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ANGLIA TOURS AIDE MEMOIRE. SURGERY AND TREATMENT ON THE WESTERN FRONT

THE WAR OFFICE

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INDEX

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SURGERY & TREATMENT TOURS

The tour itinerary has been reviewed by the awarding body to ensure that it is capable of enhancing the teaching and learning process for the related Pearson qualification.

The review confirms that the itinerary supports the content of GCSE History Option 11: The British Sector of the Western Front 1914-18: Injuries, Treatment and the Trenches and that the locations covered in each visit and the key outcomes to be delivered as part of each visit are capable of enriching the overall learning experience of this course.

To read the full endorsement, please visit www.angliatours.co.uk/tours/surgery-and-treatment-on-the-western-front/

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Pearson Edexcel
Qualifications

Endorsed for

OVERVIEW

Stages of Medical Treatment

1. Personal kit
Each soldier carried a basic first aid kit, often containing little more than a first field dressing and iodine.

2. Aid Posts
Situated within the trenches, Regimental Aid Posts (RAP) were the first place where wounded would get any kind of professional medical treatment.

3. Advanced Dressing Station
An ADS would be staffed by doctors and orderlies who would conduct triage and urgent life saving surgery. Those who survived were evacuated to the next stage.

4. Casualty Clearing Station
Generally located near a railway, to ease the movement of casualties from the battlefield and on to the hospitals. At a CCS wounded men would receive the treatment necessary to save their lives prior to a return to duty, or more commonly to enable them to be evacuated to a Base Hospital.

5. Base Hospital
Situated close to the English Channel and ideally near a port from where men who could not be returned to the front were evacuated to Britain.

6. Evacuation to 'Blighty'
Invalids, and those needing convalescence, would be evacuated to hospital in Britain – major centres were in Southampton and Scotland.

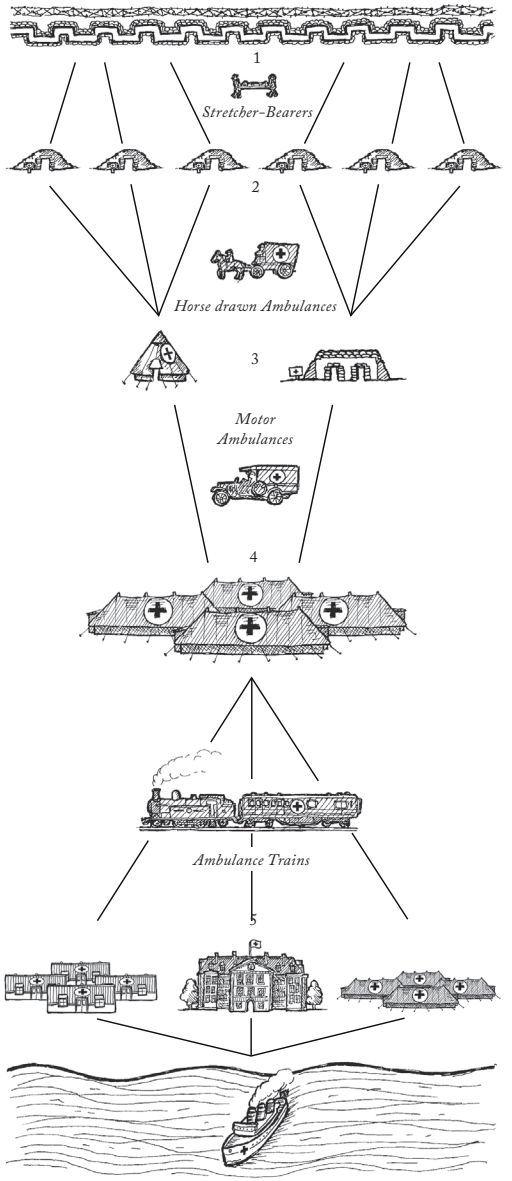


Fig 1

BRITISH TOMMY

Uniform worn in 1915

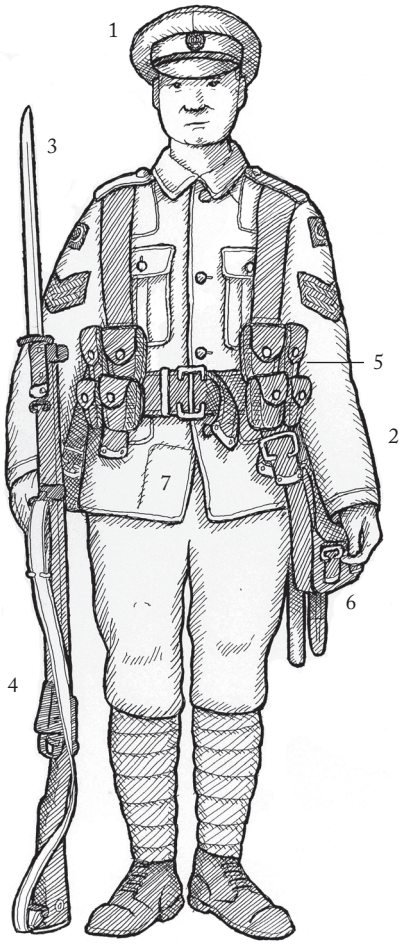


Fig 2.

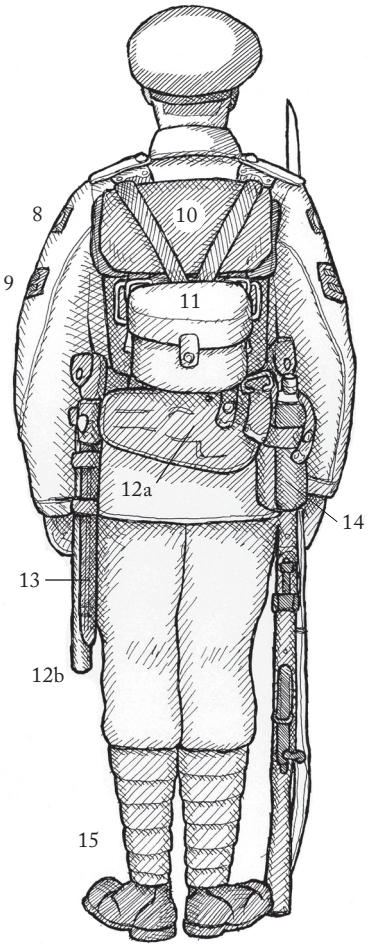


Fig 3

1. Service dress cap
2. Khaki uniform
3. 1907 Bayonet
4. Short Magazine Lee Enfield Rifle
5. 1908 Webbing
6. Small pack
7. First field dressing in tunic
8. Divisional insignia
9. Rank
10. Large pack
11. Mess tins
12. a.) Entrenching tool and b.) handle
13. Bayonet frog
14. Water bottle
15. Puttees and Boots

PERSONAL KIT

Protection and First Aid

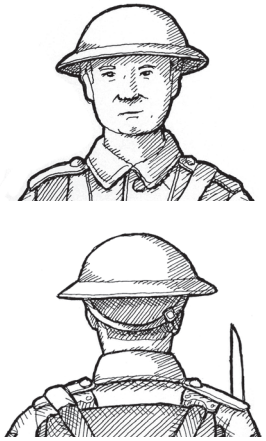


Fig 4.

Brodie Helmet

The British steel helmet was designed by engineer John Leopold Brodie and became standard issue by 1916, by which time over 270,000 had been produced.

The bowl shape and extended rim of the helmet was designed to resist spent bullets, shrapnel from above, as well as deflecting low-energy impacts.

Following its introduction, the number of head injuries reduced by 75 per cent.

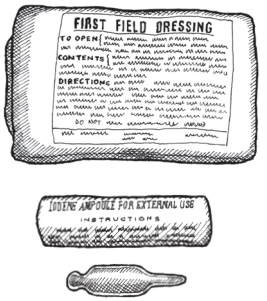


Fig 5.

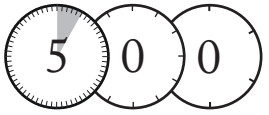
First field dressing

First field dressings were issued to all soldiers and were kept in a pocket under the right hand flap of the tunic as shown in the diagram on page 2.

It was to act as the soldier's personal first aid, consisting of a packet containing two dressings, (specifically for the entry and exit of gunshot wounds), safety pins, and ampoules of iodine.

Iodine was used to disinfect the wounds.

The idea was that the wounded soldier would have his first field dressing used upon on him.



Treatment within:
Minutes / Hours / Days

Time-frame

The diagram featured left, and throughout this booklet, shows the time-frame by which the treatment featured on that page should have ideally been administered. This could vary depending on circumstances.

CASUALTIES & TYPES OF INJURIES

On the Western Front

In military terms a 'Casualty' is someone who is not present at roll-call and therefore unable to fight. The reasons for this may be because they were either:

- **Dead**
- **Wounded**
- **Missing**
- **Taken prisoner**

Other reasons for missing roll-call could be:

- **Sickness**
- **Absent without leave** (AWOL)

The three main causes of death were:

- **Killed in action** (KIA) – those who died as a direct result of the war.
- **Died of wounds** (DOW) – those who died as a direct result of war after being received alive at a medical unit.
- **Died** – those who died from a non-military cause, such as disease or accident.

There were many causes of death other than disease, for example:

- **Friendly fire** – although not intentional, (other than executions), accidents occurred during the 'fog of war'.
- **Faulty artillery pieces** – artillery pieces wear out with constant use and as a result, become less accurate. This inaccuracy sometimes led to shells falling short onto our own positions.
- **Faulty artillery ammunition** – would detonate prematurely killing those in the vicinity.
- **Shell-fire** – by a substantial margin, shell-fire was the biggest killer during the war. It could mutilate human bodies so that they ceased to be recognisable as such.
- **Shrapnel** – a shell designed to detonate in the air, raining down lead balls, killing or wounding those beneath.
- **Bullets** – if a bullet didn't kill out right, the damage caused internally and the infections caused by detritus entering the wound as the bullet passed through, possibly would.
- **Bayonet** – the numbers killed in hand-to-hand fighting is unknown.
- **Grenades** – not unlike shrapnel, but delivered in a handy sized package.
- **Snipers** – one bullet, one kill.
- **Trench raid weapons** – silent killing tools, such as maces.
- **Gas** – primarily designed to incapacitate the enemy substances used ranged from disabling chemicals, such as tear gas, to lethal agents like chlorine, and mustard gas.
- **Mines** – mines could either instantaneously obliterate the enemy or collapse trenches, dugouts or tunnels, burying occupants alive.
- **Flame-thrower** – being burnt alive is a horrendous way to die.

ILLNESS AND DISEASE

On the Western Front

There were many illnesses and diseases a soldier could get, some even before getting to the front line, such as:

- **Ailments** – these were no different than in civilian life – illnesses had to run their course and the patient either recovered or died. However, in the military, medical aid was free unlike in civilian life, where it had to be paid for as there was no National Heath Service (NHS).
- **Drunkenness** – although understood, the condition of a soldier's liver was not the concern of the army. Hangovers weren't accepted as an excuse for sick leave.
- **Venereal Disease** (VD) – according to the *British Official History; Medical Services*, of the 13,731 sick and wounded of the BEF in France, 9% were cases of VD. It was considered a self inflicted wound – If they were diagnosed with it, NCOs would be demoted and officers reduced to the ranks.
- **Trench foot** – brought about by continuous exposure to wet and cold, leading to a lack of circulation to the feet. If not treated it could lead to gangrene and ultimately amputation.
- **Trench fever** – caused by body lice. The fever was transmitted by the soldier scratching his itching skin and forcing infected faeces from the louse into the bite, which was made by the lice when feeding off the blood of the soldier. The fever, together with severe headaches, uncontrollable giddiness and leg pains lasted 5 days and could recoccur as much as a dozen times.
- **Trench mouth** – the eroding, bleeding and ulceration of the gums, caused by bad dental hygiene. Worst cases made it painful to bite and even made talking difficult.
- **Dysentery** – caused by drinking dirty water, contaminated by faeces, rats urine, rotting bodies and carcasses, for example.
- **Influenza** – Cold and flu were quite common during the war. More serious strains, like the Spanish flu, killed millions world-wide at the end of the war.
- **Shell-shock** – this was a common name for nervous disorders or mental illness caused by the stress of war. At the time shell-shock was not generally understood or accepted as a reason not to fight. Today it is more commonly known as Post Traumatic Stress Disorder (PTSD).
- **Gas poisoning** – of those that recovered initially from gas poisoning, many were to die young a result of it after the war.
- **Self inflicted wounds** – penalties for a self inflicted wound, if diagnosed by the medical authorities, were very severe!

STRETCHER BEARERS

Duties of a Regimental Stretcher Bearer

Many of the stretcher bearers were bandsmen or infantrymen from the battalion detailed for the job – a dangerous job requiring service under fire, usually in no-man's-land, as the bearing of arms by medics was expressly forbidden in war.

From: *Field Service Regulations Part II Organisation and Administration, 1909, (reprinted with amendments 1914)*

A. When the action begins, the regimental stretcher bearers, without their arms, will be placed under the medical officer's orders. Stretchers and stretcher bearers' armlets (to be worn on the left arm in lieu of the Red Cross brassard) form part of the medical equipment.

B. The duties of the regimental medical establishments in action are:

   (i) To afford first aid to the wounded.
   (ii) To carry cases not able to walk over to the nearest and most suitable cover.
   (iii) To throw up some sort of cover to protect serious cases that cannot be moved.
   (iv) To assist the medical units after an action, if required, and if available.

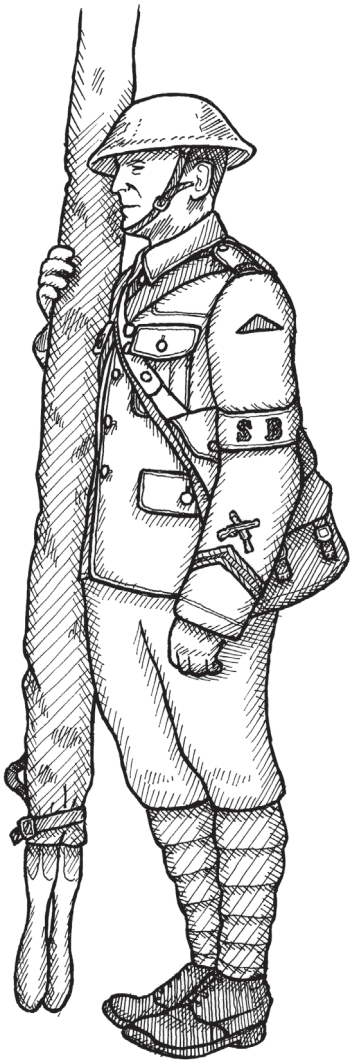


Fig 6.

SURGICAL HAVERSACK

Weight about 7 lbs. Dimensions 13" x 5" x 9 ½"

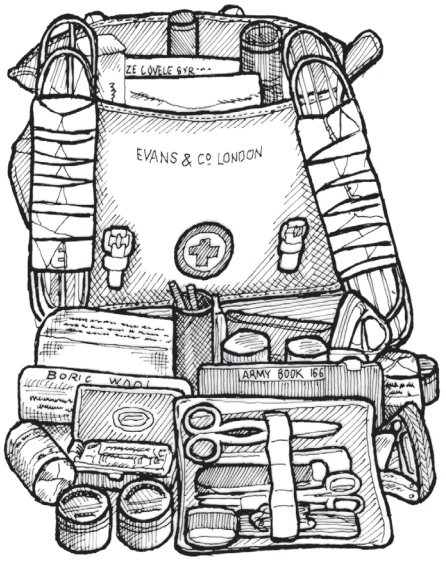
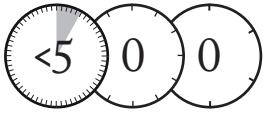


Fig 7.

From: *Manual for the Royal Army Medical Corps, War Office, 1904*

Stretcher bearers would enter no-man's-land following the aftermath of an attack and subsequent counter attack by the enemy, which could be within hours of the casualty being wounded.



Treatment within:
Minutes / Hours / Days

Contents

Bandages, loose-woven
Bandages, triangular
Clasp-knife, long bladed
Forceps, dressing, pair
Pin-cushion, emery
Pins, common
Pins, Safety
Probe and director, plated
Scissors, strong, pair
Thread, sewing, tablet
Vulcanite case, containing
  Needles, sewing
  surgeon's plated
Gauze, double cyanide
Hypodermic case, containing
  Syringe
  Needles in glass tube
  Cocaine tablets
  Morphia tablets
  Glass mortar
Medicine-cup and mortar combined, Vulcanite with 2 pestles
Plasters, rubber, adhesive,
Plaster isinglass, transparent
Silk, twisted, (S & M size) in aseptic solution
Specification tallies (Army Book 166)
Splints, wire, arm, japanned with tapes and buckles
Spirit Ammon: Aromat
Tin containing candle and wax vestas
Tourniquets, screw, small
Wool, boric, in 2-oz packets
Wool double cyanide
Waterproof canvas bag (to contain above)
Water-bottle, with felt cover, drinking cup and straps

REGIMENTAL AID POST

RAP

When a battalion went into the front line, a Regimental Aid Post (RAP), sometimes referred to as a Battalion Aid Post was set-up by its Medical Officer, (doctor).

The RAP was usually established in a shelter, dugout, cellar or a sunken lane – anything that would give protection from enemy fire.

The Medical Officer (MO) was a member of the Royal Army Medical Corps (RAMC), but most wore the cap badge of the battalion they were attached to.

The MO was assisted by two medical orderlies from RAMC and sixteen stretcher bearers from within the battalion.

The primary role of the MO was to stabilise the wounded and to try and prevent them dying before reaching the next stage of the treatment. There was not much time other than to bandage the wounds and administer morphine.

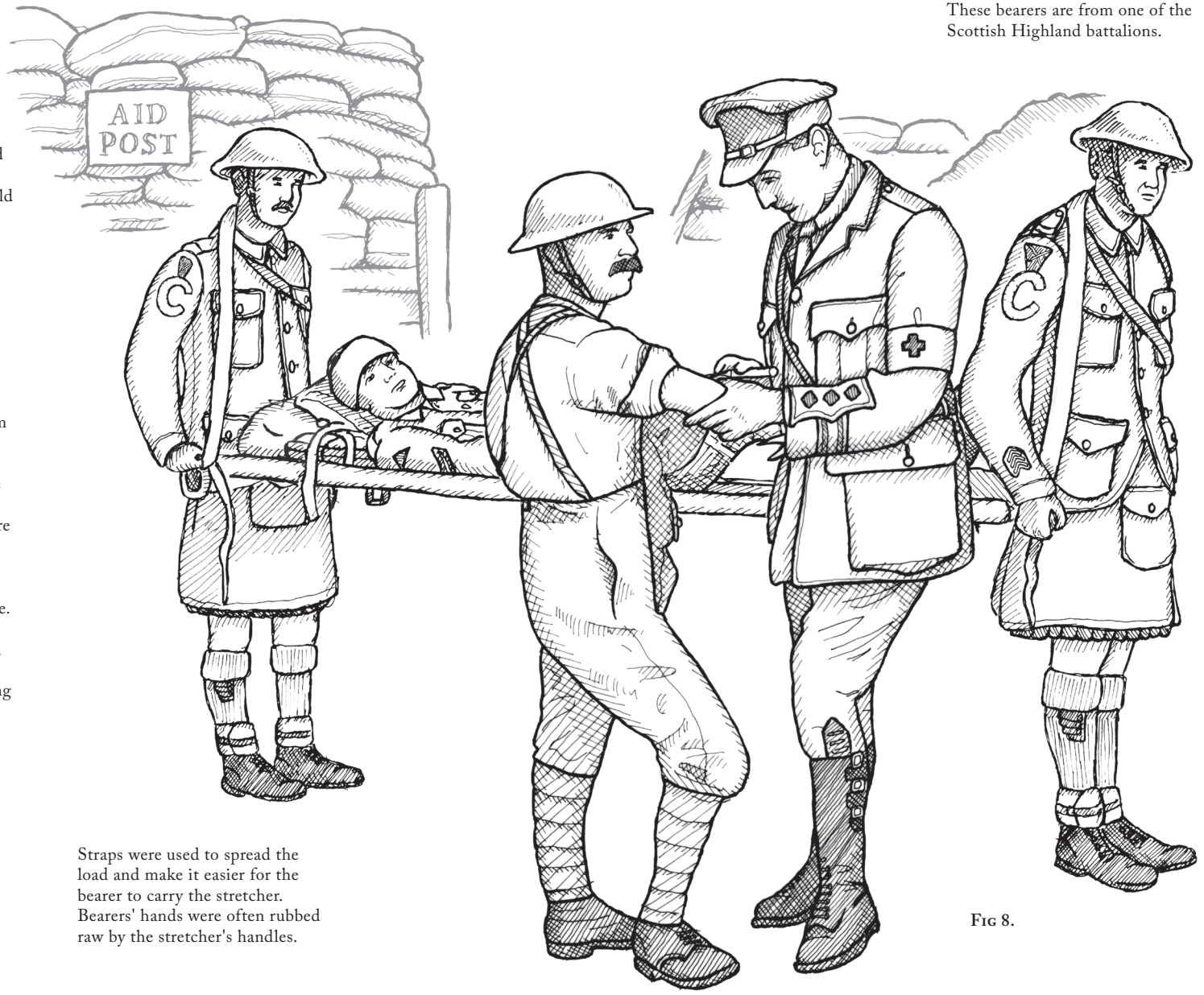
Captain Noel Godfrey Chavasse, VC & Bar, MC was the most famous MO to have served during the Great War. He was one of only three to be awarded the Victoria Cross twice.

Treatment within:
Minutes / Hours / Days

REGIMENTAL MEDICAL OFFICER

RMO

These bearers are from one of the Scottish Highland battalions.



Straps were used to spread the load and make it easier for the bearer to carry the stretcher. Bearers' hands were often rubbed raw by the stretcher's handles.

Fig 8.

ROYAL ARMY MEDICAL CORPS

Uniform worn in 1916

It could be quite some way between the Regimental Aid Posts (RAP) and Advanced Dressing Stations (ADS) for the stretcher bearers of the Army Medical Corps (RAMC). To shorten the distance, Stretcher Relay Posts were set up in between the two.

It could take up to 6 bearers to carry a stretcher casualty – one on each corner, one at the front making sure of the route and one behind, both of whom would rotate with the bearers carrying the stretcher.

Founded in 1898, the RAMC strength after mobilisation in 1914 was 18,700 of all ranks. The Corps at that time had no dental surgeons.

Numbers of the Corps grew steadily through the war, reaching a peak in April 1918 of 145,401 (comprising 12,432 offices and 132,969 other ranks), of which 769 were dental surgeons.

As non combatants, these soldiers did not carry weapons and therefore the Corps they served had no 'colours' or battle honours to its name, though they were present on every battlefield of the war. Even today, officers and soldiers of the RAMC do not draw swords or fix bayonets on ceremonial occasions.

By the end of the war, the RAMC had lost 470 officers and 3,669 other ranks killed in action or died of wounds.

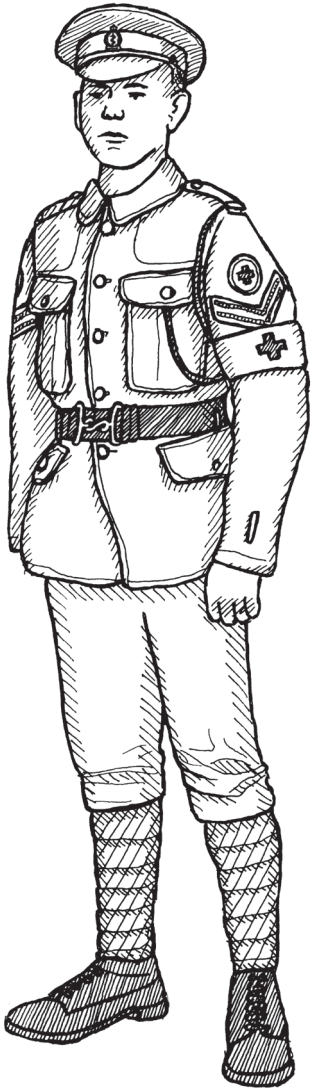


Fig 9.

FIELD MEDICAL CARD

Army Form W. 3118.

Below is the Field Medical Card belonging to Pte. T. F. Robinson 3954 of the 4th Battalion, Yorkshire Regiment, (Green Howards), wounded on Valentine's Day 1916, at Hill 60, Ypres.

Lijssenthoek II-B-39

Once the casualty reached the ADS, they were assessed in Triage, where their treatment was prioritised depending on:

- Those who were likely to live, regardless of what care they receive.
- Those who were unlikely to live, regardless of what care they receive.
- Those for whom immediate care might make a positive difference in outcome.

It would also be the first opportunity for documentation to be completed in the form of a Field Medical Card. On the card would be recorded what operations the patient had, whether they could sit or lie, and if marked with a red cross, their requirement for 24 hour care.

(9 38 14) W 714—831 300,000 4/18 H W V(P 1962) G. 330/15
9853—3909 425,000 9/15

Army Form W. 3118.

FIELD MEDICAL CARD.

(N.B.—USE LEAD PENCIL)

The reverse is to be used for notes on special cases (history, operations, special treatment, or other necessary information); also on cases requiring or receiving special treatment during evacuation.

NUMBER 3954 RANK Private

NAME Robinson TF UNIT 1/4 Yorks

Wound or Disease Gunshot wound to Head

Condition (if any) requiring special attention DI X 17 CCS

Medical Unit from which transferred

If a more detailed history is necessary, a Medical Certificate (A.B. 172), or Medical Case Sheet (A.F.I. 1237), or other statements of case may accompany.

The red edged envelope will be used for cases dangerously or severely wounded and who require immediate attention

Fig 10.

Losing your medical card could get you in a whole lot of trouble – getting treatment for the wrong condition, being sent to the wrong place, or even being ignored!

FIELD AMBULANCE

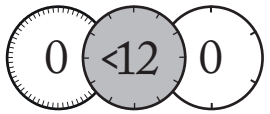
FA

The Field Ambulance (FA) was an organisation manned by members of the RAMC who were responsible for providing the casualty evacuation chain from the RAP, all the way back to the Base Hospital and beyond.

Advanced Dressing Stations (ADS) were located close to the front line in large dugouts or cellars of buildings providing protection for its occupants, as well as having good road access for ambulance transport. Sometimes they were also sited close to light railways.

An ADS would normally serve four RAPs, one per Brigade in the line. They were designed to accommodate at least 100 casualties and were often divided into two – one half to receive walking wounded, (those who had managed to bypass the walking wounded collection stations) and the other for stretcher cases.

After triage at the ADS, bandages and splints were checked and if appropriate, the casualties were given food and drink and made more comfortable. Once the Field Medical Card had been completed, causalities were then made ready to be moved onto the next part of the medical chain.



Treatment within:
Minutes / Hours / Days

ADVANCE DRESSING STATION

ADS

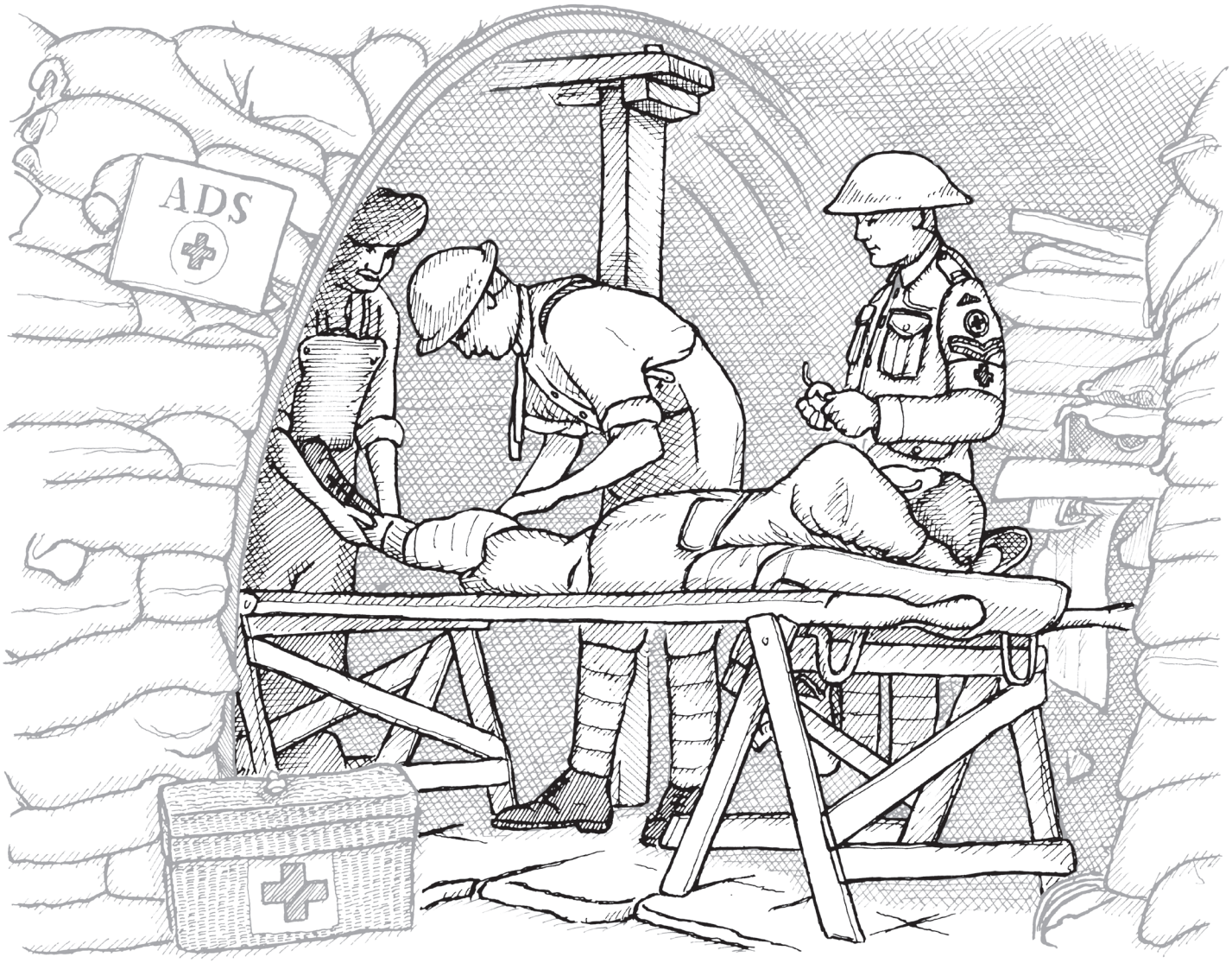


Fig 11.

MOTORISED AMBULANCES

St John and British Red Cross Ambulances

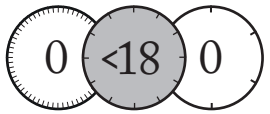
Often local communities back home in Britain would raise money to buy motorised ambulances for the St John Ambulance Association and British Red Cross Society (BRCS), who in turn would operate them for the Field Ambulance.

The motorised ambulances were driven and maintained by members of the Voluntary Aid Detachment (VAD), who were predominantly women.

They were responsible for the safe delivery of casualties from the Advanced Dressing Station (ADS) to the Casualty Clearing Station (CSS).

The VAD was formed in 1909 by the War Office to provide voluntary aid to sick and wounded soldiers. They were managed by the St John Ambulance and BRCS and given basic training in first aid, nursing and even motor mechanics.

The first detachment left for France in early October 1914 and by the end of the war, the VAD had grown in size to 90,000 women and 40,000 men and were present in every theatre of war.

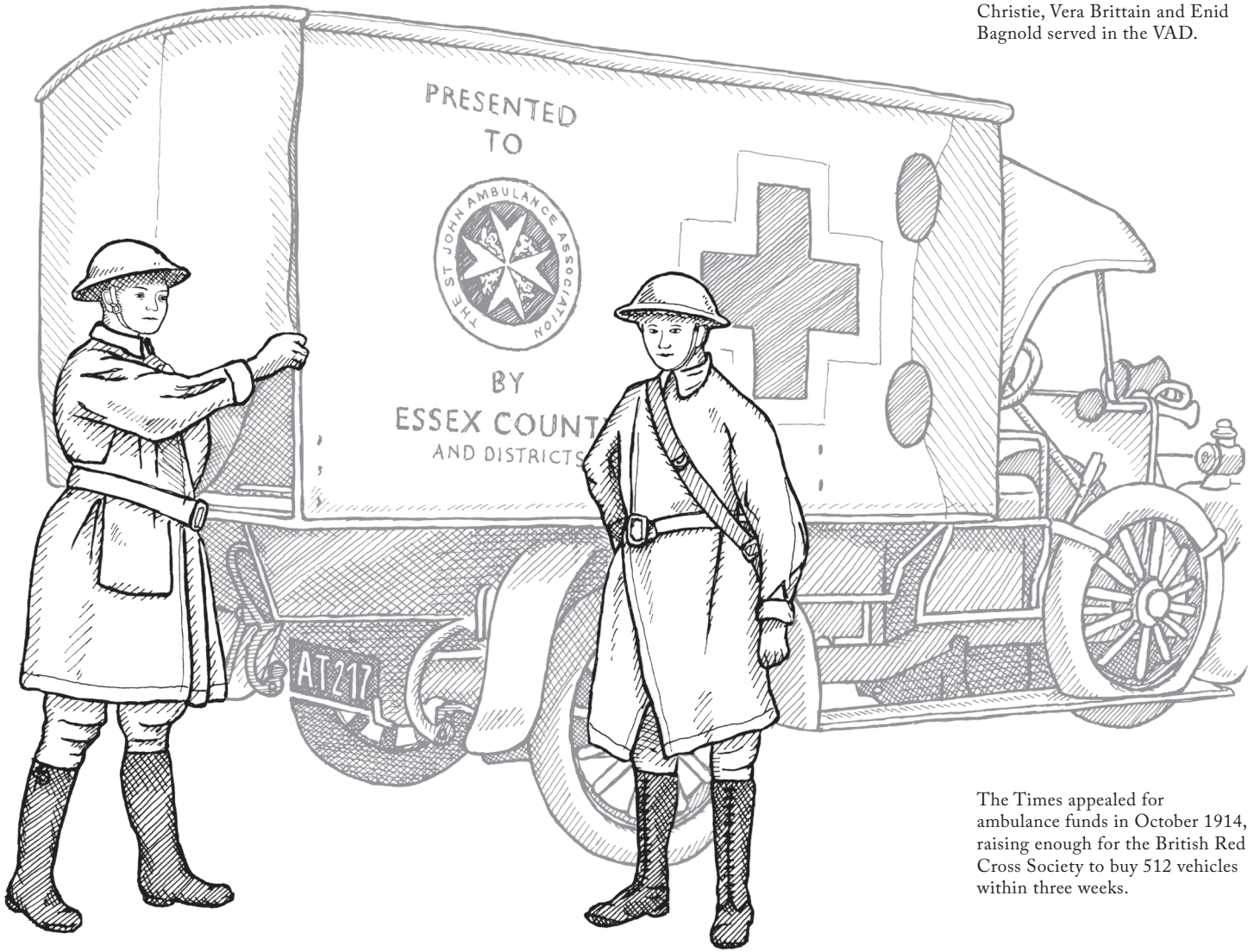


Treatment within:
Minutes / Hours / Days

VOLUNTARY AID DETACHMENT

Women Drivers and Mechanic

Famous authors such as Agatha Christie, Vera Brittain and Enid Bagnold served in the VAD.



The Times appealed for ambulance funds in October 1914, raising enough for the British Red Cross Society to buy 512 vehicles within three weeks.

Fig 12.

CASUALTY CLEARING STATIONS

Specialist

Casualty Clearing Stations (CSS) were located next to a railway line in large marquees or huts, around 10 miles behind the front line. They could hold between 500 to 1000 casualties.

During big offensives, several CCSs were sited at the same location, such as in Remy Sidings at Lijssenthoek, for example.

Its three functions were:

1. To receive and treat until fit for further evacuation all seriously wounded and sick.

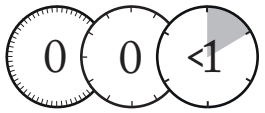
2. To expedite the immediate evacuation to base hospitals of those fit to travel.

3. To retain for early return to duty wounded or sick to recover in a few days.

CSS were able to X-ray and perform major operations.

Casualties who were too weak or suffering from shock were first sent to Resus, where they were warmed up and /or given blood transfusions to make them well enough for the operating table.

Those with no hope were sent to the moribund ward.



Treatment within:
Minutes / Hours / Days

SURGEONS

Specialist Surgeons and Staff

Fig 13.

ADVANCES IN MEDICAL TREATMENT

During the Great War

Major medical advances were made during the Great War, some of which included:

The Thomas Splint *(Fig 14)* The splint as invented by the Welsh surgeon Hugh Owen Thomas. At the beginning of the war the management of femoral fractures, which were usually compound ballistic injuries, was such that 80% of soldiers with these injuries died. Following the introduction of the Thomas Splint, fatalities from femoral fractures by 1916 had fallen by 80%.

The X-ray These were already used in hospitals at the beginning of the war. By 1915, the BEF deployed with one X-ray unit per Army, eventually increasing to one per CCS.

The French were lucky to have Marie Curie working for them as the director of the army's radiological services. She was the first woman professor of the Sorbonne and the recipient of Nobel Prizes for her work in physics and chemistry. By 1918 her twenty mobile X-ray units had taken over a million X-rays.

Inoculations An inoculation for typhoid was given to all British soldiers. Anti-tetanus serum was given to all wounded soldiers to prevent a potentially deadly infection after injury. The serum reduced fatalities from tetanus in 1914 from 63% to 38% by 1918.

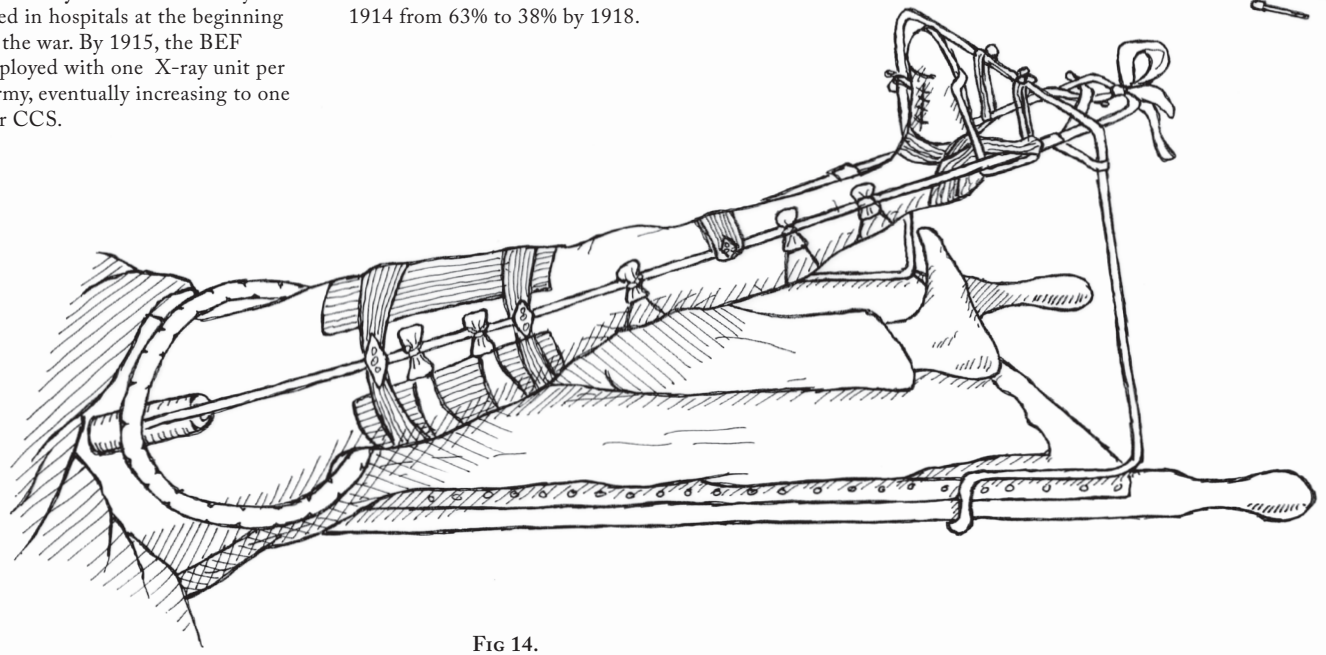


Fig 14.

ADVANCES IN MEDICAL TREATMENT

During the Great War

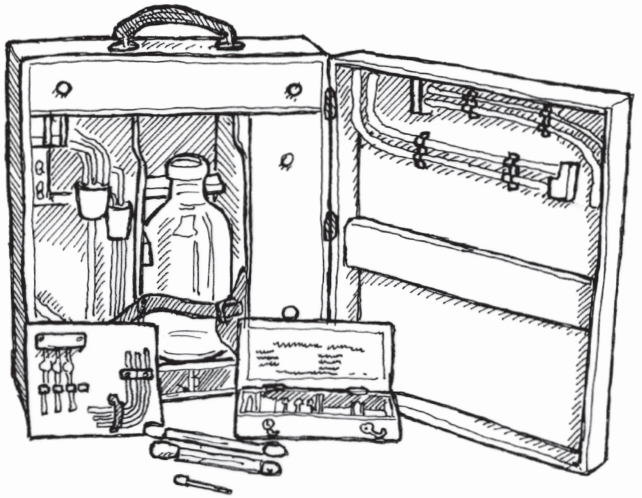


Fig 15.

Blood Transfusions *(Fig 15)* Prior to 1910, owing to the problem of coagulation, blood was transfused directly between donor and recipient. The science of refrigeration and storage of blood was in its infancy and the nature incompatibility between blood groups was not fully understood. It was not until the last two years of the war that the RAMC, together with US Army doctor Captain Oswald Robertson, established blood banks using sodium citrate to prevent blood coagulating and becoming unusable. Blood was kept on ice for up to 28 days before being transported to a CCS for use in life saving operations as well as preventing shock.

MORIBUND WARD

Hopeless cases

The Moribund Ward was the last stop at the Casualty Clearing Station for those soldiers beyond medical help. However, they were made comfortable and given morphine to help ease their passing.

These soldiers were often seen by the Military Chaplain, referred to by the soldiers as Sky Pilots, who would fulfil their spiritual needs, for example Catholics were administered the last rites – preparing the dying person's soul for death.

Besides looking after spiritual needs, Chaplains would often write the soldier's last letter home and record his last words.

Once the soldier had died, he would put the letter and last words together with the soldiers personal effects together in a white linen bag, which would eventually be sent back to the soldier's family.

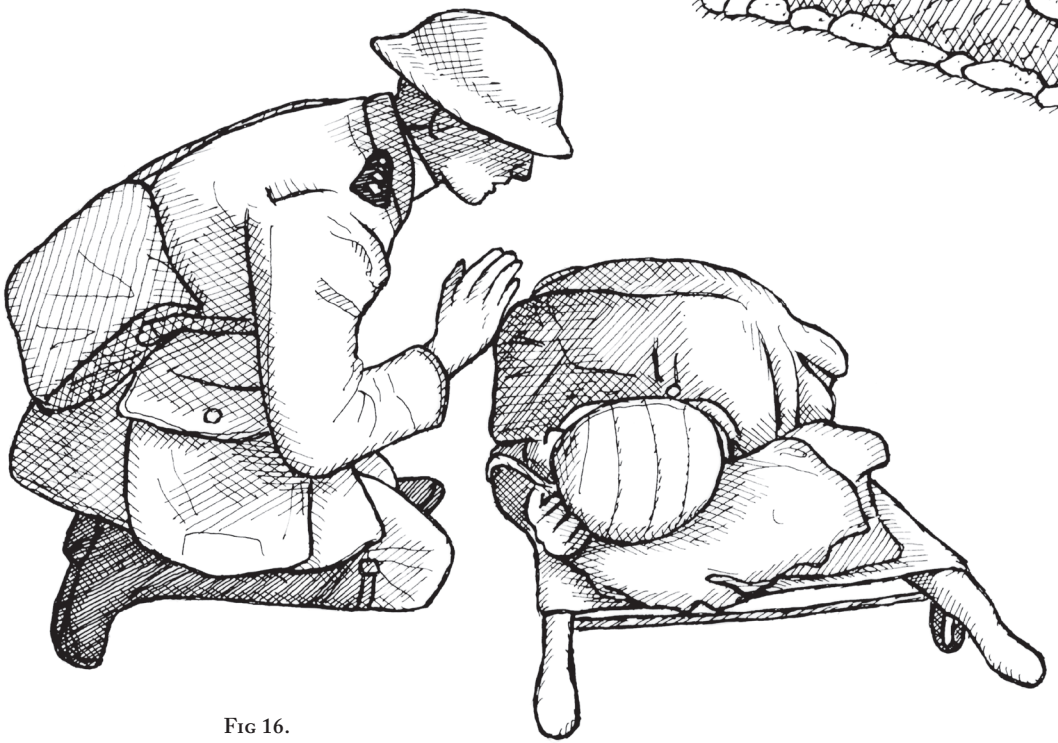


Fig 16.

BURIALS

Chaplain and Grave Registration Unit

Fig 17.

After the soldier had died, they were moved to the mortuary ward. There, RAMC orderlies would remove the soldier's jacket and, if dirty, would have it cleaned. It would then be placed in the white linen bag, together with the soldier's valuables if the Chaplain hadn't already done so.

The body would then be put into a brown army blanket and then placed on a stretcher ready for burial, which would have been presided over by the Chaplain.

Bodies were buried just a couple of feet down – there wasn't enough time to do otherwise and a simple wooden cross marked their grave. The British Red Cross Graves Registration Unit would record the soldier's details and the location of their burial.

The wooden crosses would be later replaced following the war by the headstones you see today, in cemeteries designed and maintained by the Commonwealth War Graves Commission (CWGC).

The land on which these cemeteries are located was given in perpetuity by the people of France and Belgium in recognition of the sacrifices made on their behalf during the war.

HOSPITAL TRAINS

Evacuation

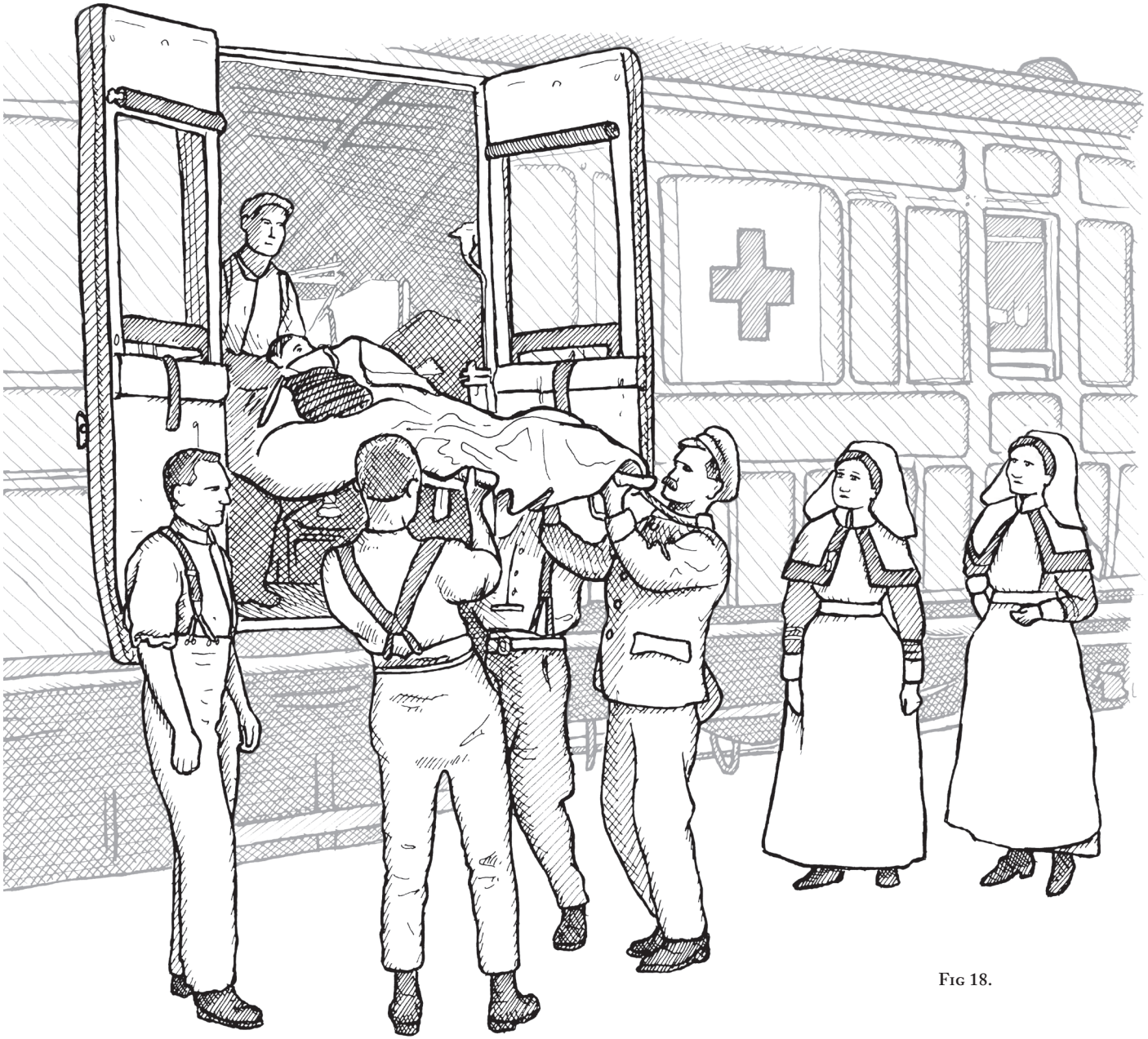


Fig 18.

HOSPITAL BARGES

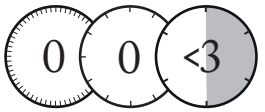
Evacuation

At the outbreak of war there was one Ambulance Train per division – 7 on the Western Front. It soon became clear this wasn't enough. By the 1st of July 1916 it had risen to 30 and 40 by the end of the war.

They were used to transport the wounded from the CCS to Base Hospitals to the rear near ports. A typical train was made-up of fifteen carriages; brake and boiler at each end; 6 bedded and 1 for sitting wounded; 1 operating theatre; pharmacy and store, cook house and dining room; and 2 for medical staff accommodation.

Ambulance Trains were staffed by RAMC Doctors, orderlies and nurses from the Queen Alexandra's Imperial Military Nursing Service (QAIMNS).

Where rivers or canals ran from the battlefield to the ports, ambulance barges were used. These were especially valued for their smooth movement through the water.



Treatment within:
Minutes / Hours / Days

BASE HOSPITAL

Rest and recovery

Base Hospitals were located to the rear, along lines of communication back to Blighty, particularly at ports along the French coast. There were many types of hospitals, the main ones being General and Stationary.

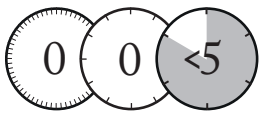
At the outbreak of war there were 2 general hospitals per division, providing 250 beds each. It was found that these hospitals were the best way to care for mass casualties following major offences and increased their size to accommodate 1,250 beds. By 1917, there were three general hospitals grouped together, each with 2,500 beds.

Stationary hospitals were by contrast intended to be small reception centres for infectious cases. As the war progressed they grew in size becoming virtually identical to general hospitals.

There were also seven hospitals specifically for the native contingents from South Africa and the Chinese Labour Corps. Besides the medical staff, they also included an interpreter.

With the exception of the hospitals provided by the St Johns Ambulance, all the other Voluntary Hospitals, numbered from 1 to 10, were provided by other organisations, such as the British Red Cross Society, Friends Ambulance Unit, Sir Henry Norman, Lady Hatfield's Anglo-American, the Liverpool Merchants', Baltic and Corn Exchange, Millicent Duchess of Sutherland's and Lady Murray's Hospitals. No 1, 2 and 8 hospitals were reserved for officers.

In 1917, of the typical proportion per 1,000 casualties that made it to hospital, 1% would die, 56% would be evacuated back to Blighty, and the remaining 43% would eventually return to duty in the front line.



Treatment within:
Minutes / Hours / Days

BASE HOSPITAL

Back to Blighty

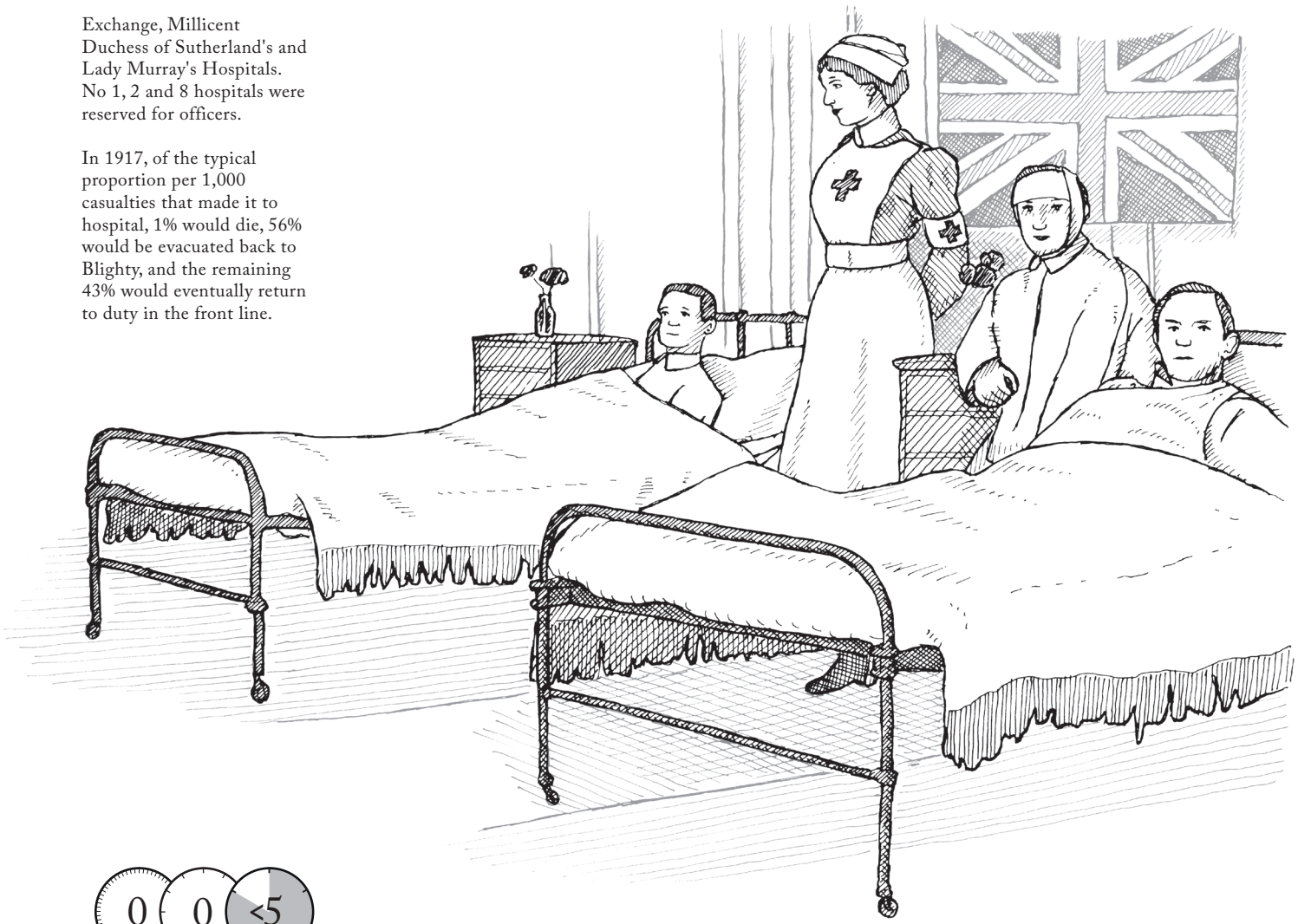


Fig 19.

Patients being cared for by a nurse from the British Red Cross Society (BRCS).

HOSPITAL BLUES

Hospital Uniforms and the Silver War Badge

Hospital Blues Uniforms, (also known sometimes as blue invalid uniforms or convalescent blues), were for those soldiers who could get out of bed. (Officers were exempt – they had to wear a white armband decorated with a red King's Crown upon it).

They were made of Oxford blue flannel material with a white lining. The jacket was single breasted and had no pockets, unpopular with patients, as they could not easily carry items like tobacco tins.

They were worn with a red tie, white shirt and a cap carrying the soldier's regimental cap badge.

Blues served an important propaganda function during the war, helping to put the wounded Tommy on public display and to facilitate public appreciation of his service to King and Country.

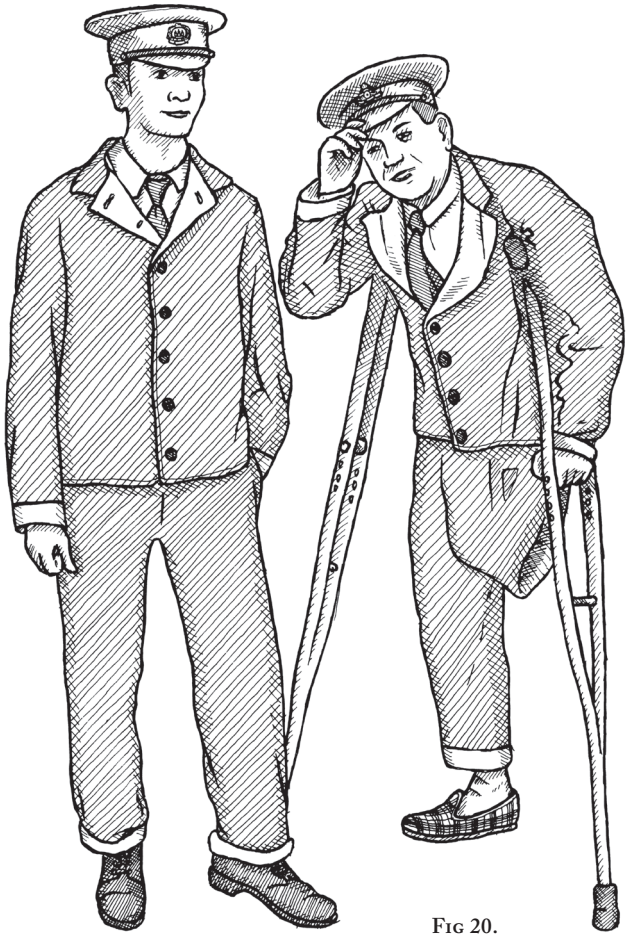


Fig 20.

Fig 21.

The Silver War Badge – British Empire

The badge was originally issued to officers and men who were discharged or retired from the military forces as a result of sickness or injury caused by their war service. The badge was made of sterling silver and was intended to be worn on the right breast of a recipient's civilian clothing. It could not be worn on a military uniform.

FACIAL AND LIMB PROSTHETICS

Putting back the pieces

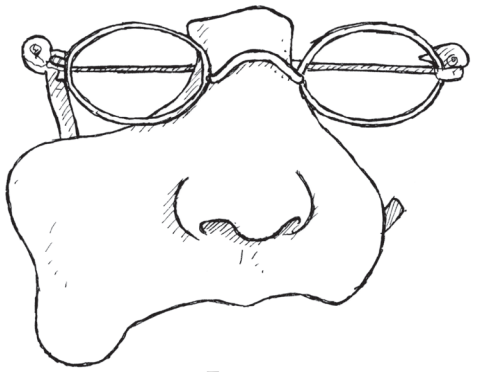
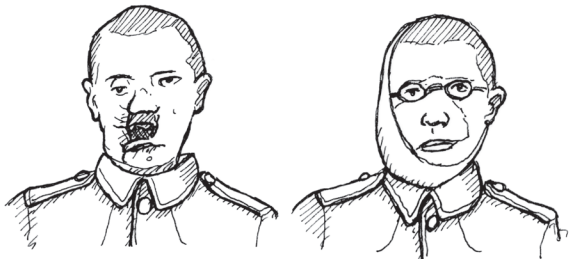


Fig 22.



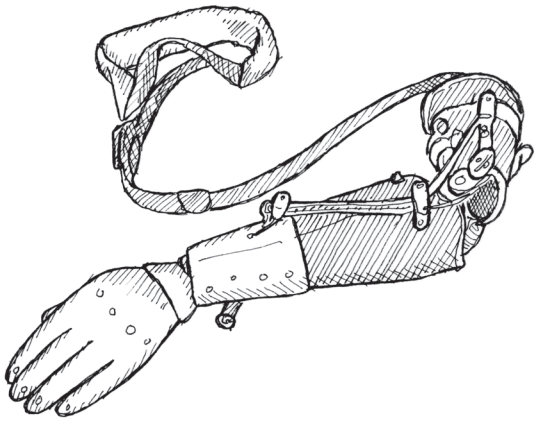


Fig 23.

The biggest killer on the battlefield was shrapnel, whose twisted white hot metal shards could rip a man's face off.

Once the wound had healed, the patient could either wear his scars with pride, avoid going out in public, wear a mask, or opt for plastic surgery.

It would be a brave man that would wear his scars with pride. Many would rather avoid going out in public, so not to be ridiculed. Nearby park benches were painted blue to designate them for men with facial injuries. However it was also done to warn local residents that the appearance of men using them may be distressing.

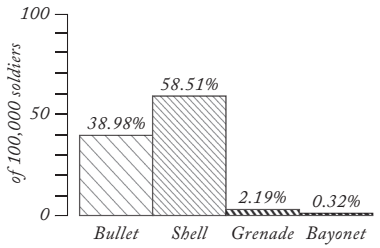
Plastic surgery was in its infancy and success wasn't great, despite many operations over several years. An alternative to that was to wear a mask from the 'Tin Noses Shop'. Here they were given copper masks, painted to their skin tone, and held in place by glasses.

The Great War saw the first mass production of artificial limbs, over 40,000 were produced for British servicemen. Queen Mary's Hospital in London became a global centre for artificial limb design and fitting.

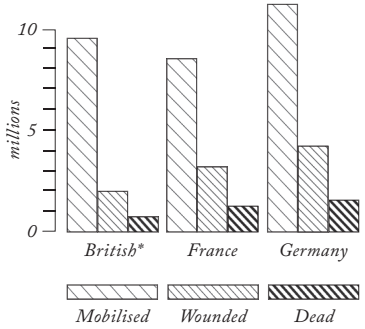
STATISTICS

From the Great War

Casualty analysis
Analysis of the causes of the 212,659 wounds seen through one typical Casualty Clearing Station throughout the Great War.



Overall mobilisation and losses
Although British losses were high, in fact only approximately 1 in 10 actually died'.

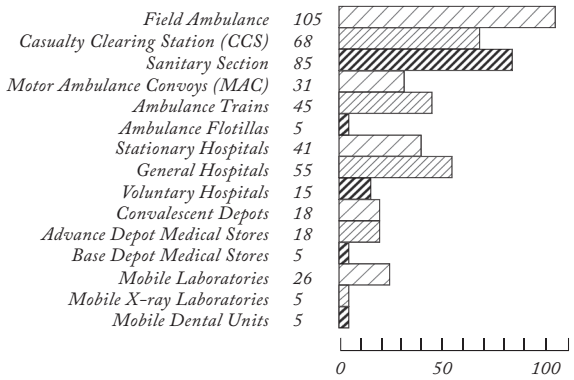


Rates of Sickness Evacuation

Year	Officers	OR*	Total
1914	*892*	*25,013*	*25,905*
1915	*5,558*	*121,006*	*126,564*
1916	*12,818*	*219,539*	*232,357*
1917	*15,311*	*321,628*	*336,939*
1918	*12,654*	*265,735*	*278,389*
Total	*47,233*	*952,921*	*1,000,154*

** Other Ranks*

Commonwealth Medical Facilities on the Western Front



SAFETY

Safety notes for the battlefield visitor

INTRODUCTION

Safety is of paramount importance. Both your guide and your group leaders have this as their priority. However, you must play your part in ensuring your safety and that of the group. You must behave in a safe and responsible manner and remain conscious of what is going on around you throughout the tour.

UNEXPLODED ORDNANCE

It is unlikely but you may come across unfired small arms ammunition during your tour, along with unexploded ordnance ranging from hand grenades to 15-inch naval shells. Most of these have the potential to explode if tampered with.

The rules are:
- **Do not touch.**
- **Alert the guide or a member of your staff.**
- **Taking "artefacts" from the battlefield is illegal in France and Belgium.**
- **"Souvenirs" in the form of ammunition, even deactivated, are not to be purchased.**
- **Those found in possession of ammunition of any type are liable to arrest by the French or British police at the Channel Tunnel or ports.**

RUSTY METAL

Even apparently innocuous items such as rusty barbed wire or pickets can pose a real risk of Tetanus or Rabies. Again, avoid them.

ROAD SAFETY

- **Be aware that UK coaches exit into the middle of continental roads.**
- **Seat belts must be worn when aboard the coach.**
- **Take care in towns and villages. Continental drivers drive on the right.**

SAFETY IS EVERYONE'S RESPONSIBILITY

Designed, illustrated, written and produced by Frank Toogood.
Co-written and edited by Ian Coyne and Sean Cripps.

Sources:
Great War Tommy – The British Soldier 1914-18 by Prof. Peter Doyle
The Great War Handbook by Geoff Bridger
The Western Front Companion by Mark Adkin
Wounded – From the Battlefield to Blighty 1914-1918 by Emily Mayhew
BBC website, bbc.co.uk
British Red Cross website, redcross.org.uk
Commonwealth War Graves Commission website, cwgc.org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