

HQ RC Med Planning Template V2 – Revised JUNE 25 (DO NOT REMOVE)

Ref - Ex RI3 HSS

19/11/2025

**Exercise RACING ICE 3– Health Service Support (HSS) Plan (20 Feb - 8 Mar 2026)
Lillehammer, Norway**

References:

- A. [JSP 375 - Management of Health and Safety in Defence v.1.2.](#)
- B. [JSP 375 Volume 1, Chapter 41 - Heat Illness Prevention](#)
- C. [JSP 375 Volume 1, Chapter 42 - Cold Injury Prevention](#)
- D. [JSP 751 - Joint Casualty & Compassionate Policy & Procedures.](#)
- E. [ACSO 1200 - The Army's Safety and Environmental Management System.](#)
- F. [AP 3394 - The RAF Aeromedical Evacuation Service.](#)
- G. [ACSO 3215 – The Planning of Health Service Support.](#)
- H. [ACSO 1209 – Authorisation of Comparable Activities Which Are Not Categorised as Adventurous Training or Sport.](#)
- I. [JSP 419 – Adventurous Training in the UK Armed Forces.](#)
- J. [20251216-Warning Order ISIC26 Lillehammer-O.docx](#)
- K. 2023DIN10-018 Army European Winter Activity Instruction 2025/26
- L. AGAI Vol 1 Ch 5
- M. JSP 800 Vol 5 Part 1. Road Transport Regulations, Feb 19.

Unit: Army Ice Sports, AWSA	Activity Lead: Capt Lucy Wyatt	
	CO/OF4 Cmd: Brig Tim Allison	
	1* Fmn (for risk escalation as per ACSO 1200): AWSA (RC)	
Dates of Deployment: 20 Feb -8 Mar 2026	Number deploying: 40	
Activity location(s): Lillehammer bobsleigh track, Norway		
Activity: Skeleton, bobsleigh and luge training and racing.		
Exercise command structure:		
OiC Bobsleigh	Capt Tom Rees	
OiC Skeleton	Capt Arran Holmes	
OiC Luge	Capt Nat Jackson	

SITUATION

1. This activity has been confirmed as Duty of Care (DoC)
2. References A – L have been consulted and direction within them followed throughout the planning process.

AIM

3. The aim of this medical plan is to ensure safe and effective delivery of Force Health Protection, Primary Healthcare, Pre-Hospital Emergency Care, Medical Evacuation, Hospital Care, Medical C4i and Medical Logistics for participating personnel.

Conduct of Exercise RACING ICE 1 – Army Novice Ice camp

4. The Novice ice camp will be conducted on one exercise
 - a. **Phase One** Travel to Lillehammer, Norway 20 Feb 26.
 - b. **Phase Two** Scheduled training and racing in Bobsleigh, Luge and Skeleton Bob 23 Feb-6 Mar 26
 - c. **Phase Three** Recover to UK 8 Mar 26

FORCE HEALTH PROTECTION (FHP)

5. **FHPI.** A Force Health Protection Instruction (FHPI) provided by AWSA is at **Annex D**. This FHPI highlights both generic health threats as well as activity-specific health risks. Direction within this FHPI is to be followed by all deploying personnel. ***If an FHPI has not been sourced, the overall risk will be no lower than MEDIUM-HIGH as per [ACSO 3215 Annex F](#).***
6. **Key Risks.** Significant risks pulled from the FHPI and from the activity include: Cold weather environment and features in the Risk Assessment at Annex E with proposed mitigations.
7. **Acclimatisation.** No activity will be undertaken within 24 hours of arrival in order for participants to rest and acclimatise.
8. **Safe training.** As training is taking place over 2 weeks there will be a 48 hour mandated rest period 28 Feb – 01 Mar to ensure athletes are physically fit to slide during the Inter service championships.
9. **Vaccinations.** Individuals deploying must be vaccinated iaw [JSP 950 Leaflet 7-1-1 Immunological Protection of Entitled Individuals](#)
10. **JMES.** Any non MFD individuals who will be deploying with an App 26 reviewed and signed by the CoC.

11. **Climate.** ALL SP to be made aware of [JSP 375](#) and Commanders Guide to [Cold Injury](#) and [Heat injury](#). Generic guidance on temperature in the workplace is also available on the [Health and Safety Executive's website](#).

12. **Force Health Protection Brief (FHPB).** As part of PDT, all deploying personnel will receive FHPB on the health risks and associated hygiene issues for living and working in their area of operations on:

- a. 28 Feb 2026 –Lead Exercise medic

PRIMARY HEALTHCARE (PHC)

13. **Medical Recce.** Medical facilities were extensively recce'd Nov 2025 during ex RACING ICE 1. further recce will be conducted by advance party on arrival.

14. **Routine Healthcare.** PHC will be facilitated through;

- a. Primary Health Care (PHC) and Emergency Dental Care assistance should be facilitated through local civilian practices in Norway. Civilian medical facilities accessed via the details as listed in Annex B. The CMTs accompanying the camps will be able to provide PHC within their scope of practice.

15. **Dental.** Dental will be facilitated through;

- a. As above.

PRE-HOSPITAL EMERGENCY CARE (PHEC)

16. **Organic Medical Capability.** The UK medical personnel identified to support this activity are detailed below.

Ser	Number	Rank	Name	Appointment/qualification	Remarks
1	TBC	TBC	TBC	CMT1	- Complete with med bergen.
2	TBC	TBC	TBC	CMT1	-Paramedic -Prior Ice Sports Experience

17. Due to the risks peculiar to Ice Sports, it is essential that at least one medic has supported Ice Sports on a previous Exercise and is deemed environmentally SQEP. This will ensure that the medical team is familiar with track operation and the risks and safety protocols associated.

18. **ITR 13.3.** All serving individuals will be current with ITR 13.3 BCD.

- a. **10 mins (POI).** In the unlikely event of a serious casualty, immediate life saving measures will be provided by the deployed CMTs within 10 mins. At all times ice sports are ongoing there will be at least one duty CMT at the track.

- b. **20 mins from POI.** Enhanced Field Care (EFC) is reliant on HN emergency services personnel and will likely be achieved within 20 mins.

- c. **1hr from POI.** Enhanced care is highly likely to be delivered within the clinical timeline by HN emergency services personnel. All persons will carry insurance documents that cover all emergency medical evacuation and treatment, whether by ground or by air.
- d. **2hrs from POI.** Access to a hospital facility capable of providing damage control surgery or acute medicine is highly likely to be achievable in <2hrs. In Lillehammer the nearest hospital is a 20min drive away and the track can generate an emergency HLS if required.

MEDEVAC

19. Emergency Medical Evacuation. In the event of serious or life-threatening injuries, military or civilian emergency services will be summoned using the emergency telephone number 112

- a. **Strategic Aeromedical Evacuation (STRAT AE)** STRAT AE will be provided through the UK [Aeromedical Evacuation Control Centre \(AECC\)](#) in conjunction with [UK Joint Casualty and Compassionate Cell \(JCCC\)](#). If access to the STRAT AE service is required, then contact the AECC on the numbers or email below. It is essential that [Reference G \(AP 3394\)](#) is accessed before deployment and sufficient copies taken on the deployment. This will provide all the necessary information on the procedure for requesting STRAT AE and how to raise a Patient Movement Request (PMR).
- b. Non-medical personnel can submit PMRs. In the absence of deployed DMS personnel or an appropriate parent unit, PMR 1 should detail a medical POC responsible for the patient's care. In such circumstances, a nominated individual is to remain in location with the patient to act as a single POC until completion of the AE mission.
- c. Where MODNET access is available, requests for STRAT AE should be raised via the [Digital Aeromed Request Platform](#). If MODNET is not available, PMRs are to be submitted to medfce-tmw-aecc@mod.gov.uk using the templates in AP 3394.
- d. If there is no IT capability on the ground to raise PMRs, then it must be ensured that the Parent Unit is aware of the AE process and would be able to generate a request on behalf of the patient.

(1). **AECC Contact Details** - Routine Contact (0800 – 1700 hrs UK Time) – +44 (0)1993 895300 or 95461 5300.

(2). Out of Hours (1700 – 0800 hrs UK Time) – Mobile +44 (0)7770 648688.

20. Hospitalisation Support Plan

- a. Personnel should deploy with an up-to-date copy of their FMed 965. *Reserve / civilian personnel should obtain a copy of their relevant medical record, which can be obtained via the NHS App (<https://www.nhs.uk/nhs-app/nhs-app-help-and-support/health-records-in-the-nhs-app/>) or directly from their GP.* In the event that a copy cannot be obtained, personnel must make a written note of any allergies,

medications taken and recent/significant medical history. Copies/notes are to be carried by the individual on their person at all times.

- b. Copies of any patient records produced in country must be obtained, and passed to DPHC for uploading to DMICP on return to the UK. *Reserve / civilian personnel should pass any patient records to their civilian GP.*
- c. The Exercise takes place at an international sporting venue used throughout the year by multiple nationalities and occasionally tourists as well. There is an assumption that the medical facilities will have someone who can speak English. in the unlikely event that there is no English speaking medic, a translator will be sourced from Hotel staff.
- d. In accordance with Ref A, personnel are required to present their GHIC and passport when accessing HN medical facilities. These items are to be carried by personnel at all times.
- e. In the event of hospitalisation personnel will be accompanied by a member of exercise DS, available at ref J

21. **CASEVAC** In certain situations, it may be necessary or appropriate for a casualty to be transferred to the next stage of medical care using a non-ambulance platform. In these situations it must be kept in mind that prolonged CASEVAC can result in deterioration of the casualty's condition. Therefore, the duration of any CASEVAC must be kept to a minimum if the casualty's condition is serious. If CASEVAC is discretionary (e.g. transferring a casualty with a slight hand injury to hospital in an Ex support vehicle), medical advice must be sought prior to transfer if there is any doubt about whether it is safe to move the casualty using a non-ambulance platform.

DEPLOYED HEALTHCARE (DHC)

22. **Locations.** All PHC, dental, pharmaceutical and emergency hospital locations can be found in Annex B and timelines found in Annex C.

23. **Surgery.** Service Personnel are advised not to agree to surgery when outside the UK unless it is to preserve life, limb or eyesight, even where the care is likely to be of a UK standard. This is because some surgical interventions can impact on future deployability, which is unlikely to be given full consideration by surgical teams outside the MoD. Once a service person is injured contact should be made early with the UK Aeromedical Evacuation Control Centre (AECC) on +44 (0) 7770 648 688. The AECC will liaise with the Royal Centre for Defence Medicine (RCDM) for advice on patient management. It may be appropriate to have surgery in situ depending on where injured SP are and the nature of the injury/illness, but the preference is often to bring SP back to the UK and perform the definitive surgery at a facility approved by the MoD for that purpose.

24. **Overseas Medical Care.** When receiving medical care overseas, even when the medical facilities or capabilities have been assured by competent medical persons, it is imperative that the UK Military Medical Chain are involved in the delivery of care. Medical care delivered overseas **may** deliver high quality care however, the care delivered may not account for the Service Person's continued employment within the Army. Inclusion of the

military medical chain may prevent further avoidable clinical procedures and ultimately prevent medical discharge. Critical Life, Limb and Eyesight/Hearing preserving treatment **must not** be impeded¹ but for all other surgical treatment as soon as practicable, prior to surgery, the RAF Aeromedical Evacuation and Control Centre (AECC) must be contacted and will provide military medical advice. The Competent Medical Authority² for the activity must also be notified in a timely manner prior to any evacuation. Any HSS and Emergency Medical Plan must explicitly make clear this requirement and include 24/7 contact details for both the CMA and AECC³.

¹ What constitutes “Critical Treatment” is not easily defined but should be considered as any treatment that must be administered immediately without delay to prevent a loss of life, limb, or eyesight.

² [ACSO 3366 Competent Medical Authorities](#)

³ AECC 24/7 Duty Ops number at the time of writing is +44 (0) 7770 648 688 full contact details and guidance on initiating Aeromedical Evacuation can be found at this [DIN](#)

MEDICAL COMMAND, CONTROL, COMMUNICATION, COMPUTERS AND INFORMATION (MED C4I)

25. Communications to next level of aid available via:

- a. **Primary** Trackphone from finish house– UNSECURE
- b. **Alternate** Trackphone via trackside intercom – UNSECURE
- c. **Contingency** Personal mobile phone from track controller – UNSECURE
- d. **Emergency** Personal mobile phone from any DS – UNSECURE

26. **Emergency Contacts.** A list of emergency contact numbers can be found at Annex A. This will be given to all Exercise DS.

27. **Duty GP.** Where there is limited access to Primary Health Care (PHC) and no medical assets on the activity, the Duty GP can be contacted for medical support on 00 44 7977 074 069. Activities taking place in the firm base/sovereign base area would usually only require support from the Duty GP outside of normal DPHC working hours.

28. **Incident Reporting.** Any significant incidents or ‘near misses’ must be reported via [MySafety \(Defence Gateway\)](#) as soon as possible (The Army Reporting Cell (ARC) has replaced the AINC and takes reports via MySafety (renamed from DURALS). If changes to procedure are required as a result of the incident, other personnel participating in the activity must be made aware at the earliest opportunity. In addition, certain incidents must be reported to the Defence Accident Investigation Branch by telephoning +441980348622: see [2024DIN06-024](#).

29. **Patient Tracking.** The tracking of UK SP who enter civilian hospitals may be challenging, particularly if they enter outside the UK CoC. If practical, a non-injured UK SP should accompany the casualty and remain with them throughout their treatment or until directed otherwise. If this is not practical advice is to be sought from the parent unit.

¹ What constitutes “Critical Treatment” is not easily defined but should be considered as any treatment that must be administered immediately without delay to prevent a loss of life, limb, or eyesight.

² [ACSO 3366 Competent Medical Authorities](#)

³ AECC 24/7 Duty Ops number at the time of writing is +44 (0) 7770 648 688 full contact details and guidance on initiating Aeromedical Evacuation can be found at this [DIN](#)

30. **FMED 965.** All individuals will request a FMED 965 as per [JSP 950 Leaflet 1-2-6](#) from their local Med Centre and deploy with these secure as part of their personal documentation. Reserve / civilian personnel should obtain a copy of their relevant medical record, which can be obtained via the NHS App (England only) (<https://www.nhs.uk/nhs-app/nhs-app-help-and-support/health-records-in-the-nhs-app/>) or directly from their GP.
31. **Medical Records.** Should any treatment occur, the patient will request a copy of the treatment records and on return to the UK, present this to their Medical Centre to capture the treatment on DMICP. *Reserve / civilian personnel should pass any patient records to their civilian GP.*
32. **Imaging.** Should any treatment occur which includes imaging the following procedure will be followed:
- a. Where an imaging capability/Radiographer is included in the medical laydown of the Med Plan then all imaging should automatically be transferred to CD Rad for reporting and archiving. Imaging held by CD Rad is subsequently available for onward transfer to the Role 4 or other UK medical facility.
 - b. Where imaging is provided by a host nation medical facility, a copy of the imaging and radiology report should be obtained for each patient. Images should be in DICOM (Digital Imaging and Communications in Medicine) format. CD Rad can accept and download images and reports provided by electronic link from the HN medical facility, alternatively CD Rad can provide an Image Exchange Portal (IEP) upload link for imaging supplied on CD/DVD/USB. Reports can be uploaded with the images via IEP or emailed separately, for a link or advice please contact UKStratCom-DMS-RCDM-CDR-Mailbox@mod.gov.uk. If the option for electronic transfer or removable media is not available hard copy x-ray film should be provided along with a copy of the radiology report.'
33. **Treatment Payment Mechanism.** The activity intends to utilise the following for treatment payment.
- a. **GHIC.** Individuals will travel with a valid [GHIC/EHIC](#) to offset part of the cost incurred from medial treatment. Note, this will only cover part payment and entitles the individuals to the same level of care as the locals. *[For an up-to-date list of countries where the GHIC is accepted, and for details of any restrictions on its use, please check [Applying for healthcare cover abroad \(GHIC and EHIC\) - NHS \(www.nhs.uk\)](#)].*
 - b. **Personal Travel Insurance.** All individuals will have personal travel and ice sports insurance to cover any activity that may be undertaken whilst not classed as 'on duty'. It is imperative that the insurance policy covers the activities. All personnel deploying on this event will take out personal accident and liability insurance to cover the whole period of the ice camp.
34. **Command.** The table found at the top of this document lists the command structure.

MEDICAL LOGISTICS

35. **First aid kits and personal prescription medicines** Unless alternative arrangements have been made, all personnel must carry a personal first aid kit stocked in accordance with the list at Annex G. They must also deploy with enough personal prescription medicines (if required) to last for the duration of their deployments and cover travel delays. Consideration must be given to how medical products will be stored in accordance with the manufacturer's instructions, e.g. relating to temperature.

36. **Blood and Blood Products.** Emergency procedures requiring the use of blood products should be considered as essential. Blood product supplies in EU member or NATO ally states should be regarded as generally safe for transfusion. Other locations or unknown states or medical facilities require a level of assurance that can be provided with advanced (21 day) notice through CD Path. CD Path should be contacted on +447500 106250 with location and facility details and will advise on the options for transfusion the patient must report to their Medical Center immediately on returning to the UK and conduct follow on screening.'

<MODNET>

Name – Lucy Wyatt

Rank - Capt

Unit – 100 Regt RA/AWSA

Annexes:

- A. Emergency Contact Details.
- B. Medical Care Facilities.
- C. Timelines Matrix.
- D. Force Health Protection Instruction (FHPI) – Ex RACING ICE 2 / Norway.
- E. Risk Assessment.
- F. Plan on a Page

EMERGENCY CONTACT DETAILS

Ser	Organisation	Contact details
1	Joint Casualty and Compassionate Centre (JCCC)	Tel: 00 44 1452 519951
2	Defence Accident Investigation Branch	Tel: 00 44 1980 348622
3	The Aeromedical Evacuation Control Centre (AECC)	<p>Working Hours:</p> <p>Tel: 00 44 1993 895300 (Mil: 95461 5300)</p> <p>Silent Hours Duty Mobile</p> <p>Tel: 00 44 7770 648688</p> <p>Email: medfce-trmw-aecc@mod.gov.uk</p>
4	Country/activity POC <i>If there is no specific POC, include details of the Defence attaché or equivalent FCDO representative in country</i>	<p>Capt Lucy Wyatt +44300159269 07921863479 Lucy.wyatt680@mod.gov.uk</p>
5	Country Emergency Services <i>Be aware that some countries use different emergency numbers for the different emergency services</i>	112
6	Duty GP Number <i>This number cannot receive a text message. A voicemail message with return contact details is to be left for all emergencies if the phone is not answered.</i>	Tel 00 44 7977 074 069.
7	International SOS (ISOS) <i>Delete if the activity is not covered by ISOS insurance. Normally, only specific Defence engagement, Sport, AT and STTT activity will be covered, and personnel are required to be registered in advance of deployment.</i> <i>Where alternatives are available (e.g. formal MoUs permitting access to local medical facilities free of charge), ISOS registration may not be necessary. Check with the Defence attaché/FCDO representative in country if unsure.</i>	Tel: 00 44 208 762 8342

MEDICAL CARE FACILITIES

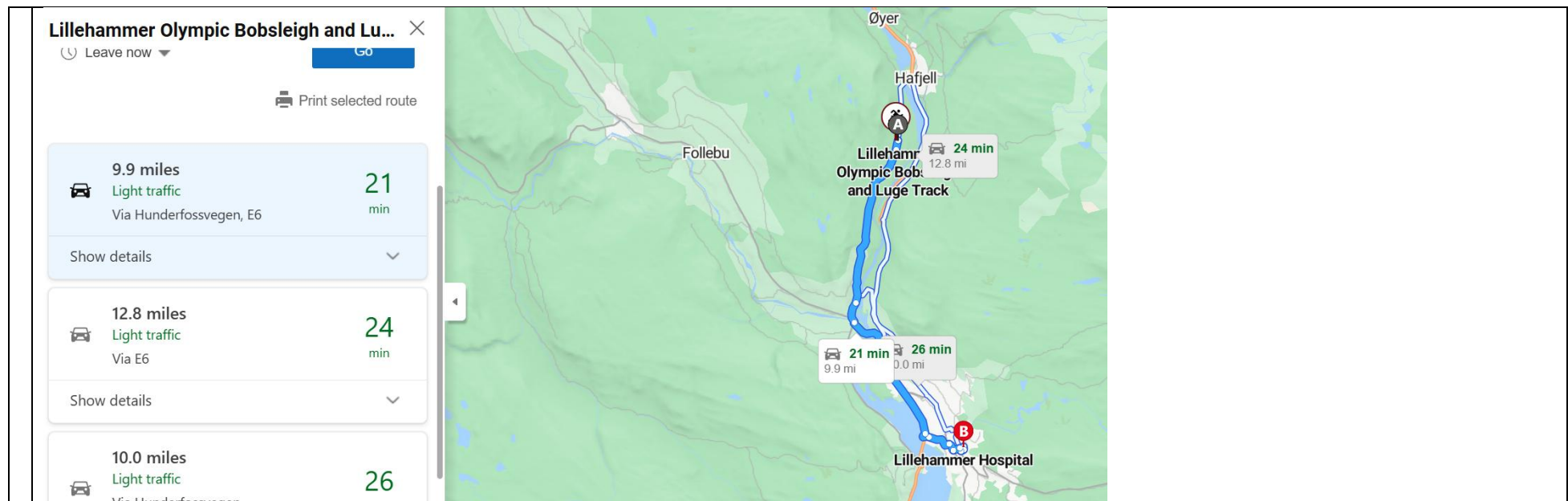
Ser	Facility	Address	Comments
1	<i>Lillehammer sykehus 24hr hospital</i> <i>Tel: +47 915 06 200</i> <i>Open: 24 hours</i>	<i>Anders Sandvigs gate 17, 2609 Lillehammer</i>	Hospital has A&E and MIU facilities with a walk in clinic staffed 24 hrs. Facilities were reced during Ex R11 - Nov 2025.
2	<i>Klinnik Lillehammer</i> <u>Tel:+4795872045</u> <i>Open: Mon – Fri 100-2100</i>	<i>Sigrid Undsets veg 50A, 2624 Lillehammer</i>	Closed Sat/sun

TIMELINES MATRIX

Please list all locations (accommodation & activity locations)

Ser	Type (Accommodation/activity type)	Location (Accommodation & every activity location)	Nearest listed Hospital (From Annex B)	Distance by road (km)	Time by road according to maps (Hr Min)	Remarks (include Rotary Wing time activity permits)
1.	Ice Sports	Lillehammer Bob track, Norway	Lillehammer sykehus 24hr hospital	15 km	21 mins	

MAPS / SCREENSHOTS



GENERIC FORCE HEALTH PROTECTION INSTRUCTION WINTER SPORTS EUROPE

INTRODUCTION

1. **Introduction.** This Fmn approved FHPI for Winter Sports in Europe must be read in conjunction with the Medical Directive/Medical Plan as well as the accompanying FHPI activity specific front cover (if required), as the activity may have locations and health risks which carry additional health threats.
2. **Governance.** Force Health Protection (FHP) is a Command responsibility. Control measures to mitigate against health risks need to be implemented and regularly reviewed to ensure they are current and Theatre specific. Feedback from Theatre on this instruction, and health threats in general, is encouraged and should be directed to LOC SO2 Med Ops to ensure currency. The following instruction will assist in mitigation of health threats but may not cover all threats.

PRE-DEPLOYMENT

3. **Medical Employment Standards (MES).** The recommended minimum employment standard is L3/E3 MLD. The Unit CoC are to complete an Appendix 26 Deployment Medical Risk Assessment (DMRA) for all individuals that do not have a Medical Deployment Standard (MDS) of MFD that they wish to deploy. The Appendix 26 is to be completed using the Appendix 9, the Unit Health Committee (UHC) and if deemed necessary by the Unit Medical Officer, Regional Occupational Health Teams for further advice.
4. **Pregnancy.** Personnel who are concerned that there is any possibility that they may be pregnant are to seek medical advice prior to deployment.
5. **Dental.** All personnel are to be dentally fit.
6. **Medical Preparation.** All personnel are to be medically prepared for deployment. Courses of vaccination may take several weeks to complete. Therefore personnel are to attend to the medical centre at the earliest opportunity, but at least eight weeks in advance wherever possible.
7. **Vaccinations.** All Regular personnel must be in date for all entry and normal Service vaccinations, in accordance with Annexes A and B of [JSP 950 Leaflet 7-1-1 Immunological Protection of Entitled Individuals](#). The requirement includes all normal entry vaccinations and those that require boosters throughout Service. Pre-deployment vaccination checks should be used as an opportunity to ensure all vaccinations and those previously unvaccinated personnel are fully in date for ALL routine vaccinations.
8. Reserve personnel deploying on this activity should refer to [JSP 950 Leaflet 1-3-6 Reserves in the Future 2020: Healthcare Provision For Reserve Forces Personnel](#). In addition, they must be in date for all vaccinations according to the UK vaccination schedule, this includes vaccinations for MMR and diphtheria-tetanus-polio.

9. The following additional vaccinations are required for this activity:

Table 1 - Vaccination information or Additional Vaccination requirements.

Ser	Vaccination	Required	Justification
	(a)	(b)	(c)
1	COVID-19	Recommended	The COVID-19 vaccination is required for some international travel and is recommended for all personnel involved in this task.

10. **Routine Medication.** Personnel requiring routine medication are to deploy with enough quantity for the duration of the duration of this activity. This includes prescribed contraception.

11. **Spectacles and Contact Lenses.** Owing to the difficulties in the provision of replacement spectacles and contact lenses, individuals who require visual correction are to deploy with a spare pair of spectacles.

12. **Pre- deployment Health Brief.** In compliance with JSP 950 Leaflet 3-2-2 Operational Deployment Health Briefs, it is mandatory that all deploying personnel receive a health brief on the health risks and associated hygiene issues for Winter Sports Activity in Europe. Health briefs can be arranged through the Fmn EHP.

COVID-19

13. **COVID-19.** The United Kingdom has now moved to the 'living with COVID' phase of the pandemic. The Government's objective for this stage of the response as a country is to manage COVID-19 in a similar manner to other endemic infectious respiratory diseases, while retaining the ability to respond if a new variant emerges. The Army's 'Working Safely in a COVID Environment' FHPI has been withdrawn – current Army guidance is [here](#). Overarching Whole Force Guidance is contained within [Defence Advice Notes](#) and should be applied whilst overseas. All SP are strongly encouraged to be fully vaccinated, including booster vaccinations against COVID in order to reduce the risk of severe illness or death.

DEPLOYMENT

14. **Climatic Illness.** Anyone who suffers from a climatic illness will require an immediate medical risk assessment and possible aeromedical evacuation. A climatic illness report⁴ and an accident report⁵ is to be raised. Deploying units should deploy with a WBGT meter where possible or use a reliable source of weather forecast information in the absence of a WBGT when planning activities.

- a. **Hot and Cold Injuries.** All deploying personnel, must be able to recognise the signs and symptoms of heat injuries, and know the immediate action drill. Commanders at all levels must consider heat / cold injuries when planning all activities and are required to undertake a risk assessment in accordance with JSP 375 ([Chapter 42 – Cold Injury Prevention](#)) to reduce the risk to as low as reasonably practicable.

⁴ The heat illness and cold injury templates on DMICP are to be used for case reporting.

⁵ Complete DURALS as directed. In addition, any sS accident and incident reporting systems are to be followed.

b. **Reporting of climatic injuries.** All cases must be reported in accordance with JSP 375; this includes cases where individuals develop temporary or permanent incapacitation i.e. are unable to continue with their duties/training because of climatic illness/injury with or without the involvement of Defence Medical Services or other medical assets. Commanding Officers (COs) must be aware that medical case recording does not replace their duty to report all cases of heat illness/cold injury meeting the reporting threshold. Specific reporting or data collation may also be required by the Chain of Command in specific Op Orders or Mounting Instructions.

c. **Additional Training.** Additional Climatic Injury Training is provided [2022DIN06-009-Revised JSP375 Chapter 41 and Heat Illness Prevention Training](#). This DIN is notification for MOD Personnel (Service and Civilian) to the introduction of Heat Illness Prevention training – Module 1, 2, 3 and 4. The training can be completed through the Defence Learning Environment (DLE) [Heat Illness Prevention Training](#) and those who complete the training will receive an automatic JPA competence (this may take up to 48 hours to appear).

d. **Clothing.** Due to extreme temperatures additional cold weather clothing must be issued and worn during this tasking.

15. **Sun damage. Sun damage is caused by ultraviolet (UV) rays, potentially leading to serious conditions such as skin cancer and loss of sight through cataracts** and short-term damage (e.g. photokeratitis) to unprotected eyes.

a. **Sun cream.** High factor sun cream should be worn on all exposed skin areas.

b. **Wearing uniform.** MTP PCS provides a high protection against sun damage, sleeves rolled down will protect the arms. The tropical hat (not tailored) provides shades the face, neck and ears as well as providing some protection to the eyes, should be worn. If the exercise will be conducted in civilian clothing, the same aims are to be followed. Personnel are to protect their arms, face, neck and ears in addition to protecting their eyes from the sun.

c. **Sunglasses.** Sunglasses that conform to European Standard EN 1836:2005 should be worn in bright sunlight.

d. **Altitude Illness.** There is a risk of altitude illness when travelling to destinations of 2,500 metres (approx. 8,200 feet) or higher. Important risk factors are the altitude gained, rate of ascent and sleeping altitude. Rapid ascent without a period of acclimatisation puts a traveller at higher risk. There are three syndromes: acute mountain sickness (AMS), High-Altitude Cerebral Edema (HACE) and high-Altitude Pulmonary Edema (HAPE). HACE and HAPE require immediate descent and medical treatment. Therefore, personnel should spend a few days at an altitude below 3,000m, be aware of the signs and symptoms of the three syndromes and be aware of the important factors.

16. **Prevention of Gastro-enteric Illness.** There is a **LOW** risk of gastro-enteric illness. The most prevalent risk to personal and communal health is from contaminated food and water supplies. This has the potential to significantly impact operational effectiveness if robust force health protection measures are not in place. All food and water to be sourced from locally assured facilities only and personnel are to exercise strict personal hygiene measures (hand washing with soap and water being the most simple and effective method

of gastro-enteric disease control), at all times. All gastro-intestinal outbreaks (2 or more cases, with same source) are to be reported to LOC SO2 Med Ops.

17. **Handwashing.** The single most important measure to help prevent the spread and impact of these diseases is adequate handwashing, particularly after using the toilet and before handling food. As a minimum, this should consist of:

- a. A supply of potable running water.
- b. The provision of liquid soap.
- c. A means of drying the hands which will not result in recontamination.
- d. The use of alcohol gels is not a substitute for the above and is not effective on soiled hands.

18. **Prevention of Contact/Sexually Transmitted Infections.** HIV and other blood borne diseases are prevalent. You should avoid exposure to blood and other body fluids, but where exposure is unavoidable personnel are to use whatever protective measures that are available to them. Sexually transmitted infections such as Chlamydia, Gonorrhoea, and Syphilis are also present in the local population, particularly amongst commercial sex workers, and may affect a high percentage of personnel who have sexual contact. Abstaining from sexual contact is the only effective control. Condoms protect against most, but not all STIs and are freely available from the medical centre. Any unprotected contact with blood or body fluids should be risk assessed to determine if treatment or follow up is required in accordance with [JSP 950 Leaflet 7-2-1 – Guidance on risk assessment and immediate management of needlestick / sharps / blood / body fluid and tissue exposure incidents](#).

19. **Airborne Disease.** Basic preventative measures should be in place. This includes avoiding the sharing of closely confined accommodation where possible, ensuring sufficient ventilation of rooms and reporting sick immediately should symptoms of respiratory distress be experienced amongst deployed personnel.

- a. **Seasonal influenza.** Seasonal influenza is a viral infection of the respiratory tract and spreads easily from person to person via respiratory droplets when coughing and sneezing. Symptoms appear rapidly and include fever, muscle aches, headache, malaise (feeling unwell), cough, sore throat and a runny nose. In healthy individuals, symptoms improve without treatment within two to seven days. Severe illness is more common in those aged 65 years or over, those under 2 years of age, or those who have underlying medical conditions that increase their risk for complications of influenza. Preventive measures should include self-isolation when unwell, avoiding individuals who are unwell, avoiding where possible enclosed, crowded locations, and maintaining good hand hygiene.

20. **Avoidance of Feral Wild and Venomous Animals.** Feral animals pose a more significant risk to personnel than wild or venomous animals as they may retain the desire for human contact. However, contact with all animals should be avoided and this is a chain of command responsibility where avoidance remains the key protection measure. There are numerous mammals in Europe with the potential to cause harm to humans either from direct confrontations resulting in bites, stings, scratches, etc or as a collision hazard when driving at night. All personnel must exercise extreme vigilance and avoidance of feral, wild

and venomous animals at all times. Anyone who suffers a bite, sting or scratch will require an immediate medical risk assessment to determine if treatment or follow up is required. The Duty holder must identify a medical treatment facility with Rabies post exposure treatment (PET).

21. **Stress Related Illness.** Preventative measures and monitoring of personnel with regard to stress related disorders are to be conducted in accordance with [JSP 950 leaflet 2 7 1](#). These are to include:

- a. Pre-deployment briefings delivered to all deploying personnel. The specific aim of which is to advise commanders at all levels on how to identify and manage Combat Stress Reaction, Combat Stress Disorder and Post Traumatic Stress Disorder.
- b. Mental health and wellbeing encountered during deployment. Certain deployments or tasks can be stressful, therefore, a deviation in mental health and/or personal wellbeing may occur, if so, personal must be encouraged to self-refer to medical staff as soon as possible or seek advice from additional support services (as per recommendations in JSP 950 Leaflet 2-7-2), such as welfare personnel, CofC, Padre, or friends/family.
- c. Briefing at end of tour, which should include all aspects of post-traumatic stress that may manifest after return, and how this may be managed. Personnel are advised to seek help if they have concerns or experience any mental health related problem. There is a range of services available to provide support, i.e. friend/family member, CofC, UWO, AWS, Padre, Unit TRiM Practitioner, and GP/Unit MO.

22. **Environmental and Industrial Hazards (EIH).** Direction on the risk assessment and operational risk management of EIH on Operations can be found with [DIN 2017DIN06-004](#). This is an essential element of Force Protection. Where there is evidence that an individual may have been exposed to a potentially harmful substance, the following details are to be recorded in accordance with the procedure given in [DIN06-004](#), and on FMed 965, and transferred to DMICP on returning from Theatre:

- a. Grid Reference of hazard, and name of site if known.
- b. Nature of hazard.
- c. DTG(s) of exposure.
- d. Duration of exposure.
- e. Any protection worn or employed.

23. **Asbestos.** Asbestos Containing Materials (ACMs) are still widely used in many developing countries; and there are potential legacy issues in developed countries. The presence of ACMs per sat does not create a health risk. The main risks to health are from the inhalation of individual airborne asbestos fibres; this may happen when fibres are released into the air by undertaking work that disturbs dust or material containing asbestos fibres e.g. drilling holes, or impact damage (however minor e.g. surface paint scraped off) to ACMs e.g. caused by vehicles manoeuvring. More information can be found in the [Field Army Environmental Health Asbestos Leaflet](#).

24. **If you suspect any ACM within the activity area stop the activity, mark and avoid and report through the chain of command .DO NOT ATTEMPT TO REMOVE THE ASBESTOS YOURSELF.**

25. **Air quality.** Some groups are especially vulnerable to problems caused by polluted air. These include children, the elderly and anyone with underlying chronic health problems such as heart disease, emphysema, bronchitis or asthma. The chemicals in polluted air can lead to acute effects, affecting the lungs resulting in wheezing, coughing, shortness of breath and even pain. Polluted air can also irritate the eyes, nose, and may interfere with the immune system function. The risk from long term (chronic) health effects is low if the exposure time is low (less than 12 months). Limiting exposure to polluted air is the best way to avoid these problems. When air quality is poor, it is advisable to avoid outdoor physical activities. While inside, keep doors and windows closed, and use an air conditioner on 'recirculate' if possible.

26. All deploying personnel with a history of asthma or other respiratory conditions should seek medical advice prior to deployment. It is strongly recommended that good administrative / procedural control measures are put in place (e.g. reducing exposure time during peak pollution periods / spending less time outdoors where possible, frequent staff rotation, use of shemaghs to minimise exposure to dust, etc) to reduce harm to vulnerable personnel.

27. **Exposure to Noise.** SP may be exposed to noise, with or without blast, which may damage hearing; this is known as Acute Acoustic Trauma (AAT). Treatment is now available for acute hearing loss caused by exposure to very loud noise where SP have been without adequate hearing protection. Early treatment can significantly reduce the severity of permanent hearing loss and is often very successful if done within a few days, even up to a few weeks. Results worsen with time and after a month are usually disappointing. New hearing loss or tinnitus should be reported to the medical team at the next available opportunity, especially after exposure to loud noise. SP must prevent noise exposure by ensuring the measures outlined in JSP 375, Vol 1, Chapter 25 are implemented.

28. **Road Traffic Collisions and High-Risk Activities.** Local road conditions and untrained erratic local drivers mean there is a threat of an RTC in country. Defensive driving is to be practised and travelling during peak periods and after dark should be minimised as far as possible. The wearing of seatbelts is mandatory. All vehicles should have a first aid pack as per CES and drivers must be aware of CASEVAC procedures. If you are a first attender at a RTC you may be at risk from a blood borne virus. All High-Risk Activities need to be highlighted so that only Mil approved blood transfusion can be used. Local theatre policy will include actions on and any PPE requirements to be carried on person or in vehicles, this should apply equally to both green and white fleet vehicles.

29. **Disease Outbreak Reporting.** To ensure that the required support is provided from HQ Fd Army any disease outbreak (2 or more cases, with same source or linked by time or symptoms) or any case of concern/importance must be reported to LOC SO2 Med Ops.

POST DEPLOYMENT

30. **COVID-19 - Returning to the UK from overseas travel.** Quarantine requirements for specified countries/regions may change, details for returning travellers can be found at [HMG Travel Advice](#). Further advice for Defence travellers may be found in the COVID 19 [Defence Advice Notes](#) (DANs), this includes potential exemption from quarantine process for 'essential Defence activity'. Further guidance on military personnel returning from deployment will be published throughout the year.

31. National, Defence and Army direction may change between the FHPI being issued and the deployment or return. Commanders must keep up to date with changes in UK and relevant partner nation regulations. Advice can be sought via HN websites, the relevant G3/J3 cell or via Fmn EH if required (note COVID advice is subject to change so check with Fmn EH).

32. **Medical Post Activity Report.** The Commander's Post Activity Report should include, where required, any medical points of concern and details of any areas of best practice. Medical formation staff must ensure that they see sight of this post activity report to action any medical concerns and highlight these where necessary to their respective CMA. Details of any best practice must be promulgated across the formations.

31. **Post Deployment Illness.** Upon returning from Winter Sport Activities in Europe, personnel are advised to seek early medical support (i.e. report sick) if they develop symptoms such as fever, prolonged diarrhoea or new skin conditions, such as discrete lesions, or any other health concerns as these symptoms could indicate a serious medical condition. They are to ensure that they inform medical staff that they have returned from Europe. As per recommendations in JSP 950 Leaflet 2-7-2 if personnel experience a change to their mental health and/or personal wellbeing personnel should seek advice and support from family, friends, CofC, UWO, AWS, Padre, Unit TRiM Practitioner, and GP/Unit MO.

<p>Key Guidance: This section provides a quick overview of some of the key concepts in Army risk assessment.</p> <p>AF5010 Risk Assessment. All routine and specific activities require risk assessment to be completed prior to commencing to ensure personnel, assets, and the environment are not exposed to unacceptable risk. Refer to notes for risk management definitions, strategy, and hierarchy of authorisation.</p> <p>Dynamic Risk Assessment (DRA). Changes to the activity situation may mean additional controls are required to continue as planned by the Activity Deliverer. Additional controls may be recorded on the AF5010 if access to IT and time allows. Alternatively record at Annex A by hand at first opportunity after implementation. The following is to be considered:</p> <p>Step 1. This takes place prior to the activity starting. The Activity Deliverer completes their final checks to ensure that all risks remain ALARP and Tolerable. If a hazard is not ALARP, then additional control measures must be developed and implemented. Ensure additional controls are communicated in the safety briefing.</p> <p>Step 2. This is conducted during the activity, normally caused by an unforeseen or unplanned event/hazard being identified. The Activity Deliverer must pause or stop the activity and identify if additional controls are required to ensure risk remains ALARP. Ensure all additional controls are communicated and understood prior to restarting the activity.</p>	<p>Likelihood (L)</p> <p>1 – Remote / Rare</p> <p>2 – Unlikely</p> <p>3 – Possible</p> <p>4 – Probable</p> <p>5 – Highly Probable (Almost Certain)</p>	<p align="center">Multiplied by</p>	<p>Impact (I)</p> <p>1 – Minor</p> <p>2 – Moderate</p> <p>3 – Major</p> <p>4 – Severe</p> <p>5 – Critical</p>	<p align="center">Equals</p>	<table border="1" style="margin: auto;"> <tr> <td colspan="6" style="text-align: center;">Risk Score Calculation</td> </tr> <tr> <td rowspan="6" style="text-align: center; vertical-align: middle;">IMPACT</td> <td>5</td> <td>5</td> <td>10</td> <td>15</td> <td>20</td> <td>25</td> </tr> <tr> <td>4</td> <td>4</td> <td>8</td> <td>12</td> <td>16</td> <td>20</td> </tr> <tr> <td>3</td> <td>3</td> <td>6</td> <td>9</td> <td>12</td> <td>15</td> </tr> <tr> <td>2</td> <td>2</td> <td>4</td> <td>6</td> <td>8</td> <td>10</td> </tr> <tr> <td>1</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td></td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td colspan="6" style="text-align: center;">LIKELIHOOD</td> </tr> </table>	Risk Score Calculation						IMPACT	5	5	10	15	20	25	4	4	8	12	16	20	3	3	6	9	12	15	2	2	4	6	8	10	1	1	2	3	4	5		1	2	3	4	5	LIKELIHOOD						
Risk Score Calculation																																																							
IMPACT	5	5	10	15	20	25																																																	
	4	4	8	12	16	20																																																	
	3	3	6	9	12	15																																																	
	2	2	4	6	8	10																																																	
	1	1	2	3	4	5																																																	
		1	2	3	4	5																																																	
LIKELIHOOD																																																							
<p>5 Step Process</p>	<p>Step 1 – Identify the hazards</p>	<p>Step 2 – Decide who might be harmed and how</p>	<p>Step 3 – Evaluate the risks and decide on precautions (control measures)</p>	<p>Step 4 – Record your significant findings and include in Ex / Coord instructions as necessary. Implement control measures</p>	<p>Step 5 – Review your risk assessment and update as necessary</p>																																																		

Dept / Sub-Unit / Unit / Formation:	Army Winter Sports Association	Assessor (No, Rank, Name):	W1055269 Capt L N Wyatt	
Activity (SSW) / Exercise:	Army Ice Sports Ex Racing Ice 2.Lillehammer Ice Track, Hunderfossen Norway	Assessor's signature:		
Generic or Specific Risk Assessment:	Specific	Assessment Date:	08/11/2025	
Relevant Publications / Pamphlets / Procedures:	JSP 375 (Management of Health and Safety in Defence), Chapter 42, Cold Injury Prevention Ver 1.0 An Individual's Guide to Cold Injury	Review Date for GRA (Step 5):	20/12/2025	

Yes (a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)
Ref	Activity / element (Step 1a)	Hazards identified (Step 1b)	Who or what might be harmed and how, e.g. • Military personnel - fatality • Civ staff / contractors - injury • General public - injury • Environment - pollution (Step 2)	Existing control measures (Step 3a)	Assessment with existing controls			Is residual risk acceptable in the context of risk appetite for the activity? (Yes / No) – Refer to Risk Score Calculation above If Yes, move to column (n). If No, identify additional controls (Step 3e)	Reasonable additional controls that can be implemented to reduce risk to ALARP (Step 3f)	Reassessment with additional control measures			List required action(s) to instigate controls (Step 3j)
					L (1 to 5) (Step 3b)	I (1 to 5) (Step 3c)	Score (L x I) (Step 3d)			L (1 to 5) (Step 3g)	I (1 to 5) (Step 3h)	Score (L x I) (Step 3i)	
1	Hazards (Include Hazard Survey)	Incorrect lifting technique of heavy equipment	Military Personnel – Injury	Briefing of correct manual handling techniques. Staff and Peer monitoring and enforcement of good MHT	3	2	6	Yes					To Run in conjunction with Army Ice

	Number where applicable)		Civ Staff - Injury										Sports Safety Plan 2025-2026 (Amended Aug 2026)
	Manual handling of sleds												
2	Sliding	Injury to athlete due to impact with track or eqpt during descent at speeds of up to 120km/h	Military Personnel – Injury Civ Staff - Injury	<p>Ex staff are aware of shortfall and monitoring progression closely of novice sliders. All sliders are to be assessed on daily basis for their suitability, ability to continue sliding.</p> <p>All athletes and DS will receive a safety briefing prior to start of Exercise. Use of appropriate PPE (helmet and gloves mandatory, padding optional at athlete discretion to minimise impact of minor impacts.</p> <p>Track safety system to be adhered to at all times.</p> <p>Sliding to be controlled by start staff and track manager at all times to ensure only one sled on track at any time.</p> <p>Two military medics will be available trackside to triage injuries and administer emergency casualty management/treatment at all times whilst sliding.</p> <p>All trackside staff (incl. medic) to have voice comms with start and finish, either direct (radio/telephone) or through relaying of messages. Hospital transit times are available in the HSS plan.</p> <p>All athletes confirmed as physically fit and alcohol-free prior to run.</p> <p>Pre-slide head injury checks following the SCAT6 process will be conducted by medics for all athletes.</p>	3	4	12	Yes	Coaching and supervision of all training runs with feedback process: no slider may slide if not deemed safe by staff	3	3	9	To Run in conjunction with Army Ice Sports Safety Plan 2025-2026 (Amended Aug 2026)

				<p>Post crash checks will be carried out by medics for a minimum of 24 hours after an incident.</p> <p>Athletes briefed and rehearsed in the actions on accidents whilst descending ice track at the respective start point and the finish straight.</p>									
3	Trackside assistance	Injury to staff and athlete due to impact with eqpt, athlete or track	<p>Military Personnel – Injury</p> <p>Civ Staff - Injury</p>	<p>Crampons/Ice spikes MUST be worn when on foot in track. Safety brief to all staff prior to exercise.</p> <p>No staff in track when sled commences descent. In the event of a crash, no person is to enter the track until the sled has come to a complete stop.</p>	3	4	9	Yes					All practicable control measures in place. Rating due to environmental conditions (ice underfoot).
4	Slips and Trip falls	Injury to slip/trip falls on ice	<p>Military Personnel – Injury</p> <p>Civ Staff - Injury</p>	<p>Brief to include good eqpt husbandry practices to minimise risk of eqpt left where it may cause an accident.</p> <p>Correct footwear to be worn at all times, appropriate to conditions (weather, temperature and activity).</p>	3	3	9	Yes					All practicable control measures in place. Rating due to environmental conditions (ice underfoot)
5	Cold weather injury/climatic illness	Injury to personnel due to exposure to cold climatic conditions	<p>Military Personnel – Injury</p> <p>Civ Staff - Injury</p>	<p>All personnel to be briefed on cold weather injury and the prevention of it in line with JSP 375 Ch 41/42 to reduce the risk to as low as reasonably practicable.</p> <p>Cold injury occurs as a result of the effects of cold, in either wet or dry conditions, on the body. The cold may affect either the whole body by reducing the core body temperature (generalised cold injury) or affect a specific body part (localised cold injury). The body normally maintains a stable core temperature of 37°C by balancing the rate of heat</p>	3	4	12	Yes	Checks to be carried out at regular intervals for cold injury Temperature will be monitored each morning and prior to sliding.	3	3	9	All practicable control measures in place. Rating due to environmental conditions (cold weather). All attendees

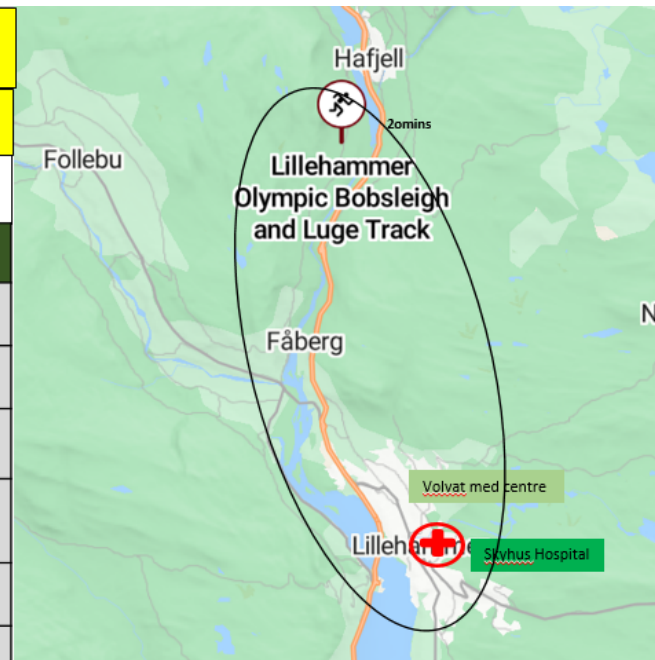
6	Movement into and out of vehicles	Injury to personnel/ damage to eqpt when entering/dismounting camion or other vehicles	Military Personnel – Injury Civ Staff - Injury	All athletes to be briefed on correct mount/dismount techniques for use of vehicles at track. Camion drivers monitor rear compartment for unsafe behaviour and intervene as necessary.	3	3	9	Yes					Note: Safe Systems of Track Provider must be adhered to.
7	Damage to eqpt: transit, wear and tear, in use, in storage	Incorrect loading, storage and handling causing eqpt to become U/S.	Military Personnel – Injury Civ Staff - Injury	All athletes briefed in manual handling, safe transit and husbandry of eqpt. Loading and storage supervised by experienced staff/athletes. Athletes to inspect eqpt prior to each slide. Suspect eqpt to be highlighted to staff immediately. Staff to inspect eqpt after sliding each day. Coach led maintenance regime to minimise risk of damage/use of U/S eqpt. Coaching and instruction to minimise risk of damage in use (on track) due to impact during descent. Staff and peer monitoring of standards, intervention where necessary.	3	3	9	Yes					To Run in conjunction with Army Ice Sports Safety Plan 2025-2026 (Amended Aug 2026)
8	Security of eqpt	Theft Damage from third parties	Military Personnel – Injury Civ Staff - Injury	Secure storage provided at track, hotel and in transit. No other storage to be utilised. All athletes briefed on eqpt husbandry and not leaving eqpt unattended and unsecured.	2	2	4						To Run in conjunction with Army Ice Sports Safety Plan 2025-2026 (Amended Aug 2026)
9	Loss of eqpt	Poor eqpt husbandry leads to loss or	Military Personnel – Injury	Staff/athletes briefed. Daily checks of equipment	2	3	6	Yes					To Run in conjunction with Army Ice

		degradation of eqpt	Civ Staff - Injury												Sports Safety Plan 2025-2026 (Amended Aug 2026)
10	Driving	Driving overseas Driving during winter conditions Fatigue driving long distances	Military personnel – fatality General Public - fatality	Defensive driving is to be practised and travelling during peak periods and after dark should be minimised as far as possible. The wearing of seatbelts is mandatory. Drivers must be competent driving in winter conditions in accordance with JSP 800. Drivers hours must be strictly adhered to and regular rest stops must be made. Overnight rest stops on road moves are mandatory. Nominated drivers to be familiar with vehicles and have a valid licence and relevant competencies on My Drive (to include European Matrix Test). <i>Noting this activity takes place in the winter months in a snowy country.</i> All vehicles should have a first aid pack	3	4	12	Yes							
11	Medical Employment standards	Athletes not medically fit to take part in activity	Military personnel - injury	All athletes must be MFD or hold app 26 prior to deployment. All athletes must complete athletes declaration prior to sliding.	1	3	3	yes							
12	Gastro-enteric and transmissible illness	Spread of gastro-enteric and transmissible illness through shared accommodation.	Military personnel - illness	Adequate handwashing, particularly after using the toilet and before handling food must be adhered to. If illness does occur, individual(s) must be isolated until 48 hrs after last episode.	2	2	4	yes							

Authorising Officer / Warrant Officer / NCO	No, Rank, Name	Post	Date	Signature
Existing and additional controls agreed	W1055269, Capt L N Wyatt	Chair Army Ice Sports	06/01/2026	<i>L N Wyatt</i>
Where risk is elevated up the CoC, CO to confirm additional controls implemented	557363, Brigadier. T J Allison	Director Army Ice Sports	06 Jan 2026	T J Allison

MEDICAL PLAN ON A PAGE (POAP)

EX RACING ICE 2 HSS – 20 Feb – 08 Mar 26			OVERALL MEDICAL RISK: MEDIUM
<p>What – Army Ice Sports Race Camp Who – Army Ice Sports and athletes from across all cap badges When – 20 Feb – 08 Mar 2026 Where – Lillehammer Bobsleigh track, Norway Why – Bobsleigh, Skeleton and Luge Inter Service championships Med Force Elements: 2x CMT 1, BATLS, reachback provided by 2 Med Gp</p>			Key Health Risks: Cold injury, sports crashes
Capabilities of Care (Risk below based on CMA HRA mitigations applied)		Completed by: Capt L Wyatt, Ice Sports, AWSA 06 Jan 26	
Force Health Protection	All pax MFD or MLD with App 26, vaccinated, iaw FHPI for Winter Sports. FHPB delivered at beginning of deployment by Lead Medic. Main threats - Cold injury, sled crashes		
Primary Health Care	PHC provided by 2x CMT 1 BATLS with med bergen. Alt PHC and emergency dental provided by HN support.		
Pre-Hospital Emergency Care	Provided by 2x CMT 1 BATLS with 584 module within 10 mins and DHC within 1-2hrs Gd Ambulance (ALS level) and HEMS available		
Medical Evacuation	CASEVAC via organic vehicles MEDEVAC via HN Ambulance and HN Helicopter EMS available Timelines of 10/ 1/ 2+2) achievable (image right with travel times)		
Deployed Hospital Care	2hr DHC available in Lillehammer with 24 A&E and ICU.		
C2, Comms and Computing Information	C2- Activity OIC is Capt L Wyatt. Duty of Care – Director Army Ice Sports. DDH – AWSA, ODH – GOC RC. CMA - RC. P – Personal mobile phones / E – Nearest landline Payment – All SPs to have personal travel insurance for Off-Duty periods. All personnel to deploy with FMed 965s and obtain physical copies of any treatment received for med records. Familiarisation on med plan and facilities to be provided on deployment.		
Medical Logistics	SPs to deploy with sufficient prescription medications (highlighting any need for temp control) and First Aid Kits. Blood screened to WHO standard. There will be no resupply for the exercise period.		
Clinical Timelines (10 – 1 – 2)			
Locations	10x mins	1 hr / MEDEVAC	2 hr / Hospitals
Lillehammer bobsleigh track	<ul style="list-style-type: none"> 2xCMT 1 BATLS 	<ul style="list-style-type: none"> CASEVAC - organic vehicles HN Gd ambulance - ALS HN Helicopter EMS 	<p>Primary – Lillehammer Skyhus hospital Alternative – Klinnik, Lillehammer Note – Klinnik Lillehammer NOT 24 hours</p>



OPCOM	CFA	TACOM	Activity OIC	Gen CMA	DACOS HC
OPCON	COS Fd Army	TACON	N/A	Op CMA	N/A
Useful Telephone Numbers					
Activity OIC			+44 7921863479		
HN Emergency Number			122		
Land Operations Control Centre (LOCC)			+44 (0) 1264 886 462		
Int SOS			+44 (0)2087628342 / 14ACMA802784		
Aeromedical Evacuation Control Centre (AECC)			medfce-tmw-aecc@mod.gov.uk Tel: 01993 895300 Mil: 95461 5300 OOH: 07770 648688		
Digital Aeromed Request Platform					
Blood Advice – CD Path			RCDM-OpSpDiv-CDPath-Blood-GpMail@mod.gov.uk Duty Mobile: +44 7855 180882/Office: +44 121 4143584		

FIRST AID KIT LISTS

Personal First Aid Kit – 1 per person.

Item	Quantity	NSN	Remarks
First Field Dressing	2	6510-99-332-2032	
CAT Tourniquet	2	6515-01-521-7976	
Disposable Gloves	2 pairs	See table 3 below	Gloves may be available via unit RAP.
Paracetamol 500g	Box of 16		Local purchase prior to deployment
Ibuprofen	Box of 28		Local purchase prior to deployment
Dioralyte	1 x box		Local purchase prior to deployment
Sun screen	1x 15ml	6508-99-579-7950	
BLS Face shield	2	6515-99-428-4729	
Plasters	1 x box of mixed sizes	TBC	Local purchase prior to deployment
BCDT Handbook	1		

Vehicle First Aid Kit – 1 per 4 people or 1 per vehicle (whichever is greater).

NSN for Vehicle First aid kit: 6515-99-505-1883

Item	Quantity
Sterile dressings	3
Burn bandages	3
First aid dressings	3
Large elastic bandage	3
Small elastic bandage	2
Adhesive bandage	8
Triangular bandages	2
Adhesive tape	1 roll
First aid rescue sheet	1
Disposable gloves	2 pairs
Scissors	1 pair

Disposable gloves (various sizes)

Item	Quantity	NSN	Remarks
Glove Surgeons Operating Neoprene Unpowdered untextured size 6 sterile disposable	Box of 25	6515-13-118-8441	DermaPrene Ultra 6
Glove Surgeons Operating Neoprene Unpowdered untextured size 6.5 sterile disposable	Box of 25	6515-13-118-8442	DermaPrene Ultra 6.5
Glove Surgeons Operating Neoprene Unpowdered untextured size 7 sterile disposable	Box of 25	6515-13-118-8443	DermaPrene Ultra 7

Glove Surgeons Operating Neoprene Unpowdered untextured size 7.5 sterile disposable	Box of 25	6515-13-118-8444	DermaPrene Ultra 7.5
Glove Surgeons Operating Neoprene Unpowdered untextured size 8 sterile disposable	Box of 25	6515-13-118-8447	DermaPrene Ultra 8
Glove Surgeons Operating Neoprene Unpowdered untextured size 8.5 sterile disposable	Box of 25	6515-13-118-8446	DermaPrene Ultra 8.5

Suggested contents for individual First Aid Kit based on Medical Module **041/042** found at [Team Leidos -In Service Medical Modules](#)