FIRST AID & EMERGENCY PROCEDURES POLICY

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1. Purpose

Koku-Ryu Martial Arts, referred to throughout this policy as "KRMA", is committed to protecting the health, safety and welfare of:

- students;
- staff;
- instructors;
- volunteers;
- parents and carers;
- visitors;
- contractors;
- spectators;
- and members of the public attending KRMA activities.

Martial arts activities may involve:

- strenuous physical exercise;
- partner work;
- impact;
- contact;
- sparring;
- throwing;
- grappling;
- takedowns;
- weapons;
- repetitive movement;
- competitions;
- public demonstrations;
- travel;

- and participation by people with existing medical or additional needs.

Although appropriate controls reduce risk, injury or sudden illness may still occur.

The purposes of this policy are to ensure that KRMA:

- has suitable first aid arrangements;
- assesses the needs of each venue and activity;
- provides access to appropriately trained people;
- maintains suitable first aid equipment;
- responds promptly to illness and injury;
- recognises situations requiring emergency services;
- protects children and adults at risk during treatment;
- communicates appropriately with parents and emergency contacts;
- records accidents and medical incidents;
- considers statutory reporting requirements;
- learns from incidents;
- and supports a safe return to participation.

This policy provides an organisational framework.

It does not replace:

- current first aid training;
- professional medical assessment;
- ambulance-service instructions;
- clinical advice;
- or emergency-service decision-making.

In an emergency, preservation of life and prevention of further harm take priority over:

- continuing the class;

- competition results;
- grading completion;
- administrative convenience;
- embarrassment;
- or concern about interrupting an event.

2. Scope

This policy applies to:

- all KRMA venues;
- regular classes;
- private lessons;
- open training;
- gradings;
- competitions;
- demonstrations;
- seminars;
- workshops;
- school programmes;
- community activities;
- fitness sessions;
- weapons training;
- sparring;
- MMA;
- grappling;
- residential activities;
- trips;
- KRMA-arranged transport;
- camps;
- events;
- and online activities where KRMA has responsibility for delivery.

It applies to:

- employees;
- instructors;
- assistant instructors;
- trainee instructors;
- volunteers;
- junior instructors;
- reception and administrative staff;
- competition coaches;
- team managers;
- event staff;
- trip leaders;
- contractors;
- visiting instructors;
- students;
- parents and carers;
- and anyone assigned an emergency responsibility.

The policy applies whether the activity takes place:

- at a permanent KRMA venue;
- at a leisure centre;
- in a school;
- at a hired hall;
- outdoors;
- at a competition venue;
- in accommodation;
- during transport;

- or at another external location.

2.1 Employees, participants and visitors

KRMA's statutory workplace first aid responsibilities principally concern employees.

KRMA will also use its first aid needs assessment to provide appropriate arrangements for:

- students;
- children;
- adult participants;
- spectators;
- visitors;
- and others who may be affected by KRMA activities.

This broader approach reflects KRMA's organisational duty to manage foreseeable risks within its activities.

2.2 External organisations

Where an activity is delivered jointly with another organisation, KRMA must establish:

- who is responsible for first aid;
- who will call emergency services;
- where equipment is located;
- who holds emergency contacts;
- who completes incident records;
- and who assesses any statutory reporting duties.

Responsibility must not be assumed merely because:

- the venue has staff;
- a competition organiser is present;
- a school owns the building;

- or another club has a first aider.

3. First Aid and Emergency Principles

KRMA will apply the following principles.

3.1 Act promptly

Illness and injury must be taken seriously and assessed promptly.

Staff must not delay action because they:

- hope symptoms will settle;
- do not wish to disturb the class;
- fear criticism;
- are uncertain whether an ambulance is necessary;
- or believe the student should "tough it out".

3.2 Make the area safe

Before providing treatment, staff should consider:

- ongoing contact;
- weapons;
- moving equipment;
- electrical hazards;
- bodily fluids;
- traffic;
- crowds;
- environmental conditions;
- aggressive behaviour;
- and other immediate dangers.

The activity should be stopped or controlled where necessary.

3.3 Work within competence

First aiders must:

- work within their training;
- follow current recognised first aid practice;
- follow emergency-service instructions;
- avoid unsupported diagnosis;
- and seek additional help where the situation exceeds their competence.

Staff who are not qualified first aiders may still:

- call 999;
- alert a trained person;
- make the area safe;
- obtain an AED;
- follow emergency-call-handler instructions;
- and provide reasonable immediate assistance.

3.4 Escalate when uncertain

Where there is reasonable doubt about the seriousness of an injury or illness, staff should seek appropriate advice.

This may include:

- calling 999;
- contacting NHS 111;
- advising medical assessment;
- contacting a parent or carer;
- or stopping participation until suitable clearance is obtained.

3.5 Protect life before records

Emergency treatment and calls for help must not be delayed while staff:

- locate a form;
- obtain a signature;

- enter information into a system;
- contact management;
- or establish who will complete the report.

Records must be completed as soon as reasonably practicable after immediate safety has been addressed.

3.6 No pressured participation

No person should be pressured to:

- continue training;
- complete a grading;
- continue competing;
- demonstrate toughness;
- return to contact;
- or ignore symptoms

after an injury or medical concern.

3.7 Respect and dignity

Treatment should protect the person's:

- dignity;
- privacy;
- cultural needs;
- communication needs;
- disability;
- and emotional wellbeing.

3.8 Safeguarding remains active

Normal safeguarding standards remain in force during a medical emergency.

The urgency of treatment may justify necessary contact or private information sharing, but it does not permit:

- unnecessary touching;
- humiliation;
- photography;
- gossip;
- or avoidable isolation with a child.

3.9 Children receive age-appropriate support

Children should receive:

- calm explanations;
- reassurance;
- age-appropriate communication;
- and an opportunity to ask questions.

Where possible, a parent or carer should be involved without delaying urgent treatment.

3.10 Learn from incidents

An incident should be reviewed where it indicates:

- an unidentified hazard;
- equipment failure;
- inadequate supervision;
- unsuitable contact;
- missing medical information;
- an ineffective emergency plan;
- or a repeated pattern.

4. Legal and Professional Framework

This policy has been developed with regard to:

- Health and Safety at Work etc. Act 1974;
- Health and Safety (First-Aid) Regulations 1981;
- Management of Health and Safety at Work Regulations 1999;
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013;
- Equality Act 2010;
- Children Act 1989;
- Children Act 2004;
- Data Protection Act 2018;
- UK General Data Protection Regulation;
- current Health and Safety Executive first aid guidance;
- current UK concussion guidance for grassroots sport;
- current Resuscitation Council UK guidance;
- and applicable safeguarding requirements.

HSE guidance requires employers to provide adequate and appropriate first aid arrangements based upon an assessment of workplace needs. This includes suitable equipment, people responsible for first aid arrangements and information for employees.

RIDDOR does not require every accident or sports injury to be reported. A report is required only where the incident meets the relevant legal conditions, including the connection with work and the type of reportable outcome.

4.1 Higher internal standards

Where KRMA adopts a higher operational standard than the minimum legal requirement, this policy will apply as the organisational standard.

For example, KRMA may require:

- trained first aid cover at every organised session;

- additional equipment for higher-risk activities;
- concussion removal procedures;
- and formal records for incidents that are not legally reportable.

4.2 Venue and contractual requirements

External venues, insurers, governing bodies or event organisers may impose additional first aid requirements.

KRMA must comply with these where they:

- apply to the activity;
- are compatible with safety;
- and do not reduce KRMA's own safeguarding or emergency standards.

5. Definitions

5.1 First aid

First aid is immediate assistance provided to a person who is injured or becomes unwell before professional medical help is available or until the person recovers sufficiently.

5.2 First aider

A first aider is a person who:

- holds appropriate current first aid training;
- has been identified by KRMA for the activity;
- and is expected to provide assistance within the scope of their competence.

5.3 Appointed person

An appointed person is someone designated to take responsibility for first aid arrangements, such as:

- calling emergency services;
- maintaining equipment;
- and coordinating assistance.

An appointed person is not automatically a qualified first aider.

5.4 Medical emergency

A medical emergency is a sudden illness or injury that may threaten:

- life;
- breathing;
- consciousness;
- circulation;
- neurological function;
- mobility;
- or long-term health

and requires urgent professional assistance.

5.5 Accident

An accident is an unintended incident that causes injury or ill health.

5.6 Incident

An incident is an event affecting or potentially affecting:

- safety;
- health;
- welfare;
- safeguarding;
- property;
- or operations.

An incident may or may not result in injury.

5.7 Near miss

A near miss is an event that did not cause injury or damage but had the realistic potential to do so.

5.8 Emergency medication

Emergency medication includes medication intended to respond to an urgent medical condition, such as:

- reliever inhalers;
- adrenaline auto-injectors;
- glucose treatment;
- seizure-rescue medication;
- or another prescribed emergency treatment.

5.9 AED

An Automated External Defibrillator, referred to as an **AED**, is a device designed to analyse a person's heart rhythm during suspected cardiac arrest and deliver a shock where advised.

5.10 Return to training

Return to training means the staged resumption of:

- ordinary activity;
- exercise;
- technique practice;
- non-contact work;
- contact training;
- sparring;
- competition;
- or full participation

following injury or illness.

6. Roles and Responsibilities

6.1 CEO and Chief Instructor

The CEO and Chief Instructor is responsible for:

- approving this policy;
- ensuring suitable first aid resources are available;
- appointing or identifying responsible leads;
- ensuring emergency procedures are embedded;
- supporting staff training;
- reviewing serious incidents;
- ensuring significant risks are addressed;
- and authorising major changes to first aid arrangements.

6.2 Health and Safety Lead

The Health and Safety Lead will:

- oversee first aid arrangements;
- coordinate first aid needs assessments;
- maintain an overview of trained personnel;
- arrange kit and equipment checks;
- ensure venue plans are completed;
- support incident investigations;
- assess RIDDOR requirements;
- monitor recurring injuries;
- and report significant concerns to senior management.

The Health and Safety Lead may delegate practical checks but retains oversight.

6.3 Designated Safeguarding Lead

The Designated Safeguarding Lead will:

- advise where an injury or medical incident may involve abuse, neglect or unsafe practice;
- ensure treatment maintains safeguarding boundaries;
- review concerning injury patterns;
- support information sharing;
- advise on parent notification where safeguarding is involved;
- and coordinate statutory safeguarding referrals where necessary.

A medical incident may also be a safeguarding incident.

6.4 Lead instructor or session leader

The person leading an activity is responsible for:

- confirming first aid cover;
- knowing where equipment is located;
- knowing the venue address and emergency access point;
- ensuring emergency routes remain clear;
- identifying relevant medical information;
- making the activity safe;
- stopping training where necessary;
- summoning first aid or emergency services;
- ensuring appropriate supervision of the remaining group;
- contacting parents or carers;
- and ensuring records are completed.

The lead instructor must not assume that another person has taken responsibility unless this has been clearly confirmed.

6.5 First aider

The first aider will:

- assess the situation within their competence;

- protect themselves and others;
- provide appropriate immediate assistance;
- call or request emergency support;
- follow emergency-call-handler instructions;
- remain with the casualty where appropriate;
- communicate calmly;
- support ambulance handover;
- use equipment safely;
- and contribute factual information to the incident report.

The first aider must not:

- provide treatment beyond their competence;
- prescribe medication;
- guarantee that an injury is minor;
- force non-emergency treatment upon a competent person;
- or allow pressure from a coach, parent or student to override safety.

6.6 Appointed person

Where an appointed person is used, they may be responsible for:

- contacting emergency services;
- obtaining the first aid kit;
- retrieving the AED;
- directing emergency vehicles;
- contacting parents;
- maintaining records;
- and checking supplies.

An appointed person must not present themselves as a trained first aider unless they hold the relevant current training.

6.7 Reception and administrative staff

Relevant administrative staff may:

- maintain emergency contacts;
- contact parents;
- print or provide emergency medical summaries;
- record attendance;
- assist emergency-service access;
- maintain incident systems;
- and help preserve records.

They must not disclose medical information beyond what is necessary.

6.8 Instructors and volunteers

All instructors and volunteers must:

- know how to summon help;
- report injuries promptly;
- stop unsafe activity;
- follow first aider directions;
- protect the casualty's privacy;
- supervise unaffected students;
- avoid crowding;
- and provide accurate information.

They must not:

- move an injured person unnecessarily;
- encourage them to continue;
- offer medication without authorisation;
- photograph the incident;

- or discuss it casually with others.

6.9 Junior instructors

Junior instructors under 18 may:

- alert an adult;
- call 999 in an emergency;
- retrieve equipment;
- help clear the area;
- and reassure students under adult direction.

They must not have sole responsibility for:

- first aid provision;
- emergency medication;
- ambulance decisions;
- parent notification;
- incident investigation;
- or supervision of a serious casualty.

6.10 Students

Students are expected to:

- report injury or illness;
- follow safety instructions;
- stop when directed;
- avoid hiding symptoms;
- disclose relevant medical information through the appropriate process;
- wear required protective equipment;
- and avoid interfering with treatment.

Students must not:

- crowd the casualty;
- film the incident;
- share rumours;
- misuse first aid supplies;
- or pressure another student to continue.

6.11 Parents and carers

Parents and carers are responsible for:

- providing accurate medical and emergency information;
- updating information when circumstances change;
- supplying required medication;
- ensuring medication is in date and correctly labelled;
- collecting a child when requested;
- seeking medical advice where advised;
- following return-to-training restrictions;
- and informing KRMA of relevant outcomes.

Parents must not pressure a child to:

- continue after injury;
- return against medical advice;
- complete a grading;
- or conceal symptoms.

6.12 Venue providers

Where applicable, venue providers may be responsible for:

- fire procedures;
- building evacuation;
- premises hazards;

- emergency lighting;
- fixed AEDs;
- access routes;
- and venue-employed first aiders.

KRMA must establish what the venue provides rather than assume provision exists.

7. First Aid Needs Assessment

KRMA will complete and review a proportionate first aid needs assessment.

The assessment should consider what first aid arrangements are adequate and appropriate for the work and activity being undertaken. HSE guidance states that needs should reflect factors such as hazards, workforce arrangements, travel, remoteness and the location in which work takes place.

7.1 Factors to consider

The assessment should consider:

- number of participants;
- ages;
- disabilities and additional needs;
- known medical conditions;
- activity type;
- contact level;
- weapons;
- throws and takedowns;
- sparring;
- competition intensity;
- fitness demands;
- environmental temperature;
- venue layout;
- stairs;
- emergency access;
- distance from medical assistance;
- session duration;
- lone working;

- travel;
- residential activity;
- instructor numbers;
- previous accidents;
- and availability of an AED.

7.2 Activity risk

Higher-risk activities may include:

- contact sparring;
- MMA;
- grappling;
- takedowns;
- throws;
- weapons;
- breaking;
- acrobatics;
- tricking;
- competition;
- intense conditioning;
- outdoor training;
- and prolonged activity in hot conditions.

These activities may require:

- enhanced first aid cover;
- additional equipment;
- a specific emergency action plan;
- closer supervision;

- and quicker access to emergency services.

7.3 Participant profile

The assessment should consider whether participants include:

- very young children;
- older adults;
- pregnant participants;
- people with asthma;
- severe allergies;
- epilepsy;
- diabetes;
- cardiovascular conditions;
- mobility needs;
- communication differences;
- or other relevant health needs.

Individual information should be used proportionately and confidentially.

7.4 Venue-specific assessment

Each regular venue should have information covering:

- complete address;
- postcode;
- access instructions;
- emergency entrance;
- ambulance parking;
- first aid location;
- AED location;
- mobile signal;

- landline access;
- fire exits;
- evacuation point;
- and any venue-specific hazards.

7.5 Events and temporary activities

A separate or event-specific assessment may be required for:

- competitions;
- public demonstrations;
- camps;
- residential activities;
- school visits;
- outdoor events;
- community festivals;
- large gradings;
- and activities involving unusual equipment.

7.6 Review triggers

The assessment must be reviewed:

- at least annually;
- after a serious injury;
- after a near miss indicating significant risk;
- when a new venue is used;
- when a new discipline is introduced;
- when participant numbers increase significantly;
- when new medical needs arise;
- when equipment changes;

- following emergency-service feedback;
- or when the existing arrangements prove inadequate.

8. Required First Aid Coverage

KRMA's organisational standard is that every organised class, grading, event or activity must have access to at least one suitably trained adult first aider.

The level of cover must reflect:

- the needs assessment;
- number of participants;
- activity risk;
- venue;
- duration;
- and whether groups may become separated.

8.1 First aider presence

For ordinary venue-based sessions, the first aider should normally be:

- physically present;
- immediately available;
- aware that they are providing cover;
- and free from duties that make an effective response impossible.

A first aider located elsewhere in a large venue is not sufficient unless:

- they can be summoned immediately;
- access is reliable;
- and the needs assessment confirms that this arrangement is appropriate.

8.2 Multiple groups

Where groups operate in separate:

- halls;
- floors;
- buildings;

- outdoor areas;
- or transport vehicles,

additional first aiders or clear emergency arrangements may be required.

8.3 Large events

Large gradings, competitions or public events should consider:

- more than one first aider;
- a designated treatment area;
- radio or telephone communication;
- crowd control;
- ambulance access;
- emergency documentation;
- AED availability;
- and an incident lead.

8.4 Absence of expected cover

Where required first aid cover is unexpectedly unavailable, the responsible person must decide whether to:

- delay the activity;
- obtain replacement cover;
- modify the activity;
- restrict higher-risk elements;
- move to a safer arrangement;
- or cancel.

A session must not proceed as normal merely because participants have already arrived.

8.5 First aiders taking part

A first aider who is:

- competing;
- sparring;
- coaching elsewhere;
- travelling separately;
- or responsible for another group

may not be practically available.

The assessment must consider whether additional cover is needed.

9. First Aiders and Appointed Persons

9.1 Selection

First aiders should be selected with regard to:

- training;
- confidence;
- reliability;
- communication;
- availability;
- ability to respond calmly;
- and familiarity with the activity.

Martial arts rank does not automatically make someone suitable to act as a first aider.

9.2 Identification

Relevant staff should know:

- who the first aider is;
- where they are positioned;
- how to contact them;
- who replaces them during breaks;
- and who will take responsibility if they become unavailable.

At larger events, first aiders should be identifiable through:

- clothing;
- badges;
- announcements;
- event information;
- or another clear method.

9.3 Limits of the appointed-person role

An appointed person may coordinate arrangements but must not undertake clinical actions beyond:

- their competence;
- ordinary emergency assistance;
- or instructions provided by emergency services.

9.4 Multiple casualties

Where several people are injured, the responsible person should:

- call emergency services early;
- stop the activity;
- make the area safe;
- allocate available first aiders;
- prevent crowding;
- identify the most urgent casualties;
- and seek additional assistance.

Staff must not attempt to manage a major incident as though it were a routine single-person injury.

10. First Aid Training and Competence

KRMA will maintain a suitable number of adults with current first aid training.

10.1 Appropriate training

The training selected should reflect:

- workplace requirements;
- martial arts and sports injuries;
- children;
- emergency medication;
- CPR;
- AED use;
- bleeding;
- unconsciousness;
- fractures;
- head injury;
- anaphylaxis;
- asthma;
- seizures;
- and the activities delivered.

10.2 Certification

KRMA should maintain a record of:

- qualification;
- provider;
- date completed;
- expiry date;
- certificate;

- and any role restrictions.

Expired certification must not be presented as current.

10.3 Refresher training

First aiders should maintain competence through:

- formal renewal;
- practical refresher sessions;
- scenario practice;
- emergency-plan briefings;
- and updates following changes in recognised guidance.

10.4 Emergency drills

KRMA may conduct drills covering:

- calling 999;
- retrieving the AED;
- directing an ambulance;
- managing the remaining class;
- contacting parents;
- evacuation;
- and responding to an unresponsive casualty.

Drills involving children should be:

- age-appropriate;
- explained;
- and designed to avoid unnecessary distress.

10.5 Training does not remove the need for emergency services

A first aid qualification does not authorise a person to:

- diagnose serious injuries;

- rule out concussion;
- decide that professional assessment is unnecessary despite red flags;
- administer prescription medication outside agreed arrangements;
- or delay an ambulance in a life-threatening emergency.

11. First Aid Kits and Medical Equipment

Every KRMA session and event must have access to a suitably stocked and clearly identifiable first aid kit.

The contents should reflect:

- the activity;
- participant profile;
- venue;
- expected injuries;
- travel;
- and distance from further medical assistance.

Resuscitation Council UK guidance recommends that public first aid kits are clearly marked, readily accessible, based on setting and expected risks, and inspected regularly.

11.1 Standard contents

Subject to the needs assessment, a general first aid kit may include:

- disposable gloves;
- sterile dressings;
- adhesive dressings;
- eye pads;
- triangular bandages;
- wound-cleaning materials;
- gauze;
- tape;
- conforming bandages;
- instant cold packs;
- foil blanket;
- face shield or resuscitation barrier;

- scissors;
- saline;
- clinical-waste bags;
- hand-cleaning supplies;
- and first aid guidance.

The kit must not contain items that:

- staff are not trained or authorised to use;
- have expired;
- are unlabelled;
- are contaminated;
- or present an unnecessary risk.

11.2 Medication in first aid kits

General first aid kits should not ordinarily contain:

- painkillers;
- antibiotics;
- antihistamines;
- or other medicines

for routine administration.

Student-specific or emergency medication must be managed under the medication section of this policy.

11.3 Martial arts and event additions

Depending upon the needs assessment, additional supplies may include:

- additional cold packs;
- larger trauma dressings;
- extra gloves;
- vomit bags;

- emergency blankets;
- biohazard materials;
- disposable masks;
- eye-wash supplies;
- torch;
- emergency contact sheet;
- and specialised equipment appropriate to the event.

11.4 Location

Kits must be:

- readily accessible;
- known to staff;
- protected from children's misuse;
- protected from heat and moisture;
- and capable of being taken quickly to the casualty.

A locked kit is unsuitable where access cannot be obtained immediately.

11.5 Checks

A named person should check each kit:

- regularly;
- after use;
- before major events;
- before off-site travel;
- and following any concern about damage or contamination.

The check should consider:

- quantity;
- expiry dates;

- packaging;
- cleanliness;
- damage;
- and accessibility.

11.6 Records

KRMA should maintain a proportionate record of:

- kit location;
- check date;
- person completing the check;
- missing items;
- expired supplies;
- and restocking action.

11.7 Disposal

Used or contaminated items must be disposed of safely.

Sharps must never be placed in ordinary waste.

Any unexpected sharp or suspected drug paraphernalia should be isolated, reported and handled using an appropriate sharps procedure.

12. Automated External Defibrillators

KRMA will consider AED access as part of its first aid needs assessment.

This should include:

- whether the venue has an AED;
- its exact location;
- hours of access;
- retrieval time;
- security code;
- maintenance responsibility;
- pad suitability;
- and whether staff know how to obtain it.

Resuscitation Council UK guidance supports early recognition of cardiac arrest, calling 999, beginning CPR and using an AED as soon as possible.

12.1 Suspected cardiac arrest

Where a person is unresponsive and not breathing normally:

1. Call 999 immediately.
2. Follow the ambulance call handler's instructions.
3. Begin CPR.
4. Send someone to obtain the AED.
5. Switch on the AED and follow its spoken instructions.
6. Continue until professional help takes over, the person shows signs of recovery or the rescuer is unable to continue.

Current Resuscitation Council UK guidance emphasises calling 999 promptly for an unresponsive person and following call-handler support for recognition and CPR.

12.2 Who may use an AED

A person should not delay using an available AED because they:

- are not a medical professional;
- have not used that exact model before;
- or fear giving an inappropriate shock.

The device analyses the rhythm and provides instructions.

Trained people should use it where available, but an untrained responder may also follow:

- the device instructions;
- and the ambulance call handler's guidance.

12.3 Children

The AED should be used according to:

- current training;
- available paediatric settings or pads;
- device instructions;
- and ambulance-service guidance.

Lack of child-specific pads must not automatically prevent use where cardiac arrest is suspected and no better option is available.

12.4 AED checks

Where KRMA owns or maintains an AED, checks should include:

- readiness indicator;
- battery condition;
- pad expiry;
- adult and paediatric provision where applicable;
- cabinet condition;
- rescue accessories;
- and registration or maintenance arrangements.

12.5 After use

After an AED is used, KRMA must:

- preserve relevant incident information;
- replace pads or consumables;
- check the device;
- follow manufacturer requirements;
- record the event;
- and provide post-incident support.

13. Emergency Information and Communication

Every venue and activity must have reliable access to emergency communication.

13.1 Venue emergency information

The lead instructor should know:

- full venue name;
- complete address;
- postcode;
- nearest road access;
- emergency entrance;
- floor or room;
- access codes;
- AED location;
- and any obstacles affecting emergency services.

This information should be displayed or readily available.

13.2 Telephone access

At least one functioning telephone should be available.

For external or remote activities, the plan should consider:

- mobile coverage;
- battery life;
- alternative networks;
- portable chargers;
- landline availability;
- radios;
- and how to summon help if coverage fails.

13.3 Calling 999

The caller should be prepared to provide:

- exact location;
- nature of the emergency;
- number of casualties;
- casualty's approximate age;
- whether they are conscious;
- whether they are breathing normally;
- known hazards;
- access instructions;
- and a callback number.

The caller should:

- answer questions clearly;
- follow instructions;
- remain available;
- and avoid ending the call until told to do so.

13.4 Directing emergency services

A suitable person should be sent to:

- the building entrance;
- gate;
- road;
- reception point;
- or another agreed location

to guide emergency personnel.

Access routes must remain clear.

13.5 Managing the remaining class

During an emergency, another suitable adult should:

- stop the activity;
- move students away;
- maintain supervision;
- prevent filming;
- reassure children;
- preserve access;
- and continue head-count and collection safeguards.

The lead first aider must not also be expected to supervise the entire remaining group.

14. General Emergency Response Procedure

The following procedure provides KRMA's general response framework.

Step 1: Stop and assess

- Stop the activity.
- Identify ongoing hazards.
- Protect the casualty, responders and others.
- Do not rush into an unsafe area.

Step 2: Summon assistance

- Alert the first aider.
- Call 999 immediately for serious or potentially life-threatening situations.
- Retrieve the first aid kit and AED where relevant.
- Contact venue staff where needed.

Step 3: Provide first aid

- Work within training and competence.
- Follow current recognised practice.
- Follow emergency-service instructions.
- Do not move the casualty unnecessarily.

Step 4: Control the environment

- Clear spectators.
- Stop photography.
- Maintain dignity.
- Keep emergency routes open.
- Supervise other students.
- Preserve evidence where an accident or safeguarding concern exists.

Step 5: Identify the casualty

Where possible, establish:

- name;
- age;
- known medical information;
- medication;
- allergies;
- emergency contact;
- and what happened.

Information gathering must not delay urgent care.

Step 6: Contact the parent, carer or emergency contact

- Contact them as soon as appropriate.
- Provide clear factual information.
- Avoid unsupported diagnosis.
- Explain where the person is being taken.
- Record attempts where contact cannot be made.

Step 7: Support professional handover

Provide ambulance or medical personnel with:

- observed symptoms;
- first aid given;
- timing;
- relevant medical information;
- medication;
- allergies;
- and known mechanism of injury.

Step 8: Record and report

After immediate safety is managed:

- complete the incident record;
- inform senior management;
- notify the DSL where safeguarding may be involved;
- preserve relevant CCTV or evidence;
- consider RIDDOR;
- notify the insurer where required;
- and review the relevant risk assessment.

15. Consent, Capacity and Refusal of Treatment

15.1 Explain before treating

Where circumstances permit, the first aider should explain:

- who they are;
- what they propose to do;
- why;
- and what the person may experience.

15.2 Competent adults

A competent adult may refuse non-emergency first aid.

Where they refuse, staff should:

- remain calm;
- explain concerns;
- advise appropriate medical support;
- record the refusal;
- and call emergency services where the person's condition presents serious concern.

15.3 Children

Children should be involved in decisions according to their:

- age;
- understanding;
- maturity;
- and the urgency of the situation.

A child's distress or objection should be considered seriously.

However, urgent action may be required to preserve life or prevent serious deterioration.

15.4 Parent unavailable

Emergency assistance must not be delayed because:

- a parent cannot be reached;
- consent documentation cannot immediately be located;
- or collection arrangements are unclear.

Emergency services should be contacted where necessary.

15.5 Reduced capacity or unconsciousness

Where a person is:

- unconscious;
- confused;
- severely distressed;
- cognitively unable to decide;
- or otherwise unable to give meaningful consent,

staff should act reasonably in their best interests and within their competence while seeking professional help.

15.6 Refusal to stop training

An instructor may stop a student's participation where continued activity presents a foreseeable safety risk, even if the student or parent wishes them to continue.

The student may be required to:

- sit out;
- leave the training area;
- be collected;
- obtain medical advice;
- or provide appropriate clearance before returning.

16. Safeguarding During First Aid

First aid may require physical contact, removal of protective equipment or access to an injured area.

This must be managed sensitively.

16.1 Necessary contact

Contact must be:

- necessary;
- proportionate;
- explained where possible;
- limited to the treatment required;
- and consistent with the person's dignity.

16.2 Visibility

Where practical, first aid involving a child should take place:

- within sight of another suitable adult;
- in an observable area;
- or with another adult present.

Privacy may still be provided through:

- screens;
- towels;
- positioning;
- or moving uninvolved people away.

Visibility does not mean treatment must occur publicly.

16.3 Clothing

Clothing should only be moved or removed where necessary to:

- assess an injury;
- control bleeding;

- use an AED;
- manage breathing;
- or follow emergency-service instructions.

The person should be covered appropriately and exposed only as much as necessary.

16.4 Intimate or sensitive areas

Where an injury concerns an intimate or sensitive area:

- dignity must be prioritised;
- another suitable adult should be present where possible;
- professional medical assessment may be more appropriate;
- and unnecessary inspection must be avoided.

16.5 One-to-one situations

An emergency may temporarily create a one-to-one situation.

The staff member should:

- seek another adult;
- remain observable where possible;
- record why the situation occurred;
- and avoid unnecessary isolation.

16.6 Injury that may indicate abuse

A concern must be reported to the DSL where an injury:

- does not match the explanation;
- shows a concerning pattern;
- appears deliberately inflicted;
- involves a disclosure;
- suggests neglect;
- or raises concern about unsafe coaching or physical punishment.

Staff must not:

- interrogate the child;
- confront an alleged perpetrator;
- photograph injuries on a personal device;
- or conduct their own safeguarding investigation.

16.7 Medical photography

An injury must not be photographed unless:

- there is a clearly authorised and necessary purpose;
- safeguarding or professional advice supports it;
- the correct device and storage process are used;
- consent and lawful-basis requirements are considered;
- and the image is handled as highly sensitive information.

Routine first aid does not require photography.

17. Privacy, Dignity and Confidentiality

Medical information and incident details must be shared only with people who require them for:

- treatment;
- safeguarding;
- parent notification;
- insurance;
- legal compliance;
- investigation;
- or organisational safety.

17.1 No public discussion

Staff, students and parents must not discuss a person's medical incident through:

- public social-media posts;
- unofficial groups;
- open reception conversations;
- or casual discussion.

17.2 Information given to other families

Other families may be told practical information such as:

- the class was stopped;
- an emergency occurred;
- or the schedule changed.

They must not normally be given:

- the casualty's diagnosis;
- medical history;
- personal circumstances;

- or identifying information.

17.3 Accurate communication

Staff should communicate facts such as:

- "The student received a head impact and was removed from activity."

They should avoid unsupported statements such as:

- "There is definitely no concussion."
- "It is only a sprain."
- "Nothing serious happened."

17.4 Record security

Medical and incident records must be:

- stored securely;
- accessed only by authorised people;
- and retained according to the Data Protection and Information Governance Policy.

18. Parent and Carer Notification

Parents and carers must be informed appropriately when a child:

- receives first aid;
- sustains a significant injury;
- becomes unwell;
- is removed from training for medical reasons;
- requires collection;
- requires professional medical assessment;
- is taken to hospital;
- receives emergency medication;
- experiences a head impact;
- or is involved in an incident that may affect later wellbeing.

18.1 Urgent notification

A parent or carer should be contacted immediately where:

- emergency services have been called;
- hospital assessment is advised;
- the child has lost consciousness;
- a head injury or suspected concussion has occurred;
- emergency medication has been used;
- the child cannot safely continue;
- the child remains significantly distressed;
- the injury is serious;
- or urgent consent, information or collection is required.

Parent contact must not delay:

- calling 999;

- CPR;
- use of an AED;
- control of serious bleeding;
- treatment of anaphylaxis;
- or another life-saving intervention.

18.2 Information provided

The person contacting the parent should provide clear factual information, including:

- the child's location;
- what was observed;
- the known mechanism of injury or illness;
- symptoms;
- first aid provided;
- whether emergency services have been contacted;
- whether the child is being taken to hospital;
- and what the parent needs to do.

Staff must not provide an unsupported medical diagnosis.

Appropriate wording may include:

"Your child received an impact to the head and has been removed from all activity. They require assessment and must not return to training today."

Staff should avoid statements such as:

"They are definitely fine."

or:

"It is only a minor concussion."

18.3 Contact attempts

Where the primary parent or carer cannot be reached, staff should:

1. Try the alternative parent or carer.
2. Use the listed emergency contacts.
3. Leave a suitable message where safe and appropriate.
4. Record each attempt.
5. Continue necessary emergency care.
6. Follow safeguarding procedures where nobody can be contacted.

Confidential medical details should not be left within an unsecured voicemail or text message.

18.4 Minor first aid

For minor treatment, notification may be provided:

- verbally at collection;
- by an approved electronic message;
- through a first aid notification form;
- or through another established KRMA process.

The notification should state:

- what happened;
- treatment provided;
- relevant symptoms to monitor;
- and whether further advice is recommended.

18.5 Serious or disputed incidents

Where an incident is:

- serious;
- disputed;
- connected with safeguarding;
- associated with instructor conduct;
- or likely to result in a complaint,

communication should be coordinated with:

- the Health and Safety Lead;
- Designated Safeguarding Lead;
- and senior management.

This must not delay essential factual communication with the parent.

18.6 Separated families

KRMA will follow recorded arrangements concerning:

- parental responsibility;
- court orders;
- contact restrictions;
- and emergency communication.

Where immediate welfare is involved, relevant information may be shared with an appropriate parent, carer or statutory agency where lawful and necessary.

19. Ambulance and Hospital Transfer

19.1 When to call 999

Emergency services should be called immediately where there is a suspected threat to:

- airway;
- breathing;
- circulation;
- consciousness;
- neurological function;
- or life.

Examples include:

- cardiac arrest;
- abnormal or absent breathing;
- serious breathing difficulty;
- anaphylaxis;
- uncontrolled major bleeding;
- prolonged or first seizure;
- serious head injury;
- suspected spinal injury;
- loss of consciousness;
- signs of stroke;
- chest pain suggesting a medical emergency;
- severe heat illness;
- significant burns;
- or rapid and unexplained deterioration.

First aid providers should call for help early, use an organised assessment and use only equipment or medication that they are trained to use.

19.2 Uncertainty

Staff do not need certainty that a condition is life-threatening before calling 999.

Where symptoms are severe, worsening or unclear, early escalation is preferable to delaying assistance.

The ambulance call handler may:

- assess the urgency;
- provide instructions;
- alter the response;
- or recommend another service.

19.3 Information for the ambulance service

The caller should provide:

- full venue address and postcode;
- exact room or access point;
- casualty's approximate age;
- whether they are conscious;
- whether they are breathing normally;
- significant symptoms;
- mechanism of injury;
- first aid provided;
- relevant medical conditions;
- emergency medication used;
- number of casualties;
- and known hazards.

A person should be sent to meet and direct the ambulance where possible.

19.4 Ambulance handover

The first aider or responsible adult should provide a concise factual handover covering:

- what happened;
- time of the incident;
- symptoms observed;
- changes in condition;
- treatment provided;
- medication used;
- known allergies;
- medical information;
- and emergency-contact details.

Medication, action plans and relevant records should accompany the casualty where appropriate.

19.5 Children travelling to hospital

Where a child is transported by ambulance, a parent or carer should normally accompany them.

Where this is not immediately possible, KRMA should identify a suitable adult to travel or follow, subject to:

- ambulance-service instructions;
- safeguarding;
- availability;
- supervision of the remaining group;
- and the child's needs.

The accompanying adult must:

- remain calm;
- protect confidentiality;

- carry relevant emergency information where available;
- maintain safeguarding boundaries;
- and remain until responsibility is transferred appropriately.

19.6 Private transport

A seriously injured or unwell person must not be transported in a private vehicle merely to avoid calling an ambulance.

Private transport may be considered only where:

- the condition is stable;
- ambulance transport is not required;
- the person can travel safely;
- a responsible adult is available;
- and appropriate medical advice has been followed.

The injured person must not drive themselves.

19.7 Remaining students

Where an instructor accompanies a casualty, KRMA must ensure that:

- the remaining students remain properly supervised;
- collection arrangements are maintained;
- no child is left with an unauthorised person;
- and staffing does not fall below safe levels.

The remaining activity may need to be:

- stopped;
- modified;
- or cancelled.

19.8 Hospital outcome

Parents, adult students or staff should be asked to inform KRMA of relevant outcomes where these affect:

- return to training;
- incident investigation;
- safeguarding;
- RIDDOR;
- insurance;
- or risk-assessment review.

KRMA should request only information reasonably necessary for these purposes.

20. Head Injuries and Suspected Concussion

Any impact to the:

- head;
- face;
- neck;
- or body

that may have transmitted force to the brain must be treated seriously.

A person does not need to have been knocked unconscious to have sustained a concussion.

Possible signs include:

- headache;
- dizziness;
- nausea or vomiting;
- confusion;
- memory problems;
- unusual behaviour;
- visual changes;
- balance problems;
- sensitivity to light or noise;
- slower responses;
- increased sleepiness;
- loss of awareness;
- or seizure.

20.1 Immediate removal

Where concussion is suspected:

1. Stop the person's participation immediately.

2. Remove them from all training and contact.
3. Do not allow same-day return.
4. Observe for deterioration.
5. Contact the parent or emergency contact.
6. Arrange appropriate medical advice.
7. Record the incident.
8. Preserve relevant footage or evidence where necessary.

The UK grassroots sport guidance uses the precautionary principle:

If in doubt, sit them out.

It recommends immediate removal, no return within 24 hours, contact with NHS 111 within 24 hours and a gradual return to normal life and sport.

KRMA's policy is stronger in one important respect:

A person suspected of concussion must not return to any training on the same day, even if symptoms appear to resolve.

20.2 Red-flag symptoms

Call 999 immediately where a person following a head injury:

- remains unconscious;
- cannot be woken;
- cannot remain awake;
- has a seizure;
- develops weakness or numbness;
- has difficulty speaking, understanding, walking or balancing;
- has significant vision or hearing problems;
- has clear fluid from the nose or ears;
- bleeds from the ears;
- has a penetrating injury or skull deformity;

- has rapidly worsening symptoms;
- or shows another sign of serious neurological injury.

Staff should also seek urgent professional advice where the person:

- vomits;
- becomes increasingly dizzy;
- develops unusual behaviour;
- has a worsening headache;
- takes blood-thinning medication;
- or causes any ongoing concern.

20.3 Observation

The person must not be:

- left alone;
- allowed to continue exercise;
- sent home unaccompanied;
- permitted to drive;
- or asked to make complex decisions while confused.

Staff should monitor:

- alertness;
- breathing;
- speech;
- memory;
- balance;
- behaviour;
- and worsening symptoms.

20.4 Concussion checks

Instructors must not rely upon:

- asking only whether the student feels fine;
- a quick balance test;
- a student's desire to continue;
- parent pressure;
- or the absence of unconsciousness.

A first aider or coach cannot definitively rule out concussion through an informal dojo assessment.

20.5 Leaving KRMA

A child with suspected concussion should be released only to an appropriate adult who has been told:

- what happened;
- symptoms observed;
- that the child must not return to activity;
- what medical advice has been recommended;
- and that deterioration requires urgent medical help.

Written concussion information should be provided where available.

20.6 Return to learning, work and training

Return must be gradual and consistent with:

- current grassroots concussion guidance;
- symptoms;
- medical advice;
- and the individual's age and circumstances.

The person must not return directly to:

- sparring;
- throws;

- takedowns;
- grappling;
- weapons;
- tricking;
- contact pad work;
- or competition.

A graduated return should move through appropriate stages such as:

1. Daily living and recovery.
2. Return to education or work.
3. Light non-contact activity.
4. Progressive exercise.
5. Controlled martial arts technique.
6. More demanding non-contact training.
7. Contact practice only when appropriate.
8. Full training and competition.

The person should move back a stage if symptoms return.

20.7 Medical clearance

KRMA may require medical confirmation before return where:

- symptoms were significant;
- loss of consciousness occurred;
- symptoms persisted;
- repeated concussion is suspected;
- the person is returning to contact;
- the student or parent disputes restrictions;
- or an instructor reasonably considers clearance necessary.

20.8 Repeated head injuries

Repeated head impacts or suspected concussions must trigger:

- review by the Health and Safety Lead;
- review of training practices;
- review of contact and protective equipment;
- consideration of medical advice;
- and possible longer-term activity restrictions.

21. Suspected Spinal Injury

A spinal injury should be suspected following incidents such as:

- an uncontrolled throw;
- fall onto the head or neck;
- awkward takedown;
- high-impact collision;
- significant fall;
- crushing incident;
- or severe head or neck trauma.

Possible signs include:

- neck or back pain;
- altered sensation;
- numbness;
- tingling;
- weakness;
- loss of movement;
- abnormal posture;
- breathing difficulty;
- confusion;
- or loss of consciousness.

21.1 Immediate action

Where spinal injury is suspected:

1. Stop all activity.
2. Call 999.
3. Instruct the person not to move.

4. Prevent others from moving them.
5. Support the head in the position found where trained and safe.
6. Monitor airway and breathing.
7. Follow the ambulance call handler's instructions.
8. Keep the person warm and reassured.

21.2 Movement

The casualty must not be:

- sat up;
- helped to stand;
- walked around;
- rolled unnecessarily;
- or moved to make the class easier to continue.

Movement may be necessary where:

- the airway cannot be maintained;
- breathing is absent;
- CPR is required;
- there is an immediate environmental danger;
- or emergency services direct movement.

Preserving airway and breathing takes priority over concerns about possible spinal movement.

21.3 Protective equipment

Protective headgear should not be removed unnecessarily.

It may need to be removed where:

- it prevents airway care;
- breathing cannot be assessed;
- CPR or AED use requires removal;

- or emergency services direct it.

Only people able to do so safely should assist.

21.4 Remaining group

The area must be:

- cleared;
- kept quiet;
- protected from filming;
- and preserved for emergency access.

Training must not continue around the casualty.

22. Unconsciousness and Cardiac Arrest

22.1 Unresponsive person

Where a person appears unresponsive:

1. Check the area is safe.
2. Check for a response.
3. Call 999 or instruct someone to call.
4. Check whether they are breathing normally.
5. Follow current CPR training and call-handler instructions.
6. Retrieve and use the AED.
7. Continue until emergency professionals take over or the person recovers.

First aid guidance emphasises scene safety, early 999 contact and rapid response to abnormal breathing or reduced responsiveness.

22.2 Abnormal breathing

Occasional gasps or irregular noisy breaths must not be treated as normal breathing.

Where the person is unresponsive and not breathing normally:

- presume cardiac arrest;
- begin CPR;
- and use the AED as soon as possible.

22.3 Recovery position

An unconscious person who is breathing normally and has no immediate life-threatening problem should normally be placed in the recovery position, unless movement is unsafe because of suspected spinal or other serious injury.

The airway and breathing must continue to be monitored.

22.4 AED use

The AED should be:

- switched on;
- attached as instructed;
- allowed to analyse without anyone touching the casualty;
- and followed exactly according to its prompts.

CPR should resume immediately when instructed.

22.5 Privacy and dignity

During CPR or AED use:

- clothing may need to be moved;
- the chest may need to be exposed;
- and physical contact will be necessary.

Staff should:

- clear unnecessary spectators;
- prohibit photography;
- use screens or people to provide privacy without obstructing treatment;
- and avoid delaying life-saving action.

22.6 Following resuscitation

Where the person shows signs of recovery:

- continue monitoring;
- maintain the airway;
- follow 999 instructions;
- do not allow them to stand;
- and await professional assessment.

All cardiac arrests and resuscitation attempts require:

- formal incident reporting;
- senior-management notification;

- equipment replacement;
- safeguarding consideration where relevant;
- and post-incident support.

23. Breathing Emergencies and Asthma

Breathing difficulty may be caused by:

- asthma;
- anaphylaxis;
- choking;
- chest injury;
- infection;
- panic;
- cardiac illness;
- or another medical emergency.

Staff must not assume breathlessness is anxiety without considering more serious causes.

23.1 Signs of significant breathing difficulty

Possible signs include:

- wheezing;
- gasping;
- rapid breathing;
- inability to speak normally;
- use of neck or chest muscles to breathe;
- pale, blue or grey appearance;
- exhaustion;
- confusion;
- collapse;
- or reduced responsiveness.

23.2 General response

Staff should:

1. Stop the activity.
2. Sit the person upright where this helps them breathe.
3. Reassure them.
4. Help them access their prescribed medication.
5. Follow their emergency action plan.
6. Call 999 if symptoms are severe, worsening or not responding.
7. Continue monitoring.

23.3 Asthma attack

Where a person appears to be having an asthma attack:

- help them use their reliever inhaler;
- use a spacer where their plan provides one;
- follow their personal asthma action plan;
- keep them upright;
- and remain with them.

Current NHS advice distinguishes between blue reliever inhalers and AIR or MART inhalers, so the person's own plan and medication instructions should be followed rather than applying one fixed dose to every inhaler.

23.4 Call 999 where

Emergency services must be called where the person:

- becomes worse at any point;
- does not improve after the maximum dose in their action plan or current NHS instructions;
- does not have an inhaler;
- becomes exhausted or confused;
- cannot speak normally;
- shows colour change;
- collapses;

- or causes serious concern.

If symptoms remain unimproved while waiting for the ambulance, continue to follow:

- the person's action plan;
- current NHS instructions;
- and the 999 call handler's directions.

23.5 After an asthma attack

The person must not return to training that day after a significant asthma attack.

Parents or the adult student should be advised that follow-up medical review may be required.

The incident and use of medication should be recorded.

24. Anaphylaxis and Severe Allergic Reactions

Anaphylaxis is a severe and potentially life-threatening allergic reaction.

Possible signs include:

- swelling of the lips, mouth, throat or tongue;
- difficulty breathing;
- wheezing;
- choking sensation;
- difficulty swallowing;
- sudden confusion;
- dizziness;
- collapse;
- unusual drowsiness;
- or a child becoming limp or unresponsive.

Skin changes may occur but are not required before anaphylaxis is suspected.

24.1 Immediate action

Where anaphylaxis is suspected:

1. Use the person's adrenaline auto-injector immediately where available.
2. Call 999 and state clearly: **"Anaphylaxis."**
3. Follow the device instructions.
4. Keep the person lying down.
5. If breathing is difficult, allow the shoulders to be raised or the person to sit up slowly.
6. Do not allow them to stand or walk.
7. Use a second auto-injector after five minutes if symptoms have not improved, in accordance with current NHS guidance.

8. Monitor breathing and prepare for CPR and AED use.
9. Ensure hospital assessment takes place even where symptoms improve.

24.2 Staff assistance

A staff member may:

- hand the device to the person;
- help them self-administer;
- or administer it where trained, authorised and acting under the emergency plan.

The emergency must not be delayed merely because the parent cannot be contacted.

24.3 Positioning

The person should not suddenly stand or walk.

They should normally remain lying down, with adjustments made where:

- breathing difficulty requires a supported position;
- pregnancy requires left-side positioning;
- vomiting requires airway protection;
- or the 999 call handler advises differently.

24.4 Known allergies

Parents and adult students are responsible for ensuring that:

- allergy information is current;
- auto-injectors are available;
- devices are in date;
- action plans are supplied;
- and replacement devices are provided following use.

24.5 After the incident

Following anaphylaxis:

- the person must go to hospital;
- KRMA must record the incident;
- used devices must accompany the casualty where requested;
- medication arrangements must be reviewed;
- and no return to training is permitted that day.

25. Seizures and Epilepsy

25.1 During a convulsive seizure

Staff should:

- stay calm;
- note the start time;
- remove nearby hazards;
- protect the person's head;
- loosen restrictive clothing where appropriate;
- allow the seizure to run its course;
- preserve dignity;
- and prevent crowding.

Staff must not:

- restrain the person;
- force their movements to stop;
- place anything in their mouth;
- give food, drink or oral medication during the seizure;
- or attempt to move them unless they are in immediate danger.

25.2 After the seizure

When the seizure stops:

- check breathing;
- place the person in the recovery position where appropriate;
- remain with them;
- reassure them as consciousness returns;
- allow rest;
- protect privacy;

- and follow their individual seizure plan.

The person may remain:

- confused;
- tired;
- distressed;
- or unaware of what happened.

25.3 Call 999 where

An ambulance must be requested where:

- it is the person's first known seizure;
- the seizure lasts longer than usual for them;
- it lasts more than five minutes where their usual duration is unknown;
- another seizure begins before full recovery;
- they do not regain full consciousness;
- they sustain a serious injury;
- they have difficulty breathing;
- or their care plan requires an ambulance.

25.4 Emergency seizure medication

Emergency seizure medication may be administered only where:

- it has been prescribed for the person;
- a written healthcare plan is available;
- parental or adult consent arrangements are in place;
- the staff member is trained and authorised;
- and the circumstances within the plan have been met.

Emergency services should be contacted in accordance with:

- the plan;

- staff training;
- and the person's condition.

25.5 Aftercare

The person must not return immediately to training.

A child's parent or carer must be contacted.

The incident report should include:

- start and finish time;
- movement observed;
- consciousness;
- breathing;
- injuries;
- medication;
- recovery;
- and emergency-service involvement.

26. Diabetes and Blood-Sugar Emergencies

People with diabetes may experience:

- low blood sugar;
- high blood sugar;
- or another diabetes-related emergency.

Staff should follow the person's individual healthcare or diabetes plan.

26.1 Possible low blood-sugar symptoms

Symptoms may include:

- hunger;
- shaking;
- sweating;
- dizziness;
- irritability;
- confusion;
- weakness;
- unusual behaviour;
- reduced concentration;
- or loss of consciousness.

26.2 Conscious and able to swallow

Where low blood sugar is suspected and the person is conscious and able to swallow safely:

- stop activity;
- help them check their glucose where they normally do so;
- provide or help them take their planned fast-acting glucose;
- remain with them;
- reassess in accordance with their care plan;

- and provide longer-acting carbohydrate after recovery where their plan requires it.

NHS guidance recommends fast-acting carbohydrate, reassessment after approximately 10–15 minutes and longer-acting carbohydrate once symptoms and glucose have improved.

26.3 Unconscious or unable to swallow

Where the person is unconscious, not responding normally or unable to swallow:

- do not give food or drink;
- call 999;
- check breathing;
- use the recovery position where appropriate;
- provide glucagon only where it is available and the responder knows how to use it;
- and remain with the person.

Prepare for CPR and AED use if normal breathing stops.

26.4 High blood sugar

Possible concerns may include:

- extreme thirst;
- frequent urination;
- nausea;
- abdominal pain;
- deep or rapid breathing;
- unusual breath odour;
- drowsiness;
- or confusion.

Staff should:

- stop activity;
- follow the individual care plan;
- contact the parent or emergency contact;
- seek urgent medical advice;
- and call 999 where consciousness, breathing or general condition deteriorates.

Staff must not give an additional insulin dose unless this is:

- self-administered by the person;
- specifically covered by their agreed plan;
- and within the staff member's authorised role.

26.5 Return to participation

The person must be fully recovered and safe before leaving first aid supervision.

They must not return immediately to strenuous training following a serious hypo or hyperglycaemic episode.

27. Major Bleeding, Wounds and Blood Exposure

27.1 Life-threatening bleeding

Where bleeding is severe:

1. Call 999.
2. Use disposable gloves where available.
3. Apply firm direct pressure.
4. Use a suitable dressing.
5. Maintain pressure.
6. Monitor for shock.
7. Follow 999 instructions.

Current first aid guidance prioritises early emergency contact and direct manual pressure. Haemostatic dressings or tourniquets should only be used where appropriate equipment is available and the responder is trained.

27.2 Embedded objects

An embedded object must not be removed.

Pressure should be applied around it without pressing directly onto the object.

27.3 Tourniquets

A tourniquet may be used for life-threatening limb bleeding that cannot be controlled by direct pressure where the responder:

- is trained;
- has appropriate equipment;
- and follows current first aid guidance.

Where applied:

- record the time;
- do not loosen or remove it;
- and ensure ambulance personnel are informed.

Improvised tourniquets should not be used casually or for minor bleeding.

27.4 Minor wounds

Minor cuts and grazes may be:

- cleaned;
- covered with an appropriate sterile dressing;
- and monitored.

The person must not return to contact activity while:

- bleeding continues;
- the wound is uncovered;
- or bodily-fluid exposure could occur.

27.5 Nosebleeds

The person should:

- sit leaning forward;
- breathe through the mouth;
- pinch the soft part of the nose;
- and avoid swallowing blood.

Medical advice should be sought where bleeding:

- is heavy;
- follows significant trauma;
- does not stop;
- is associated with breathing difficulty;
- or causes concern.

27.6 Blood on training surfaces

Where blood contaminates:

- mats;
- clothing;

- protective equipment;
- weapons;
- or other surfaces,

training in the affected area must stop.

The area must be:

- isolated;
- cleaned using an appropriate bodily-fluid process;
- and made safe before use resumes.

27.7 Exposure to another person's blood

Where blood contacts:

- broken skin;
- eyes;
- mouth;
- or another mucous membrane,

the person should:

- wash or rinse the affected area promptly;
- report the exposure;
- obtain urgent professional medical advice;
- and complete an incident report.

Staff must not attempt to judge infection risk solely from the other person's appearance or disclosed history.

27.8 Contaminated clothing and waste

Contaminated materials must be handled using:

- gloves;
- suitable bags;
- safe disposal;

- and cleaning procedures.

Sharps must be placed in an approved sharps container and must never enter ordinary waste.

28. Fractures, Dislocations and Soft-Tissue Injuries

Possible signs of fracture or dislocation include:

- severe pain;
- swelling;
- deformity;
- shortening;
- abnormal movement;
- inability to use the limb;
- numbness;
- colour change;
- or bone visible through the skin.

28.1 Immediate response

Staff should:

- stop activity;
- support the injured area;
- keep the person still;
- remove rings or restrictive items where swelling is likely and removal is safe;
- monitor circulation;
- obtain medical assistance;
- and call 999 for serious injuries.

28.2 Do not realign

Staff must not attempt to:

- straighten a suspected fracture;
- push a joint back into place;
- manipulate deformity;

- test movement repeatedly;
- or ask the person to “walk it off”.

28.3 Open fracture

Where bone is visible or a wound is associated with a suspected fracture:

- call 999;
- control bleeding around the injury;
- do not press directly on exposed bone;
- cover the wound appropriately;
- and keep the person still.

28.4 Limb circulation

Call 999 urgently where the limb becomes:

- pale;
- blue;
- cold;
- numb;
- pulseless;
- or increasingly painful.

28.5 Sprains, strains and soft-tissue injuries

For less serious injuries, staff may:

- stop activity;
- protect the area;
- use a wrapped cold pack for comfort where appropriate;
- and advise further assessment if function is significantly affected.

Cold packs must:

- be wrapped;

- not be placed directly on skin;
- and not be used for excessive periods.

28.6 Return to training

A student must not return while:

- movement is significantly restricted;
- weight bearing is unsafe;
- pain alters technique;
- protective equipment cannot be worn;
- or participation risks worsening the injury.

Medical or physiotherapy advice may be required.

29. Heat Illness, Dehydration and Environmental Emergencies

Martial arts training can create significant heat load because of:

- physical intensity;
- uniforms;
- protective equipment;
- crowded spaces;
- limited ventilation;
- high humidity;
- and age or medical vulnerability.

29.1 Prevention

KRMA should manage heat risk through:

- venue-temperature monitoring;
- ventilation;
- hydration opportunities;
- additional breaks;
- reduced intensity;
- modification of uniform or protective equipment where safe;
- reduced contact;
- shorter sessions;
- activity relocation;
- and cancellation where conditions cannot be managed safely.

29.2 Heat-exhaustion symptoms

Possible signs include:

- tiredness;
- weakness;

- dizziness;
- headache;
- nausea;
- muscle cramps;
- intense thirst;
- heavy sweating;
- or feeling faint.

29.3 Heat-exhaustion response

Staff should:

1. Stop activity.
2. Move the person to a cool area.
3. Remove unnecessary clothing or equipment.
4. Provide cool fluids where they are conscious and able to swallow.
5. Cool the skin.
6. Use wrapped cold packs where appropriate.
7. Remain with the person.
8. Monitor symptoms.

NHS guidance recommends moving the person to a cool place, removing unnecessary clothing, providing fluids and actively cooling the skin.

29.4 Suspected heatstroke

Call 999 where the person:

- remains unwell after approximately 30 minutes of cooling;
- has a very high temperature;
- has hot skin that is not sweating;
- develops confusion;
- loses coordination;

- breathes rapidly;
- has a seizure;
- loses consciousness;
- or otherwise appears seriously unwell.

Continue active cooling while awaiting emergency services.

29.5 Fluids

Fluids should only be given where the person is:

- conscious;
- able to swallow;
- and not vomiting repeatedly.

Nothing should be given by mouth to an unconscious or significantly confused person.

29.6 Dehydration

Possible signs include:

- thirst;
- dry mouth;
- headache;
- dizziness;
- fatigue;
- reduced concentration;
- dark urine;
- and reduced performance.

The person should be:

- removed from strenuous activity;
- allowed to rehydrate;
- monitored;

- and prevented from returning until safely recovered.

29.7 Cold conditions

Outdoor or poorly heated activities may create risks of:

- hypothermia;
- reduced coordination;
- loss of sensation;
- and cold-related injury.

The person should be moved to shelter, warmed gradually and assessed.

Call 999 where there is:

- confusion;
- marked drowsiness;
- abnormal breathing;
- unconsciousness;
- or significant concern.

30. Burns, Electric Shock and Other Emergencies

30.1 Thermal burns

For a burn:

1. Stop the burning process.
2. Cool under cool running water for at least 20 minutes where possible.
3. Remove clothing or jewellery near the burn unless stuck to the skin.
4. Protect the person from becoming excessively cold.
5. Cover the cooled burn loosely with an appropriate clean covering.
6. Seek professional medical assistance.

Creams, oils, ice and adhesive dressings must not be applied to the burn. NHS first aid guidance recommends at least 20 minutes of cool running water and loose covering after cooling.

30.2 Call 999 where

Emergency assistance should be requested for:

- extensive burns;
- deep burns;
- burns to the face, airway, hands, feet, joints or genital area;
- electrical burns;
- chemical burns;
- inhalation injury;
- significant burns involving a child;
- or signs of shock or breathing difficulty.

30.3 Chemical burns

Staff should:

- protect themselves;
- remove contaminated clothing where safe;

- brush away dry chemicals before adding water where relevant;
- rinse thoroughly with running water;
- identify the substance where possible;
- and call 999.

Staff must not attempt to neutralise a chemical with another chemical.

30.4 Electrical injury

Before touching the casualty:

- isolate the electrical supply;
- ensure the area is safe;
- and call emergency services where significant exposure has occurred.

The person may require medical assessment even where visible burns appear small.

Where they are unresponsive and not breathing normally:

- call 999;
- begin CPR;
- and use the AED.

30.5 Choking

Where a person is choking:

- encourage effective coughing;
- follow current first aid training;
- call 999 where the obstruction is not cleared;
- and use the recognised sequence appropriate to the person's age.

Anyone receiving abdominal thrusts or experiencing significant choking should be advised to obtain medical assessment.

30.6 Chest pain and possible heart attack

Where a person develops unexplained chest pain, particularly with:

- sweating;
- nausea;
- breathlessness;
- collapse;
- or pain spreading elsewhere,

staff should:

- stop activity;
- call 999;
- keep the person at rest;
- monitor breathing;
- and prepare the AED.

Staff must not dismiss chest symptoms as poor fitness or anxiety.

30.7 Suspected stroke

Possible signs may include sudden:

- facial weakness;
- arm weakness;
- speech difficulty;
- confusion;
- visual disturbance;
- severe headache;
- or balance problems.

Call 999 immediately and record the time symptoms began or the person was last known to be well.

30.8 Poisoning and substance exposure

Where poisoning, overdose or harmful substance exposure is suspected:

- call 999 for serious symptoms;

- follow professional instructions;
- preserve containers or product information;
- do not induce vomiting;
- and protect staff from exposure.

Where illegal substances may be involved, safeguarding and police procedures may also apply.

31. Medication

KRMA will manage medication in a way that balances:

- individual independence;
- emergency access;
- safety;
- safeguarding;
- staff competence;
- and accurate recording.

31.1 Parental and adult responsibility

Parents, carers and adult students are responsible for providing:

- accurate medication information;
- the correct medication;
- clear instructions;
- a current action plan where required;
- in-date medication;
- appropriate labelling;
- and replacement medication after use or expiry.

31.2 Self-administration

Students should self-administer medication where they are:

- competent;
- able to do so safely;
- and authorised under their arrangements.

This may include:

- inhalers;
- glucose;

- insulin;
- and adrenaline auto-injectors.

Staff may provide appropriate assistance.

31.3 Staff administration

Staff may administer or assist with medication only where:

- there is a legitimate need;
- the medication belongs to the person;
- appropriate consent exists;
- written instructions or an emergency plan are available;
- the staff member is trained where necessary;
- and the action falls within KRMA's agreed procedure.

31.4 Emergency action

In a life-threatening emergency, staff should:

- call 999;
- follow the person's emergency plan;
- use medication they are trained and authorised to use;
- and follow emergency-service instructions.

Parent contact must not delay emergency medication.

31.5 Medication storage

Medication must be:

- clearly labelled;
- stored according to its requirements;
- protected from unauthorised access;
- readily accessible in an emergency;
- and not locked away where delay could cause danger.

Emergency medication must accompany the student during:

- off-site events;
- trips;
- competitions;
- and residential activities.

31.6 Controlled or specialist medication

Medication requiring specialist administration or controlled storage must have:

- an individual plan;
- authorised staff;
- appropriate records;
- and secure arrangements.

Where KRMA cannot safely meet the requirement, this must be discussed before participation.

31.7 Routine pain relief

KRMA staff will not normally provide routine:

- painkillers;
- antihistamines;
- cold remedies;
- or other non-prescribed medication

from a communal supply.

A parent should not ask staff informally to give medication without completing the required arrangements.

31.8 Recording administration

A medication record should include:

- student name;
- medication;

- dose or device used;
- date and time;
- reason;
- person administering or assisting;
- response;
- parent notification;
- and any emergency-service involvement.

31.9 Medication errors

Any error involving:

- wrong medication;
- wrong person;
- wrong dose;
- missed emergency medication;
- expired medication;
- or unauthorised administration

must be:

- acted upon immediately;
- referred for medical advice;
- reported to the parent or adult concerned;
- recorded as an incident;
- and reviewed.

32. Infection Prevention and Hygiene

First aid arrangements must reduce the risk of infection to:

- the casualty;
- first aider;
- staff;
- and other participants.

32.1 Hand hygiene

Hands should be cleaned:

- before treatment where practicable;
- after treatment;
- after removing gloves;
- and after contact with bodily fluids.

Gloves do not replace hand hygiene.

32.2 Personal protective equipment

Disposable gloves should be used where there is a risk of contact with:

- blood;
- vomit;
- saliva;
- open wounds;
- or another bodily fluid.

Additional protection may be required where splashing is possible.

32.3 Resuscitation barriers

A face shield or resuscitation mask should be available where identified by the needs assessment.

Its use must not unreasonably delay CPR.

32.4 Contaminated surfaces

Areas contaminated by bodily fluids must be:

- closed temporarily;
- cleaned with appropriate products;
- allowed to dry or become safe;
- and checked before training resumes.

Normal class cleaning products may not be sufficient for blood contamination.

32.5 Shared equipment

Pads, gloves, headguards and other shared equipment should be:

- cleaned regularly;
- cleaned after contamination;
- checked for damage;
- and removed from use where they cannot be hygienically maintained.

32.6 Open wounds

A person with an open wound must not participate in contact training unless the wound:

- is no longer actively bleeding;
- has been treated;
- is securely covered;
- and does not create an infection risk.

32.7 Illness

A person showing symptoms of a contagious illness may be required to:

- avoid training;
- leave the activity;
- follow public-health or medical advice;
- or return only when the risk to others has reduced.

Decisions should be proportionate and must not be based upon stigma or assumptions.

32.8 Sharps

Needles, lancets and other sharps must:

- be used only for their intended medical purpose;
- be controlled by the individual or authorised adult;
- and be disposed of within an appropriate sharps container.

They must never be placed within ordinary bins or first aid bags.

32.9 Cleaning responsibility

A named responsible person should ensure that:

- bodily-fluid kits are available;
- contaminated areas are cleaned;
- waste is disposed of safely;
- reusable equipment is decontaminated;
- and supplies are replaced.

A junior instructor must not be tasked with cleaning another person's blood or bodily fluids.

33. Accidents, Incidents and Near Misses

All relevant accidents, medical incidents and near misses must be reported and recorded.

The purpose of reporting is to:

- protect the person involved;
- ensure appropriate follow-up;
- identify hazards;
- recognise patterns;
- support safeguarding;
- improve risk assessments;
- fulfil insurance and legal duties;
- and prevent recurrence.

Reporting an incident does not automatically mean that:

- someone is at fault;
- the activity was unsafe;
- a formal complaint has been made;
- or a RIDDOR report is required.

33.1 What must be recorded

KRMA should record incidents including:

- injuries requiring first aid;
- suspected concussion;
- loss of consciousness;
- breathing emergencies;
- seizures;
- anaphylaxis;
- emergency medication use;

- serious illness;
- hospital attendance;
- ambulance involvement;
- blood or bodily-fluid exposure;
- medication errors;
- equipment failure;
- uncontrolled contact;
- significant falls;
- heat illness;
- participant collapse;
- safeguarding-related injuries;
- and near misses with realistic potential for harm.

Minor incidents may be recorded proportionately.

However, a seemingly minor incident should not be ignored where:

- it involves the head or neck;
- symptoms may develop later;
- the person is a child;
- the same hazard has caused previous concerns;
- the explanation is unclear;
- or a complaint or safeguarding issue may arise.

33.2 Immediate verbal reporting

The incident must be reported promptly to:

- the session leader;
- first aider;
- Health and Safety Lead;

- or another responsible senior person.

The Designated Safeguarding Lead must also be informed where the incident may involve:

- abuse;
- neglect;
- bullying;
- inappropriate physical contact;
- unsafe coaching;
- violence;
- unexplained injury;
- or another welfare concern.

33.3 Written report

A written report should normally be completed:

- as soon as reasonably practicable;
- preferably on the same day;
- and before relevant details are forgotten.

A serious incident should be reported to senior management immediately, rather than waiting for routine administration.

33.4 Information to record

The report should include:

- full name of the injured or unwell person;
- date of birth or age where relevant;
- date and time;
- venue and exact location;
- activity taking place;
- what happened;

- mechanism of injury where known;
- symptoms observed;
- body area affected;
- first aid provided;
- medication used;
- whether the activity was stopped;
- whether 999 or NHS 111 was contacted;
- ambulance or hospital involvement;
- parent or emergency-contact communication;
- names of staff involved;
- witnesses;
- equipment involved;
- environmental conditions;
- immediate controls introduced;
- safeguarding concerns;
- and recommended follow-up.

33.5 Factual recording

Records must distinguish between:

- what was directly observed;
- what the person reported;
- what a witness said;
- professional medical information;
- and the recorder's opinion.

Appropriate wording may include:

"The student reported feeling dizzy after receiving contact to the side of the head."

The record should not state:

"The student definitely suffered a concussion."

unless this has been confirmed by an appropriately qualified medical professional.

Similarly, a report should not state that:

- another person deliberately caused the injury;
- equipment was defective;
- supervision was inadequate;
- or a student was dishonest

unless the available evidence supports that conclusion.

33.6 Witness information

Where witnesses are relevant, their accounts should be obtained:

- separately where appropriate;
- using open questions;
- without coaching;
- and as soon as reasonably practicable.

A child must not be repeatedly questioned by several adults.

Where the incident may involve safeguarding or criminal conduct, the DSL should advise before detailed statements are sought.

33.7 Record completed by the first aider

The first aider should record:

- assessment;
- observable symptoms;
- treatment;
- changes in condition;
- advice given;

- and professional assistance requested.

Where another person completes the main report, the first aider should confirm that the first-aid information is accurate.

33.8 Parent or adult acknowledgement

A parent, carer or adult participant may be asked to acknowledge that they were informed.

A signature confirms receipt of the information.

It does not necessarily mean that the person:

- agrees with every detail;
- accepts responsibility;
- waives legal rights;
- or considers the matter closed.

Refusal to sign must not result in the record being destroyed or ignored.

The staff member should record that notification was provided and that the person declined to sign.

33.9 Corrections

Records must not be altered dishonestly or rewritten to conceal an error.

Where a correction is required:

- the original entry should remain identifiable where practicable;
- the correction should be dated;
- the person making it should be identified;
- and the reason should be clear.

33.10 Near misses

Near misses should be reported where they reveal a meaningful risk.

Examples may include:

- a weapon leaving the training area;
- damaged equipment nearly causing injury;

- an uncontrolled takedown;
- a student almost leaving unnoticed;
- emergency access being blocked;
- an AED being inaccessible;
- missing medication;
- a student nearly colliding with a wall;
- or dangerous heat conditions developing before illness occurred.

Near-miss reporting helps KRMA identify hazards before someone is harmed.

33.11 Preservation of evidence

Following a serious or disputed incident, KRMA may need to preserve:

- CCTV;
- photographs taken for an authorised evidential purpose;
- damaged equipment;
- risk assessments;
- registers;
- coaching plans;
- messages;
- first aid records;
- venue reports;
- and witness accounts.

Evidence must not be:

- altered;
- discarded;
- repaired before appropriate examination;
- posted online;

- or shared with uninvolved people.

Dangerous equipment should be removed from use, labelled and stored securely.

33.12 Reporting by children

Children should be encouraged to report:

- pain;
- dizziness;
- fear;
- unsafe contact;
- bullying;
- unexplained symptoms;
- or something that almost caused injury.

A child must not be mocked or punished for honestly reporting a concern.

34. RIDDOR Assessment and Reporting

RIDDOR stands for the **Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013**.

RIDDOR requires responsible organisations and people to report certain work-related:

- deaths;
- injuries;
- diseases;
- and dangerous occurrences

to the relevant enforcing authority.

Not every accident, first aid incident, hospital visit or martial arts injury is reportable.

Every significant incident must nevertheless be considered, recorded internally and assessed where RIDDOR may apply.

34.1 Responsible person

A RIDDOR report may normally be submitted only by the legally responsible person, such as:

- the employer;
- an appropriate self-employed person;
- or the person in control of the premises.

Where KRMA uses an external venue, responsibility may depend upon:

- who controlled the premises;
- whose work activity caused the incident;
- who employed the injured person;
- and the circumstances of the event.

KRMA must not assume automatically that the venue or event organiser will report on its behalf.

34.2 Who decides whether a report is required

RIDDOR decisions should be made or authorised by:

- the Health and Safety Lead;
- CEO and Chief Instructor;
- or another suitably competent and authorised senior person.

The decision-maker may seek advice from:

- the Health and Safety Executive;
- venue management;
- insurers;
- governing bodies;
- legal advisers;
- or a competent health and safety professional.

An individual instructor should not submit a RIDDOR report independently unless authorised or legally responsible.

34.3 Work-related requirement

An incident is not reportable merely because it happened during a KRMA activity.

There must normally be a connection between:

- the accident; and
- the way work or the activity was organised, managed or carried out.

Possible work-related factors include:

- defective equipment;
- unsafe premises;
- inadequate supervision;
- inappropriate instruction;
- insufficient risk control;
- dangerous class organisation;

- unsafe staffing;
- or failure to follow an established procedure.

34.4 Ordinary sports injuries

Most injuries arising solely from the normal risks of taking part in sport are not reportable under RIDDOR.

A routine injury caused by ordinary participation does not automatically become reportable because the student:

- required first aid;
- sustained a fracture;
- or went to hospital.

An injury may become reportable where it arose from a work-related failing, such as:

- defective equipment;
- inadequate supervision;
- or poor organisation and management of the activity.

34.5 Death

A work-related accident resulting in the death of:

- an employee;
- volunteer;
- student;
- visitor;
- contractor;
- or another person

may be reportable.

Police, insurers, safeguarding agencies and other authorities may also need to be informed.

34.6 Specified injuries to workers

Certain specified injuries sustained by employees or other workers following a work-related accident are reportable.

Examples within the statutory categories include specified:

- fractures;
- amputations;
- permanent loss or reduction of sight;
- crush injuries;
- serious burns;
- scalping;
- loss of consciousness;
- and injuries arising from work in an enclosed space.

The precise legal definition must be checked against current HSE guidance rather than relying on an informal summary.

34.7 Over-seven-day incapacity

A work-related injury to a worker is reportable where it results in the worker being:

- away from work; or
- unable to perform their normal duties

for more than seven consecutive days.

The day of the accident is not counted, but weekends and rest days are included. The report must be made within 15 days of the accident.

34.8 Over-three-day incapacity

A work-related injury resulting in more than three consecutive days of incapacity must be recorded even where it does not reach the threshold requiring a RIDDOR report.

Recording the incident in the accident record may be sufficient unless another reporting category applies.

34.9 Students, customers and other non-workers

An injury to a student, spectator, parent or other person who is not at work may be reportable where:

1. The injury resulted from a work-related accident; and
2. The person was taken directly from the scene to hospital for treatment of that injury.

A journey to hospital may be by:

- ambulance;
- parent;
- friend;
- taxi;
- or another appropriate means.

A precautionary visit without an identified injury requiring treatment is not automatically reportable.

34.10 Volunteers

A volunteer's status under RIDDOR depends upon the relevant circumstances and legal reporting category.

A volunteer may be treated as a person other than a worker for some reporting purposes.

KRMA should seek competent advice rather than automatically applying employee rules to every volunteer incident. HSE confirms that incidents involving volunteers may be reportable where they arise from work activity and meet the applicable reporting threshold.

34.11 Occupational disease

Certain diagnosed occupational diseases affecting workers may be reportable where:

- a medical professional provides the relevant diagnosis;
- and the disease is linked to the person's work.

The Health and Safety Lead should obtain advice where a work-related condition may fall within a reportable category.

34.12 Dangerous occurrences

Some specified high-risk events must be reported even where nobody is injured.

These are legally defined dangerous occurrences and may involve matters such as:

- serious equipment failure;
- electrical incidents;
- structural collapse;
- pressure systems;
- lifting equipment;
- or another event listed within the regulations.

A near miss is not automatically a reportable dangerous occurrence. The event must fall within a defined category.

34.13 Reporting timescales

For most reportable incidents, including:

- deaths;
- specified injuries to workers;
- qualifying injuries to non-workers;
- and dangerous occurrences,

the enforcing authority must be notified without delay, and the report must normally be received within ten days.

Over-seven-day worker injuries must normally be reported within 15 days.

34.14 RIDDOR record

Where a report is made, KRMA should retain:

- the submitted report;
- HSE reference number;
- date submitted;

- person submitting;
- evidence considered;
- correspondence;
- and any later amendments.

HSE requires records to be kept of reportable injuries, over-seven-day injuries, diseases and dangerous occurrences.

34.15 Internal report remains required

An incident may require:

- a KRMA accident report;
- safeguarding report;
- insurance notification;
- venue notification;
- or internal investigation

even where it is not reportable under RIDDOR.

A decision that RIDDOR does not apply does not mean that:

- the injury was unimportant;
- the risk assessment was adequate;
- or no further action is required.

35. Off-Site Classes, Competitions and Events

First aid arrangements must be established before KRMA delivers or attends an off-site activity.

Examples include:

- competitions;
- demonstrations;
- seminars;
- school programmes;
- festivals;
- grading venues;
- public displays;
- outdoor sessions;
- and community events.

35.1 Pre-event information

The responsible leader should confirm:

- full venue address;
- postcode;
- emergency access;
- first aid arrangements;
- first aider availability;
- AED location;
- ambulance access;
- treatment area;
- venue emergency number;
- fire and evacuation arrangements;
- mobile-phone coverage;

- nearest appropriate medical facility;
- and who controls the premises.

35.2 Event organiser arrangements

Where an organiser states that first aid is provided, KRMA should establish:

- who provides it;
- qualifications or competence;
- operating hours;
- treatment location;
- how help is summoned;
- whether an ambulance is onsite;
- whether an AED is available;
- and whether the provision covers warm-up, competition and departure periods.

KRMA may still require its own first aider where:

- students are spread across several areas;
- the organiser's provision is limited;
- the activity has particular risks;
- or the team may travel separately.

35.3 KRMA first aid equipment

The team leader should ensure access to an appropriate portable first aid kit.

Depending upon the activity, the emergency bag may also include:

- emergency contact information;
- medical summaries;
- medication;
- concussion information;
- gloves;

- additional dressings;
- cold packs;
- emergency blankets;
- bodily-fluid supplies;
- and communication equipment.

35.4 Student medical information

Relevant medical information must be:

- current;
- accessible to authorised staff;
- protected from unnecessary disclosure;
- and available during the entire activity.

Medical information must not be left:

- unattended;
- openly displayed;
- or accessible to other competitors or families.

35.5 Medication

The responsible person should confirm before departure that required emergency medication is:

- present;
- correctly labelled;
- in date;
- accessible;
- and accompanied by the relevant plan.

A student whose essential emergency medication is missing may be unable to participate safely.

35.6 Registration and handover

KRMA should maintain an accurate record of:

- students attending;
- arrival;
- location;
- category or activity;
- collection;
- and departure.

A child must not leave the event without the responsible KRMA adult being informed.

35.7 Injury during competition

Where a student is injured:

- the competition must stop for that student;
- the authorised first aid provider should assess them;
- KRMA staff must cooperate;
- head-injury restrictions must be enforced;
- and competition pressure must not influence the medical decision.

A student must not enter another category after:

- suspected concussion;
- significant breathing difficulty;
- anaphylaxis;
- loss of consciousness;
- serious injury;
- or another condition making further participation unsafe.

35.8 Organiser and KRMA records

The event organiser may complete its own incident report.

KRMA should also complete its own record where:

- a KRMA student, staff member or volunteer was involved;
- further action is required;
- safeguarding is relevant;
- or the incident may affect future participation.

A copy of, or reference to, the organiser's report should be requested where appropriate.

35.9 Emergency cancellation

An activity may be:

- delayed;
- modified;
- or cancelled

where first aid arrangements are missing or inadequate.

The fact that:

- entry fees were paid;
- participants travelled;
- or the event has already started

must not override safety.

36. Trips, Travel and Residential Activities

Trips and residential activities require additional planning because participants may be:

- away from familiar surroundings;
- separated from parents;
- travelling for extended periods;
- staying overnight;
- or at greater distance from medical assistance.

36.1 Trip emergency plan

The trip leader should have access to:

- itinerary;
- participant list;
- staff list;
- emergency contacts;
- relevant medical information;
- medication plans;
- accommodation details;
- transport details;
- insurance information;
- local emergency numbers where outside the UK;
- and contingency arrangements.

36.2 First aid coverage

The needs assessment should consider:

- length of the trip;
- group size;
- student ages;

- medical needs;
- activities;
- transport;
- accommodation;
- distance from medical services;
- overnight supervision;
- and whether groups may separate.

More than one first aider may be required where:

- the group is large;
- separate vehicles are used;
- multiple activities take place;
- or one first aider may need to accompany a casualty.

36.3 Travelling first aid kit

A suitable first aid kit should accompany the group.

It should remain accessible rather than being stored:

- under inaccessible luggage;
- in another vehicle;
- or in accommodation while the activity takes place elsewhere.

36.4 Medication during travel

Emergency medication must remain:

- readily accessible;
- protected from extremes of temperature;
- correctly labelled;
- and with the relevant person or authorised adult.

It must not be placed in inaccessible checked luggage where it may be required during travel.

36.5 Vehicle incidents

Following a road incident, staff should:

- make the scene as safe as possible;
- contact emergency services where required;
- follow driver and emergency-service instructions;
- account for all passengers;
- avoid unnecessary movement of injured people;
- contact parents and senior management;
- and activate the travel contingency plan.

Road-traffic reporting responsibilities may differ from RIDDOR duties.

Specialist advice should be sought where necessary.

36.6 Illness during a trip

Where a student becomes unwell, staff should consider:

- symptoms;
- infection risk;
- medication;
- supervision;
- isolation where appropriate;
- parental contact;
- medical advice;
- and whether the student should return home.

A child must not be left alone in accommodation because they are unwell.

36.7 Hospital attendance

Where a child needs hospital treatment:

- an appropriate adult should accompany them where possible;

- another adult should remain responsible for the wider group;
- parents should be informed;
- transport and accommodation arrangements should be revised;
- and relevant documents should accompany the child.

The accompanying adult should remain until responsibility is transferred appropriately.

36.8 Overnight incidents

Residential staff must know:

- how to summon help during the night;
- room locations;
- access routes;
- emergency exits;
- medication location;
- first aid location;
- and who is on duty.

A student requiring overnight medical monitoring beyond staff competence must receive professional medical assistance.

36.9 Overseas activities

For overseas trips, the plan should also consider:

- local emergency-service numbers;
- travel insurance;
- European or international healthcare documentation where relevant;
- consular assistance;
- language barriers;
- medication documentation;
- local legal requirements;

- and medical repatriation arrangements.

36.10 Parent collection or early return

Where a child must return home early, KRMA should agree:

- authorised collector;
- transport;
- handover;
- medication;
- relevant information;
- and responsibility during the journey.

A child must not be sent home alone unless this is explicitly safe, lawful and agreed.

37. Emergency Plans for External Venues

Every regularly used external venue should have a basic KRMA emergency information record.

37.1 Venue emergency record

The record should include:

- venue name;
- complete address;
- postcode;
- telephone number;
- responsible venue contact;
- room used;
- emergency entrance;
- ambulance access;
- parking barriers or codes;
- AED location;
- first aid location;
- fire exits;
- assembly point;
- lockdown arrangements where applicable;
- mobile coverage;
- and known hazards.

37.2 Pre-session check

Before the activity starts, the responsible instructor should check:

- access is available;
- exits are clear;
- the training space is safe;

- first aid equipment is accessible;
- the telephone works;
- the AED remains available where expected;
- and no venue change has invalidated the emergency plan.

37.3 Venue induction

Relevant staff should understand:

- who has overall premises control;
- who calls emergency services;
- who meets the ambulance;
- whether venue staff provide first aid;
- who controls evacuation;
- and how the building is secured.

37.4 Fire and medical emergencies

Where a medical incident occurs during an evacuation:

- preservation of life remains the priority;
- emergency services should be informed;
- the casualty should not be placed at greater risk;
- and staff should follow professional instructions.

A casualty should not be moved unnecessarily solely to complete an evacuation unless the location creates immediate danger.

37.5 Lockdown or security incident

Where a medical emergency occurs during a security incident, staff must balance:

- urgent medical need;
- risk from the external threat;
- emergency-service instructions;

- and the safety of the wider group.

37.6 Shared responsibility

Where KRMA hires only part of a building, responsibility may be shared with:

- the landlord;
- leisure-centre operator;
- school;
- event organiser;
- or another dutyholder.

The division of responsibility should be understood and recorded.

37.7 Changes and temporary venues

A previous emergency plan must not be assumed to apply where:

- the room changes;
- access changes;
- building work occurs;
- an AED is moved;
- emergency routes are blocked;
- or KRMA uses the venue at a different time.

38. Records, Data Protection and Retention

First aid and medical records contain personal information and may include special category health information.

They must be handled in accordance with:

- the Data Protection and Information Governance Policy;
- Privacy Notice;
- safeguarding requirements;
- insurance requirements;
- and KRMA's retention schedule.

38.1 Record format

KRMA may use:

- secure digital records;
- paper accident forms;
- an accident book;
- event forms;
- medication records;
- and safeguarding records.

The system used must allow KRMA to:

- identify incidents;
- protect confidentiality;
- monitor patterns;
- retrieve information;
- and demonstrate action taken.

Where an organisation has more than ten employees, an accident book or equivalent record is required under applicable social-security requirements. HSE also recommends incident records because they help identify patterns and support risk management and insurance matters.

38.2 Separation of records

Where appropriate:

- routine first aid information should be held within the accident system;
- safeguarding information should be held within the safeguarding system;
- medication information should be held within the relevant health record;
- and staff records should be held within authorised personnel files.

A brief cross-reference may be used without duplicating sensitive details unnecessarily.

38.3 Access

Access should be restricted to people with a legitimate need, which may include:

- first aid leads;
- Health and Safety Lead;
- DSL;
- authorised senior management;
- insurer;
- legal adviser;
- regulator;
- or the individual exercising a lawful data right.

General instructors should not have unrestricted access to historical medical incidents.

38.4 Parent information

Parents may receive:

- first aid notification;
- relevant symptoms;

- treatment given;
- and advice provided.

They do not automatically receive:

- another student's information;
- confidential witness statements;
- staff disciplinary information;
- or the complete investigation record.

38.5 Medical professionals

Information supplied to healthcare professionals should be:

- accurate;
- relevant;
- and limited to what may assist treatment or immediate safety.

38.6 Retention periods

Retention should consider:

- the age of the injured person;
- seriousness;
- safeguarding;
- insurance;
- employment law;
- limitation periods;
- RIDDOR;
- possible legal claims;
- and whether the incident indicates a continuing pattern.

Records involving children may need to be retained beyond the date the student leaves or reaches adulthood.

The exact retention period should be set within KRMA's Data Retention Schedule rather than relying upon one universal period.

38.7 RIDDOR records

Where an incident is reportable, KRMA must retain the required report and related information in accordance with legal requirements and its retention schedule.

38.8 Subject access and disclosure

An accident or medical record may fall within a data-rights request.

Before disclosure, KRMA may need to protect:

- other people's information;
- safeguarding sources;
- legally privileged information;
- police enquiries;
- and confidential witness material.

38.9 Security

Paper forms must not be:

- left at reception;
- displayed on noticeboards;
- left inside unlocked vehicles;
- or carried indefinitely by instructors.

Digital records must not be stored through:

- personal email;
- open spreadsheets;
- public links;
- or unapproved messaging systems.

38.10 Secure destruction

When the authorised retention period ends, records should be:

- securely deleted;
- confidentially shredded;
- or anonymised where statistical information remains useful.

Records must not be destroyed while relevant to:

- a complaint;
- safeguarding process;
- legal claim;
- insurance matter;
- RIDDOR enquiry;
- or regulatory investigation.

39. Post-Incident Support and Review

A medical emergency may affect more than the injured person.

It may also cause distress to:

- other students;
- parents;
- first aiders;
- instructors;
- junior instructors;
- witnesses;
- and staff involved in the response.

39.1 Immediate welfare support

After a serious incident, KRMA should consider:

- a quiet area;
- parent or family contact;
- emotional reassurance;
- relief from duties;
- transport home;
- medical support;
- and safeguarding assistance.

A person involved in CPR, severe bleeding, anaphylaxis or another traumatic event should not automatically be expected to resume normal duties immediately.

39.2 First aider debrief

The first aider should have an opportunity to:

- explain what happened;
- identify equipment used;

- record decisions;
- raise concerns;
- and request support.

A debrief must not become an accusatory interrogation.

Its initial purpose is to:

- protect welfare;
- preserve facts;
- and identify immediate action.

39.3 Student witnesses

Children who witnessed a serious emergency should receive:

- calm, age-appropriate reassurance;
- clear information without unnecessary medical detail;
- an opportunity to ask questions;
- and support from parents or safeguarding staff where required.

Staff must avoid:

- speculation;
- graphic discussion;
- or asking children to repeatedly recount distressing events.

39.4 Serious-incident review

A formal review should be considered where an incident involved:

- death;
- cardiac arrest;
- ambulance attendance;
- hospital treatment;
- suspected spinal injury;

- significant head injury;
- anaphylaxis;
- major bleeding;
- serious safeguarding concern;
- multiple casualties;
- equipment failure;
- or a repeated pattern.

39.5 Review questions

The review should consider:

1. What happened?
2. What activity was taking place?
3. What immediate causes were identified?
4. Were there underlying organisational factors?
5. Was the risk assessment suitable?
6. Were rules and controls followed?
7. Was supervision appropriate?
8. Was equipment suitable and maintained?
9. Was medical information available?
10. Was emergency medication accessible?
11. Was first aid cover adequate?
12. Was 999 called promptly?
13. Was the AED accessible?
14. Were parents informed appropriately?
15. Was safeguarding considered?
16. Were records completed?

17. Does RIDDOR apply?
18. Does the insurer need notification?
19. What should change?
20. Who is responsible for each action?

39.6 Investigation approach

The purpose of investigation is to:

- establish facts;
- identify causes;
- improve safety;
- and meet legal or safeguarding duties.

It must not begin with an assumption that:

- the injured person was careless;
- martial arts injuries are inevitable;
- an instructor was automatically at fault;
- or the activity must never be delivered again.

39.7 Immediate corrective action

KRMA does not need to wait for the final investigation before introducing obvious safety improvements.

Possible action includes:

- removing equipment;
- suspending a technique;
- reducing contact;
- changing class layout;
- increasing supervision;
- retraining staff;
- revising medication arrangements;

- improving emergency access;
- or temporarily relocating the activity.

39.8 Risk-assessment update

Relevant risk assessments must be reviewed where the incident shows that:

- a hazard was missed;
- likelihood or severity was underestimated;
- controls failed;
- procedures were not followed;
- staffing was inadequate;
- or circumstances changed.

39.9 Insurance notification

KRMA should notify its insurer or insurance adviser where required by:

- policy terms;
- seriousness;
- potential claim;
- hospital treatment;
- allegation against staff;
- or significant property damage.

Staff must not:

- admit legal liability;
- promise compensation;
- or speculate publicly

without authority.

This does not prevent KRMA from:

- expressing concern;

- apologising for distress;
- providing factual information;
- or taking immediate corrective action.

39.10 External communication

Any public communication following a serious incident should be authorised.

It must:

- protect personal information;
- avoid speculation;
- avoid identifying children unnecessarily;
- avoid prejudicing investigations;
- and provide only confirmed information.

No staff member, volunteer or student may publish:

- photographs;
- medical information;
- ambulance footage;
- rumours;
- or confidential details

about the incident.

39.11 Return to training

Following injury or illness, KRMA may require:

- a period away;
- temporary restrictions;
- a staged return;
- an individual risk assessment;
- parent confirmation;

- or professional medical clearance.

Return decisions should consider:

- symptoms;
- medical advice;
- technique demands;
- contact;
- protective equipment;
- risk to the individual;
- and risk to training partners.

A student must not be rushed back because of:

- an upcoming grading;
- competition;
- demonstration;
- or team commitment.

39.12 Closing the review

The incident review should remain open until:

- immediate controls are completed;
- responsible persons are identified;
- RIDDOR has been considered;
- safeguarding action is complete;
- equipment has been replaced;
- relevant records are secured;
- and outstanding actions have review dates.

40. Training, Monitoring and Policy Review

40.1 Training matrix

KRMA should maintain a training record showing:

- qualified first aiders;
- qualification type;
- provider;
- certificate date;
- expiry date;
- venue or role;
- additional medication training;
- concussion briefing;
- AED training;
- and refresher requirements.

40.2 Core staff awareness

All staff and volunteers should know:

- how to call 999;
- who the first aider is;
- where the first aid kit is;
- where the AED is;
- how to report an incident;
- how to protect the remaining group;
- and when to contact the DSL.

40.3 Role-specific training

Additional training may be required for people responsible for:

- emergency medication;

- trips;
- residential activities;
- competitions;
- contact disciplines;
- weapons;
- high-intensity conditioning;
- outdoor training;
- or students with identified medical needs.

40.4 Emergency drills

KRMA should periodically rehearse suitable elements of its emergency arrangements.

Drills may include:

- calling 999;
- retrieving the AED;
- clearing the training area;
- directing an ambulance;
- supervising the wider class;
- contacting parents;
- and locating emergency information.

Drills should not:

- use an unsuspecting person as a casualty;
- create unnecessary distress;
- or interrupt emergency-service systems.

40.5 Equipment monitoring

Checks should include:

- first aid kit stock;

- expiry dates;
- AED readiness;
- medication availability;
- bodily-fluid supplies;
- communication equipment;
- emergency signage;
- and access routes.

40.6 Incident trends

KRMA should review incident records for trends involving:

- particular techniques;
- classes;
- venues;
- instructors;
- equipment;
- age groups;
- contact levels;
- heat;
- slips and falls;
- head impacts;
- and missing protective equipment.

Patterns should be addressed even where each individual incident appears minor.

40.7 Observation and supervision

Class observations may consider:

- warm-up;
- progression;

- partner matching;
- contact control;
- mat spacing;
- equipment;
- hydration;
- instructor positioning;
- first aid readiness;
- and response to injury.

40.8 Policy compliance audit

Periodic audits may review:

- first aid qualifications;
- venue emergency plans;
- kit checks;
- medication;
- incident forms;
- parent notifications;
- RIDDOR decisions;
- risk-assessment updates;
- safeguarding referrals;
- and record security.

40.9 Policy deviations

Any planned departure from this policy must be:

- justified;
- risk assessed;
- authorised;

- recorded;
- and time limited where appropriate.

Convenience, cost or staff shortage alone does not justify removing essential emergency controls.

40.10 Review frequency

This policy will be reviewed:

- at least annually;
- following a serious injury or medical emergency;
- following an AED or CPR incident;
- after an identified RIDDOR event;
- following changes to first aid or resuscitation guidance;
- after significant changes to activities;
- when opening or changing venues;
- after insurer or emergency-service feedback;
- or whenever a weakness is identified.

Emergency Response Summary

In a medical emergency:

1. **Stop the activity.**
2. **Make the area safe.**
3. **Call the first aider.**
4. **Call 999 early where the situation may be serious.**
5. **Retrieve the first aid kit and AED.**
6. **Follow current training and emergency-service instructions.**
7. **Protect the casualty's dignity and safeguarding.**
8. **Supervise the remaining students.**
9. **Contact the parent, carer or emergency contact.**

10. **Support ambulance or medical handover.**
11. **Complete the incident report.**
12. **Consider safeguarding, RIDDOR and insurance.**
13. **Review the risk assessment and lessons learned.**

Policy Approval

Policy title: First Aid & Emergency Procedures Policy
Organisation: Koku-Ryu Martial Arts
Version: 2.0
Policy owner: CEO and Chief Instructor
Operational responsibility: Health and Safety Lead
Safeguarding responsibility: Designated Safeguarding Lead
Designated Safeguarding Lead: Kayleigh Humphreys
Deputy Designated Safeguarding Lead: Andrew Banks
Approved by: Andrew Banks – CEO and Chief Instructor
Effective date: 14 July 2026
Next review date: 14 July 2027

Organisational Commitment

Koku-Ryu Martial Arts recognises that prompt and effective emergency action can:

- preserve life;
- prevent deterioration;
- reduce long-term harm;
- protect dignity;
- and provide confidence to students, families and staff.

Every instructor and staff member must understand that:

- safety comes before training;
- uncertainty is a reason to seek help;
- a child must never be pressured to continue;
- safeguarding remains active during treatment;
- and every significant incident provides an opportunity to improve.

Stop. Make safe. Get help. Give appropriate first aid. Protect the person. Record and learn.