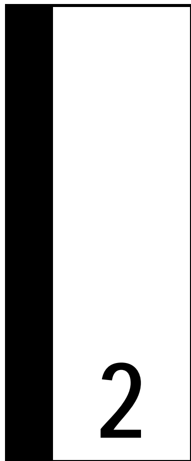

Immediate Action

2.1 This chapter addresses the action taken immediately, following a wounding or injury, on operations. It follows the immediate first-aid, the helicopter ride back to medical support, the phone call to the family and the first in-theatre medical treatment. It considers preparation individuals receive prior to deployment, and the importance of families in the repatriation and recovery of the individual.

Responsibilities

2.2 The Department of Defence (Defence) summarised their responsibilities, noting that the health and welfare of members is a command responsibility, which ultimately rests with the Chief of each Service regardless of where the Australian Defence Force (ADF) member may be posted. The Surgeon General Australian Defence Force/Commander Joint Health is responsible for the technical control of ADF health services.

2.3 The provision of health care to ADF personnel does not start when an individual is injured or wounded, and the Defence health care system provides a continuum of care from enlistment through to transition from the ADF and during all phases of an operation – pre-deployment, provision of treatment and evacuation during deployment and post-deployment.

2.4 When ADF personnel are injured or wounded, there is a reasonable expectation that they will receive prompt and effective health care which meets contemporary Australian standards and this underpins the continuum of care that is provided to the men and women of the ADF.[1]

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1 Department of Defence, *Submission 17*, p. 9.

Air Marshal (AIRMSHL) Mark Binskin AO, Acting Chief of the Defence Force (CDF), told the Committee:

> The provision of health care to ADF personnel is a continuum from enlistment through to transition from the ADF back into civilian life.[2]

2.5 The Department of Veterans' Affairs (DVA) submitted that each injury is unique in terms of effects on the person and their family, and the care and support they need. DVA takes full responsibility for care and support for those wounded or injured personnel who leave the ADF.[3]

Combat first aid

2.6 Defence submitted that, that the type of treatment received in-theatre is based on the severity of wounds or injuries. Treatment can obviously be complicated by the tactical situation, particularly if troops are still engaged with the enemy.

2.7 Defence advised that the casualty treatment process is layered to provide the best possible care for Australian troops. All Australian soldiers are trained in basic first aid. Initially casualties are provided first aid or administer self-aid with combat medical supplies they carry themselves, within ten minutes of being wounded where possible.

2.8 During force preparation training at Al Minhad Air Base, all personnel deploying into Afghanistan receive refresher training in first aid that includes the management of catastrophic haemorrhage and airway management. The care of battle casualties training is conducted in a simulated battlefield scenario and provides personnel with the opportunity to refresh their skills immediately prior to going into combat. In the event of battle casualties, personnel can then correctly apply the lifesaving medical supplies provided to them.[4]

2.9 During initial first aid, an assessment is made as to the severity of the wounds and injuries and if required, the soldiers will then call for additional medical support or an evacuation of the wounded or injured person.

2.10 Tactical units may also include combat first aid trained personnel who have received advanced training in the initial treatment of wounds likely to be encountered on a battlefield. Special Forces patrols often include a

2 AIRMSHL Mark Binskin AO, Acting CDF, *Committee Hansard*, 9 October 2012, p. 1.

3 Department of Veterans' Affairs, *Submission 18*, p. 9.

4 Department of Defence, *Submission 17*, p. 11.

Patrol First Aider or Advanced Combat First Aider. These soldiers are trained in advanced first aid procedures and are similar to paramedics in the civilian sense.

2.11 If required, the wounded or injured person will be evacuated to a medical facility for further treatment. This evacuation is conducted by the most suitable and expedient means and this is most usually by helicopter. Timings for aeromedical evacuation in Afghanistan are based on medical severity. For life-threatening wounds or injuries the following timings are mandated by the International Security Assistance Force (ISAF) and have been endorsed by Australia:

- Evacuation assets aim to reach seriously wounded soldiers within one hour of wounding, and provide en-route care based on the clinical needs of the patient. This one hour guidance is not always possible when the tactical situation delays evacuation.
- All attempts are made to evacuate casualties to a medical facility able to provide surgery within two hours of wounding. This is the basis for the 10:1:2 rule – first aid within ten minutes, advanced resuscitation within one hour and surgery within two hours of wounding.
- For non-life threatening wounds the timings are extended, although in many cases the evacuation process is such that the same timings result.[5]

2.12 The Committee received a body of evidence relating to the immediate care of wounded or injured soldiers in the operational area as being exceptional[6] and world best,[7] for which the Committee commends the Department of Defence.

2.13 This sentiment was frequently echoed, for example the Returned and Services League of Australia (RSL) Victorian Branch highlighted the lifesaving skills of combat medics on the ground in Afghanistan:

> Their skills have ensured greater survivability odds for their colleagues. The Branch believed that the tried and true method of air medical evacuation to the nearest medical treatment centre in the theatre of operations has saved lives.[8]

Pre-deployment training

2.14 Defence advised that the initial response at the point of injury is crucial. The provision of bleeding and airway control for the most seriously

5 Department of Defence, *Submission 17*, pp. 11-12.

6 Name withheld, *Submission 2*, p. 2.

7 Vietnam Veterans' Association of Australia, *Submission 27*, p. 3.

8 Returned and Services League of Australia, *Submission 11*, p. 4; Young Diggers, *Submission 22*, p. 1.

injured must take place within 10 minutes of injury. To provide this, combat personnel (non-health personnel) are trained and competent to deliver enhanced first aid, principally to stop bleeding and secure the airway.

2.15 Every member of the ADF routinely receives training in first aid with an emphasis on the skills required in a military environment. Selected members are provided with advanced first aid skills tailored to their Service environment and are periodically refreshed as part of the normal training cycle. These include:

- the Minor War Vessel Medical Care Provider Course;
- the Combat First Aid Course; and
- the Patrol Advanced First Aiders Course.[9]

2.16 Based on the risk associated with the operational deployment there is further tailored refresher and skills extension training conducted at all levels of the first aid and emergency medical response. For forces deploying into Afghanistan the pre-deployment training is conducted under the Exercise Primary Survey framework. All members are trained and assessed in Care of the Battle Casualty with significant resources being utilised to create realistic combat scenarios where the skills in management of combat injuries are developed and assessed by experienced medical observers.

2.17 Defence submitted that Combat First Aiders, Patrol Advanced First Aiders and deploying health staff conduct additional high fidelity training focused on comprehensive pre-hospital treatment and evacuation. The training is overseen by both military and civilian trauma specialists and adapted to reflect current best practice. Scenarios are based on the experiences of health staff that have recently returned from Afghanistan. The final component of the exercise series targets the health staff, refreshing and enhancing their trauma skills. It involves live tissue training and challenging simulated resuscitation drills overseen by military trauma specialists.

2.18 During Reception, Staging, Onward Movement and Integration (RSO&I) in Al Minhad Air Base, all members deploying into Afghanistan receive further high fidelity refresher training in Care of the Battle Casualty. This training is delivered by a contractor utilising ex-serving, combat experienced medics and overseen by ADF health staff. It involves a combination of lectures, individual skill refresher stations with an emphasis on control of massive haemorrhage, and extraction of casualties resulting from an improvised explosive device strike. The training

9 Department of Defence, *Submission 17*, p. 5.

culminates in an assessment of all skills within a realistic simulated battlefield environment.

2.19 Whilst deployed, members receive ongoing refresher training often conducted in conjunction with range firing practices. Training focuses on maintaining currency in the application of the Combat-Application-Tourniquet (CAT) and production of the North Atlantic Treaty Organization (NATO) medical evacuation request. This is a message that is transmitted quickly to request an urgent medical evacuation and contains information that includes: the condition; number and nationality of the casualties; their location; what special equipment will be required; and the conditions on the ground that might inhibit their extraction.

2.20 Combat First Aiders and health staff maintain their skills by routinely participating in the Role 2E trauma roster and by augmenting during multiple casualty incidents. The currency and competency of first aiders and health staff are regularly tested with real time trauma patients. Defence submitted that coalition partners have consistently observed that the quality and responsiveness of Australian first aiders and health staff in trauma cases is first class.

2.21 Specialist health personnel are qualified, current and competent in their clinical and operational skills and must meet the credentialing requirements of Australia and coalition partners.[10]

In-theatre health facilities

2.22 The operational health care system provides for the continuum of care from initial first aid via a dedicated evacuation chain to increasing levels of specialist health care delivery. This system is organised into roles of health care, which range from first aid through to definitive health care and rehabilitation. Roles of health care extend from the point of injury or illness providing continuous care to casualties. Each tier has increasingly sophisticated treatment capabilities and each casualty is treated at the most appropriate role of health care. This may involve either movement through the care continuum or casualty evacuation to the most appropriate health facility.[11] Lieutenant Colonel (LTCOL) Michael Reade, Defence's Professor of Military Medicine and Surgery, told the Committee that:

> The trauma care is excellent. It is a trauma system that has evolved dramatically in the last 12 or so years. I think it would be fair to say it was something in need of development at the start but

10 Department of Defence, *Submission 17*, pp. 4-5.

11 Department of Defence, *Submission 17*, p. 6.

> that development has been very actively pursued. I think it is a more responsive trauma system; that would be true of any civilian system anywhere in the world. … It is responsive to the operational need, it is very well resourced and it is comprehensive in its care. It is very much focused on getting people out of the deployed environment quickly.[12]

2.23 Defence submitted that a Role 1 health facility provides primary health care, triage and basic resuscitation and stabilisation in the theatre of operations.

2.24 A Role 2 health facility provides enhanced clinical support based on formed health teams and is capable of advanced resuscitation and treatment of casualties prior to evacuation.

2.25 A Role 2 enhanced (Role 2E) health facility provides secondary health care built around primary surgery, intensive care and nursed beds and treats and prepares casualties for evacuation to a Role 3 health facility or directly out of theatre.

2.26 A Role 3 health facility provides comprehensive secondary health care including primary and specialist surgery, major medical and nursing services and casualty holding for treatment and return to duty.

2.27 A Role 4 health facility offers the full spectrum of definitive care and is provided from or within the national support base.[13]

ADF responsibility

2.28 The ADF is responsible for the provision of Role 1 health support to ADF elements in the Middle East Area of Operations (MEAO). Role 2 support is provided at the ADF health facility at Al Minhad Air Base and Role 2E support is provided at the United States (US) led ISAF facility in Tarin Kot. Role 3 health support is provided to ADF members at the Multinational US led ISAF facility at Kandahar. Role 4 health support is provided from either the US Landstuhl Regional Medical Center in Germany or from Australian tertiary civilian hospital facilities.[14]

Public information during incidents

2.29 The Minister for Defence provides information on broad categories of injuries sustained by our troops in his regular Ministerial Statements to Parliament.

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12 LTCOL Michael Reade, Professor of Military Medicine and Surgery, *Committee Hansard*, 25 March 2013, p. 24.

13 Department of Defence, *Submission 17*, p. 6.

14 Department of Defence, *Submission 17*, p. 6.

2.30 Defence aims to provide public information on every operational incident involving battle casualties (wounded and killed in action). Operational tempo, ongoing operations and Special Operations are three factors which may lead to occasional inconsistency in reporting. Media information about casualty figures is however updated as appropriate, when operational circumstances permit. Defence guidance on the release of public information during incidents includes:[15]

- The ADF will not release the names of casualties until Next of Kin (NOK) procedures have been completed.
- The ADF will not comment on the circumstances or causes of an incident until any investigation has been completed and if it is likely to be subject to disciplinary proceedings.
- In order to align with the civilian practice for reporting patient medical condition without compromising the medical-in-confidence nature of the wounds and injuries, Defence has adopted a nomenclature for public information relating to battle casualties:
  - ⇒ Life Threatening. Injury and wounds that will likely lead to death if not immediately treated (for example, fragmentation and gunshot wounds involving vital organs or the head). Also applicable to an illness requiring admission to an intensive care facility.
  - ⇒ Serious. Injury and wounds requiring immediate medical care and hospitalisation but not considered life threatening (for example, fragmentation and gunshot wounds to torso). Also applicable to an illness requiring hospitalisation.
  - ⇒ Slight/Minor. Injury and wounds requiring medical care and hospitalisation (for example, fragmentation and gunshot wounds to the extremities). Also applicable to an illness requiring basic medical care/monitoring and restriction of duties.
  - ⇒ Superficial. Injury and wounds not requiring hospitalisation.[16]

Notification of casualty

2.31 Notification of casualty (NOTICAS) is the name for the formal reporting of casualties within the ADF. This reporting informs the chain of command and provides information that is passed to families of deployed personnel. NOTICAS reports are raised for every wounding and the reporting is undertaken as quickly as possible.

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15 Department of Defence, viewed 4 April 2013, <www.defence.gov.au/op/afghanistan/info/personnel.htm>.

16 Department of Defence, *Submission 17*, p. 12.

2.32 Defence submitted that notification of wounding or injury is raised as quickly as possible to ensure both the family and command chain is informed as soon as practicable. Contact between the member and the family also takes place as soon as possible.[17]

2.33 Defence Families of Australia (DFA) submitted that NOK need to be kept informed and included throughout the repatriation process in order to address and allay concerns of the NOK and to reduce the family's stress.[18]

Public release of names

2.34 Defence advised the Committee that their policy regarding the release of the names of members wounded or injured is:[19]

- Names of ADF members (not afforded protected identity status) remaining in an operational area following an announced wounding or injury will not be released;
- Names of ADF members (not afforded protected identity status) returning to Australia for treatment will remain protected until authorised for release by the individual member concerned while the names of ADF deceased will be released in consultation with the member's family;
- Only Special Forces soldiers, who have protected identity status, may have their names withheld when they are admitted into non-military hospitals; and
- There is no policy to hide the identity of other Australian soldiers undergoing medical treatment and rehabilitation in private or public hospitals.

Medical evacuation

2.35 Defence submitted that the objective of casualty evacuation is the safe and efficient movement of casualties, with the provision of en route medical care, from point of injury or illness to the appropriate health facility as soon as possible. Evacuation comprises both surface evacuation and aeromedical evacuation.

2.36 The evacuation system aims to evacuate casualties 24 hours a day, in all weather, over all terrain and in any operational scenario. The system

17 Department of Defence, *Submission 17*, p. 12.

18 Defence Families of Australia, *Submission 8*, p. 1.

19 Department of Defence, viewed 4 April 2013, <www.defence.gov.au/op/afghanistan/info/personnel.htm>.

provides clinical sustainment of the casualty throughout the journey, using appropriately trained clinical staff and accurately tracks patients and equipment throughout the evacuation. Casualties are evacuated to the most appropriate facility in the shortest time while applying appropriate clinical processes.

2.37 This approach enables forward deployment of health elements and concentrates resource-intensive casualty care in more secure areas where health facilities are not required to move with changing tactical situations. Casualty regulation directs the casualty to the health facility that is best able to manage the condition in terms of nature and availability of required treatment. Regulation ensures proper routing of patient to health facilities and minimises casualty handling and transfer. In the MEAO, aeromedical evacuation of a patient from the scene of injury or illness to the initial treatment facility and evacuation of a patient between health facilities within the area of operation is the responsibility of coalition partners.[20]

2.38 Australians serving in Uruzgan rely on a team of highly skilled US and Australian trauma and medical staff working in a well-equipped ISAF Role 2E health facility in Tarin Kot. This facility performs initial trauma management similar to that provided by the emergency department of a civilian hospital and if required, the facility can also undertake emergency surgery to treat the wounded or injured.[21] One soldier who was evacuated commented that the American medical staff were 'really good…. they were really helpful'.[22]

2.39 Not everyone who is wounded or injured requires evacuation, and those ADF members who suffer only minor physical impairment are treated and, once fit, return to duty.

2.40 Casualties that require more specialist care than can be provided at the Role 2E at Tarin Kot are evacuated to the Kandahar Role 3 Multinational Medical Unit (MMU). Depending upon the treatment required, casualties may receive further surgery, be clinically stabilised, and/or provided supportive care. The facility is predominately staffed by US health specialists but is currently being augmented by ADF specialist reserve staff. The ADF has a general surgeon, anaesthetist, orthopaedic surgeon, two perioperative nurses and two intensive care nurses embedded in this facility.

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20 Department of Defence, *Submission 17*, p. 7.

21 Department of Defence, *Submission 17*, p. 12.

22 Soldier J, *Committee Hansard*, 26 March 2013, p. 9.

2.41 Once stabilised, seriously wounded or injured personnel will be returned to Australia for additional treatment and rehabilitation which is managed by Joint Health Command.[23]

Operational health support

2.42 Defence informed the Committee that the ADF provides comprehensive health services whether the environment is permissive, uncertain or hostile. In addition to caring for Defence personnel, ADF health elements may provide humanitarian health care to a civilian population in higher threat environments until the situation has sufficiently stabilised for handover to civilian providers.

2.43 Military health support is commensurate with force strength and assessed health risks and is designed to ensure that appropriate treatment and evacuation capabilities exist to maximise the early return to duty of casualties. Support starts before deployment and expands as the force strength expands and risks increase. It focuses on both battle casualties as well as disease and non-battle injuries. Health support has a surge capacity to support peak casualty periods.

2.44 As noted previously, when ADF personnel are injured or become ill, there is an expectation that they will receive prompt and effective health care. ADF health care meets contemporary professional Australian standards except when the exigencies of military operations dictate otherwise.[24] LTCOL Reade told the Committee that ADF medical staff volunteering for deployment to Afghanistan had shown 'quite a depth of skill and were willing contributors'.[25]

2.45 LTCOL Reade went on to explain that it would be very expensive to train a contract health practitioner to be able to go to Afghanistan and deal with that high-level, high-intensity everyday trauma that is being experienced.[26]

Committee comment

2.46 The Committee acknowledges Defence's submission that management of the wounded and injured in Afghanistan is currently the most difficult

23 Department of Defence, *Submission 17*, p. 12.

24 Department of Defence, *Submission 17*, p. 6.

25 LTCOL Michael Reade, Professor of Military Medicine and Surgery, *Committee Hansard*, 25 March 2013, p. 24.

26 LTCOL Michael Reade, Professor of Military Medicine and Surgery, *Committee Hansard*, 25 March 2013, p. 26.

area for the provision of health care and the lessons learnt in this operation have been, and are applied to, other operations and exercises.

2.47 The Committee agrees that it is not appropriate for Defence to provide more specific details on an incident immediately due to medical-in-confidence and privacy reasons and that, where possible, contact with the NOK takes precedence over all other considerations.

2.48 The Committee also agrees with the general Defence policy regarding the release of the names of members wounded or injured.