, SIC	App Q-24, Q-25
70	Duty Social Worker, Children's Services, SIC	App Q-24, Q-25
71	British Red Cross, Shetland District	App Q-22
72	Chief Inspector, Shetland Command Area	

<b>Copy</b>	<b>Holder</b>	<b>Action Lists</b>
73	Lerwick Police Station, Police Scotland	
74	Police Liaison Officer, Police Scotland	
75	Duty Controller, Sullom Voe Terminal	
76	Risk & Emergency Planning Officer, SAS, Inverness	
77	Accident & Emergency Team Leader, SAS, Lerwick	
78	Bristow Helicopters, Sumburgh	
79	District Controller, HM Coastguard, Lerwick	
80	Chief Executive, Lerwick Port Authority (LPA)	
81	Airport Manager, HIAL, Sumburgh Airport	
82	EPO, Highland NHS Board, Inverness	
83	EPO, Orkney NHS Board	
84	EPO, Western Isles NHS Board	
85	EPO, Grampian Health Board, Aberdeen	
86	Airport Manager, Tingwall Airport, Gott	
87	Watch Officer, HM Coastguard, Aberdeen	



## **Part A – Overview**

### **1 Introduction**

- 1.1 In the last ten years the Shetland NHS Board and Gilbert Bain Hospital have not been put under any direct pressure with regard to major incident medical response. However, events such as the capsizing of the “Bourbon Dolphin in April 2007, illustrate the strains that may be put on organisations in handling just the media aspects of any high profile incident.
- 1.2 The recent terrorist events have opened up a new range of threats to community stability. In Shetland the old problems of remoteness, weather related incidents, public health and natural disasters have not receded but we must now be ready to respond to new challenges such as Chemical, Biological, Radiological and Nuclear (CBRN), SARS, Pandemic Flu as well as a potential upsurge of terrorist activity in the wake of conflicts around the globe.
- 1.3 The experiences and lessons from incidents and exercises have informed the production of the Major Emergency Procedure and all of its subsequent revisions, and will continue to do so.
- 1.4 By its nature, the plan is comprehensive and complex, but its purposes are simple and unchanged from previous versions, namely:
  - (a) to assist individuals to react positively to an emergency;
  - (b) to provide advice and information to enable the NHS response to an emergency to be structured, co-ordinated and managed effectively.
- 1.5 Much work has gone into ensuring that the plan fulfils these purposes, predominately by the Board's Emergency Planning Officer and his assistant and they are to be commended for this work. It is, however, now up to the individual recipients of the plan to thoroughly familiarise themselves with the sections of relevance to them in order to turn this plan into the means whereby all future incidents are handled to greatest beneficial effect.

## **2 Preface**

- 2.1 This Plan is the property of Shetland NHS Board, copyright being vested in the Board Chief Executive, on behalf of the Board.
- 2.2 Under the terms of the Board's Service Level Agreement with the Local Authority the Plan will be updated by the Emergency Planning Service of the Shetland Islands Council. Emergency Planning will be responsible for inviting amendments, will collate all amendments and issue updated pages. Nil returns will be required.
- 2.3 It is the responsibility of holders to ensure that amendments are notified on request, that amended pages are inserted as soon as possible after receipt, and that the pages removed from the file are returned to the Emergency Planning Service for destruction.

## **3 Aim**

- 3.1 The aim of Shetland NHS Board's Major Emergency Procedure is identical to that of Scottish Executive Health Department's Emergency Planning Guidance to the NHS in Scotland:

**To ensure that the NHS is capable of responding to major incidents of any scale in a way that delivers optimum care and assistance to the victims, that minimises the consequential disruption to healthcare services and that brings about a speedy return to normal levels of function; it will do this by enhancing its capability to work as part of a multi-agency response across organisational boundaries.**

## **4 Legislation**

- 4.1 Central government's approach to civil contingency planning is built around the concept of resilience. This is defined as the ability at every relevant level to detect, prevent and, if necessary, to handle and recover from disruptive challenges. The processes, which underpin resilience, form the fundamental elements of civil protection.
- 4.2 Civil protection or civil contingency planning can be defined as the application of knowledge, measures and practices to anticipate, guard against, prevent, reduce or overcome any risk, harm or loss that may be associated with natural, technological or man-made crises and disasters in peacetime.

4.3 In November 2005, the Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Regulations 2005 came into force. The Act does not change what we currently do, or should be doing, at all levels of management within NHS Shetland but it now places a statutory duty on the Health Board to undertake these duties. The Act focuses on three types of threat:

- an event or situation which threatens serious damage to human welfare;
- an event or situation which threatens serious damage to the environment; or
- war, or terrorism, which threatens serious damage to security.

4.4 The act placed statutory duties on a number of responders. There were placed in two categories:

Cat 1: Local Authorities, Health Board, Police, Fire, Ambulance, Maritime and Coastguard Agency and SEPA. (represented in Shetland by the Shetland Emergency Planning Forum [SEPF] Executive).

Cat 2: Utilities, Public Communications Providers (landlines and mobiles), Harbour Authorities, Airport Operators, Health & Safety Executive and Health Protection Scotland. (represented in Shetland by the SEPF Full Forum).

Those responders in Category 1 have duties placed upon them to:

- Assess local risks and use this to inform emergency planning, (Community Risk Register [CRR]);
  - Put in place emergency plans; (NHS Shetland Major Emergency Procedure, SIC Emergency Plan, Control Of Major Accident Hazard (COMAH) Plans, Pipeline Safety Plans and Multi-agency Response Plans, (e.g. to Airports, Life-line links, Public Health (pandemics));
  - Put in place Business Continuity Management (BCM) arrangements, (i.e. maintain services during major incident response or resource/staff shortage);
  - Put in place arrangements to 'warn and inform the public' about civil protection matters and to advise the public in the event of a major emergency without alarming the public unnecessarily;
  - Share information with other local responders to enhance co-ordination;
  - Co-operate with other local responders to enhance co-ordination and efficiency, and
  - Provide advice and assistance to businesses and voluntary organisations about BCM. (Local Authorities only).
-

- 4.5 Responders in Category 2 have a duty placed upon them to co-operate, co-ordinate and assist those in Category 1 to undertake the above duties.
- 4.6 The Act places responsibilities and consequently accountability on all levels of management throughout the Category 1 Responders to partake in these duties.
- 4.7 The Shetland Emergency Planning Forum, comprised of Category 1 and 2 responders, originally formed in 1988, ensures compliance with the legislation, regulations and guidance and will provide the communities of the Shetland Islands with a fully integrated, cohesive, efficient, and quality civil contingencies planning, management and response service. This Forum meets three times a year.
- 4.8 In May 1998 the Shetland Islands together with Highland, Orkney and the Western Isles established the Highlands and Islands Strategic Co-ordinating Group with the aim of ensuring optimum response by the emergency services, public bodies and support agencies in the event of a major civil emergency or natural disaster. This Group, based in Inverness meets three times a year.
- 4.9 In January 1999 the Highlands and Islands Emergencies Planning Group was established to deal with issues as identified by either the Highlands and Islands Strategic Co-ordinating Group or the four local authorities groups / forums. This Group will advise on policy and strategic direction in relation to all emergency planning matters. This Group, also based in Inverness meets four times a year.

## 5 Definitions

- 5.1 The following Scottish Executive Health Department's definitions have been adopted by Shetland NHS Board as the basis of the Board's emergency planning:
- (a) **routine emergency** – one which can be met within the normal capacity and procedures of those faced with it. It is one which places no abnormal demand upon health care services.
  - (b) **major emergency** – a situation, either arising or threatened, which requires the special mobilisation and/or redeployment of staff or other resources with consequent interruption to routine activities.

- (c) **major incident** – this is a widely accepted term used by the emergency services to describe any emergency that requires the implementation of special arrangements by one or more of the emergency services, the NHS or the local authority. Individual NHS organisations can self-declare a major incident when their own facilities and/or resources, or those of its neighbours are overwhelmed.
- (d) **beyond a major incident** – covers incidents that threaten severe disruption to health and social care and exceed the collective local capability available to the NHS.

## 6 Background

- 6.1 Shetland has three active airports and six airstrips on the outlying islands, the large oil terminal and gas liquefying plant at Sullom Voe, a considerable amount of heavy road traffic and a busy port at Lerwick which supports the lifeline ferries. Offshore, large-scale oil and gas exploration and production is carried out both in the East Shetland Basin and to the West of the islands, on the Atlantic Shelf. Practically every form of major accident can be envisaged with the exception of railway accidents.
- 6.2 In terms of Scottish Executive Health Department's Emergency Planning Guidance, the Gilbert Bain Hospital is both a Designated Receiving Hospital (a hospital designated by the Board as having the facilities to receive and treat patients who are seriously injured or critically ill, on a 24-hour-day basis) and a Control Hospital (a Designated Receiving Hospital equipped to provide initial co-ordination of all NHS activities connected with a major emergency unless or until a Board Control Centre is activated).

## 7 Associated Plans and Documentation

- 7.1 This is Shetland NHS Board Major Emergency Procedure and describes the roles and responsibilities of employees when responding to an emergency. It cannot be read in isolation as it forms part of an integrated emergency management system designed to cover all aspects of emergency response in Shetland.

- 7.2 An emergency or major incident may involve only Shetland NHS service in which case this plan details the response. In an emergency that requires a multi-agency response, the Shetland Emergency Planning Forum Multi-Agency Initial Response Plan would be put into action and this plan would detail the NHS response within it.
- 7.3 This plan may be activated in isolation or alongside / as part of the response within one of the following plans.
- 7.4 The following Plans and Procedures, some of them belonging to external agencies, are associated with, and refer to, this document. Plans marked '\*' are currently under review.

**NHS Board Shetland**

Flu Pandemic Plan

Viral Haemorrhagic Fever Plan \*

Food-borne Disease Outbreak Plan (joint NHS / SIC) \*

Shetland Public Health Incident (Outbreak) Plan which includes Shetland Hospital Outbreak Plan

**Shetland Islands Council**

Control of Major Accident Hazards (CoMAH) Off-site Plan–Sullom Voe Terminal Pipeline Safety Plan – Brent & Ninian Pipelines\*

Sullom Voe Harbour Authority - Emergency Plan

Sullom Voe Harbour – Oil Spill Plan

Scalloway Harbour Authority – Oil Spill Response Contingency Plan

Shetland Marine Pollution Contingency Plan (MCA - National Contingency Plan)

Foot and Mouth Disease Plan\*

Rabies Plan\*

**Shetland Emergency Planning Forum**

Multi-Agency Initial Response Plan

**Highlands and Islands Strategic Coordinating Group (HISCG)**

Implementing a Strategic Response – A Guidance Document

CBRN Joint Initial Response Plan

Failure of the '999' Service – A joint Response

**Sullom Voe Terminal**

Sullom Voe Terminal – Emergency Response Plan

SVT Onshore Oil Import Pipelines Emergency Response & Repair Contingency Plan

**Lerwick Port Authority**

Lerwick Port Authority – Oil Spill Contingency Plan

**Scottish & Southern Energy plc**

Lerwick Power Station – Emergency Response Plan

**Sumburgh & Scatsta Airports**  
Airport Emergency Procedures  
Multi-Agency Initial Response Plans

**Category 1 & 2 Responders**  
Business / Service Continuity Plans

## **8 Associated Guidance**

### **8.1 Scientific and Technical Advice Cell (STAC)**

8.1.1 Emergency co-ordinating groups often require expert advice on a range of public health, environmental, scientific and technical issues in order to deal effectively with the immediate and longer term consequences of an emergency. There is a need to ensure that this advice is co-ordinated.

8.1.2 Guidance has been created to provide public health, environmental, scientific and technical advice to emergency co-ordinating groups in Scotland through establishment of a Scientific and Technical Advice Cell (STAC).

<http://www.scotland.gov.uk/Publications/2008/11/20093421/08>

### **8.2 Guidance for Healthcare Staff and Police Officers to address Crown Office Requirements (Requiring Body Parts and Other Possessions of Live People) in the Event of Mass Casualty / Fatality Incidents**

8.2.1 Recent incidents have highlighted certain difficulties for police officers and healthcare professionals in the management of live casualties during a mass casualty/fatality incident.

8.2.2 People are under a great deal of pressure as they are expected to respond in the best manner possible in such complex situations, which usually does not give much notice for preparation, while continuing to undertake other urgent/emergency activities.

8.2.3 However, despite the challenging situation, it is presumed that the health and wellbeing of the patient, healthcare professionals, and the public, should always be protected and maximised. An agreed protocol clarifies specific issues related to such mass casualty / fatality incidents.

## **9 Business / Service Continuity**

- 9.1 Business continuity is one of the key features of resilience and a key corporate management process. Shetland NHS Board has gone through this process and now have business continuity plans in place.

## **10 Risk Registers**

- 10.1 Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Regulations 2005 gave Category 1 and 2 Responders statutory duties. Among these was the requirement to produce a Community Risk Register (CRR).
- 10.2 With the requirement to Risk Assess - the experience and involvement in major incidents of the organisations comprising the Shetland Emergency Planning Forum provided a comprehensive list of potential hazards that Shetland may face and these were then analysed as to the frequency, severity and potential for them happening again. A Community Risk Register was then produced and agreed by the Forum.
- 10.3 Another requirement is to “Warn and Inform” therefore the CRR will be published on pertinent websites in due course, along with other relevant risk registers:

Shetland NHS Board – Corporate Risk Register  
Shetland Emergency Planning Forum – Community Risk Register  
Highlands and Islands Strategic Co-ordinating Group – Community Risk Register (include risks for Shetland, Orkney, Western Isles and Highland)

## **11 Audits – Internal and National**

- 11.1 The Emergency Planning Service of the Shetland Islands Council, who prepare and review this plan, are internally audited on a five yearly basis. The Service was audited in July 2007 and the key observation has been addressed.
- 11.2 This Plan was also audited by the Scottish Executive Health Department, Emergency Planning Unit in August 2006. The plan complied with the audit criteria with a few amendments suggested. These have been incorporated in the current version of this plan.



## 12 Requests for Medical or Nursing Assistance at an Incident

- 12.1 From time to time requests are received to provide medical and nursing reinforcements at the scene of an incident (i.e. a Site Medical Team). National experience suggests that such assistance is of limited value unless large numbers of casualties are trapped and can only be extricated with difficulty. The resources available to the Gilbert Bain Hospital are such that providing on-site assistance may mean that it is no longer possible to manage adequately those casualties who reach the hospital. **Any decision to dispatch a Site Medical Team can therefore only be made by a person in a position to assess the overall situation, and this must be the Hospital Medical Controller.** If deployed to the site, staff will be equipped with clothing, including footwear and headgear, sufficiently robust and weather proof to withstand working in exposed and hazardous conditions and complying with the relevant British Safety Standards. High-visibility jackets and protective helmets will be marked to identify workers as medical or nursing workers.
- 12.2 Shetland NHS Board will regard staff required to attend major incident sites as working on normal NHS duties and thus subject to the provisions of the NHS Superannuation and Injury Benefit Scheme as well as the Industrial Injuries Scheme.
- 12.3 Medical, nursing and paramedical staff who have a commitment to the Gilbert Bain Hospital must consider this to be their over-riding priority throughout the period of a major alert. Any request by a responsible person for assistance at the scene of an incident will therefore be relayed as rapidly as possible to the Hospital Medical Controller. The Hospital Medical Controller will consult with the Duty Consultant Surgeon, in the case of medical staff, with the Chief Nurse, Acute Services, in the case of nursing staff. **Only the Hospital Medical Controller is authorised to permit the detachment of staff from the Gilbert Bain Hospital.** The Hospital Medical Controller may, with their agreement, deploy otherwise non-involved GPs to assist at the scene of an incident.

## 13 Voluntary Organisations' Aid

- 13.1 British Red Cross is usually despatched through the Scottish Ambulance Service to an incident. If the HMC considers that their presence would be helpful at the hospital they can discuss with the MIO who will provide information about capacity at the scene and the British Red Cross liaison via the national number: 07748 608648. Normally their presence at the scene would take precedence.

## **14 Supplies**

- 14.1 Each ward and department maintains a limited stock of medical supplies. Additional supplies can be obtained at short notice from the NHS Shetland's Supplies Department or out of hours via the central stores at Lerwick Health Centre or, if necessary, from Aberdeen by air freight.
- 14.2 A cost centre for major emergencies has been created which will be made available if a major emergency is declared formally. 10 purchase order numbers have been generated which would be chargeable to the major emergency cost centre. The Senior Manager on call is authorised to use these to obtain goods or services out of hours or at short notice if the supplier insists on a purchase order. These are kept in a sealed envelope marked SMT on-call in the emergency box in GBH.

## **Part B – Message / Reporting System**

### **1 Introduction**

- 1.1 It is imperative to log all elements in response to a major emergency, especially in the aftermath when formal investigations may result. It is important therefore that log sheets, records of events, communications, of decisions taken, and other relevant contemporaneous materials are preserved.

### **2 Information**

- 2.1 Because hospital reception will, as at present, have to deal with all initial communications traffic from the emergency services and the public and then, as the incident progresses, will remain one of the most important links to and from Hospital Control, the importance of proper records, procedures and equipment in this area cannot be over-emphasised.

### **3 Message/Reporting System**

- 3.1 During an emergency personnel at key locations will receive two types of messages:
- (a) those which require acknowledgement but no further action; and
  - (b) those which require acknowledgement and follow-up action either by the recipient or someone else.

- 3.2 It is important to record all messages, written or verbal, passed during an emergency.

Experience has demonstrated the necessity of adopting a formal message/recording system to deal with issues including:

- (a) The drafting and publication of such reports as may be required by the Board, the Local Authority, the Secretary of State or other formal agency;
  - (b) Legal and/or financial claims arising from an incident; and
  - (c) The determination of the overall and detailed costs of the incident and, where appropriate, the rendering of accounts.
- 3.3 A diagram showing the information flow is attached at **Appendix B-1**.
- 3.4 In order to effectively protect the Board's interests, the event log described and shown in **Appendix B-2** will be, from the time an emergency is

formally declared until it is formally closed, used by all departments and units.

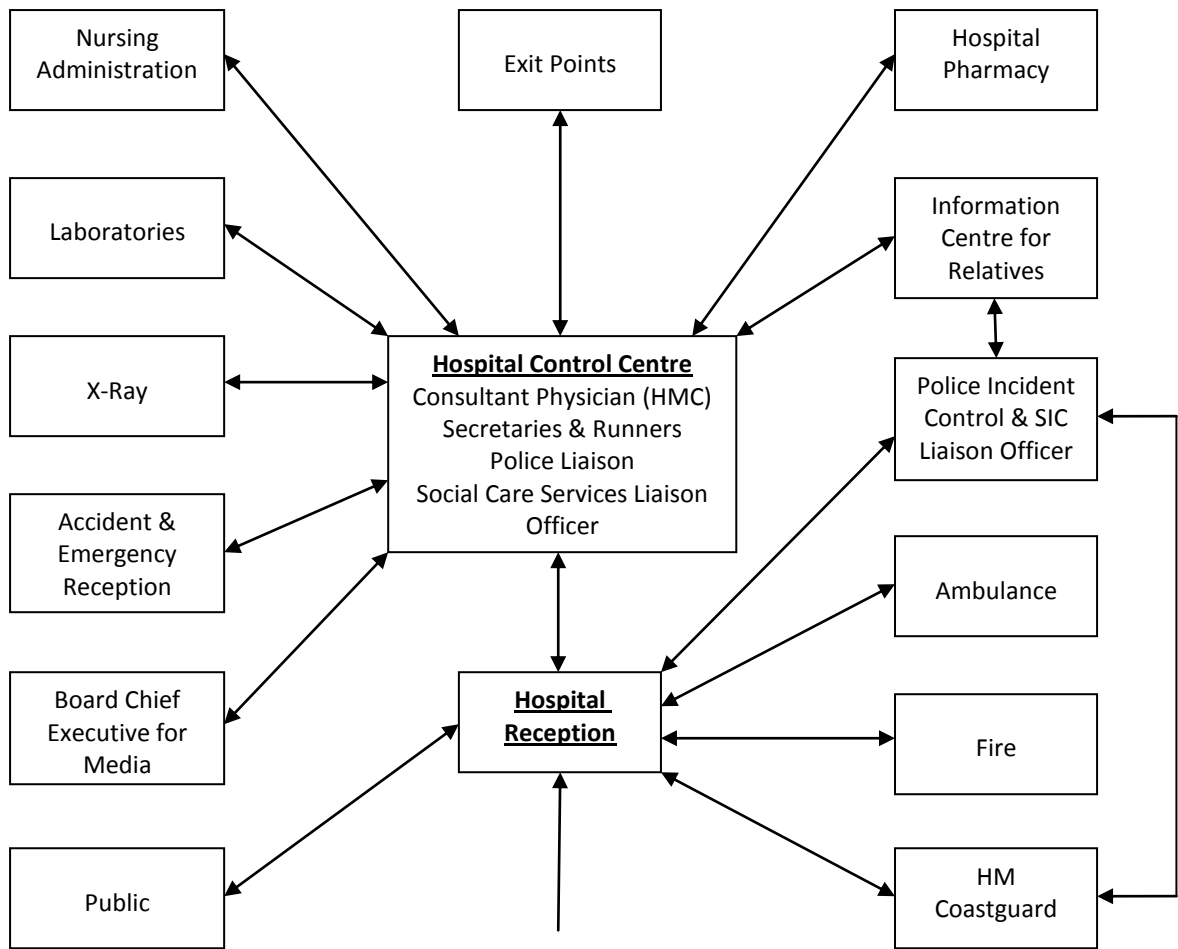
#### **4 Stocks of Event Logs**

4.1 Pads of Event Logs, ready for immediate use will be retained in the following locations:

- Each ambulance (for use on-site by Medical Incident Officer)
- Hospital Control Centre (for Hospital Control Centre and Accident and Emergency Exit Point)
- Board Chief Executive's Office
- Health Centre
- Laboratories
- Hospital Mortuary
- Hospital Reception (for Hospital Reception and Accident and  
▪ Emergency Reception)
- Operating Theatres
- Ward 1
- Day Surgery
- Ward 3
- Maternity Ward
- Ronas Ward
- Medical Imaging Department

#### **5 Supplies of Event Logs**

5.1 The Facilities Manager will be responsible for ensuring that stocks of Event Log are maintained at an adequate level, and that each of the locations listed in Paragraph 4.1 above is pre-supplied. Further supplies are available from central stores.






**Appendix B-2 – Event Log**

**1 Event Log**

1.1 All communications and activities must be recorded using the event log which will then:

- (a) Serve as a true record of events;
- (b) Act as a personal Aide-Memoire;
- (c) Assist operational decision making;
- (d) Facilitate handovers of responsibility;
- (e) Aid the compilation of post operational reports
- (f) Be available for reference during both debriefs and any subsequent enquiries; and
- (g) Be a true record of events and include details of, or references to, every communication, verbal or written, together with the details of decisions made and actions taken.

1.2 The event log should be completed as fully as possible. A copy is shown below:



**NHS Shetland – Major Emergency Procedure – Event Log** No. **0901**

For: ..... From: .....

Of: ..... Mobile: .....

Telephone: ..... Fax: .....

**Write message below**

Telephoned  .....

Please ring back  .....

Returned your call  .....

Would like to see you  .....

**URGENT**  .....

Date: ..... Time: ..... Taken By: .....





## **Part C – Stages of Alert and Activation**

### **1 Introduction**

1.1 The Scottish Ambulance Service has specific responsibilities in terms of alert NHS Board in the event of an emergency and/or major incident. These are:

- immediate notify, or confirm with police and fire controls, the location and nature of the incident, including identification of specific hazards, for example, chemical, radiation or other known hazards
- alert the Gilbert Bain Hospital
- alert the wider health community as the incident dictates

1.2 **Appendix C-1** lists the action required by the person receiving the information.

### **2 Accident Information Form**

2.1 A copy of the 'Accident Information Form' will be found in **Appendix C-2**. It is produced in 'sets' of four copies, printed on no-carbon-required (NCR) paper.

2.2 When as much information as is immediately available has been noted on the Accident Information Form, the copies will be passed with the minimum of delay to:

- (White) -
- (Pink) - Nurse in Charge of GBH
- (Blue) - Duty Surgical Junior Officer
- (Backing card) - Hospital Records Office, for Hospital Control Centre

### **3 Stages of Alert and Activation**

3.1 The **Senior Nurse on Duty** (action list **Appendix Q-9**) on being notified of a serious accident/incident will, based on the information received, decide whether or not to order a major incident alert.

3.2 A decision may be made to activate the Major Emergency Procedure for an internal incident, in which case the decision to initiate the alert should be taken by the Senior Management Team Manager on-call. In this case the decision to report to and involve other agencies should be discussed with the Director of Public Health / Public Health Consultant on-call.

- 3.3 If the Major Emergency Alert should be initiated, the Senior Nurse on Duty will declare to the Hospital Receptionist the appropriate **Stage Of Alert** as described at **Appendix C-3**.
- 3.4 Hospital Reception holds and maintains the call out lists associated with each stage of alert. The Hospital Receptionist will execute the alert procedure. An action list for the Hospital Receptionist is held at **Appendix Q-10**.
- 3.5 The initial response to an incident will include call-out of the local GP during working hours, and the on-call duty GP out-of-hours, who will attend the scene as the Medical Incident Officer.

#### **4 Action Lists**

- 4.1 Action lists for all personnel are detailed in the **'Q' Appendices**.

#### **5 Stocks of Accident Information Forms**

- 5.1 Sets of Accident Information Forms, ready for immediate use, will be retained at the following locations:
- (a) Hospital Reception; and
  - (b) Lerwick Health Centre Switchboard.

#### **6 Supplies of Accident Information Forms**

- 6.1 The Medical Records Manager will be responsible for ensuring that stocks of Accident Information Forms are maintained at an adequate level, and that each of the locations listed in paragraph 4.1 above is pre-supplied with 'sets' of forms, ready for immediate use in an emergency.

#### **7 Finance**

- 7.1 A cost centre for major emergencies has been created which will be made available if a major emergency is declared formally. 10 purchase order numbers have been generated which would be chargeable to the major emergency cost centre. The Senior Manager on call is authorised to use these to obtain goods or services out of hours or at short notice if the supplier insists on a purchase order. These are kept in a sealed envelope marked SMT on-call in the emergency box in GBH.
- 7.2 The Senior Manager on call is thereafter responsible for supervising the financial management of the incident in terms of the Board's financial policies and regulations, liaising with the Board's Finance Manager.

**Appendix C-1 – Receipt of Alert**

**ACTION required by first staff member to receive information about a**

**SERIOUS ACCIDENT/INCIDENT**

**(i.e., any accident/incident believed to have resulted in several casualties)**

**1 Write down the following information:**

- a. Where is the accident/incident?
- b. What has happened?
- c. Name of informant?
- d. Where is he/she telephoning from? Tel No.....

**2 Complete an 'Accident Information Form' which you will find in:**

Hospital Reception;  
Health Centre Switchboard.

**3 With the minimum of delay, pass the second (pink) copy to the Senior Nurse on Duty.**

**4 After assessing the information the Senior Nurse on Duty will declare a **STAGE OF ALERT** as deemed necessary in accordance with the definitions at **Appendix C-3.****

**5 The Hospital Receptionist will execute the alert procedure.**

**THESE INSTRUCTIONS TO BE PLACED BY EACH TELEPHONE  
IN HOSPITAL CLINICAL AREAS, RECEPTION,  
AND AT LERWICK HEALTH CENTRE**



**Accident Information Form**

WRITE DOWN THE MAIN FACTS, as follows (Write clearly - print if possible):

- 1 What has happened?.....  
.....  
.....
- 2 Where? (Get details to enable the Ambulance Service to find the place without delay if the alert has not come from the Ambulance Service)  
.....  
.....
- 3 Time & Date of Incident .....hrs (use 24 hr clock) on (date) .....
- 4 Number of persons thought to be involved .....
- 5 Nationality of casualties if known .....
- 6 Any other facts about casualties .....
- 7 Have the Police been informed so far as informant knows? YES/NO \*  
**If 'NO' ask informant to notify the Police as soon as possible**
- 8 Has the Scottish Ambulance Service been notified? YES/NO \*
- 9 Has the local GP been notified? YES/NO \* If YES, name? .....
- 10 Name of informant? ..... Where phoning from? .....
- 11 Time this message received? ..... hrs, on ..... (date if other than above)

PRINT your own name ..... and designation .....

**TELEPHONE/FAX THIS INFORMATION WITHOUT DELAY TO:**

- (1<sup>st</sup> copy – **white**)      Nurse in Charge of GBH    passed to ..... at .....
- (2<sup>nd</sup> copy - **blue**)      Duty Surgical Junior Doctor    passed to ..... at .....
- (3<sup>rd</sup> copy - **green**)      Hand in to Hospital Records Office at the first opportunity.

- Notes:
- (a) If you cannot get all the information above, don't worry, but pass on the essentials with the minimum delay.
  - (b) If your informant does not know whether the Police have been notified of the accident or not, and if you are not able to contact the Nurse in Charge of GBH without delay, pass this information to the Police yourself. ***This could be most important.***
  - (c) If, after completing and distributing this form, you are in any doubt as to whether the Police have been informed, Check yourself.



## **Appendix C-3– Stages of Alert and Activation**

Hospital Reception holds and maintains the call out lists associated with each stage of alert.

### **STAGE 1 ALERT – Major Incident - Standby**

When the information received indicates that a serious accident/incident has occurred and **MAY** require a medical response greater than is currently available.

### **STAGE 2 ALERT – Major Incident Declared – Activate Plan**

When the information received indicates that a serious accident/incident has occurred and **WILL** require a medical response greater than is currently available.

### **STAGE 3 ALERT**

When the information received indicates that a serious accident/incident has occurred and **ALL** resources will be required for the response.

### **Major Incident - Cancelled**

This message cancels Alert Stages 1- 3.

### **Major Incident – Stand Down**

Alert when all live casualties have been removed from the site. Where possible, the on-site Incident Commander will make it clear whether any casualties are still en-route.

### **HIGH PROFILE – Minor Incident**

When the information received indicates that an incident has taken place where the injuries are not serious but involve a VIP, (e.g. Royalty, Ministerial Visitor, etc.).





## **Part D – Hospital Control Centre**

### **1 Hospital Control Centre**

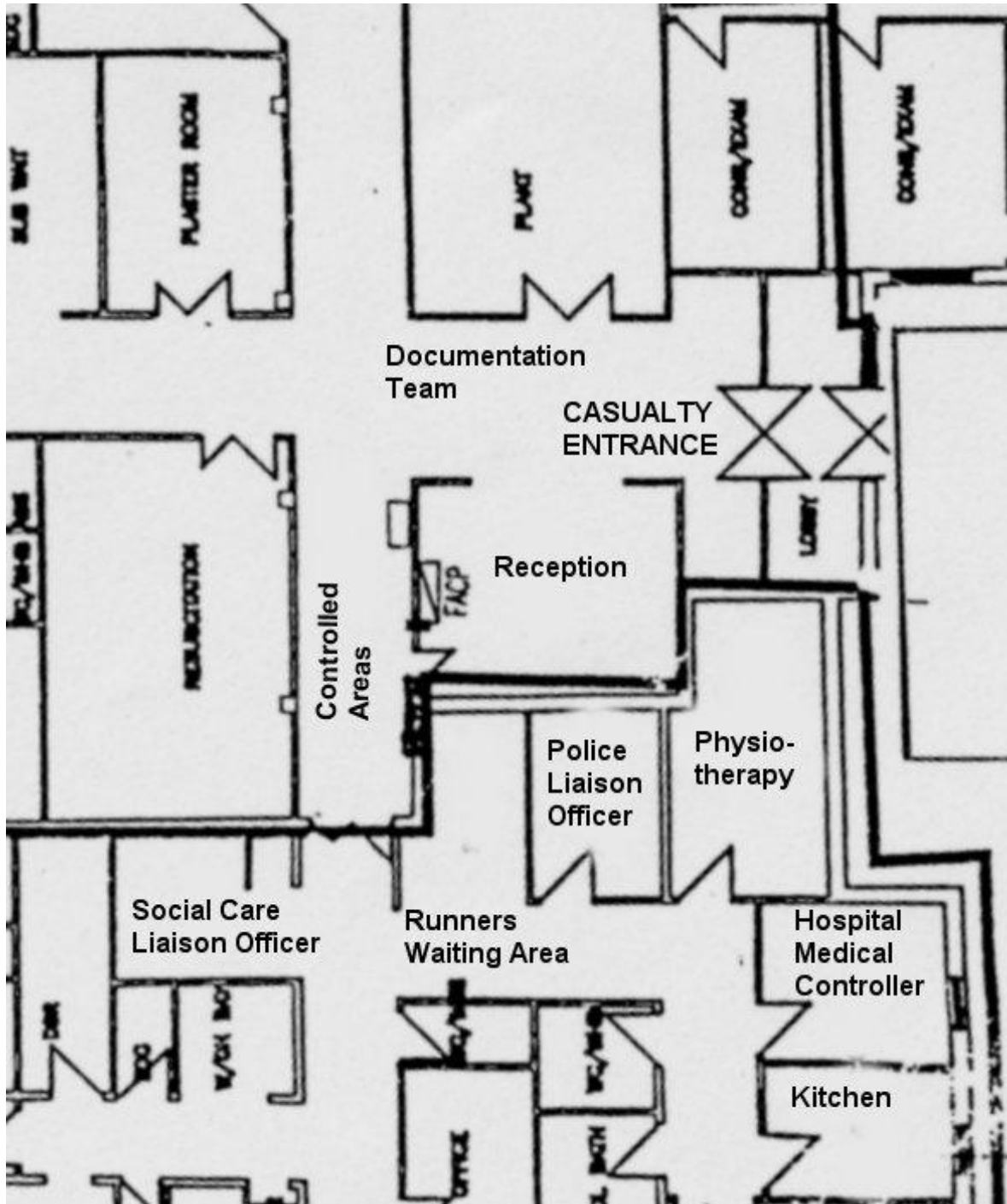
- 1.1 The Hospital Control Centre (which, unless and until specific instructions are issued to the contrary, will also act as Shetland NHS Board's Control Centre) will be sited in the offices normally occupied by Physiotherapy and Occupational Therapy. These offices are equipped for this purpose and identified in the floor plan included as **Appendix F-2**.
- 1.2 In addition to a normal extension on the Shetland NHS Board's number (01595 743000), the Hospital Control Centre is fitted with two direct ex-directory telephone lines and the facility to be connected to the Emergency Communication Network (ECN) telephone.
- 1.3 A detailed floor plan of the Hospital Control Centre is attached as **Appendix D-1**.

### **2 Hospital Control Team**

- 2.1 At the Hospital Control Centre, the **Duty Consultant Physician will act as Hospital Medical Controller**, and will be supported by a clerical unit of not less than two clerical assistants drawn from the staff at the Gilbert Bain Hospital and Shetland NHS Board's offices.
- 2.2 A detailed Action List for the Consultant Physicians (Hospital Medical Controller) is annexed as **Appendix Q-1**.
- 2.3 The Hospital Control Clerical Units Action List forms **Appendix Q-14**.



Appendix D-1- Hospital Control Centre





## **Part E – Hospital Evacuation Scheme**

### **1 Hospital Evacuation**

- 1.1 As soon as a major emergency is declared consideration will require to be given to bed-space requirements, measured against actual occupancy rates at the time.
- 1.2 At the earliest opportunity, and if at all possible before any casualties reach the hospital, the **Nurse in Charge of each Ward** will take the preliminary action described in **Appendix Q-15**.

### **2 Initiation of Evacuation Scheme**

- 2.1 **The hospital evacuation scheme will be initiated only on the authority of the Hospital Medical Controller.**
- 2.2 Should the scheme be activated, the primary aim will be to use all available beds at Montfield.
- 2.3 Access to Montfield will be made by Hospital Control, acting on behalf of the Hospital Medical Controller, and arrangements will be recorded on appropriate Message/Report Forms.

### **3 Transport of Patients**

- 3.1 As part of its remit to provide transport services in terms of **Part 'C' of the SIC Emergency Plan**, Departments within the Council may be asked to assist the Scottish Ambulance Service to evacuate the Gilbert Bain Hospital, providing vehicles and, for each, a driver and a driver's mate. On each occasion a vehicle is carrying a patient, an escort will be provided by the Scottish Ambulance Service or NHS Shetland.
- 3.2 Patients evacuated to Montfield will be admitted via the normal entrance.



## Part F – Casualty Treatment & Reception

### 1 Treatment at Accident Scene

- 1.1 Initial treatment of casualties at the scene of a major accident will, in most cases, be undertaken by a local general practitioner, or practitioners. The doctor, or if there is more than one in attendance, that one appointed to undertake the duty, will act as **Medical Incident Officer (MIO)**.

### 2 Medical Incident Officer

- 2.1 The Medical Incident Officer will be provided with an identifying tabard, one of which is carried in each of the local ambulances. **The tabard must be worn by the MIO throughout the incident.**
- 2.2 An Action List for the **MIO** is annexed as **Appendix Q-3**. Essentially, s/he is responsible for conducting on-site triage and formulating a casualty evacuation plan.

### 3 Triage

- 3.1 Triage is designed to ensure that available resources are used to best effect, rather than for those with minor injuries or those who have little chance of survival. Triage is a continuous process, requiring regular re-assessment and review. Both at the site and in Hospital Reception, casualties must be clearly and visibly labelled with their triage category which, as colour-coded on the 'Casualty Label' are:

<b>Priority 1:</b>	<b>RED</b>	Immediate evacuation and treatment required to save life
<b>Priority 2:</b>	<b>YELLOW</b>	Urgent evacuation required
<b>Priority 3:</b>	<b>GREEN</b>	Evacuation and treatment as soon as possible, but after Priorities 1 & 2
<b>Priority 4:</b>	<b>WHITE</b>	Dead

### 4 Casualty Transportation and Notification

- 4.1 It is the responsibility of the Scottish Ambulance Service to transport casualties from the scene of an incident to the Gilbert Bain Hospital. The hospital will be notified of a casualty transfer using the pre-printed form supplied to Reception, (Information on Emergency Patients for A&E). A copy of the form is at **Appendix F-1**.

- 4.2 The form is a two part NCR (no carbon required) form. After completion the top copy will be passed to A&E by the fastest possible means and the second copy passed to the Hospital Medical Controller.

## **5 A & E Entrance**

- 5.1 Following a major incident, all casualties will be admitted to the Gilbert Bain Hospital via the main entrance. The entrance is illustrated in the 'floor plan' included as **Appendix F-2**. Staff will report for duty via the same entrance. Access to all other personnel will be denied until separate arrangements can be made to open a second entrance. When circumstances permit the opening of a second entrance, both will be manned by Porters and where possible by a Policeman. The **Porter's Action List** forms **Appendix Q-16** to this Plan.

## **6 Security**

- 6.1 The Duty Porter will be responsible for ensuring that all entrances to the hospital are locked, and that, to prevent unauthorised access by that route, the exit point from the A & E reception/treatment area is secured.
- 6.2 All staff have a duty to ensure, as far as possible, that only people with a bona-fide reason are allowed to remain on Hospital premises. In case of difficulty, a Police Officer should quickly be available, via the Hospital Control Centre or the Reception Area.

## **7 Reception Triage**

- 7.1 At the Gilbert Bain Hospital, triage and initial documentation of casualties will be undertaken in the area immediately inside the main entrance (See ground floor plan, **Appendix F-2**), i.e. Accident and Emergency Reception.
- 7.2 Triage will be supervised by a Casualty Receiving Officer nominated by the Hospital Medical Controller after consultation with the Duty Consultant Surgeon. Until relieved by the nominated Casualty Receiving Officer, triage will be performed by the Duty Junior Doctor assisted by any other available Doctor.
- 7.3 The Duty Junior Doctors' (Surgical and Medical) Action Lists are annexed as **Appendix Q-7**.
- 7.4 An Action List for the Consultant Surgeons will be found in **Appendix Q-5**.



## 8 Medical Records Reception

- 8.1 A revised 'Casualty Registration Form' (i.e. Major Incident Casualty Card) has been introduced and will be used in all major emergencies.
- 8.2 Medical Records registration point will be situated, along with triage, at the Accident and Emergency reception point immediately inside the main entrance (See ground floor Plan, **Appendix F-2**).
- 8.3 Not less than two clerical assistants, drawn from the staff of the Medical Records offices, will be provided by the Medical Records Officer, and will undertake medical registration duties as detailed on the Action List, **Appendix Q-17**.
- 8.4 On arrival at hospital, casualty documentation will be raised on all casualties - whether with major, minor or no physical injuries - irrespective of whether they have been labelled and documented at the site of the emergency.

## 9 Major Incident Casualty Cards

- 9.1 Major Incident Casualty Cards are produced in 'sets' of three on NCR (no carbon required) paper, backed onto a white folder. The first copy is coloured (Blue), the second copy (Green), the third copy (Pink), backed by a four page (White Card Folder). A sample of the Major Incident Casualty Card will be found in **Appendix F-3**.
- 9.2 Major Incident Casualty Cards will be completed and routed as follows:
  - (a) on admission of the patient, Sections 1, 2 and 3 will be completed as far as circumstances allow;
  - (b) if the patient is unconscious Section 4 is also to be completed in the presence of a Police Officer;
  - (c) sections 1, 2 and 3 having been completed as far as possible, the copies two (Green) and three (Pink) will be detached and delivered immediately to the Hospital Control Centre;
  - (d) copy three (Pink) will be given to the Police Liaison Officer to support 'Police Casualty Bureau' documentation;
  - (e) remaining copies **MUST** stay with the patient;
  - (f) copy one (Blue) and the (White Folder) will be completed during processing of the patient in the Accident and Emergency area;

- (g) on exit from the Accident and Emergency area copy one (Blue) will be detached from the (White Folder) and delivered to the Hospital Control Centre to 'marry-up' with copy two (Green). The (White Folder) will accompany the patient to the Ward. If the patient is to be discharged from hospital at this stage, the (White Folder) is to be returned along with copy one (Blue) to Hospital Control.
- (h) by 'marrying' copies one (Blue) and two (Green), the Hospital Control Centre will be able to check that all patients have been properly processed and accounted for. At this stage copies one (Blue) and two (Green) will be stapled together and retained as Control's 'Master' record.

9.3 **Appendix F-4** illustrates the movement of Major Incident Casualty Cards detailed above.

## **10 Unidentified Casualties**

- 10.1 In the event of a patient's identity not being established for whatever reason, Section 4 of the Major Incident Casualty Card will be completed on admission by the Medical Registration Team but with the assistance of an attending Police Officer.
- 10.2 Major Incident Casualty Cards for unidentified casualties will be routed in the same way as previously described.

## **11 Stocks of Major Incident Casualty Cards and Information Forms**

- 11.1 Sets of Major Incident Casualty Cards and Information Forms, ready for immediate use, will be retained at the following locations:
  - (a) Hospital Reception (for Accident & Emergency Reception Point)
  - (b) Hospital Control Centre (for Resuscitation and Treatment Rooms)

## **12 Supplies of Major Incident Casualty Cards and Information Forms**

- 12.1 The Medical Records Manager will be responsible for ensuring that stocks of Major Incident Casualty Cards and Information Forms are maintained at an adequate level, and that each of the locations listed in Para 10.1 above is pre-supplied with pads, ready for immediate use in an emergency.

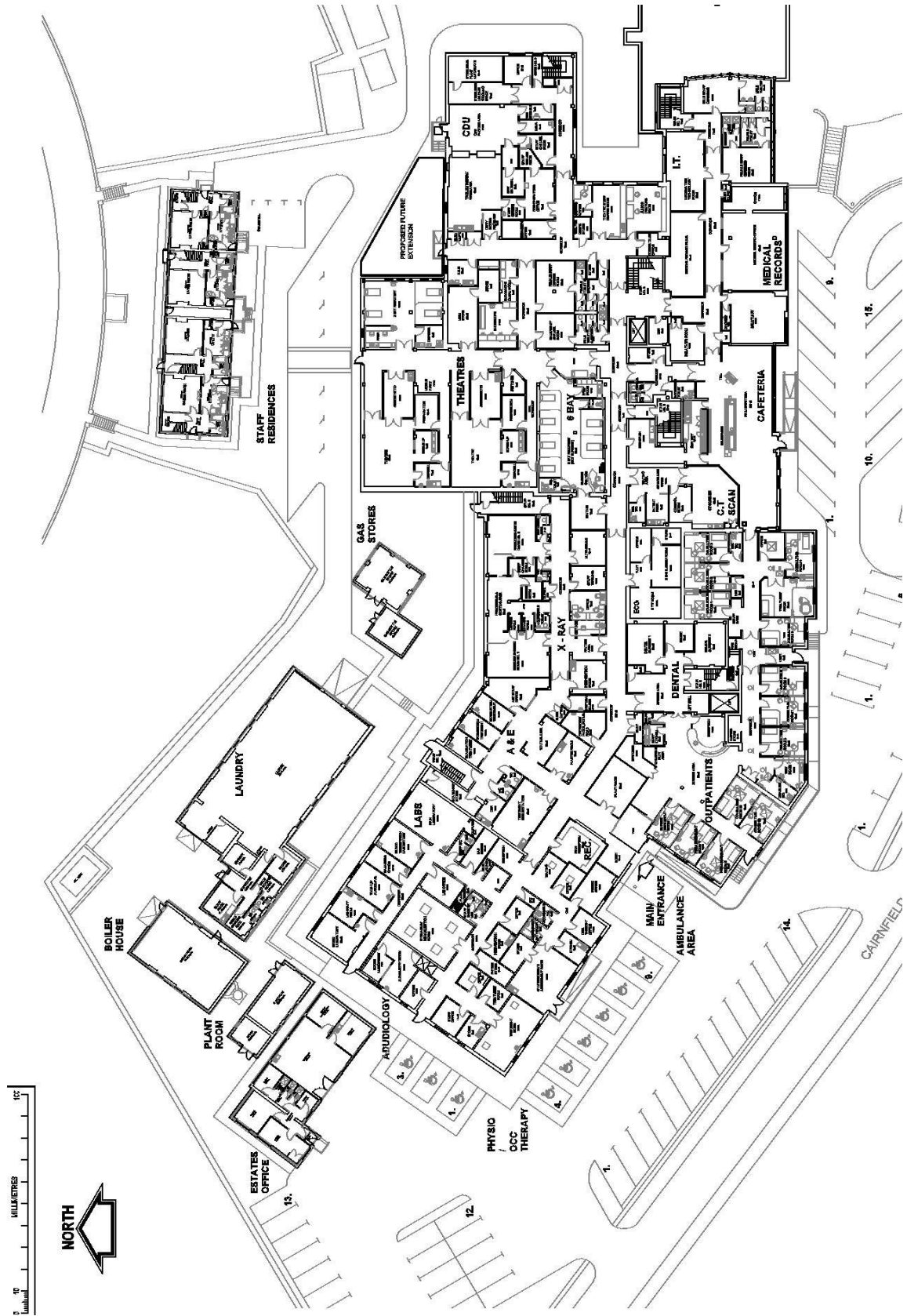
**Appendix F-1 – Sample "Information on Emergency Patients for A&E Dept".**

<b>SHETLAND HEALTH BOARD</b>					
<b>INFORMATION ON EMERGENCY PATIENTS FOR A &amp; E DEPT</b>					
AGE	SEX	LEVEL OF CONSCIOUSNESS			
		A	V	P	U
Nature of Incident					
Illness / Injury					
Vital Signs	Pulse	Respiration	Blood Pressure		
Complications					
Treatments & Additional Information					
<b>ETA</b>	___ : ___ Hrs	<b><u>Message Timed At</u></b> ___ : ___ Hrs			

To be completed by Reception and passed to A&E by fastest possible means



**Appendix F-2 – Ground Floor Plan, Accident & Emergency**





**Appendix F-3 – Sample "Major Incident Casualty Card"**

**MAJOR INCIDENT CASUALTY CARD**

Hospital Casualty No. \_\_\_\_\_  
Date ..... Time .....

[ 1 ] CASUALTY CONSCIOUS [ ] UNCONSCIOUS [ ]

FAMILY NAME ..... FORENAME(S) .....

SEX: [ ] M [ ] F [ ] UNKNOWN AGE ..... DOB .....

ADDRESS .....

RELIGION ..... NATIONALITY .....

[ 2 ] NEXT OF KIN  
NAME & ADDRESS ..... Tel No. ....

**GENERAL PRACTITIONER**  
NAME & ADDRESS ..... Tel No. ....

[ 3 ] IDENTIFICATION YES [ ] NO [ ]  
[ ] SELF [ ] OTHER PERSON (Specify) .....  
[ ] OTHER (Specify) .....

[ 4 ] DETAILED DESCRIPTIVE : UNCONSCIOUS CASUALTY ONLY

Build: \_\_\_ Fat \_\_\_ Heavy \_\_\_ Stocky \_\_\_ Medium \_\_\_ Slim \_\_\_ Thin \_\_\_ Other (specify) \_\_\_\_\_

Hair Colour: \_\_\_ Dk Brown \_\_\_ Lt Brown \_\_\_ Black \_\_\_ Fair \_\_\_ Blonde  
\_\_\_ Grey \_\_\_ White \_\_\_ Ginger \_\_\_ Auburn \_\_\_ Other (specify) \_\_\_\_\_

Hair Type: \_\_\_ Bald \_\_\_ Thinning \_\_\_ Receding \_\_\_ Straight \_\_\_ Curly \_\_\_ Wavy \_\_\_ Dyed  
\_\_\_ Wig \_\_\_ Short \_\_\_ Collar Length \_\_\_ Shoulder Length \_\_\_ Very Long \_\_\_ Other (specify) \_\_\_\_\_

Eyes: \_\_\_ Blue \_\_\_ Brown \_\_\_ Hazel \_\_\_ Green \_\_\_ Grey \_\_\_ Cast \_\_\_ Staring \_\_\_ Other (specify) \_\_\_\_\_

Complexion: \_\_\_ Fresh \_\_\_ Pale \_\_\_ Ruddy \_\_\_ Tanned \_\_\_ Fair \_\_\_ Spotted \_\_\_ Other (specify) \_\_\_\_\_

Facial Hair: \_\_\_ Beard \_\_\_ Moustache \_\_\_ Bushy Eyebrows \_\_\_ Long Sideburns \_\_\_ Other (specify) \_\_\_\_\_

Glasses: \_\_\_ Yes \_\_\_ No \_\_\_ Dont Know \_\_\_ Contact Lenses Use: \_\_\_ Worn All The Time \_\_\_ Limited Wear ( e.g. Reading Only )

Marks/Scars/Tattoos/Peculiarities/Abnormalities ( Specify location on body and approx. size ) \_\_\_\_\_

Jewellery ( List and describe only if unusual ) eg. Bracelet, brooch, earrings, neckchain, pendant, pin, ring, watch, other. \_\_\_\_\_

Other: \_\_\_\_\_

Personal effects ( To include pocket contents and documentation and show location on person ) \_\_\_\_\_

**Copy No 1 to be Blue**  
**Copy No 2 to be Green**  
**Copy No 3 to be Pink**  
**Copy No 4/Folder to be White**

Recorder's Signature .....

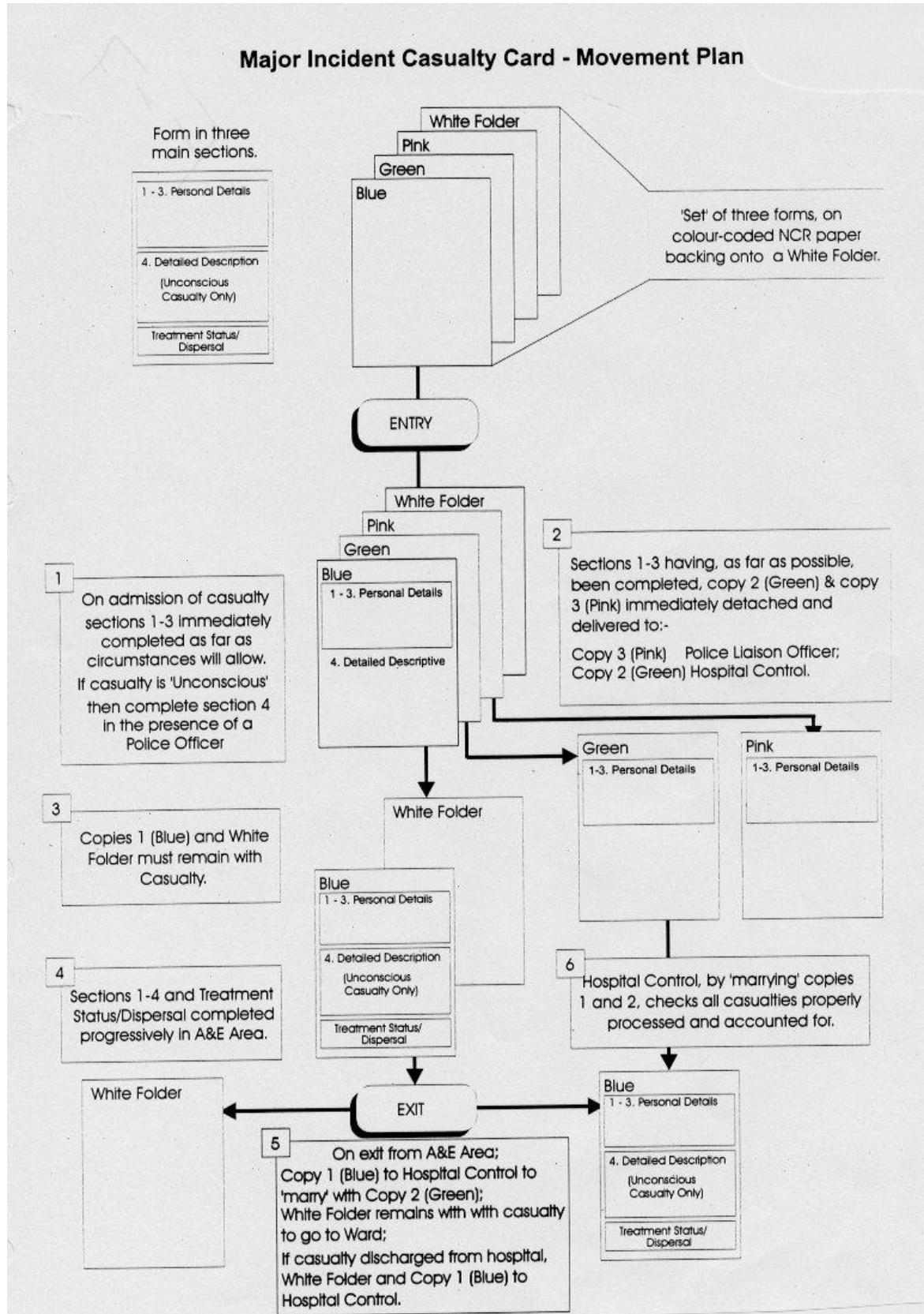
<b>TREATMENT STATUS</b> <input type="checkbox"/> IMMEDIATE <input type="checkbox"/> URGENT <input type="checkbox"/> NON-URGENT <input type="checkbox"/> DEAD <small>Please tick appropriate box</small>	<b>PATIENTS SOCIAL NEEDS ASSESSED?</b> <table border="1" style="margin: auto;"> <tr> <td style="padding: 5px;">YES</td> <td style="padding: 5px;">NO</td> </tr> </table> Delete as applicable	YES	NO	<b>DISPERSAL</b> <input type="checkbox"/> DISCHARGED <input type="checkbox"/> ADMIT WARD ..... <input type="checkbox"/> ATTEND CLINIC <input type="checkbox"/> MORTUARY
YES	NO			

Blue: To be given to Medical Records Officer on patients discharge from A&E  
Green: To be given to Medical Records Officer on completion  
Pink: To be given to Police on completion  
White & Folder: To accompany patient to Ward, normal documentation will apply





**Appendix F-4 – Movement Plan – Major Incident Casualty Card**





**Part G – Finance**

**1 Introduction**

- 1.1 In reacting to a major emergency, it is likely that Shetland NHS Board but more specifically the Gilbert Bain Hospital will incur significant additional costs. Because such incidents cannot be foreseen, and so cannot be allowed for in the normal budgetary process, it is essential that, as far as practicable, exceptional expenditure is accurately identified and properly accounted for.
- 1.2 A cost centre for major emergencies has been created which will be made available if a major emergency is declared formally. 10 purchase order numbers have been generated which would be chargeable to the major emergency cost centre. The Senior Manager on call is authorised to use these to obtain goods or services out of hours or at short notice if the supplier insists on a purchase order. These are kept in a sealed envelope marked SMT on-call in the emergency box in GBH.
- 1.3 The Senior Manager on call is thereafter responsible for supervising the financial management of the incident in terms of the Board's financial policies and regulations, liaising with the Board's Finance Manager if available.



## Part H – Media & Other Enquiries

### 1 Introduction

- 1.1 Almost any major incident will generate media interest, on a national and even international scale. Media handling on both local and national levels must be seen as an integral part of emergency planning because:
- The media will be used as the main channel for communicating with the public. The Board will be required to utilise the media for information dissemination at each stage of an incident.
  - Local media will play a key role in message dissemination where an incident is localised
  - The national media reach millions of people and it is therefore important to ensure they have accurate and timely information.
- 1.2 The Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Regulations 2005 require that there should be provision for public warning and informing and advising the public before, during and after an emergency.
- 1.3 It is vitally important that the arrangements made by individual responders complement those of their partners and are integrated with the overall management arrangements. Co-ordinated public warnings, advice and media services will enhance public safety and promote confidence and reassurance within the affected community.
- 1.4 If a Casualty Bureau is established there will be a requirement to liaise, via the Hospital Control Centre with the Police, who will wish to be advised of all next-of-kin reporting to the Hospital Information Centre
- 1.5 On behalf of NHS Shetland, the Chief Executive (or Senior Manager on call in the absence of the Chief Executive) will act as, or nominate, a Press Officer. The Press Officer will be responsible for all contacts with the media, and for dealing with all enquiries from press, radio, television and, along with the staff of the Hospital Information Centre, from relatives and friends of survivors, and from the general public. The Chief Executive's Action List is detailed in **Appendix Q-2**.
- 1.6 A pro-active media policy will apply, so that not only are arrangements made to provide regular and accurate news briefings but also that the media is used in a positive way as part of the emergency response.

- 1.7 A Service Level Agreement exists between Shetland Islands Council (SIC) on behalf of Shetland Emergency Planning Forum (SEPF) and Shetland Islands Broadcasting Company (SIBC) for the purpose of broadcasting urgent messages to the public during periods of disruption to normal life within Shetland. Details are annexed at **Appendices H-3 to H-6**.
- 1.8 Membership of SEPF includes SIC, NHS Shetland, Northern Constabulary, Highland & Islands Fire Brigade, Scottish Ambulance Service and Maritime and Coastguard Agency.
- 1.9 BBC Radio Shetland is also available to broadcast information or requests to the public should this be required.

## **2 Media Enquiries**

- 2.1 Experience suggests that a major incident in Shetland is likely to attract 200 - 600 reporters, including a large number of television teams.
- 2.2 Arrangements have been made via Shetland Emergency Planning Forum for Shetland Islands Council, acting on behalf of all the services and organisations involved, to arrange press conferences (**Appendix H-1**). Details of the agreement, including means of activating it, are contained in **Appendix B-5 of the SIC Emergency Plan**, but for ease of reference can be summarised as:
- (a) starting as soon as practicable, press conferences will be held at times mutually agreed with the press
  - (b) each service or organisation will, if possible, be represented at each formal press conference, which will be chaired by the lead agency
- 2.3 Up to date information with regard to the BBC initiative Connecting in a Crisis can be found on their website, details are appended at **Appendix H-2**.

## **3 Ad-Hoc Arrangements**

- 3.1 During any emergency there may be a requirement to hold ad-hoc briefings for the members of the Press. The Board Chief Executive, or nominee, will decide who is to give the briefings and where the briefings are to be held.
- 3.2 In order to maintain security within the Hospital, the principle of taking the spokesperson to the Press should be observed.

## **Appendix H-1 – Press Conferences**

### **1 Introduction**

- 1.1 Experience suggests that a major incident in Shetland is likely to attract a large number of reporters, including television teams, and that they will wish to be located as near the centre of operations as possible. The consensus is that it would be futile to arrange press conferences or briefings for a location other than one a very short distance from the scene of action.

### **2 Arrangements**

- 2.1 On behalf of all the services and organisations involved, the venues of press conferences and the provision of essential items of equipment will be arranged by Shetland Islands Council.
- 2.2 Arrangements can be activated by contacting the Duty Emergency Planning Officer either through Hospital Reception and/or, out of hours, through the Police Station.

### **3 Equipment**

- 3.1 On behalf of NHS Shetland the Senior Manager on Call will action facilities requirements for the media, this is detailed in the action list attached at **Appendix Q-27**.
- 3.2 If required, National Emergency Linkline can be contacted 24 hours a day for the installation of additional lines. Their contact details are held in Hospital Reception. Media requirements will only be treated by BT as a priority if specifically asked for by the Emergency Services.

### **4 Press Conferences and Briefings**

- 4.1 As soon as practicable, the press should be provided with a list of current 'contact' numbers (e.g. police press liaison officer).
- 4.2 To meet local/national reporting 'deadlines' it is recommended that, starting as soon as practicable after the emergency services have met the initial demands placed on them by the nature of the incident, formal press conferences be held by mutual arrangement between the lead agency and representatives of the media.
- 4.3 Less formal, one to one, press briefings can also be arranged via the information desk, when established.

- 4.4 Each of the services/organisations involved in the emergency should, if possible, be represented at press conferences and should contribute appropriate items for each press briefing. **Press conferences will be chaired by the senior representative of the lead agency.**
- 4.5 Subject to the media policy of each service or organisation, all practical steps must be taken to ensure that information released via the media forms a coherent whole, particularly as regards such fundamental items as casualty numbers, names/address, times, dates, places, flight numbers and routes, **and that all relevant material has, before release, been properly 'cleared' (e.g. in the case of every fatal accident, by the Procurator Fiscal).**
- 4.6 In line with NHS Shetland Board policy, members of staff will not deal with the media unless under direct instruction from the Chief Executive or a nominated Press Officer. All enquiries will be passed to the Chief Executive or nominated Press Officer to be dealt with.



## **Appendix H-2 – Connecting in a Crisis**

### **1 A Guide to Working with BBC Scotland in an Emergency**

- 1.1 'Connecting in a Crisis' is an initiative by the BBC to help ensure that the public has the information it needs and demands during a civil emergency. It sets out to encourage emergency planners to work more closely with broadcasters in the preparation of strategies for communicating essential information.
- 1.2 The on-line guide explains how to access the range of communication outlets offered by the BBC at local, regional and national level. It identifies key information needs and the logistical issues that must be tackled to meet those needs, as well as highlighting good practice and innovative partnership ideas from around the UK.

<http://www.bbc.co.uk/scotland/aboutus/ciac/>



**Appendix H-3 – Radio Shetland & Radio Orkney**

**1 Standing Arrangements**

- 1.1 On behalf of Shetland Emergency Planning Forum, standing arrangements for the broadcasting of emergency announcements have been made with the Senior Producers of both BBC's Radio Shetland and Radio Orkney.
- 1.2 Although the local stations do not transmit locally-originated programmes for 24 hours a day, the local Senior Producers have the authority and facility to broadcast local material on the station transmitters at any time to meet local contingencies.
- 1.3 The local station will also be responsible, unless agreed otherwise at the time of the request being made, for contacting the relevant BBC Regional Centre so that consideration can be given to the need for a national or regional radio or television announcement directing public attention to the locally-broadcast information.
- 1.4 Both Radio Shetland and Radio Orkney broadcast on frequency 92.7.
- 1.5 The local stations are normally staffed on week-days between:
  - (a) Radio Shetland: 0930 - 1830 Summer  
0930 - 2000 Winter
  - (b) Radio Orkney: 0630 - 1800
- 1.6 Apart from its advertised telephone number of 01595 694747 (linked to an answering machine), Radio Shetland has two ex-directory telephone numbers which are held by Hospital Reception staff in their Contact List.



## **Appendix H-4 – Shetland Islands Broadcasting Company Ltd. (SIBC)**

### **1 Introduction**

- 1.1 Shetland Islands Council, on behalf of the Shetland Emergency Planning Forum, have entered into a Service Level Agreement with SIBC Ltd. for the purpose of broadcasting urgent messages to the public during periods of disruption to normal life within Shetland.
- 1.2 There will be two distinct types of service, namely:
- A message service linked directly to a major disruptive challenge to the community which is being co-ordinated from an Integrated Emergency Control Centre (hereafter referred to as IECC), and
  - A routine emergency message service announcing, e.g. school closures, ferry cancellations and bad weather.
- 1.3 The main subject of the agreement is the support given in the aftermath of a major disruptive challenge to the community. Any such incident will be co-ordinated by an IECC. Messages will be co-ordinated through the IECC and passed to SIBC for broadcasting verbatim. These messages will be delivered to SIBC for immediate broadcast, subject to the company's ability to interrupt normal programming and/or at the next normal news broadcasting time. An agreed format for these messages is appended at **Appendix H-5** as SIBC Form A.
- 1.4 'Out of hours' access to SIBC staff for emergency messages will be via the SIC Duty Emergency Planning Officer who maintains a record of the necessary contact details.
- 1.5 The routine emergency broadcast facility currently provided to SEPF members is to continue as now. These messages are to be generated by individual agencies or Council Departments, attributable to an authorised individual and presented in the format appended at **Appendix H-6** as SIBC Form B.
- 1.6 These messages do not qualify for calling SIBC staff 'out of normal hours', but should be delivered to SIBC by fax preferably, or by telephone, as early as possible on the day of broadcast. Should the information be available earlier, i.e. that a school is to be closed the next day, early notification to SIBC would be appreciated.
- 1.7 Messages of a routine emergency nature will be subject to the charges currently applying and invoiced directly to the originating agency or Council Department.
-



Appendix H-5 – SIBC Form A

<p><b>Shetland Emergency Planning Forum</b> <b>Integrated Emergency Centre Broadcast</b></p>			
<p>Date and Time of Production: _____</p>			
<p>Author's Name (Capitals): _____</p>			
<p>Authorised Signatory: _____</p>			
<p>Broadcast (please tick box):</p>	<p>ASAP:</p>	<input type="checkbox"/>	<p>Next News Broadcast:</p>
<p>Message:</p>			
<p>When Completed:</p>			
<p>Fax to SIBC: 01595 695696 / Telephone: 01595 695299 / Deliver by Hand</p>			
<p>SIBC Only</p>	<p>Use</p>	<p>Time Received:</p>	<p>Time First Broadcasted:</p>





**Appendix H-6 – SIBC Form B**

<b>Shetland Emergency Planning Forum</b> <b>URGENT - Agency/Council Department Broadcast</b>						
<b>Agency/Council Department:</b> _____						
<b>Date and Time of Production:</b> _____						
<b>Author's Name (Capitals):</b> _____						
<b>Authorised Signatory:</b> _____						
<b>Broadcast (please tick box):</b>	<b>ASAP:</b> <input style="width: 40px; height: 20px; border: 2px solid black;" type="checkbox"/>	<b>Next News Broadcast:</b> <input style="width: 40px; height: 20px; border: 2px solid black;" type="checkbox"/>				
<b>Message:</b>						
<b>When Completed:</b> <b>Fax to SIBC: 01595 695696 / Telephone: 01595 695299 / Deliver by Hand</b>						
<b>SIBC Only</b>	<b>Use</b>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;"><b>Time Received:</b></td> <td style="width: 50%; padding: 5px;"><b>Time First Broadcasted:</b></td> </tr> <tr> <td style="width: 50%; padding: 5px;"><b>Invoice To:</b></td> <td style="width: 50%; padding: 5px;"><b>Invoice Sent:</b></td> </tr> </table>	<b>Time Received:</b>	<b>Time First Broadcasted:</b>	<b>Invoice To:</b>	<b>Invoice Sent:</b>
<b>Time Received:</b>	<b>Time First Broadcasted:</b>					
<b>Invoice To:</b>	<b>Invoice Sent:</b>					



## **Part I – Exercises and Testing**

### **1 Introduction**

- 1.1 To remain effective, the terms of each emergency plan must be regularly reviewed and, where appropriate, tested.

### **2 Exercises**

- 2.1 A minimum of two exercises will be held each year.
- 2.2 Where appropriate, advantage will be taken of major exercises mounted by individual services or organisations, or collectively via the Shetland Emergency Planning Forum, in order to test all or parts of this Emergency Procedure.
- 2.3 The tests of the alerting procedure, and the degree of participation in major exercises, will be the responsibility of the Director of Public Health (DPH).

### **3 Exercise Evaluation**

- 3.1 After each test or exercise the DPH will call for reports from each of the principal participants, and in the light of these will prepare a consolidated report for submission to the Senior Management Team and subsequently the Board. In any event, the DPH will report annually to the Board, not later than the Board's September meeting, on the outcome of the reviews of major accident procedure. A report on each exercise is required by the NHS Management Executive, giving details of particular successes or difficulties experienced.

### **4 Amendments to the Plan**

- 4.1 As detailed in the Preface, the Emergency Planning Service, acting on behalf of Board Chief Executive, will invite amendments from each individual, service or organisation holding a copy of the Plan (detailed in the Distribution List prefixing this Plan). It is the responsibility of each holder to check the Part(s)/Appendices of the Plan applying to his/her area of responsibility, and notify the Emergency Planning Service of any changes required.
- 4.2 The Emergency Planning Service will collate all amendments and issue updated pages.



## **Part J – Social Care Services to Casualties, Survivors and Next-of-Kin**

### **1 Introduction**

- 1.1 Major accidents/incidents provoke extreme anxiety in the relatives of those involved. Bereavement is particularly stressful. In these circumstances the importance of social support is widely recognised, as is the need for effective pre-planning.

### **2 Children’s Services, Shetland Islands Council**

- 2.1 The Shetland Emergency Planning Forum considered the most sympathetic means by which the social needs can be met. It was agreed that the responsibility will primarily rest with Children’s & Families, Children’s Services of Shetland Islands Council, in terms of **Part 'E' of the SIC Emergency Plan** which details their Care for People Plan. The Children and Families Service will organise, in conjunction with NHS Shetland, the welfare and counselling needs of casualties, survivors and next-of-kin in and around the Hospital confines.
- 2.2 In the exercising of its role Children and Families will organise voluntary effort as the circumstances dictate and in consultation with Hospital Control call on any medical resources deemed necessary, with the aim of ensuring that next-of-kin are met, transported, escorted, accommodated, counselled and supported as their family circumstances for the time being require.

### **3 Notification**

- 3.1 The Duty Social Worker will be notified of a major emergency alert by the Receptionist, Gilbert Bain Hospital, in accordance with the Contact List held in Hospital Reception.
- 3.2 On receipt of a Major Emergency Alert, the Duty Social Worker will notify, by the fastest possible means, the Executive Manager / Chief Social Work Officer or a nominated Depute.

### **4 Executive Manager / Chief Social Work Officer**

- 4.1 On being advised of a Major Emergency Alert the Executive Manager / Chief Social Work Officer or Depute, will nominate a Social Work Liaison Officer to report to the Hospital Control Centre.

## 5 Action Lists

- 5.1 Action Lists for the Executive Manager / Chief Social Work Officer and Social Work Liaison Officer are annexed at **Appendix Q-24** and **Appendix Q-25** respectively.

## **Part K – Transport – Road & Air**

### **1 Road Transport**

- 1.1 NHS Shetland road transport is limited, but it is not thought that in the event of a major incident the carriage of supplies would present problems.
- 1.2 The surface transportation of patients may well raise difficulties, the maximum capacity of available ambulances being 5 trolleycoats and 12 walking cases.
- 1.3 As part of its remit to provide transport services in terms of **Part 'C' of the SIC Emergency Plan**, Departments within the Council may be asked to assist the Scottish Ambulance Service by providing additional vehicles and, for each, a driver and a driver's mate. On each occasion a vehicle is carrying a patient, an escort will be provided by the Scottish Ambulance Service or NHS Shetland. Requests for such transport must, in the first instance, be routed via the Hospital Control Centre to the SIC Liaison Officer at Police Incident Control.
- 1.4 Should surface transport be required for the evacuation of hospital patients, reference should be made to **Part 'E' of this Plan**, which details arrangements, procedures and requirements (eg: for medical escorts).

### **2 Air Transport**

- 2.1 Air Ambulance is organised through Ambulance Control / Emergency Medical Dispatch Centre.
- 2.2 A search and rescue helicopter, on contract to Maritime and Coastguard Agency, is based at Sumburgh Airport and may be available.
- 2.3 A helicopter for use as an air ambulance may also be obtained from HM Forces via Ambulance Control / Emergency Medical Dispatch Centre.
- 2.4 All NHS Shetland requests for air transport must be referred to the Hospital Control Centre, and they are sanctioned by the Hospital Medical Controller or a Consultant General Surgeon before being actioned.

### **3 Emergency Helicopter Landing Site**

- 3.1 The Emergency Helicopter Landing Site is situated at Clickimin and will be the primary location for casualty transfer when using a helicopter. This is co-ordinated through the Maritime and Coastguard Agency.





## **Part L – NHS 24**

### **1 Health Advice to the Public**

- 1.1 In many circumstances the general public will seek reassurance about the state of their health if they think they may have been involved in an incident.
- 1.2 NHS 24 can, if requested, establish a helpline, staff by Health Information Advisors, who can answer questions from those worried about their health – the “worried well”.
- 1.3 NHS 24 also acts as an interface between the public and NHS emergency care; undertaking telephone triage, provision of clinical advice and re-directing patients to appropriate services.
- 1.4 Any incident will affect the volume of calls from the general public before a helpline is established and even after one is in place. In addition there may be an impact on the advice given to callers about the need to contact their local GP, out-of-hours service, A&E or SAS for problems not associated with an incident.
- 1.5 Therefore, there is a need to liaise with NHS 24 at an early stage to discuss the impact on local services (including on NHS 24) and the actions to take to moderate the impacts; and to continue that liaison until stand down.
- 1.6 Depending on the nature of the incident, liaison may be Operational, Tactical or Strategic level.
- 1.7 General Points:
  - Special helplines are set up on a temporary basis to cover specific local or national situations
  - Lines cover a local or national area
  - Calls will be handled by either the North or West Centres (calls will come into Health Information Advisors only)
  - The requesting organisation will provide specific information for each of these lines in the form of “Frequently Asked Questions” and responses
  - The lines will generally run for 3-4 days depending on need
  - No call records will be created for these calls
  - If a caller appears symptomatic they will be advised to contact their own GP

### **2 NHS 24 Special Helpline**

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2.1 The NHS 24 process for establishing a Helpline and how calls are handled is detailed below. Part of the sample template is attached at Appendix L-1. The complete template is held in the Hospital Reception.

2.2 Processes:

- The decision to request a Special Helpline should be made by the Director of Public Health in consultation with the Hospital Medical Controller and the Chief Executive
- The initiating organisation should telephone NHS24 Clinical Service Manager – number is held in Hospital Reception
- NHS 24 will pass on the contact number for the Medical Director on-call, who will discuss details of the request with the initiating organisation
- If the Associate Medical Director agrees that the helpline should go ahead, they will notify Team Leader 1
- Team Leader contacts initiating organisation to ensure they have a template and contact numbers available
- The Director of Public Health will complete the template and contact numbers
- Initiating organisation will forward the completed template to [alert.helpline@nhs24.scot.nhs.uk](mailto:alert.helpline@nhs24.scot.nhs.uk) or faxed to 0141 435 3902
- Team Leader will check the completed template for operational appropriateness e.g., number of Questions and length of Answers provided
- Associate Medical Director will check the template for clinical accuracy to ensure information provided is valid and up to date
- If any changes are required the Associate Medical Director will inform the initiating organisation who will amend the template and resend
- Once the Team Leader and Associate Medical Director are completely satisfied with the completed template the Associate Medical Director will sign off for publishing

### 2.3 Call Handling

- All calls will be dealt with by Health Information Advisors
- Verbal information will be given on the specific topic (as per scripting)
- No permanent record will be created
- Completed call capture sheet, if provided, will be passed to initiating organisation
- If call is symptomatic, they will be advised to contact their own GP or other person specified by the initiating organisation. Health Information Advisors will not contact or forward calls to GP's or others on patient's behalf
- If call is not displaying symptoms and has received all information required, call is closed



**Appendix L-1 - NHS Special Helpline Sample Template**

The information provided on this form will be used by NHS 24 to support the provision of a dedicated Special Helpline. Please ensure that the information provided is complete and accurate and includes:

- Details of organisation requesting the activation of the special helpline along with 24-hour contact details for a single point of contact within the organisation with responsibility for the alert
- FAQ's and any general / background information relating to the special helpline topic which may be helpful

Please click on / tab through the grey shaded boxes and enter the required information. The fields in the form will expand to accommodate any required text. Completed forms should be returned to:

[specialhelpline@nhs24.scot.nhs.uk](mailto:specialhelpline@nhs24.scot.nhs.uk) or faxed to 0141 435 3902

NHS 24 - The following information should be used to answer any public enquiry calls to the following Special Helpline which has been activated in response to a Health Alert.

Title of Special Helpline	

Dates of Helpline Operation			
Date of activation		Date of expiry (anticipated)	

Health Alert Details	
Affected/target population	
Geographical area affected	

General / Background Information

FAQs

Date of Issue	
Time of Issue	



**Part M – Police Liaison, Mortuary Services and VIP Visits**

**1 Police Liaison Officer and Casualty Documentation Team**

- 1.1 As soon as practicable after a major incident has been declared, and where circumstances dictate, the Police Incident Officer will arrange for a casualty documentation team to be sent to the Gilbert Bain Hospital.
- 1.2 The senior member of the documentation team will act as Police Liaison Officer and will be responsible for:
- (a) providing a link between the Hospital Control Centre and the Police Incident Control Room
  - (b) obtaining personal particulars of all casualties admitted to the hospital by reference to the (Pink) copy of the Major Incident Casualty Card which will be filed in the Hospital Control Centre. This information will be transmitted to the Police Incident Control Room
  - (c) assisting the Medical Registration Team to complete Section 4 of the Major Incident Casualty Card for Unconscious Casualties
  - (d) providing suitable assistance, as necessary, to hospital personnel engaged in hospital security duties

**2 Mortuary Services**

- 2.1 In the event of a major incident, the responsibility for arranging mortuary facilities rests with the Police Incident Officer.
- 2.2 The selection of such a mortuary will depend on the size and location of the incident.
- 2.3 Fatally injured victims will be conveyed direct to the mortuary. In instances where casualties are found to be dead on arrival at hospital or die following admission, the Police Liaison Officer will be informed as soon as possible and arrangements will be made with the Hospital Control Centre to transfer the body to the Incident Mortuary.

### 3 VIP Visits

3.1 As an aftermath of a major disaster, NHS Shetland should be prepared for members of the Royal Family, Ministers and/or Members of Parliament to wish to visit casualties in hospital and to meet people involved in dealing with the emergency. The overall co-ordination of such visits will be undertaken by the Police. The Board, via the Hospital Medical Controller, will be responsible for ensuring that the:

- (a) informed consent of individual patients is obtained both to:
  - (i) their meeting the VIP
  - (ii) any consequent publicity
- (b) needs of clinical confidentiality are observed



## **Part N – Post-Incident Requirements**

### **1 Introduction**

- 1.1 At the conclusion of an incident all supervisors will take action as outlined below.

### **2 Debrief**

- 2.1 Internal and multi-agency debriefing is seen as best practice and should be carried out at the earliest opportunity. Results from internal debriefs should inform the multi-agency debrief. Debriefing of all those involved in responding to a Major Civil Incident has several important functions:

- (a) to identify both the effective and less effective elements of the response and to “learn the lessons”. Where appropriate the plan can be re-written to incorporate the improvements
- (b) to allow participants to express a range of opinions, some of which will be relevant to the planning process
- (c) to inform a formal Incident Enquiry

- 2.2 It is the Director of Public Health’s responsibility to ensure that a debrief happens.

- 2.3 All participants should be invited to comment both verbally, soon after the conclusion of the Incident, and in writing at a later date. Verbal debriefing is best undertaken in the small groups who worked together on the response.

- 2.4 Each debrief should be facilitated by someone not directly involved in that group’s response. It should result in a written report. All such reports should be passed to the Chief Executive. The CE should prepare a formal report to the Health Board and Scottish Executive.

- 2.5 The log, additional notes and de-brief report may be used in a formal enquiry.

### **3 Reports**

- 3.1 Major emergency reports will be compiled under the direction of the Director of Public Health following the de-briefing procedure detailed above. Reports will, in the first instance, be submitted to Shetland NHS Board and thereafter (having been expanded to take account of any Board requirement(s)), to the NHS Management Executive.

### **4 Formal Inquiry**

- 4.1 Any Major Incident may result in criminal or civil proceedings and / or a Fatal Accident, Public Enquiry or similar (Health & Safety Executive, Royal Commission etc). The log, additional notes, debrief reports, statements made to Police or Health & Safety etc. may be used as evidence and individuals called as witnesses.
- 4.2 If such an enquiry is likely then potential witnesses are advised to prepare and retain their own written report as well as submitting one for the internal debrief.
- 4.3 Professional organisations, Unions, Medical Defence bodies etc. can provide additional advice and may provide legal support if necessary.

## **5 Stress**

- 5.1 The potential needs of both casualties and staff for stress and trauma counselling must be remembered.
- 5.2 The provision of breaks, variation of duties or avoidance of long shifts, if possible, can reduce staff stress during an incident.
- 5.3 The provision of post-incident stress and trauma counselling may aid recovery in some circumstances for both casualties and staff. However, this should not be automatically arranged. Staff and casualties should be made aware that they can access counselling if they want. Managers should also be prepared to refer staff (with agreement) if they think this is indicated. Normal referral arrangements should apply within the Board's Occupational Health procedures.

## **6 Re-Stocking**

- 6.1 While it is hoped that stocks will be replaced almost as they are used, it is accepted that in the case of some items of equipment and 'consumables' this will not be possible. In these circumstances it is essential that supervisors ensure that deficiencies are quickly established and stock replenished as soon as possible after the incident, and in any case within twelve hours of the formal stand-down. Should by this limit there still be stock deficiencies, all shortages will be formally notified, via normal channels, to the Chief Nurse, Acute Services for clinical supplies and Facilities Manager for hotel services supplies.

## **Part O – Chemical and Biological Hazards**

### **1 Chemical Hazards**

1.1 The Fire & Rescue Service will identify hazardous chemicals spilled from road, rail tankers etc. or released during a fire. They will also provide an initial indication of the specific hazards. However, they do not have laboratory chemical analysis facilities. General guidance for responding to Incidents involving potentially hazardous chemicals is:

- Stay upwind
- Stay uphill
- Do not enter the area until the Fire and Rescue Service gives permission
- Take precautions as advised by the Fire and Rescue Service

### **2 Biological Hazards**

2.1 Numerous viruses, bacteria and other organisms can endanger health. The majority are naturally occurring, either within this country or overseas.

2.2 The speed of international travel means that most infectious diseases acquired abroad can present for diagnosis in this country.

2.3 The mainstay in preventing the spread of “exotic” diseases is awareness, among clinicians, of unusual diseases presenting locally and enhanced surveillance for increases in unusual presentations of disease or higher than expected levels of disease.

2.4 Reference should be made to the appropriate plan, e.g., Outbreak Control Plan, Pandemic Influenza Plan, and the SARS Plan for general guidance on managing outbreaks.

Advice on chemical, radiological and biological agents can be obtained from Health Protection Scotland:

Tel: 0141 300 1100

Fax: 0141 300 1170

[www.show.scot.nhs.uk/enviro/cbrn.aspx](http://www.show.scot.nhs.uk/enviro/cbrn.aspx)

Health Protection Agency web site [www.hpa.org.uk/Topics/](http://www.hpa.org.uk/Topics/)

### 3 Contamination

- 3.1 Individuals may be contaminated with chemicals, biological agents or radioactive material, either intentionally, “accidentally” or as part of a hoax.
- 3.2 Any person known or suspected of being contaminated should be decontaminated at the scene of the incident. Treatment, transport and admission to hospital of contaminated people risks additional contamination of staff, vehicles and buildings.
- 3.3 If potentially contaminated people arrive at a hospital they should not be admitted, nor treated, until a risk assessment has been undertaken and appropriate protection is available for staff and facilities.
- 3.4 Only individuals known to be minimally contaminated with an identified substance that can be easily removed and carries minimal risk to others and the local environment should be considered for treatment and admission prior to decontamination; and only if their clinical condition requires urgent management and if they can be treated in a segregated area.
- 3.5 The hospital has been supplied with a portable decontamination tent and personal protective equipment for staff. These resources are intended for use by casualties who leave (self-evacuate) the incident scene before it is fully controlled; or by casualties who have been decontaminated at the site but where it is realised in transit that there is residual contamination.
- 3.6 The prime responsibility of both Scottish Ambulance Service and Highlands and Islands Fire and Rescue Service decontamination teams is decontaminating casualties at the incident scene. They will only undertake decontamination at a hospital if the hospital is the incident site or if their prime responsibility has been discharged.
- 3.7 Decontamination by Scottish Ambulance Service or by hospital teams will only deal with recognisable skin contaminants. Substances may be adsorbed or ingested and subsequently eliminated from the body in breath, sweat, urine or faeces. Residual skin contamination by radioactive substances may be detectable but there is limited ability to detect residual chemical contaminants and practically no ability to detect biological contaminants. It should be assumed that casualties may continue to pose a risk to others and their environment unless there is certainty that the contaminant has been removed.
- 3.8 A Scottish Ambulance Service Special Operations Response Team (SORT) is based in Aberdeen. If decontamination of casualties is required they can use the air ambulance facilities to come to Shetland and assist in the response.
- 3.9 Stockpiled pharmaceuticals and equipment have been established for dealing with CBRN incidents anywhere in the UK. They can be accessed through the Scottish Ambulance Service West CCC on **03333 990119**.

## **Part P – Radiation Incidents**

### **1 Introduction**

- 1.1 The procedures outlined in this document are for admission and treatment of radiation casualties. These include those who may be contaminated with radioactive material, and those who may have been exposed to a significant dose of ionising radiation.

### **2 Radiation Hazards**

- 2.1 For practical purposes, two types of radiation hazard exist.
- (a) The first hazard is from contamination with a radioactive source which is unsealed. This may be in solid, liquid or gaseous form and may contaminate not only the patient's skin and clothes, but also get into eyes, nose, mouth, be swallowed or inhaled. In addition the patient may spread radioactivity on to his/her surroundings, including those persons in attendance. Treatment of life-threatening injury should take priority. However, if the patients' life is not in immediate danger, the priority is to remove the radioactive contamination.
  - (b) The second hazard arises from exposure to X-rays from an X-ray machine or gamma ( $\gamma$ )-rays (electromagnetic radiation) or neutrons from a neutron generator or a radioactive source. In this case damage can only be inflicted during the actual exposure and after moving the patient from the source of radiation the only treatment possible is symptomatic e.g: treatment of resulting skin burn.
- 2.2 In both cases there will probably be no symptoms at the time of exposure (if there are, this indicates very severe exposure). Symptoms may not develop for 1-3 weeks, and all cases should be treated as potentially serious. If the patient has been working with radiation he/she should know what type is involved and the approximate dose, therefore ask.

### **3 Categories of Radiation Casualties**

3.1 Radiation casualties fall into two categories:

#### **Category A - May be Contaminated**

Those who have, or may have, been in contact with unsealed radioactive materials or a damaged radiation source and consequently may have become contaminated with such material.

Such persons must be admitted through the A & E entrance of the Gilbert Bain Hospital after initial preparatory procedures have been initiated.

#### **Category B – Exposed but not Contaminated**

Those who have, or may have, been subjected to excessive local or whole body radiation exposure, but have not been in contact with open radioactive material.

Such persons may be admitted through normal A & E Department procedures.

3.2 Persons in either of these groups may or may not have also suffered injuries which make other medical attention necessary. If such additional injuries are severe any necessary medical treatment for them may take precedence over decontamination or treatment for excessive exposure.

3.3 Clinicians in the A & E Department will decide whether medical treatment should take precedence.

### **4 Receiving Reports of Radiation Casualties**

4.1 If a report of a radiation casualty is received from any source every effort should be made to find out whether this comes into Category A or Category B above so that the correct procedure can be followed.

4.2 Two important rules in this context are:

(a) Exposure to X-rays or sealed sources of radioactivity can never normally lead to radioactive contamination of the individual concerned. Examples of such sources are:

- Hospital X-ray Machines
- Industrial X-ray Machines
- Sealed Radiotherapy Implants
- Sealed Radionuclide sources (e.g. Industrial Radiography, Well Logging)

- (b) When an incident is initially reported by a third party the distinction between overexposure and contamination is seldom appreciated. It is common either for no information to be given or for the report to indicate contamination even where later information shows that the actual incident can only have led to overexposure.

The term 'over exposure' is often misinterpreted even if the distinction between 'over exposure' and 'contamination' is made, particularly in industry. Over exposure is often referred to as exceeding statutory dose or dose rate limits, particularly the latter. Careful questioning should establish, if known, the source material, size of source and distance from the source. This will allow the Radiation Protection Adviser (RPA (ARI)) to estimate the dose even though the RPA may be in Aberdeen. The statutory limits are orders of magnitude less than what would constitute a real over exposure in medical terms.

In any case of doubt it should be assumed that a radiation casualty is contaminated and comes into Category A (may be contaminated) until it has been conclusively shown either by accurate reports of the incident or by full scale monitoring, that this is incorrect.

- 4.3 On receipt of a report of a radiation casualty, the A & E Department and the Senior duty radiographer and appointed local Radiation Protection Supervisor must be contacted immediately.

#### 4.4 **History Taking**

When measures to alert personnel and admit the patient have been initiated, further information should be sought about the incident giving rise to the exposure. The history of the incident will need to be verified when the patient is admitted.

#### 4.5 **History taking should include:**

- (a) Whether source of radiation was sealed or unsealed.

Note - if unsealed, patient may be radioactive and could spread radioactive contamination

- (b) Type of radiation involved, including name and atomic number of Radionuclide(s) if known, and whether  $\chi$ -rays,  $\gamma$ -rays,  $\beta$ -rays or  $\alpha$ -rays

Note - too much time should not be spent trying to ascertain the radiations received, only the Radionuclide involved. Once the nuclide is known the radiations emitted can be obtained from a reference book

- (c) Approximate dose, or quantity involved, if known
- (d) Time of exposure: (When it happened and for how long exposed)
- (e) In the case of an unsealed source, whether skin decontamination has already been attempted, at the site of the accident

## **5 Treatment of Radiation Casualties**

### **5.1 Category A – May be Contaminated**

Decontamination should be carried out as soon as possible to prevent further exposure. These patients are then to be admitted via the A & E entrance of the Gilbert Bain Hospital. Procedures to be followed are outlined in Section 6. If the casualty may have received a large radiation exposure, they should then be treated as described in Paragraph 5.2.

### **5.2 Category B – Exposed but not Contaminated**

Although such casualties may occasionally have experienced distressing radiation burns before admission, treatment is seldom urgent and normal admission procedures can usually be safely followed. It is desirable for haematological samples to be obtained as soon as possible.

The emergency services of a Radiographer or Radiation Protection Adviser, if in attendance, should be sought if there is the possibility of a 'rogue' radioactive source to be located as quickly as possible or if the person is thought to have received a high dose of radiation. The incident should in any case be reported to the Radiation Protection Adviser (RPA (ARI)) as soon as is convenient.

### **5.3 Symptoms**

#### **(a) Burns**

Probably localised burns, appearing some days or even weeks after exposure and varying from 1st to 3rd degree, depending on dose. Burns require a very high dose but it is possible to get them particularly to the fingers and hand by holding industrial sources and not having significant whole body doses which would produce radiation sickness. If the eye is affected, the patient may have a severe burn from a small dose. Treatment as for thermal burns. If the eye is affected make an urgent appointment for an ophthalmological opinion.

#### **(b) Radiation Sickness**



A large Whole-Body dose of radiation whether from sealed or unsealed source may produce systemic effects such as bone marrow depression (leading to infection and bleeding tendency), anorexia, vomiting or diarrhoea, mental changes e.g. apathy, drowsiness, confusion. These may not appear until 1-3 weeks after exposure. They are an indication for immediate admission to hospital. Discussion with the RPA (ARI) will decide whether the patient may be contaminated with radioactivity and isolation is therefore needed.

(c) **Other Indications for Clinical Referral**

If the RPA (ARI) thinks there has been a significant radiation hazard, the patient, even if asymptomatic, should be referred for follow-up by an appropriate clinician. In particular, ingestion of Radioiodine or Phosphorus 32 may induce later changes in thyroid or bone marrow function.

If Radioiodine has been ingested, and the intake may have occurred within the last 24 hours, Potassium Iodide tablets (100mg) or solution should be administered by mouth as soon as possible.

## 6 **Decontamination of Radiation Casualties**

Instructions for use of Decontamination Area are at **Appendix P-1**.

### 6.1 **Equipment Required**

Most of the equipment required will be held in the store for the decontamination equipment. Soaps, medical equipment and medication are held in the Plaster Room.

- (a) Large polythene bags or sheets for disposal of radioactive clothing, swabs, etc.
- (b) Disposable swabs e.g. paper towels
- (c) Mild soap and Lanolin
- (d) Plastic sponges
- (e) Polythene bucket
- (f) Large plastic bins and liners for disposal of contaminated cleaning materials
- (g) White oversuits, rubber gloves, rubber boots and masks. Masks should be worn to prevent inhalation and ingestion of particulate water material
- (h) Warning signs - to be put up at each point of access

- (j) Gastric lining set and container for vomit/washings; Soft scrubbing brushes (for use if initial decontamination fails), and toothbrushes for cleaning mouth
- (k) Solutions required if radioactive material has been swallowed:
  - 10% Magnesium Sulphate Solution;
  - Potassium Iodide Solution.

## **6.2 Staff**

Such staff as are required for treatment of the casualty will be provided by the A & E Department. This would typically comprise: one Doctor, and three Nurses.

Monitoring of radioactivity will be supervised by the Senior Duty Radiographer and appointed local Radiation Protection Supervisor using the monitor located in the secure red box marked “radiation contamination monitors” in the Medical Imaging Department server room.

Hospital staff who have been trained in the use of decontamination equipment and chemical personal protective equipment should be selected to carry out the decontamination of each patient. These, together with a Radiographer and an assistant to carry out monitoring of radioactivity, should put on chemical personal protective clothing.

No unnecessary personnel must be allowed into the decontamination area.

No eating, drinking or smoking is allowed.

All staff involved in the decontamination must remain in the Decontamination Area until the procedure is complete, and they have been monitored and cleared by the Senior Duty radiographer and appointed local Radiation Protection Supervisor.

## **6.3 Preparation of Decontamination Facility**

Wherever possible, the decontamination of persons should be carried out at the scene of the incident.

Where decontamination at the scene is not possible and it occurs on the hospital site, the monitoring will be undertaken prior to persons entering the decontamination unit.

The store beyond the Estates Office is where the hospital decontamination equipment is held. This includes the derobing tent, decontamination shower, CPPE suits and equipment. This equipment is maintained by the A & E Department.

Hospital staff have been trained in the use of this equipment for the purposes of decontaminating casualties.

If decontamination at the scene is not possible, the decontamination equipment should be erected in the outside the estates offices with access to the hospital via the fire door at the end of the physiotherapy department corridor. The physiotherapy department should be emptied of all staff not required for the decontamination and treatment of casualties. Barriers should be erected across the laboratory corridor to prevent access from the remainder of the hospital. Ambulances carrying potentially contaminated patients should be directed to the decontamination unit and not to the main hospital entrance. The casualties must stay in the ambulance until the decontamination unit is ready to accept them.

The physiotherapy gymnasium should be used for the treatment of any casualties that have serious injuries. Equipment necessary for their stabilisation should be brought from the Accident and Emergency Department along with any personnel required.

All contaminated patients should go through the decontamination unit prior to commencement of any treatment unless they have a life threatening condition. In these cases, the patients should be transported on a trolley from the decontamination facility to the physiotherapy gymnasium. All staff who come into contact with these patients should remain in the gymnasium at all times until their own contamination status has been clarified. "Runners" will be available to fetch equipment needed from the remainder of the hospital and should hand over the equipment at the gymnasium door.

After decontamination, any casualties with minor injuries can then go to the Accident and Emergency Department for their treatment.

#### 6.4 **Multiple Casualties**

Ideally, only one casualty should be decontaminated at any one time.

Other casualties should remain in the ambulance in which they are brought, until they can be dealt with.

If other casualties are in need of urgent medical attention, procedures to be followed must be decided by the Consultant Physician, the Senior Duty Radiographer and appointed local Radiation Protection Supervisor.

#### 6.5 **Ambulance**

When an ambulance bringing a casualty arrives, the ambulance staff should prepare the patient for transfer from the vehicle on a trolley, and

wait within the vehicle until they are told that the Decontamination Area is ready to receive them.

Under no circumstances may the patient walk outside the decontamination area.

Ambulance staff should then return to their vehicle and remain there.

The trolley and ambulance or other vehicle (including any helicopter that may have been used) must not depart until the Senior duty Radiographer and appointed local Radiation Protection Supervisor has monitored, and if necessary, decontaminated it.

No eating, drinking or smoking is allowed.

#### 6.6 **Monitoring**

The Senior Duty Radiographer and appointed local Radiation Protection Supervisor, if present, should monitor the patient for radioactivity to determine the extent and level of contamination. Periodic monitoring will be necessary to evaluate the success of the decontamination and determine further steps to be taken.

During any incident in which a Radiographer is called upon to carry out decontamination an assistant must be allocated to the Radiographer for the entire time until decontamination is completed. A Porter may be needed to collect measuring instruments or items of equipment needed for the decontamination operations.

#### 6.7 **Undressing Casualty**

The patient should be undressed carefully in the derobing tent. Headwear, gloves, footwear and clothes should be removed by gentle cutting with scissors and folding the cut material outwards to minimise the further spread of contamination. All clothing which might be contaminated should be collected in polythene bags for disposal by the Radiation Protection Service. If the patient's hands are contaminated, they should be covered with polythene bags until they have been cleaned.

#### 6.8 **Decontamination of Casualty**

Begin decontamination with eyes, mouth and wounds, if involved:

- (a) **Eyes:** Wash under copious running water. Ensure none of this water enters mouth or nostrils. (This should be done immediately before everything else

- (b) **Mouth/Nose:** Wash with multiple rinses, warning patient not to swallow. Forced coughing should be encouraged. Blow the nose into tissues (retained for measurement) and irrigate if necessary
- (c) **Wounds:** Irrigate under copious running water as absorption may occur through broken skin. Gentle debridement may be necessary and bleeding allowed. If there is a severe wound and/or considerable contamination apply a venous tourniquet. Cover clean wounds with waterproof tape before treating skin
- (d) **Skin:** Carefully remove any large pieces of contaminated material with dry swabs. Swab gently with warm water to remove as much of the contamination as possible. Use EDTA soap, if available. Avoid splashing or excessive amounts of water
- (e) **Hands:** Wash contaminated hands with soap and running water. Clean nails with a brush for four minutes. If monitoring confirms residual contamination, repeat the procedure for four minutes with Hibiscrub, abrasive detergent (Scrubbing should not proceed any further if skin damage is detected), or Potassium Permanganate followed by application of Sodium Bisulphite. If stubborn contamination remains, overnight skin occlusion using adhesive tape may be necessary;
- (f) **Face:** To decontaminate the face, close eyes and plug ears. Carefully swab the face with saline or Hibiscrub or similar. Wash hair with Hibiscrub or similar, if necessary.

Waste water should all go into the containers supplied. Place all contaminated cleaning materials in bins provided.

The casualty should not be given a shower until local decontamination procedures are complete.

**6.9 Contaminated Mouth or Radioactive Substance Swallowed**

Proceed to stomach washout, keeping washings for analysis. Then give Magnesium Sulphate 10 ml of 10% orally.

If Radioactive Iodine has been swallowed, give Potassium Iodide solution or tablets (containing 100 mg of KI) as soon as possible by mouth, to block thyroid uptake. During these procedures care must be taken to ensure that no further radioactive material is ingested.

**6.10 Contaminated Materials**

Keep all swabs, towels, patient's clothes, attendants' gowns and gloves in polythene bags for monitoring and disposal by the Radiation Protection Service. These bags must be marked with the radioactive trefoil, details of the radionuclides and a name to identify the incident, before they are removed from the area.

**6.11 Checking of Casualty**

When the RPA (ARI) or Senior duty radiographer and appointed local Radiation Protection Supervisor is satisfied that adequate decontamination of the patient has been achieved, the patient should be treated for radiation exposure (see Category B) or other injuries, as appropriate.

**6.12 Monitoring of Staff Including Ambulance Officers**

All staff who have been in contact with the casualty must remain in or near the Decontamination Area until they have been cleared by the RPA (ARI) or Senior duty radiographer and appointed local Radiation Protection Supervisor.

The Doctor detailed to supervise the decontamination procedure (Appendix P-2 Paragraph 6.2) will, supervise the monitoring of staff, post-decontamination using the second (clean) monitor stored in the Medical Imaging Department server room.

**6.13 Decontamination of Facility**

After the decontamination has been carried out, the Decontamination Area is to be kept secured until it has been thoroughly checked, cleaned and cleared by Senior duty Radiographer and appointed local Radiation Protection Supervisor. The assistance of Porters may be required to move bags of contaminated waste and contaminated clothing.

## **7 Instructions to Receptionists**

7.1 If a warning is received that a radiation casualty is to be sent to the hospital the following action must be taken:

- (a) connect the caller to the A & E Department
- (b) inform the Senior Duty Radiographer.

## **7.2 Confirm an Ambulance Has Been Called**

If the receptionist has to call on an ambulance to collect a radiation casualty, available information on the nature of the incident must be passed on to the appropriate Ambulance personnel and the need to treat the incident as one involving a radiation casualty must be stressed at the time the call for an ambulance is made.

## **8 Instructions for Senior Duty Radiographer**

8.1 The Senior duty Radiographer will telephone the Radiation Protection Adviser and report details of the incident (with the estimated time of arrival of the casualty).

8.2 The callout list is held by the Senior Duty Radiographer and appointed local Radiation Protection Supervisor and hospital switchboard.

## **9 Instructions to Ambulance Staff**

9.1 Ambulance staff dealing with potentially contaminated people must use full Chemical Personal Protection Equipment and follow the guidelines provided by the Scottish Ambulance Service.

## **10 Instructions to the Senior Doctor or Nurse on Duty**

10.1 The first intimation of a radiation casualty is likely to be by telephone to the Senior Doctor or Nurse on Duty. At this time the following information must be sought from the caller:

- (a) is medical attention thought to be urgently necessary?
- (b) has decontamination already been attempted?
- (c) is radioactive material thought to have been inhaled or ingested?
- (d) are there any open wounds which could be contaminated?
- (e) is the type of radionuclide involved known?

## **11 Instructions to Medical and Nursing Staff**

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- 11.1 Where medical treatment of a suspected contaminated casualty is necessary, full chemical personal protective clothing must be worn at all stages of the treatment. Decontamination will be carried out according to instructions on the 'Treatment of Radiation Casualties'. Once this is completed the staff concerned must remain in the treatment area until they have been monitored and, if necessary, decontaminated by a Radiographer or Radiation Protection Adviser, if in attendance.

## **12 Instructions to Nurses Assisting in the Decontamination Area**

- 12.1 In the event of a nurse being required to assist with the care of a radiation casualty in the Decontamination Area she/he will work under the guidance of the Radiographer, Radiation Protection Adviser if in attendance.

Details of decontamination and treatment are given in Section 5 'Treatment of Radiation Casualties'.

## **13 Instructions to Porters**

- 13.1 Special arrangements are required when a casualty is known or thought to have been contaminated by radioactive material (Category A).
- 13.2 The Porter should assist as required, until decontamination is complete. The Porter may be required to carry out a variety of tasks including:
- (a) erect appropriate warning signs
  - (b) ensure unauthorised personnel are excluded from the area until decontamination is complete
  - (c) a Porter may be required to collect and deliver instruments or items of monitoring equipment needed for the decontamination operations

When the decontamination process is complete, the assistance of Porters may be required for moving bags containing contaminated waste and clothing.

## **14 Major Nuclear Accidents**

- 14.1 In the event of a major radiation accident involving risks to large numbers of persons in the region and the possibility of monitoring members of the public, plans appropriate to the incident would be drawn up for Shetland NHS Board by a group including the Director of Public Health and the Radiation Protection Adviser, and convened by the DPH.



- 14.2 Action taken would be along the lines of that recommended in Planning Guidance for the NHS in Scotland - 'Incident Involving Ionising Radiation' - Annex J.



## **Appendix P-1 - Decontamination**

### **1 Radiation Decontamination Area Location**

- 1.1 The Decontamination Area is situated outside the garage area to the North of the Hospital.
- 1.2 Its use in this role will be for decontaminating patients who have been or may have been contaminated.

### **2 Aim**

- 2.1 The aim in the use of the Decontamination Area is to manage these patients safely while minimising the risk of contamination of the fabric, equipment and staff of the A & E Department and the remainder of the hospital.

### **3 Prior Warning**

- 3.1 The proper use of the Decontamination Area depends entirely on the A & E Department being given prior warning that a Category A casualty is expected and this information would normally come from the Ambulance Service, the Fire Service or the Police.

### **4 Access to Hospital**

- 4.1 No person who has been present at the scene of any radiation incident will be allowed access to the A & E Department or any other part of the hospital except via the Decontamination Area.

### **5 Instructions to Senior Doctor/Nurse on Duty**

- 5.1 Immediately it has been ascertained that a Category A patient is expected, declare a 'Stage 1 Alert' in accordance with Part C.
- 5.2 Arrange for barriers and signs to be erected, the Decontamination Area to be made ready and the main door to A & E entrance is to be secured to prevent the access of non-essential personnel.
- 5.3 The new out patients corridor fire exit can be opened to allow for non-contaminated access to the hospital if the A & E entrance is contaminated.
- 5.3 In exceptional circumstances it may be decided that the physical injuries are so severe that the patient must immediately be treated in the Resuscitation Room, this treatment taking precedence over decontamination. This decision will only be taken by the Consultant Physician and verbal instructions issued thereafter.

## **6 Decontamination Team**

- 6.1 In addition to the Senior Duty Radiographer and appointed local Radiation Protection Supervisor/Depute or Radiation Protection Adviser (RPA (ARI)), if in attendance, the Decontamination Team will consist of personnel trained in decontamination. A Porter may be required outside the contaminated area to collect and deliver instruments or items of equipment required for the decontamination operations. The team will go to the Decontamination Area and proceed according to Section 6 - 'Decontamination of Radiation Casualties'.
- 6.2 A Doctor working outside the Decontamination Area will be responsible for recording details of all personnel involved in the decontamination process. Details of the patient are to be recorded on the 'Patient Report Form' (**Appendix P-2**) and the 'Patient Decontamination Record' (**Appendix P-3**). The Doctor will also supervise the monitoring of all staff, including Ambulance Officers and any others who have been in contact with the patient. A separate 'monitor' is retained in the Medical Imaging Department server room.

**Appendix P-2 – Radiation Decontamination Patient Report Form**

**HOSPITAL:** GILBERT BAIN HOSPITAL

**DATE:**

**PATIENT'S NAME:**

**INCIDENT:** Radionuclide(s)

Total Activity Involved:

Physical Form

Chemical Form:

Time of Occurrence:

Medical Attention before Monitoring/Decontamination:

Monitoring done by:

Monitor type:

Decontamination done by:



**Appendix P-3 – Patient Decontamination Record**

HOSPITAL: GILBERT BAIN HOSPITAL

DATE:

PATIENT'S NAME:

INCIDENT: Radionuclide(s)  
Total Activity Involved:  
Physical Form

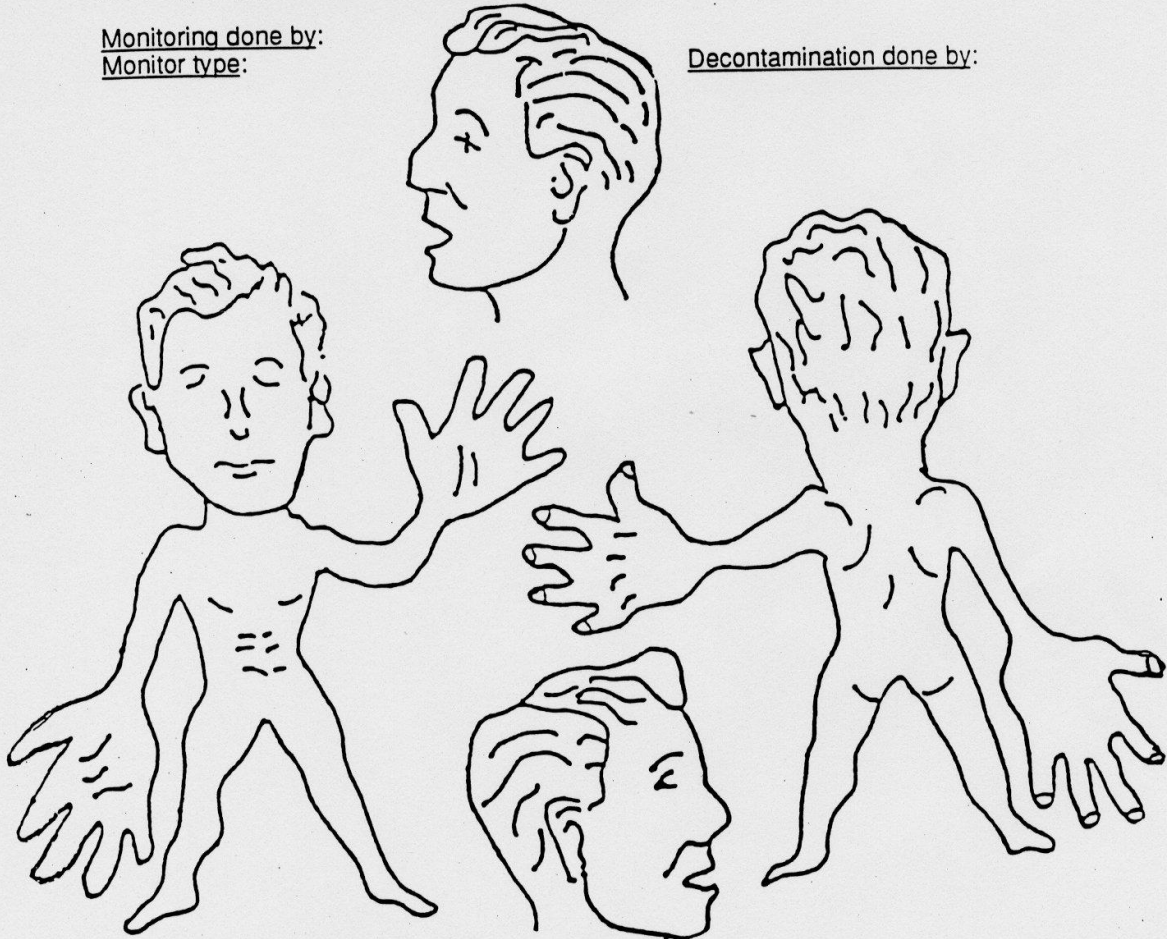
Chemical Form:

Time of Occurrence:

Medical Attention before Monitoring/Decontamination:

Monitoring done by:  
Monitor type:

Decontamination done by:



Have there been previous attempts at decontamination:  
(How Many? Methods Used? State of Skin?)





**Appendix Q-1 – Action List – Duty Consultant Physician / Hospital Medical Controller**

**On receipt of a major emergency alert, the Duty Consultant Physician will:**

- 1 Go to the Gilbert Bain Hospital.
- 2 Mark 'in' on the major accident 'in/out' board at Reception.
- 3 Report arrival to the Nurse in Charge of Gilbert Bain Hospital.
- 4 Be satisfied that the Hospital Control Centre is being established, staffed and equipped.
- 5 Assign a members of staff in the control room to scribe (timing, logging details, etc.)
- 6 **Assume duty as Hospital Medical Controller (HMC)** and, via Hospital Control Centre, take immediate steps to ensure that the Board's response to the emergency is effectively controlled and co-ordinated.
- 7 Liaise with the Senior Scottish Ambulance Service operative on duty to understand the disposition of available ambulance resources.
- 8 Understand the presence and identity of a Medical Incident Officer and establish a route of contact (usually via the Scottish Ambulance Service). If necessary task the Senior Manager on call to source additional GP cover for the MIO role (for instance due to delay in attendance at the scene)
- 9 In order to free resources for emergency use suspend such aspects of the Board's normal service to the public as the situation appears to require, including the cancellation of routine admissions, out-patients clinics, treatment sessions and operating lists.
- 10 With the Duty House Officers and the Consultant General Surgeon(s), assess the availability of doctors, dentists, medical students and Locums.
- 11 After discussion with the Consultant General Surgeon(s), appoint an experienced medical practitioner as Casualty Receiving Officer, responsible for triage at hospital Accident and Emergency reception.
- 12 If necessary, appoint a Deputy Casualty Receiving Officer.
- 13 Where necessary, direct additional doctor(s) to the site of the accident or to meet casualties.

- 14 British Red Cross is usually despatched through the Scottish Ambulance Service to an incident. If the HMC considers that their presence would be helpful at the hospital they can discuss with the MIO who will provide information about capacity at the scene and the British Red Cross liaison via the national number: 07748 608648. Normally their presence at the scene would take precedence.
  - 15 If appropriate appoint a medical practitioner to undertake the venesection of blood donors in the Physiotherapy Department, Gilbert Bain Hospital, and advise the Laboratory Scientific Officer accordingly.
  - 16 At the earliest opportunity, call the relevant key Health Service personnel to a briefing, and there provide them with all available information on the emergency, and the nature and extent of the Board's response.
  - 17 Via the briefing meeting, determine details of communications so as to ensure, as far as possible, that there will be no impediment to a smooth flow of information between key Health Service personnel and the other Services and Organisations involved.
  - 18 Arrange to receive regular situation reports from all Departments at agreed intervals.
  - 19 Satisfy yourself that the Board's response has been properly initiated, and that its ability to sustain services over the projected period of the emergency is assured.
  - 20 If evacuation of patients to Aberdeen becomes necessary, appropriate liaison links should be established.
  - 21 Liaise with EMDC Inverness, over patient evacuations.
  - 22 In managing the Board's response to an emergency the Hospital Medical Controller will, in addition to the above, ensure that:
    - (a) the most effective use continues to be made of available resources;
    - (b) effective liaison is being maintained with the Director of Public Health, other Emergency Services, Health Boards and Scottish Executive Health Department (SEHD), as necessary;
    - (c) Key Health Service personnel are regularly provided with progress reports and immediately advised of policy decisions affecting their area(s) of responsibility; and
    - (d) the performance of staff and volunteers is monitored and, where necessary, action initiated to remedy stress, weaknesses or omissions.
-

- 23 When emergency arrangements appear to be no longer necessary, ensure that the hospital is adequately staffed and equipped to carry out its normal functions, and advise all concerned of a stand down.
- 24 Following the conclusion of the emergency, ensure that all staff are formally de-briefed, and that all necessary reports are prepared and presented.



**Appendix Q-2 – Action List – Board Chief Executive / Senior Manager on-call**

**On receipt of a major emergency alert, the Board Chief Executive or in their absence the Senior Manager on-call will:**

1. Alert, and keep briefed, the Chairman of the Board.
2. Consider whether or not it would be desirable to co-ordinate information to the media with the other services/organisations involved or obtain assistance with media enquiries by invoking the terms of the Media element of the **SIC Emergency Plan** relating to press conferences and briefings. If so, initiate arrangements via the Hospital Control Centre and the SIC Liaison Officer attached to the Police Incident Room.

**Detailed notes on media briefing, and the information required during each of the three phases of media handling, will be found in Annex O to Scottish Government Health Directorates Emergency Planning Guidance to the Scottish Health Service, a copy of which is retained in the Board Chief Executive's Office.**

3. **Telephone line: Lerwick 01595 743060** should be used initially for all enquiries. A runner should be appointed from the Health Board office staff at Montfield to relay messages between the Health Board and the Hospital Control Centre.
4. If the accident involves a Company, it may wish to handle all media enquiries about its employees. In these circumstances it should be borne in mind that the Police, through its central Casualty Enquiry Bureau, will be co-ordinating all information about victims and survivors, will be contacting next-or-kin and, after immediate relatives have been informed, will be formally releasing details to the media. In large-scale incidents it is likely that the Company primarily involved will have a liaison officer at the Central Casualty Bureau. The Board Chief Executive will liaise through the Police Incident Room, about any media releases including reports on the condition of patients involved.
5. Until the conclusion of the incident, the Hospital Control Centre must be advised of the Board Chief Executive's whereabouts and be given a contact telephone number.



**Appendix Q-3 – Action List – General Practitioner First at Scene / Medical Incident Officer (MIO)**

- 1 If summoned to a major accident by anyone other than the Police, check that Police have been informed. If necessary, inform Police.
  - 2 Because of the limit and spread of medical services throughout Shetland, it is likely that during the critical initial phases of a major incident you will be the only General Practitioner at the scene. This means that you will be responsible for both triage and treatment of casualties. **Your priority role is to co-ordinate and decide on priorities for the treatment and evacuation of casualties.** Only when this phase of the operation has been completed should you get involved in the treatment of individual casualties.
  - 3 On arrival at the scene, identify yourself to the Police Incident Officer, and then in collaboration with the Ambulance Incident Officer:
    - (a) make contact through the Police Incident Officer with the Forward Control Point and understand site, nature of casualties and position / preparedness of Casualty Reception Station;
    - (b) formulate a casualty evacuation plan;
    - (c) request from the Hospital Medical Controller the provision of special equipment or surgical expertise as needed, eg: to extricate trapped persons from wreckage, or carry out immediate amputations; and
    - (d) consider, in discussion with the Hospital Medical Controller the need for any specialist assistance (e.g., surgical for emergency amputation for extraction) bearing in mind that the scale of resources in Shetland does not usually allow for a full site medical team.
  - 4 In consultation with the Ambulance Incident Officer and the Police Incident Officer establish:
    - (a) a first-aid post/casualty clearing station; and
    - (b) ambulance loading point.

Signs will be brought by the ambulance staff.
  - 5 Obtain the Medical Incident Officer's (MIO) identifying tabard from the doctor's car (if available) and wear it at once, and until such time as on-site action is no longer required.
-

- 6 Priorities for evacuation to hospital must be decided in consultation with an Ambulance Incident Officer.
- 7 Communicate your assessment of the situation personally to the Police Incident Officer, and by arrangement with him, to the Hospital Medical Controller at the Hospital Control Centre in the Gilbert Hospital Bain. Keep the Control Centre informed of the situation, the number, nature and condition of casualties and of any other relevant information.
- 8 If unable to pass these messages personally, always give your message to a competent third party in writing. Use of a pad of SHB Message/Report Forms (carried by ambulance) is recommended so that a copy will be available for later reference.
- 9 Ambulances carry supplies of 'Casualty Labels', as do Police Cars. Documentation must be the minimum required by receiving hospital staff. Attach the label firmly to the patient and record nature of injury, treatment given, and time and route in the case of drugs such as Morphine.
- 10 In the event of a senior and more experienced doctor arriving at site, consider handing over to him as MIO. If you mutually decide to do this, first inform the Police and Ambulance Incident Officer, **then hand over the MIO tabard.**

**Remember, there must be only ONE Medical Incident Officer (MIO), whose decisions as to priority for evacuation are final.**

- 11 In conjunction with the Police, make arrangements for the verification of death prior to removal of bodies. The dead will not be conveyed by ambulance. Disposal of the dead will be decided by the Police Incident Officer, normally after the evacuation of treatable casualties has been completed. Walking wounded can often be conveyed satisfactorily by transport other than ambulance - the Police Incident Officer should be consulted if in any difficulty.
- 12 Remain on-site to support Police activities even after the final living casualty has been removed.



**Appendix Q-4 – Action List – Director of Public Health**

- 1 The Director of Public Health or Duty On-Call Public Health Consultant will act as the initial link between the hospital and the Scottish Executive.
- 2 The DPH / On-Call Consultant will liaise with:
  - Medical Co-ordinator
  - Scottish Executive
  - Board Chief Executive
  - other Health Boards (if patients are transferred)
  - other emergency services and other organisations (if there is a need for a Strategic response)
- 3 It is the Director of Public Health / On-call Consultant's responsibility to liaise with the Incident Control Room.
- 4 The Director of Public Health should initially provide the medical presence at a Multi-agency Strategic Group if required. However, if there is a well circumscribed civil incident and affected population, where there may be issues around the management of those who are injured, this role may be delegated to another relevant clinician.
- 5 In some circumstances the Director of Public Health may provide health advice directly to the Chief Constable and chair the Joint Health Advisory Cell or Health Advisory Group.
- 6 Ensure arrangements for surge capacity are initiated if necessary via the Memorandum of Understanding with other Boards in the North of Scotland.
- 7 Work closely with Health Protection Scotland to provide public health advice, support and leadership especially in responding to major public health incidents.
- 8 Be responsible for deciding on and arranging for the establishment of a special Helpline if necessary (Part L – NHS 24).
- 9 Ensure sign off of any public health and health protection messages to be communicated to the public.
- 10 Be responsible for arranging internal de-brief and contributing to multi-agency debriefs. Be responsible for reporting after an incident to the Board and other organisations as required (Part N – Post-Incident Requirements).



**Appendix Q-5 – Action List – Duty Consultant Surgeon**

**On receipt of a major emergency alert, the Duty Consultant General Surgeon will:**

- 1 Go to the Gilbert Bain Hospital.
- 2 Mark 'in' on the major accident 'in/out' board at Reception.
- 3 Report arrival to the Nurse in Charge of Gilbert Bain Hospital.
- 4 In the absence of the Consultant Physicians or Director of Public Health act as **Hospital Medical Controller**, as detailed in **Appendix Q-1** or nominate someone to act as Hospital Medical Controller.
- 5 Call the second / third surgeon.
- 6 If circumstances permit, act as Casualty Receiving Officer until a suitably qualified Doctor is nominated by the Hospital Medical Controller to relieve you, and as such, supervise the preparations for, and reception, of casualties, including triage and initial documentation.
- 7 In consultation with Hospital Medical Controller (Duty Consultant Physician), take such other action as circumstances for the time being dictate.
- 8 Ensure the Hospital Control Centre is provided with regular progress reports, and that all requests for assistance, supplies and equipment are routed via that office.



**Appendix Q-6 – Action List – Duty Consultant Anaesthetist**

**On receipt of a major emergency alert, the Duty Consultant Anaesthetist will:**

- 1 Go to the Gilbert Bain Hospital.
- 2 Mark 'in' on the major accident 'in/out' board at Reception.
- 3 Report arrival to the Nurse in Charge of Gilbert Bain Hospital.
- 4 In the absence of the Consultant Physicians or Director of Public Health act as **Hospital Medical Controller**, as detailed in **Appendix Q-1** or nominate someone to act as Hospital Medical Controller.
- 5 Call the second and third Consultant Anaesthetist.
- 6 Ensure that anaesthetic / resuscitation equipment in A&E and Theatres is formally checked and logged as fully functioning, either by yourself or by the second Anaesthetist as time and circumstances permit.
- 7 In the absence of the Consultant Surgeon act as Casualty Receiving Officer until a suitably qualified doctor is nominated by the HMC to relieve you. As such, supervise the preparations for and reception of casualties, including triage and initial documentation.
- 8 In consultation with the HMC and Consultant Surgeon take other action as circumstances for the time being dictate.
- 9 Ensure the Hospital Control Centre is provided with regular progress reports via the Consultant Surgeon, and that all requests for assistance, supplies and equipment are routed via that office.



**Appendix Q-7 – Action List – Duty Junior Doctor (Surgical)**

**On first being advised of a serious accident, the Surgical Junior Doctor on duty at the Gilbert Bain Hospital will:**

- 1 Report arrival to the Nurse in Charge of Gilbert Bain Hospital.
- 2 Notify the Duty Consultant General Surgeon, if not already informed.
- 3 Alert your off-duty colleagues, requesting them either to keep in touch by telephone or to report to the Hospital, as appropriate.
- 4 Alert any medical student who may be attached to the Surgical Unit at the time.
- 5 Check with telephonist that the **Major Emergency Alerting Procedure** has been initiated.
- 6 The Surgical Junior Doctor with the Senior Nurse on duty in each Surgical ward, will make a written list of those patients who can reasonably be moved to the day rooms to make way for casualties. **Do not have patients moved yet.**
- 7 Proceed to the Accident and Emergency reception area and there act as Casualty Receiving Officer, supervising casualty reception, assessment and primary treatment until the arrival of a Consultant General Surgeon or such time as formally relieved of such duty.
- 8 Keep Reception and the Hospital Control Centre informed of your whereabouts.

**Appendix Q-7 – Action List – Duty Junior Doctor (Medical)**

**On first being advised of a serious incident, the Medical Junior Doctor on duty at the Gilbert Bain Hospital will:**

- 1 Report arrival to the Nurse in Charge of Gilbert Bain Hospital.
- 2 Notify the Consultant Physician, if not already informed.
- 3 Alert your off-duty colleagues, requesting them either to keep in touch by telephone or to report to the Hospital, as appropriate.
- 4 Alert any medical student who may be attached to the Medical Unit at the time.
- 5 Check with telephonist that the **Major Emergency Alerting Procedure** has been initiated.
- 6 The Medical Junior Doctor with the Senior Nurse on duty in each Medical ward, will make a written list of those patients who can reasonably be moved to the day rooms to make way for casualties. **Do not have patients moved yet.**
- 7 Proceed to the Accident and Emergency reception area and there act as directed by the Hospital Medical Controller.
- 8 Keep Reception and the Hospital Control Centre informed of your whereabouts.



**Appendix Q-8 - Action List – Chief Nurse, Acute Services**

**On receipt of a major emergency alert, the Chief Nurse, Acute Services will:**

- 1 Go to the Gilbert Bain Hospital;
- 2 Mark 'in' on the major accident 'in/out' board at Reception.
- 3 Report arrival to the Nurse in Charge of Gilbert Bain Hospital.
- 4 Ensure that adequate staff are on duty to cope with anticipated casualties. If not, rectify this situation so far as is practicable using off-duty staff, Bank Staff, Community Nurses (in liaison with Chief Nurse, Health & Social Care Directorate).
- 5 Ensure that the time of arrival of all personnel is properly recorded.
- 6 Check with the Nurse in Charge of Gilbert Bain Hospital, the bed state.
- 7 Be satisfied that the Hospital Control Centre is being established, staffed and equipped.
- 8 When circumstances permit assist with the administration and running of the Hospital Control Centre.
- 9 As soon as circumstances permit, arrange for the relief of first-shift nursing staff, and for regular shift-working to continue until such time as the formal stand-down has been declared and appropriate arrangements are in place to ensure ongoing monitoring of the situation.



**Appendix Q-9 – Action List - Senior Nurse on Duty**

**Part 1 Alerting**

**On first being advised of a serious accident, the Nurse in Charge of Gilbert Bain Hospital will:**

- 1 Decide, based on the information received, whether or not to order an **ALERT STAGE** as defined at **Appendix C-3**. Review any further information received and amend the Alert Stage as deemed necessary.

**NOTE: When deciding whether or not to declare an ALERT, remember it is better to be partly prepared than to be caught totally unprepared.**

- 2 If you decide to declare an ALERT:
  - (a) instruct duty telephonist to initiate Alert Procedure:  
**STAGE 1 ALERT**  
**STAGE 2 ALERT**  
**STAGE 3 ALERT** or a  
**HIGH PROFILE - MINOR INCIDENT**
  - (b) alert the Duty Junior Doctors, if not already informed
  - (c) alert reception who will notify A&E and Theatre on-call staff

**Part 2 Reception of Casualties**

**On completion of PART 1, proceed immediately to prepare for reception of casualties by a general check that:**

- (a) wards are preparing the list of ambulant patients who may be moved to day areas at short notice
- (b) supplies of bedding are adequate for the early admission of up to ten casualties
- (c) all senior staff who should have already been alerted have been
- (d) Duty Surgical Junior Doctor and Theatre Sister are now on duty in the Hospital
- (e) all visitors and relatives have left the Hospital



## Appendix Q-10 – Action List - Receptionist/Telephonist, GBH

### INITIAL REPORT

#### **On receipt of a report of a serious accident:**

- 1 Note as many details as are immediately available on an 'Accident Information Form' (copy annexed as **Appendix C-2**) and pass copies of the form without delay to:

- Emergency Medical Dispatch Centre (Top copy - White)
- Nurse in Charge of GBH (2nd copy - Pink)
- Duty Surgical House Officer (3rd copy - Blue)
- Hospital Records Office /  
Hospital Control Centre (4th copy - Backing card)

Should the initial telephone call be from the police via 01595 743000, the receptionist/telephonist should ask the caller to 'ring off' and then contact the Police Office to confirm the call. **This is to reduce the risk of hoax calls.**

### MAJOR EMERGENCY ALERT

#### **On being instructed to institute a Major Emergency Alert (ie: ALERT STAGE 1, 2 or 3) by the Nurse in Charge of Gilbert Bain Hospital, take action as follows:**

- 1 Check that the emergency telephone circuit between Gilbert Bain Hospital and the Lerwick Police Station is functioning, and that the Police are aware of the incident and the Hospital Major Emergency ALERT STAGE. Confirm with the Police that the Emergency and Resilience Planning Officer, (in his capacity as Local Authority Liaison Officer) has been informed, if not, request that the Police inform him.
- 2 Confirm with the Police that the Ambulance Service has been alerted and, if not, pass on information for Accident Information Form.
- 3 Using the GBH Cascade Call-Out (held and updated by the Receptionist) alert in order. If unable to make immediate contact, go to next on list. As soon as possible go back over list and attempt to alert anyone missed first time round. If unable to contact GP for Medical Incident Officer role (or if their arrival at the scene will be delayed,) immediately advise Senior Manager on call to source alternative MIO and advise Police.

3 **HIGH PROFILE-MINOR INCIDENT (injuries involving a VIP):**

Ensure that the personnel listed are notified immediately.

4 Report completion of all above action to the Nurse in Charge of Gilbert Bain Hospital as soon as possible, listing any person whom it has **NOT** been possible to contact.

5 When the Chief Nurse, Acute Services arrives at the Hospital, supply them with the names of any person not contacted.

6 At the conclusion of the emergency, you will be instructed to declare a 'stand down'. Pass this information to all the persons contacted.

**Appendix Q-11 – Action List – Receptionist, NHS Shetland Board HQ (Brevik House)**

**If a major emergency occurs during normal office hours, initial notification will be received from the receptionist at Gilbert Bain Hospital. On receipt of such a report, note the ALERT STAGE and:**

- 1 Write down the following information:
  - (a) place of accident
  - (b) time of accident
  - (c) type of accident
  - (d) number of persons thought to be involved
  - (e) source of information

**MAJOR EMERGENCY ALERT:**

**Alert the following, in order, informing them of the appropriate ALERT STAGE.**

**If unable to make immediate contact, go to next on list. As soon as possible go back over list and attempt to alert anyone missed first time round.**

- Director of Health & Social Care
- Director of Public Health (DPH)
- Board Chief Executive
- Chief Administrative Dental Officer (CADO)
- Consultant Psychiatrist





**Appendix Q-12 – Action List – Receptionist, Lerwick Health Centre**

The initial report of a serious accident will normally be received by the telephonist on duty at the Gilbert Bain Hospital, but it is conceivable that you will receive the first report, in which case you will:

**1 Write down the following information:**

- (a) Place of Accident
- (b) Time of Accident
- (c) Type of Accident
- (d) Number of persons thought to be involved, and
- (e) Source of information.

**2 If the report has been received direct:**

- (a) immediately pass all available information to the telephonist on duty at the Gilbert Bain Hospital.

**3 Pass the information without delay to:**

- (a) All General Practitioners available in Lerwick
- (b) The Chief Nurse, Health & Social Care Directorate at Breiwick House
- (c) Any other Doctor who may be holding a clinic at the time
- (d) Practice Manager



**Appendix Q-13 – Action List – Medical Records Officer**

**On receipt of a Major Emergency Alert, the Medical Records Officer will, pending the arrival at the Gilbert Bain Hospital of the Head of Estates & Facilities:**

- 1 Deploy from Medical Records and other available administrative/clerical staff:
    - (a) at least two persons to set up and man a casualty documentation point at Accident and Emergency Reception (obtaining sets of 'Major Incident Casualty Forms' from the stock maintained by the duty receptionist), and there proceed in terms of Part 1 of the Action List annexed as **Appendix Q-17**
    - (b) at least one person to man the exit point from the Emergency Reception/Treatment area, and there take action as detailed in Part II of **Appendix Q-17**, and
    - (c) at least two persons to set up and man the Hospital Control Centre in the office of the Occupational Therapist, pre-selected for this purpose, and in particular to ensure that the necessary seating, additional telephones and stocks of 'Message Report Forms' (from the stock stored in the room), pens (both ball-point and markers for use on white wall-boards) and notepads are deployed and ready for immediate use. The Action List for the Hospital Control Centre Clerical Team will be found in **Appendix Q-14**
    - (d) two persons to act as writer for the Hospital Medical Controller
  - 2 Should the **Major Emergency Alert** be declared outwith office hours, the Medical Records Officer will, before reporting to the Gilbert Bain Hospital alert five members of staff to undertake the duties specified in paragraph 1 above.
  - 3 Ensure that adequate staff have been summoned and mustered for:
    - (a) Manning switchboards, and
    - (b) Documenting and assisting in the reception of casualties on arrival at the hospital.
  - 4 Take responsibility to ensure that the office of the Occupational Therapist, pre-selected as the '**Hospital Control Centre**', is properly prepared for such use, and in particular that the necessary seating, telephones and stationery are deployed.
-

- 5 Ensure that Major Incident Casualty Cards are available to staff employed on this duty.
- 6 As soon as circumstances permit, arrange for the relief of first-shift administration and support staff in Hospital Reception, the Hospital Control Centre, Health Board offices and Lerwick Health Centre, and for regular shift-working to continue until such time as the formal stand-down is declared.

**Appendix Q-14 – Action List – Hospital Control Centre Clerical Unit**

On being advised of a 'major emergency alert' the Medical Records Officer will, in terms of the Action List (**Appendix Q-13**) detail at least two persons to set up and man the Hospital Control Centre in the Occupational Therapy Offices pre-selected for this purpose. A plan of the area will be found in **Appendix D-1**.

**On being so detailed, the staff forming the Hospital Control Clerical Unit will:**

- 1 Obtain the key to the secure trolley held in the physiotherapy office from Reception (Reception also holds the key [No. 19] for the key cabinet outside the kitchen door which holds the keys for all the occupational therapy rooms). Thereafter establish the Hospital Control Centre. (Using the trays provided clear away carefully any loose papers and documentation which may be on the desks).
- 2 Plug in and test each of the two direct 'outside' telephone lines.
- 3 Plug in and test each of the two FAX machines kept in the secure trolley designated for this purpose. The test should take the form of sending a test message from one machine to the other.
- 4 Ensure that an adequate stock of Major Incident Casualty Cards, SHB Message/Report Pads, SHB Log-Sheets, notepads, ball-point pens, whiteboard marker pens and cleaning cloths are available, and deployed for use by the Clerical Assistants, Police Liaison Officer and Social Care Liaison Officer.
- 5 On arrival of the Hospital Medical Controller assume duties as Hospital Control Assistants and take action as instructed, with the primary aims of recording all incoming and outgoing Messages/Reports, filing and 'marrying' casualty documentation forms, and keeping wall-board and other records up-to-date.



**Appendix Q-15 – Action List – Nurse in Charge of Each Ward**

**On being advised of a Major Emergency Alert the Nurse in charge of each ward will:**

- 1 If possible, contact a doctor (in the case of the Surgical Wards the Duty Surgical Junior Doctor or a doctor nominated by the Duty Consultant Surgeon), and in the case of the Medical, Maternity Wards, the Duty Medical Junior Doctor, or a doctor nominated by the Consultant Physician), to identify and list those patients who could be discharged to
  - (a) Home, or
  - (b) Montfield Hospital (if it were opened for decanting)
  
- 2 **When the lists have been prepared they must be:**
  - (a) shown to the Duty Consultant Physician and the Duty Consultant Surgeon, and then
  - (b) taken to Hospital Control Centre





**Appendix Q-16 – Action List – Duty Porter**

**On receipt of a major emergency alert, the Duty Porter will:**

- 1 If the alert takes place out of normal hours, call the Portering Manager or his Depute who will:
  - (a) call out sufficient Porters to assist with the following:

- 2 Secure all doors and corridors on the ground floor of the Hospital leaving only the Front Entrance open for reception of casualties. Leave one Porter, accompanied by a Policeman, at the Main Door to prevent unauthorised access.

**Only those personnel with appropriate Identity Badges will be admitted.**

- 3 Place the "Major Accident" and "Emergency Blood Donors" notices, and the Police "No Parking" bollards in their pre-determined positions, both outside and inside the hospital and periodically check that they are in position.
- 4 Arrange for the drivers of all unauthorised vehicles which may be obstructing access of ambulances etc to remove them forthwith.
- 5 Assist Ward staff to usher from the building all visitors and relatives who may happen to be in the Hospital at the time.
- 6 Once all visitors have left the Hospital, check that all doors are locked **except the A & E Reception.**
- 7 Man the A & E Reception entrance to prevent unauthorised access, and, as soon as manpower permits, the exit point from the Accident and Emergency area and the visitors entrance.
- 8 Report to Nurse in Charge of Gilbert Bain Hospital when the above action is completed.
- 9 Report similarly to the Head of Estates & Facilities.
- 10 Remain on duty until relieved.



## **Appendix Q-17 – Action List – Medical Registration Team**

On receipt of a major emergency alert, the Medical Records Officer will, in terms of the Action List reproduced as **Appendix Q-13**, detail at least two members of medical records or other available administrative/clerical staff to set up and man a casualty documentation point at Accident and Emergency reception and at least one to man the exit point from the Accident and Emergency Treatment Area.

### **PART I**

#### **Members of staff selected for casualty documentation duties will:**

- 1 Obtain sets of 'Major Incident Casualty Cards' from the stock maintained by the duty receptionist.
- 2 Take up station at the Accident and Emergency reception point, situated immediately inside the main entrance to the hospital.
- 3 As each casualty enters the hospital, allocate to him/her a patient number (on a simple, sequential, basis - with care being taken to ensure that no duplication occurs). Casualty documentation will be raised on all casualties whether with major, minor or no physical injuries and irrespective of whether they have been labelled and documented at the site of the emergency.

**(NOTE: Should emergencies arrive at the hospital whose illness or injury has not been the result of the major incident, they also should be allocated a 'major incident number').**

- 4 As far as circumstances permit, complete the personal particulars in Sections 1 to 3, on the Form. Should the casualty be unidentified for whatever reason, Section 4 should be completed with the assistance of a Police Officer. **While nothing should be done to delay medical treatment, it may be possible to obtain the essential items of information by, for instance, accompanying the patient towards the Treatment/Resuscitation area.**
- 5 Immediately the required information (or as much of it as possible) has been noted, detach the second (**Green**) and third (**Pink**) copy of the form and have it delivered to Hospital Control. It is emphasised that, as these copies are Control's first formal record of the casualty, the details must be as accurate and complete as possible, and delivered with the minimum of delay.
- 6 Ensure that the first (**Blue**) and fourth (**White Folder**) copies of the Form are attached to the patient's person.

### **PART II**

**The member of staff detailed for duty at the exit point will:**

- 1 As each casualty leaves the accident and emergency treatment area, recover the first **(Blue)** copy of the Major Incident Casualty Card, and send it to the Hospital Control Centre, there to be 'married' with second **(Green)** copy.

**NOTES:**

- (a) While it is expected that all casualties will exit via the one point, the possibility exists that one or more may be evacuated from the accident area via the lift. Should this occur, patients will arrive in Wards with the first **(Blue)** and the fourth **(White Folder)** copies of the Major Incident Casualty Card attached. **Any member of staff noticing this will be expected to arrange for the immediate delivery of the first (Blue) copy to the Hospital Control Centre.**
- (b) Personnel manning the A & E Entrance must be aware of the possibility of 'walking wounded' patients attempting to leave the hospital. Do not allow them to do so until you have sought the advice of a senior member of nursing staff.

**Appendix Q-18 – Action List – Duty Laboratory Biomedical Scientist**

**On being advised of a major emergency alert the Duty Laboratory Biomedical Scientist and ask the officer to report for work immediately. On arrival the Duty Laboratory Biomedical Scientist will:**

1. Check the department's main and emergency analysers are calibrated and ready for use.
2. Check the available supply of blood and blood products in the light of what is known about expected casualties. Discuss the situation regarding the blood and blood product stocks with the Hospital Medical Controller / Consultant Anaesthetist(s) / Consultant Surgeon(s) as seems appropriate and decide on whether or not to obtain further supplies from the Regional Transfusion Centre in Aberdeen.
3. If necessary, depending on the time of day and the availability of flights, ask the Hospital Medical Controller / a Consultant Anaesthetist or Consultant Surgeon as seems appropriate to authorise the air ambulance to fly the blood and blood products to Shetland.
4. Arrange for the hospital taxi service to collect the blood and blood products from the airport on arrival and bring them directly to the Gilbert Bain Hospital.



**Appendix Q-19 – Action List – Physiotherapist & Occupational Therapist**

**On being advised of a major emergency alert the Physiotherapy and Occupational Therapy staff will:**

**During Normal Hours**

1. The Physiotherapist and Occupational Therapist will conclude all treatment being undertaken and return the patients to their wards or homes as appropriate. Cancel any further treatment sessions planned for the remainder of the day, or as seems appropriate in the light of the information received.
2. The Physiotherapist and Occupational Therapist should remove any equipment from the physiotherapy room as appropriate ready for staff (**Appendix Q-14**) to establish the Hospital Control Centre.
3. Stand by to assist Hospital Control as necessary.

**Outwith Normal Hours**

1. When called, proceed to the Gilbert Bain Hospital.
2. Report arrival to the Nurse in Charge of Gilbert Bain Hospital and Hospital Control, if established.
3. Proceed as above if Hospital Control is not already established.
4. Stand by to assist Hospital Control as necessary.





**Appendix Q-20 – Action List – Duty Radiographer**

On being advised of a major emergency alert, the Duty Radiographer will stand by for emergency duty at the Hospital, or report for duty immediately as dictated by the circumstances, and the Medical Imaging Department's Departmental Emergency Procedure should be followed.



**Appendix Q-21 – Action List – Chief Nurse, Health & Social Care Directorate, Montfield**

**On being advised of a major emergency alert, the Chief Nurse, Health & Social Care Directorate will:**

- 1 Set up a Hospital Information Centre in the Lerwick Health Centre with the objective of maintaining morale, giving information, consolation and practical assistance to the distressed and/or bereaved, and as far as possible keeping relatives and next-of-kin away from the actual Accident and Emergency reception area in the Gilbert Bain Hospital.
- 2 Decide on the levels of staff and facilities likely to be required, bearing in mind the following guidelines:
  - (a) Clinics under way in ante-natal and Chiropody rooms can, if necessary, be cancelled;
  - (b) the need to liaise with GPs, Practice Manager, Practice Nurses, and Hospital Chaplains and Social Work Department, SIC, re staffing of the Hospital Information Centre, and keep them informed of developments;
  - (c) the need to liaise, via the Hospital Control Centre, with the Police, who will be operating a Casualty Bureau and who will wish to be advised of all next-of-kin reporting to the Hospital Information Centre;
  - (d) documentation for recording names and addresses of relatives will be required, and should be obtained from the stock of police next-of-kin forms stored in the Hospital Control Centre. A small ready use stock should be held in the Lerwick Health Centre;
  - (e) liaison will be required with the Hospital Control Centre, to ensure earliest receipt of casualty information: all such information should be confirmed in writing, and delivered by 'runner';
  - (f) the need to keep the Police and Social Work Liaison Officers' at the Hospital Control Centre informed of developments and in particular of number of relatives being dealt with, or if situation is becoming in any way difficult;
  - (g) the need, if asked by laboratory officer, to arrange for nurse(s) to help with emergency blood donors;
  - (h) the need, as requested by the Hospital Control Centre, to contact other community nursing staff to supplement hospital nursing staff levels;
  - (j) the need as required to liaise, via the Hospital Control Centre, with the Social Work Department with regard to appropriate Social Work assistance.



**Appendix Q-22 – Action List – Shetland District, British Red Cross**

**The duty Emergency Planning Officer, on receipt of notification of a major incident will, at the earliest opportunity, notify the appropriate officers within the British Red Cross. This will usually be only the First Aid Team Co-ordinator in the first instance, or in their absence the advised First Aid Team Leader.**

**On being advised of a major emergency alert, the representative of the Shetland District, British Red Cross will:**

1. Write down the following information:
  - Place of accident
  - Time of accident
  - Type of accident
  - Number of persons thought to be involved
  - Source of the information
2. Pass this information without delay to fellow volunteers whose names and telephone numbers are listed in the Major Accident Contact List; plus such additional Red Cross members as seems appropriate.
3. Advise the Hospital Control Centre of the name and telephone number of the Red Cross Officer who will be the official contact for the duration of the emergency.

**NOTE: Volunteers on duty in the Gilbert Bain Hospital or in the Health Centre should carry an Identity Card.**



**Appendix Q-23 – Action List - Pharmacist**

**On being advised of a major emergency alert, the Pharmacist will stand by for emergency duty at the Hospital, or report for duty immediately as dictated by the circumstances, and:**

**Outwith Normal Hours**

1. Proceed to Gilbert Bain Hospital;
2. Report arrival to the Nurse in Charge of Gilbert Bain Hospital;
3. Proceed to the Pharmacy;
4. Check that supplies are likely to be adequate to handle the casualties expected.
5. Make an assessment of whether additional Pharmacists / Technical Staff should be called in including Community colleagues where necessary.
6. Assist in any way possible with medicines / information required for the safe discharge of patients from hospital.





**Appendix Q-24 – Action List – Executive Manager / Chief Social Work Officer, Shetland Islands Council**

**On receipt of notification of a Major Emergency Alert the Executive Manager / Chief Social Work Officer, will:**

1. Nominate a Social Work Liaison Officer to attend the Hospital Control Centre;
2. establish a co-ordination cell within the Children and Families;
3. establish contact with the Social Work Liaison Officer in the Hospital Control Centre;
4. establish contact with the Chief Nurse, Health & Social Care Directorate who maintains the Hospital Information Centre;
5. monitor the social needs of casualties and next-or-kin and action appropriately;
6. co-ordinate the deployment of the voluntary sector in accordance with the SIC Emergency Plan;
7. deploy, in conjunction with the Hospital Control Centre, any medical or nursing support that may be deemed necessary;
8. inform the Hospital Control Centre of any specific problems proving difficult to resolve;
9. render to the Hospital Medical Controller such reports as may be periodically required;
10. relieve the Social Work Liaison Officer when necessary.



**Appendix Q-25 – Action List – Social Work Liaison Officer, SIC**

**On receipt of notification of a Major Emergency Alert the Social Work Liaison Officer will:**

1. Go to the Gilbert Bain Hospital;
2. report arrival to the Hospital Control Centre and establish contact with the Hospital Medical Controller;
3. establish contact with the Police Liaison Officer and the Executive Manager / Chief Social Work Officer and maintain close contact throughout the incident;
4. establish contact with the Hospital Information Centre, if necessary, via the Police Liaison Officer;
5. ensure that the social needs of casualties, survivors and next-of-kin within the Hospital environs are being met and report to Departmental Co-ordination Cell;
6. render to the Hospital Medical Controller such reports as may be periodically required;
7. render such reports to the Departmental Co-ordination Cell as may be periodically required.



**Appendix Q-26 – Action List – Head of Estates & Facilities**

**On receipt of a major emergency alert the Head of Estates & Facilities or in his absence the Maintenance/Facilities Manager will:**

- 1 Go to the Gilbert Bain Hospital.
- 2 Mark 'in' on the major accident 'in/out' board at Reception.
- 3 Report arrival to the Nurse in Charge of Gilbert Bain Hospital
- 4 Make available stock of protective clothing if required.
- 5 Ensure that adequate staff have been summoned and mustered for:
  - (a) portering
  - (b) maintenance
  - (c) acting as 'runners' between Medical Reception, the Hospital Control Centre, the Board Chief Executive's office and Lerwick Health Centre, as circumstances dictate
  - (d) security duties at A & E entrance
  - (e) directing relatives to the '**Information Desk**' in Islesburgh House
  - (f) other duties, as the situation from time to time requires
- 6 Ascertain what services are required and:
  - (a) in the role of Fire Officer provide advice on matters of hospital security
  - (b) assist the Hospital Medical Controller in any other appropriate manner
- 7 If requested, ensure the safe manning the exit point from the accident and emergency treatment area.
- 8 Keep the Hospital Control Centre regularly advised of your situation.



**Appendix Q-27 – Action List – Senior Manager on Call**

**On being advised of a major emergency alert, the Senior Manager on Call will plan and prepare for good media liaison. This will include:**

- 1 Update themselves on details of emergency via Hospital Medical Control.
- 2 Specific responsibility for finding alternative GP cover for Medical Incident Officer role if necessary - to be advised by Hospital Switchboard.
- 3 Liaison with Director of Public Health for strategic co-ordination of multi-agency response.
- 4 Identify Communications Leads for those organisations involved in the major emergency.
- 5 Preparation for media handling in line with Board's policies and procedures.
- 6 Ensure plans are linked to any local multi-agency press briefing arrangements, which may be run by other Category 1 Responders, and (in liaison with the Director of Public Health) previously identified regional / national spokesperson eg from Health Protection Scotland or other relevant body depending on nature of incident..
- 7 Plan facilities which can be made available at short notice, such as rooms for the media, telephone lines, IT, staff support for communications role etc.
- 8 Have in place arrangements to call for extra support, at short notice, for communications. In the first instance calling on mutual aid arrangements with NHS Grampian and subsequently with other Boards in the North of Scotland in the first instance, to enable capacity to be boosted at short notice and to provide cover.
- 9 Prepare simple, easily digestible information about NHS Shetland that might include size, staff numbers, specialties names and positions / responsibilities of key people to hand out to the media in the event of a major incident and to supplement this with prepared messages appropriate to local risks in specific areas, i.e., CoMAH facilities or other local situations that may occur.
- 10 Ensure all communications leads, designated spokespersons and others who might have to fulfil the role of spokesperson, have appropriate training and development opportunities to enable them to fulfil their role.





**Appendix Q-28 – Action List – Facilities Manager**

On being advised of a major emergency alert, the Facilities Manager will ensure that there will be adequate food and linen available.



**Part R – Mutual Aid**

**1 Introduction**

1.1 Two generic Mutual Aid agreements are relevant to this plan:

1.1.1 The North of Scotland Planning Group for NHS specific mutual aid is attached as Appendix R-1

1.1.2 The Highlands and Islands Strategic Co-ordinating Group is attached as Appendix R-2

1.2 There are also a number of specific mutual aid agreements in circulation, i.e., Pandemic Influenza and Fuel Planning.

1.3 Guidance has been created to provide public health, environmental, scientific and technical advice to emergency co-ordinating groups in Scotland through establishment of a Scientific and Technical Advice Cell (STAC).

1.4 Requests for Mutual Aid and the requirement for expert advice through the creation of a STAC will be at the discretion of those involved in managing the response. Flexibility will be critical in making these arrangements work as there is a wide range of possible scenarios which could arise. Much will depend on assessing the situation at the time, which will dictate the approach to be taken. Rapid and close liaison between key personnel in local and national agencies and Scottish Government will be essential to identifying and activating the most appropriate mechanism.



## **Appendix R-1 – Mutual Aid – North of Scotland Planning Group**

The North of Scotland Planning Group has suggested the following wording for mutual aid:

### **Mutual Aid**

A major incident may overwhelm the capacity and resources of NHS (insert health board name). In these circumstances all efforts will be made locally to respond to the incident, treat those affected and maintain critical services, however, NHS (insert health board name) may need to seek mutual aid from other health board areas in the North of Scotland. The types of assistance required could include:

- Capacity for patients
- Staff, including specialists
- Supplies

Major incidents differ in nature and could affect more than one health board area, therefore the ability to provide mutual aid or specify the type of mutual aid available from other health board areas cannot be predetermined.

The Chief Executives of the following health board areas are committed to providing mutual aid within the best of their ability given the circumstances at the time:

- NHS Tayside
- NHS Grampian
- NHS Highland
- NHS Orkney
- NHS Shetland
- NHS Western Isles

To request mutual aid the Chief Executive or Deputy of NHS (insert health board name) will assess requirements and discuss these with the Chief Executive(s) or Deputies of the most appropriate health board areas who may be able to offer assistance.

All requests must be reasonable, impact assessed, timed, agreed and documented. Any providing health board area has the right to withdraw mutual aid at any time if circumstances change e.g. in response to a local major incident.

Provision must be in place for the reimbursement of any costs incurred by the health board area (s) providing mutual aid. This will include a system of recording and monitoring. This arrangement will be in no way legally binding.



**Appendix R-2 – Mutual Aid – Highlands & Islands Strategic Coordinating Group**

The agency members of the Highlands and Islands Strategic Co-ordinating Group agree, where practicable, to render all possible help to each other in the event of a major accident/incident occurring. The incident may be the result of natural, man-made or technological causes or a mass casualty incident (hereinafter ‘disaster’), which impacts on the operational capabilities of any agency. The affected agency may request assistance from any or all of the other agencies.

In the event of a disaster, an affected agency should contact the other agencies to request, agree and arrange the level of assistance required. The extent of the assistance given will be at the discretion of responding agency members, having regard to their own local needs/situation at the time.

The arrangements to be conducted under the following conditions:

- The Chief Executive/Chief Officer of the requesting agency accepts full liability for all aid received, whether human or material, for the total period of deployment.
- The Chief Executive/Chief Officer of the requesting agency pays for, or reimburses the assisting agency, for travel, subsistence and overtime payments made to individuals during the period of deployment.
- The Chief Executive/Chief Officer of the requesting agency accepts liability for insurance cover for aid received, whether human or material.
- The Chief Executive/Chief Officer of the assisting agency accepts responsibility for paying the basic salary and allowances of individuals seconded to assist.
- The Chief Executive/Chief Officer of the assisting agency accepts responsibility for any overtime payments within their own organisation to cover any absence due to providing mutual aid.
- The duration of the requested mutual aid is kept to a minimum.
- The requesting agency will meet the cost of any further involvement of seconded individuals with the incident, for legal or any other reason.

**Effective date and future amendment**

This Agreement shall become effective from ..... (Date).

An Agency may terminate its participation in this Agreement by giving notice to the next substantive meeting of the Highlands and Islands Strategic Co-ordinating Group.

This Agreement shall be reviewed periodically (not exceeding two years) to ensure it meets the requirements of all the Agencies.





## **Part S – Counter Terrorism**

### **1. Introduction**

- 1.1 Terrorist attacks in the UK are a real and serious danger. Simple good practice coupled with vigilance and well exercised contingency arrangements may be all that is needed. Existing crime prevention measures will also provide a deterrent against terrorism.
- 1.2 Terrorism can come in many forms, it is not limited just to a physical attack on life and limb. It can include interference with vital information or communication systems, causing disruption and economic damage. Terrorism also includes threats or hoaxes designed to frighten and intimidate.

### **2. Managing the Risks**

- 2.1 Dealing with the potential threat of a terrorist attack needs to sit alongside and be a part of the service Business Continuity Plans, and a part of the role of the Board's Security Adviser (Facilities Manager for NHS Shetland).
- 2.2 In most cases preparedness for counter terrorism requires a review of what security measures, policies and procedures are already in place as well as compliance with these, and simple good practice coupled with vigilance and well exercised contingency arrangements.

### **3. Identifying the Threats**

- 3.1 The Public Health Department via the Shetland Emergency Planning Forum Executive and the Emergency Planning and Resilience Officer with SIC provide updates on the current security climate or about recent terrorist activities, and will alert the service appropriately.
- 3.2 Regular liaison with the local Police service will advise about crime and other problems in the area.
- 3.3 There is nothing specific about NHS Shetland's site and activities that would directly attract terrorist attention, but the proximity to the oil industry and related activities provide some measure of risk, dealt with through Control of Major Accident Hazards (COMAH) plans and the Shetland multi-agency response plans. It is possible that collateral damage will occur from an attack on a high risk neighbour, though the geographical siting of Sullom Voe terminal and off-shore activity make this unlikely – further details available via the Emergency Planning and Resilience web-site: <http://www.shetland.gov.uk/emergencyplanning/>



- 3.4 NHS Shetland does not carry out or participate in any animal and / or nuclear research, which may be a target for Animal Rights groups.
- 3.5 This is written to communicate information about possible threats and response to staff. Any changes to threat levels or response will be communicated via the Board's usual communication routes which may include Team Brief, Message of the Day, direct communications from the DPH or Chief Executive.
- 3.6 The Board's Major Emergency Procedure and Business Continuity Plans are in place to respond to and deal with a direct attack leading to loss or disruption of healthcare asset.
- 3.7 If a visiting VIP is in attendance their Police escort / Co-ordinator is expected to control of their safety.

#### 4. Protecting and identifying vulnerabilities

Priorities for protection fall under the following categories:

- 4.1 People (staff, patients, contractors and the general public) - NHS Shetland has HR procedures in place for assessing the integrity of those we employ or who provide contracted services.
- 4.2 Physical assets (buildings, contents, equipment, plans and sensitive materials e.g. pathogens) - NHS Shetland has arrangements in place for dealing with fire and crime, and security measures in place to limit accessibility to vulnerable areas.
- 4.3 Information (limiting access to electronic and paper data) - Protection from IT viruses and hackers is dealt with via the Board's Information Security Policy, as is the confidentiality and availability of information to the public.

#### 5. Identifying measures to reduce risk

- 5.1 Although the likelihood of a terrorist act may be lower than burglary or theft, the impact of such an act may be critical to the delivery of health care, and **TERRORISM IS A CRIME** so many of the security precautions typically used to deter criminals are also effective against terrorists.
- 5.2 The Board's Facilities Manager, in his role as Security Officer, will ensure that good basic security practices are in place and regularly review existing security policies and procedures, revising and/or introducing new policies and procedures as appropriate.



6. Rehearsing and revising emergency and contingency plans and reviewing security measures

6.1 The Board's emergency and business continuity plans are tested regularly through exercising and through real life events with regular review and revision as necessary. Specific counter-terrorism awareness and training has been undertaken via participation in Project Argus – health, and will continue appropriately in the future as part of the Board's training plan.

7. Security Planning

7.1 Responsibility for undertaking vulnerability and risk assessment, and the implementation of protective security measures lies with the Security Officer (Facilities Manager in NHS Shetland) who has the authority to direct action in response to a security threat. The Security Officer will take the terrorist dimension into account in security planning which should include:

- Details of all the protective security measures to be implemented, covering physical, information and personnel security
- Instructions/briefings to staff including the types of suspicious behaviour to look for and methods of reporting
- Instructions on how to respond to a threat (e.g. telephone bomb threat)
- Instructions on how to respond to the discovery of a suspicious item or event
- A search plan
- Evacuation and lockdown plans, including both partial and full evacuation/lockdown measures
- Business continuity plans to include mutual aid arrangements in the event of a major incident that results in an evacuation/lockdown
- Links to the Board's Communications and media strategy to include handling enquiries from concerned family and friends

8. Physical Security

8.1 Physical security is important in protecting against a range of threats and addressing vulnerability. Security measures should be put in place to remove or reduce vulnerabilities but must not compromise the safety of staff and patients. Security measures include good housekeeping (keeping communal areas clean and tidy), CCTV, perimeter fencing, intruder alarms, computer security and lighting.



9. Security awareness

9.1 **Staff vigilance is essential to protective measures. Staff know their own work areas very well and are encouraged to be alert to unusual behaviour or items out of place. Staff should report any suspicions knowing that reports – including false alarms - will be taken seriously and regarded as a contribution to the safe running of the service.**

9.2 Staff should look out for packages, bags or other items in odd places, carefully placed (rather than dropped) items in rubbish bins and unusual interest shown by strangers in less accessible places.

10. Access control

10.1 Access points to vulnerable areas should be kept to a minimum and the boundary between public and private areas should be clearly demarcated, signed and secure.

10.2 NHS Shetland offers a range of services open to the public 24/7, and the welfare and care of staff, patients and visitors, and members of the public on legitimate business should be our first concern.

10.3 Staff and contractors should wear their ID badges at all times. The issuing of ID badges is controlled in line with Board policy, and procedures are in place to ensure that ID badges are returned to the human resources department when staff leave the service. Passes include a photograph of the bearer.

10.4 Staff or official visitors not wearing identification should be politely challenged, and visitors and members of the public should be helped to find their way around our facilities.

11. Traffic and parking controls

11.1 If you believe you might be at risk from a vehicle bomb, the basic principle is to keep all vehicles at a safe distance. Controls include the potential for proper access control, careful landscaping, traffic-calming measures and robust, well-lit barriers or bollards. Ideally, non-essential vehicles should be kept at the maximum possible distance from the site.





12. Good Housekeeping

- 12.1 Good housekeeping improves the ambience of sites, reduces the opportunity for placing suspicious items or bags and helps to deal with false alarms and hoaxes.
- 12.2 Good practice in relation to waste is included in the Board's waste management policy.
- 12.3 Receptionist staff are trained in bomb threat handling procedures and have ready access to instructions - and know where these are kept. (See bomb threat checklist attached to this annex, held at reception GBH and Brevik).
- 12.4 The CCTV system is reviewed on a regular basis to ensure it has sufficient coverage both internally and externally.
- 12.5 Fire Extinguishers are appropriately marked and authorised for the locations they are kept. Regular checks are made to ensure that they have not been interfered with or replaced.
- 12.6 A secondary secure location is identified for the Hospital control room as part of the Board's Business Continuity plans.

13. Response

- 13.1 The Major Emergency Plan is written to cover the generic response to a major incident including procedures for managing contaminated casualties presenting directly at the site as victims or suspects.
- 13.2 Appendix 1 details the Bomb Threat checklist to be used.
- 13.3 Appendix 2 details advice to respond to a Firearm or Weapons attack. The section on Planning should be used within department's Business Continuity Plans to take account of a Firearm or Weapons threat.

Further counter terrorism advice is available via Emergency Planning colleagues in SIC or from Police Scotland.

References:

Counter Terrorism Protective Security Advice for Health. Produced by NaCTSO  
National Counter Terrorism Security Office

<http://www.shetland.gov.uk/emergencyplanning/>

**Appendix S-1 – Bomb Threat Checklist**

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**This checklist is designed to help your staff to deal with a telephoned bomb threat effectively and to record the necessary information.**

Visit [www.cpni.gov.uk](http://www.cpni.gov.uk) to download a PDF and print it out.

**Actions to be taken on receipt of a bomb threat:**

Switch on tape recorder/voicemail (if connected)  
Tell the caller which town/district you are answering from  
Record the exact wording of the threat:

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**Ask the following questions:**

Where is the bomb right now? \_\_\_\_\_

When is it going to explode? \_\_\_\_\_

What does it look like? \_\_\_\_\_

What kind of bomb is it? \_\_\_\_\_

What will cause it to explode? \_\_\_\_\_

Did you place the bomb? \_\_\_\_\_

Why? \_\_\_\_\_

What is your name? \_\_\_\_\_

What is your address? \_\_\_\_\_

What is your telephone number? \_\_\_\_\_

**(Record time call completed:)**

Where automatic number reveal equipment is available, record number shown:

\_\_\_\_\_

Inform the premises manager of name and telephone number of the person informed:

\_\_\_\_\_

Contact the police on 999. Time informed: \_\_\_\_\_

**The following part should be completed once the caller has hung up and the premises manager has been informed.**

Time and date of call: \_\_\_\_\_

Length of call: \_\_\_\_\_

Number at which call was received (i.e. your extension number): \_\_\_\_\_

**ABOUT THE CALLER**

Sex of caller: \_\_\_\_\_

Nationality: \_\_\_\_\_

Age: \_\_\_\_\_

**THREAT LANGUAGE (tick)**

- Well spoken?
- Irrational?
- Taped message?
- Offensive?
- Incoherent?
- Message read by threat-maker?

**CALLER'S VOICE (tick)**

- Calm?
- Crying?
- Clearing throat?
- Angry?
- Nasal?
- Slurred?
- Excited?
- Stutter?
- Disguised?
- Slow?
- Lisp?
- Accent? If so, what type? \_\_\_\_\_
- Rapid?
- Deep?
- Hoarse?
- Laughter?
- Familiar? If so, whose voice did it sound like? \_\_\_\_\_

**BACKGROUND SOUNDS (tick)**

- Street noises?
- House noises?
- Animal noises?
- Crockery?
- Motor?
- Clear?
- Voice?
- Static?
- PA system?
- Booth?
- Music?
- Factory machinery?
- Office machinery?
- Other? (specify) \_\_\_\_\_

**OTHER REMARKS:**

Signature \_\_\_\_\_

Date \_\_\_\_\_

Print name \_\_\_\_\_

**Appendix S-2 - Firearm and Weapon Attacks**

Attacks involving firearms and weapons are still infrequent but it is important to be prepared to cope with such an incident.

The important advice below will help you plan.

**In the event of an attack take these four actions:**

**Stay Safe**

- Under immediate GUN FIRE – Take cover initially, but leave the area as soon as possible if safe to do so
- Nearby GUN FIRE – Leave the area immediately, if possible and it is safe to do so.
- Leave your belonging behind
- Do not congregate at evacuation points

COVER FROM GUN FIRE	COVER FROM VIEW
Substantial brickwork or concrete	Internal partition walls
Engine blocks of motor vehicles	Car doors
Base of large live trees	Wooden fences
Earth banks/hills/mounds	Curtains

**REMEMBER** – out of sight does not necessarily mean out of danger, especially if you are not in “cover from gun fire”.

**IF YOU CAN'T ESCAPE** – consider locking yourself and others in a room or cupboard. Barricade the door and stay away from it.

If possible choose a room where escape or further movement is possible.

Silence any sources of noise, such as mobile phones, that may give away your presence.

**The more information that you can pass to the Police the better but NEVER risk your own safety or that of others to gain it. Consider CCTV and other**

**remote methods where possible to reduce the risk. If it is safe to do so, think about the following:**

**See**

- Is it a firearms/weapons incident?
- What else are they carrying?
- Moving in any particular direction?
- Are they communicating with others?
- Exact location of the incident
- Number and description of gunmen
- Type of firearm – long-barrelled or handgun
- Number of casualties/people in the area

**Tell**

- **POLICE** –contact them immediately by dialing 999 or via your control room, giving them the information shown under “See”
- Use all the **channels of communication** available to you to inform staff, visitors, neighbouring premises, etc of the danger

**Act**

- Secure your immediate environment and other vulnerable areas
- Keep people out of public areas, such as corridors and foyers
- Move away from the door and remain quiet until told otherwise by appropriate authorities or if you need to move for safety reasons, such as a building fire

**Armed Police**

**In the event of an attack involving firearms or weapons, a Police Officer's priority is to protect and save lives. Please remember:**

- Initially they may not be able to distinguish you from the gunmen
- Officers may be armed and may point guns at you
- They may have to treat the public firmly. Follow their instructions; keep hands in the air/in view
- Avoid quick movement towards the officers and pointing, screaming or shouting

### **Planning**

**Consider the following when planning for a firearms/weapons incident**

- How you would communicate with staff, visitors, neighbouring premises, etc.
- What key messages would you give to them in order to keep them safe
- Have the ability to secure key parts of the building to hinder free movement of the gunmen
- Think about incorporating this into your emergency planning and briefings
- Test your plan at least monthly

If you require further information then please liaise with your Security Adviser (Facilities Manager)

### **Taking Cover**

#### **The 4Cs**

- **Cover**
- **Confirm**
- **Contact**
- **Control**

**ALL OF YOUR ACTIONS SHOULD BE UNDERTAKEN WITHOUT UNNECESSARILY EXPOSING YOURSELF TO DANGER.**

#### **Cover**

The first action you are likely to take is to find some cover. There is an important distinction that you need to understand in relation to cover.

There are two types of cover:

- Cover from view
- Cover from fire (ballistic cover)

Cover from view means that the gunman cannot see you, but you could still fall victim to a gunman because you may not have effective ballistic protection.

For example, hiding behind a wooden fence may keep you out of sight, but bullets can pass easily through a wooden fence because it provides no ballistic cover.

Ballistic cover can provide you with the protection you need from the lethal effects of firearms.

**HAVING MADE THIS DISTINCTION THE IMPORTANT POINT TO CONSIDER IS THE TYPE OF AVAILABLE COVER.**

**Examples of good ballistic cover could be:**

- Behind substantial material: brickwork, reinforced concrete and steel
- Behind the engine block of a motor vehicle
- Behind a substantial living tree at its base
- If in the open look for undulating ground and seek out hollows or mounds that provide substantial protection

**Examples of poor ballistic cover could be:**

- Behind a wooden fence.
- Behind the doors of a motor vehicle.
- Behind glazing.

Remember, most internal walls (partition walls) are unlikely to provide ballistic cover.

**Confirm**

- It is a firearm incident
- The exact location of firearm incident
- The number of gunmen



- The type of firearms. Are they handguns or long-barrelled?

*This is important, as long-barrelled weapons are generally effective over a very long distance, unlike a handgun that is effective over a much shorter distance. The police and others will need to know the potential firearms capability of the terrorists and this information will assist them.*

- The direction of travel of the gunmen.
- Be prepared to answer other questions the 999 operator may ask you.

### **Contact**

- The police must be contacted immediately via 999 with the information set out under “Confirm”
- Use all the communication channels available to you to inform staff, customers and others of the danger
- Plan for a firearms incident:
  - *How would you communicate with staff and customers?*
  - *What key messages would you give them to help keep them safe?*
  - *Think about incorporating this type of incident into your Incident management Plan (IMP) BS25999 Part 1.*
- Test your plan at least annually

### **Control**

- As far as you can limit access to your immediate environment
- Encourage people to avoid public areas such as corridors and foyers
- If you are in a room stay there and lock the door
- Move away from the door and remain quiet