



Veterinary Responder

Equine Guide



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Veterinary Responder Recommended Kit Checklist

Miscellaneous Equipment			
Head Collar		Torch	
Rope		Waterproofs	
Lunge Lines x 2		Bucket	
Needles and Syringes		Duct Tape	
Small Sharps Bin		Cotton Wool (for ears)	
Clinical Waste Bag		Towel (to cover eyes)	
Disinfectant Wipes		Duct Tape	
Alcohol Gel		Bailing Twine	
Watch / Timer		Cable Ties	
Head Torch			
Bandaging and Splinting			
Splints		Cohesive Layer (e.g. Vetwrap)	
Orthopaedic under padding (e.g. Soffban)		Elastic Adhesive Bandage (e.g. Tensoplast)	
Cotton Wool		Casting Material	
Conforming Layer (e.g. Knitfirm)		Splinting Material (purpose made/improvised)	
Spirit			
Sedation and Anaesthesia			
Acepromazine (ACP)		Ketamine	
Atipamezole		Methadone	
Butorphanol		Romifidine	
Detomidine		Xylazine	
Diazepam			
Analgesia			
Flunixin (IV)		Meloxicam (IV)	
Phenylbutazone (IV)			
Antibiotics			
Gentamycin (IV)		Penicillin (IV/IM)	
Oxytetracycline (IV)			
Catheter Kit			
Clippers with spare batteries and blades		Bung	
Scalpel blade – number 11		Flush (Heparin)	
Scrub		Suture material (Pre-threaded)	
Spirit		Extension set	
Mepivacaine (2ml syringe and orange/blue needle)		Tape	
Short stay catheter (14g x 8cm)		Sterile gloves / Nitrile gloves	
Euthanasia			
Somulose		Potassium Chloride (following GA)	
Pentobarbital			

BARTA recommend utilising one of their vet designed response bags to hold your emergency kit, for details contact:

info@bartacic.org

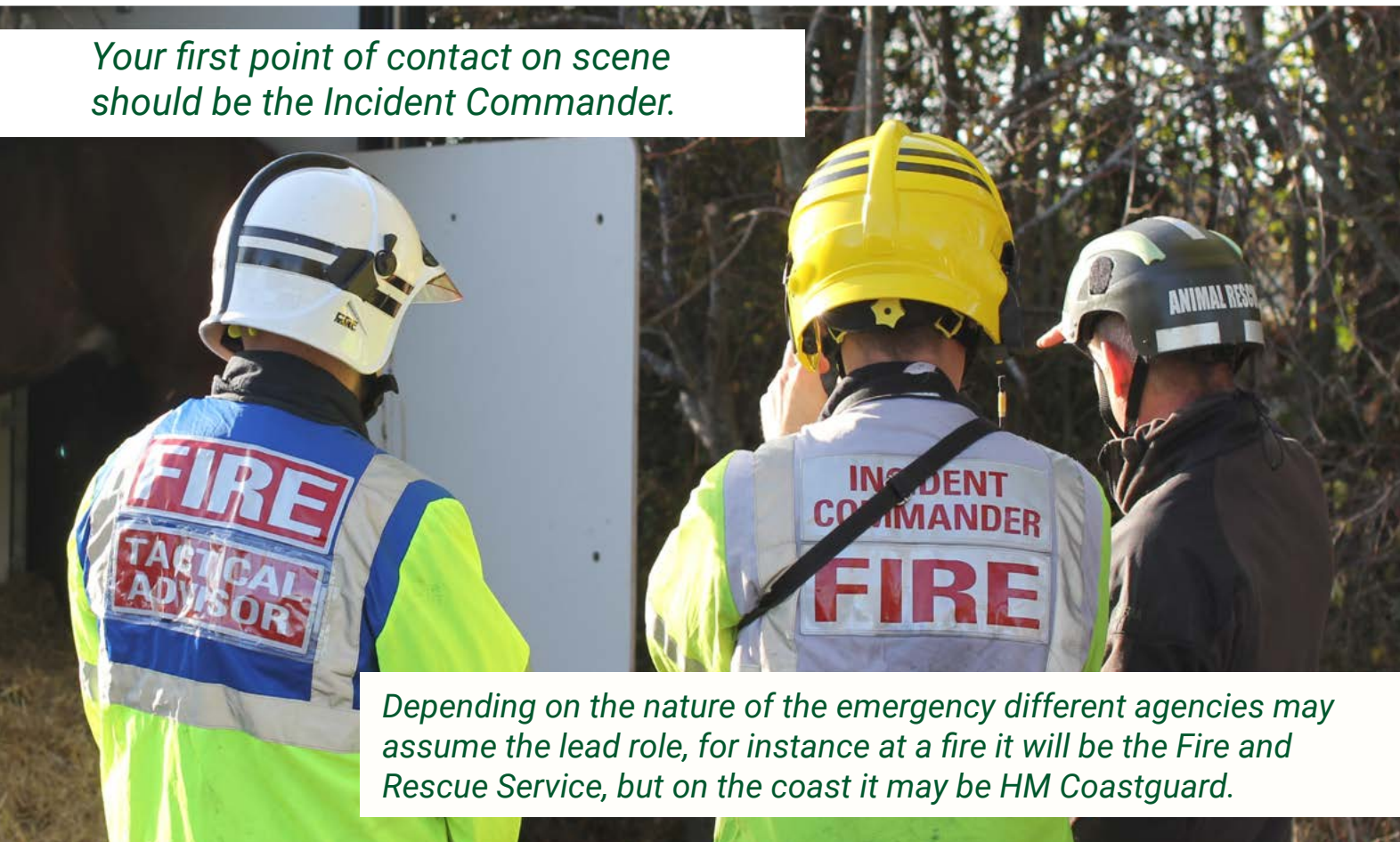
Attending a Multi-Agency Emergency Response

On receipt of a call from an emergency services control room at the practice, it's vitally important that you or the reception staff gather the right information to help inform your response.

Ask the following questions, but remember not all the information might be available at the time of the initial call;

1. What is the nature of the emergency?
2. Are there any human casualties?
3. What animals are involved and how many?
4. What kind of injuries do they have?
5. What is the exact location?
6. Is the owner present (details)
7. Who is the lead emergency service organisation?
8. Are there any particular risks or advice for veterinary responders?

Your first point of contact on scene should be the Incident Commander.



Depending on the nature of the emergency different agencies may assume the lead role, for instance at a fire it will be the Fire and Rescue Service, but on the coast it may be HM Coastguard.

In order to manage dynamic situations where there are competing pressures, the emergency services use a management structure called the Incident Command System which clearly defines roles that are necessary to return an emergency situation to normality.

One role that will always be present is the Incident Commander. This person has the designated responsibility for the overall plan, tactics and safety of everyone on the incident.

Where multiple agencies are working at the same scene, they operate under Joint Emergency Services Interoperability Principles (JESIP) This promotes clear, unambiguous language, common terminology and a joint understanding of risk.



3 key responsibilities of the veterinarian;

1. You are responding to perform a specialist role within the Incident Management Structure. This may directly impact on the event, for instance when supporting the extrication of an animal, or it may be in support of an incident, such as providing veterinary care to animals suffering as a result of the wider situation.
2. Within your response role you have responsibility both for animal welfare and safety of people at the scene and may contribute heavily towards the incident tactical plan. However, ultimate decisions and responsibility for the scene as a whole rests with the Incident Commander. Contrary to regular clinical situations the vet is not in charge (which should be a relief to many of you!)
3. An emergency incident is a workplace and agencies supporting operations must recognise the legislative responsibilities they have when sending staff out. This will involve assessing the nature of the role you will play and the environments you will be working in, equipping yourself with suitable PPE and resources.

Checklist for Treatment

Consider	Indications	Comments
Assistance Required	Multiple casualties Multiple locations Long time period Need more supplies Moral or physical support Recognition of own limitations and requirement for expertise	Check kit list Alert potential backup that they may be required
IV Catheter	Requirement for top ups of sedation Intravenous fluid therapy (IVFT) Analgesia Antibiotics Potential for GA	If IV access is available and the area can be adequately prepped, place an IV catheter and extension set
Fluids	Dehydration Haemorrhage Hypovolaemia Potential myopathies/prolonged recumbency Repeated/prolonged sedation or GA Potential colic	Consider if administration via Nasogastric tube is more appropriate
Antibiotics	Wounds/potential wounds Aspiration Smoke inhalation	IV TMPs contra-indicated due to interaction with sedatives. https://www.beva.org.uk/Guidance-and-Resources/Medicines/Antibiotics/protect-me-toolkit
Pain Relief	Entrapments Wounds Potential myopathies	Check CV status- consider use of opioids until fluid therapy can be initiated
Blood Sample <ul style="list-style-type: none">HaematologyBiochemistryLactate	Any rescue May give indication to underlying cause and further treatment required post rescue	Take blood as soon as possible before administering treatment and take blood at end of rescue

Common Reasons for Horses to be Recumbent			
Reason	What to Check	Consider	
Gastrointestinal: Colic, haem-abdomen	Full colic exam when possible	Pain relief (pain relief given in rescue may mask signs)	Fluids
Musculoskeletal: Fractures, severe lameness, laminitis, myopathies, atypical myopathy	Crepitus/swelling/haemorrhagic shock (pelvis/upper limb), digital pulses, swelling, pain on palpation	Controlled roll over technique to check dependent limbs	
Cardiorespiratory: Haemothorax, severe blood loss, pneumonia, pericardial effusion	Heart and respiratory rate, thoracic and cardiac auscultation, mucous membranes, CRT.	Fluids, antibiotics, pain relief	
Neurological: EHV, head injury, vestibular disease, peripheral neuropathy, tetanus, botulism	Cranial nerve exam and neurological exam, mentation, skin sensation	Pain relief, antibiotics and fluids, isolation (EHV), mechanical lifting may be required	
Exhaustion		Give them time, food and water	
Chronic disease/old age/decrepitude	History and full clinical exam	Consider whether a rescue is in the best interests of the horse's welfare	

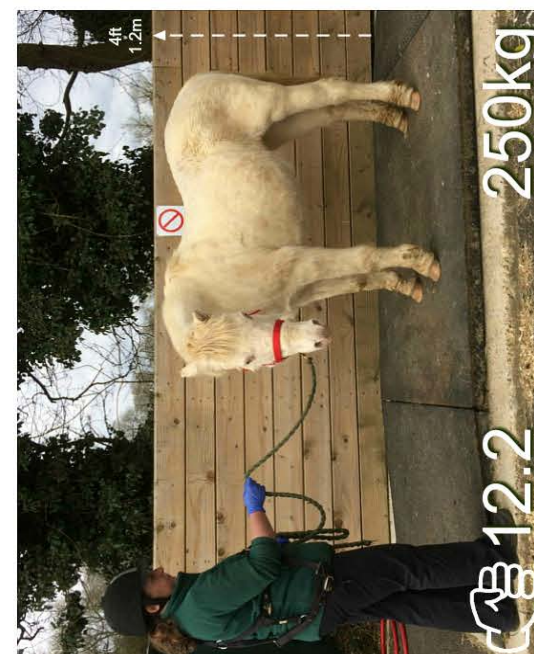
Drug Doses

These doses are a guide; the attending vet must base the decision on what to use following assessment of the patient.

- In rescue/emergency situations there is more adrenaline therefore you are likely to need the higher end of the therapeutic dose.
- Advisable to use a generous dose initially rather than repeated top-ups
- If after a top-up of sedation there is no increase in level of sedation try a different drug, combination with opioids or consider switching to GA.
- Don't forget shires and draught breeds: consider about 2/3 the dose expected
- Remember to wait 5-10 mins after IV and 30-40 mins IM for full effect: Start timer!!!
- Depth of sedation can be assessed and monitored using the following signs: Drooping lip, lowered head carriage, lack of response to stimuli (e.g. finger in ear, menace response, loud noises)
- Remember a sedated horse can still react violently at any time.
- **Remember to wait** 5-10 mins after IV and 30-40 mins IM for full effect: Start timer!!!



WEIGHT GUIDE



Intramuscular (IM) Sedation Doses					
Drug	100kg	250kg	500kg	750kg	Comments
Detomidine (Dom) 10mg/mg	0.2-0.4ml	0.5-1ml	1-2ml	1.5-3ml	Use in combination with Butorphanol or other opioid for synergistic effect
Butorphanol (Torb) 10mg/ml	0.4-1ml	1ml	2ml	3ml	Improves sedation quality
Methadone (10mg/ml)	2-4ml	5-10ml	10-20ml	15-30ml	Use in combination with any alpha-2- improved analgesia c.f. butorphanol
Romifidine	0.5-2.5ml	1.5-6ml	2.5-12ml	3.5-18ml	Use in combination with Butorphanol for synergistic effect Less ataxia than other alpha-2's
Xylazine 10%	1.5-3ml	4-7.5ml	7.5-15 ml	10-20ml	Short duration rarely useful in rescues
Acepromazine (ACP)	0.4 ml	1ml	2 ml	3ml	Don't use alone - mild and unpredictable Avoid with hypotension
Multimodal sedation ACP DOM Torb	0.4 ml	1 ml	2ml	3ml	
	0.2-0.4ml	0.5-1ml	1-2ml	1.5-3ml	
	0.5-2 ml	1-2 ml	2-4ml	3-6 ml	
Atipamezole 5mg/ml IM	1-2ml	2.5- ml	5-10ml	7.5-15ml	Start with the lowest end of dose range Give half dose IM, wait 5-10 minutes Give other half of dose IV if needed Watch out can work very quickly!

Intravenous (IV) Sedation Doses					
Drug	100kg	250kg	500kg	750kg	Comments
Detomidine (Dom) 10mg/mg	0.1-0.4 ml	0.25-1ml	0.5- 2ml	0.75-3ml	Use in combination with Butorphanol for synergistic effect
Butorphanol (torb) 10mg/ml	0.2-0.4 ml	0.5-1ml	1-2ml	1.5-3ml	Improves sedation quality
Methadone (10mg/ml)	0.7-1.25ml	1.25-2.5ml	2.5-5ml	5-7.5ml	Use in combination with any alpha-2- improved analgesia c.f. butorphanol
Romifidine	0.25-1.2 ml	0.7-3ml	1.25-6ml	2-9ml	Use in combination with Butorphanol for synergistic effect Less ataxia than other alpha-2's
Xylazine 10%	0.5-1 ml	1.25-2.5ml	2.5-5 ml	4-7.5ml	Short duration rarely useful in rescues
ACP	0.4 ml	1ml	2 ml	3ml	Don't use alone- mild and unpredictable Avoid with hypotension - FLUIDS!
Multimodal sedation ACP Dom Torb	0.4 ml	1 ml	2ml	3ml	
	0.1-0.4ml	0.25-1ml	0.5-2 ml	0.75-3ml	
	0.4-0.8ml	0.5-1ml	1-2ml	1.5-3ml	

Continuous Rate Infusion (CRI) Sedation Doses									
Weight in KG	100kg	200kg	300kg	400kg	500kg	600kg	700kg	800kg	900kg
Detomidine: 10mg/ml Butorphanol: 10mg/ml	Give 0.1 ml detomidine and 0.2ml butorphanol	Give 0.2 ml detomidine and 0.4ml butorphanol	Give 0.3 ml detomidine and 0.6ml butorphanol	Give 0.4 ml detomidine and 0.8 ml butorphanol	Give 0.5 ml detomidine and 1ml butorphanol	Give 0.6 ml detomidine and 1.2ml butorphanol	Give 0.7 ml detomidine and 1.4ml butorphanol	Give 0.8 ml detomidine and 1.6ml butorphanol	Give 0.9 ml detomidine and 1.8ml butorphanol
Wait 5 minutes then.....	Add 1.2ml detomidine (10mg/ml) to 500ml saline								
Infuse at....	1 drops per second	2 drops per second	3 drops per second	4 drops per second	4 drops per second	5 drops per second	5 drops per second	6 drops per second	6 drops per second
Once desired level of sedation is reduce to....	1-2 drops every 5 seconds	1-2 drops every 4 seconds	1-2 drops every 3 seconds	1-2 drops every 2 seconds	1-2 drops per second	2-3 drops per second	2-3 drops per second	3-4 drops per second	3-4 drops per second
Note: Expect recovery 15 minutes after cessation of CRI									

General Anaesthetic (GA)					
Drug	100kg	250kg	500kg	750kg	Comments
Note: Ensure heavily sedated prior to administration					
Ketamine (100mg/ml) Diazepam (5mg/ml) Gives 10-15 mins GA	3ml Ketamine and 1ml diazepam	8ml Ketamine and 2ml diazepam	15ml ketamine and 4ml diazepam	23ml Ketamine and 4ml diazepam	Ideally place a IV catheter Make sure horse is well sedated Can follow multimodal sedation More top ups mean poorer recovery
Note: Top up (at 10 minutes)					
	0.5 ml xylazine and 1.2 ml ketamine	1.25ml xylazine and 3 ml ketamine	1.5 ml xylazine and 5ml ketamine	3ml xylazine and 8 ml ketamine	

Rapid Anaesthesia Induction (Recumbent Horse)

Intravenous catheter placement is strongly recommended for the administration of intravenous (IV) drugs.

Please be aware that suggested doses are for healthy adult horses. Doses may need to be adjusted for compromised patients.

Veterinary surgeons should always use their own experience and judgment.

Accurate weights are needed to ensure correct drug doses. If estimating weight, care must be taken to not underestimate weight as this may result in inadequate doses of drugs administered and an insufficient level of sedation/general anaesthesia.

Ideally horses should be sedated with an alpha-2 agonist (xylazine/detomidine/romifidine) before administering IV Induction agent (ketamine). If this is not possible for human safety reasons and the horse is already recumbent, sedation drugs (xylazine/detomidine) can be administered concurrently with ketamine by IV injection.

Please be aware that if sedatives and induction agents are administered concurrently by IV injection, induction of anaesthesia may not be optimal. Excessive limb rigidity and movement can be reduced by concurrent administration of a benzodiazepine (diazepam/midazolam) and is recommended.

Where sedatives and induction agents (ketamine) are to be administered concurrently by IV injection, xylazine is preferable as the choice of sedative as its onset of action is shorter than that of detomidine.

Consider whether restraint during anaesthesia induction (for example leg hobbles) would be beneficial for human safety. Please be aware that use of some restraint methods may be detrimental to lung ventilation and will potentially reduce the ability of the horse to oxygenate. It may be appropriate to supplement oxygen to any recumbent horse. This can be achieved by nasal insufflation at 12-15 L per minute.

Before inducing general anaesthesia in a horse, careful thought must be given to the recovery from general anaesthesia. For example, is there an appropriate area, equipment and personal to assist with recovery?

Be aware that recovery from general anaesthesia in the horse is potentially high risk and can result in human and animal injuries.

Rapid Anaesthesia Induction - Recumbent Horse - Intravenous (Secure IV Access)			
IV Notes: 1. If possible give xylazine OR detomidine IV first, wait 3-5 mins then administer ketamine + diazepam IV (mixed in same syringe) 2. If human safety requires immediate induction of General Anaesthesia xylazine OR detomidine + ketamine + diazepam can be administered concurrently IV			
Drug	Xylazine 1.1 mg/kg	Ketamine 3 mg/kg	Diazepam 50 µ/kg
Volumes required if using stated drug concentration			
Weight	100 mg/ml	100 mg/ml	5 mg/ml
400kg	4.4 ml	12 ml	4 ml
500kg	5.5 ml	15 ml	5 ml
600kg	6.6 ml	18 ml	6 ml
Drug	Detomidine 20 µ/kg	Ketamine 3 mg/kg	Diazepam 50 µ/kg
Volumes required if using stated drug concentration			
Weight	10 mg/ml	100 mg/ml	5 mg/ml
400kg	0.8 ml	12 ml	4 ml
500kg	1.0 ml	15 ml	5 ml
600kg	1.2 ml	18 ml	6 ml

Rapid Anaesthesia Induction - Recumbent Horse - Intramuscular			
IM Notes: 1. If IV access is not possible for human safety concerns, general anaesthesia can be achieved by IM injection. 2. Be aware IM injection of ketamine can be painful and induction of anaesthesia will be prolonged, taking up to 15-20 minutes 3. The following combination will achieve heavy sedation/ light general anaesthesia			
Drug	Detomidine 60 µ/kg	Ketamine 4 mg/kg	Butorphanol 80 µ/kg
Weight	10 mg/ml	100 mg/ml	10 mg/ml
400kg	2.4 ml	16 ml	3.2 ml
500kg	3.0 ml	20 ml	4 ml
600kg	3.6 ml	24 ml	4.8 ml

Analgesia					
Drug	100kg	250kg	500kg	750kg	Comments
Buprenorphine (0.3mg/kg)	3-6ml	7.5-15ml	15-30ml	22-45ml	More potent analgesia than butorphanol note: less efficacious after butorphanol
Phenylbutazone (200mg/ml)	2.2ml	5.5ml	11ml	16.5ml	
Flunixin (50mg/ml) IV or IM	2ml	5ml	10ml	15ml	
Meloxicam (20mg/ml) IV or IM	3ml	7.5ml	15ml	22.5ml	
Methadone 10mg/ml IV or IM	1ml IV 4ml IM	2.5 ml IV 10ml IM	5ml IV 20ml IM	7.5ml IV 30 ml IM	More potent analgesia than butorphanol note: less efficacious after butorphanol
Note: Don't forget pain is a stimulant. Consider fluids if hypotensive/dehydrated					

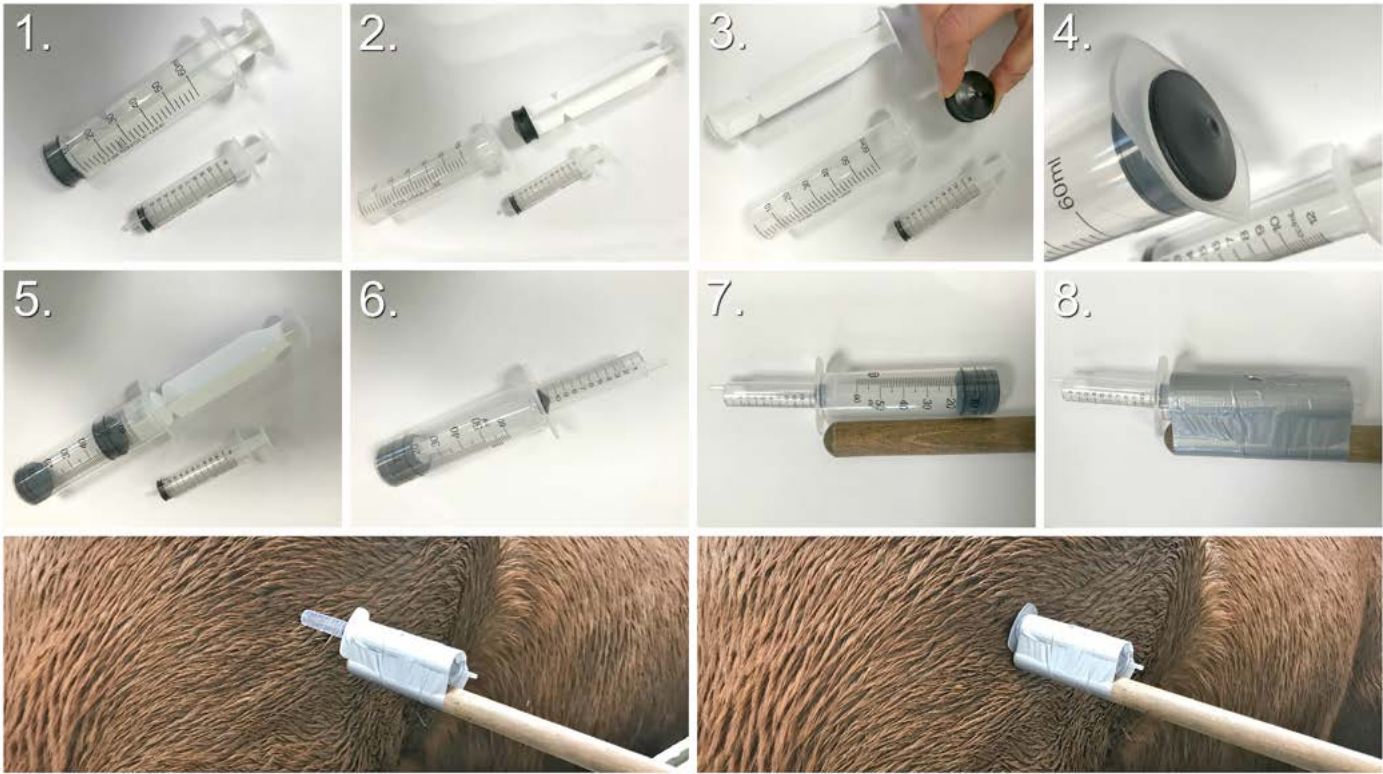
Fluids			
Fluid	100kg	250kg	750kg
Isotonic saline (0.9%) or lactated ringers solution (Hartmanns)	1-2 litres	2-5 litres	5-10 litres
			Give as bolus and reassess. Care in uncontrolled haemorrhage.

How to Make an Improvised Remote Injection Pole

If you don't have a purpose made remote injection pole you can improvise with two syringes, a broomstick or similar for reach. Consider asking the emergency responders on scene what equipment they might have available to use as to make your improvised pole.

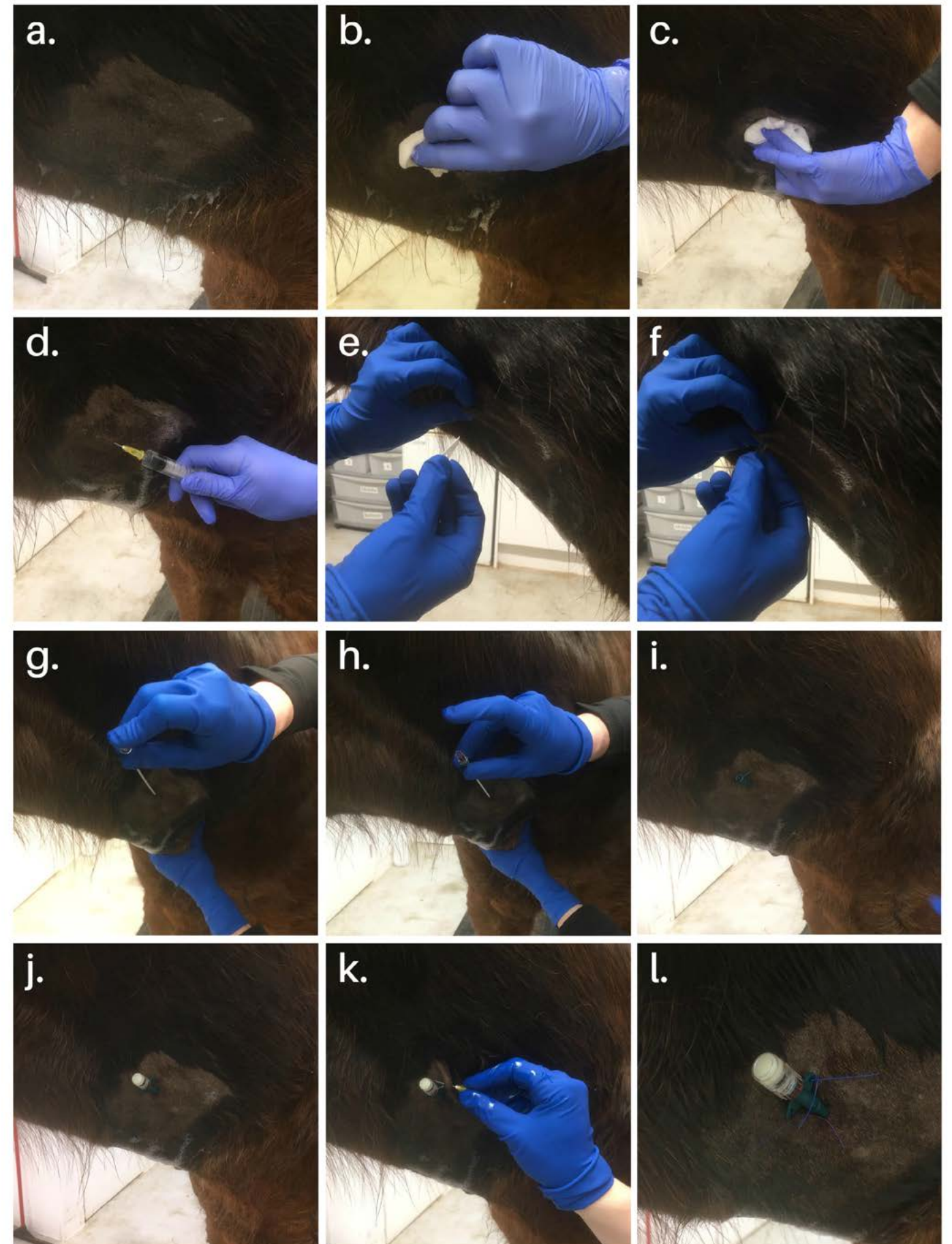
- 1. Take two syringes, we used a 60ml and a 12ml (Known as a 10ml)
- 2. Remove the plunger from the larger one
- 3. Remove the rubber seal from the plunger
- 4. Place this back into the larger syringe
- 5. Push the rubber seal into the end of the larger syringe
- 6. Place the small syringe inside the larger one
- 7. Get a broomstick or another lightweight pole
- 8. Duct tape the two together

Tip: Practice this a few times before you have to do it in an emergency!



Catheter Kit and Placement

1. Fill the extension set with 0.9% saline and attach a bung to the end, slide the clip across to close, attach a tape butterfly.
2. Clip a 10cm x 10cm square over the jugular in the cranial third of the neck. (a)
3. Wear clean nitrile gloves.
4. Carry out an aseptic scrub of the site. (b and c)
5. Inject 1.5ml mepivacaine subcutaneously over the vein in the distal third of the clip. (d)
6. Inject 0.5ml mepivacaine about an inch higher for suturing the catheter in place +/- 0.5ml mepivacaine dorsally to the point of catheter placement where the extension set will be sutured in. (d)
7. Make a stab incision through the skin over the jugular where you injected the local anaesthetic (e and f)
8. Raise the vein (creating a dirty hand) and advance the catheter and stylet through the skin at a 50° angle. (g)
9. Once you see blood well up into the hub, place the catheter almost parallel with the neck and advance another couple of inches (checking you are still in the jugular) then slide the remainder of the catheter off the stylet into the vein with the clean hand, whilst removing the stylet with the dirty hand (Keep raising the vein at this time to minimise the risk of air embolism and attach the extension set). (h and i)
10. Put a bung on the end and suture the catheter in place. (j and k)
11. Attach the extension set to the catheter. Use 20ml 0.9% saline to flush the catheter and extension set. Ensure blood can be drawn back into the extension set to confirm correct placement of the catheter within the jugular.
12. Add one suture at the base of the extension set (where your local bleb is) and one suture through each wing of the catheter.
13. Suture butterfly to the skin.
14. Trim the ends of the sutures.(l)



Bandaging and Splinting Equipment

Primary wound contact dressing (various sizes from categories below)

Donate moisture: Hydrocolloids, hydrogels

Absorb: Absorb moisture from the wound

Donate properties to assist healing: medical grade honey, silver dressings

Equipment

- Cast material (4-5)
- Cotton wool (4-5)
- Synthetic orthopaedic padding
- Open weave conforming bandage (10)
- Duct tape (1-2 rolls)
- PVC guttering (split orange drainage pipe- stronger) (1) Picture
- Oscillating saw
- 5 x 2.5cm (or similar) wooden baton/plank (2 full length to be cut or multiple of different lengths)

Standard bandage

1. Wound dressing
2. Synthetic orthopaedic padding (holds wound dressing in place)
3. Uniform layer of cotton wool overlapping one third to a half
4. Open weave bandage (conforming layer), pulled tight, and massaged to create uniform column
5. Cohesive bandage
6. Elastic adhesive bandage at proximal and distal extremities

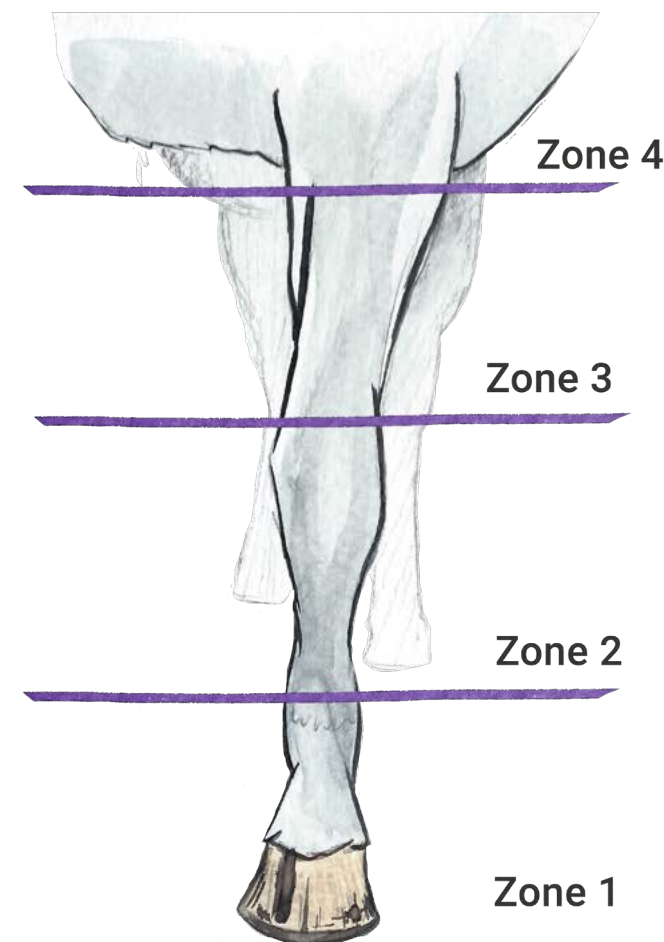
Robert Jones: (bandage made up of multiple layers of standard bandage)

1. Create multiple layers of cotton wool and open weave bandage
2. Cohesive layer (eg. vet wrap) at the end only

Other options

Bandage cast- if you feel your bandage needs more support then you can turn your bandage/ Robert Jones into a bandage cast.

Splinting Techniques - Forelimb Fracture Zones



Zone 4 - Elbow and above: No stabilisation necessary and distal limb bandaging will act as pendulum. If triceps function lost stabilise carpus in extension to reduce anxiety and allow some weight bearing

Zone 3 - Proximal radius and below- Full limb Robert Jones and caudal splint (Guttering) to elbow and lateral splint to mid scapula region

Zone 2 - From just above fetlock to distal radius (Just above knee), Full limb RJ's with Caudal (guttering) and lateral splint to level of elbow

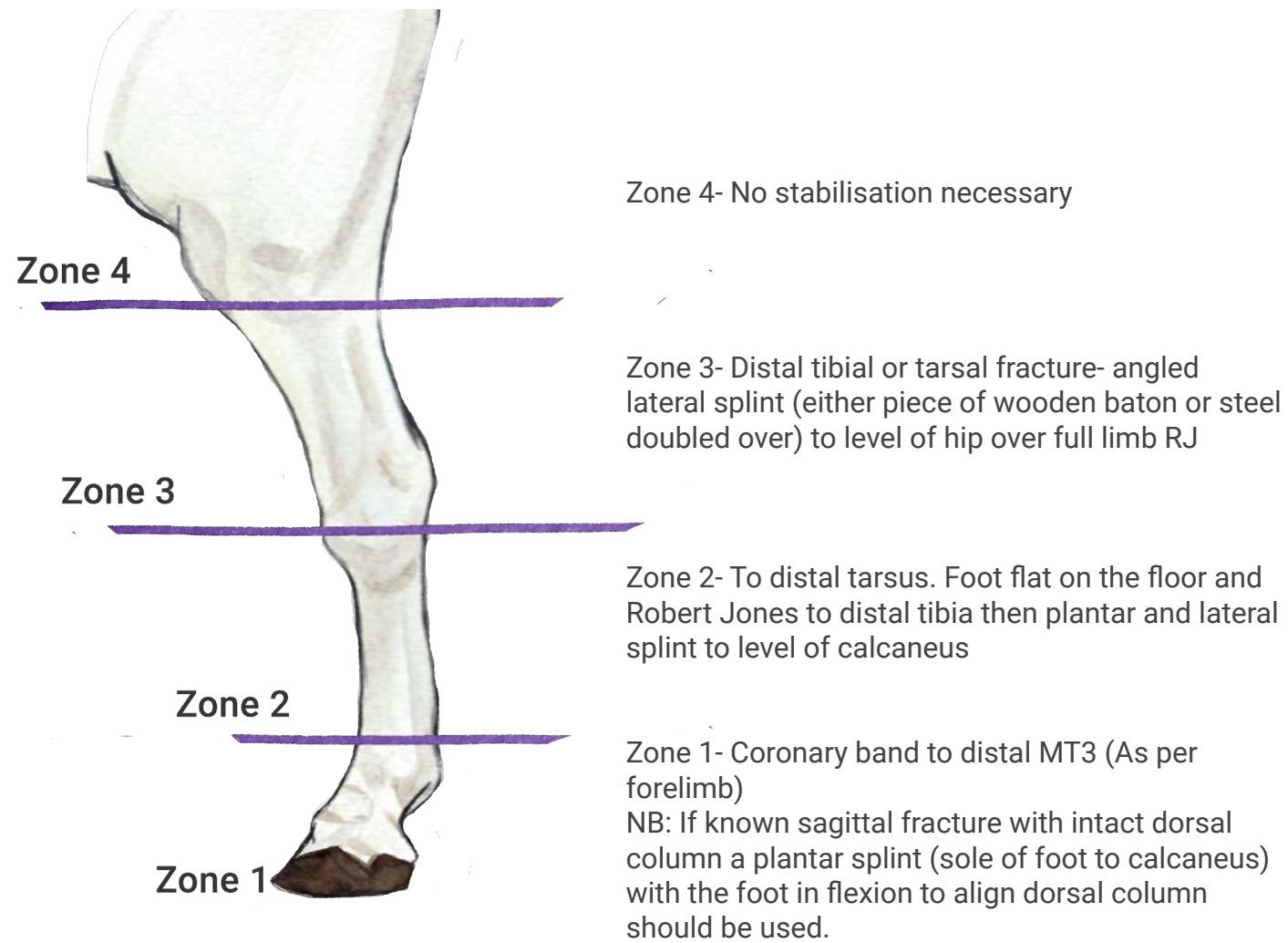
Zone 1 - From coronary band to distal MCIII: 360-degree support- RJ bandage to carpus with medial and lateral splint or casting.

*Can also use a compression boot if available

NB: If it is a known sagittal fracture with an intact dorsal cortex then a foot wedge should be used to raise the heel and align the dorsal cortices (or Kimzey splint).

Splinting Techniques - Hindlimb Fracture Zones

Notes



Euthanasia				
Method	<250kg	<500kg	<750kg	Comments
Somulose	25ml	50ml	75ml	Use IV catheter Always have an extra 50ml to hand. Give first half of injection slowly then second half quickly (full dose over 15 seconds)
Pentobarbital 400mg/ml 35ml/100kg	100ml	200ml	300ml	Sedate Use catheter and extension set Inject quickly Keep injecting until death occurs (even when it starts to be anaesthetised Will move back/away from you while injecting
Pentobarbital 400mg/ml 35ml/100kg	70ml	150ml	200ml	
Potassium Chloride	50ml	100ml	150ml	Draw up correct amount of tepid tap water- dissolve as much KCl powder as possible in water (saturated solution) Only in horse under GA Rapid IV until heart stops This can appear very frightening- Legs and muscles will move- Be careful and make sure you warn others
Shooting	Can use sedation first to lower head and keep still Make sure you have spare rounds available Be aware of your environment - bullets ricochet! Animal may bleed heavily - beware slippery floors			Do not do this unless trained and licensed
Refer to: Guide to Best Practice for Veterinary Surgeons When Considering Euthanasia on Humane Grounds: Where Horses are Insured Under an All Risks of Mortality Insurance Policy. Consider: Informed consent and second opinion. Ownership and identification of the horse.				

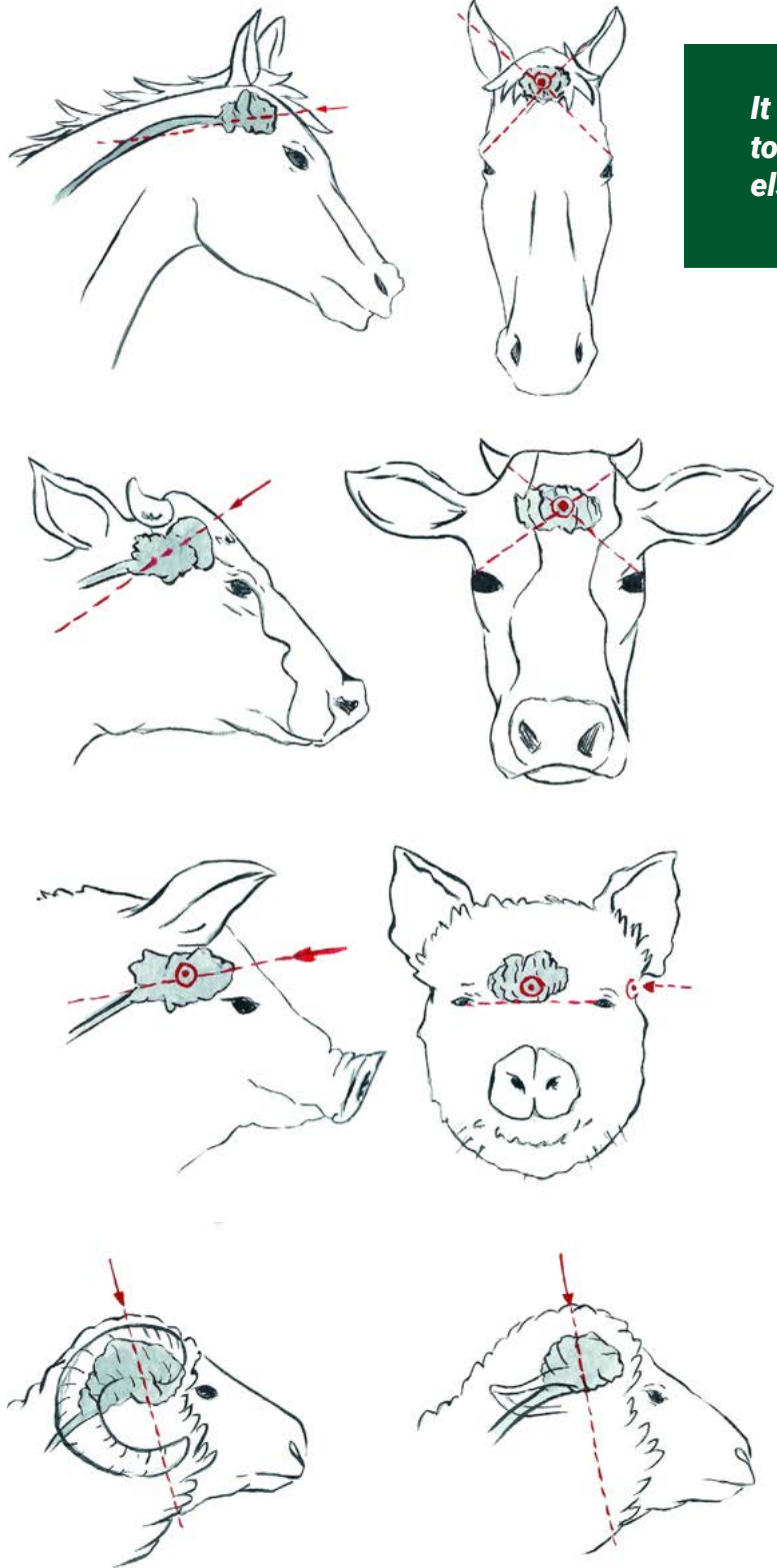
<https://www.beva.org.uk/Guidance-and-Resources/Routine-Healthcare/euthanasia>

Use of a Firearm

The use of a firearm is a very efficient method of euthanasing a horse, when administered by an experienced person.

The weapon should be fired with the muzzle close to the head (but never against the skull) at the correct location and in the required direction to ensure that the shot penetrates the brain and causes significant damage

It is essential that the horse is properly restrained. Muscle twitching may still occur even though the shot has been lethal.



It is illegal to use a firearm that is registered to another person but you can direct someone else in the technique

The most commonly used equipment includes:

Humane killers (specifically manufactured/adapted, single-shot weapons and ‘Bell Guns’ of various calibres)

Shotguns
(12, 16, 20, 28 bore and .410)

Rifles
(.22, .243, .270, .308)

Handguns
(various calibres from .32 to .45)

Ref: Humane Slaughter Association (HSA)

How to make an Improvised Head Collar

This is a simple four step process to make an improvised head collar from a lunge line, if you don't have a purpose made head collar available. It's worth practicing this a few times before you have to do it in an emergency!

Place the loop end of the lunge line over the head, behind the ears.

Whilst holding the end loop on the lunge line, push the other part of the line through the existing loop to form another larger loop. (This should be big enough to fit over the nose).

Place the larger loop over the nose, ensuring you don't compromise the airway.

Tighten and hold, remember the line can loosen so hold it close to the head.



Standard Manual Stopping Techniques

The majority of large animal rescues are undertaken using one or a combination of manual techniques, often in conjunction with a rescue glide.

In some circumstances, following assessment and wider understanding or situational awareness, the use of powered mechanical advantage or lifting may be the preferred option.

When choosing a method in conjunction with the team leader, the following should be considered;

- Is the proposed method an agreed technique and appropriate for the species involved?
- Are there circumstances which require adaptation of an agreed method?
- Is there appropriate veterinary triage, assessment and supervision available on scene?
- Are there any medical or welfare considerations that might preclude a chosen method?
- In the hierarchy of rescue techniques, can a simple low-tech solution be utilised?
- Will chemical control measures available be suitable and sufficient for the plan?
- Can the animal rescue lead be confident that the rescue method promotes a casualty centred and safe rescue where benefits outweigh risks?

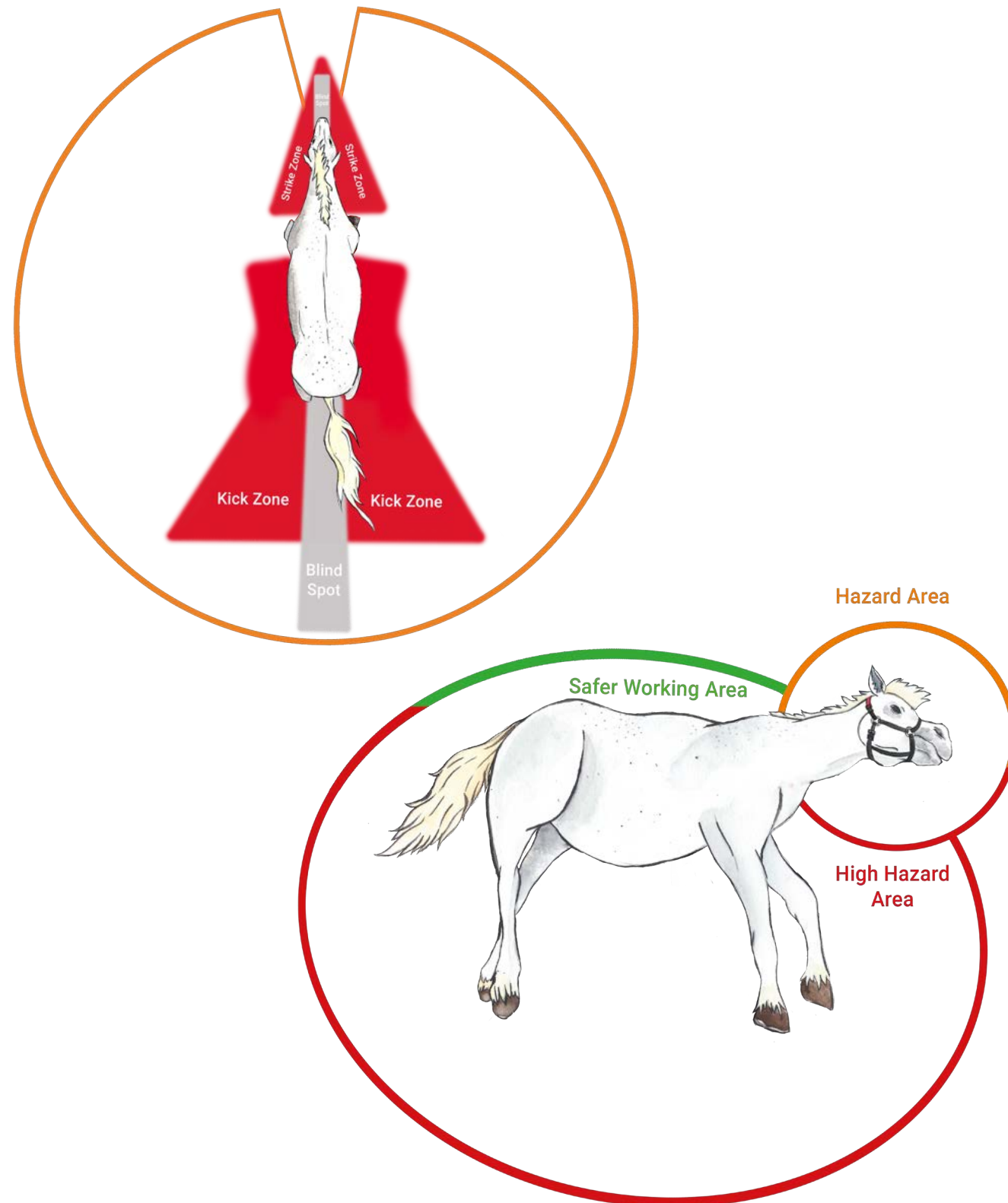


Safer Working Areas

Trained animal rescue responders operate in structured teams with common methodology.

A risk based approach will be applied to each situation and protocols observed which include strict adherence to the safety zones below.

Where operating in high risk areas is necessary, the role of the vet will be to deliver control measures commensurate with the risk and operational plan.

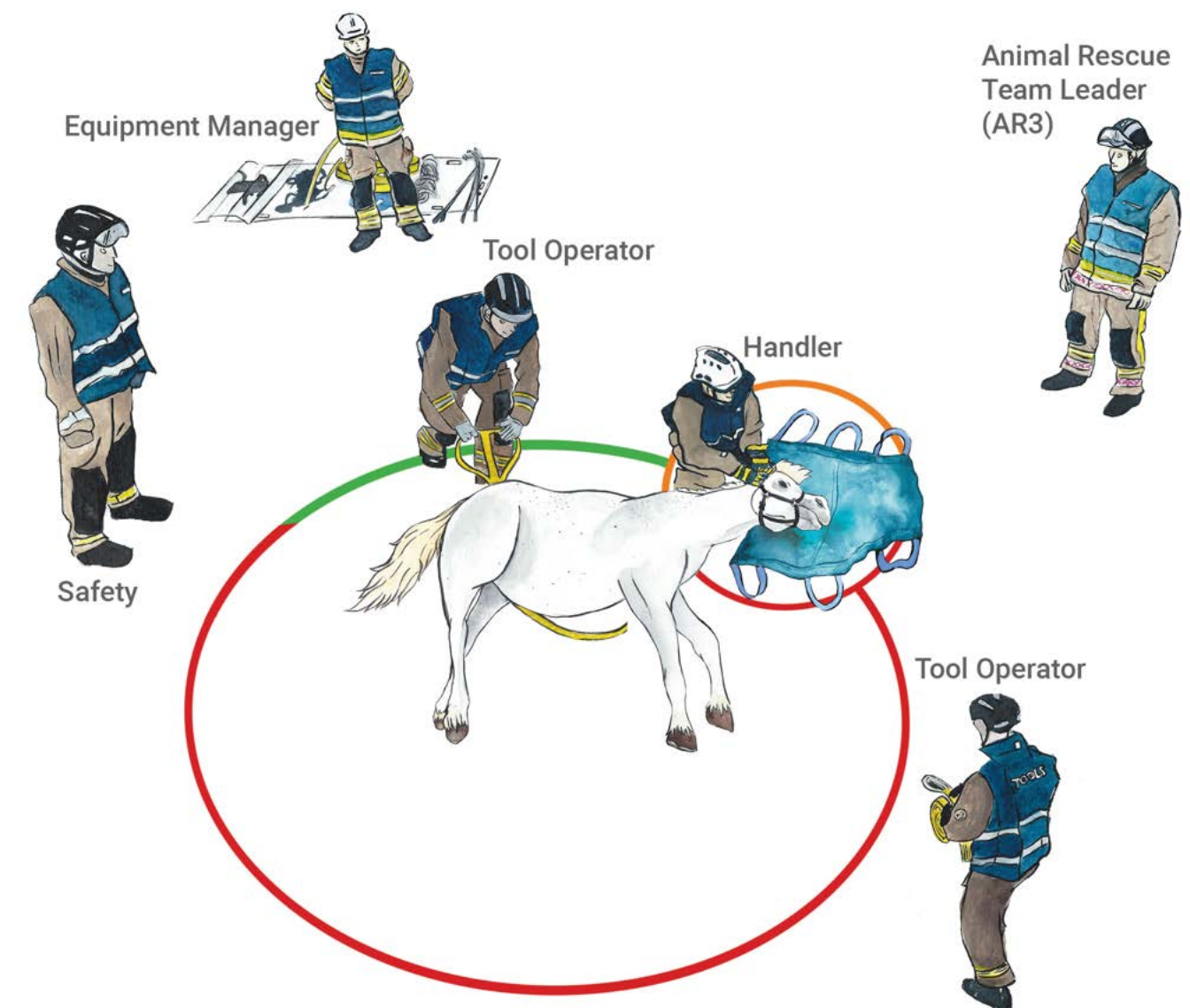


Fire and Rescue Service Animal Rescue Trained Crew Positioning

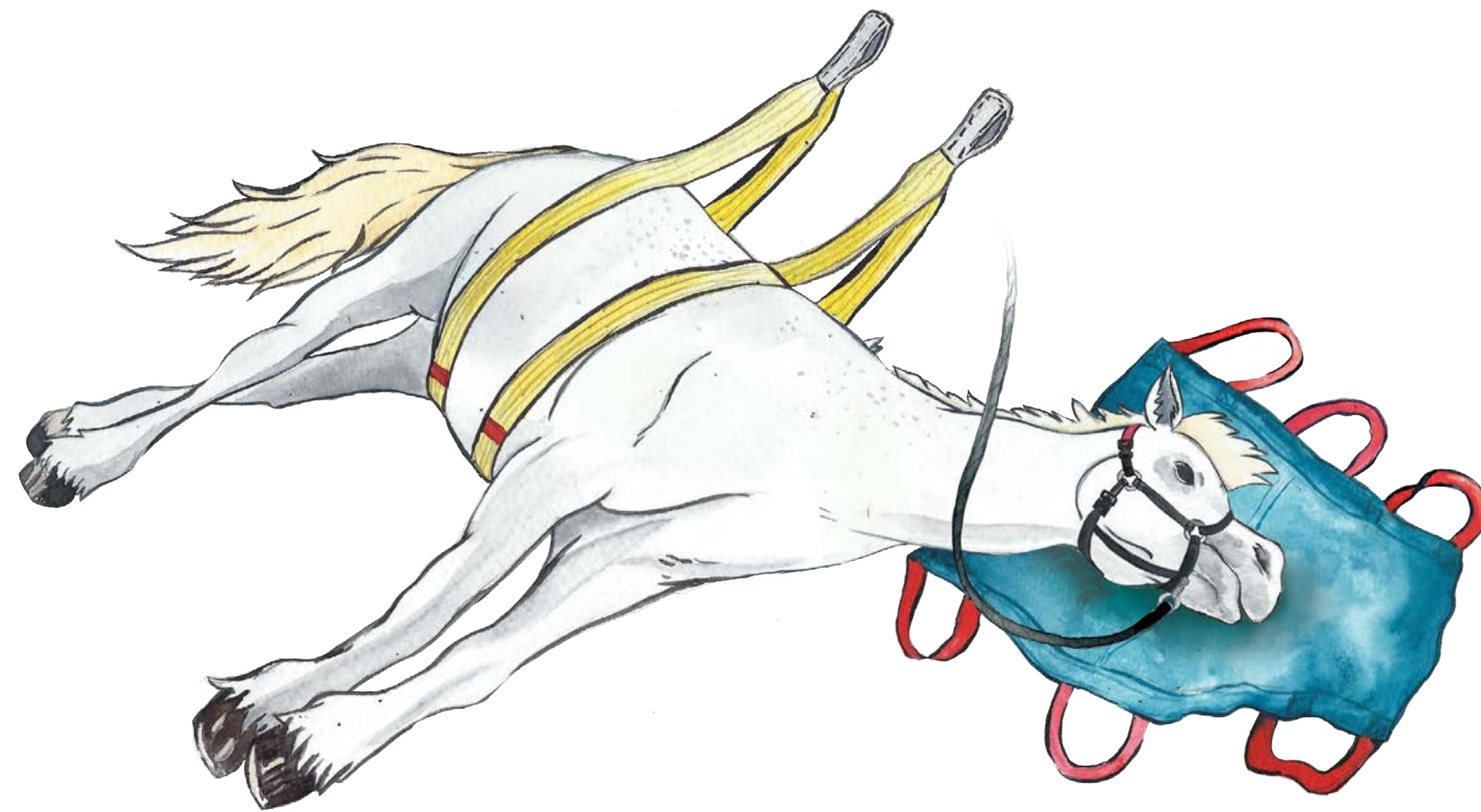
At rescues, allocation of roles and responsibilities allow for structured and practiced techniques.

The role of the vet will be to support the delivery of a casualty centred rescue and the vet will be responsible for supervising the wellbeing and casualty care afforded to the animal.

Therefore priorities must be led by the needs of the casualty unless human life saving actions take precedence.



Barrel Skid



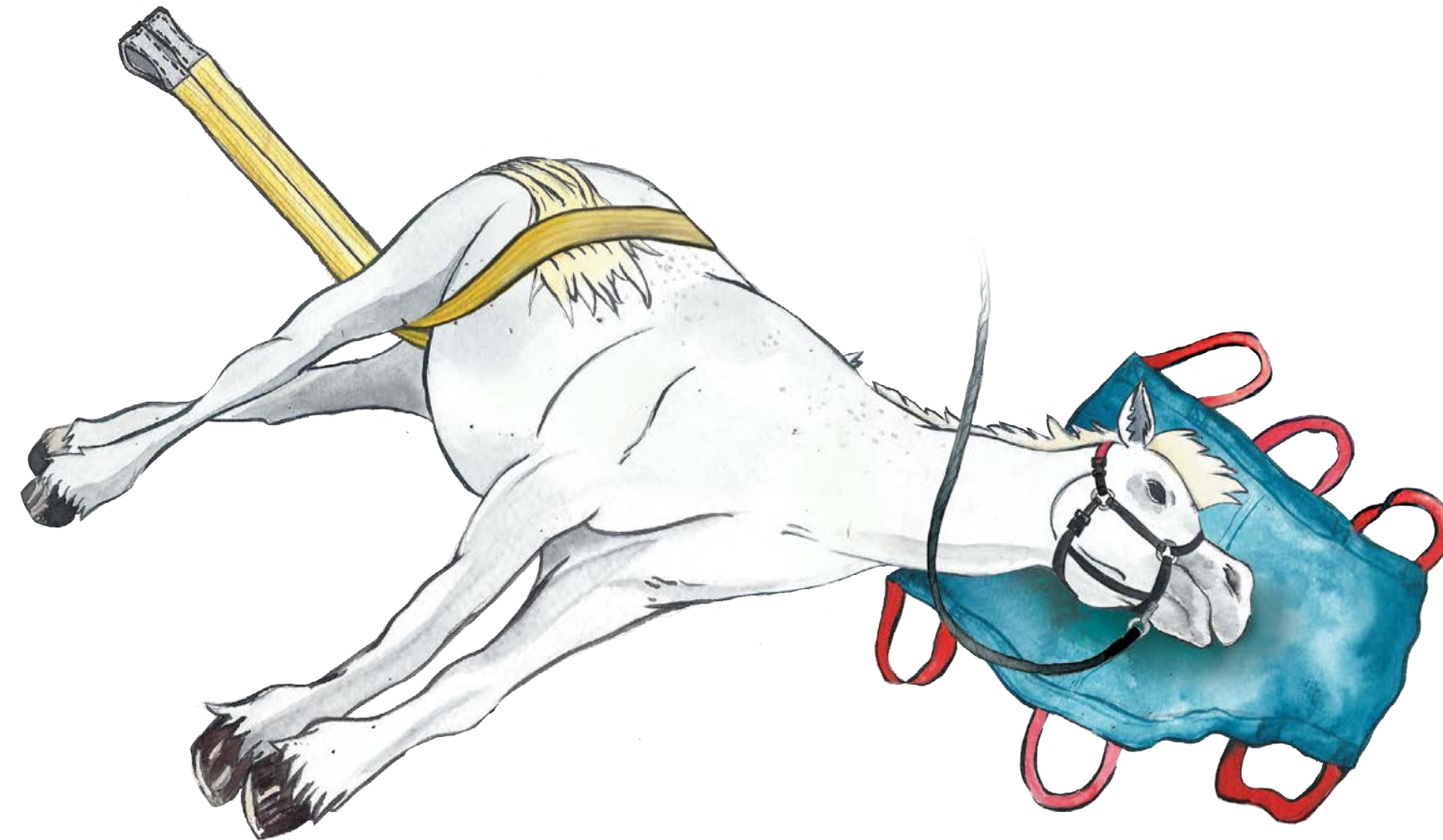
Advantages:

1. Used to manually ease a compromised standing animal where steep sides prevent a sideways skid and an element of lift is required, i.e. swimming pool edge, deep ditch
2. Simple to apply
3. Can be applied from single side if required
4. Can be used with mechanical assistance and a rescue glide for combination lift and skid

Disadvantages:

1. If used without mechanical advantage, animal weight and centre of gravity in relation to the top of the obstruction edge must be considered.
2. Once out, if continuing to skid with barrel configuration, expect an element of roll to the torso and potential for stimulation.

Rearwards Skid



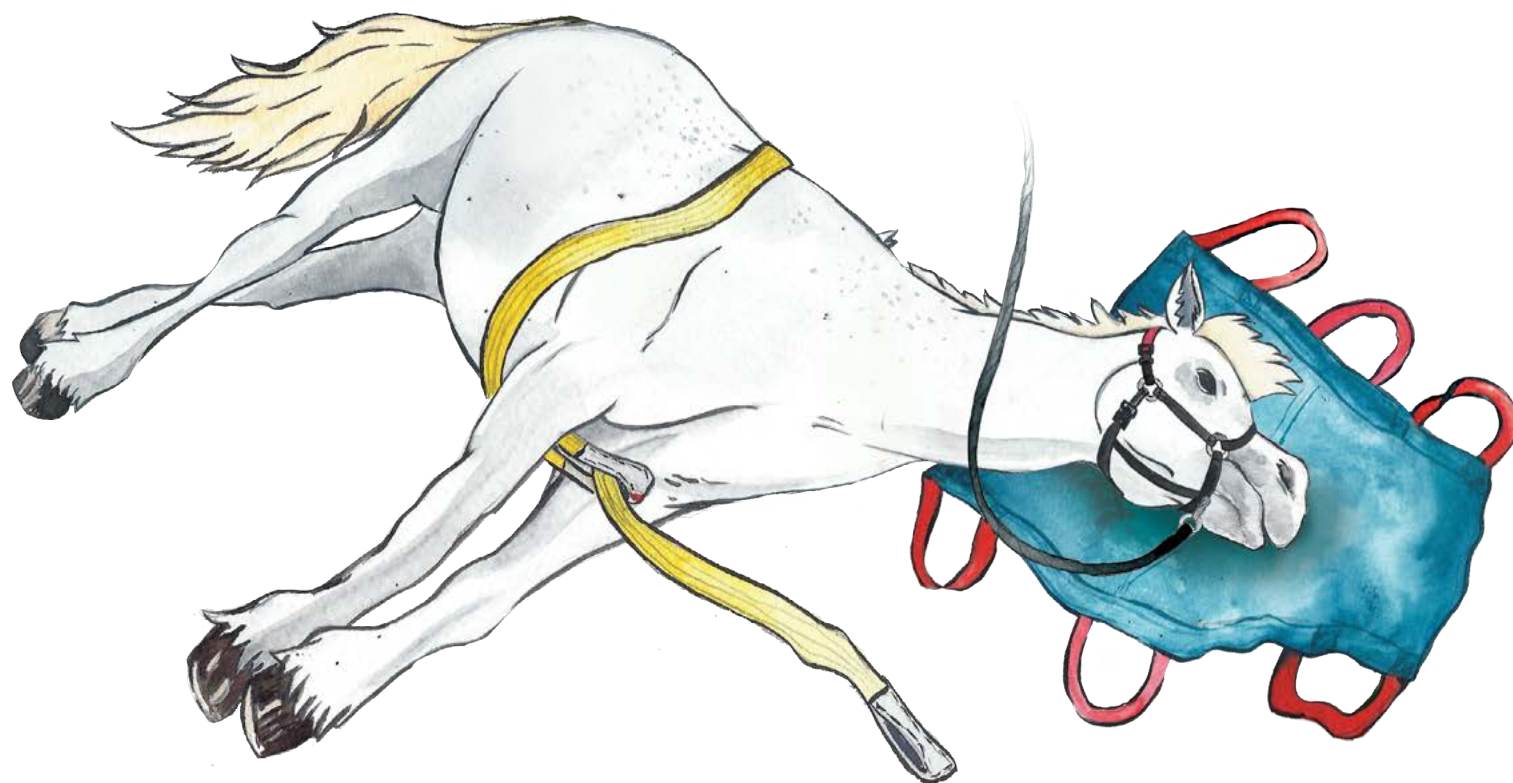
Advantages:

1. Simple to apply
2. Can be used to manoeuvre animals through narrow gaps as the legs naturally fold forwards
3. Fits securely around the torso
4. Strops configured to avoid genitalia
5. Avoids using legs, tail and head for traction
6. Responders managing the head are walking behind the hazard which is a safer position than the forwards skid

Disadvantages:

1. Pressure is concentrated around one area of the torso

Forwards Skid



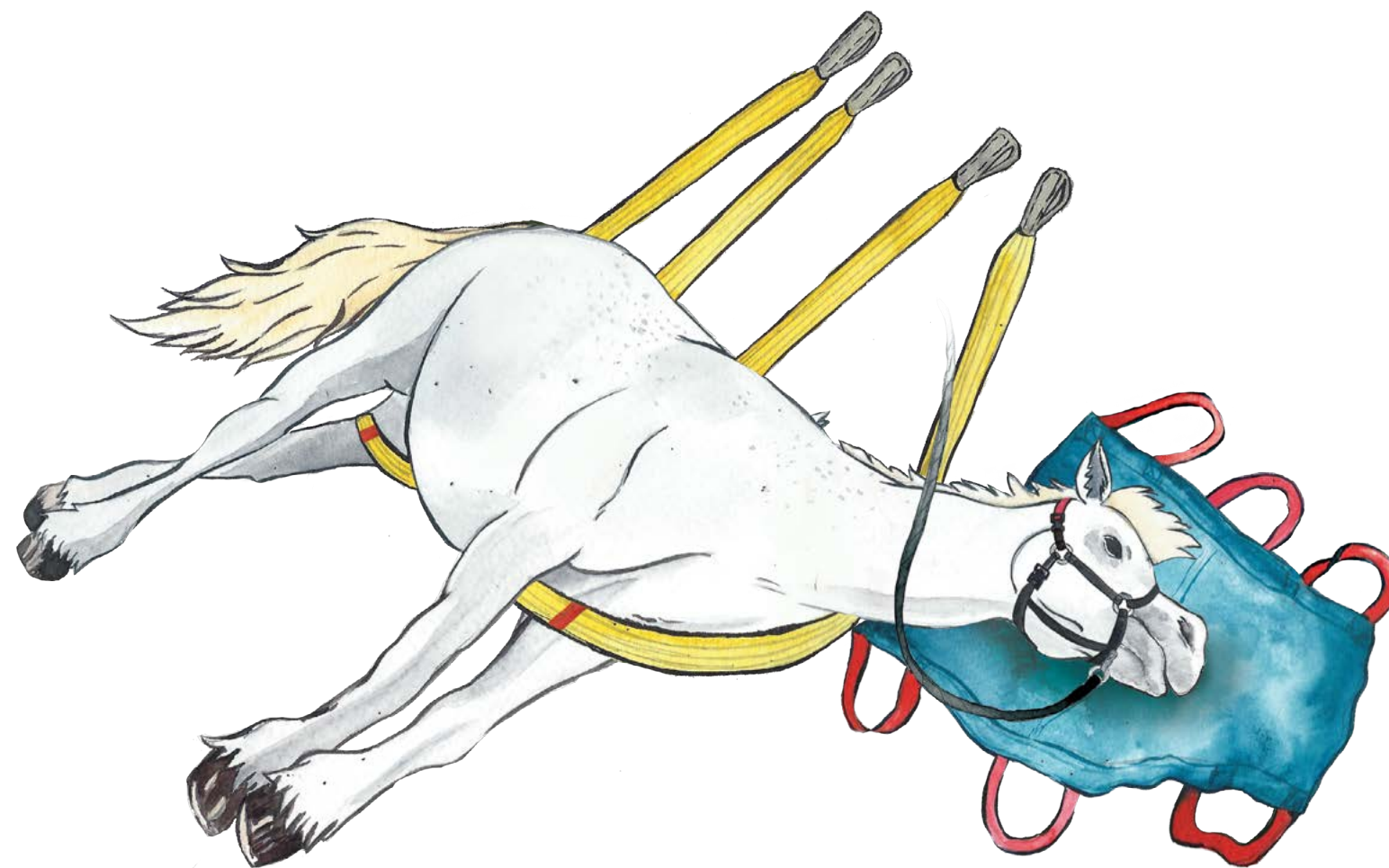
Advantages:

1. Allows simple stropping configuration for when an animal presents front forwards
2. Avoids traction on head or legs. Easy to apply to an animal in a restricted space
3. Can be used for limited vertical movement

Disadvantages:

1. Places direct pressure around one area of the torso
2. If not applied correctly may slip over narrow shoulders
3. Uses a larks foot configuration so not truly quick release
4. Responders on the head will be walking in front of the animal during the skid which might compromise them if they slip.

Sideways Skid



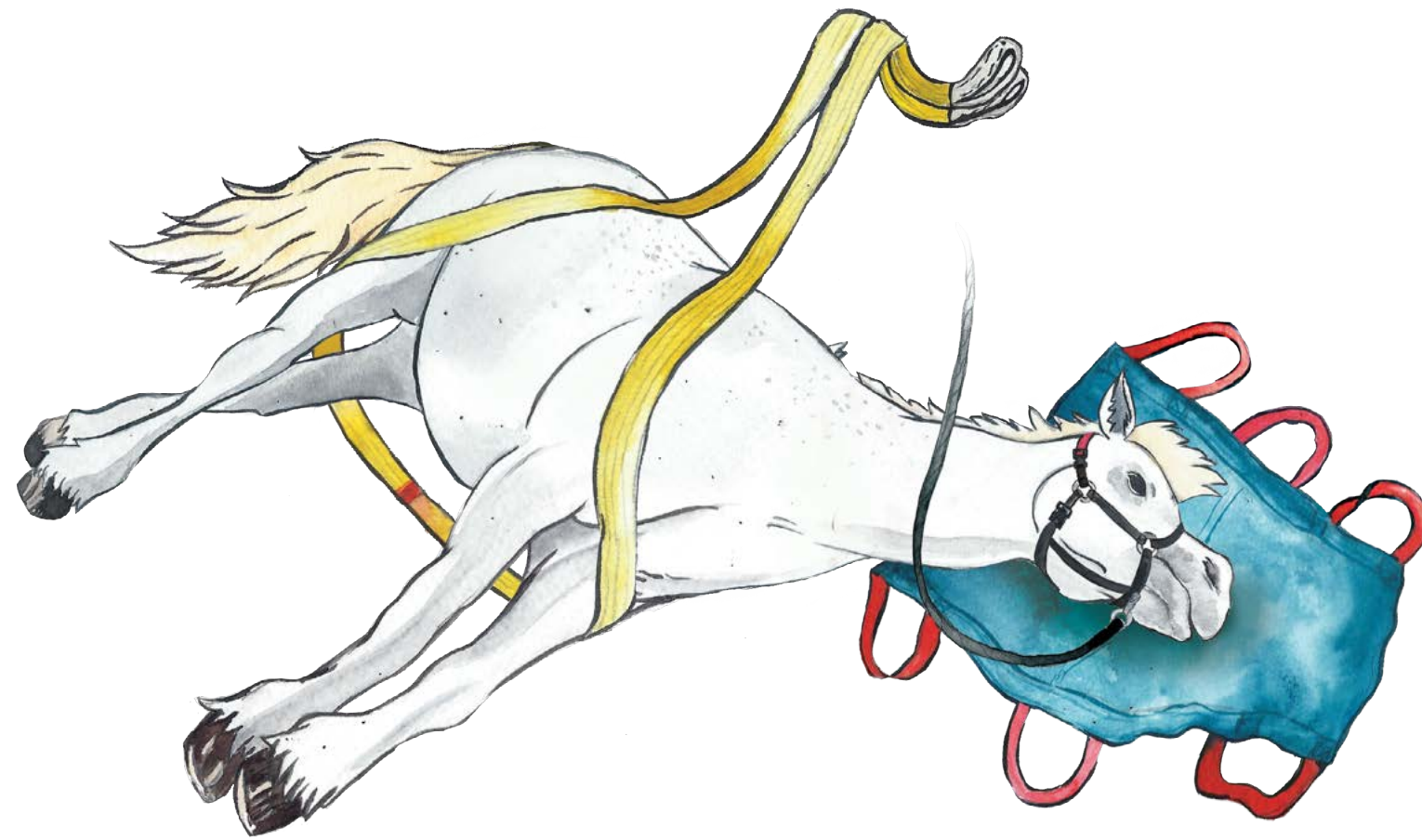
Advantages:

1. Two points of contact minimises pressure on the torso, positioning of strops similar to carrying a human under their armpits
2. Technique avoids the torso rolling and stimulating the animal
3. Responders are in two lines which spreads the effort
4. Communication is aided by having the team closer to the animal
5. Manoeuvrability is extremely flexible and legs remain in perfect alignment not being pulled forwards or backwards

Disadvantages:

1. As with any skidding the ground conditions and distance are limiting factors.

Rollover



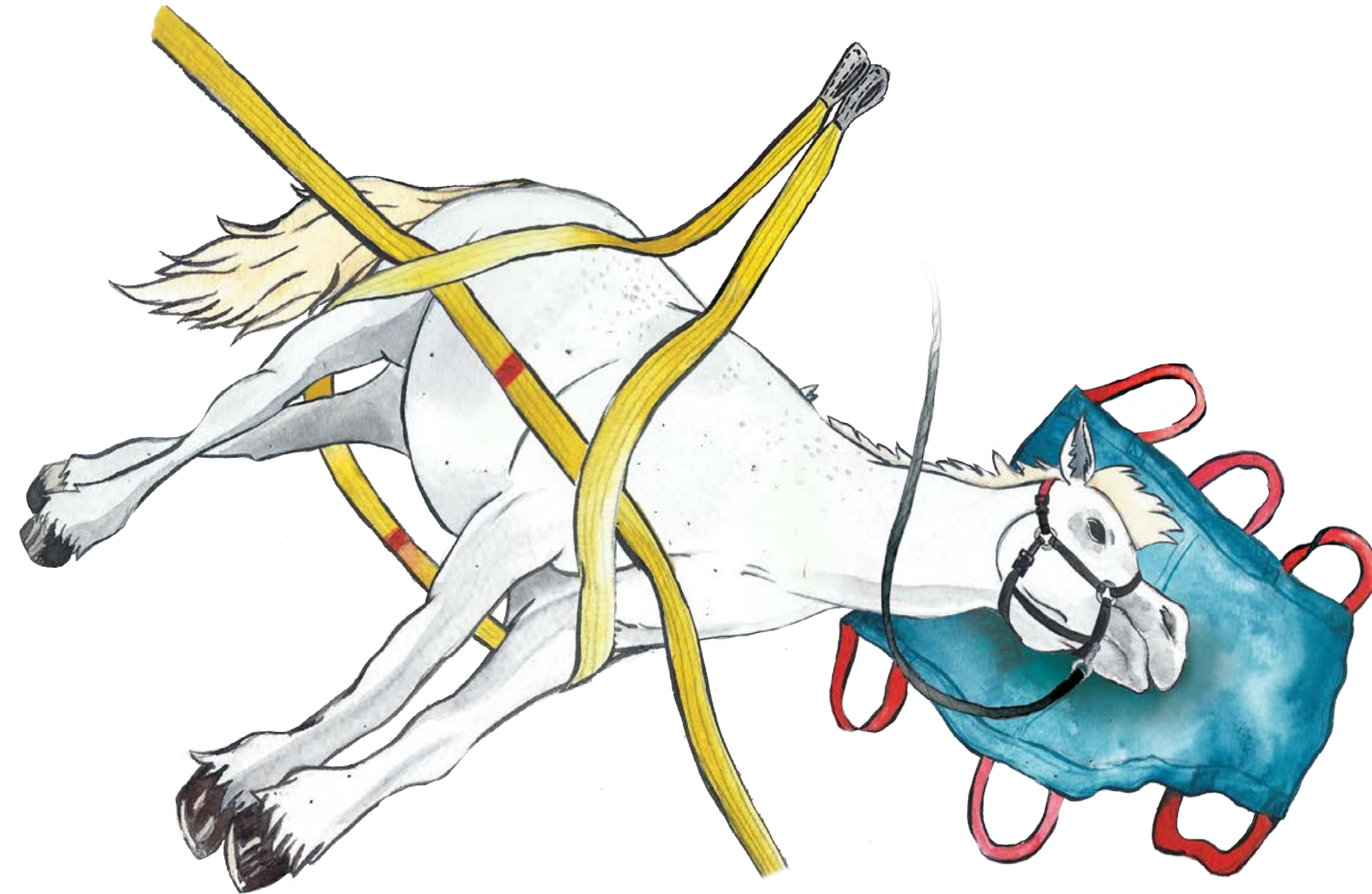
Advantages:

1. Effective method of rolling an animal in order to stimulate it to rise
2. Uses wide webbing on the muscle structure of the animal rather than using legs as levers
3. Technique can be carried out on any size animal with minimal personnel
4. All persons remain out of risk areas

Disadvantages:

1. Should not be used in isolation if the rollover needs to be controlled

Controlled Rollover



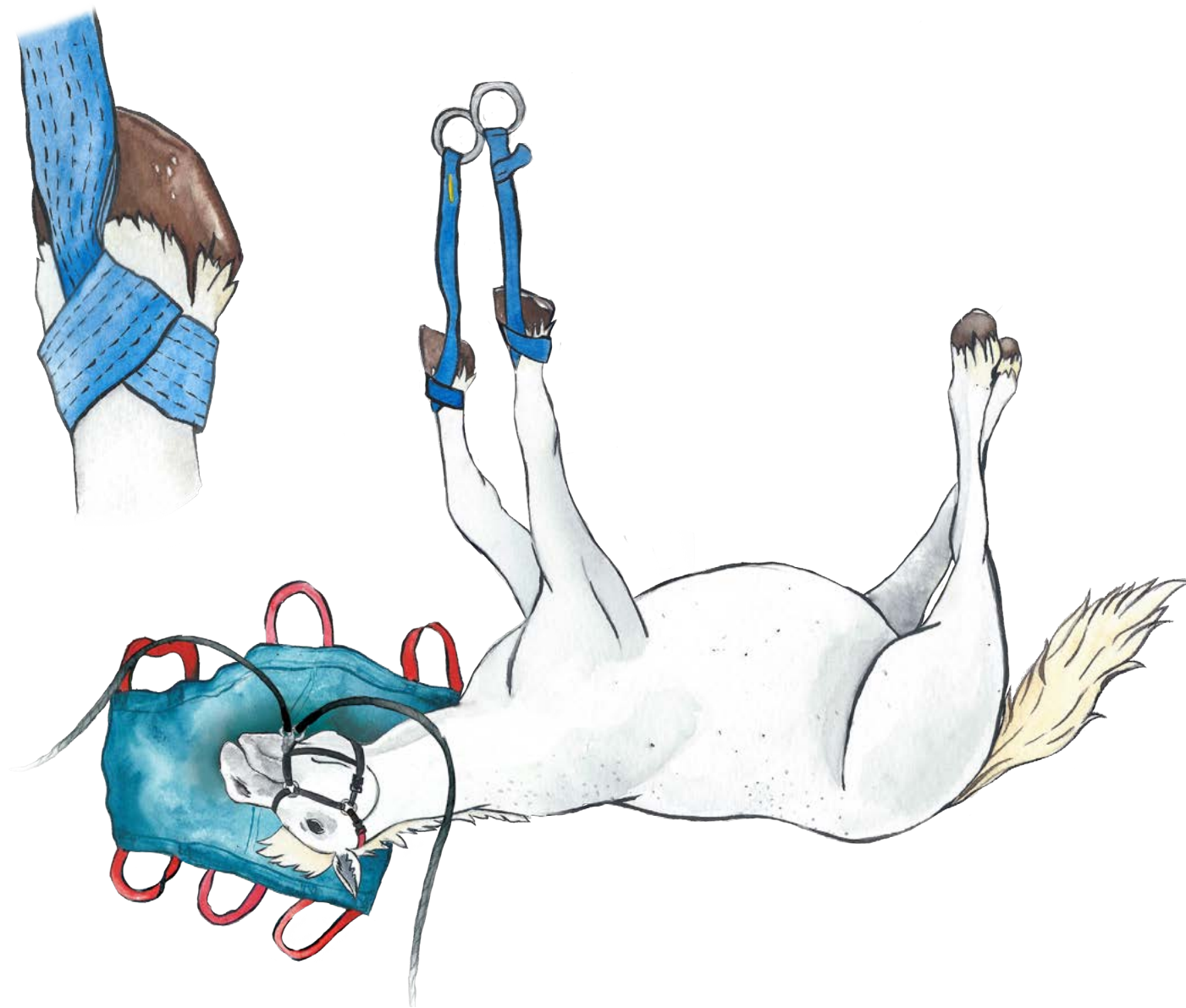
Advantages:

1. Effective method of rolling an animal carefully for positioning or veterinary consideration
2. Uses wide webbing on the muscle structure of the animal rather than using legs as levers
3. Technique can be carried out on any size animal
4. All persons remain out of risk areas

Disadvantages:

1. Requires sufficient personnel to achieve, dependant on weight of animal

Hobbled Dorsal Rollover



Advantages:

- 1. Useful option for rapidly removing a dorsally recumbent animal that is trapping a human underneath
- 2. Utilises singular hobbles and doubled up rope which when quickly removed post rescue allows an animal freedom to move.
- 3. Could be used in some circumstances for a regular rescue of a dorsal recumbent animal should time constraints (i.e. medical prognosis) or lack of mechanical device in a timely fashion prioritise its immediate release

Disadvantages:

- 1. Extremely stimulating so post release behaviour should be anticipated and planned for

BARTA Animal Casualty Handover Form		
Contact Address	Phone Number	Email
Practice name and contact		
Referral hospital 1		
Referral hospital 2		
Carcass Disposal		
Local Pet Crematorium		
Notes:		
Name of Owner		
Address / Postcode		
Contact Details		
FRS Incident Number / IC		
RSPCA Incident Number		
Time of Incident		
Incident History	Fire / RTC / Entrapment / Chemical / Water / Fall / Unknown / Other	
Exposure Time		
Further Details		
Name of Pet / Animal		
Breed		
Age		
Type of Trauma		
Injuries Identified		



BARTA working groups are made up of experts from our stakeholder agencies and associations.

Focus of the groups and participants are directed by current workstreams, set by the BARTA Board following consultation with industry and sector leads to determine priorities and objectives.

BARTA advice and direction will, wherever possible be evidence based or a consensus opinion by industry leads.

The terms of reference for the working groups are:

- Review industry requirements following stakeholder engagement
- Identify appropriate expertise from stakeholder organisations to support workstreams
- Collaborate with industry leads to support a standard approach across agencies
- Oversee development of materials and resources with appropriate methods of delivery ready for stakeholder sign off.



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