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Policy

Casualty Evacuation in the Field

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POLICY ON CASUALTY EVACUATION IN THE FIELD

A. PURPOSE

1. The purpose of this document is to provide policy direction on the management of casualty evacuation (CASEVAC) across United Nations (UN) field missions. The policy adopts a patient centred approach where timeliness and speed of evacuation are paramount.

B. SCOPE

2. This Policy applies to all UN field missions administered by the Department of Peace Operations, Department of Peacebuilding and Political Affairs and Department of Operational Support. It does not address resourcing implications and defers to Mission leadership to prioritise resources to meet CASEVAC tasks. Medical evacuation (MEDEVAC)[1] operations and the transportation of human remains are not within the scope of this policy.

C. RATIONALE

3. UN field and special political missions are typically conducted in a high threat and austere operating environment. This drives the requirement for the UN to provide capabilities for the evacuation and treatment that recognises there is direct correlation between timely evacuation and survival in those suffering traumatic injury and acute life-threatening medical conditions. Efficient evacuation requires the orchestration of a range of organisations and assets. This Policy articulates the tangible actions required for timely evacuation of UN personnel from the point of injury/illness (POI) to an appropriate medical treatment facility (MTF)[2].

D. POLICY

D.1. DEFINITION OF CASEVAC AND GUIDING PRINCIPLES

4. CASEVAC is defined as the evacuation of a casualty[3] from the POI to the closest appropriate MTF, utilising the most effective means of transportation. [4] It is a continuum of care that supports a resuscitative process from the POI, through evacuation, into surgery and on to intensive care where this is required.

5. Responsibility for the Mission's casualty evacuation system rests with the Head of Mission (HoM), though normally managed by the Director or Chief of Mission Support (DMS/CMS) and Chief Medical Officer (CMO) or other officials delegated to fulfil this task. The CASEVAC system must be simple in structure, lean in management and easily understood by those who use it.

[1] Medical evacuation (MEDEVAC) is the process of evacuation from one medical facility to another. Once a casualty has been admitted to a medical facility, all onward movement for medical purposes is considered to be MEDEVAC.
[2] MTFs are UN Level 1, 1+, 2 and 3 medical facilities. Surgical intervention is available at all levels from Level 2 and may be available in some Level 1+ facilities.
[3] Casualty here is used to mean those suffering a trauma injury and those with sudden onset, acute life-threatening conditions requiring immediate expert medical intervention.
[4] In extremis, this may mean exploiting any means of transport available.

6. CASEVAC takes priority over all other Mission activities except actions to counter immediate threats to UN personnel. CASEVAC operations will be further prioritised taking into consideration the category and number of patients.

7. In the case of penetrating trauma, there is no inflection point in time after injury at which death or residual disability rates rise sharply, rather there is a progressive, largely linear, increase. Consequently, delay in treatment leads to an increased rate of death and disability. For operational health planning purposes, guidelines have emerged that seek to trade-off clinical need against operational risk. The metric adopted in the UN system is the "10-1-2" guideline[5]; this requires:

10	Immediate life saving measures are applied by personnel trained in first aid. Bleeding and airway control for the most severely injured casualties is to be achieved ***within 10*** **minutes** and a casualty alert message transmitted.
1	Advanced resuscitation / treatment is commenced by emergency medical personnel ***within 1 hour*** of injury / illness onset.
2	Where required damage control surgery (DCS) is commenced as soon as practicable, ***but no later than 2 hours*** after injury / illness onset[6].

8. To meet this demanding timeframe a philosophy of *'ownership at the highest level and execution at the lowest level'* will be adopted (see para 17). While the ownership of the CASEVAC system is invested in senior mission leadership, authority to launch CASEVAC operations is devolved to the lowest practical level[7] without *the need to seek permission from* the 'ownership level'.

D.2. IMPLICATIONS OF 10-1-2 WITHIN UN MISSION CONTEXT

9. **Resources.** Adherence to the 10-1-2 guideline should be given equal weight to that of other mission essential planning factors when establishing the mission medical system structure. It demands that a matrix of ground and aerial evacuation platforms is provided and that there are enough MTFs able to provide resuscitative surgery. This may be a mix of Contingent, UN owned, contracted and host nation capabilities. In peacekeeping missions, all available assets will be referenced in the Mission Health Support Plan (HSP) as should associated assets, such as attack helicopters, needed to support CASEVAC operations. Responsibility for the Mission's health system ultimately rests with the Head of Mission (HoM), though managed by the Director or Chief of Mission Support (DMS/CMS) and Chief Medical Officer (CMO) or other official delegated to fulfil this task.

10. **Risk management.** If adherence to the 10-1-2 guideline is not achievable, the HoM must decide whether or not the risks are acceptable within the provisions of the mission mandate. This decision should be based on a comprehensive risk assessment including advice from the CMO and articulated in the Mission HSP. Formal risk acceptance should also be notified to the Medical Director at UNHQ for information.[8]

11. The CMO must ensure that the mission leadership has a clear understanding of the medical risks for which they are responsible. If the HoM decides to accept risks related to a

[5] The 10-1-2 guideline was developed in relation to the type of penetrating trauma typically seen on the battlefield. As UN personnel are exposed to these types of injury, this guideline informs the structure of UN CASEVAC systems. See Reference A.
[6] The 10-1-2 guideline cumulative; the total time lapse between injury/onset and surgery should be under two hours (120 minutes).
[7] The lowest possible level will be the Designated Operations Centre or Centers where CASEVAC responsibilities can be devolved, including to the sector level as required.
[8] Collection of epidemiological data across missions and over time against specific risk profiles allows the UN to better understand the risks being accepted and provides the basis for informed decision making int the future.

foreseeable inability to implement elements of the 10-1-2 guideline, this should be formally detailed in the Mission Plan, risk register or Health Support Plan (or other appropriate document) and every reasonable effort should be made to mitigate the risk. The decision to accept risks of non-implementation should be regularly reviewed by the mission leadership; and, if or when circumstances allow, or the risk profile changes to a level unacceptable to the HoM, the deviation from the timelines should be rectified, or operations modified so that risk exposure is reduced to an acceptable level.

12. **First Aid**. Actions taken in the first minutes after injury are among the most important in determining survival. Consequently, all military and police personnel deployed in any UN Mission should be trained and certified in basic trauma First Aid to the UN directed standard and supplied with trauma focussed equipment to facilitate 'Self' and 'Buddy First Aid'[9]. Additionally, in locations where the Security Risk Management process has identified the need for a First Responder Programme, the Head of Mission, in their function as the Designated Official (DO), will appoint the United Nations Security Management (UNSMS) First Responders from among civilian personnel (please refer to Security Policy Manual Chapter IV Section A on Security Risk Management and Security Management Operations Manual Chapter III on Guidelines on First Responder Programme).[10] Equipment and training must emphasise the control of catastrophic bleeding and securing a patent airway.

13. **First Responders and extended field care**. First Responders are individual non-medical personnel trained in advanced First Aid who are able to treat a casualty at the POI for an extended period before emergency medicine trained personnel arrive.[11] Within the UN, First Responders are referred to as Field Medic Assistants (FMA). They must be trained to manage a casualty for an extended period until emergency care personnel arrive. Consequently, their skills extend beyond the initial care of the first 10 minutes and sometimes beyond the first hour of the 10-1-2 metric. First Responders must be equipped appropriately to fulfil this role[12].

14. **Emergency care personnel.** Emergency care personnel are normally members of the health services/medical branch of the of the Troop/Police Contributing Country (TCC/PCC) or civilian UN or contracted staff employed to fulfil this role. This includes ambulance crew, field/combat medical technicians, paramedics, nurses and doctors trained in pre-hospital trauma care.

15. **En-route care.** Evacuation must be effected by a team able to deliver advanced emergency medical care en-route, irrespective of the platform used. In the case of Aeromedical Evacuation Teams (AMET), the team will be led by a doctor trained in pre-hospital emergency care.[13]

16. **Initial surgery.** The initial surgical intervention is conducted within the philosophy of Damage Control Surgery (DCS) with rapid onward medical evacuation (MEDEVAC) for definitive care if required.

[9] This must meet the standard of the UN Buddy First Aid Course (UNBFAC) as a minimum.

[10] These First Responders includes those civilian personnel who successfully complete the Emergency Trauma Bag First Responder Course (ETB FRC) and/or the Individual First Aid Kit (IFAK) course.

[11] First responders must be able to deal with those factors resulting in most trauma deaths, the so called 'lethal triad'.

[12] Minimum first aid equipment requirements have been included in Reference B. The equipment provided is more comprehensive than that of the IFAK and is designed for team use.

[13] The standard UN staffing requirement for an AMET provides for two sub-teams each consisting of one doctor and two nurses or paramedics – total six personnel – trained in emergency care and aeromedical evacuation. In the absence of internationally agreed standards of training for certain medical specialisations - notably Emergency Medicine - the required clinical skill set, and necessary credentialing documentation required to support these, are defined by the Medical Director UNHQ. All personnel filling these positions will be subject to a formal UNHQ led credentialing process. Minimum equipment requirements for an AMET are articulated in Reference B, Chapter 3, Annex C, Appendix 8.

17. **Command and control philosophy.** While the ownership of the CASEVAC system is invested in a senior Mission leader – normally the DMS/CMS – authority to launch CASEVAC operations will be devolved to the lowest practical level without *the need to seek permission from* the 'ownership level'. Timely evacuation requires high levels of trust between the senior leader and those subordinates given delegated authority to execute CASEVAC operations. In most missions, launch authority will be delegated to a headquarters staff with situational awareness of the security, air and medical asset situation across the whole mission area. In larger missions, where Field Offices, Sector Headquarters are established at the sub-national level (Heads of Office, Police, Military Sectors), authority for CASEVAC operations may be decentralised and delegated to these headquarters where appropriate. This will require staff in those headquarters to undertake Duty Officer functions as articulated below in the Process section. The Mission Operational and Health Support Plans must articulate where delegated authorities within the CASEVAC system rest.

Temporary allocation of resources and Operational Control (OPCON). Health support is a key component of operational planning. The availability of CASEVAC capabilities must be taken into account in operational planning on all levels. Risks to timely evacuation, such as adverse weather conditions or technical impediments, must be reflected in mission planning and execution and may constrain operational activity. Risk mitigation may involve the temporary relocation of treatment and evacuation assets. During the conduct high-risk operations, it may be necessary for a specified time period – typically for the duration of the high-risk operation – to allocate resources, particularly helicopters with an Aero-Medical Evacuation Team (AMET), exclusively to support these operations. This would include the temporary operational control of these assets in response to a CASEVAC as necessary. This allocation is approved by the HoM. Command and Control (C2) arrangements must be aligned to the DPO-DOS Policy on Authority, Command and Control (Reference C).

18. **Special Political Missions (SPM)**. In SPMs where a designated operations centre which could coordinate CASEVAC support does not exist, the HoM will need to establish a system for the management of wounded, injured or ill individuals tailored to the needs of the mission. The system should seek to comply with the 10-1-2 guideline and align with the processes articulated in this policy using a combination of UN and other assets available in the mission area. Once established, the system should be tested on a periodic basis as for other missions. The HOM is to appoint an individual responsible for the CASEVAC system and this should be articulated in the Mission Operational and Health Support Plans.

D.3. PROCESS (See Schematic at Annex A)

19. **Alert message**: As soon as possible after injury an alert message must be transmitted to a Mission Designated Operations Centre (DOC)[14] to initiate a CASEVAC response. The alert message format will be defined in the mission CASEVAC SOP but mandatorily comprises of these minimum four separate pieces of information:

- Location of event, including grid reference and callsign.
- Nature of incident (IED strike, motor vehicle accident etc).
- Actions currently being taken at the scene (treatment and security).
- Number of casualties and special resources required due to the patients' conditions.[15]

20. Verbal transmission of this information should be direct from the incident site to the DOC where the Mission communications architecture facilitates this. Where this is not

[14] The Mission Health Support Plan and CASEVAC SOP should clearly articulate a single designated operations centre (this may be the JOC, MOC, TOC, MAOC, POC, MSC etc) responsible for CASEVAC operations, this may be at 'Mission' level or where appropriate delegated to Sector level as per paragraph 16. The Head of Mission is to designate which HQ will own the Designated Operations Centre responsibility.

[15] An example alert message format - "the '9 liner" - appears in the SOP template at Annex B.

achievable, as few intermediate nodes as possible should be involved in the passage of this information. Intermediate HQs between the incident site and the DOC – such as Battalion, Sector and UNPOL HQs – will be bypassed during the initial alert message where the communications architecture permits, although these HQs must be informed as soon as reasonably practical. Receipt of the alert message by the DOC *MUST* trigger a speedy CASEVAC response.

21. **Warning Order (WngO).** On receipt of Alert Message, the DOC Duty Operations Officer (D/OpsO) issues an immediate WngO to those assets most likely to be used for the evacuation, typically a helicopter unit, Aeromedical Evacuation Team (AMET) and a receiving MTF; typically, a Level 2 facility. Where there may be several alternative assets that could be used to fulfil a task, a WngO should be communicated to all pending final determination as to the precise assets required. The WngO should include all information from the Alert Message. Where not co-located, AMETs that have received a WngO must move immediately to the location of their designated evacuation platform.

22. **Launch consult.** Immediately after, or simultaneously with the issuing of the WngO, the D/OpsO will consult with the Duty Air Operations Officer (D/Air OpsO)[16] and Duty Evacuation Medical Officer (D/EvacMO) to confirm the requirement for the CASEVAC launch, clarify the aviation and general security situation (a formal Emergency Ground Risk Assessment – EGRA – may be required in some high risk missions[17]) and confirm a receiving MTF.[18] Once these three authorities have confirmed the need for CASEVAC launch, the D/OpsO will transmit the launch authority to the aviation or ground evacuation asset and the associated AMET/evacuation team.[19] They will also inform the receiving MTF and provide an estimated time of arrival (ETA) and estimated number of casualties. If for any reason the D/OpsO and D/Air OpsO cannot rapidly obtain medical advice, they have authority to launch a CASEVAC without reference to the D/EvacMO. The D/OpsO may also authorise the use of ground evacuation assets without reference to the D/Air OpsO when air evacuation is not required. Where air evacuation is to be used, the D/Air OpsO must confirm the launch in order to comply with aviation safety requirements.[20] The D/OpsO is responsible for all aspects of coordinating the CASEVAC process from receipt of the alert message to the arrival of the last patient at an MTF.

23. **Coordinating information.** The D/OpsO is to ensure that coordinating information is known to those at the incident site, Air Ops and the evacuation asset/AMET (air or ground), this information is required before they issue the launch authority. This includes:

- Grid reference of incident.
- Grid reference of helicopter Landing Site (HLS)/pick-up point if different from incident.
- Call signs of evacuation asset and incident site commander.
- Main and any alternate radio frequencies.
- Number of casualties expected to be moved.
- Name and location of receiving Medical Treatment Facility (MTF).
- EGRA information (if required).

24. **Casualty situation report (CASSITREP).** The purpose of a casualty situation report is to inform the D/EvacMO of the status of the casualty. This is usually compiled by first responders who must be trained and equipped to provide the information required. This

[16] Typically located in the Mission Air Operations Centre (MAOC). See Reference D.

[17] An example EGRA format appears in the SOP template at Annex B.

[18] There may be more than one MTF where there are multiple casualties.

[19] The D/OpsO may delegate the task of transmitting the launch authority to the relevant aviation unit and MTF to the D/AirOpsO and D/EvacMO respectively ***where doing so will speed the process.***

[20] The Mission CASEVAC SOP must state who (by appointment) the D/OpsO is to contact if there is disagreement on the launch decision between the D/OpsO and D/Air OpsO for a final decision on launch.

report should be updated and transmitted at regular intervals to the D/EvacMO at the DOC where the communications architecture permits. The D/EvacMO is to transmit all relevant clinical information to the receiving MTF(s) – and AMET teams en-route if possible – including the number of casualties they can expect to receive and estimated time of arrival. A CASSITREP *is not* required to make a launch decision and receipt of this information must not delay this decision.[21]

25. **First Medical Report (FMR):** The FMR is provided by the MTF(s) receiving casualties and transmitted directly to the D/EvacMO within one hour of a casualty's arrival. This report informs the mission leadership of the status of the casualty and forms the basis for a decision on possible further medical evacuation (MEDEVAC).[22]

26. **'Need to know'**. During the launch approval process, there is no need to routinely consult or inform individuals outside the DOC however this must be done by the D/OpsO, or their staff, as soon as reasonably practical after all other higher priority coordinating actions are complete. This information can, in most cases, be transmitted by email during the normal working day, although may require telephone communication out of routine working hours. Those not directly involved in the decision making and coordination of the CASEVAC must refrain from seeking information from the DOC staff until after casualties have arrived at the receiving MTFs, however, within the capacity of the DOC and the incident being managed, the D/OpsO through should keep key external stake holders informed.

27. **After Action Review (AAR)**. Within 72 hours of a CASEVAC event, the CMO is to conduct a formal AAR to confirm the CASEVAC processes and identify lessons learned and make recommendations for improvement to the system. This is to be submitted to the CMS/DMS or individual appointed by the HOM for the overall quality management of the CASEVAC system.

D.4. PATIENT CATEGORIES AND EVACUATION PRIORITIES

D.4.1 Patient categories

28. For the purposes of this policy, patients are triaged and categories in relation to the priority of medical attention and evacuation are as follows:[23]

- **Category Alpha (Critical)**. Life is immediately threatened. Rapid evacuation, urgent resuscitation and/or surgery are required to save life, limb or sight. In the absence of immediate and appropriate medical and/or surgical procedure, there will be a significant chance of mortality or significantly increased morbidity.
- **Category Bravo (Urgent)**. Life, limb or eye is in serious jeopardy. Evacuation should be conducted as soon as possible. This category remains a priority for stabilisation, treatment at point of injury and evacuation except that predicted deterioration or a negative outcome is unlikely within six hours.
- **Category Charlie (Delayed or Hold)**. Life, limb or eye is not in serious jeopardy. Evacuation should be affected as soon as a suitable transport mode is available. This category remains a priority for medical attention. The mechanism and localisation of injury/illness do not predict a negative outcome in the next 24 hours.
- **Category Delta (Expectant).** Casualties who have injuries inconsistent with survival. They will be evacuated after other Category Bravo patients.

29. Triage of patients into these categories is dynamic and may be changed as they are reassessed while awaiting evacuation or when assessed by a more senior clinician during any stage of the evacuation. For example, an AMET doctor arriving at the scene of a mass

[21] An example CASSITREP message format appears in the SOP template at Annex B.

[22] An example FMR format appears in the SOP template at Annex B.

[23] Categorisation of casualties is conducted on site by the individual with the highest level of clinical training.

casualty event where there is no doctor, may re-triage casualties if the number exceed the capacity of the aircraft to ensure the most ill/injured are moved first.

D.4.2 Evacuation priorities

30. **General principles**. CASEVAC takes priority over all other Mission activities except actions to counter immediate threats to UN personnel. CASEVAC operations will be prioritised taking into consideration the category and number of patients.

31. **Mass casualty incident**. A mass casualty incident (MCI) occurs when the number of live patients is greater than the resources available to evacuate or treat them in a timely manner and where delay is likely to result in otherwise preventable death. A MCI is usually declared 'bottom up', from each level of command or medical facility. A MCI may have a significant impact on current operations and therefore needs to be managed 'top down'. Where an MCI has been declared the CMO or their nominated delegate must be available in the DOC in order to advise on the regulation of casualties to appropriate MTFs and the use of clinical and evacuation resources. The principles of treatment may need to be changed from focusing on the individual patient needs to achieve the best outcome for the greatest number of casualties. A MCI may also be declared 'top down' by the D/OpsO on the advice of the D/EvacMO or CMO. Once a mass casualty incident has been declared, the following principles apply:

- Category Alpha patients have the highest priority. These patients shall be evacuated directly to the most appropriate medical treatment facility;
- Category Delta patients will be evacuated after Category Alpha and Bravo casualties;
- Category Charlie patients shall remain at the point of injury/illness until all category Alpha, Bravo and Delta patients are evacuated.
- Category Bravo and Charlie patients may first be evacuated to a Level I MTF for initial care in order to relieve pressure on Level 1+ (surgical), Level 2 and Level 3 facilities.
- Should there be remaining capacity in a CASEVAC asset arriving at the MCI, but not required for additional category Alpha patients, evacuation of category Bravo and Charlie patients should not be delayed.
- Personnel declared dead at the MCI site will be moved last using an appropriate method of transportation.

D.5. CASEVAC SERVICES FOR NON-MISSION INDIVIDUALS AND ENTITIES

D.5.1 CASEVAC for non-mission United Nations personnel

32. In mission areas where there is United Nations Country Team (UNCT), the United Nations Security Management System (UNSMS) develops Security Plans approved by the Designated Official in consultation with the Security Management Team, and in accordance with the relevant policies and guidelines of the UNSMS. The Security Plan(s) include a CASEVAC Plan as part of the medical plans. In mission settings, the Principal/Chief Security Adviser or the Chief Security Officer where relevant, supports the DO in including in the Security Plans, the CASEVAC plans, which have been developed and coordinated with the Senior Leaders responsible for the overall ownership/management of the CASEVAC system in the mission and UNSMS organizations. In this respect, they should all work together to ensure a cohesive response including in instances of incidents impacting both Mission and other UNSMS personnel.[24]

[24] UNSMS personnel are those personnel as defined by the UN-system wide policy on "Applicability of the United Nations Security Management System" (Security Policy Manuel Chapter III, Section A.)

D.5.2 CASEVAC for non-United Nations patients

33. Hostile combatants and civilians injured by UN forces during the conduct of UN operations must be treated and evacuated along with UN personnel in order of clinical priority.[25] Evacuation of non-UN civilians will normally be to non-UN facilities and may be achieved in cooperation with local health services where available. Individuals deemed to be hostile combatants are to be evacuated to either a UN facility or other facility directed by the HoM in the HSP.[26]

34. Non-UN patients who have been injured or become ill in circumstances that are not attributable to UN action may also be provided CASEVAC assistance. This may be initiated upon request from a third-party (non-UN) through the Office of the Head of Mission or other Office as directed by the Head of Mission and be authorized by the HoM or by an individual delegated by them to make this decision. When mission CASEVAC assets are used for non-UN entities, the HoM or delegate must ensure that reserve capacities are available for the CASEVAC of UN personnel and other personnel where directed in their mandate.

D.5.3 Non-United Nations medical treatment facilities

35. Patients may be evacuated to a local or a neighbouring country MTF to get proper and timely treatment should it be more feasible or if the situation requires. Missions are responsible for establishing arrangements for access to Non-United Nations medical treatment facilities as necessary. This may include inspection, certification, contracting and approvals (including flight approvals) for cross-border CASEVAC. Location and contact information of the local and neighbouring country medical facilities shall be included in the mission CASEVAC plan.

E. AUTHORITIES, ROLES AND RESPONSIBILITIES

E.1. United Nations Headquarters

E.1.1 Under-Secretary-General for Operational Support

36. The Under-Secretary-General for Operational Support is accountable to the Secretary-General to:

- Confirm that CASEVAC system specific to each United Nations field mission is established, appropriately resourced, supported and monitored throughout the mission lifecycle.
- Provide strategic guidance for budgeting, staffing and logistics resources to support the Mission CASEVAC systems.
- Ensure that United Nations health governance standards are established for CASEVAC systems and are monitored and enforced.

E.1.2 Under-Secretary-General for Peace Operations

37. The Under-Secretary-General for Peace Operations is accountable to the Secretary-General to:

[25] This is a requirement of the Laws of Armed Conflict. See: https://ihl-databases.icrc.org/applic/ihl/ihl.nsf/Comment.xsp?action=openDocument&documentId=CECD58D1E2A2AF30C1257F15

[26] It may be necessary to provide security during evacuation and in the facilities where hostile combatants are cared for. Where missions develop a formal EGRA process this issue must be included. Every effort must be made to ensure this decision does not cause any unnecessary delay in evacuation.

- Ensure that at the mission start-up phase, CASEVAC is included in the Mission Concept[27].
- Ensure that all peacekeepers comply with this and related UN Policies.
- Ensure the generation of relevant contingent resources for use in CASEVAC.

E.1.3 Under-Secretary-General for Peacebuilding and Political Affairs

38. The Under-Secretary-General for Peacebuilding and Political Affairs is accountable to the Secretary-General to:

- In coordination with relevant Departments at HQ, support the respective field based Special Political Missions in establishing CASEVAC arrangements.
- Ensure that at mission start-up phase, CASEVAC is included in the mission concept.

E.1.4 Under Secretary-General for Safety and Security

39. The Under-Secretary-General for Safety and Security is accountable to the Secretary-General to ensure implementation, compliance and support for security aspects of the activities of the UNSMS for the protection of United Nations Personnel, who are covered by the applicability of the United Nations Security Management System.

E.2. In the Field

E.2.1 Head of Mission

40. The HoM is accountable to the Secretary-General to:

- Ensure that an integrated CASEVAC system is in place and tested as soon as possible after the establishment of the mission area of responsibility.
- Ensure that the Mission has in place the administrative and logistical support to conduct CASEVAC operations and that all mission personnel are aware of their authorities, roles and responsibilities within the system through the conduct of regular exercises of the system.
- Designate a Senior Leader responsible for the overall ownership/management of the CASEVAC system.
- Direct a single Designated Operations Centre to lead in the coordination of CASEVAC operations at Mission level, and where appropriate sub-national/sector level.
- Conducts regular training exercises to test the CASEVAC system at intervals of not greater than four months. [28]
- Seek opportunities to rationalise CASEVAC resources in the Mission area with other UN, local, NGO and other recognised international entities present in the mission area.
- Work with Host Country governments to create an environment that enables the CASEVAC system and where possible conduct joint CASEVAC exercises.
- Ensure that where the Mission CASEVAC system is to be extended to other UN entities, other governmental and non-governmental organizations, members of diplomatic corps, or to nationals and other non-entitled personnel on humanitarian grounds, the terms and conditions under which the support is to be provided are clearly

[27] It should also be included in the Mission Support Concept and Mission Plan.

[28] Four monthly exercises must be regarded as the absolute minimum for the conduct of such exercises, the ideal interval is two monthly and should wherever possible be aligned with major troop rotations to ensure newly arrived units are familiar with the processes involved.

spelt out including the administrative, financial and logistics parameters in a separate agreement.[29]

- For the protection of United Nations Personnel as defined by the Organization's system-wide policy on "Applicability of United Nations Security Management System" (see Reference E), the HoM, in their function as the Designated Official (DO), is accountable to the Secretary-General through the USG for Department of Safety and Security (DSS) for the implementation of UNSMS policies and guidelines including those related to security risk management.
- The responsibility and authority for the implementation of this Policy, rests with the HoM who can delegate in writing to any senior mission official ownership and management (command and control) responsibility for the Mission CASEVAC system, although this would normally be the DMS/CMS.[30]

E.2.2 Head of Military and Police Components

41. The Head of Military and Police components are accountable to HoM for:

- Issuing and implementation of instructions to ensure that the military and police components comply with this Policy and the associated mission framework.
- Ensuring that operational planning includes a risk assessment / casualty estimate that articulates the need for CASEVAC resources.
- Contribute information, control ground evacuation routes, securing landing zones and provide protection to ground and air evacuation teams as required.
- Ensuring that the conduct of casualty evacuation is described or referenced[31] in all operational orders for all military and police activities conducted within their area of responsibility.
- Ensuring that all military and police personnel receive a mandatory briefing on the Mission-CASEVAC SOP, and understand their roles responsibilities in the CASEVAC system.
- Ensuring assignment and integration of Military and Police personnel into mission structures responsible for coordination/execution of CASEVAC.
- Ensuring the Force Medical Officer is aware of their responsibilities in a CASEVAC system.
- The provision of training, rehearsal and incorporation of medical assets in all operations.

E.2.3 Director/Chief of Mission Support [32]

42. The Director/Chief of Mission Support shall implement all delegated authority to ensure the timely and seamless conduct of CASEVAC in the mission and are accountable for:

- Ensuring that a coherent and integrated CASEVAC system is in place to meet the requirements of this policy across the entire mission area of operation and to establish

[29] The details of this arrangement *should not* be laid out in detail in the Mission CASEVAC SOP but detailed elsewhere.

[30] Note that in those cases where management of the CASEVAC system is attributed to anyone other than the DMS/CMS, where subordinates, such as the CMO, in this policy are held accountable to the DMS/CMS for aspects of the CASEVAC system, this accountability would be to the nominated official rather than the DMS/CMS.

[31] The reference will normally be the Mission CASEVAC SOP.

[32] This only applies where the HOM has delegated 'ownership' of the CASEVAC system. Where another official is given this delegation on a permanent basis that individual assumes these responsibilities.

and implement the procedures that would support and ensure effective and transparent governance protocol for CASEVAC in the mission.

- Ensuring that the budget for CASEVAC resources is included in the Mission's annual budget requirements.
- Ensuring that Mission assets, whether UNOE or COE, including medical, transport (air, land and sea), communication assets etc. are adequate, fully integrated and are at optimal functional status at all times to support CASEVAC activities in the Mission.
- In collaboration with all stakeholders, developing and issuing Mission-specific SOP for CASEVAC (a suggested format is at Annex B). Such SOP must spell out the authorities, roles and responsibilities of all stakeholders including their channel of communication and reporting lines, procedures, available resources and their distribution, etc.
- Establishing access to medical treatment facilities that comply with United Nations medical standards to augment those provided by the Military and Police Components as necessary.
- Instituting, in collaboration with Military and Police component commanders and other key stakeholders[33] an integrated training programme for CASEVAC in the Mission.
- Ensuring an official Notification of Casualty (NOTICAS) record is submitted to UNHQ, as instructed in Reference F.
- Providing support for the establishment and proper functioning of the CASEVAC system Designated Operations Centre as directed by the HoM.
- Implementing all instructions from the HoM as they relate to the provision of CASEVAC support to UN AFPs, governmental and non-governmental organizations, humanitarian organizations, members of diplomatic corps, as well as nationals and others on medical and humanitarian grounds.

E.2.4 Chief of Staff (COS)

43. The Chief of Staff is to ensure that the processes and capability are in place to support coordination of all casualty evacuation in the mission's area of responsibility.[34]

E.2.5 Chief Medical Officer (CMO)

44. The CMO is accountable to the CMS/DMS for:

- Clinical standards within the CASEVAC system.
- Maintaining a duty system to ensure that a D/EvacMO is always available (24 hr).
- Ensuring all Mission AMET are held at the level of readiness directed by the CMS/DMS.
- Ensuring data is entered in the UN EarthMed CASEVAC Module.
- Production of an After-Action Review on each CASEVAC as directed by the CMS/DMS or individual appointed by the HOM.
- Establishing and supervising a curriculum for the training of mission health staff in the conduct of CASEVAC operations.

E.2.6 Force Medical Officer

45. The FMO is accountable to the CMO for:

[33] Such as those responsible for UN civilian staff.

[34] For a full explanation of the COS role see DPO-DOS Policy on Authority, Command and Control (Reference C).

- Ensuring military medical capabilities are provided and maintained as per the apprlicable UN standards and in compliance with Reference B and the contingent specific MOU.
- The training of uniformed health personnel in the conduct of CASEVAC operations.

E.2.7 Chief Aviation Officer

46. The Chief Aviation Officer is accountable to the DMS/CMS for:

- Availability of air assets in support of CASEVAC operations.
- Ensuring that aircraft and crews are held at the level of readiness directed by the DMS and in complicance with their applicable contract or LOA.
- Confirming the currency of helicopter landing site (HLS) lists and providing all necessary HLS information to the relevant Mission entities in a timely manner.
- Maintain a duty system to ensure that a D/AirOpsO is always available (24 hr).

E.2.8 Principal/Chief Security Adviser/Chief Security Officer

47. The Principal/Chief Security Adviser/Chief Security Officer should include in the Security Plans the CASEVAC plans which have been developed and coordinated with the Senior Leaders responsible for the overall ownership/management of the CASEVAC system in the mission and UNSMS organizations.

48. Work together with the Senior Leaders responsible for the overall ownership/management of the CASEVAC system in the mission and UNSMS organizations to ensure that plans are aligned, coordinated and to ensure a cohesive response including in instances of incidents impacting both Mission and other UNSMS personnel.

E.2.9 Commanding Officer / Manager of Receiving Medical Treatment Facilities

49. Commanding Officer / Manager of Receiving Medical Treatment Facilities shall:

49.1. Ensure that First Medical Reports are completed and submitted in the time and format required.

49.2. Assist the CMO in completion of the AAR through the provision of clinical and other information as requested by the CMO.

F. REFERENCES

50. This Policy should be read in conjunction with the following documents.

a. 2015.12 Medical Support Manual for United Nations Field Missions - 3rd Ed.
b. Manual on Policy and Procedures Concerning the Reimbursement and Control of Contingent Owned Equipment of Troop/Police Contributors Participating in Peacekeeping Missions (GA, A/72/288 2017)
c. 2019.23 Policy on Authority, Command and Control in UN PKOs
d. 2018.21 Aviation Manual
e. United Nations Security Management System *Security Policy Manual* and *Security Management Operations Manual*
f. 2017.22 SOP on Notification of Casualties (NOTICAS) in Peacekeeping Operations and Special Political Missions
g. UN Crisis Management Policy (2018)

G. MONITORING AND COMPLIANCE

51. The Departments of Peacekeeping Operations, Peacebuilding and Political Affairs and Operational Support have the authority for oversight and monitoring of the compliance to this Policy in their respective areas. The heads of these Departments should work together to ensure that Heads of Missions are properly informed of this policy.

H. CONTACT

52. All enquiries about this SOP and requests for amendment should be sent to the Chief, Medical Support Section, SSS/LD/OSCM/DOS.

I. HISTORY

53. This policy shall be reviewed in three years from the date of promulgation. This Policy supercedes any previous versions, including: 2018.12 Policy on Casualty Evacuation in the Field.

APPROVAL SIGNATURES:

Rosemary DiCarlo
Under-Secretary-General
for Peacebuilding and Political Affairs

DATE OF APPROVAL

5/21/20

Atul Khare
Under-Secretary-General
for Operational Support

DATE OF APPROVAL

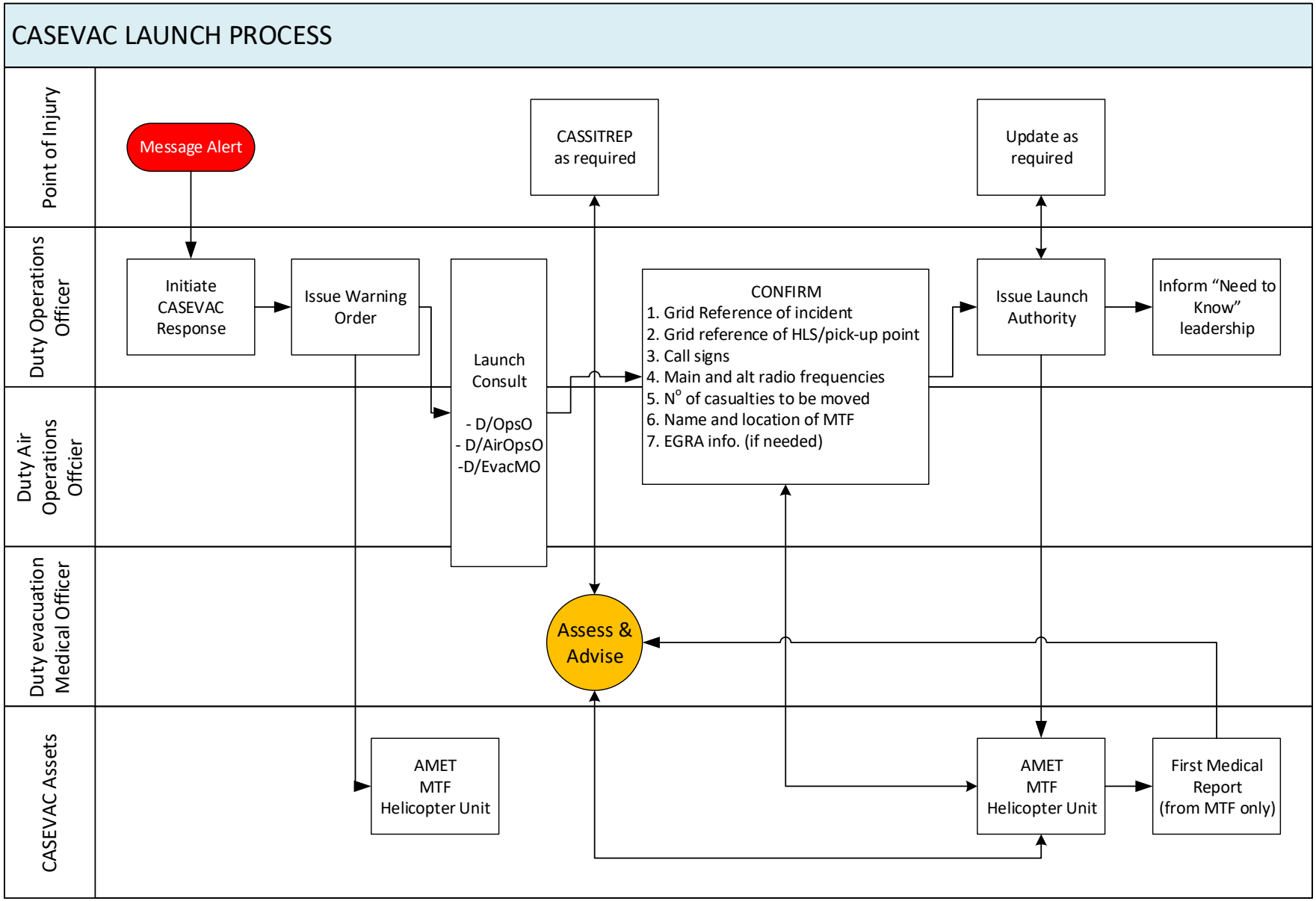
Jean-Pierre Lacroix
Under-Secretary-General
for Peace Operations

DATE OF APPROVAL

Gilles Michaud
Under-Secretary-General
for Safety and Security

DATE OF APPROVAL

Annex A. CASEVAC Launch Process Flow Chart



Annex B. Example - Missions Casualty Evacuation SOP

UNXXX STANDARD OPERATING PROCEDURE FOR CASUALTY EVACUATION (CASEVAC)[35]

Contents:

A. PURPOSE

1. This Standard Operating Procedure (SOP) provides instruction to all Mission personnel involved in a casualty evacuation (CASEVAC) operation.

B. SCOPE

2. Compliance with this SOP is mandatory. It applies to all Mission civilian, police and military personnel including formed police units and contingent military units deployed throughout the AOR, in Mission headquarters, sector headquarters, and other field bases.

C. RATIONALE

3. CASEVAC is a complex process involving multiple stakeholders and considerable coordination. This SOP dictates actions required, to provide timely evacuation from the point of injury/illness (POI) to an appropriate medical facility.

D. UNDERPINNING PRINCPLE

4. **10-1-2 Guideline**. A simple time metric has been developed to guide actions and inform the structure of the Mission CASEVAC system; this is the 10-1-2 *guideline* which requires:

10 Immediate life saving measures are applied by personnel trained in first aid. Bleeding and airway control for the most severely injured casualties is to be achieved ***within 10*** **minutes** and a casualty alert message transmitted.

[35] SOPs should not laboriously repeat background information from the Health Support Plan or other Mission operational planning orders/instructions unless they materially affect the *process* to be followed.

1 Advanced resuscitation / treatment is commenced by emergency medical personnel ***within 1 hour*** of injury / illness onset.

2 Where required damage control surgery (DCS) is commenced as soon as practicable, ***but no later than 2 hours*** after injury / illness onset[36].

5. The Mission leadership recognises strict compliance with the 10-1-2 guideline is not always possible. Where this is the case, risks must be managed accordingly, with active mitigation to establish alternate health support measures.

6. CASEVAC takes priority over all other Mission activities except for imminent threats related to safety and security of personnel.

E. PROCEDURE

E.1. Initial Actions at the Point of Injury/Illness (POI):

7. POI inside a Mission compound/base with a Medical Facility (Level 1 or above): Within 10 minutes personnel at the POI should provide:

   7.1. Basic first aid to control major bleeding and airway for breathing; and

   7.2. Transmit the alert message to the duty doctor on site. Mission Alert Message format is at Annex A.

8. Within 10 minutes from the receipt of the alert message, the compound medical facility will deploy a doctor led Medical Emergency Response Team (MERT) to the POI to stabilize the patient and transport to the medical facility and/or request CAEVAC to a higher-level facility if required. If the MERT decides evacuation to a higher level is required, the procedure is the same as for incidents occurring outside a Mission compound.

9. **POI outside Mission compound/bae**. Within 10 minutes personnel at the POI should:

   9.1. Provide basic first aid to control major bleeding and airway for breathing; and

   9.2. Transmit the alert message, in the format at Annex A, to the Designated Operations Centre (DOC).

E.2. Initial Actions at the Designated Operations Centre

10. **Launch consult and warning order.** Within **10 minutes** from receipt of the first alert message, DOC Duty Operations Officer will, in priority order:

    10.1. Alert and consult with the Duty Aviation Officer.

    10.2. Alert and consult with the Duty Medical Evacuation Officer.[37]

    10.3. Conduct quick risk assessment.

DUTY OEPRATIONS OFFICER MAKES PROVISIONAL LAUNCH[38] DECISION

[36] The 10-1-2 guideline cumulative; the total time lapse between injury/onset and surgery should be under two hours (120 minutes).

[37] Duty Ops and Aviation Staff should not delay the provisional launch decision if for any reason they cannot contact the Duty Medical Evacuation Officer

[38] The term 'Launch' here is used to refer to both air and ground evacuation platforms.

10.4. Issue Warning Order to asset(s) (ground vehicles, helicopter, evacuation teams receiving Medical Treatment Facilities {MTF}) likely to be involved in the CASEVAC. The Duty Operations Officer may delegate this task to the Aviation Duty Officer and Medical Evacuation Duty Officer.[39]

11. **Duty Aviation Operations Officer**: Within **15 minutes** of the provisional launch decision is to:

11.1. Confirm the closest potential helicopter landing site(s) (HLS) to the incident/POI and those to be used at receiving Medical Treatment Facility.

11.2. Confirm the air asset to be utilised for the CASEVAC.

11.3. Confirm the aviation /launch safety/airspace approvals.

12. **DOC Duty Operations Officer**: Within **15 minutes** of provisional launch decision is to confirm: *[40]*

- Grid reference of incident.
- Grid reference of HLS / pick-up point if different from incident.
- Route plan for ground evacuation assets to POI/ pickup point.
- Call signs of evacuation asset and POI/incident site commander.
- Main and any alternate radio frequencies and or telephone contact details.
- Number of casualties expected to be moved.
- Name and location of receiving MTF(s).
- Known threats.
- Inform other Operations Centres/duty personnel that may be required to provide additional assets/support for the CASEVAC, e.g. MOVECON, Security personnel.

13. **Duty Evacuation Medical Officer**: Within **15 Minutes** of the provisional launch decision is to:

13.1. Confirm the CASEVAC plan to include: [41]

- Evacuation priority.
- Additional medical support needed at POI and during transportation.
- Confirm the most appropriate means of evacuation from a clinical perspective (ground, air).
- The most appropriate MERT/AMET to assist at the POI and during transportation.
- Confirm receiving MTF(s).

13.2. Inform the receiving MTF(s) and provide update on the casualty status and CASEVAC flight ETA.

[39] In some missions it may be necessary to arrange escorts for aircrew and AMET to move from their accommodation to their aircraft.

[40] Some Missions may need to impose a quick “risk assessment” matrix to guide for duty officers which require them to seek higher level approval for launch where risk is above a directed threshold. Where this is imposed, the risk assessment matrix should be an annex to this SOP.

[41] The Duty Evacuation Medical Officer should only determine priorities where they have direct contact with the POI and were no more senior clinician is at the POI – otherwise *trust those on the ground to decide the priority.*

NO LATER THAN 20 MINUTES AFTER PROVISIONAL LAUNCH DECISION – DUTY OPERATIONS OFFICER CONFIRMS LAUNCH ORDER

14. **Tasked CASEVAC/Medical Assets**. Within **15 minutes**[42] of receipt of the warning order:

14.1. Helicopter air and ground crew are to be in position commencing pre-flight procedures.

14.2. Aeromedical Evacuation Teams (AMET) are to be at the aircraft commencing pre-flight procedures. Including radio contact with POI if this can be established.

14.3. Ground evacuation vehicle crews ready for departure and awaiting detailed brief as required. Where possible radio/telephone contact with POI is established.

14.4. MTF trauma teams are assembled in their relevant departments (emergency, operating, pathology laboratory, medical imaging etc) preparing for receipt of patients.

E.3. Subsequent actions - At the POI

15. The site commander / individual in charge is to ensure:

15.1. First Aid for the casualty(s) continues.

15.2. A Casualty Situation Report (CASSITREP) is forwarded to DOC every 15 minutes.

15.3. Where there are multiple casualties, they are sorted into a priority for evacuation. Priorities as described in Annex B.

15.4. Confirm the HLS/Pickup Point grid reference with the DOC.

15.5. Prepare the HLS in accordance with Mission Aviation SOPs. Including radio contact with evacuation platforms if this can be established.

E.4. Subsequent actions - At the DOC.

16. **DOC Duty Operations Officer.** The DOC Duty Operations Officer is to:

16.1. Stand-down all assets issued with a warning order to participate in the CASEVAC not required once this has been established. This may be delegated to the Aviation and Medical Evacuation Duty Officers.

16.2. Inform the following of the CASEVAC as soon as possible after launch and update them as directed:

- As required by Mission leadership
- As required by Mission leadership

16.3. Coordinate CASEVAC operation through to conclusion acting as focal point for all communications.

16.4. Within 24 hours of the conclusion of the CASEVAC operation lead in the drafting of an After Action Report in collaboration with the Aviation and Medical Evacuation Duty Officers.

17. **DOC Duty Aviation Operations Officer**

17.1. Assist in the Coordination of CASEVAC operations conducted by air through to conclusion.

[42] It is acknowledged that the arrangements for the parking of aircraft and the accommodation of aircrew and AMET may make this impossible in some missions and that a different time metric may need to be used, however, every effort must be made to ensure this time is no greater than 30 minutes.

17.2. Within 24 hours of the conclusion of the CASEVAC operation assist in the drafting of an After Action Report in collaboration with the Operations and Medical Evacuation Duty Officers.

18. **DOC Duty Evacuation Medical Officer**

18.1. Assist in the Coordination of CASEVAC operations conducted by air through to conclusion.

18.2. Provide clinical advice to personnel at the POI as required.

18.3. Pass casualty updates from POI to receiving medical teams (AMET, MTF etc).

18.4. Within 24 hours of the conclusion of the CASEVAC operation assist in the drafting of an After Action Report with the Aviation and Operations Duty Officers.

18.5. Draft a Medical-in-Confidence annex to the above report for inclusion in the CMO copy if required.

18.6. Submit a report in the UN EarthMed CASEVAC Module.

18.7. Submit post-facto formal CASEVAC request through Mission adopted air assets' requesting/tasking system(s).

F. CASEVAC OF NON-UN PATIENTS

19. In accordance with international humanitarian law, the UN is required to treat members of hostile forces and civilians injured by UN forces within the capacity of the UN health system where alternate hostile force or civilian health capability is not immediately available. Such casualties are to be treated and evacuated in accordance with the clinical priorities described in Annex B alongside UN casualties. Costs are borne by the UN until handover to a relevant authority.

20. CASEVAC of casualties not associated with UN operations are permitted upon request from a third-party (non-UN) through the Office of the Humanitarian Coordinator and be authorized by the HoM. In cases that mission CASEVAC assets are used for non-UN entities, the Mission should ensure that reserve capacities are available for the CASEVAC of UN personnel.

G. TRAINING, TESTING AND EVALUATION

21. All DOC should be trained and competent in the collection and management of alert messages and the actions to take upon receipt.

22. All Mission personnel involved in CASEVAC should be trained and tested in procedures, equipment, skills, communication and behaviour of the entire process.

23. The Mission shall test and evaluate the CASEVAC procedures through table-top and field exercises no less than every four months. Rehearsals and specific skills should also be tested through full scale exercises no less than every six months.

H. REFERENCES

A. Casualty Evacuation in the Field, 2019
B. Medical Support Manual for United Nations Field Missions (3rd Edition); DPO/DOS, Ref. 2015.012
C. Aviation Manual; DPO/DOS, Ref. 2018.21

D. Authority, Command and Control; DPO/DOS 2019.23
E. United Nations Security Management System Policy Manual; DSS, 2011

I. MONITORING AND COMPLIANCE

24. *Missions will need to establish how they will monitor and comply with this SOP. This section should articulate who 'owns' the process on behalf of the HoM and to whom delegation for launch authority is delegated by appointment not by name. This ensures that duty personnel understand authorities delegated to them by virtue of their appointment.*

J. CONTACT

25. *The contact information of the mission department or team that developed the CASEVAC SOP. Do not use personal e-mail addresses, but rather generic departmental e-mail address.*

K. HISTORY

26. *This section should contain the date that this CASEVAC SOP was first approved and issued. It should include the dates of each subsequent review and modification. It should also indicate any previous CASEVAC SOPs that were substantively altered, repealed or terminated as a result of the issuance of this SOP. If necessary, a schedule of amendment dates and the amendments made should be added as an attachment.*

APPROVAL SIGNATURE:

DATE OF APPROVAL:

ANNEX A to SOP

CASEVAC Alert Message

(9 Line Format)

Line	**UN CASEVAC 9-LINE ALERT MESSAGE**		
	DTG:		
1	LOCATION:	MAP NO:	GZD:
		GPS GRID:	
2	C/S & FREQ:	C/S	FREQ:
3	NUMBER OF PATIENTS / PRECEDENCE:	CAT A	A.
		CAT B	B.
		CAT C	C.
		CAT D	D.
4	SPECIALIST EQUIPMENT REQUIRED:	NONE	A.
		HOIST (to hoist in helo)	B.
		EXTRACTION (wreckage)	C.
		OTHER	D.
5	NUMBER OF PATIENTS BY TYPE:	LITTER (stretcher)	L.
		WALKING (ambulatory)	W.
6	SECURITY AT PICKUP SITE:	NO THREAT IN AREA	N.
		POSSIBLE THREAT IN AREA	P.
		THREAT IN AREA	E.
		ARMED ESCORT REQUIRED	X.
7	MARKING OF PICKUP SITE:	AME PANELS	A.
		PYRO (star cluster / flare)	B.
		SMOKE (+ colour)	C.
		STROBE	D.
		OTHER	E.
8	NUMBER OF PATIENTS BY NATIONALITY & STATUS:	UN MILITARY	A.
		OPPOSING FORCES	B.
		OTHER	C.
9	PICKUP ZONE TERRAIN & OBSTACLES:	% SLOPE (lay of ground)	A.
		OBSTACLES	C.
		SECURITY AT PICKUP	D.
		NUMBER OF PASSENGERS	E.
		VEHICLES SECURING SITE	F.
		DIR TO THREAT FORCES	G.

(4 Line Format)

Line	**UN CASEVAC 4-LINE ALERT MESSAGE**		
	DTG:		
1	LOCATION AND CALL SIGN	PLACE NAME / DESCRIPTION	A
		GPS GRID REFERENCE	B
		CALL SIGN OF INCIDENT SITE COMMANDER	C
2	INCIDENT DETAILS	WHAT HAS HAPPENED? (Shooting, road accident, explosion etc).	D
		HOW MANY CASUALTIES ARE THERE?	E
3	ACTIONS BEING TAKEN AT SCENE	TREATMENT BEING GIVEN AND PREPERATIONS FOR EVACUATION	
4	RESOURCES REQUIRED AT SCENE TO TREAT AND EVACUATE PATIENT	GROUND AMBULANCE, AIR EVACUATION, AMET	

ANNEX B to SOP

Emergency Ground Risk Assessment Format*

1	Current situation at incident location/Lansing Site	No combatants in vicinity ☐	Combatants within 10-20kM ☐	Combatants within 5kM ☐
2	Is there fighting in the immediate area	No ☐	Unknown ☐	Yes ☐
3	Type of weapons being used or in the area	Small weapons rifles and pistols / No weapons ☐	Heavy weapons (e.g. heavy machine guns / RPG ☐	Vehicle mounted weapons/MANPAD ☐
4	Sentiment of controlling forces towards UN personnel/forces in the immediate area	Friendly ☐	Neutral ☐	Hostile ☐
5	Sentiment of controlling forces towards UN personnel/forces in the surrounding area	Friendly ☐	Neutral ☐	Hostile ☐
6	Presence of friendly forces able to provide security/protection	Adequate ☐	Minimal ☐	None ☐
7	Recommended risk level	Low ☐	Medium ☐	High ☐

*The absolute minimum information required during casualty evacuation is outlined at paragraph 20 of the main policy. Staff responsible for creating the Mission Casualty Evacuation SOP should give due consideration to:

1. the overall threat level;
2. the training and experience of Mission personnel;
3. any communications system limitations; and
4. language difficulties

when deciding on the format of Alert Messages and the need for and format of Emergency Ground Risk Assessments (EGRA) and Casualty Situation Reports (CASITREP). Obtaining confirmed EGRA and CASSITREPS information should not impede a launch decision.

ANNEX C to SOP

CASUALTY SITUATON REPORT (CASSITREP)*

A	Age and Sex of Patient:
T	Time of Incident or Update Report:
M	Mechanism of Injury:
I	Illness/Injuries Sustained or Suspected:
S	Signs & Symptoms: • Airway clear – Yes/No • Breathing – Yes/No Rate: • Pulse – Yes / No Rate: • Blood Pressure • Temperature • Consciousness: Alert / Voice Response / Pain Response / Unconscious
T	Treatment provided and Required:

*The absolute minimum information required during casualty evacuation is outlined at paragraph 20 of the main policy. Staff responsible for creating the Mission Casualty Evacuation SOP should give due consideration to:

1. the overall threat level;
2. the training and experience of Mission personnel;
3. any communications system limitations; and
4. language difficulties

when deciding on the format of Alert Messages and the need for and format of Emergency Ground Risk Assessments (EGRA) and Casualty Situation Reports (CASITREP). Obtaining confirmed EGRA and CASSITREPS information should not impede a launch decision.

ANNEX D to SOP

Patient Categories and Evacuation Priorities

Patient categories. For the purposes of this SOP, patient categories in relation to the priority of medical attention and evacuation are as follows:

Category Alpha (Critical). Life is immediately threatened. Rapid evacuation, urgent resuscitation and/or surgery are required to save life, limb or sight. In the absence of immediate and appropriate medical and/or surgical procedure, there will be a significant chance of mortality or increased morbidity within two hours.

Category Bravo (Urgent). Life or limb is in serious jeopardy. Evacuation should be conducted as soon as possible. This category remains a priority for stabilisation, treatment at point of injury, and evacuation except that predicted deterioration or a negative outcome is unlikely within six hours.

Category Charlie (Delayed or Hold). Life or limb is not in serious jeopardy. Evacuation should be affected as soon as a suitable transport mode is available. This category remains a priority for medical attention. The mechanism and localisation of injury do not predict a negative outcome in the next 24 hours.

Category Delta (Expectant). *This category is only to be used when the **Mission HQ** has declared a Mass Casualty event.* Casualties who have injuries inconsistent with survival. They will be evacuated after other Category Alpha patients.

ANNEX E TO SOP

DISTRIBUTION TO HEALTH STAFF ONLY

FIRST / UPDATE MEDICAL REPORT

1	DATE AND TIME OF REPORT	12 NOVEMBER 2019 – 13:40
2	NAME (FAMILY/Given)	SMITH Peter Robert
3	MILITARY/POLICE/CIVILIAN	MILITARY
4	RANK (Military / Police)	CORPORAL (Military)
5	NATIONALITY	CANADIAN
6	UNIT	CANBAT 1
7	CURRENT LOCATION	INDIAN LEVEL 3 GOMA
8	PRINCIPAL DIAGNOSIS	FRACTURE LEFT TIBIA AND FIBULA; TRAUMATIC AMPUTATION LEFT HAND
9	BRIEF CLINICAL SUMMARY	SUSTAINED INJURY TO LEFT AREM AND LEG IN IED STRIKE ON ARMOURED PERSONNEL CARRIER. FRACTURE/DISLOCATION OF LOWER THIRED OF LEFT TIBIA AND FIBULA. TRAUMATIC AMPUTATION OF LEFT-HAND AT WRIST. STABLE AND CONSCIOUS ON ADMISSION TO LEVEL 3. NIL OTHER MAJOR INJURIES IDENTIFIED ON ADMISSION. MILD HYPOVOLEAMIC SHOCK.
10	TREATMENT	LEG STABALISED AND SPLINTED AT INCIDENT SITE. TOURNIQUET APPLIED TO LEFT UPPER ARM, WOUND TO HAND DRESSED WITH COMPRESSION BANDAGE. ANALGESIA AND INTRAVENOUS FLUIDS COMMENCED AT INCIDENT SITE. ON ADMISSION TO LEVEL 3: OPEN REDUCCTION OF LEG FRACTURES AND EXTERNAL FIXATATION APPLIED. DEBRIDEMENT OF LEFT-HAND INJURY – PRIMAY DELAYED CLOSURE. COMMENCED IV ANTIBIOTICS. ADMITTED TO INTENSIVE CARE FOR POST OPERATIVE CARE.
11	PROGNOSIS	GOOD.
12	IS MEDICAL EVACUATON OUT OF MISSION AREA REQUIRED	YES.
13	DATE OF NEXT UPDATE	13 NOVEMBER 2019 – 12:00
14	RELEASE AUTHORITY:NAME AND APPOINTMENT	COLONEL B. RAWAT COMMANDING OFFICER INDIAN LEVEL 3 HOSPITAL GOMA

DISTRIBUTION TO HEALTH STAFF ONLY