CLASSIC PAPER

The Battle for Goose Green - The RMO's view

Commentary
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Introduction

Next year sees the twentieth anniversary of the Falklands Islands War of 1982, Captain Steve Hughes's paper was one of many written in the aftermath of the campaign but none match it for its clear and harrowing description of medical support for an infantry unit engaged in close quarter battle. It remains an important record for it highlights the essential difficulties and dangers faced by front line medical personnel during conventional war. The story told in this paper is also a reminder of the threat to life and limb faced by medical personnel throughout the many wars fought during the twentieth century. It is all the more important as most of the medical veterans of the Falklands campaign have retired or left the Defence Medical Service (DMS) and with their departure has gone what Professor Howard Champion in Washington refers to as *Institutional Memory* of medical support in combat. (1)

In face of such loss of collective memory this paper by Steve Hughes should serve as a reality check and a jolt to the memory.

The RMO in the Twenty First Century

The Regimental Medical Officer (RMO) of the future may doubt the value of this paper. We live in a changed world with a diminishing risk of global conflict and a rapid increase in deployments as peacekeepers, peace makers, and as humanitarian aid workers in uniform. Yet we should be careful. Morgan-Jones in a previous commentary on a classic paper (2) reminds us of a noticeable shift back to expeditionary war. Recent operations in the Gulf and Kosovo are evidence of this and, in an increasingly unstable world, more will follow. The RMO and regimental medical personnel need to be reminded that the need for provision of close support to fighting infantry is a task that has not passed into history and may arise at very short notice. What then should be gleaned from this paper that might benefit our current group of RMOs and their medical colleagues?

Training

The German military strategist, von Clausewitz, described the battlefield as the

realm of danger with its four elements: danger, exertion (exhaustion), uncertainty and chance (1). RMOs and their teams are not exempted - the closer the provision of support, the greater the influence of these elements. The opening paragraphs of Hughes's paper provide vivid illustration. These elements cannot be removed - they are an inherent part of war. Their effects can be minimised and this is largely achieved by training. But how many RMOs are now posted exclusively in support of an infantry battalion, armoured regiment or battle group? It seems increasingly likely that medical support personnel in the future will be trawled from a variety of units and teams may not know each other, or have trained together, apart from a brief period of pre-deployment training. Again turning to the paper; not only were the medical teams a vital part of the battlegroup, they were seamlessly integrated and manoeuvred skillfully among the fighting paratroopers on the forward edge of the battlefield. This was not a chance performance by a group of gifted amateurs - the RMO and his team were fully trained parachute brigade soldiers who had passed the same selection process as all other arms in the unit.

In summarising this section, Hughes's paper brutally brings home the need for comprehensive and continuing training. It may be left to the reader's imagination to picture what would have ensued had an untrained RMO been deployed with 2 Para's battlegroup in 1982.

Provision of medical care

This author recalls hearing a former Prime Minister state in the House that "in future service personnel injured on operations could expect as good as, if not better care than, provided by the National Health Service (NHS)". The paper under review provides a much needed reality check. The text and figures clearly illustrate the limits of care under fire and tactical care immediately behind the firing line. The Regimental Aid Posts were in the open, forward and frequently under fire. Despite the hostile environment, much was achieved and this is well recorded. All wounded had wounds dressed, IV access achieved, fluids administered and analgesics given. Casualties were then prepared for evacuation by air on an opportunist basis.

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21st Century technology

In a climate of increasing technological support in trauma care, it is tempting to shoe horn civilian solutions into military problems. Civilian solutions often work well on other operations, UN operations for example, and it is easy to envisage a growing reliance on advanced technology, and to expect such support under all circumstances. Even if such devices as hand held ultrasound, syringe pump drivers, oxygen generators and monitoring devices were available in 1982, it is doubtful if Hughes and his team would have been able to use them. It should be noted that Hughes's medics were carrying in excess of 80lbs of medical kit. Even if such new toys had been brought forward by other means, there would have been little scope for using them in the middle of a mobile battle with care provided out in the open amid burning gorse. Again, a reality check is indicated.

Mental health

One of the most harrowing aspects described in the paper was the loss of friends and comrades. Hughes and his medics were part of the regimental family and would have known most, if not all of the members of 2 Para. The death of so many must have been devastating, worse when many of the dead were close friends. Mental health considerations and training to cope with bereavement are important, if often neglected, elements of RMO education. There are two lines in Hughes's paper, which particularly illustrate the suffering he and his medics endured - "*The day had been long and hard, tragic and frightening. The night was bitterly cold, and none of us has sleeping bags.*" To endure such austerity demands a robustness of mind and body.

Risk aversion

Risk aversion is a term increasingly encountered. It implies a society averse to danger or hardship. In the developed world it has endangered a fear among politicians and sociologists of battlefield death and injury and a view that soldiers in body bags are no longer to be tolerated. There is also a politically correct slant to all of this, which is affecting the Defence Services. It is an attempt by politicians, analysts and lobbyists to impose such thinking on defence training under the guise of prevention of discrimination and guaranteeing human rights. While laudable, the consequences of such pressures on defence training could be considerable. Would the training and selection process undergone by Hughes and his medics be permitted in a politically motivated risk aversion environment? How would it be possible to realistically train for an event such as the Battle for Goose Green? The effects on purely military training would have even greater consequences. This section

may appear far-fetched to some readers - it is not. Real forces are at work to create a military environment incompatible with effective training and preparation.

Planning for the Future

The paper clearly summarises the role of the RMO and supporting medics. It is to know the unit intimately, to train and deploy with it, to access unit casualties, to provide life saving medical skills, to hold and then evacuate those casualties in a safe and timely manner. What does the future hold? In a climate of defence cost studies and swinging cuts in spending it is easy to imagine a commanding officer of a deploying front line unit meeting his unit doctor for the first time on the steps of an aircraft or gangplank of a ship. This has already happened on UN and humanitarian deployments. To allow it to occur on a war fighting deployment risks tragedy. It is with a battalion or regiment that the young military doctor learns the nuts and bolts of military life. It is here too where values such as loyalty, Esprit de Corps and comradeship are instilled. Hughes and his medics displayed these values 'in spades' during the battle for Goose Green and the many other operations that followed.

In an ideal world all new entry medical officers would have the experience of a two year deployment at the exclusive service of a commanding officer and his regiment or battalion. In this author's view the ideal model is that which used to exist within Airborne Forces - an uninterrupted tour with a unit for a two or three year period, free of family practice and other commitments. In a climate of clinical governance and pressure to complete professional training it is hard to imagine this being possible in the 21st century.

Conclusion

The Hughes paper illustrates the need for, and the role of the Regimental Medical Officer and supporting medics. The paper should be compulsory reading for all new entrant officers, including Medical Support Officers. It provides a robust defence of the RMO system and should be widely disseminated throughout the Army in general.

Planners must recognise that the RMO and his like cannot be bought off the shelf. The current cadre of RMOs must not allow themselves to be pushed easily into the fog of history.

References

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The Battle for Goose Green - The RMO's View

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Summary

By virtue of the Battalion I serve with, I was the first Task Force Doctor on to the Falklands. On Friday the 21st May, 2 Para made an assault beach landing, thankfully unopposed, on San Carlos beach; the RAP was with them.

Introduction

2 Para occupied the Sussex Mountains for six days and on Wednesday 26 May, moved off at last light to Camilla Creek House, 5 miles from Darwin. The Battalion laid up in the area of Camilla Creek during 27 May and early the next morning moved out to create history...

Goose Green-Friday 28th May, 1982

We set off from Camilla Creek House at about 2 a.m. tired before we started after the previous night's TAB* on our backs and the RAP (Regimental Aid Post) Medics were all carrying in excess of 80lbs of medical kit and the uneven ground ensured that we all fell regularly.

We laid up near the mortar line just north of the Darwin Peninsula whilst A and B companies put in their first attacks. There was a steady drizzle, and those of us who had worn our waterproofs were glad of them - some of us even dozed.

About 2 hours after the initial H hour, Battalion Main HQ, (including the RAP), moved off and down the narrow track onto the Peninsula itself. To our left, a large area of gorse had been ignited by white phosphorus grenades and the flames lit up the night sky. The crackle of burning gorse could be heard above the reassuring crump of the naval gunfire support.

We had just come level with the cache of Argentinian prisoners, on the edge of the track, when the first salvo of the Argentinian guns bracketed the track.

We heard the distant crump and the incoming whistle and barely hit the ground before the first rounds of "HE" hit the peat on either side of the track. We wormed our bodies in, face down to the banks on either side of the track, so that our Bergens gave our backs some protection. The reality of war began to sink in.

Again we were bracketed, but miraculously nothing landed on the track, and the soft, wet peat, off the track, kept the shrapnel to a minimum. We had no casualties.

A tracer round cracked 6 ins over my head from somewhere off to the right - a stray round. I buried my head further into the earth.

The first two attacks had had no casualties, but now D Coy came up against stiffer opposition and Chris Keeble, the Bn2IC, asked me to move forward up the track to deal with the first casualties. His parting words, as I led the RAP of were, "Watch out for the sniper on the right flank."

I then realised where that not so stray round had come from, and was convinced that the collar of my waterproof jacket would make me a perfect target. It may well have but nothing happened.

We ran low and fast for about 400 metres, until we came across two D Coy wounded, both minor gunshot wounds. It was about 6 a.m. still, with a further 4 hours of darkness - so after finishing our treatment regime, all we could do was reassure them and keep them warm and sheltered from the rain until dawn, when the first choppers would fly.

The CO, 'H' appeared, with his TAC HQ and came in to find out how the casualties were - "Alright Sir, we'll try to get them back to Camilla Creek in the captured Landrover." He and the adjutant, one of my close friends, David Wood, were joking about a shell that had landed between them, yet had left them both unscathed "These Argies have got some shit ammunition." It was to be the last time I would see either of them alive again.

TAC 1 disappeared and Battalion Main moved in around us. Time drifted by and the shelling periodically came our way. As the sky started to brighten we lost the benefit of the naval gun support and as dawn came we found ourselves in a natural bowl of land to the north of Coronation Point.

One or two more casualties were brought in together with our first dead. Two of my Medics had lost friends and I had lost some of my own patients - we were all affected. We improvised shelter for the wounded using a captured Argie tent until at first light helicopters came in bringing ammunition resupply. We got the casualties in the Choppers and I went back to my routine listening in to the Battalion Command net -

*Editor's Note. TAB is the Parachute Regiment's version of "Yomping" but faster.

Reading the Battle.

There was a big battle raging ahead of us, and nothing seemed to be moving. We all began to dig in to the peat because the shelling was now more constant, our own guns becoming less vociferous.

Shortly after 1300, I heard the message over the net "Sunray has been hit." The Battalion called for a helicopter to pick him up and it became more obvious that there were other casualties in trouble. I rounded up my medics and split them up into two teams - one under my command and the other under Capt Rory Wagon, the Doctor who had been attached to us from the Ajax Bay Field Hospital (Table 1).

Table 1.
2 Para Regimental Aid Post (2 & 9)

Team A	Team B
RMO (Doctor)	Attached Doctor
Radio Op	Radio Op
L/Cpl - RMA	Cpl - RMA
Pte - RMA (3)	Pte - RMA (2)

Padre and his bodyguard moved with Team A. RAP Deployment possibilities - 1. A & B Co-Located. 2. A & B Deployed independently. 3. A & B "Leapfrog" - One moves, other deals with casualties.

Both forward companies had casualties in locations 1½ km apart. Rory's team went out to the right flank and I moved my lads out to the left, to the hills around Darwin. As we moved forward we had to dive for cover as two Pucara aircraft appeared ahead. They roared over us and I turned in time to see them spot two scout helicopters emerge from the direction of Camilla Creek House. The Pucara swooped, like hawks, and the choppers took desperate evasive action. One chopper disappeared up in the valley whence it had come and managed to escape. The other chopper exploded in a ball of flame. The Pucara disappeared.

We found 'A' Company on a hill 1km to the west of Darwin, their casualties collected together at the base of the hill, amongst them the Company Medic. Again the shock of dealing with the people you knew in a far from clinical environment - but we steeled ourselves and went to work.

We dealt with the casualties and I'd once more called for helicopters. Ahead of us the battle carried on. There was no sign of "H" so I asked the Sgt Major. 'H is dead, Sir and Captain Wood, and Captain Dent' - the CO and two good friends all at once; - but there was nothing else but to continue the job.

The casualties had all had their wounds dressed and drips set up. We'd given them pain killers and filled them full of antibiotics. We tried to keep them dry and warm and kept up a steady banter to reassure them, especially a lad with a head injury, who I didn't want to go into a coma.

By now we were beginning to run low on medical supplies - there's a limit to how

much you can manpack. At least no more casualties had come in, although there were some wounded amongst the Argie prisoners for whom we did what we could.

Then over the hill came, what for me will always be the seventh Cavalry - 4 scout helicopters, fitted with Casevac Pods and bringing our medical resupply. We got all the wounded away and even some of the more seriously wounded Argie prisoners. Then the shelling started again and we moved up the hill slightly, into a gulley which gave natural cover against low trajectory artillery fire (Figs 1 & 2). It was here that I spent the rest of the day. The helicopters coming in under cover of the hill.

We continued to treat casualties, our own, and in quiet phases Argentinians, with the smoke of the battle field and the burning gorse at times almost fogging us out. Fatigue was setting in and we all wondered how much longer we could go on. For most of the afternoon the battle had seemed to be going against us, but as dark set in, it swung back in our favour and as darkness fell the artillery fell silent and gunfire became sporadic. We were all still holding three battle sick - twists and sprains - and though we tried for a helicopter we knew they would keep, if it didn't arrive.

Fig 1. Team A in the Gulley West of Darwin.

Fig 2. The Gulley from Darwin Hill.

We were all expecting the battle to start afresh the next day, so we set up a stag system to look after the casualties and laid down in the gorse to sleep, after I'd first sat down with the RSM and the Padre to work out who our dead were.

The day had been long and hard, tragic and frightening. The night was bitterly cold, and we none of us had sleeping bags. Some people lay down actually in burning gorse in

an effort to keep warm. I lay down in a large clump of non-burning gorse and thanked my lucky stars for the space blanket I'd bought in the UK and shoved in the back of my smock! I managed to wrap my body in this totally non-tactical piece of foil. The silvered surface caught a flicker of gorse flames and I crinkled like a Sunday roast, but it made the temperature bearable.

Although I was exhausted I wondered whether I would sleep after the horrors of the day and as I lay in a twilight state every rustle of my foil blanket was a machine gun and every crackle of gorse was an artillery shell. I was aware of the tricks my mind was playing on me - and wondered if I was cracking up.

I slept.
I awoke in the half light of mid-morning and couldn't feel my feet. Then I could and they were painful. Around me the RAP was stirring.

Chris Keeble happened by and told the Padre and I of his plan. He would give them the opportunity of an honourable surrender.

There followed a void; a lack of hostilities. Whilst the Battalion took the time to fly in ammunition, we took the time to fly out our casualties and do what we could for the remaining injured amongst the prisoners.

It was as we were treating the prisoners that we heard news of the surrender. The battle was over. Although our work was not quite finished yet, at least it would not get any worse.
All told we treated 33 of our own (Table 11) and over twice that number of Argentinians.

Table 11.
The Battle for Darwin and Goose Green - Casualties

	Wounded	Killed in Action	All wounds fatal and non-fatal
Gunshot wounds	*16	12	28 (56%)
Shrapnel/Fragments	*17	4	21 (42%)
Shot down - Helicopter pilot (Massive injuries)		1	1
Totals	33 (66%)	17 (34%)	50

*There were no burns, psychiatric or mine injuries. One case of a fatality caused by close proximity explosion of a 30mm anti-aircraft shell has been included as a fragment wound.
* All survived*

Fig 3. Team A after battle (excluding Padre Cooper).