



AUSTRALIAN DEFENCE FORCE PUBLICATION

OPERATIONS SERIES

ADFP 53

HEALTH SUPPORT

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AUSTRALIAN DEFENCE FORCE PUBLICATION

OPERATIONS SERIES

HEALTH SUPPORT

Australian Defence Force Publication 53 (ADFP 53)—*Health Support*, is issued for use by the Australian Defence Force (ADF) and is effective forthwith. This edition supersedes ADFP 53, first edition 1994 issued on 22 July 1994, all copies of which should be destroyed in accordance with current security instructions.

A handwritten signature in black ink, appearing to read 'C.A. Barrie', with a large loop at the end.

C.A. BARRIE
Admiral, RAN
Chief of the Defence Force

Australian Defence Headquarters
CANBERRA ACT 2600

18 December 1998

FOREWORD

1. ADFP 53—*Health Support* details joint procedures for planning and providing health support in joint operations. This ADFP is based on the general principles and doctrine contained in ADFP 1—*Doctrine* and ADFP 2—*Division of Responsibilities within the Australian Defence Force*.
2. The doctrine and procedures herein are to be used within the single Services for joint training and exercise purposes, as well as for joint operations.
3. The Chief of the Defence Force is the approval authority for ADFP 53. Commander Australian Theatre is the document sponsor and Commandant Australian Defence Force Warfare Centre (ADFWC) is responsible for its continued development, amendment and production. Further information on ADFPs is promulgated in Defence Instructions (General) ADMIN 20–1—*Production and Control of Australian Defence Force Publications*.
4. Every opportunity should be taken by the users of this publication to examine constructively its contents, applicability and currency. If deficiencies or errors are found, amendment action should be taken. ADFWC welcomes any assistance, from whatever source, to improve this publication. Users should note that a major review of health support is currently underway in the context of the JP 2060 Project, ADF Deployable Medical Capability. The results of this study may impact the contents of ADFP 53.
5. **ADFP 53 is not to be released to foreign countries without the written approval of the Commandant Australian Defence Force Warfare Centre.**

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ADFP 1	<i>Doctrine</i>	7610-66-139-0587
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ADFP 3	<i>Rules of Engagement</i>	7610-66-136-3884
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ADFP 6	<i>Operations</i>	7610-66-139-4138
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Supplement 3	<i>Air Operations</i>	7610-66-141-6925
ADFP 9	<i>Joint Planning</i>	7610-66-139-3518
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Supplement 2	<i>Australia's Maritime Jurisdiction</i>	7610-66-141-6561
ADFP 10	<i>Communications</i>	7610-66-139-4139
ADFP 11	<i>Offensive Support</i>	7610-66-139-4140
ADFP 12	<i>Amphibious Operations</i>	7610-66-139-4141
Supplement 1	<i>Amphibious Operations Handbook</i>	7610-66-141-6920
ADFP 13	<i>Air Defence and Airspace Control</i>	7610-66-139-4142
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ADFP 21	<i>Movements</i>	7610-66-139-4149
ADFP 22	<i>Sea Transport</i>	7610-66-139-4150
ADFP 23	<i>Targeting</i>	7610-66-139-4151
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ADFP 39	<i>Airborne Operations</i>	7610-66-139-4156
ADFP 41	<i>Defence Public Information Policy During Periods of Tension and Conflict</i>	7610-66-139-6630
ADFP 44	<i>Civil Military Cooperation</i>	7610-66-141-6921
ADFP 45	<i>Special Operations</i>	7610-66-139-4158
ADFP 53	<i>Health Support</i>	7610-66-139-3258
ADFP 56	<i>Explosive Ordnance Disposal</i>	7610-66-139-4159

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Symbols of Protection



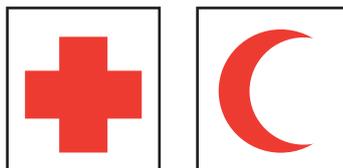
Distinctive Sign of:

Sign

Application/ Explanation

Civilian and Military Medical Units &
Religious Personnel

International Red Cross and Red
Crescent Movement
(Geneva Conventions I-IV, 1949)
(Protocols I & II, 1977)

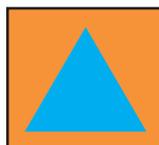


Used as a symbol to protect medical units
including field hospitals, transports,
medical and religious personnel.

Protective emblem of ICRC delegates in
conflicts.

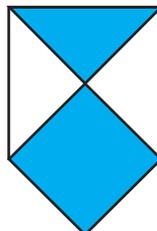
Used to indicate activities of National
Societies, such as the Australian Red
Cross Society. In times of conflict, a
National Society can only use the emblem
as a protective sign if they are an official
auxiliary to the medical services of the
armed forces.

Civil Defence
(Protocol I, 1977)



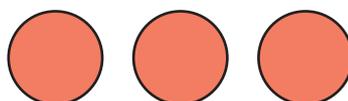
Used as a symbol to protect personnel and
equipment engaged in providing assistance
to civilian victims of war. The symbol is
used by personnel such as firefighters,
police and emergency rescue workers.

Cultural Property
(The Hague Convention of 1954)
(Protocol I, 1977)



Provides general protection to places and
object of cultural significance. Special
protection for places that are registered
with UNESCO e.g. churches, archaeo-
logical sites, monuments and museums.

Dangerous Forces
(Protocol I, 1977)



Provides specific protection to works or
places that may contain dangerous forces
e.g. dams or atomic reactors.

**For further information, please contact the International Humanitarian Law Officer,
Australian Red Cross Society in your State/Territory capital city:**

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CHAPTER 1

INTRODUCTION

General

1.1 The provision of health support is a vital consideration in any joint or combined operation. In joint operations, casualty management depends upon close cooperation and effective coordination between the Services, each of which has specific responsibilities in the treatment and evacuation process. The provision of health support will be closely coordinated with the provision of other support.

1.2 Objective. The objective of health support is the conservation of personnel to maintain operational capability and to facilitate operational success. This will be achieved by ensuring that a joint force is deployed at optimal fitness, that adequate preventive measures are in place and that appropriate treatment and evacuation capabilities exist to maximise the early return to duty of casualties. Health support on operations therefore embraces:

- a. monitoring the health fitness of personnel;
- b. environmental, preventive and occupational health services;
- c. health intelligence;
- d. medical and dental treatment;
- e. evacuation of casualties, within or from an area of operations (AO); and
- f. medical and dental supply services.

Levels of health support

1.3 Health support in operations is based on a hierarchical system of casualty management which involves five levels of treatment. These are as follows:

- a. **Level one.** The first level in the hierarchy includes the location and removal from danger of casualties and provision of immediate first aid. It may involve self or buddy aid, examination and emergency lifesaving measures such as maintenance of airway, control of bleeding, prevention and control of shock, and prevention of further injury. It may include treatment at an aid post or similar facility with trained medical personnel where treatment could include restoration of airway, use of intravenous fluids, antibiotics and application of splints and bandages.
- b. **Level two.** The next level is the collection, sorting, treatment and evacuation of casualties and provision of resuscitative procedures where appropriate. It is provided at a minimal care facility which can include basic laboratory, pharmacy and temporary holding facilities. Surgical support is not normally provided. At this level, medical examinations and observations can be conducted in a more deliberate manner than at level one. The focus is on sustaining care and evacuation, resuscitation and stabilisation.
- c. **Level three.** At this level, first formal surgery, including initial wound surgery, is performed and hospitalisation is provided for medium and high intensity nursing of the wounded, sick and injured. Facilities are staffed and equipped to provide resuscitation, initial surgery and post-operative treatment. Care at this level may be the initial step towards restoration of functional health, as distinct from procedures that stabilise a condition or prolong life. Treatment is provided with greater preparation and deliberation. Level three medical units are able to prepare for evacuation those patients who require care beyond the scope and management of the unit.
- d. **Level four.** Specialised surgery, rehabilitation and hospitalisation are provided at this level within the limits of the holding policy. It is normally the highest level of care provided in an AO.

- e. **Level five.** This is the highest level of care which is normally provided only in the support area. It includes specialised and sophisticated management and care associated with the most advanced range of medical capabilities. Research facilities are also provided.

Principles of health support

1.4 The provision of health support may be affected by numerous factors, including political considerations, weapon systems and other technologies, the changing nature of contemporary warfare, medical and physical fitness of the force, emerging disease patterns, the availability of Australian Defence Force (ADF) health services and evacuation assets, the availability of other ADF resources, and the extent and availability of civilian health infrastructure. Regardless of the factors, there are a number of proven principles that should be applied in providing health support, these are:

- a. **Prevention.** Significant personnel savings can be achieved by the use of measures designed to promote health and prevent non-battle casualties. This could include training of personnel, application of appropriate preventive measures before and after deployment, ongoing medical surveillance and continued provision of health advice.
- b. **Conformity.** Health plans must complement the operational and logistics plans and must also conform to the highest level of professional practice, standards and ethics.
- c. **Control.** Senior health service officers must exercise technical control and an appropriate degree of operational authority over health resources to ensure economy of effort and avoidance of duplication. These resources will include personnel, facilities, and materiel. Deployed resources must provide the optimum support for the greatest number. Communications between key health service facilities and staff, and the supported force are an essential element of control.
- d. **Continuity.** Treatment and evacuation must be continuous in a process that does not terminate until the patient has been returned to duty or discharged from military service. Health support is provided to stabilise patients, so they can be evacuated to a facility where appropriate definitive care can be provided. Whilst delays or interruptions in treatment will increase morbidity and mortality rates, no patient should be evacuated further than their physical condition requires, or than the operational situation warrants.
- e. **Flexibility.** Health support plans must be flexible in order to meet changes in the operational situation.
- f. **Mobility.** Health units must have sufficient mobility to maintain contact with supported forces. Prompt evacuation of casualties and patients and the availability of good communications are essential to maintaining mobility.
- g. **Proximity.** Rapid initiation of treatment will significantly reduce morbidity and mortality rates. Health support resources must be located as close to an area of combat operations as time and distance factors and the tactical and medical situations allow. Rapid clearance of casualties from the area of combat and provision of resuscitative treatment as far forward as possible are critical factors. However, health facilities must not be located so that they interfere with, or compromise the security of, combat operations.

Responsibilities for health support

1.5 Health support of assigned forces is a command responsibility whether at the strategic, operational or tactical level and is exercised on the advice of officers of the ADF health services.

1.6 **Joint operations.** As detailed in Australian Defence Force Publication 2—*Division of Responsibilities within the Australian Defence Force* chapter 53, Service responsibilities for health support in joint operations are as follows:

- a. The Royal Australian Navy is responsible for:
 - (1) provision of level one support in submarines and minor fleet units,
 - (2) provision of level two or higher support in major fleet units,
 - (3) provision of medical and dental treatment facilities at base ports,

- (4) provision of medical and dental treatment facilities and evacuation in ships allocated to that role in maritime and offshore operations, and
 - (5) forward aeromedical evacuation (AME) in maritime operations.
- b. Army is responsible for:
- (1) provision of medical and dental treatment facilities and convalescent and rehabilitation facilities within the land AO and along the lines of communication where surface evacuation is employed,
 - (2) provision of surface evacuation beyond unit level in the land AO, and
 - (3) forward AME in the land AO.
- c. The Royal Australian Air Force is responsible for:
- (1) provision of medical and dental treatment facilities on RAAF bases, RAAF aircraft and, at appropriate locations in the tactical and strategic aeromedical evacuation systems:
 - (a) tactical and strategic AME, and
 - (b) provision of casualty staging facilities at operational and transit airfields in the AME system.

Disposal of the dead

1.7 Disposal of the dead is not a health services responsibility. Responsibilities for graves and mortuary services are detailed in ADFP 2, chapter 54 and are, in general, a responsibility of the administrative organisation.

Combined operations

1.8 In combined operations, health support may be provided to another nation's combat forces. Alternatively, ADF forces may utilise health support from other nations. The coordination of this support will be more complex than for joint operations but similar considerations will apply. In-place arrangements and agreements provide the initial basis for this coordination.

CHAPTER 2

HEALTH SUPPORT CAPABILITIES

General

2.1 Each of the Services can provide a range of operational health support capabilities which are derived from strategic guidance and reflect the division of responsibilities as detailed in [chapter 1—'Introduction'](#) and in Australian Defence Force Publication 2—*Division of Responsibilities within the Australian Defence Force*, chapter 53. Wherever practicable within a joint force area of operations (JFAO), health support is to be provided on a joint basis and unnecessary duplication of capabilities avoided. In some circumstances, single Service health units may be allocated in support of personnel from other Services or in support of other Service health units.

Australian Defence Headquarters

2.2 At the strategic level, the Defence Health Service (DHS) Branch of the Defence Personnel Executive provides health support advice to the Chief of the Defence Force, through the Vice Chief of the Defence Force. The DHS branch is comprised of 10 directorates:

- a. Strategic Health Planning and Intelligence,
- b. Health Capability Development,
- c. Clinical Policy,
- d. Health Personnel Professional Development,
- e. Health Materiel and Logistics,
- f. Nursing Services and Health Training,
- g. Dental Services and Corporate Planning,
- h. Health Information Policy and Planning,
- i. Occupational Medicine and Health Surveillance, and
- j. Australian Defence Force (ADF) Health Records.

Joint and Joint Force Headquarters

2.3 All joint force headquarters include a senior health officer and appropriate health services staff who provide operational health support advice, input to the operational and administrative planning processes and exercise technical control over the provision of health support.

2.4 **Headquarters Australian Theatre (HQAAT).** The Commander Australian Theatre (COMAST) exercises theatre command at the operational level through the HQAAT component commanders: the Naval Component Commander, the Land Component Commander, the Air Component Commander, and the Special Operations Component Commander. HQAAT, including each component, contains appropriate health service staff to provide operational level health planning and to exercise technical control over the provision of health support. The Chief Staff Officer (CSO) Health, also known as the J07, provides health advice to COMAST and chairs the Theatre Health Planning Group, ensuring the development of coordinated health support plans.

2.5 **Maritime Headquarters (MHQ).** The fleet medical officer is a member of the Administrative Planning Group in MHQ and responsible to the Maritime Commander Australia (MCAUST), in conjunction with the CSO Support, through the Chief of Staff for:

- a. acting as command medical officer for Maritime Command;
- b. operational level health planning within MHQ;
- c. monitoring medical and dental operational readiness in fleet units;

- d. developing health annexes to single Service and joint operational orders involving Maritime Command;
- e. controlling the disposition of medical and dental officers in Maritime Command;
- f. providing medical and dental advice to Maritime Command;
- g. monitoring standards for medical and dental equipment, procedures and protocols within Maritime Command;
- h. monitoring standards of public, environmental and occupational health in Maritime Command;
- i. supervising the compilation and distribution of port and countries health intelligence;
- j. performing medical and dental duties at sea as directed;
- k. representing MCAUST at joint health planning group meetings; and
- l. supervising the Maritime Command health program.

2.6 Land Headquarters (LHQ). Colonel Health Services is the principal medical adviser to Land Commander Australia and has technical control of all Land Command medical units and is responsible for the planning and conduct of medical support to land operations.

2.7 Headquarters Air Command (HQAC). The Director of Health Services (DHS) is the principal medical adviser to the Air Commander Australia. Health Directorate HQAC is responsible for ensuring the capabilities and performance of the Royal Australian Air Force (RAAF) operational health support, conducting operational health planning, and through the exercise of technical control over Air Command health resources, providing health care within the command. DHS HQAC and staff officers provide advice on:

- a. air operations health planning;
- b. aviation/clinical medicine;
- c. aviation/clinical dentistry;
- d. aeromedical evacuation;
- e. medical logistics and pharmacy services;
- f. pathology services;
- g. environmental health; and
- h. nursing services.

2.8 Headquarters Special Operations (HQSO). The SO2 MED Admin in HQSO provides health support advice to Commander Special Forces. The nature of special force operations requires special arrangements in respect to health support, these will normally be established by the commander assigning the mission after consultation with the Surgeon General Australian Defence Force and HQSO.

2.9 Headquarters Northern Command. Health advice to Commander Northern Command is provided by Staff Officer Grade One, Joint Health. The Joint Health Branch may be augmented as required.

2.10 Deployable Joint Force Headquarters (DJFHQ). The senior medical officer (SMO) is the principal health adviser to the commander and provides health advice and technical control of Army medical units allocated under command of the DJFHQ. When the DJFHQ is activated as a joint task force or as part of a combined task force the SMO is responsible for the planning and conduct of health support to joint and combined operations. On these occasions residual command and technical control of Army medical units will normally transfer to LHQ.

Royal Australian Navy

2.11 Maritime health support. In the Royal Australian Navy, health support up to level two is organic to ships. Level three health support may be deployed on a limited number of ships if operationally required.

- a. **Level one.** Level one health support is provided in all minor war vessels (MWW).
- b. **Level two.** Level two health support is provided in all major fleet units (MFU). A medical officer will be embarked during combat operations.

2.12 Ship's action medical organisation:

- a. **Role.** A ship's action medical organisation provides level one health care to a ship's company and embarked forces during combat action or ship board emergencies.
- b. **Characteristics.** The ship's action medical organisation consists of:
 - (1) one or more first aid posts (FAP)/battle dressing stations (BDS) containing stocks of emergency medical materiel for the provision of lifesaving first aid to casualties and sited appropriately within the ship so as to minimise the risk of damage or loss of stores;
 - (2) in larger MFU, an emergency operating station (EOS) to provide emergency facilities for surgical procedures after the combat action or emergency has passed (the EOS may be one of the FAP/BDS); and
 - (3) approximately three to seven percent of the ship's company to act as the ship's medical emergency teams (SMET) and staff the FAP/BDS.
- c. **Tasks.** The ship's action medical organisation is responsible for:
 - (1) providing emergency first aid to personnel wounded during combat action or ship-board emergencies;
 - (2) evacuating casualties to the FAP/BDS in conjunction with the ship's damage control teams;
 - (3) stabilising casualties prior to evacuation; and
 - (4) providing nursing care to casualties retained on board.
- d. **Capabilities.** The SMETs provide personnel support to ship's medical staff in the management of single or multiple casualties occurring as a result of ship damage. Casualties sustained from major combat damage are likely to exceed the capability of the action medical organisation, in which case the principles of mass casualty triage will be applied (see [chapter 5—'Triage, evacuation and regulation'](#)).
- e. **Allocation.** All ships have a ship's action medical organisation commensurate with their size and layout.
- f. **Organisation.** The ship's action medical organisation is managed by the ship's medical officer (or senior medical sailor if an medical officer (MO) is not aboard). The MO is stationed in the ship's damage control centre/headquarters during the action and, once the casualty situation has become clear, moves through the ship to attend to casualties as required. Each FAP/BDS is manned by a SMET of a size commensurate with the size of the ship's company.

2.13 Ship's sick bay:

- a. **Role.** A ship's sick bay provides level one or two health support to a ship's company and embarked forces.
- b. **Characteristics.** The sick bay is a specialised space in a ship designed, sited and equipped for treatment of the sick and injured and administration of health requirements. Its size and complement of medical staff vary with the type of ship. Additional characteristics are:
 - (1) limited short-term holding capability—up to four berths;
 - (2) capability to provide limited emergency resuscitation and surgery; and
 - (3) limited diagnostic capability.
- c. **Tasks.** Sick bays are responsible for:
 - (1) monitoring and maintaining the health of the ship's company;
 - (2) treating minor illness;
 - (3) collecting and providing essential first aid to casualties;
 - (4) preparation of casualties for evacuation from the ship; and
 - (5) raising and maintaining documentation with respect to illness and casualties.
- d. **Capabilities.** Sick bays in MFUs are generally able to support emergency resuscitative surgery, and low dependency nursing care. MWVs are able to provide nursing care to the limit of the training of health care personnel borne.
- e. **Allocation.** MFUs (except submarines) will normally have purpose-built sick bays. MWVs have space designated to provide for this function.
- f. **Organisation.** The manning of a sick bay varies with the class of ship. MFUs include an MO and two medical branch sailors of petty officer and able seaman rank. Medical management in MWVs is provided by specifically trained non-medical personnel. Usually, the vessel's coxswain is trained to manage daily medical matters (including emergencies) with the able seaman cook providing assistance in emergencies or action.

2.14 Primary casualty reception facility (PCRF)—afloat medical facility (AMF):

- a. **Role.** A PCRF provides level three or, in special circumstances, level four health support afloat to maritime forces, and to land-based forces where appropriate facilities do not exist ashore.
- b. **Characteristics.** PCRFs will normally be deployed in a combat ship specifically equipped with the space and equipment necessary to provide the level of health care. Alternatively, an existing ship, or ship taken up from trade, could be temporarily modified to include appropriate space and equipment to provide a capability to receive, operate on and hold casualties post-operatively. This would however, be at a cost of reduced capability and efficiency, and conversion could prove expensive, difficult and time consuming.
- c. **Tasks.** PCRFs are responsible for:
 - (1) receiving casualties, usually by rotary wing aircraft, but also by sea transfer;
 - (2) providing acute medical, surgical and dental care to casualties;
 - (3) providing high dependency nursing;
 - (4) holding casualties pending evacuation to shore-based medical facilities;
 - (5) providing medical augmentation and specialist medical advice to other ships; and
 - (6) providing surgical teams on detachment to support other maritime or land facilities.

- d. **Capabilities.** An indicative PCRFB consists of approximately 50 beds, of which 10 are high dependency beds, two operating tables, the ability to receive up to six priority one casualties simultaneously, and basic X-ray and pathology (including blood banking) services.
- e. **Allocation.** A PCRFB will normally be provided in a maritime area of operations (AO) where maritime or land forces are engaged in operations in excess of three hours evacuation from land-based level three medical facilities.
- f. **Organisation.** An indicative PCRFB organisation is in annex A, [figure 2A-1](#).

2.15 Port medical facility:

- a. **Role.** Where shore medical facilities are inadequate to meet the needs of maritime forces based in port, a supplementary health care capability may be provided in the form of a port medical facility. The characteristics, tasks, capabilities and allocation of the facility will be tailored to meet the requirements as they arise.
- b. **Characteristics.** Reserved.
- c. **Tasks.** Reserved.
- d. **Capabilities.** Reserved.
- e. **Allocation.** Reserved.
- f. **Organisation.** Reserved.

2.16 Hospital ship—AMF:

- a. **Role.** A hospital ship provides level three or level four care to forces in the maritime AO.
- b. **Characteristics.** A hospital ship has health care characteristics similar to those of a PCRFB, although a larger number of beds, operating tables, and more extensive diagnostic services may be provided. A hospital ship, if deployed, will be declared and protected by the law of armed conflict and therefore:
 - (1) will require markings and lighting in accordance with the Geneva Conventions,
 - (2) is unable to have any form of offensive weaponry embarked, and
 - (3) is only able to communicate in the clear.
- c. **Tasks.** Reserved.
- d. **Allocation.** Reserved.
- e. **Capabilities.** Reserved.
- f. **Allocation.** Reserved.
- g. **Organisation.** Reserved.

Australian Army

2.17 General. Health support elements are provided to Australian Army units in accordance to anticipated requirements and will vary depending on the scale and intensity of the operation/exercise. The organisation and role of some health support elements are detailed in the following paragraphs.

2.18 Regimental aid post (RAP):

- a. **Role.** A RAP provides level one medical support to its parent unit.
- b. **Characteristics.** The size of the RAP varies with the type and size of the unit of which it is part. In an infantry battalion, the RAP is manned by the medical platoon of the administrative company.

- c. **Tasks.** The medical platoon of an infantry battalion is responsible for:
 - (1) maintaining health within the battalion;
 - (2) treating minor illness;
 - (3) collecting and providing essential first aid to casualties;
 - (4) preparing casualties for evacuation from the battalion area; and
 - (5) raising and maintaining documentation on injuries and illness.
- d. **Capability.** A RAP is capable of providing level one medical support to its parent unit.
- e. **Allocation.** All major units have a RAP. Smaller units normally have some integral medical support. Where this is not the case, personnel utilise other medical units for level one medical care.
- f. **Organisation.** An indicative organisation of a RAP is in annex A, [figure 2A-2](#).

2.19 Field ambulance:

- a. **Role.** A field ambulance provides collection, evacuation and treatment of casualties and advice to supported commanders on measures designed to promote health and to prevent disease.
- b. **Characteristics.** A field ambulance is a mobile, self-contained unit with the capacity to hold 75 patients on stretchers for short periods. This capacity may be varied by the attachment or detachment of treatment sections. Other major characteristics include the following:
 - (1) The unit has no surgical capacity. However, in exceptional circumstances, it may foster a surgical element for short periods pending deployment of a field hospital.
 - (2) Treatment sections can operate independently and include limited diagnostic facilities. When deployed, sections require administrative support.
 - (3) The evacuation section with its ambulance vehicles provides a limited casualty evacuation capability. During periods of intense activity, these resources may be pooled under the control of the commander medical services within a tactical area of responsibility (TAOR). Alternatively, the vehicles may be supplemented by casualty transportation from outside the TAOR, including wheeled ambulances, armoured personnel carriers, rotary wing and fixed-wing aircraft.
 - (4) A health officer is included in the establishment to advise units on preventative health measures.
- c. **Tasks.** Field ambulances are responsible for:
 - (1) evacuating casualties from unit medical establishments (RAPs);
 - (2) acting as a RAP for local units without a regimental medical officer (RMO) on establishment;
 - (3) treating and return to duty those personnel who are fit for duty;
 - (4) when necessary, holding minor sick and injured;
 - (5) preparing patients for further evacuation; and
 - (6) providing technical supervision of preventive health personnel assigned in support.

- d. **Capabilities.** Field ambulances can provide level two medical support to a brigade, but they require the following to remain effective during prolonged periods of intense activity:
 - (1) rapid and continual evacuation from treatment sections;
 - (2) augmentation of personnel, equipment, evacuation transport and stretcher and blanket pools at evacuation loading and unloading terminals; and
 - (3) guaranteed resupply of medical stores.
- e. **Allocation.** There are three field ambulances to each division. They are also held in Corps troops.
- f. **Organisation.** An indicative organisation for a field ambulance is in annex A, [figure 2A-3](#).

2.20 Administrative support battalion medical company:

- a. **Role.** The brigade administrative support battalion (BASB) medical company (med coy) performs the same role as the field ambulance in independent brigade operations.
- b. **Tasks.** The tasks of the BASB med coy are identical to those of a field ambulance.
- c. **Characteristics.** The characteristics of the BASB med coy are identical to a field ambulance, with the exception that the unit is not administratively self-contained.
- d. **Capabilities.** The capabilities of the BASB med coy are as for a field ambulance, with the exception that medical companies are not structured to support task force operations.
- e. **Organisation.** The organisation of the BASB med coy is similar to the organisation of the medical company of a field ambulance except there is a health section in the BASB med coy but no dental section, and the pathology and X-ray sections are distinct elements and not part of the treatment sections.

2.21 Field hospital:

- a. **Role.** A field hospital provides first formal surgery, including initial wound surgery, and hospitalisation for the seriously ill in the combat zone.
- b. **Characteristics.** A field hospital is a mobile, self-contained unit without sufficient transport to move itself. Other major characteristics are:
 - (1) The medical company contains both medical and surgical elements. It has four treatment sections and an intensive care section totalling 110 beds.
 - (2) Treatment sections may be detached or supplemented from other sources, varying the total bed capacity. Care must be exercised to ensure that the effectiveness of the hospital is not diminished by detaching components.
 - (3) The unit has three operating teams. In emergency situations, one may be detached to support other field medical units. A field integrated resuscitation and surgical team (FIRST) may be attached to the unit from theatre level troops.
 - (4) Diagnostic facilities (pathology and X-ray) are available and can be included in any detachment to support another field medical unit.
 - (5) The unit does not have the ambulance resources to participate in the casualty evacuation plan.
- c. **Tasks.** Field hospitals are responsible for:
 - (1) receiving casualties evacuated from field ambulances and other sources;
 - (2) treating and caring for sick and injured patients so that they can be returned to duty, or stabilising them for further evacuation;

- (3) providing a limited central sterilising service for other field medical establishments and a laundry service for hospital lines;
 - (4) acting as a RAP for local units without an RMO on establishment;
 - (5) providing support to field ambulances by augmenting them with surgical and patient-care facilities in exceptional circumstances; and
 - (6) providing dental services.
- d. **Capabilities.** In conjunction with a field ambulance, the field hospital can provide support to a brigade task force under normal activity rates.
- e. **Organisation.** An indicative organisation for a field hospital is in annex A, [figure 2A–4](#).

2.22 FIRST:

- a. **Role.** A FIRST augments the surgical service in the AO.
- b. **Tasks.** A FIRST is employed to complement the surgical services provided by a field hospital. It may enable either a 24-hour operating capability in the supported medical unit or the ability to handle a surge of surgical casualties. A FIRST is a level three organisation which can augment a level three facility.
- c. **Characteristics.** A FIRST consists of a surgeon, anaesthetist, transfusion officer and four operating theatre technicians. Further characteristics are as follows:
- (1) It is lightly equipped and capable of rapid deployment. When deployed, to enable a 24-hour operating capability in a supported medical unit, it need not carry equipment. However, when deployed for 'surge' management, a complete equipment module is required.
 - (2) In terms of surgical capability, it is self-contained for only a 24-hour period after which it will require central sterile supply department support. It is not administratively self-contained and will normally be attached to either a forward general hospital or a field hospital.
- d. **Capability.** The average time taken for an operation on a priority-one casualty is one hour. A FIRST cannot be expected to deal with more than 12 priority-one casualties in 24 hours. Priorities assigned to casualties are detailed in [paragraph 5.4](#).
- e. **Allocation.** A FIRST is allocated on the basis of three per task force deployed. In a theatre of two task forces, three FIRSTs are allocated to the commander theatre medical services, while three remain available to support the communications zone.
- f. **Organisation.** An indicative organisation of a FIRST is in annex A, [figure 2A–5](#).

2.23 Forward surgical team (FST):

- a. **Role.** A FST provides forward surgical support in the land AO.
- b. **Characteristics.** A FST is a lightly scaled rapidly deployable unit with the following characteristics:
- (1) It will normally be attached to a level two medical facility such as a field ambulance, or BASB med coy, and rely on the host unit to provide administrative and logistic support.
 - (2) It has limited pathology and X-ray services, and no evacuation capacity.
 - (3) It can receive and treat small numbers of surgical casualties on an ongoing basis or manage a casualty surge for a period not normally exceeding 24 hours. It can perform up to 12 initial wound surgery operations or resuscitate up to 36 priority-one or two casualties in a 24-hour period.

- (4) Casualties treated by an FST will normally require subsequent evacuation to, and further treatment in a field hospital.
- (5) It is deployable by air, land or sea.
- c. **Tasks.** A FST provides level three medical facilities to independent brigade operations where lines of communications extend casualty evacuation times to level three medical care, beyond normally accepted limits. Tasks are likely to include triage and resuscitation, initial wound surgery, short-term post-operative holding and treatment of post-operative surgical patients and emergency medical patients and preparation of patients for evacuation.
- d. **Allocation.** FST can be allocated on the basis of one per independent brigade deployed.
- e. **Organisation.** An indicative organisation for a FST is in annex A, [figure 2A-6](#).

Royal Australian Air Force

2.24 Aeromedical evacuation (AME) team:

- a. **Role.** An AME team provides pre-flight preparation and in-flight medical care to patients during tactical and strategic AME missions.
- b. **Characteristics.** An AME team comprises personnel of the RAAF health services specifically trained in aeromedical evacuation. It can function in a range of Service and civilian aircraft operating in a dedicated or non-dedicated AME role. An AME team's composition depends on the number and type of casualties being evacuated and the length of flight. These aspects are usually determined by pre-mission planning.
- c. **Tasks.** An AME team provides:
 - (1) pre-flight assessment and determination of in-flight requirements for patients, including assessment of measures required to maximise stabilisation in-flight;
 - (2) pre-flight briefing of patients and aircrew, documentation, preparation of aircraft and equipment, loading and administration;
 - (3) loading of patients in accordance with applicable loading plans to optimise patient care in-flight;
 - (4) en route clinical and general nursing care and patient documentation; and
 - (5) post-flight debriefing, unloading, equipment resupply, preparation of mission reports and administration.
- d. **Organisation.** The composition of AME teams will be determined by the designated aeromedical evacuation coordinating officer (AECO). Factors influencing the composition of AME teams include the number of patients and their medical condition, the duration of the total flight and of intermediate stages, aircraft type and facilities and medical and support facilities available en route. The requirement for the inclusion of MO is based on clinical grounds and on facilities available en route and at terminal airfields. The inclusion of clinical specialists who are AME trained will be necessary in certain circumstances. [Annex B](#) provides a guide to the minimum nursing staffing of AME teams.

2.25 Health Services Flight (HSF):

- a. **Role.** A HSF provides health support to all personnel associated with air operations at a RAAF base.
- b. **Characteristics.** A HSF is a fixed facility located on air bases. A HSF is a level two facility which can range in capability from small health clinics to large health centres depending on the size of the population being supported. A HSF may be capable of limited expansion. Staff can be deployed to provide level one or level two health support

to a range of activities associated with air operations. HSF are not administratively self-contained and are part of a base support organisation such as a combat support squadron or a support unit.

- c. **Tasks.** HSF tasks will vary with the nature of the operations being supported and the availability of other military and civilian medical facilities. HSF will normally provide level one and level two health support and be responsible for:
 - (1) monitoring and maintaining the medical and dental fitness of operational aircrew and other military personnel on the air base,
 - (2) providing health care to operational aircrew and other military personnel on the air base,
 - (3) providing triage and resuscitative care to casualties,
 - (4) receiving casualties by ambulance or helicopter,
 - (5) providing an AECO and AME teams when required,
 - (6) providing support for base search and rescue (SAR) operations,
 - (7) providing specialist aviation medicine advice and support, and
 - (8) providing environmental health support to the base.
- d. **Capability.** Capability depends on individual base requirements. A SMO is normally the flight commander of each HSF and is also senior medical adviser to the base executives. The senior dental officer is the dental section commander and adviser to base executives on dental issues.
- e. **Allocation.** One HSF is allocated per RAAF base when deployment of a level three facility is not indicated.
- f. **Organisation.** An indicative organisation for a HSF is in annex A, [figure 2A-7](#) and [figure 2A-8](#).

2.26 RAAF hospital:

- a. **Role.** A RAAF hospital provides level three health support to all personnel associated with air operations on a RAAF base.
- b. **Characteristics.** RAAF hospitals are located in fixed facilities on large established air bases near major population centres or at centres of air transport operations. The majority of staff are able to be deployed to provide level one, two or three support to a range of activities associated with air operations. RAAF hospitals have a major role in the training of health services personnel for military roles and act as major centres for the reception of AME patients during operations.
- c. **Tasks.** Tasks vary according to the primary function of the command they support. They are likely to include:
 - (1) monitoring and maintaining the medical and dental fitness of all military personnel on the base,
 - (2) providing health care including emergency and elective surgery to military personnel on or near the base,
 - (3) providing triage and resuscitative care to casualties,
 - (4) receiving casualties by helicopter or ambulance,
 - (5) providing an AECO and AME teams when required,
 - (6) providing support for base SAR operations,
 - (7) providing specialist aviation medicine advice and support,

- (8) providing environmental health support to the base,
 - (9) acting as major centres for the reception of patients involved in AME during operations,
 - (10) providing military health training for health services personnel, and
 - (11) providing staff and equipment for a variety of deployable RAAF health facilities.
- d. **Capability.** The capability of RAAF hospitals varies depending on individual base requirements and specific operational and training roles.
- e. **Allocation.** One RAAF hospital per RAAF base when provision of a level three facility is indicated.
- f. **Organisation.** An indicative organisation for a RAAF hospital is in annex A, [figure 2A-9](#).

2.27 Aeromedical evacuation staging facility (ASF):

- a. **Role.** An ASF provides short-term health support and management of patients within an aeromedical evacuation system (AES), provides AME teams for the conduct of AME missions and provides health support to military personnel associated with air operations at a deployed air base.
- b. **Characteristics.** An ASF is a rapidly deployable health facility which will normally be located on an air base or strip which is in the AME chain and/or associated with tactical air operations, and which:
- (1) may be collocated with a HSF or sited to support land-based facilities such as a field ambulance or a field hospital;
 - (2) may in standard configuration continuously hold 18 litter patients for up to six hours every 24 hours, with the holding time able to be extended to 24 hours in emergencies, and with augmentation may increase capacity and duration as required;
 - (3) may be augmented with a fly away surgical team (FAST), or become an air transportable health centre (ATHC) or air transportable hospital (ATH); and
 - (4) is not administratively self-contained and is part of an airfield support organisation.
- c. **Tasks.** An ASF is responsible for:
- (1) receiving and holding patients entering or in transit through the AES;
 - (2) providing clinical management, assessment of fitness and preparation for AME of patients in the AES;
 - (3) providing health care up to level two and health support for operational aircrew and other military personnel on an air base;
 - (4) monitoring and maintaining the medical fitness of operational aircrew and all other military personnel on an air base;
 - (5) redirecting patients unsuitable for AME to alternative facilities;
 - (6) providing an AECO and AME teams;
 - (7) providing specialist aviation medicine advice and support;
 - (8) replenishing medical supplies for AME missions as necessary;
 - (9) providing airfield emergency medical response and support for SAR operations; and
 - (10) providing airfield environmental health support.

- d. **Capability.** An ASF is capable of providing AME support, level one and limited level two medical support.
- e. **Allocation.** An ASF will normally be provided at the airfield nearest each level two or three medical facility and to each deployed contingent at an airfield unless a higher level of support is indicated or this function can be fulfilled by an existing HSF or RAAF hospital.
- f. **Organisation.** An indicative organisation for an ASF is in annex A, [figure 2A-10](#).

2.28 FAST:

- a. **Role.** A FAST is an air-deployable, limited level three surgical capability available for deployment at minimal notice.
- b. **Characteristics.** A FAST is an air-deployable lightweight surgical section and consists of RAAF and RAAF specialist reserve members who are all AME trained. It can be deployed by air at minimal notice (usually within three to six hours) without prior warning. Surgery can be undertaken irrespective of the presence or absence of health facilities at the location of the patient.
- c. **Tasks.** A FAST performs triage, resuscitation, initial wound surgery and surgery for acute surgical conditions in areas where evacuation to established level three facilities exceeds acceptable time limits or is impractical. Typical tasks include surgical support of special AME during peacetime, provision of a limited surgical capability at deployed RAAF health facilities where the establishment of an ATH is pending or not indicated, provision of specialist care for tactical and strategic AME and provision of an immediate response surgical capability following an aircraft accident or natural disaster.
- d. **Capability.** A FAST in standard configuration has the capacity to perform three to four operations and then evacuate the patients. This capacity can be increased if a longer notice to move is available.
- e. **Allocation.** A FAST is allocated as required for operational support and commensurate with the nature, or potential nature, of the associated tasks.
- f. **Organisation.** An indicative organisation for a FAST is in annex A, [figure 2A-11](#).

2.29 ATHC:

- a. **Role.** An ATHC provides non-surgical health support to a contingent of personnel conducting or supporting air operations at a deployed air base and provides AME support.
- b. **Characteristics.** An ATHC is a rapidly deployable and mobile level two health facility which has no surgical capacity, but in exceptional circumstances, may incorporate a FAST for short periods, pending deployment of an ATH. The ATHC is designed as the middle component of RAAF deployable health facilities and can augment an ASF or be augmented to become an ATH. The ATHC is not administratively self-contained and is part of an airfield support organisation such as an air base wing or operational support unit. ATHC are able to:
 - (1) be located in fixed or tented facilities on air bases;
 - (2) provide a full range of health support including dental, psychiatric, pathology and radiography services to an air base population where surgical support is not available at other nearby facilities;
 - (3) support AME support; and
 - (4) provide an 18-bed in-patient capability and can stage an additional 18 patients for up to six hours in every 24 hours.

- c. **Tasks.** Tasks will vary with the primary function of the units supported. They are likely to include:
- (1) monitoring and maintaining the medical and dental fitness of all military personnel on the base;
 - (2) providing triage and resuscitative care to casualties;
 - (3) receiving casualties by aircraft or ambulance, including those entering or in transit through the AES;
 - (4) providing an AECO and AME teams when required;
 - (5) clinical management, assessment of fitness for AME and preparation for AME of patients in the AES;
 - (6) providing support for base SAR operations;
 - (7) providing specialist aviation medicine advice and support;
 - (8) providing critical incident stress debriefing; and
 - (9) providing environmental health support to the base.
- d. **Capability.** An ATHC can provide level two medical support to an air base population and AME support as required.
- e. **Allocation.** An ATHC is provided with each deployed contingent at an air base where a deployable middle level health facility is required.
- f. **Organisation.** An indicative organisation for an ATHC is in annex A, [figure 2A-12](#).

2.30 ATH:

- a. **Role.** An ATH provides a full surgical and in-patient capability to a deployed RAAF contingent on an air base and provides AME support.
- b. **Characteristics.** An ATH is a rapidly air-deployable level three unit which incorporates all ATHC features. Major characteristics are:
- (1) medical, dental and surgical elements, an outpatient area, an emergency resuscitation area, medical logistic support and a 27-bed capacity with the ability to stage an additional 18 patients for up to 6 hours in every 24 hours;
 - (2) surgical support where this is not otherwise available or feasible;
 - (3) two operating teams one of which may be detached to form a FAST;
 - (4) integral diagnostic facilities which can provide a 24-hour emergency capability; and
 - (5) administrative support obtained from an airfield support organisation.
- c. **Tasks.** An ATH is able to provide the full range of health services required at a deployed base. It includes integral dental and environmental health services. Tasks include:
- (1) monitoring and maintaining the medical and dental fitness of all military personnel on the base;
 - (2) providing medical and dental treatment and care for patients so that they can be returned to duty, or stabilised for further evacuation;
 - (3) providing collection, triage, resuscitation, surgical and post-operative care to casualties;
 - (4) receiving casualties evacuated from off-base areas, including those entering or in transit through the AES;

- (5) providing an AECO and AME teams when required;
 - (6) clinical management, assessment of fitness for AME and preparation for AME of patients in the AES;
 - (7) providing support for base SAR operations;
 - (8) providing specialist aviation medicine advice and support;
 - (9) providing environmental health support to the base; and
 - (10) providing a limited central sterilising service for other deployed RAAF medical establishments.
- d. **Capability.** An ATH can provide level three support to an air base population and AME support as required.
 - e. **Allocation.** An ATH is provided to support a major RAAF deployment.
 - f. **Organisation.** An indicative organisation for an air transportable hospital is in annex A, [figure 2A-13](#).

2.31 Aeromedical evacuation control centre (AECC):

- a. **Role.** An AECC coordinates appropriate aspects of aeromedical evacuation in conjunction with medical regulating staff.
- b. **Characteristics.** An AECC consists of an AECO, clerk medical and other staff as determined by the headquarters (HQ). An AECC is not administratively self-contained.
- c. **Tasks.** An AECC coordinates AME activities with the staff of the HQ to which it is attached and AECCs attached to other HQ.
- d. **Allocation.** One AECC is allocated to each HQ that has tasking authority for AME. It is normally part of the joint health staff of the HQ and coordinates air tasking for AME with the tactical air control post.

Forces of other nations

2.32 In combined operations, access to health support capabilities provided by other nations may be available. Similarly, the ADF may be required to provide health support to forces of other nations. Specific capabilities of health facilities of other nations will need to be determined early in the planning process and will need to be interoperable to ensure that treatment and evacuation, as well as regulation of casualties are not adversely affected. Documents such as ADFP 9 Supplement 1—*ANZUS Planning Manual* provide relevant guidance. Support to or from another nation will normally be provided under the terms of a status of forces agreement, memorandum of understanding, or similar legal arrangement.

Civilian infrastructure

2.33 Wherever practicable, ADF health services should make use of available civilian infrastructure. This could include a variety of buildings and other facilities, the utilisation of which may save time and cost in deployment, or fully staffed and equipped civilian health facilities capable of providing the level of support required, or civilian casualty evacuation resources. Utilisation of civilian health facilities in a JFAO is most likely to be practicable in low-level operations where the infrastructure remains in place. Utilisation may be limited as these facilities will continue to perform their primary role of providing health care to the civilian population and there may be little spare capacity that the ADF can utilise.

Annexes:

- A. [Indicative organisation of health support units](#)
- B. [Guide to minimum nursing staffing of aeromedical evacuation teams](#)

INDICATIVE ORGANISATION OF HEALTH SUPPORT UNITS

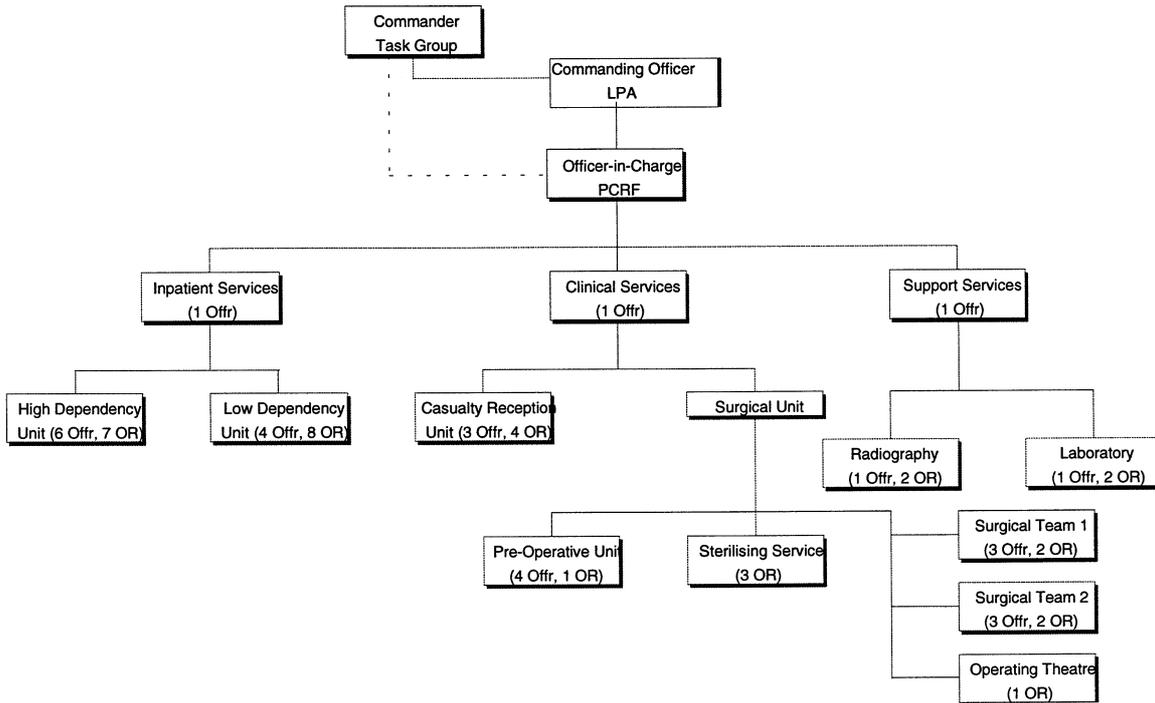


Figure 2A–1: Functional organisation of primary casualty reception facility

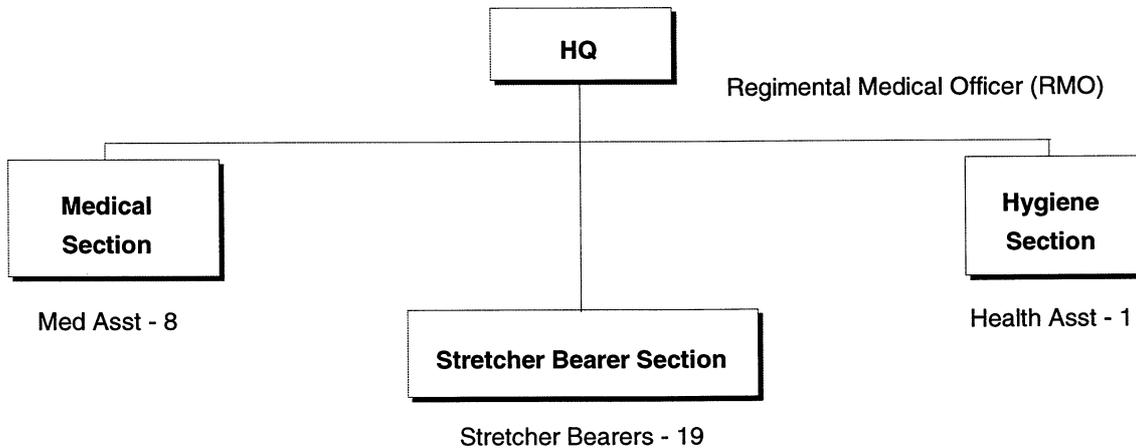


Figure 2A–2: Organisation of the regimental aid post of an infantry battalion

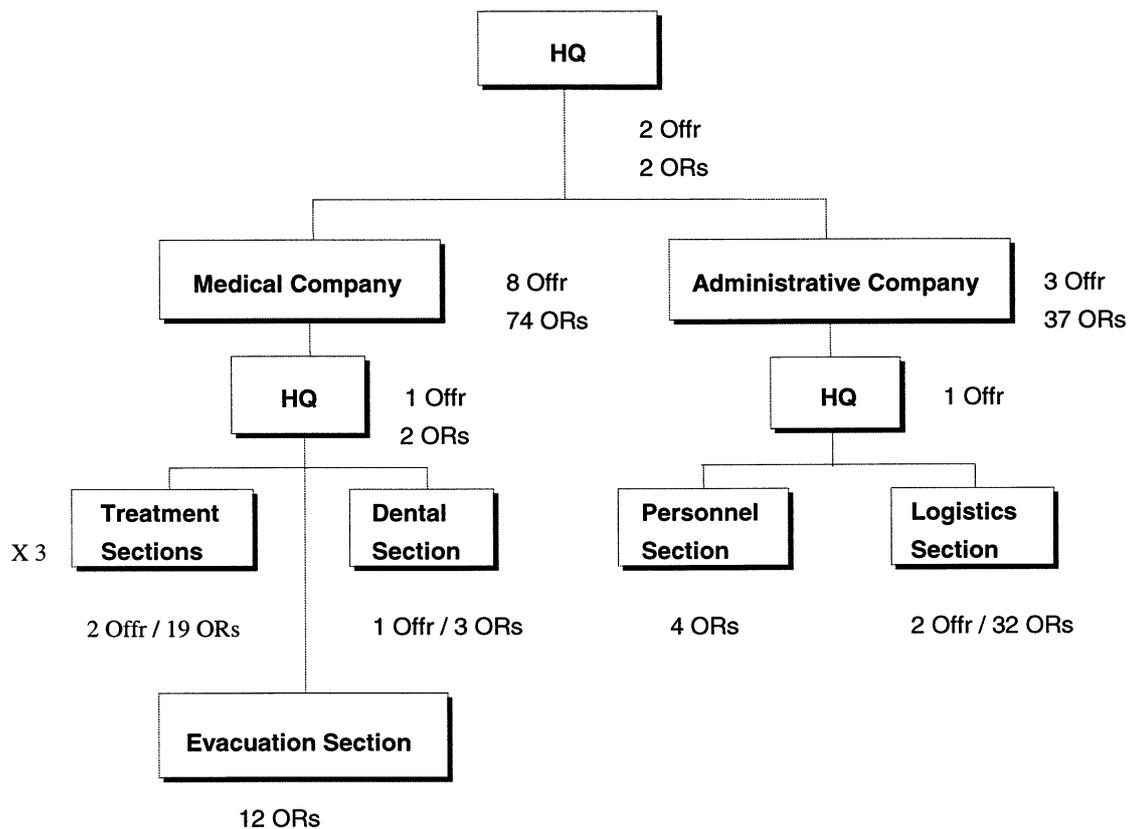


Figure 2A-3: Organisation of a field ambulance

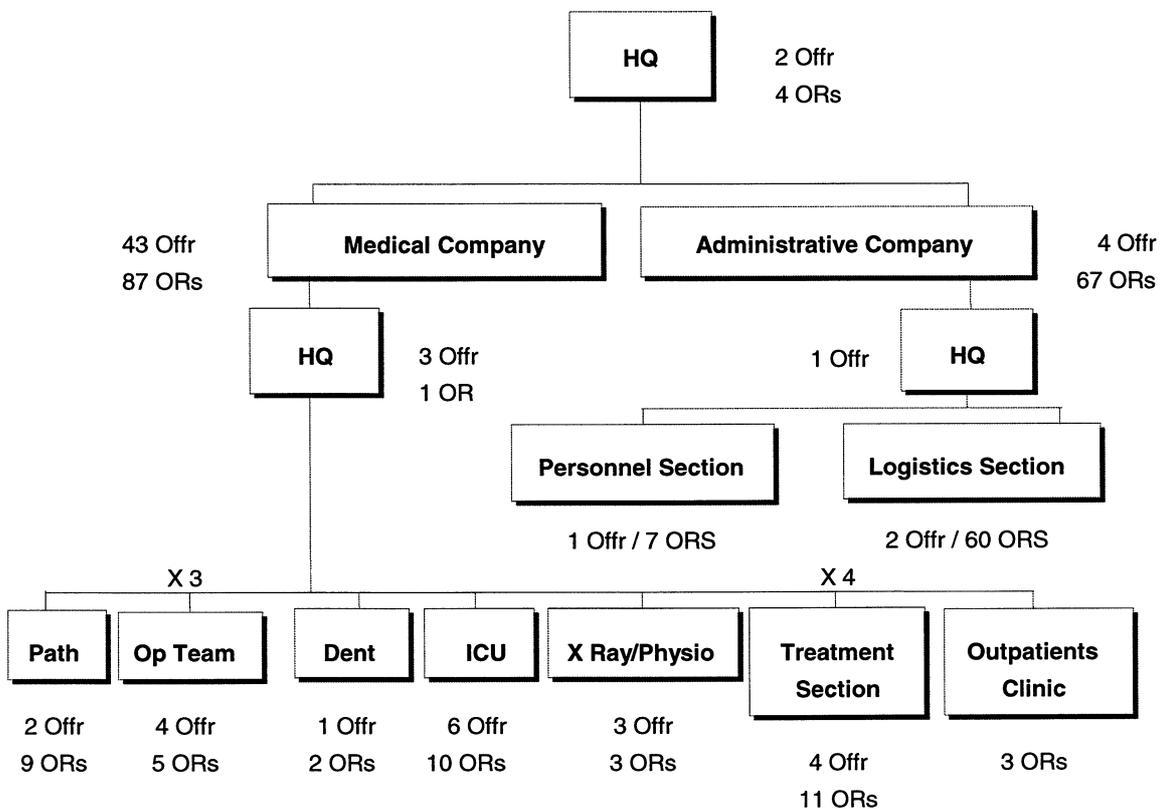


Figure 2A-4: Organisation of a field hospital

FIRST

- 1 Surgeon
- 1 Anaesthetist
- 1 Transfusion Officer
- 4 Op Theatre Technicians

Figure 2A-5: Organisation of a field integrated resuscitation and surgical team

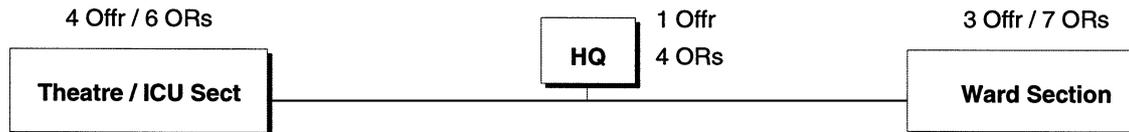


Figure 2A-6: Organisation of a forward surgical team

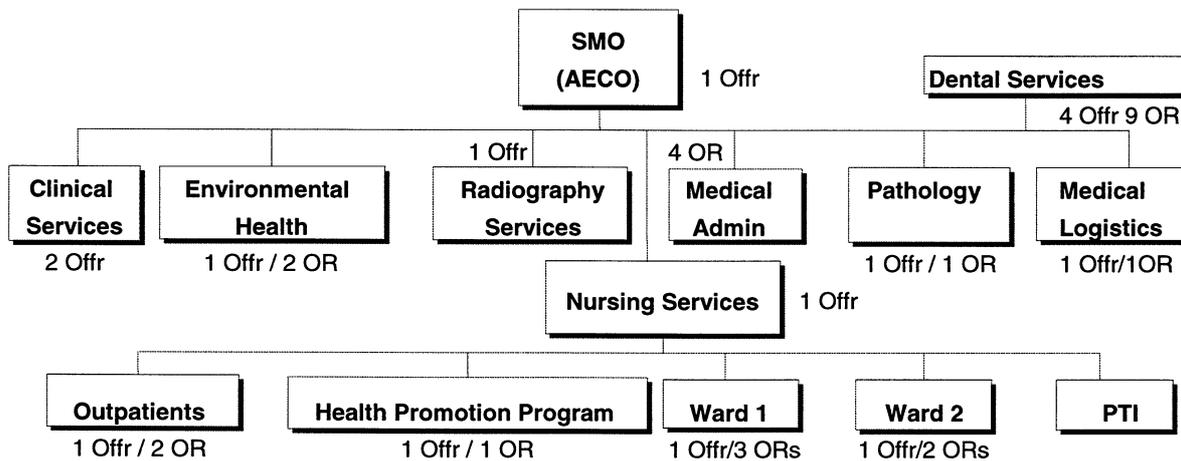


Figure 2A-7: Organisation of a health services flight (medical section)

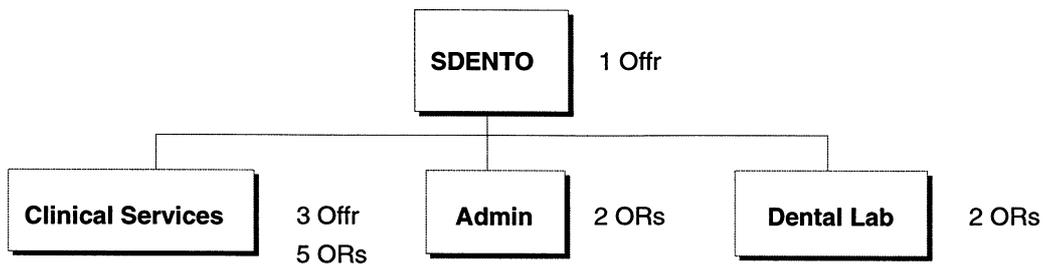


Figure 2A-8: Organisation of a health services flight (dental section)

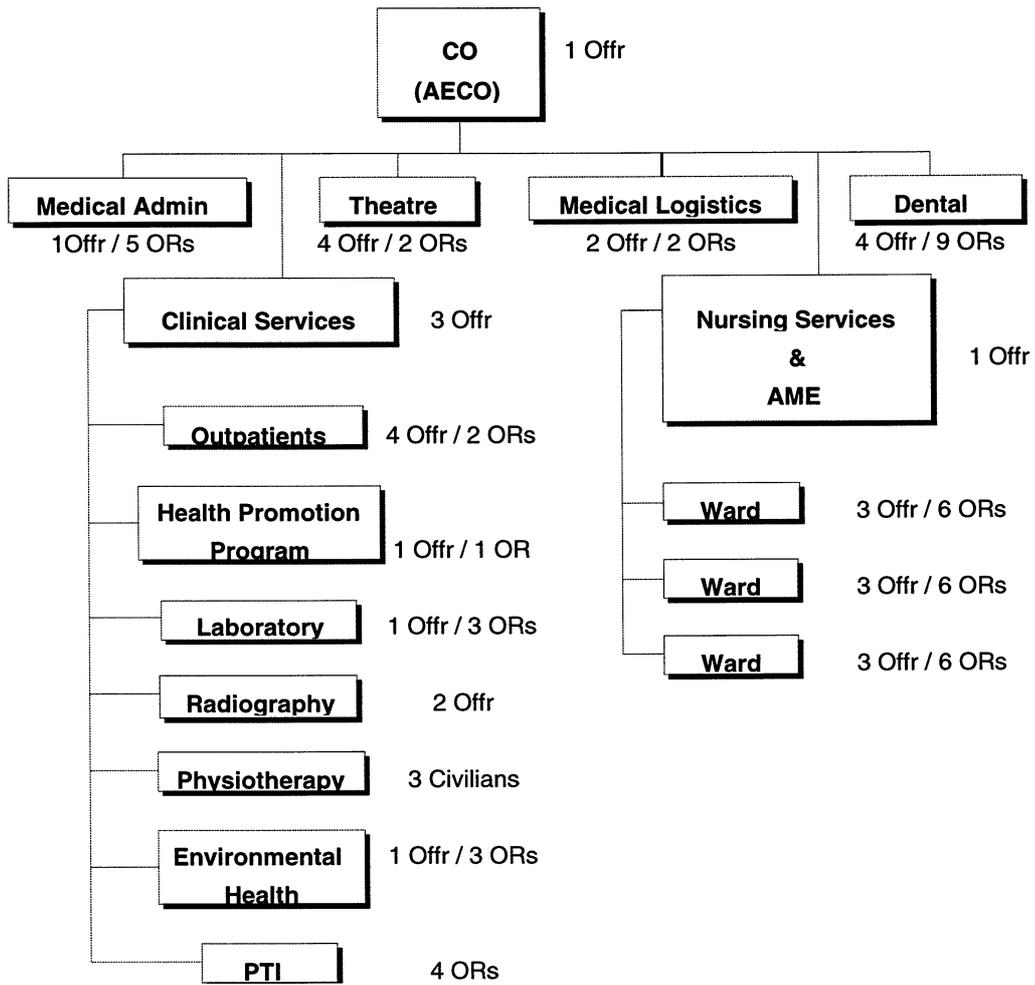


Figure 2A-9: Organisation of a Royal Australian Air Force hospital

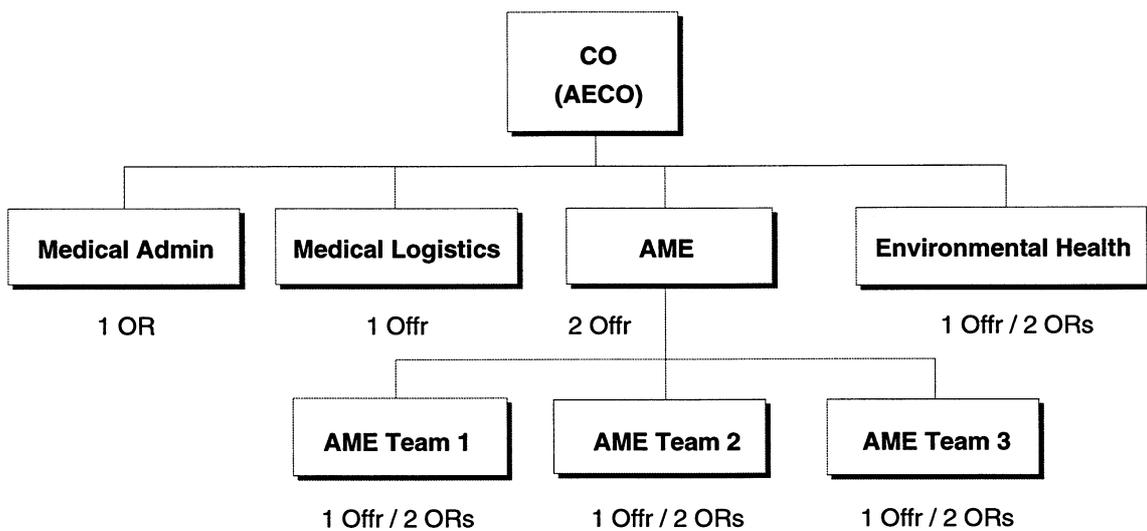


Figure 2A-10: Organisation of an aeromedical evacuation staging facility

FAST

- 1 Surgeon
- 1 Anaesthetist
- 1 Theatre Trained NO
- 2 Theatre Trained MEDASSTs

Figure 2A-11: Organisation of a fly away surgical team

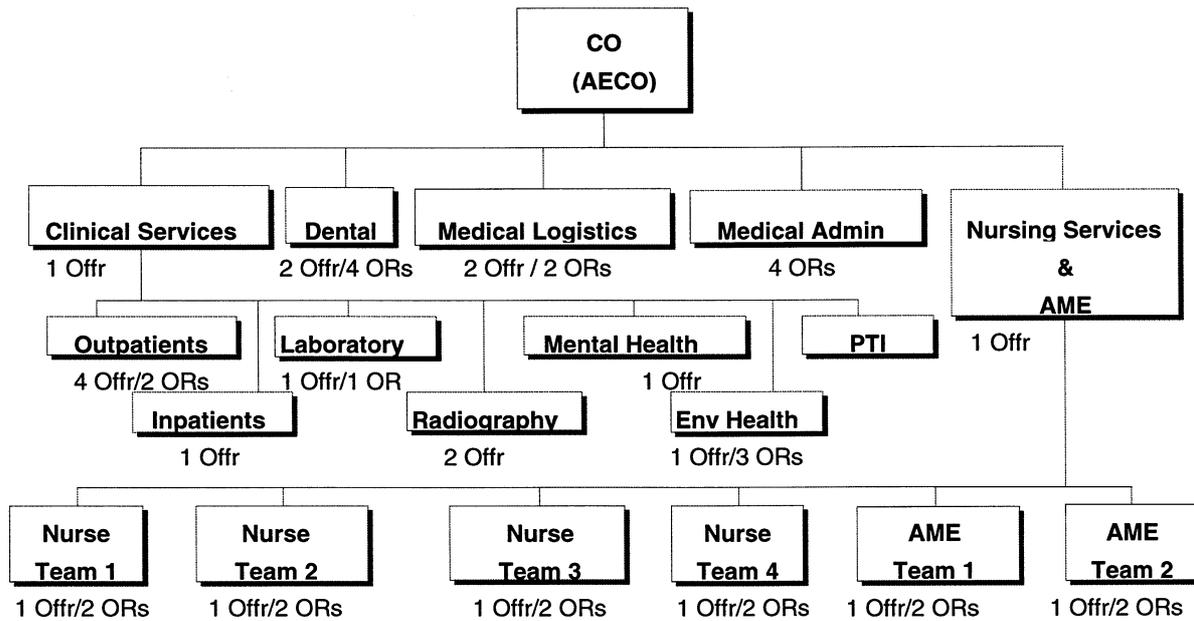


Figure 2A-12: Organisation of an air transportable health centre

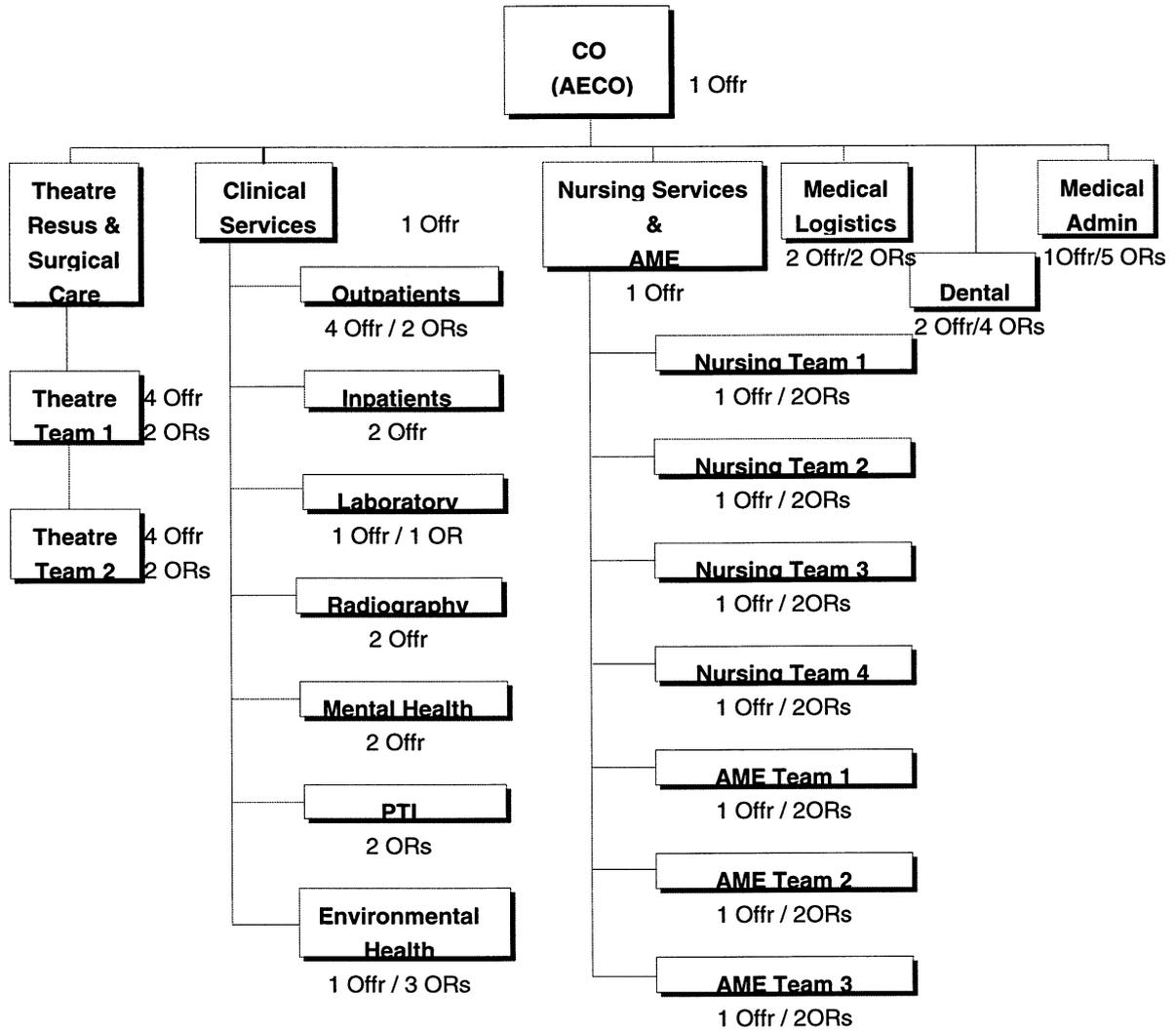


Figure 2A-13: Organisation of an air transportable hospital

GUIDE TO MINIMUM NURSING STAFFING OF AEROMEDICAL EVACUATION TEAMS

Normal patient loads

1. On flights less than five hours:
 - a. one to six patients—one nursing officer (NO) or one medical assistant (medasst);
 - b. seven to 20 patients—one NO and two medasst; and
 - c. 20 to 40 patients—two NO and two medasst.
2. On flights of between five to ten hours:
 - a. one to six patients—one NO and two medasst;
 - b. seven to 20 patients—two NO and three medasst; and
 - c. 20 to 40 patients—two NO and three medasst.
3. On flights of over 10 hours:
 - a. one to six patients—two NO and two medasst;
 - b. seven to 20 patients—two NO and three medasst; and
 - c. 20 to 40 patients—three NO and four medasst.

High dependency patients

4. When high dependency patients are to be carried, provision of additional NO is to be considered by the aeromedical evacuation coordinating officer irrespective of the duration of the flight, as follows:
 - a. one to two special patients—one additional NO; and
 - b. three to five special patients—two additional NO.

CHAPTER 3

AUSTRALIAN DEFENCE FORCE HEALTH PLANNING

General

3.1 Timely and effective health planning is essential to ensure optimum health support during operations.

3.2 Australian Defence Force (ADF) health planning at all levels is conducted as part of the broader planning for administrative support of operations and involves close cooperation and interaction with both operational and administrative planning staffs. A joint health support plan must complement the concept of operations or operational plan and will be developed from a health appreciation. The broader joint planning process is described in Australian Defence Force Publication (ADFP) 9—*Joint Planning*.

3.3 The intentions of health support plans are conveyed to subordinate elements and others involved in their implementation through written or verbal orders and instructions. The form and content vary with the level and complexity of the operation or plan.

Health appreciations

3.4 A health appreciation is the process by which a planner considers all circumstances relevant to the provision of health support to a particular operation. The outcome is a health support plan.

3.5 Health appreciations generally follow the military appreciation format detailed in ADFP 9. The key headings are:

- a. review of the situation,
- b. the aim,
- c. factors affecting the aim,
- d. health support options,
- e. identification of the preferred health support option, and
- f. health support plan.

3.6 Specific content and format of a health appreciation varies according to the complexity and level of planning, and the time available. At the tactical level, this could involve a quick mental consideration of factors relevant to health support to an imminent operation. In other circumstances, it will involve more detailed and lengthy consideration. Health appreciations will normally be written at the strategic and operational levels. A general check list is in [annex A](#).

Health intelligence

3.7 Timely, accurate, succinct and relevant health intelligence (HI) is crucial to the health appreciation process. It will provide the primary source of intelligence for consideration in the health aspects of the appreciation factor 'environment', and a preliminary source of intelligence on points of military geography and non-health infrastructure of importance to the appreciation. Health intelligence is not the only source of intelligence that must be considered in the health planning process. The majority of intelligence on non-health issues must be obtained from operations and intelligence staff sources.

3.8 Health intelligence is the knowledge resulting from the collection, evaluation, collation and interpretation of civil and military medical, environmental and biotechnological information. Within the ADF it applies particularly to the implications of that knowledge for ADF operations and includes intelligence on:

- a. environmental health factors:
 - (1) topography and climate;

- (2) socio-economic factors including population, attitudes to foreigners, travel restrictions and entry requirements (visas, vaccinations, human immunodeficiency virus testing, etc), living conditions, nutrition availability and status, health aspects of customs and religious practices, languages, drug abuse and prostitution;
 - (3) public health, water supply and potability, sanitation, food-handling hazards, housing or living standards;
 - (4) animal and plant hazards; and
 - (5) military trauma and related hazards;
- b. epidemiology and morbidity factors including current data on regional diseases, especially the following:
- (1) mosquito and other insect vector diseases (malaria, arboviral fevers, dengue fever, viral haemorrhagic fever and scrub typhus);
 - (2) animal-borne diseases (ie rabies);
 - (3) infectious diseases particularly gastrointestinal and respiratory diseases;
 - (4) soil contact diseases such as hookworm, melioidosis and the potential for tetanus;
 - (5) water contact diseases such as leptospirosis and schistosomiasis; and
 - (6) sexually transmitted diseases;
- c. health services and support infrastructure (for both the civil and military organisations):
- (1) organisational structure;
 - (2) capabilities of hospitals and treatment facilities;
 - (3) casualty evacuation and emergency medical services and capabilities;
 - (4) specialist health support; and
 - (5) medical materiel, blood banking and clinical laboratory capabilities.

3.9 Health intelligence is relevant to the health planning process at the strategic, operational and tactical levels. The health intelligence cycle (ie the steps by which information is assembled, converted into intelligence and disseminated to users) closely follows the steps of any other intelligence cycle. The sequence is as follows :

- a. **Direction.** The area of primary interest and the time frame of interest are to be determined. At the strategic level this is achieved by strategic guidance, agreements with allies and operational planning. At the operational level it is determined by operational planning priorities and will relate to an actual or potential joint force area of operations (JFAO). At the tactical level it will be determined by specific operations and relate to areas in which these operations are being conducted. Once the area of interest or operations and the time period have been established, a request for information is made. At the strategic level, the HI Cell in the Defence Health Service (DHS) Executive will examine the task in terms of the most effective means of collecting the information and establishing a continuous flow of updated information from the designated area, and where relevant, adjoining areas. Orders and requests will be issued to sources and collection agencies via the Defence Intelligence Organisation (DIO) and command channels, and their productivity will be checked.
- b. **Collection.** There are many sources of health information. At the strategic level, international agreements provide for the exchange of finished health intelligence. At the tactical level, commanders and ADF health services personnel are responsible for collection of health intelligence. All opportunities should be exploited. Non-operational opportunities include exercises, aircraft staging, training activities and port visits. Health

intelligence can also be obtained from professional journals of various countries, government publications, the news media, intelligence reports, friendly agencies, and visitors to the particular area. Health intelligence in any format (photographs, diagrams, posters, pamphlets, etc) is valuable. In joint and combined operations, timely passage of health information is essential. At tactical levels, medical staff have a responsibility to obtain local information on health matters and pass it rapidly to higher levels within the time frame specified. Secure (particularly in relation to casualty estimation and figures) and rapid means of communication must be utilised by collectors when necessary.

- c. **Processing.** The accumulated information is evaluated, collated and interpreted to provide medical intelligence. At the strategic level, this is a formal and ongoing activity of the HI Cell in the DHS Executive. At other levels, this normally occurs as part of the health appreciation process in planning for specific operational activity. Processing is further defined as follows:
- (1) **Evaluation.** This includes appraisal of an item of information in terms of its credibility, reliability, relevancy and accuracy.
 - (2) **Collation.** Related items are grouped to provide a record of events and facilitate further processing. It comprises resolution of an item of information into its component elements (analysis) and critical comparison of these elements with related items of basic and correct intelligence (integration).
 - (3) **Interpretation.** Determining the significance of information is time consuming and requires experience. The answers to the following questions, fitted into the pattern of the overall health intelligence picture, lead to deductions and then intelligence, which can be disseminated:
 - (a) **Identification.** Who or what is it?
 - (b) **Activity.** What is it doing? Where?
 - (c) **Significance.** What does it mean?
- d. **Dissemination.** Whether it be verbal or written, health intelligence must be disseminated in time for it to be of value to the user. Means of distribution include formal health intelligence briefs, message or telephone responses by the HI Cell in the DHS Executive, operation or administrative orders and instructions, individual health information booklets, and a variety of other oral, written or graphic forms. It is important that the health intelligence meets the requirement of the user.

3.10 Health intelligence is to be sought as early as possible in the appreciation and planning process. The requirements are to be focussed to the area of interest at the earliest point of time. Health planners are also to keep the HI Cell in the DHS Executive informed of geographic or time changes that may require a change in focus or further development of the health intelligence product.

3.11 Requests for health intelligence support by command or health staff are to be through intermediate headquarters (HQ) chain of command. Commands are encouraged to contact the HI Cell in the DHS Executive to determine how their requirements can best be met.

3.12 Single Service reporting on health conditions (using health intelligence report (HEALTHINTREP) format) is to occur during and following operations to enable updating of databases to ensure technical accuracy. The HEALTHINTREP format is detailed in [annex D](#) to chapter 6. Collection and reporting of health information is a responsibility of health services personnel. The tasking of lower level health commands to regularly collect and report health information is a responsibility of operations staff. Single Services are to collect and report such information to the HI Cell in the DHS Executive.

3.13 Health facilities may be requested through the command chain to provide specialised health assistance to the HI Cell in the DHS Executive. Some examples; are compiling environmental data pertinent to health aspects of military operations, conducting investigations of disease caused by endemic or epidemic pathogens, and suspected enemy use of biological weapons, and providing data on health aspects of enemy operations.

3.14 The data provided will be analysed and processed into HEALTHINREPs which will be promulgated through ADF Health Services technical channels, and as appropriate, through general intelligence and operational channels. HEALTHINREPs on specific subjects are to be requested from the HI Cell in the DHS Executive through command channels.

3.15 Medical personnel who gain information through casual observation of activities in plain view, in the course of the discharge of their humanitarian duties are to report this to their supporting HQ. Reporting of such information by medical units does not conflict with the requirements of the law of armed conflict.

Casualty estimation

3.16 Like HI, casualty estimation is a crucial part of the health appreciation and planning process. The extent to which the health appreciation process is able to predict where, when, in what numbers, and what types of casualties will occur, has a major influence on the effectiveness of health support on operations. Casualty estimation information is also of use to commanders and personnel staffs.

3.17 A casualty estimate must be recognised as simply an estimate based as it is on a number of assumptions that may or may not prove to be appropriate. Computer modelling techniques are available that allow estimates to be rapidly produced for a range of scenarios and may also increase their accuracy.

3.18 Types of casualties include:

- a. battle casualties (BCas)—personnel who are killed, wounded, missing or captured as a consequence of action against the enemy;
- b. combat stress reaction (CSR)—personnel who become ineffective for a military role for medical reasons other than wounds, trauma and organic diseases; and
- c. non-battle casualties (NBCas)—personnel losses not directly attributable to being in action, including sick or diseased, accidentally injured, and non-battle missing.

3.19 Responsibilities. Operations staff at all levels are responsible for the preparation of BCas estimates, with advice from health services staff. Health services staff are responsible for the preparation of the NBCas estimates and for ensuring that commanders and their staffs are informed of the estimates. Historically, the incidence of NBCas has been higher than the incidence of BCas on operations. It is essential that commanders and their staffs can assess the impact of NBCas on the operational plan. CSR casualty estimates are prepared through consultation between operations staff and their health service advisers.

3.20 The following factors can affect casualty rates:

- a. BCas are influenced by the type, intensity and duration of operations and also by variables such as own force tactics and weapons systems, enemy tactics and weapons systems, and individual and other protective measures.
- b. NBCas are influenced by the environment and epidemiology of the area of operations, and the state of preparedness of forces.
- c. CSR are largely determined by battle intensity levels but are also influenced by the morale, training and state of preparedness of the force.

3.21 Casualty estimation methodologies. A range of methodologies, including computer modelling, are available for casualty estimation. BCas estimates, because of the nature of the variables involved, will be more difficult to produce accurately than NBCas estimates which are influenced more by factors that are relatively constant. Tables based on historical operational experience are available as an aid to the preparation of the BCas estimates. Similar tables are available for NBCas, but these must be used with caution, and appropriate account taken of changing epidemiology, preventive measures employed and other factors. Elementary formulae for casualty estimation are included in [annex B](#) (land casualties) and [annex C](#) (maritime casualties).

3.22 Access to casualty estimates is an essential part of health support planning. However, there could be security, political or other constraints placed on their release to other agencies, or for other purposes.

Health support plans

3.23 The outcome of a health appreciation is a health support plan. The plan should avoid too much detail but give sufficient general direction to enable the preparation of the relevant sections of the operational/administrative order or instruction which is to put the plan into effect.

3.24 Health support plans generally follow the format for plans detailed in ADFP 102—*Defence Writing Standards*, chapter 23, with key headings being:

- a. situation,
- b. mission,
- c. execution:
 - (1) general outline,
 - (2) groupings and tasks, and
 - (3) coordinating instructions,
- d. administration and logistics, and
- e. command and signals.

3.25 As with the appreciation, the form and content of a health support plan vary with the complexity and level of planning, and the time available.

Strategic level planning

3.26 The strategic level operational planning process is described generally in ADFP 9. Strategic level health support planning involves the interaction of staff of the DHS with other operational and administrative planning staffs within Australian Defence Headquarters and the HQ of each Service.

3.27 To ensure early activation of the HI and planning process, the DHS Executive is to be advised by Strategic Command Division (SC Div) whenever a strategic appreciation is being conducted. On certain occasions, it may be necessary for the immediate planning group (IPG) to consult with the DHS Executive to develop the appreciation. A representative of the DHS Executive will normally participate in an expanded IPG. DHS Executive staff will work closely with DIO in preparing the health input to assessments required for Government decision.

3.28 Once a Government decision has been made for an ADF operational deployment, the DHS Executive will be directly involved in strategic level administrative planning—through its membership of the Strategic Logistic Planning Group (SLPG) when formed. DHS Executive staff will conduct a strategic health appreciation from which a strategic health support concept is prepared. This will form part of the strategic administrative support concept.

3.29 The strategic health support concept will normally cover aspects such as:

- a. preventive measures,
- b. medical and dental preparation,
- c. levels of medical and dental treatment to be provided,
- d. use of the civilian health infrastructure,
- e. casualty evacuation and regulation,
- f. health support provided to or by other nations,
- g. health aspects of the law of armed conflict,
- h. medical training,
- i. employment of Reserve health personnel,

- j. medical and dental supplies,
- k. provision of blood, and
- l. management of casualty information.

3.30 In consultation with the SLPG, and where necessary with SC Div, DHS Executive staff are to ensure that appropriate health aspects are included in the Chief of the Defence Force (CDF) warning orders, directives and operation/administrative instructions. An example of health paragraphs in a CDF operation instruction is in [annex D](#).

3.31 Initial strategic planning to assess availability of the civilian health infrastructure will be coordinated through the Defence Health Consultative Group. This body is chaired by the Surgeon General Australian Defence Force and includes as members representatives from the Department of Health, Housing, Local Government and Community Services, Department of Veterans' Affairs, the Australian Medical Association, Australian Dental Association, and the Royal Australian College of Nursing. Civilian specialists and representatives of other organisations may be invited to attend.

Operational level planning

3.32 The operational level planning process is described generally in ADFP 9. Health support planning will be conducted as part of the broader administrative planning process and aspects will be considered by the joint administrative planning group (JAPG) as part of its coordination of administrative and logistic input to the joint operational plan (JOP). An appropriate senior health officer will be included in the membership of the JAPG.

3.33 The theatre health planning group (THPG), comprising the senior health officers of Headquarters Australian Theatre, maritime, land and air Commands, Headquarters Northern Command, deployable joint force headquarters and Head of the Joint Health Support Agency, will coordinate health planning at the operational level and maintain a technical link between the Services. The THPG ensures that optimum health support is provided to joint operations and that there is no unnecessary duplication of health services in the JFAO.

3.34 The THPG, through its representative on the JAPG, is to ensure that health aspects are adequately covered in the JOP. In the same way, the THPG is to ensure that relevant aspects of the operational health support plan are included in warning orders and operation or administrative orders/instructions issued by commanders.

3.35 At the operational level, the health support plan will be developed from an operational level health appreciation and will cover aspects which include:

- a. the medical mission;
- b. execution including general outline of health support plan, groupings and tasks of health support units, and coordinating instructions such as holding policy; evacuation policy; medical and dental preparations; health briefings; pre-deployment medical training; environmental health measures; casualty regulation; use of civilian facilities and services; treatment of prisoners of war; application of Geneva Conventions and Protocols; biological, chemical warfare casualty procedures; and medical interoperability;
- c. administration and logistics including medical and dental supplies, blood supply, repair of medical and dental equipment and health documentation; and
- d. command and signals including appointment of senior health officer, health reports and returns, liaison and medical communications.

3.36 An example of a health annex to a joint force headquarters (JFHQ) administrative order is in [annex E](#).

Tactical level planning

3.37 The nature of health support on operations and the division of responsibilities are such that tactical level health support will always involve a degree of joint planning. For example, tactical aeromedical evacuation (AME) which is a Royal Australian Air Force responsibility, would normally be a consideration in an Army tactical level plan.

3.38 In a JFHQ, a joint force health adviser (JFHA) and other health services personnel will normally be included on the staff. The JFHA will be responsible for preparation of the joint health support plan, in close consultation with J1 and J4 staff. Where the component method of command is employed, health service representatives from component HQ will have substantial input to the joint health support plan.

3.39 A tactical level health support plan will be developed from a tactical level health appreciation. At lower levels such as unit or ship, this may involve a purely mental process where the plan is issued subsequently as part of verbal orders. At higher levels, a written plan will normally be produced. While the content of a tactical level health support plan will vary substantially with the operating environment and the level of planning, relevant aspects of the following should be included:

- a. the medical mission;
- b. execution:
 - (1) general outline—broad statement of how health support is to be provided, broken down (where appropriate) into operational phases;
 - (2) groupings and tasks—a list of health service elements or units in a logical sequence, detailing the health support tasks for which elements/units are responsible during the operation, by phases where appropriate; and
 - (3) coordinating instructions—matters of coordination necessary for successful implementation and explanation of the plan:
 - (a) timings;
 - (b) locations and boundaries;
 - (c) holding or staging policies;
 - (d) casualty evacuation, including procedures for surface evacuation and AME;
 - (e) locations and capabilities of supporting health facilities;
 - (f) opening and closing times of medical facilities;
 - (g) medical reserves;
 - (h) treatment of prisoners of war;
 - (i) preventive medicine/environmental health measures;
 - (j) procedures for nuclear, biological and chemical (NBC) casualties;
 - (k) movement of medical units or elements;
 - (l) specific clinical requirements;
 - (m) priorities for evacuation and treatment; and
 - (n) protection and working of health personnel, facilities and transport;
- c. administration and logistics—to include holdings and resupply of medical and dental stores, repair of medical and dental equipment, arrangements for exchange of and reserve pools for litters and blankets, blood supply, documentation of casualties; and
- d. command and signals—appointment of medical commander or senior health officers and alternatives, locations of medical commanders and senior health officers, medical communications networks, medical reports and returns, medical liaison, health planning groups and conferences.

3.40 An example of a health appendix to a naval logistic annex which details health support at the tactical level for a maritime operation is in [annex F](#).

Annexes:

- A. Check list for health appreciation process
- B. Land casualty estimation and hospital bed calculation
- C. Maritime casualty estimation
- D. Example of a health subparagraph of an Australian Defence Headquarters operational instruction
- E. Example of a health annex to a joint force headquarters administrative order
- F. Example of a health appendix to a naval logistic annex

CHECK LIST FOR HEALTH APPRECIATION PROCESS

Serial	Heading	Considerations
1.	Review of the situation	Background to operation being planned, current operational situation, current health support situation.
2.	Aim	Reflects and conforms with the aim of the operational appreciation, eg 'To provide health support to TG 327.2 during Operation DAMASK'.
3.	Factors affecting the aim. These are statements or facts, or reasonable assumptions, bearing on the aim, from which deductions can be drawn. Factors relevant to a specific appreciation will vary according to the circumstances. Factors could include:	
	a. Enemy —strength, weapon systems, intention, concept of operations, attitude to LOAC, health threats posed, interference with evacuation.	Deductions: Battle casualty (BCas) rates, where and when BCas will occur, types of injuries, precautions or protection required by health service units/elements, levels of support to be provided, requirement for reserve health support capability, medical countermeasures, (including nuclear, biological and chemical), evacuation routes and means, requirement to treat enemy casualties, declaration and marking of health service personnel, facilities and evacuation transport.
	b. Own forces —composition, strength, locations, concept of operations for forces being supported; other friendly forces; health support available from other forces; morale, medical, dental, physical and psychological fitness; vaccination status; degree of acclimatisation, health education status; evacuation resources available; general concept of administrative/ logistic support.	Deductions: BCas rates, where and when BCas will occur, non-battle casualty (NBCas) rates, levels of support to be provided, locations, types and tasks of health service units, need to provide health support to non-organic forces, interoperability, evacuation means, evacuation routes, requirement to provide a health support reserve, grouping of health support, command and control, requirement for pre- and post-deployment health briefing and medical training, deficiencies in health support capabilities available, time required to prepare force, health constraints on operational and administrative plans.
	c. Environment —vegetation; topography; elevation; latitude; weather (temperature, humidity, wind); sea states; terrain; infrastructure including roads, buildings, airfields, ports and port facilities, communications systems, water supply, sewerage system, sanitation and waste disposal, civilian health facilities and resources; local population including endemic and epidemic diseases, social economy, housing, local food and nutrition, obstacles to evacuation, concealment; ease of cross-country going.	Deductions: NBCas rates, types of NBCas, medical specialties required, medical countermeasures, environmental health and preventive medicine support, health education requirements, need for acclimatisation, modification to clothing, specific requirements for medical and dental stores (eg vaccinations), evacuation means, time frames and routes, sites of health service facilities, civil health infrastructure to be utilised, requirement for engineer assistance, identification of health arrangements for employment of local civilians, health constraints on operational or administrative plans, arrangements for treating civilian casualties.

Serial	Heading	Considerations
d.	Political —imperative to minimise casualties, quality health care to be available, support from civilian medical community.	Deductions: Scope of care to be provided, casualty information system, public relations arrangements, degree of reliance on reserve health practitioners, utilisation of certain health facilities in the support area.
e.	Medical logistics —general concept of administrative/logistic support, locations of support bases and areas, lines of communication, security of logistics areas, availability of pharmaceuticals and other class 8 supplies from other forces and civil infrastructure, local safe supply of blood and blood products, repair and replacement of medical equipment.	Deductions: Locations of health facilities, surface evacuation routes, holdings of class 8 supplies required, blood-banking requirements, repair capability for medical and dental equipment, reserve holdings of medical and dental equipment, arrangement for providing health support in logistic/administrative areas and along lines of communication.
f.	Time and space —deployment time frame, D Day, H hour, timings for operational phases, dispersion of forces, speed of manoeuvre at advance, ability of health support to maintain contact with supported forces.	Deductions: Effectiveness of counter-measures; acclimatisation; requirement for reserve and/or 'step-up' capability; choice of surface evacuation or aeromedical evacuation, evacuation priorities, location of level three support, mobility of health support, arrangements for redeployment of health support.
4.	Health support options	The option or options for achieving the aim of the appreciation that become apparent from consideration of factors affecting the aim and deductions. Courses may differ in locations of health facilities, levels of support to be provided, type of and priorities for evacuation, availability of reserve capabilities, use of civil infrastructure, holding policy, casualty staging policy etc. Each option should be examined on its merits. Advantages and disadvantages of each should be considered against the aim and the concept of operations.
5.	Identification of the preferred health support option	The selection of the preferred course is the culmination of the appreciation. It is that option that best meets the aim of the appreciation.
6.	Health support plan	This is developed from the preferred option.

LAND CASUALTY ESTIMATION AND HOSPITAL BED CALCULATION

(see page 3B–4 for notes)

CASUALTY ESTIMATION

1. Formulae:

Battle casualties (BCas)

$$\begin{array}{r} \text{Force} \\ \text{strength} \\ \text{(note 1)} \end{array} \times \begin{array}{r} \text{Casualty} \\ \text{rate} \\ \text{(note 2)} \end{array} = \begin{array}{r} \text{Casualties} \\ \text{per day} \end{array} \times \begin{array}{r} \text{Days or} \\ \text{battle} \\ \text{intensity} \\ \text{period} \\ \text{(note 3)} \end{array} = \begin{array}{r} \text{Total} \\ \text{casualty} \\ \text{estimate} \end{array} - \begin{array}{r} \text{Non-} \\ \text{patients} \\ \text{(note 4)} \end{array} = \begin{array}{r} \text{Casualty} \\ \text{estimate} \end{array}$$

Non-battle casualties (NBCas)

$$\begin{array}{r} \text{Force} \\ \text{strength} \\ \text{(note 1)} \end{array} \times \begin{array}{r} \text{Casualty} \\ \text{rate} \\ \text{(note 2)} \end{array} = \begin{array}{r} \text{Casualties} \\ \text{per day} \end{array} \times \begin{array}{r} \text{Days} \\ \text{(note 3)} \end{array} = \begin{array}{r} \text{Total} \\ \text{casualty} \\ \text{estimate} \end{array}$$

Stress reaction casualties

$$\begin{array}{r} \text{Force} \\ \text{strength} \\ \text{(note 1)} \end{array} \times \begin{array}{r} \text{Casualty} \\ \text{rate} \\ \text{(note 2)} \end{array} = \begin{array}{r} \text{Casualties} \\ \text{per day} \end{array} \times \begin{array}{r} \text{Days or} \\ \text{battle} \\ \text{intensity} \\ \text{period} \\ \text{(note 3)} \end{array} = \begin{array}{r} \text{Total} \\ \text{casualty} \\ \text{estimate} \end{array}$$

2. **BCas component experience.** Analysis of military experience indicates that components of the total BCas estimate will approximate:

- a. killed in action (KIA)—20 per cent (range 15 to 25 per cent);
- b. wounded in action (WIA)—70 per cent (range 45 to 80 per cent); and
- c. captured and missing—10 per cent (range 5 to 40 per cent).

3. **Return to duty rates.** The percentages of casualties expected to be returned to duty within 90 days are shown in [table 3B–1](#) below. The majority of casualties returned immediately will be BCas with minor injuries who are treated at level one. Of those casualties returned to duty within 0–3 days, approximately 77 per cent are expected to be stress reaction casualties. The remaining 14 per cent beyond 90 days consists primarily of those unfit for further service, as well as patients who died of wounds after admission to medical facilities.

Time frame	Rate of return as a percentage of total casualty estimate	Cumulative total
Immediately	10%	10%
0–3 days	28%	38%
3–7 days	6%	44%
8–30 days	9%	53%
31–60 days	18%	71%
61–90 days	15%	86%

Table 3B–1: Return to duty rates

4. **Walking, sitting, litter percentages.** Rates of walking, sitting and litter casualties based on the total casualty estimate are in [table 3B-2](#) below.

Type of patient	Point of wounding to level one	Level one to level two	Rearward of level two
Walking	45%	N/A	N/A
Sitting	25%	54%	25%
Litter	30%	36%	37%
Casualty evacuation rates beyond level one based on total casualty estimate	90%		62%

Table 3B-2: Percentages of walking, sitting and litter casualties

5. **Evacuation priorities.** Predicted rates of casualties by evacuation priority, as related to the total casualty estimate are shown in [table 3B-3](#) below. The rates between the point of wounding and level two facilities are adjusted for varying battle intensity levels (severe, moderate, light, minimal).

Priority assigned	Average evacuation rates				Rearward of level two ##
	Between point of wounding and level two medical facility **				
	Battle intensity level				
	Severe	Moderate	Light	Minimal	
One	14%	19%	22%	23%	18.6%
Two	17%	22%	26%	27%	12.4%
Three	59%	49%	42%	40%	31%

** As % of total casualty estimate and allowing for 10% return to duty rate at level one.

##As % of total casualty estimate and allowing for 28% return to duty rate at level two

Table 3B-3: Casualty rates by evacuation priority

6. **Anatomic wound distribution.** Distribution of wounds as a percentage of total wounds is predicted as:

- head, face or neck—15 per cent;
- thorax—10 per cent;
- abdomen—6 per cent;
- upper extremities—28 per cent; and
- lower extremities—41 per cent.

7. **NBCas experience.** Historically, NBCas losses have exceeded BCas losses over an extended period by ratios of from 3 to 1 to more than 6 to 1. Historical data based on geographic zones is shown in [table 3B-4](#).

Geographic zone	Daily average per cent	Daily average per thousand	Daily hospital admission rate per thousand
Temperate	0.15	1.5	1.0
Tropical	0.3	3.0	2.0

Table 3B-4: Non-battle casualty estimation—historical data

ASSESSMENT OF HOSPITAL BED REQUIREMENTS

8. Holding policy. The holding policy stipulates the maximum time for which sick, wounded and injured are held in health service units in the joint force area of operations (JFAO). It is normally specified by the operations staff in consultation with health services staff. Any casualty not expected to return to duty within the number of days expressed in the holding policy is evacuated as soon as practicable. A longer holding policy provides for greater return to duty of patients within a JFAO but will increase the requirement for hospital beds. A shorter holding policy will reduce the requirement for hospital beds in the JFAO.

9. Calculation of hospital beds. The estimate for bed requirements is based on empirical data for the two major categories of WIA and NBCas. The empirical data is adjusted to take into consideration factors such as holding policy and the need for segregating patients by sex or nature of contagious disease.

a. **Factors.** The following factors are considered in the calculation of total hospital bed requirements (JFAO and support area):

(1) **Size of force.**

(2) **Estimated daily hospital admission rates:**

(a) **BCas.** This is derived from the forecast BCas rate provided by operations staff. Only the WIA component of the BCas rate is used in assessing hospital bed requirements. Of the WIA, approximately 10 per cent are held and treated in medical units other than hospitals.

(b) **NBCas.** This is derived from the forecast NBCas by health services staff. Approximately 33.3 per cent of NBCas are held and treated in medical units other than hospitals.

(3) **Average stay in hospital.** This factor is used in calculating total hospital beds only.

(4) **Accumulation factor.** This is an average time spent by patients in JFAO hospital beds in the context of a given holding policy. This factor is used to calculate JFAO beds only.

(5) **Dispersion factor.** At any given time a proportion of hospital beds will not be available because of segregation by sex or types of illness or injury, by fluctuations in disease or by movement of hospital units. To provide for this, a dispersion factor (usually 1.25) is included for calculating both total and JFAO beds. A factor of 1.25 leads to an increase of 25 per cent in these beds. Of the resultant total, 20 per cent is thus provided as a dispersion allowance.

b. **Formulae:**

(1) **Total Beds:**

(a) Beds for WIA =

Daily admission rate (note 5)	X	Size of force (note 6)	X	Average stay (note 7)	X	Dispersion factor (note 8)
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(b) Beds for NBCas =

Daily admission rate (note 5)	X	Size of force (note 6)	X	Average stay (note 7)	X	Dispersion factor (note 8)
----------------------------------	---	---------------------------	---	--------------------------	---	-------------------------------

(c) Total beds = beds for WIA + beds for NBCas.

(2) **JFAO beds:**

(a) JFAO beds for WIA =

Daily admission rate (note 5)	X	Size of force (note 6)	X	Accumulation stay (note 7)	X	Dispersion factor (note 8)
----------------------------------	---	---------------------------	---	-------------------------------	---	-------------------------------

(b) JFAO beds for NBCas =

Daily admission rate (note 5)	X	Size of force (note 6)	X	Accumulation stay (note 7)	X	Dispersion factor (note 8)
----------------------------------	---	---------------------------	---	-------------------------------	---	-------------------------------

(c) JFAO beds = JFAO beds for WIA + JFAO beds for NBCas.

10. Surgical workload data. One surgeon performs 12 surgical procedures in 24 hours. Each operating room functions 24 hours per day.

Notes:

1. Total troops at risk for the estimate.
2. For BCas and stress reaction estimation, this is provided by the operations staff. It is expressed as a daily percentage of the force strength (or in the case of forward areas of the combat zone (CZ), a daily percentage of force strength for each of the four levels of battle intensity). For NBCas estimation, the casualty rate is provided by the health services.
3. For forward areas of the CZ, battle intensity period is used for the calculation of BCas and stress reaction casualties. This is expressed as the number of days predicted for each battle intensity level (severe, moderate, light, minimal). For BCas and stress reaction casualty estimation in areas of the JFAO other than forward areas of the CZ, and for NBCas estimation in all areas of the JFAO, it is expressed as the number of days in the entire period of the estimate.
4. Includes KIA, MIA and prisoners of war.
5. Daily admission rates:
 - expressed as per 1000 troops per day;
 - for WIA, is 90 per cent WIA rate; and
 - for NBCas, is 66 per cent NBCas rate.
6. Force strength expressed as total strength over 1000.
7. Average stay for:
 - WIA—50 days, and
 - NBCas—20 days.
8. Dispersion factor:
 - 1.25 for 20 per cent allowance,
 - 1.33 for 25 per cent allowance, and
 - 1.50 for 33 per cent allowance.
9. **JFAO beds.** For a 30-day holding policy, a figure of three per cent of force strength should provide an adequate planning guide in calculating JFAO bed requirements.

10. Accumulation factor (see below).

Holding policy	Accumulation factor	
	WIA	NBCas
15 days	9.53	7.48
30 days	15.06	10.85
60 days	24.94	14.67
90 days	32.56	16.96
120 days	38.00	18.29

MARITIME CASUALTY ESTIMATION

Background

1. In the absence of any reliable Australian data, maritime casualty estimation formulae have been derived from recent computer modelling and epidemiological work conducted in the United States (US) and United Kingdom (UK), adapted to the Royal Australian Navy (RAN) order of battle. An Australian manual planning model is under development, therefore this model is transitional.
2. Maritime casualty occurrence contrasts significantly with land casualty occurrence and is characterised by;
 - a. low numbers of non-battle casualty (NBCas) admitted to level three, and
 - b. intermittent occurrences of very high battle casualty (BCas), with periods of no casualties in between.

Non-battle casualties

3. Daily maritime NBCas numbers are calculated as:

$$\text{Force strength} \times \text{casualty rate} = \text{Casualties per day}$$

4. **Maritime NBCas rates.** Daily maritime NBCas rates are estimated as:

- a. total—1.3 per cent of force strength at level one and two, of whom 90 per cent return to duty;
- b. admitted at level one and two—0.13 per cent of force strength, of whom 90 per cent return to duty from level one and two;
- c. admitted at level three—0.013 per cent of force strength.

5. **NBCas joint force area of operations (JFAO) beds.** Maritime NBCas produce a minimal requirement for JFAO beds. Applying the formula given in chapter 3, [annex B](#), paragraph 9b(2)(b), and using a holding policy of 15 days (accumulation factor = 7.480 and a dispersion factor of 1.25, to a force strength of 1000 in approximately 5 x major fleet units (MFUs) gives the daily casualty numbers and JFAO bed requirements shown in [table 3C–1](#).

	Daily NBCas	JFAO Beds
Presenting at level one/two	13.0	N/A
Admitted at level one/two	1.3	12
Admitted at level three	0.13	1.2

Table 3C–1: Daily non-battle casualties, non-battle casualties admissions and joint force area of operations bed requirement for a force strength of 1000

6. The provision in most MFUs of a two-berth sick bay can be expected to adequately provide the level one and two JFAO bed requirement. In the absence of level three beds afloat, one aeromedical evacuation can be expected every 7.7 days.

Battle casualties

7. Given the nature of maritime combat operations, where significant casualties are inflicted during short duration engagements, the use of an 'average' rate for maritime casualties is not valid. Casualty rates are therefore determined on a 'per engagement' basis.

8. The nature of an engagement can also significantly affect casualty generation. Computer modelling suggests that an engagement based on an air or surface attack, using modern anti-surface missiles, will produce more personnel casualties than a sub-surface attack, even though the latter may produce more structural damage to affected ships.

9. The casualty rates estimated for representative RAN task groups (maritime (1 x LPA, 1 x DDG, 1 x FFG-1, 1 x FFG-150, 1 x AO) and amphibious (2 x LPA, 1 x DDG, 2 x FFG and 1 x AOR)) have been derived from computer modelling conducted in the US, modified to suit RAN crew sizes for particular classes of ships. A representative air-delivered threat at a 'light' engagement intensity has been used.

10. **Maritime BCas rates.** Derived BCas rates for amphibious and maritime task groups are shown in [table 3C-2](#).

	Task Group	
	Amphibious	Maritime
Killed in action/missing in action	2.8%	3.8%
Combat stress reaction	0.3%	0.4%
Wounded in action (WIA)	2.3%	3.1%
Total	5.4%	7.3%

Table 3C-2: Battle casualty rates per engagement

11. An engagement is assumed to occur over a period of time of less than one day, therefore all casualties generated require treatment or hospitalisation within the required time frame from wounding. Based on recent maritime combat experience, it has been estimated that 60 per cent of all WIA are in triage category T1 and T2, and hence require early evacuation to a level three facility. It has also been estimated that 80 per cent of all T3 casualties will require delayed evacuation to level three, and therefore the total number of casualties requiring admission to level three is 92 per cent of all WIA. All casualties admitted to level three are likely to require evacuation to a level four facility.

12. Combat stress reaction casualties are calculated as 12 per cent of WIA. Of these casualties, 20 per cent will require evacuation to a level three facility.

13. The case distribution, as percentages of WIA at level one and two is shown in [table 3C-3](#).

Wound site	Triage category			Total
	T1	T2	T3	
Abdominal	12%	3%	0%	15%
Chest	4%	9%	2%	15%
Multiple	8%	6.5%	0.5%	15%
Upper limb	1%	1.5%	5.5%	8%
Lower limb	2%	1.5%	8.5%	12%
Head and neck	1.5%	3.5%	5%	10%
Burns	1%	4%	15%	20%
Smoke inhalation	0.5%	1%	3.5%	5%
Total	30.0%	30.0%	40.0%	100.0%

Table 3C-3: Case distribution as percentage of wounded in action

14. Given the nature of maritime warfare, the total number of JFAO beds required at level three must be sufficient to admit all casualties within one or two days. Thus, the level three bed requirement is 92 per cent of the respective WIA estimates plus 20 per cent of the combat stress reaction casualties.

15. **Maritime JFAO beds.** Assuming only one day of combat occurs with sufficient time for all casualties to be evacuated to level four facilities, the estimated number of level three beds required in the JFAO are:

- a. amphibious task group—2.2 per cent of force strength; and
- b. maritime task group—2.9 per cent of force strength.

16. Should a second day of combat occur before casualties can be evacuated to level four, additional beds will be required.

**EXAMPLE OF A HEALTH SUBPARAGRAPH OF AN AUSTRALIAN
DEFENCE HEADQUARTERS OPERATIONAL INSTRUCTION****SECURITY CLASSIFICATION**

EXER/RIMPAC//

MSGID/GENADMIN/HQAST//

SUBJ/HEALTH//

RMKS/1. HEALTH INT ASSESSMENTS AND MEDICAL COUNTERMEASURES ADVISED BY DSH EXECUTIVE. 2. SUPPORT CONCEPT. LEVELS 1, 2 AND 3 AND LIMITED LEVEL 4 SUPPORT IN JAO. FULL LEVELS 4 AND 5 IN SUPPORT AREA USING CIVIL FACILITIES. LEVEL 3 AFLOAT IN MARITIME AO. MAXIMUM USE OF AME INCLUDING CIVIL. 3. SUPPORT IN JAO. ASSIGNED ADF HEALTH SERVICE UNITS TO PROVIDE LEVELS 1, 2 AND 3 SUPPORT. MCAUST TO PROVIDE LEVEL 3 AFLOAT SUPPORT. CIVILIAN FACILITIES TO BE USED TO PROVIDE ESSENTIAL LEVEL 4 SUPPORT. AME TO BE NORMAL MEANS OF EVACUATION FOR PRIORITY 1 AND 2 CASUALTIES AND ON AN OPPORTUNITY BASIS FOR PRIORITY 3. COMNORCOM IS TO COORDINATE FORWARD AND TACTICAL AME USING ASSIGNED ASSETS. ACAUST IS TO PLAN AND PROVIDE AECC AND ASF AS APPROPRIATE. SMO NORCOM IS APPOINTED SENIOR HEALTH OFFICER FOR THE JAO AND IS TO COORDINATE JFAO HEALTH SUPPORT PLAN. SMO NORCOM IS TO CHAIR AND CONVENE ADF HEALTH PLANNING GROUP AS REQUIRED. 4. SUPPORT AREA. CA IS TO PLAN AND COORDINATE HEALTH SUPPORT IN THE SUPPORT AREA (INCLUDING LOC) AND IS TO APPOINT A SUPPORT AREA SMO. SINGLE SERVICE HEALTH FACILITIES AND CIVILIAN FACILITIES (SPECIFICALLY FOR LEVELS 4 AND 5 SUPPORT) ARE TO BE USED. A JOINT HEALTH PLAN FOR THE SUPPORT AREA IS TO BE PREPARED WITH ADVICE FROM CN AND CAF. A SUPPORT AREA ADF HEALTH PLANNING GROUP IS TO CONVENE AS DIRECTED BY SMO SUPPORT AREA. SUPPORT AREA JOINT HEALTH PLAN IS TO IDENTIFY ARRANGEMENTS FOR TREATMENT, HOSPITALISATION, CONVALESCENCE AND REHABILITATION, AND FOR AME, SURFACE EVACUATION AND CASUALTY REGULATION TO, AND WITHIN, THE SUPPORT AREA. 5. BLOOD SUPPLY IS TO BE IAW ADFP 53 FROM AS RED CROSS SOURCES. 6. APPROPRIATE ASPECTS OF GENEVA CONVENTIONS AND PROTOCOLS IN REGARD TO MARKING AND PROTECTION OF ADF HEALTH FACILITIES, TRANSPORT AND PERSONNEL AND TO THE TREATMENT OF PW CAS ARE TO APPLY.//

SECURITY CLASSIFICATION

EXAMPLE OF A HEALTH ANNEX TO A JOINT FORCE HEADQUARTERS ADMINISTRATIVE ORDER

SECURITY CLASSIFICATION

ANNEX C TO
HQNORCOM ADMIN ORD 091
OF 200730ZJUL97

OPERATION DISPATCH JOINT HEALTH SUPPORT

1. **Situation:**
 - a. **Enemy.** See HQNORCOM INTSUMS 001–019 and HQNORCOM OPORD 023. En expected to lodge ground forces to engage in harassing ops. Some penetration of the ADIZ and MEZ is probable. En capacity to engage AS ground forces and generate BCas is limited.
 - b. **Friendly forces:**
 - (1) NORCOM concept of ops and phasings as per OPORD 023—Administrative support concept and phasings as per paragraphs 9 to 12.
 - (2) **Support area.** Support area health support in accordance with SCA ADMINORD 051. Joint cas reg cell loc HQAC to regulate evac from JFAO to support srea. Support area levels 4 and 5 DMF for cas evacuated from the JFAO are:
 - (a) Burns—Royal Brisbane, Concord Sydney.
 - (b) Facio-maxillary—Princess Alexandra Brisbane, Prince Alfred Sydney.
 - (c) Head/spinal injuries—Royal Brisbane, Royal North Shore Sydney.
 - (d) General orthopaedic—Townsville General, 3 RAAF Hosp, HMAS PENGUIN, 2 Fd Hosp (Rear).
2. **Mission.** To provide health support to the joint force during OP DISPATCH.
3. **Execution:**
 - a. **Gen Outline.** All units to deploy with organic level one support. Level two support is to be provided with 3 Bde and in DARWIN. Level 3 support is to be provided by 1 Fd Hosp in KATHERINE, 2 Fd Hosp in KUNUNURRA and Royal Darwin Hospital. Limited level four support in JFAO to be provided by Royal Darwin Hospital. Other civil health facilities in JFAO may be utilised where ADF facilities not available. AME is to be primary means of evacuation in the JFAO, with forward AME at KATHERINE and KUNUNURRA.
 - b. AME originated from DARWIN and TINDAL. ASF loc DARWIN, TINDAL, KUNUNURRA and with 3 Bde.
 - c. **Gp and Tasks.** Appendix 1.
 - d. **Coord Instr:**
 - (1) **Locs.** Appendix 1.
 - (2) **Timings.** Appendix 1.
 - (3) **Cas Holding Policy.** Holding policy for JFAO to be 14 days, with:
 - (a) 3 BASB initial max of 48 hours,
 - (b) 11 Fd Amb(-)—4 days,
 - (c) 321 ABW HSF, 322 ABW HSF—10 days,
 - (d) 1, 2 Fd Hosps—14 days, and
 - (e) AME staging policy to be six hours.

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SECURITY CLASSIFICATION

C-2

- (4) **Casevac:**
- (a) **AME.** Normal means of evac for Pri one and two cas and for Pri three cas on an opportunity basis.
 - (b) **Fwd AME.**
 - i. UH60 with AME crew loc KUNUNURRA.
 - ii. UH60 with AME crew loc TINDAL.
 - iii. Fwd AME requests to AECC HQNORCOM, except where AME assets are organic to requesting formation. Requests in accordance with SOP 25.1.
 - (c) **Tac AME:**
 - i. AME staging by 321 CSW HSF, ASF KUNUNURRA, ASF 2 OSU in spt 3 BASB.
 - ii. Requests for Tac AME to AECC HQNORCOM.
 - (d) **Strat AME:**
 - i. AME staging by 321 CSW HSF, 322 CSW HSF.
 - ii. HQNORCOM will initiate requests for strat AME to support area joint cas reg cell and HQAC.
- (5) **Civilian cas:**
- (a) Civilian cas normally treated and evac by civil facilities. SMO may use discretion in providing emergency medical support to civilian cas.
 - (b) Any civilian cas treated to be reported on the next CASSITREP.
- (6) **En cas:**
- (a) En cas of all priority treated and evacuated as for own troops.
 - (b) Any en cas treated to be reported to SMO NORCOM on next CASSITREP.
 - (c) En cas held in med facility need protection as PW.
- (7) **Use of civilian med facilities:**
- (a) All civilian hosps in JFAO close to full occupancy. Use in emergency only, unless SMO authorises.
 - (b) Civilian rd/air amb used only where tasking svc tpt would result in clinically unacceptable delay. Auth by SMO each case.
 - (c) Notify SMO NORCOM of use of civilian resources ASAP.
 - (d) Invoices to be passed ASAP to HQNORCOM for SMO.
 - (e) Transfer to svc facility to be effected at earliest opportunity.
- (8) **Health:**
- (a) Comd are responsible for health matters in their areas. Assistance provided by elms of 4 Pvnt Med Coy in each area and by environmental health staff on air bases. Health officers and staff on med unit establishments are to:
 - i. monitor and maintain health standards; and
 - ii. provide advice on health matters.
 - (b) Req for pvnt med spt to be submitted to HQNORCOM for SMO.

SECURITY CLASSIFICATION

SECURITY CLASSIFICATION

C-3

- (c) **Sanitation:**
 - i. **Solid waste.** Use of local facilities first choice. Develop own tips as required.
 - ii. **Sullage water.** Civil, bore hole or deep soakage facilities only to be used.
 - iii. **Human waste.** Civil facilities used where possible. Demountable units or individual portaloos are to be used within town boundaries. Outside town boundaries, bore hole latrines and urinals with soakage pits are to be used wherever practicable.
 - iv. **Medical waste.** Health facilities are to liaise with civil authorities and ensure appropriate disposal.
- (d) **Health brief.** Individual health brief to be distributed by HQNORCOM.
- (e) **Health int.** Reports in accordance with HQNORCOM SOP 25.1.
- (9) **Geneva Conventions.** All health service pers to carry Red Cross ID cards and wear Red Cross armbands. All dedicated casualty carrying vehicles and aircraft to be marked. 1 Fd Hosp, 2 Fd Hosp, elm Royal Darwin Hospital, 1 Fd Amb, HSF TINDAL, HSF DARWIN, ASF KUNUNURRA declared and are to be marked. Med coy and ASF 3 BASB to be marked at discretion of 3 Bde.
- 4. **Administration and logistics:**
 - a. **Class 8 sup:**
 - (1) All med and dent facilities to deploy with 30 days class 8 and maintain stocks at this level.
 - (2) Med facility to ensure class 8 substances stores in accordance with manufacturers instruction. All pharm substances to be maintained below 25 degrees C.
 - (3) Resupply class 8 by demand on 2 Fd Sup Bn.
 - b. **Spectacles.** All ADF pers deploying who wear spectacles or contact lenses are to deploy with two pairs and a current prescription for replacement.
 - c. **Med documents.** Field medical cards are to be used as the primary med documentation. Navy medical records are to accompany personnel on ships.
 - d. **Blood.** In accordance with ADFP 53 and ADFP 711.
- 5. **Command and signals:**
 - a. **Loc.** SMO NORCOM loc HQNORCOM DARWIN. Alt SMO is AEEO.
 - b. **Technical control.** Senior medical officers as fol:
 - (1) SMO DARWIN area—SMO HSF 321 CSW.
 - (2) SMO KATHERINE—CO 1 Fd Hosp.
 - (3) SMO 3 Bde.
 - (4) SMO KUNUNURRA area—CO 2 Fd Hosp.
 - (5) SMO TINDAL area—SMO 322 CSW.
 - c. **Comms.** Trunk system.
 - d. **Reports and returns.** In accordance with HQNORCOM SOP 25.1.

Appendix:

- 1. Health services groupings and tasks

SECURITY CLASSIFICATION

SECURITY CLASSIFICATION			
APPENDIX 1 TO ANNEX C TO HQNORCOM ADMIN ORD 091 OF 200730ZJUL97			
HEALTH SERVICES GROUPINGS AND TASKS			
Serial	Unit/loc	Gp	Tasks
1.	1 Fd Hosp (-) loc KATHERINE	a. Under comd HQ LCN. b. Under comd for admin HQ LSG.	a. Open by 2 Aug 97. b. Prov level three med spt to NORCOM.
2.	2 Fd Hosp (-) loc KUNUNURRA	a. Under comd HQ LCN. b. Under comd for admin HQ 10/27 RSAR.	a. Open by 9 Aug 97. b. Prov level three med spt to NORCOM.
3.	1 PST	a. Under comd HQ LCN. b. In spt and under comd for admin 3 RAR.	a. Prov level three spt for airborne ops. b. Prov level three res for SMO NORCOM.
4.	1 Fd Amb (-) loc DARWIN	a. Under comd HQ LCN. b. Under comd for admin HQ LSG.	a. Prov level two evac and resus in DARWIN area. b. Prov limited level three road evac to 1 Fd Hosp. c. Prov 25 bed minor holding in DARWIN area. d. Prov CCP on 24 hours NTM as SMO NORCOM Reserve.
5.	4 Pvnt Med Coy	a. Under comd HQ LCN. b. Under comd for admin HQ LSG.	a. Prov health sect under comd 1 Fd Hosp. b. Prov health sect under comd 2 Fd Hosp. c. Prov health spt to NORCOM.
6.	3 BASB Med Coy loc 3 Bde TAOR.	Under comd 3 BASB.	Prov level two spt to 3 Bde.
7.	3 BASB Den Coy loc 3 Bde TAOR	Under comd 3 BASB.	Prov den spt to 3 Bde.
8.	HSF loc DARWIN, TINDAL	Under comd 321 ABW, 322 ABW.	a. Prov AME staging facility DAR and TDL. b. Prov tac AME spt to resp areas. c. Prov AECO. d. Prov inpatient spt to resp areas. e. Prov envh spt. f. Prov den spt to DAR, TDL.
9.	ASF loc 3 Bde	Under opcon HQNORCOM.	a. Prov AME staging facility for 3 Bde. b. Prov tac AME spt to 10/27 RSAR.
10.	Elm 3 Avn Regt One UH60 acft loc TDL, KUNUNURRA	Under opcon HQ ACN.	Prov fwd AME as req during phase one and two.
SECURITY CLASSIFICATION			

EXAMPLE OF A HEALTH APPENDIX TO A NAVAL LOGISTIC ANNEX**SECURITY CLASSIFICATION**APPENDIX 3 TO
ANNEX D TO
OPORD NO 19**HEALTH SUPPORT**

1. **Situation:**
 - a. **General.** Threat to TF327 is detailed in paragraphs 5 to 10. Main threat is missile strikes from enemy surface units and aircraft penetrating the MEZ. Burns and blast casualties are likely to predominate, with up to 50 casualties from successful strikes on major friendly units.
 - b. **Health support.** Available in land AO. The following health support is available in the land AO.
 - (1) Level two—10 Fd Amb—DERBY;
 - (2) Level three—2 Fd Hosp—BROOME;
 - (3) Level four—3 FGH—WYNDHAM; and
 - (4) Aeromedical evacuation staging facilities—DERBY, BROOME and WYNDHAM.
 - c. **Strategic aeromedical evacuation.** Available from BROOME and WYNDHAM.
2. **Mission.** To provide health support to TF327 during Operation DAMOCLES.
3. **Execution:**
 - a. **General outline.** All units to include level one support. Major units to include medical officers and a limited level two capability. Level three afloat for TF327 to be provided by AURORA AUSTRALIS.
 - b. **Groupings and tasks:**
 - (1) Minor war vessels (MWVs). Provide organic level one support.
 - (2) **FFG/DDG:**
 - (a) Provide organic level two support.
 - (b) Be prepared to:
 - i. Augment level one support for MWV.
 - ii. Accept transit casualties from MWV and other major units.
 - iii. Provide forward AME within the AO.
 - (3) **AURORA AUSTRALIS:**
 - (a) Provide level three afloat.
 - (b) Coordinate forward AME within TF327.
 - (c) Coordinate surface evacuation and AME of casualties from TF327 to health facilities in the land AO.
 - (d) Coordinate support provided from land-based health facilities.
 - c. **Coordinating instructions:**
 - (1) **Holding policy:**
 - (a) MWV. Nil.
 - (b) Major units. Six hours.
 - (c) AURORA AUSTRALIS. Three days.
 - (2) **Evacuation.** Evacuation by helo for priority one and two casualties to AURORA AUSTRALIS. Priority three surface evacuation, or helo on an opportunity basis. Requests in accordance with SOP 27.03.

SECURITY CLASSIFICATION

SECURITY CLASSIFICATION

D3-2

- (3) **Casualty regulation.** AURORA AUSTRALIS includes cell to coordinate casualty regulation.
 - (4) **Display of Red Cross.** AURORA AUSTRALIS is to be marked with the Red Cross and is to conform with all other requirements of the Geneva Conventions relating to protection of hospital ships.
 - (5) **Reserve.** HMAS TOBRUK to be prepared to embark a reconstituted level three capability if required.
4. **Administration and logistics:**
- a. **Class 8.** All units to hold 30 days. Resupply from AURORA AUSTRALIS which is to hold 60 days.
 - b. **Blood.** AURORA AUSTRALIS to provide blood-banking facilities. Holdings TBA. Local bleeding where necessary from cleared donor pool.
 - c. **Litters/blankets.** AURORA AUSTRALIS to hold following reserves:
 - (1) litters—100, and
 - (2) blankets—500.
5. **Command and signals:**
- a. **Tech control.** Senior medical officer embarked on AURORA AUSTRALIS is appointed senior health officer TF327.
 - b. **Reports and returns.** In accordance with SOP 27.09.

SECURITY CLASSIFICATION

CHAPTER 4

HEALTH SUPPORT TO A DEPLOYED FORCE

INTRODUCTION

4.1 Employment of health support in joint operations will complement the operational plan and be coordinated with the provision of other logistic support. Health support plans will be prepared for each operation in accordance with joint health planning procedures detailed in [chapter 3—'Australian Defence Force health planning'](#).

4.2 The principles of health support listed in chapter 1, [paragraph 1.4](#) will apply in joint operations. The requirements vary with the nature of operations and the environment of the joint force area of operations (JFAO). The provision of health support will vary in a number of ways such as:

- a. the levels of support to be provided in the JFAO;
- b. whether health facilities are sited in forward areas or in rear areas;
- c. the holding policy of the force;
- d. the concealment or declaration of health facilities;
- e. whether aeromedical evacuation (AME) or surface evacuation will be utilised;
- f. whether support should be land-based or sea-based or both;
- g. the provision where required for treatment and evacuation of nuclear, biological and chemical casualties;
- h. the requirement to defend, harden or protect health facilities; and
- i. the casualty regulating arrangements.

MARITIME OPERATIONS

General

4.3 The support provided for maritime operations will vary with the nature of those operations. For example, the medical support required for coastal patrolling is likely to be substantially less than that required for a task group or task force operating well offshore and in which surface combatants may be subject to sub-surface threats, missile strikes or other forms of offensive action. The requirement for rapid evacuation of casualties, and particularly the need to ensure that seriously ill or wounded casualties reach a level three facility within three hours of wounding, is likely to be complicated in maritime operations by factors such as the dispersion of forces involved, and sea and weather conditions. However, the principles of health support detailed in [chapter 1—'Introduction'](#) apply.

Level one support

4.4 All ships are capable of providing a minimum of level one support to their complements. The role, organisation, characteristics and tasks of a ship's sick bay are detailed in [chapter 2, paragraph 2.15](#). Ships are also capable of providing that support to other ships in a task force or task group which are unable to do so themselves through damage sustained or other circumstances.

Level two support

4.5 This level of support will normally be provided within a task force or task group by ships other than those which have sustained casualties. Scope of support will vary with the nature and intensity of operations. It is likely to include search and rescue (SAR) procedures; winching of casualties from the sea and from damaged ships by helicopters of the task force or task group; collection and transfer of casualties by helicopter, sea boat, life raft or jackstay; sorting and resuscitation of casualties aboard one or more undamaged vessels; and preparation for subsequent evacuation of casualties out of the task

group or task force to afloat or land-based level three facilities. These arrangements will be conducted in accordance with standing operating procedures and orders for the maritime operation concerned, and will be subject to the ongoing requirements for defence of the task group or task force and the operational priorities for damage control. A maritime surgical support team (MSST) may be placed aboard an appropriate vessel in a task group or task force to assist with sorting and resuscitation of casualties.

Level three support

4.6 In maritime operations, level three support can be provided by an afloat medical facility (AMF), or land-based level three facility, eg port medical facility (PMF), Army field hospital or forward general hospital, or a civilian hospital. In maritime operations where battle casualties (BCas) cannot be evacuated to land-based level three facilities within three hours of wounding, an AMF will normally be allocated to support operations. Roles, organisation, characteristics and tasks of an AMF are detailed in [chapter 2—‘Health support capabilities’](#). The ship utilised as an AMF is likely to operate remote from the task group or task force it is supporting, possibly in conjunction with an underway replenishment group or mobile support group. Where the ship is declared a hospital ship and protected under international law, it is likely to operate alone and will be subject to restrictions appropriate to declaration. Major advantages of an AMF are its mobility and capacity to provide for subsequent surface evacuation of the casualties it receives and treats. The surgical capability of an AMF could be enhanced by the addition of one or more MSST. The role, organisation, characteristics and tasks of a PMF are detailed in [chapter 2](#). A PMF is likely to operate as part of a Royal Australian Navy (RAN) forward support base. Its surgical capability could be enhanced by the addition of a MSST, or surgical team from another service, eg field integrated resuscitation and surgical team (FIRST), fly away surgical team (FAST).

Casualty evacuation

4.7 Policy and procedures for casualty evacuation are detailed in [chapter 5—‘Triage, evacuation and regulation’](#). Casualties from a task group or task force can be evacuated by helicopter or surface means to a manned and equipped exchange point in the land area of operations (AO) or an AMF, or alternatively, from the task group or task force by helicopter to a land-based level two, three or four medical facility. When deployed, an AMF will normally perform a regulating function for casualties evacuated from the task group or task force.

LAND OPERATIONS

General

4.8 Health support provided for land operations will vary with the level and intensity of operations. While historically the incidence of non-battle casualty (NBCas) has exceeded BCas in land operations, the requirement to treat and evacuate BCas will normally be the major consideration in employment of health support in land operations. The nature of operations, whether offensive or defensive, static or mobile, predominantly infantry, mechanised or motorised infantry or armoured, will determine what levels of support are to be provided, where and when.

4.9 Factors that affect siting of medical units include the role of the unit, access to areas cleared by operations and/or logistic staff for ‘real estate’ purposes, the tactical vulnerability of different sites, access to surface evacuation routes, landing sites and airfields, the proximity of logistic support, and where appropriate, civil infrastructure. In forward areas, siting of medical units will be governed more by operational circumstances than in rear areas. Unless declared, medical facilities should be concealed in accordance with operational requirements. In certain operations, medical facilities may need to be dug in with overhead protection.

Level one support

4.10 A regimental aid post (RAP), or similar medical elements organic to fighting units, will provide level one support in land operations. The role, organisation, characteristics and tasks of a RAP are detailed in [chapter 2](#). A battalion RAP would normally be sited near battalion headquarters and provide medical assistants and stretcher bearers to each company.

4.11 In mobile phases of operations such as advance, pursuit or withdrawal, RAP and company aid posts are likely to be continually moving, collecting casualties, providing ‘tailgate’ treatment and moving casualties to collection points along routes from which they will be evacuated by forward AME or a brigade administrative support battalion (BASB) medical company (med coy). In more static operations

such as area defence or attack, the medical resources are more likely to be centralised, established in a static position with appropriate protection, and capable of providing a higher quality of care to larger numbers of casualties. In these circumstances, casualties will normally be evacuated by stretcher bearers to the RAP, treated, and then evacuated by forward AME or a BASB med coy.

Level two support

4.12 Field ambulances and BASB med coys provide level two support in land operations. Their roles, organisations, characteristics and tasks are detailed in [chapter 2](#). They are controlled by formation health staff in accordance with the medical plan. They are normally allocated in support of a brigade task force, conform to the movements of that brigade, and are responsible for the evacuation of its casualties. The location, opening and closing of these units is controlled by formation health staff.

4.13 Field ambulances and BASB med coys are deployed to ensure rapid and efficient clearance of casualties from unit RAP. Treatment sections establish the main treatment facility or main dressing station and are also capable of deploying smaller treatment elements forward to operate casualty collection posts (CCP). The evacuation section collects casualties from RAP or CCP and transports them to the main dressing station.

4.14 In mobile operations, these units must maintain contact with supported RAP. Casualties are not to be held and the priority is on rapid clearance to level three facilities. Supported brigade affiliations are likely to change as level two medical units leap-frog forward or to the rear to maintain contact. Individual units will have a capability to step-up or step-back. In more static operations, they will be established well forward, be open and cleared of casualties in preparation for specific operations, and protected where appropriate. Casualties could be held for short periods. Main dressing stations are normally located in brigade maintenance areas or brigade administrative areas. Casualties are collected from level two medical units by forward AME or motor ambulance units of the Royal Australian Corps of Transport. Having been cleared of casualties, a field ambulance/BASB med coy can close, redeploy and re-establish in a new location in six to eight hours.

Level three support

4.15 Field hospitals provide level three support in land operations. The role, organisation, characteristics and tasks of field hospitals are detailed in [chapter 2](#). Field hospitals provide the first formal surgery or initial wound surgery in the land AO, and also provide hospital care of a limited nature for the minor sick and wounded. Field hospitals would normally be located in rear maintenance areas but could be located forward in the task force area. The siting of field hospitals will be influenced by the requirements to provide surgery within acceptable time frames and the tactical situation. They should be located far enough to the rear to avoid having to move as a result of enemy action. They would be declared whenever operational circumstances allow.

4.16 Having cleared its casualties, a field hospital will take three to five days to close, redeploy and re-establish in a new location. Field hospitals would normally be cleared of patients in anticipation of a specific phase of the land operation. Their surgical capability can be enhanced by the attachment of one or more FIRST. Casualties treated at a field hospital would normally arrive by forward AME or road ambulance. Casualties requiring level four care, or whose hospitalisation will exceed the holding policy, will be evacuated from field hospitals out of the combat zone to facilities in the communications zone (commZ). Tactical AME or surface evacuation would be used for this purpose.

Level four support

4.17 Forward general hospitals (FGH) provide level four support in the land AO. FGH provide specialised surgery within the land AO. They are located in the commZ and are normally declared wherever circumstances allow. They are not mobile and would take several weeks to close, redeploy and re-establish in a new location. Casualties requiring ongoing care would either be evacuated to other medical facilities in the commZ or out of the land AO to the support area.

Other support

4.18 Field medical stations and convalescent and rehabilitation units augment medical support in the land AO.

AIR OPERATIONS

General

4.19 The nature of health support for air operations varies less than that for maritime or land operations. Whether counter-air, targeting, aerial reconnaissance, surveillance or electronic warfare, airlift, combat air support or sustainment operations, the nature of support will remain relatively constant, although its intensity may vary substantially. The key health support functions required in support of all operations include base support (including to forward deployed bases), AME staging, and tactical and strategic AME, including the provision of AME teams.

Base support

4.20 This function is normally performed by health service flights (HSF) or Royal Australian Air Force (RAAF) hospitals on established RAAF bases. The role, organisation, characteristics and tasks of HSF are detailed at [chapter 2](#). HSF normally provide level one and two medical support to base operations. In deployed situations, airfield support is provided by an aeromedical evacuation staging facility (ASF), air transportable health centre (ATHC) or air transportable hospital (ATH). The level of support will depend on the nature of operations being supported and the access within acceptable time frames to other land-based facilities. Key functions of the health facilities are maintenance of fitness for flying, management of casualties in aircraft returning from operations and as a result of enemy action on or near the airfield, provision of specialist aviation medical advice and environmental health support.

4.21 Deployment and location of health facilities will be determined by air operations basing considerations. In the rapid occupation and development of forward-deployed bases, an ASF will be included early in the deployment sequence, with all elements progressively deployed until an ATHC or ATH is established as appropriate. Established facilities have ambulances for collection and movement of casualties on the base and in the local area. Airfield health facilities are directly involved in base SAR operations.

4.22 Casualties requiring further care may be evacuated by road ambulance, or forward or tactical AME to other land-based facilities such as field hospitals or FGH or rearward to the support area by strategic AME. A FAST can be employed to either provide a limited surgical capability during the early stage of base development or to enhance the surgical capability of an established ASF, ATHC or HSF.

Aeromedical staging

4.23 Aeromedical staging is performed by ASF. The role, organisation, characteristics and tasks of an ASF are detailed in [chapter 2](#). ASF will normally be located on or in the vicinity of an emplaning or deplaning air base or strip in the tactical or strategic AME chain. They may be collocated with other land-based medical facilities such as field hospitals, but remain a separate entity and perform a separate function. ASF normally hold casualties for no more than six hours. In certain circumstances, a FAST may be deployed with and in support of an ASF. Further details of the aeromedical staging function within the tactical and strategic AME systems are provided in [chapter 5](#).

Tactical and strategic aeromedical evacuation

4.24 Requests for AME are forwarded to the aeromedical evacuation control centre of the superior headquarters from where appropriate aircraft and health assets are tasked with the conduct of AME. Details of procedures for tactical and strategic AME are provided in [chapter 5](#). The in-flight care of patients in the strategic and tactical chain is provided by RAAF AME teams whose role, organisation, characteristics and tasks are detailed in [chapter 2](#).

AMPHIBIOUS OPERATIONS

4.25 Amphibious operations are joint operations involving a variety of ship types, landing forces, weapons and aircraft in a coordinated effort to project land forces from the sea or to withdraw such forces to ships at sea. The types of amphibious operations include amphibious assault, amphibious tactical lodgment, amphibious raids, amphibious insertion of special forces, amphibious demonstration and amphibious withdrawal. Australian Defence Force (ADF) doctrine for amphibious operations is provided in Australian Defence Force Publication (ADFP) 12—*Amphibious Operations*. Health support for amphibious operations is extensively detailed in ADFP 12.

4.26 Amphibious operations will directly involve health support capabilities of the RAN and Army, and indirectly those of the RAAF. Participating ships and Army units will include integral level one support which should be available throughout the operation. In the absence of land-based level two and level three medical support, the RAN will provide such support through an AMF. This support could be provided from an amphibious transport or other suitable ship which is part of the amphibious force, or from another suitable ship dedicated to the function of hospital ship and declared and protected under international humanitarian law. The RAN will also have primary responsibility for forward AME in amphibious operations during periods when it has primary responsibility for levels two and three support.

4.27 During lodgment operations, Army will establish level two and three support ashore as soon as operational circumstances allow. Because of the time taken to deploy a field hospital, a degree of level three support ashore could be provided as an interim measure by the attachment of a forward surgical team (FST) to a BASB med coy. During withdrawal operations, Navy will assume responsibility for provision of level three support as early as possible, allowing Army to close and redeploy its support. Army will provide level two support ashore for as long as operational circumstances allow.

4.28 Medical manning of surface craft used for casualty evacuation remains a responsibility of the Service to which they belong. The point at which RAAF assumes responsibility for tactical and strategic AME will depend upon establishment of airfields ashore and the location of airfields or air bases along the sea/air lines of communication.

AIRBORNE OPERATIONS

4.29 An airborne operation may be a combined or joint force operation involving aircraft and ground forces from any Service, or an operation conducted in concert with allied forces and/or resources. While airborne operations will primarily involve Army ground forces and RAAF air assets, the RAN may be included in either element of the airborne force or in providing support. The significant feature of an airborne operation is that the ground force may be required to engage in combat immediately on leaving the aircraft (or, in the case of paratroop operations, once the paratroops have arrived at the drop zone).

4.30 The force may be delivered by airlanding, rappelling, parachute or any other delivery technique from either fixed-wing or rotary wing aircraft. Airborne operations can be either strategic or tactical and include airlanded operations by fixed wing or rotary wing aircraft, airmobile operations, paratroop operations, composite air mobile/paratroop/airlanded operations, special forces operations and extraction operations. ADF doctrine for airborne operations is provided in ADFP 39—*Airborne Operations*.

4.31 Airborne operations are likely to directly involve health support capabilities of the RAAF and Army, and possibly those of the RAN. RAAF and Army elements participating in the operation will include integral level one medical support. The provision of levels two and three support will depend on the nature of the operation and, specifically, the means of entry. RAAF has responsibility for provision of base support to airborne forces at mounting bases, forward operating bases and recovery airfields where these are operated primarily by RAAF. RAAF will also have responsibility for providing ASF support at airfields in the tactical and strategic AME chain, and for providing AME teams on aircraft used for tactical and strategic AME.

4.32 Army has responsibility for providing level two and three support to the ground force as soon after landing as operational circumstances allow. This would involve BASB med coys (or elements of them), parachute surgical team or FST. These facilities will hold casualties pending AME. When RAAF assumes responsibility for base support at an advanced landing ground, it will also establish level two or three support as required. In certain airlanded operations, this may include early deployment of an ASF or a FAST.

OTHER ASPECTS OF HEALTH SUPPORT

Environmental medicine

4.33 Preventive medicine, environmental health and occupational health support will be provided by a range of health service units in joint operations. In maritime operations, such support is provided by ships' sick bays and PMF to naval installations ashore. All Army medical units include an element of preventive medicine support but the preventive medicine coy provides the major capability for this support within the land AO. Environmental health support is integral to deployed RAAF health facilities.

4.34 Appropriate environmental medicine measures will minimise the amount of personnel lost through NBCas. Threats to health can take many forms. These include diseases and/or injury caused by:

- a. biting insects;
- b. envenomation by animals;
- c. eating contaminated food or drinking impure water;
- d. contact with or ingestion of toxic or injurious plants;
- e. heat stress and low water consumption;
- f. carbon monoxide, noise or chemicals (environmental or occupational injuries);
- g. lack of physical or mental fitness; and
- h. cold injuries caused by low temperatures, wind and wetness.

Dental support

4.35 The requirement for dental care within a JFAO is reduced by ensuring that all combat and combat support personnel maintain a high standard of dental fitness, and meet dental fitness classification prescribed for particular deployments by the mounting authority. First aid for minor dental trauma, involving the temporary relief of pain and control of haemorrhage, can often be provided by non-dental personnel in a level one medical facility such as a ship's sick bay or RAP. All other treatment requires specialised equipment and professional dental personnel. Dental personnel in AMF, PMF, field dental units, HSF, ATHC, ATH, field hospital (fd hosp) and FGH provide a range of dental treatment including relief of pain, control of infection, management of minor trauma, stabilisation of major facial trauma, repair of traumatised dentition and repair or replacement of prosthesis. This range of treatment is focussed on keeping combat and combat support personnel operationally capable and preventing the need for evacuation of dental casualties. Maxillo-facial surgery for the management of severe facial trauma can be provided within the JFAO at fd hosp, ATH, AMF, PMF, and FGH facilities.

Combat stress management

4.36 All ADF health support elements have some capability to provide combat stress management. Within the land AO, Army may deploy stress management teams which can provide psychological advice and support, and particularly, immediate crisis counselling. Combat stress casualties will normally be managed as far forward as possible. Critical incident stress debriefing can also be conducted by RAAF personnel in an ASF, ATHC and ATH. In particular, ATHC and ATH have a psychiatrist to coordinate and control the provision of mental health support in deployed situations.

CHAPTER 5

TRIAGE, EVACUATION AND REGULATION

INTRODUCTION

General

5.1 Triage is the process for sorting casualties based on their need for treatment, evacuation, and return to duty. Casualty evacuation is the process of moving any person who is wounded, injured or diseased to and/or between medical treatment facilities. It includes surface evacuation and aeromedical evacuation. Regulation is the process which directs the casualty to the medical facility best able to cope with the condition, in terms of nature of treatment required and the availability of treatment.

Triage

5.2 Triage is a dynamic process. The casualty category may vary throughout the evacuation process and may even change whilst the casualty is at a single point in the evacuation chain. A group of injured patients can be satisfactorily evaluated and resuscitation begun using whatever resources are available. Treatment is rendered based on the airway with cervical spine control, breathing, circulation with haemorrhage control priorities.

5.3 Two types of triage situations can occur. They are when:

- a. The number of patients and the severity of their injuries do not exceed health service support resources. In this situation, patients with life-threatening problems and those sustaining multiple-system injuries are treated first.
- b. The number of patients and the severity of their injuries exceed health services resources. In this situation, those patients with the greatest chance of survival, with the least expenditure of time, equipment, supplies and personnel are managed first. This is a mass casualty situation.

5.4 The following triage categories are used:

- a. **T1—immediate (red)**, the highest priority:
 - (1) immediate intervention is required in order to save and stabilise an individual with life-threatening injuries;
 - (2) the casualty has an expected high chance of survival; and
 - (3) the casualty will be recategorised (usually to T2) once resuscitation/stabilisation is complete.
- b. **T2—delayed (yellow)**, the next priority:
 - (1) the general condition of the casualty permits a delay in active intervention or surgery without endangering life;
 - (2) prognosis of the casualty is good;
 - (3) early surgical intervention is required, but the casualty will survive several hours with supportive measures until it can be provided; and
 - (4) continual reassessment may lead to a change in category to T1.
- c. **T3—minimal (green)**:
 - (1) these casualties have minor non-capacitating problems needing minimal treatment with no urgency; and
 - (2) treatment can often be provided by first aid trained personnel.

- d. **T4—expectant (blue)**, the lowest priority:
- (1) this triage category may not have application in a non-mass casualty situation as these seriously injured patients would normally be treated as immediate;
 - (2) casualties have serious or multiple injuries with poor chance of survival;
 - (3) treatment requires intensive therapy with extensive use of personnel, equipment and stores, or time;
 - (4) these casualties should be given basic supportive and analgesic treatment; and
 - (5) as the mass casualty scenario changes, these casualties could be retriaged to T1.
- e. **Dead (black)**. This triage category may not have application in a non-mass casualty setting as lifesaving resuscitation would normally be attempted in most cases before a casualty is declared dead.

Evacuation process

5.5 The pattern of the evacuation system is that of a funnel, with casualties from the broad base forward in an area of operations (AO) being channelled through first and second level medical facilities until they reach the more specialised treatment facilities of the third and fourth level medical units.

5.6 Casualties are evacuated no further than their condition or the operational situation demands. Evacuation is normally, but not always, undertaken by the next higher level of medical support. Control of evacuation flow and the means of evacuation lie with the headquarters which controls the destination medical facilities (DMF).

5.7 The following categories are used to prioritise the medical evacuation of casualties to the appropriate DMF. It should be noted that there is no direct correlation between triage categories and evacuation priorities.

- a. **Priority one (urgent)**. Life is immediately threatened. Rapid evacuation, urgent resuscitation, and/or surgery are required to save life.
- b. **Priority two (priority)**. Life or limb is in serious jeopardy. Evacuation should be effected as soon as possible.
- c. **Priority three (routine)**. This priority is for those casualties whose life or limb is not in serious jeopardy. Evacuation should be effected as soon as possible.

Requirement for rapid evacuation

5.8 Rapid evacuation of casualties makes a positive contribution to operational effectiveness in that early evacuation and treatment offers a high probability of success in saving life and limb and also operational commanders are freed of their responsibilities for casualties and are able to concentrate on operational issues. Furthermore, prompt and efficient evacuation of casualties has a positive effect on morale.

5.9 Battle casualty survival and minimisation of morbidity are particularly dependent on the promptness of evacuation from the time of wounding to the time of surgery. In spatial terms, this equates to evacuation from the point of wounding to a level three medical facility. Historical data relating to seriously wounded battle casualties indicates that there is a substantial increase in the mortality rate of battle casualties who do not undergo surgery until the start of the fourth hour after wounding. There is a further dramatic increase between the sixth and seventh hours. Accordingly, medical planning in operations should ensure, wherever practicable, that seriously wounded or injured casualties can commence surgery in a level three facility within three hours of wounding. This requirement will have implications for the location of medical facilities and the allocation and employment of evacuation resources.

5.10 Evacuation of patients who have undergone surgery is influenced less by the need for speed and more by the need for post-operative stabilisation, careful clinical assessment for evacuation, and higher levels of care during subsequent evacuation to level four or other medical facilities in the evacuation chain.

Surface evacuation

5.11 Aeromedical evacuation (AME) is the preferred means of evacuation in most situations. However, there will clearly be circumstances where surface evacuation is necessary, particularly during the early stages of the evacuation process when the forces involved are still engaged with the enemy. Surface transport will also be used for evacuation when AME is not available or practicable such as priority three casualties for whom rapid evacuation is not crucial, post-operative patients in a maritime AO and for local movement between medical facilities or between medical facilities and aircraft loading points.

5.12 Means of surface evacuation can include military or civilian vehicles, road ambulances, ambulance buses, ambulance trains, armoured vehicle ambulances, hospital ships and other ships, and stretcher bearers.

5.13 [Annex A](#) illustrates the system for surface evacuation of casualties within a joint force area of operations (JFAO).

AEROMEDICAL EVACUATION

General

5.14 Movement of patients within an AO and to, or within, the support area should be by air whenever suitable airlift resources are available and their use is practicable. When justified in terms of evacuation commitment and the availability of suitable resources, aircraft may be dedicated to the AME role.

5.15 Speed, range, comfort and versatility of aircraft that are equipped and crewed for AME greatly reduce the morbidity and mortality rate of casualties, increase the choice of appropriate medical facilities and provide flexibility of medical support without the need for frequent relocation of medical units. The capability and capacity of aircraft communications provide a major advantage for casualty regulation and the overall command and control of the evacuation system. The capabilities of aircraft that may be available to the Australian Defence Force (ADF) for AME are detailed in [annex B](#). The civilian aviation infrastructure is likely to make a major contribution to strategic AME.

5.16 Some special advantages of rotary wing aircraft used in the AME role stem from their capability to land in areas and/or under conditions unsuitable for fixed-wing aircraft. This capability can significantly reduce the delay between wounding and evacuation and increase flexibility in choosing the most appropriate medical facility at which treatment is available. These advantages apply primarily to aircraft engaged in forward AME.

5.17 AME can be generally classified as follows:

- a. Forward AME is the phase of evacuation which provides airlift for patients between points within the battlefield to the initial point of treatment, and to subsequent points of treatment within the combat zone (CZ). In operations where the boundaries of the CZ are not clear (eg most low-level operations), forward AME will be conducted between points in the AO as designated by the joint force commander (JFC).
- b. The airlift of patients from the CZ to points in the AO is known as tactical AME.
- c. The airlift of patients from the AO to points outside the AO, or between points within the support area is known as strategic AME.

5.18 The benefits of AME can be reduced if casualties are evacuated further than the medical or operational situation warrants. Specific limitations on the use of AME include the following:

- a. Forward AME aircraft are susceptible to the effects of weather conditions and enemy action. Despite these limitations, forward AME is normally preferable to other means of casualty evacuation. Operational support may be required to neutralise enemy action. The use of fixed-wing aircraft for forward AME could be limited by the terrain and the absence of suitable landing points.

- b. Delays on tactical and strategic AME may be imposed due to adverse weather conditions, enemy air activity, ground fire or the limited availability of aircraft and airfields.

5.19 Air Commander Australia (ACAUST) is responsible to Commander Australian Theatre for planning at the operational level to provide a coordinated aeromedical evacuation system (AES) in support of ADF operations. This system facilitates AME throughout the evacuation chain. An AES also provides:

- a. control of casualty movement by air;
- b. AME trained personnel and equipment for in-flight supportive medical care;
- c. facilities on or in the vicinity of airheads and airbases for the limited care of casualties entering, en route through, or leaving an AES; and
- d. information transfers with originating, en route, and destination medical facilities concerning casualty movement requirements.

5.20 Given the likely demands placed on air assets, liaison between health and movements staff is essential. Tactical and strategic level AES movements are coordinated with joint movements group to facilitate the movement of other freight and passengers during the pre-positioning or return of aircraft from AME tasks, as agreed between the aeromedical evacuation control centres (AECC) and the movements organisation.

5.21 Royal Australian Air Force (RAAF) has primary responsibility for provision of tactical and strategic AME while Army has primary responsibility for provision of forward AME in the land AO. Navy has primary responsibilities for provision of forward AME in the maritime AO. Although each of the Services has responsibilities for the provision of AME, the AES ensures a smooth and coordinated AME flow during ADF operations.

5.22 To facilitate an effective AES, AECC are established at appropriate headquarters. In addition, AME assets are located at appropriate points in the AME chain.

5.23 Director of Health Services, Headquarters Air Command (HQAC) prepares operational level AES plans for ADF operations. These plans are promulgated in operation orders or instructions and include detail on the provision of AECC and aeromedical evacuation staging facility (ASF), and appropriate AME procedures.

5.24 The AES depends on the:

- a. nature and disposition of medical facilities;
- b. number and type of both fixed-wing and rotary wing aircraft available;
- c. area geography;
- d. forecast casualty rate;
- e. tactical situation; and
- f. weather.

Forward aeromedical evacuation

5.25 Responsibilities. The responsibilities for forward AME are as follows:

- a. Each of the Services has aircraft that can be used in the forward AME role, and is therefore responsible for the conduct of AME using its aircraft, coordinated when necessary by the AECC for the JFC in the JFAO. Because of the advantages of rotary wing aircraft in the forward AME role, Army has primary responsibility for forward AME in land operations. Similarly, RAN has responsibility for forward AME in maritime operations, and also in amphibious operations until this can be assumed by Army.
- b. Aircraft dedicated to forward AME are to be marked and identified in accordance with [chapter 10—'Medical aspects of the law of armed conflict'](#).

- c. Aircrew who may be involved with forward AME tasks should be familiar with the basic procedures for the carriage of casualties to enable them to assist medical personnel. Aircraft dedicated to forward AME tasks should carry AME trained medical personnel. When a non-dedicated aircraft is required to perform an AME mission, only AME trained medical personnel should be used to accompany casualties other than in exceptional circumstances.

5.26 Evacuation procedures. The procedures for forward AME are as follows:

- a. Forward AME requests will normally be in the form of the DUSTOFF message in [annex C](#). This format should be repeated in unit and formation standing operating procedures (SOP).
- b. DUSTOFF messages should be processed in accordance with current SOP and orders. They will normally be sent through the command radio net to the headquarters of the superior formation (to the AECC when established) or command element of a maritime group. With advice from air and medical staff, as required, the operations/AECC staff will action the request.
- c. When Royal Australian Navy or RAAF aircraft are used on forward AME tasks in the land AO, appropriate liaison staff will usually be provided to relevant headquarters normally as part of a joint force air operations centre (JFAOC) tactical air control party (TACP), air transport operations centre and to the AECC.
- d. In most cases, forward AME is the preferred means of evacuating casualties within the CZ. However, for resource, tactical and medical reasons, use of air evacuation might be neither possible nor desirable. Care in selection of casualties for forward AME must therefore be exercised. In the event that casualties must be evacuated for tactical, operational or logistic reasons, evacuation should be requested stating the assigned medical priority followed by a statement outlining the reasons for early evacuation.
- e. Transport of the dead in forward AME aircraft will be undertaken in accordance with operation and administrative orders.
- f. In the interests of economy of effort and effectiveness, casualty regulation must be coordinated at the highest practicable level and will be conducted by appropriate headquarters (HQ). See [paragraphs 5.35 to 5.38](#) below.
- g. A field medical card or other documentation must be raised and will remain with the casualty during forward AME. Medication administered during flight must be accurately recorded and all documents are to be passed to the medical authorities at the destination medical facility (DMF). Wherever practicable, an AME mission report is to be completed and forwarded to the superior HQ/AECC.
- h. Where aircraft are dedicated to the forward AME role, they should be equipped and medically stocked in accordance with the medical plan, and requirements detailed by the AECC, after consultation with the casualty regulation HQ, the senior medical officer (SMO) or the supported formation or unit, and where appropriate, the aeromedical evacuation coordination officer (AECO). The SMO or the officer responsible for casualty regulation should ensure that adequate medical supplies are available whether or not aircraft are dedicated to the AME role.

Tactical aeromedical evacuation

5.27 In accordance with Australian Defence Force Publication 2—*Division of Responsibilities Within the Australian Defence Force* the air component commander will normally be required to provide assets to establish the tactical AME links in the overall medical evacuation chain. Actual employment and deployment of these resources will be the responsibility of the JFC in the JFAO. RAAF will provide trained staff to establish an AECC on the joint force headquarters (JFHQ). This staff will coordinate and control all requests for AME and will normally form part of the staff of the TACP in the HQ concerned. It will maintain close liaison with the TACP or JFAOC staff, as appropriate. The aeromedical evacuation operations officer (AEOO) on the AECC will provide advice to the JFC and staff on the employment of tactical AME and on the disposition of ASFs. Roles and responsibilities of AEOO are detailed in [annex D](#).

5.28 Evacuation procedures. The procedures for tactical AME are as follows:

- a. The movement precedence to be used for tactical and strategic AME is in [annex E](#). Units and medical facilities requiring tactical AME should assign movement precedence and submit requests to the AECC of the appropriate HQ in accordance with the medical and operational requirements. The message procedures for tactical AME will usually consist of the AME REQUEST, AME TASKING, AME MOVE and AME DEPART messages detailed in annex F. AME DEPART messages are forwarded to the AECC of the superior HQ. After validation, an AME TASKING message will be sent to an appropriate health facility, where the appointed or duty AECO will organise the AME mission. The AECO will issue an AME MOVE message to advise all concerned of the arrangements for the mission. If the message is urgent, the AECC may issue an AME MOVE message on behalf of the AECO.
- b. A RAAF medical officer (MO) will be appointed as the AECO in each medical unit involved in tactical AME operations. The AECO is responsible for selection and classification of patients for tactical AME, provision of aviation medicine advice, coordination of message procedures for tactical AME operations, and for the local tasking of AME teams.
- c. [Annex G](#) outlines the general principles for selection of patients. The operational situation may dictate some latitude in the process.
- d. Patients selected for tactical AME are to be classified in accordance with [annex H](#).
- e. AECO are to ensure that AME flight teams comprise only those medical personnel who have undergone training in AME procedures. AME flight teams will be deployed, as appropriate, to meet anticipated evacuation requirements. Composition of the team will be arranged by the AECO having regard to the number and nature of the patients requiring evacuation.
- f. Casualty regulation will be conducted by appropriate HQ within the land AO, normally in the communications zone.
- g. Adequate facilities should be available for the clinical assessment, administrative processing and short-term holding of patients within the tactical AME chain. When existing facilities are not appropriate, a RAAF ASF is to be deployed.
- h. AECO are responsible for ensuring that all necessary documentation is prepared in accordance with the relevant instructions and documents relating to patients are passed to the senior member of the AME team. AME mission reports are to be completed after each mission and forwarded as soon as possible to the AECC of the tasking HQ.
- i. AECO should ensure that supplies of AME equipment are adequate to meet local requirements and are maintained in serviceable condition. AECO will establish adequate supplies of equipment at originating medical facilities within the tactical AME system to enable equipment exchange procedures to be undertaken when patients are transferred from these facilities.
- j. Aircraft dedicated to tactical AME are to be marked and identified in accordance with [chapter 10—'Medical aspects of the law of armed conflict'](#).

Strategic aeromedical evacuation**5.29** Responsibilities for strategic AME are as follows:

- a. ACAUST is responsible for the provision and operation of RAAF aircraft employed in strategic AME and coordinating the operations of civilian aircraft employed in strategic AME. RAAF is responsible for transporting patients from airfields servicing originating medical facilities in the JFAO to terminal airfields servicing identified DMF. This responsibility includes provision of ASF at originating, transit and destination airfields and provision, when necessary, of short-term patient care at intransit medical facilities (IMF) within the strategic AME chain. Strategic AME operations may include regular scheduled services, individual missions or opportunity evacuation.

- b. Where aircraft involved in strategic AME are dedicated to the AME role, they are to be marked and identified in accordance with [chapter 10](#).

5.30 For strategic AME operations casualty regulation will be conducted by the senior medical regulating HQ in the support area.

5.31 [Annex F](#) details the message procedures to be followed in strategic AME operations.

5.32 Before patients and cargo are carried on missions, air movement officers should ensure that the AECO concerned approves the proposed loading configuration. Before issuing approval, AECO should ensure that:

- a. the load plan will not interfere in any way with the primary AME task;
- b. adequate space is provided for the patients and AME team;
- c. the section of the aircraft occupied by patients, particularly litter cases, is suitably screened off;
- d. access to aircraft facilities used by patients or the AME team is not impeded in any way; and
- e. no delay or other interference is incurred with the loading or unloading of patients or with action during aircraft emergencies, having particular regard to the medical condition of patients.

5.33 AECO are responsible for ensuring that all necessary documentation is prepared in accordance with the relevant instructions and that documents relating to patients are passed to the senior member of the AME team. AME mission reports are to be completed after each mission and forwarded as soon as possible to the AECC of the tasking HQ.

5.34 **Selection and classification of patients.** Patients are to be selected and classified as follows:

- a. A RAAF medical officer will be attached to each medical unit involved in strategic AME operations. The officer is responsible for selection and classification of patients for strategic AME, provision of aviation medicine advice, provision of advice on message procedures for strategic AME operations, and tasking and employment of AME teams.
- b. AECO should ensure that patients are selected for strategic AME in accordance with the principles outlined in [annex G](#).
- c. Patients selected for strategic AME will be allocated a movement precedence in accordance with the system described in [annex E](#). This precedence is not to be confused with the treatment and evacuation priorities detailed at [paragraph 5.4](#). Patients selected for strategic AME are to be classified in accordance with [annex H](#).

5.35 **AME flight teams.** AME flight team composition will be determined by the AECO at the originating AME facility. The requirement for inclusion of MOs should be based on clinical grounds and on facilities available at transit airfields, IMF and terminal airfields. The inclusion of clinical specialists will be necessary in certain circumstances.

5.36 **Responsibilities of medical facilities.** [Annex I](#) details the responsibilities of medical facilities involved in strategic AME.

CASUALTY REGULATION

General

5.37 Within a JFAO and support area, control of casualty evacuation is necessary to ensure proper routing of casualties to appropriate treatment facilities, to achieve an even distribution of patients, and to ensure there are adequate beds and treatment capabilities for current and anticipated needs. Evacuation is controlled at the highest level consistent with the distances and evacuation time involved. Usually, this control function will be carried out by the medical regulation office of the health services staff of a JFHQ or other appropriate HQ.

5.38 Effective medical regulation will decrease the number of times a casualty is handled within the evacuation chain and will also prevent the routing of surface evacuation and AME from one treatment facility to another in an attempt to find available beds or treatment capability. Effective medical regulation is heavily dependent upon direct and uninterrupted communication between health services staff, health services units and casualty evacuation agencies.

Casualty regulation in the joint force area of operations

5.39 Casualty regulation will be conducted at all levels within a JFAO, regardless of the means of evacuation. At lower levels where evacuation choices are limited and treatment dependencies established, regulation will be less formal. At JFHQ, casualty regulation will normally be performed by a medical regulating cell within the health services staff of the HQ. Within the land AO, casualty regulation will mainly involve directing casualties to appropriate level three medical facilities within acceptable time frames utilising surface evacuation and forward AME. Subsequent casualty regulation will mainly involve directing patients to appropriate level four or other facilities utilising tactical AME or surface evacuation originating in the AO.

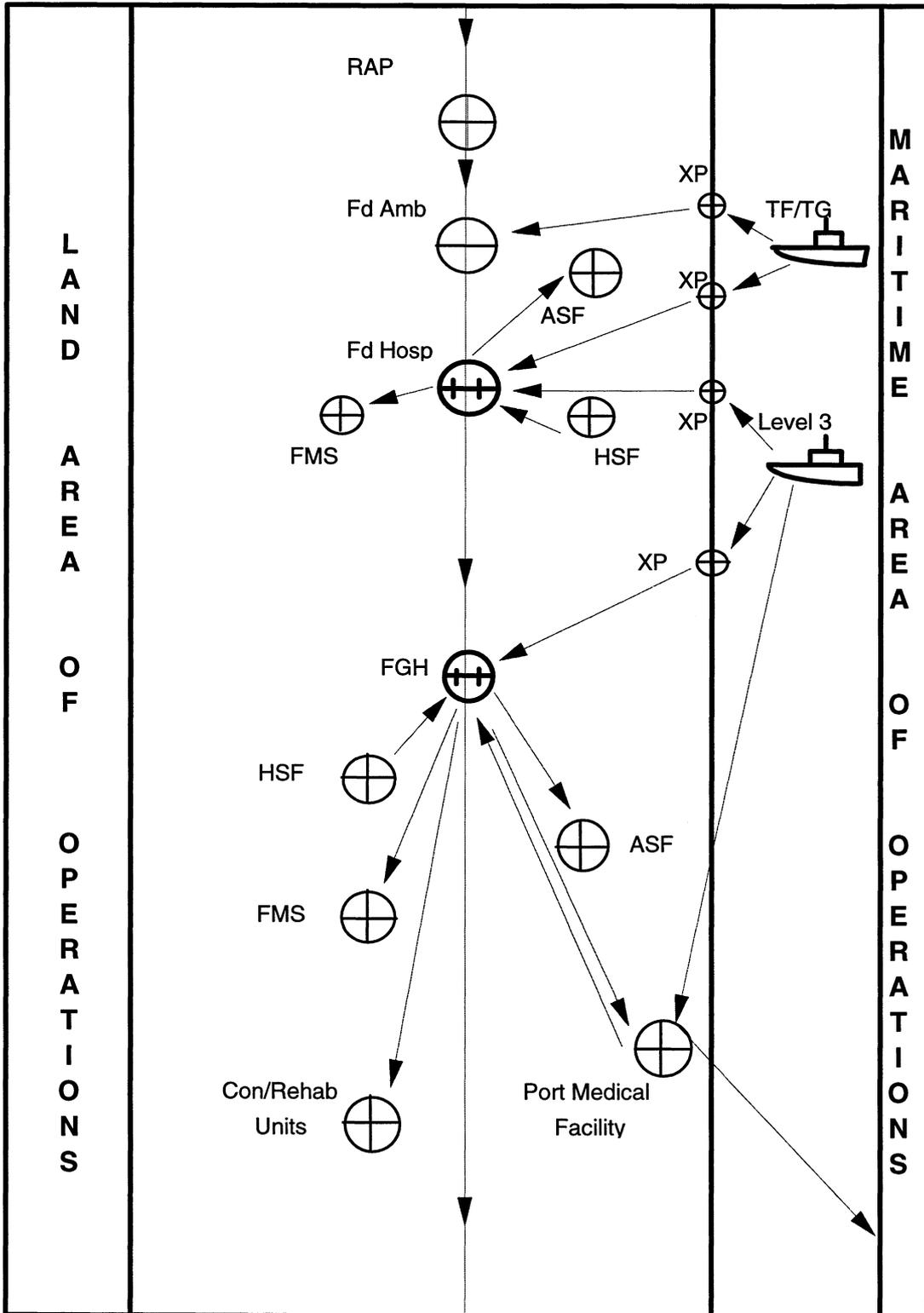
Casualty regulation in the support area

5.40 Casualty regulation will be necessary within the support area to ensure patients evacuated from the JFAO and casualties occurring along the lines of communication are directed to appropriate level three, four or five medical facilities. Casualty regulation within the support area is normally performed by the medical regulating cell of an appropriate joint or single Service support area HQ. This will be designated the ADF medical regulation office (ADFMRO). Casualty regulation identifies appropriate DMF for patients evacuated from the JFAO using strategic AME or surface means. Casualty regulation does not impinge on the responsibilities of HQAC which, where the means of evacuation from the JFAO is strategic AME, is responsible for transporting patients to the airfield nearest the DMF, using appropriate airframes, airlinks, aeromedical staging and the intransit medical facilities. In certain circumstances where the casualty load from the JFAO requires planning and provision of health support in the support area to be coordinated on a joint basis, the medical regulation function may be assigned to the support area HQ given that responsibility (*see also* [chapter 7—‘Health support in the support area’](#)). The organisation and capabilities of the ADFMRO are in [annex J](#).

Annexes:

- A. [Surface evacuation of casualties within a joint force area of operations](#)
- B. [Capabilities of aircraft for aeromedical evacuation](#)
- C. [Request for forward aeromedical evacuation DUSTOFF message](#)
- D. [Roles of aeromedical evacuation operations officers in aeromedical evacuation control centres](#)
- E. [Movement precedence of patients for tactical and strategic aeromedical evacuation](#)
- F. [Message procedures for tactical and strategic aeromedical evacuation operations](#)
- G. [Principles for selection of patients for tactical and strategic aeromedical evacuation](#)
- H. [Classification of patients for tactical and strategic aeromedical evacuation](#)
- I. [Responsibilities of medical facilities involved in tactical and strategic aeromedical evacuation](#)
- J. [Organisation and capabilities of an Australian Defence Force medical regulating office](#)

SURFACE EVACUATION OF CASUALTIES WITHIN A JOINT FORCE AREA OF OPERATIONS



CAPABILITIES OF AIRCRAFT FOR AEROMEDICAL EVACUATION

Serial	Aircraft	Seats	Litters	Ferry Range (km)	Cruising Speed (km)
1.	Bell 206B-1	4	2	460	185
2.	Iroquois UH-1H	7	6	350	190
3.	Black Hawk ^(a)	10	6	450	220
4.	Black Hawk ^(b)	10	6	750	200
5.	Seahawk	10	6	450	220
6.	Sea King	21	9	925	200
7.	Chinook	32	24	555	250
8.	Squirrel	1	1 seat 1 paraguard	555	220
9.	Nomad	16	3 ARA 1 RAAF	835	275
10.	HS748	30	6	2 038	405
11.	Caribou	31	20	2 220	265
12.	Hercules C130 E	91	74	7 315	515
13.	Hercules C130 H	91	74	7 685	590
14.	B707 (RAAF) ^(c)	155	27	11 112	870
15.	F900 (RAAF)	8	1 or 2	4 630	870
16.	Fokker F27	40	24	4 260	785
17.	Fokker F50	46		2 780	490
18.	Fokker F28/100	60		2 038	775
19.	Fokker F28/200	69		2 038	775
20.	BAe146-200	80		1 100	730
21.	DC9-30	105		2 870	830
22.	Boeing 727-100	108		5 770	970
23.	Boeing 737-300	110		4 400	815
24.	Boeing 727-200	130		5 930	955
25.	Airbus A320	132		5 380	815
26.	Boeing 707-320C	162		12 050	980
27.	Airbus A300	242		4 630	840
28.	Boeing 747B	371		13 230	975
29.	Boeing 767-200	211		9 200	870
30.	C5	329		10 411	680
31.	C141	200	103	10 280	800
32.	C17	102	48	TBA	775

Notes

- (a) Without external fuel tanks.
- (b) With external fuel tanks.
- (c) Potential maximum depending upon availability of litter kits.
- (d) The information contained in this annex is intended only as a guide. When detailed planning is being undertaken, close liaison should be established with the authority operating the aircraft.

REQUEST FOR FORWARD AEROMEDICAL EVACUATION DUSTOFF MESSAGE

Purpose

The standard form of message whereby a unit requests forward aeromedical evacuation.

Format

FORMAT (not to be transmitted) ^(a)	EXAMPLE MESSAGE
--	------------------------

CONFIDENTIAL

From: From: 2 RAR

To: To: 3 BDE

AVIATION SUPPORT REQUEST DUSTOFF (an Army HAWKEYE)

<p>A. Map reference</p> <p>1. Type of support</p> <p>2. Unit/sub unit to</p> <p>3. Operating areas/landing zones/etc ^(b)</p> <p>4. Timings and locations:</p> <p style="padding-left: 20px;">a. Briefing ^(c)</p> <p style="padding-left: 20px;">b. Commence task</p> <p style="padding-left: 20px;">c. Finish task ^(e)</p> <p style="padding-left: 20px;">d. Debriefing ^(f)</p> <p>5. Contact at supported unit/sub unit ^(g)</p> <p>6. Radio callsigns and frequencies ^(h)</p> <p>7. Passenger detail ⁽ⁱ⁾</p> <p>8. Load detail ⁽ⁱ⁾</p> <p>9. Other information</p>	<p>A. MAP TOOLAN, SHEET 3682, EDITION 1, SERIES R514, 1:50 000</p> <p>1. DUSTOFF requested</p> <p>2. D COY be supported</p> <p>3. PZ GR 811142</p> <p>4B. ASAP ^(d)</p> <p>6. CS EM4D FREQ 44.35, ALTN 53.25</p> <p>7A. 1 X PRI 1, LITTER, GUNSHOT WOUNDS TO CHEST AND LIMBS</p> <p>7B. 1 X PRI 2, LITTER, GUNSHOT WOUND TO ARM</p> <p>8. 2 x PERS EQUIP 100 LBS</p> <p>9. BEST APP TO PZ FROM SW. EN ACTIVITY TO NORTH AND NW 500M. SMK AVAL IF REQ. JP REQ</p>
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Notes

- (a) Those serials for which no information is required should not be included in the transmitted message. For all other serials, the serial numbers must be retained as listed and must be included in the text of the message.
- (b) Identification of the type of Landing Zone and its location are required.
- (c) Briefings initiated by the requesting unit will rarely be required for DUSTOFF tasks. In some cases specific briefings might be required for medical and/or operational reasons. Such briefings would be in addition to any conducted as part of normal flying procedures.
- (d) In accordance with the principles of medical support, DUSTOFF tasks will normally commence ASAP. There may, however, be occasions, usually for operational reasons, when DUSTOFF aircraft should enter or leave an area within a particular time frame.

- (e) This serial will rarely be a requirement of the originating unit.
- (f) If required by originating unit.
- (g) Not normally required unless the originator is remote from the casualty.
- (h) Originator's callsign and alternate frequencies.
- (i) Passenger detail must include the numbers of casualties to be collected, their priorities, nationality, if other than Australian, the nature and site of wounds, and whether they are on litters or are sitting. Details of medical attendants must be included, when appropriate.
- (j) Load detail must include the type and weight (preferably in lbs) of the load, including personal equipment.

ROLES OF AEROMEDICAL EVACUATION OPERATIONS OFFICERS IN AEROMEDICAL EVACUATION CONTROL CENTRES

1. Aeromedical evacuation control centres (AECC) are established as part of the tactical air control party (TACP) of appropriate headquarters (HQ) in the aeromedical evacuation (AME) chain. The AECC provides centralised coordination of assigned AME resources. For forward AME, the functions of the AECC are normally performed as staff functions within appropriate HQ.
2. All AME missions undertaken using assigned assets are to be controlled and coordinated by the HQ. Aircraft are to be tasked for AME duties by the commander of the airlift assets, or the TACP or joint force air operations centre (JFAOC) as appropriate. Health assets are tasked to perform AME duties by the AECC.
3. The aeromedical evacuation operations officer (AEEO) in the AECC is to determine the requirement for and the disposition of AME teams and aeromedical evacuation staging facility within the HQ area of responsibility. These AME facilities are to provide AME teams with an appropriate notice to move as determined by the AEEO.
4. On receipt of an AME request, the AEEO is to:
 - a. validate the requirement for the AME mission, and confirm or allocate a priority;
 - b. liaise with the senior medical officer or medical regulating officer of the HQ to ascertain an appropriate destination medical facility for the patient(s);
 - c. liaise with the airlift provider, the JFAOC or TACP as appropriate, to task an appropriate aircraft to undertake the required AME mission; and
 - d. select and task a health facility to provide an appropriately trained AME team.
5. All AME mission reports are to be forwarded to the AECC. The AEEO is to maintain records of AME missions and patient movement details. Any action that arises from mission reports is to be initiated, rectified, followed-up or coordinated by the AEEO as appropriate.
6. Any deficiency in the ability to perform AME in the area of responsibility is to be notified to the next higher HQ.
7. Any requirement for AME rearward of the HQ is to be forwarded to the AECC of the superior HQ.

MOVEMENT PRECEDENCE OF PATIENTS FOR TACTICAL AND STRATEGIC AEROMEDICAL EVACUATION

1. Patients selected for tactical and strategic aeromedical evacuation (AME) are to be allocated a movement precedence according to the following:
 - a. **Urgent.** Patients for whom speedy evacuation is necessary as a lifesaving measure, or to avoid serious permanent disability.
 - b. **Priority.** Patients who are liable to suffer unnecessary pain or discomfort unless evacuated by the quickest possible means and those who urgently require specialised treatment not available near the place of emplanement.
 - c. **Routine.** Patients whose immediate treatment requirements are within the powers of the place of emplanement but whose prognosis would definitely benefit by AME rather than evacuation by other means.

MESSAGE PROCEDURES FOR TACTICAL AND STRATEGIC AEROMEDICAL EVACUATION OPERATIONS

AME REQUEST message

1. **Tactical aeromedical evacuation (AME).** Request messages (AME REQUEST) for tactical AME are to be initiated at the originating medical facility (OMF) or headquarters (HQ) and sent to the aeromedical evacuation control centre (AECC) in the appropriate joint force headquarters (JFHQ) in accordance with the medical plan. As AME REQUEST messages contain clinical information they are to be classified 'MEDICAL-IN-CONFIDENCE'. On receipt, the duty aeromedical evacuation operations officer (AEEO) in the AECC will validate the requirement and liaise with the casualty regulating cell within the joint force area of operations (JFAO) to determine the destination medical facility (DMF). The AEEO will then liaise with air operations staff to task an appropriate aircraft. The AECC will issue an AME TASKING or AME MOVE message to task an appropriate health facility or aeromedical evacuation staging facility (ASF) to conduct the mission. On receipt of an AME TASKING message, the AECO will release an AME MOVE message. The AME MOVE message informs the OMF and all other facilities involved (or potentially involved) along the AME mission route. Other HQ and units which have responsibilities are made information addressees on the AME MOVE message. A flow chart for tactical AME requests is in [appendix 1](#).

2. **Strategic AME.** A flow chart for strategic AME requests is in [appendix 2](#). Request procedures for strategic AME are as follows:

- a. **Strategic AME from a JFAO.** Requests for strategic AME from units within an area of operations are to be coordinated by the AECC of an appropriate JFHQ within the JFAO. Requests are to be forwarded to Headquarters Air Command (HQAC) with the OMF preferred DMF or DMF locality. The AECC within HQAC will validate the AME requirement and liaise with the support area joint medical regulating cell to confirm or determine an appropriate DMF. The AECC will then liaise with air operations staff to task an appropriate aircraft. The AECC will issue an AME TASKING or AME MOVE message to task an appropriate health facility or ASF to conduct the AME. On receipt of an AME TASKING message, the AECO of the tasked facility will organise the AME mission and dispatch an AME MOVE message. The AME MOVE message informs the OMF and all other facilities involved (or potentially involved) along the AME mission route. Other HQ and units which have responsibilities are made information addressees on the AME MOVE message.
- b. **Strategic AME in the support area.** Units within the support area requiring AME are to forward strategic AME REQUEST messages directly to HQAC during peacetime or operations. An important aspect is whether a Royal Australian Air Force AME trained medical officer (MO) has assessed the fitness of patients. If this has been done, this should be indicated on the message request. If not, the point of contact should include the name and telephone number of the MO who is directly responsible for the clinical care of the patient in the OMF. This will enable the AEEO in HQAC to determine specific AME requirements for each patient.

3. **AME REQUEST message format.** The AME REQUEST message is similar to those used for TRANSREQ, TRANSAR and TRANSLAND messages. Examples of tactical and strategic AME REQUEST messages are in [appendix 3](#) and [appendix 4](#) respectively.

4. An AME TASKING message is to be despatched by an appropriate JFHQ within the JFAO in the case of tactical AME, and by HQAC in the case of strategic AME, in response to a request for tactical or strategic AME. The message is only sent once the appropriate medical regulating HQ has determined the DMF and assets requested for the evacuation have been identified. An example of an AME TASKING message is in [appendix 5](#).

AME MOVE message

5. At an appropriate time before an aircraft is due to depart on a strategic AME flight, the AECO at the OMF is to send a message giving preliminary information to all in-transit facilities, the DMF, the regulating HQ and other appropriate HQ, units and agencies. Times are to be expressed in ZULU. An example AME MOVE message is in [appendix 6](#).

AME REQUEST and CLINICAL DETAILS message

6. AME REQUEST messages addressed to non-health facilities are not to be classified as 'MEDICAL-IN-CONFIDENCE'. In such circumstances, clinical information that is required by health facilities in the aeromedical evacuation system, is to be forwarded to such health facilities by a separate 'MEDICAL-IN-CONFIDENCE' message, referencing the AME REQUEST message. An example of AME REQUEST and CLINICAL DETAILS message is in [appendix 7](#).

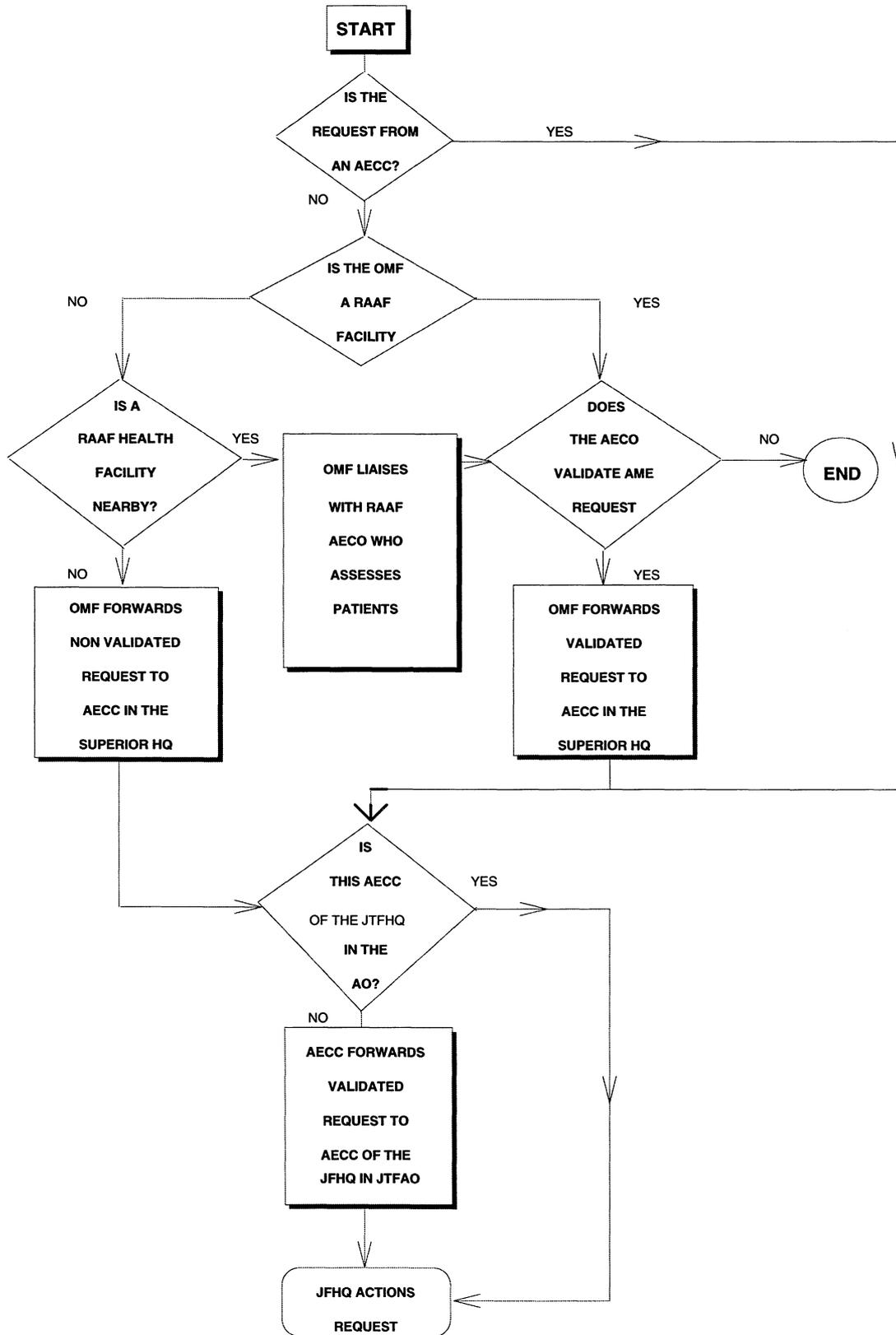
AME DEPART message

7. Immediately following departure of a tactical or strategic AME aircraft from the departure airfield or transit airfield, the AECO is to send a message to all addressees included in the AME MOVE message. An example AME DEPART message is in [appendix 8](#).

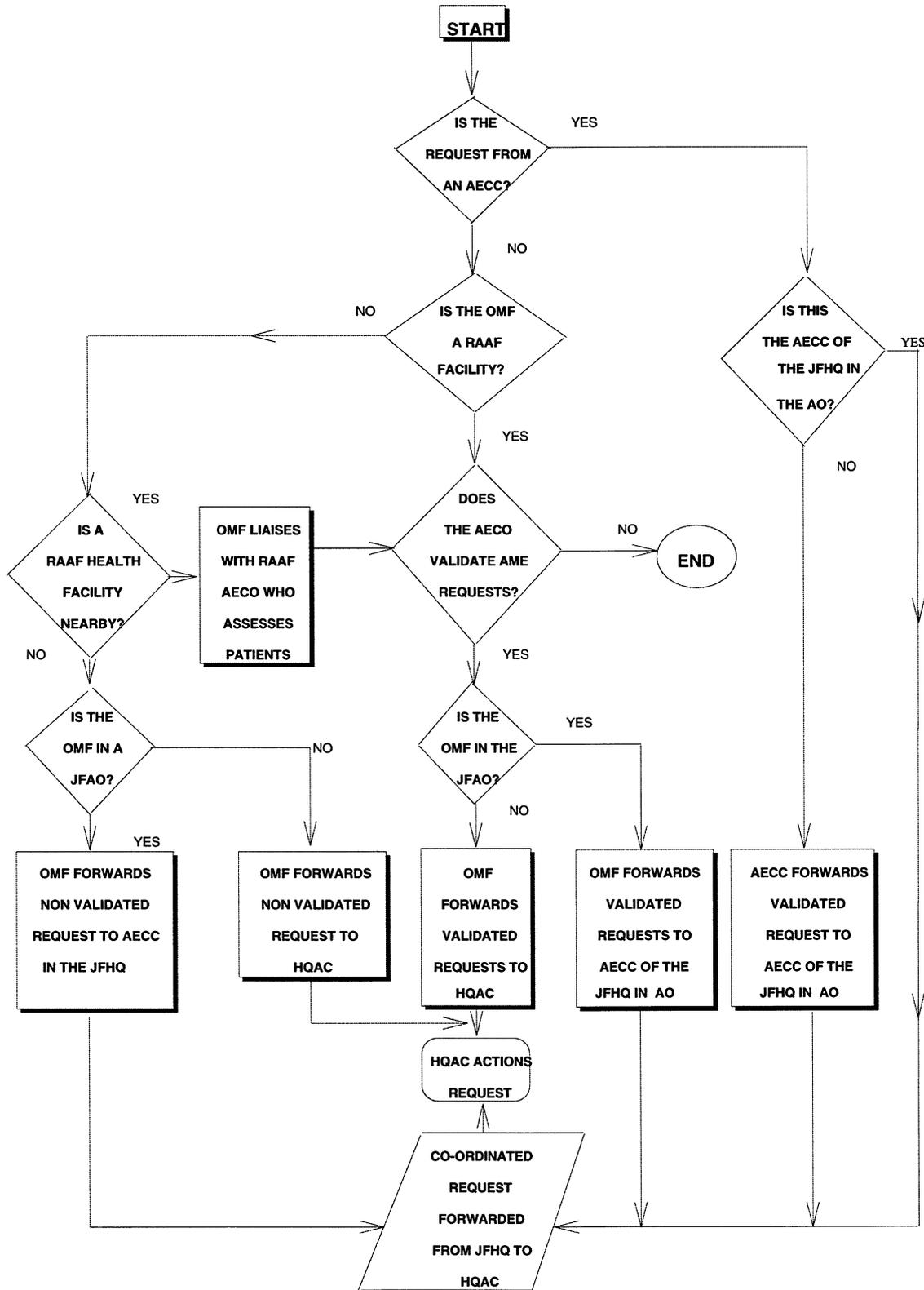
Appendixes:

1. [Flowchart—tactical aeromedical evacuation request](#)
2. [Flowchart—strategic aeromedical evacuation request](#)
3. [Example tactical aeromedical evacuation request message](#)
4. [Example strategic aeromedical evacuation request message](#)
5. [Example aeromedical evacuation tasking message](#)
6. [Example aeromedical evacuation move message](#)
7. [Example aeromedical evacuation request and clinical details message](#)
8. [Example aeromedical evacuation depart message](#)

FLOWCHART—TACTICAL AEROMEDICAL EVACUATION REQUEST



FLOWCHART—STRATEGIC AEROMEDICAL EVACUATION REQUEST



EXAMPLE TACTICAL AEROMEDICAL EVACUATION REQUEST MESSAGE

130130ZJUL97
FM HQ 1 BDE
TO JFHQ ALICE SPRINGS
INFO 2 FD HOSP
3 FWD GEN HOSP
ASF 2 OSU
HQAC AUST
SIC ABA/KSV/....
SECURITY CLASSIFICATION
PRECEDENCE
TABULATE
MEDICAL-IN-CONFIDENCE
SUBJ: **TACTICAL AME REQUEST**
1. MEDICAL FACILITY:
A. 2 FD HOSP.
B. GR173172.
C. HSF DAR (ALL PATIENTS).
D. RUNWAY UP TO CCO8 CLASS.
E. 130430Z JUL97.
F. 45.75 MHZ.
G. FGHZ.
2. LOAD SUMMARY:
A. TOTAL—11.
B. LITTER—3 (C2B-2, C2C-1).
C. WALKING—8 (C3A-6, C3B-2).
3. PERSONNEL SUMMARY:
A. ARMY—7.
B. NAVY—1.
C. RAAF—3.
4. DETAILS OF INDIVIDUAL PATIENTS:
A. 245678 PTE HURTE 3RAR.
(1) GSW ABDOMEN 12 JUL: TRANSFUSED WITH 2 UNITS O NEG BLOOD COMMENCED 130020Z
PATIENT BLOOD GROUP B POS. BLOOD LOSS CONTROLLED.
(2) IV THERAPY X 2 LINES. IV ANALGESIA. ANTI-EMETICS.
(3) URGENT.
B. A321798 CPL CHAPPS 2AFDS.
(1) MINE INJURY—BELOW R KNEE AMPUTATION. 12 JUL: TRANSFUSED WITH 2 UNITS O NEG
BLOOD COMMENCED 122215Z. PATIENT BLOOD GROUP A NEG. BLOOD LOSS CONTROLLED.
(2) IV THERAPY X 2 LINES. IV ANALGESIA.
(3) PRIORITY.
5. AECO ACTION—VALIDATED BY AECO ASF 2 OSU.
6. POINT OF CONTACT—FLT LT L. MCKAY AECO ASF 2 OSU. PHONE (08) 9123 456.
7. GENERAL INFORMATION—NIL.

Notes

- (a) **Message format.** The AME REQUEST message format is similar to those used for TRANSREQ, TRANSAR and TRANSLAND messages. The message instructions are to include the word 'TABULATE' and the message is to be drafted using the following numeric sequence as shown in subsequent notes.
- (b) Item 1—**medical facility:**
- Originating medical facility (OMF); pick-up point grid reference, departure, in-transit, and/or terminal airfields (departure/in-transit/terminal airfields used in strategic AME request).
 - Delivery point grid reference or terminal airfield (if the destination medical facility (DMF) has been identified by the appropriate regulating headquarters).
 - AME aircraft options—specify potential for fixed-wing or rotary wing aircraft and/or aircraft type.
 - Proposed date time group (ZULU) of proposed arrival time (strategic AME only).
 - Communication frequencies (tactical AME only).
 - Callsigns (tactical AME only).

- (c) **Item 2—load summary.** Total number of patients, number of litter patients and number of walking patients by class.
- (d) **Item 3—personnel summary.** Parent organisation of patients by parent Service.
- (e) **Item 4—details of individual patients.** When indicated, the following details are to be provided for special patients only on tactical AME REQUEST messages. These details are to be provided for all patients on strategic AME REQUEST messages.
- Personal details including age and sex when indicated, eg in the case of civilian patients:
 - Diagnosis, onset date and brief notes on present condition.
 - An outline of special management required during the flight, on arrival at the terminal airfield or at the DMF.
 - Movement precedence.
 - Subsequent personal details are to be recorded in prefix order.
- (f) **Item 5—aeromedical evacuation coordinating officer (AECO) action.** Indicate if the request has been validated by an AECO.
- (g) **Item 6—point of contact.** Indicate a point of contact within the OMF or joint force headquarters requesting the AME.
- (h) **Item 7—general information.** This section contains any information of a general nature relating to the flight, including numbers of passengers and/or accompanying personnel.

EXAMPLE STRATEGIC AEROMEDICAL EVACUATION REQUEST MESSAGE

132000Z JUL96
 FROM: JFHQ ALSP
 TO: HQAC AUST
 INFO: HQAST
 SIC KSV
 230/AECC
 SECURITY CLASSIFICATION
 PRECEDENCE
 TABULATE
 SUBJ: **STRATEGIC AME REQUEST**
 A. JFHQ ALSP SIC ABA/KSV 231/AECC OF 13 JUL96
 1. MEDICAL FACILITY:
 A. OMF—3 FWD GEN HOSP
 B. DEPARTURE/INTRANSIT/TERMINAL AIRFIELDS:
 (1) DAR AIRPORT (ALL PATIENTS).
 (2) AMSRIC/ADELAIDE AIRPORT.
 C. N/A.
 D. AME AIRCRAFT—C130.
 E. PROPOSED ARRIVAL TIME—151700Z JUL96.
 2. LOAD SUMMARY:
 A. TOTAL—8
 B. LITTER—1 (C2A—1).
 C. WALKING—7 (C1C—2, C3A—4, C3B—1).
 3. PERSONNEL SUMMARY:
 A. ARMY—4.
 B. NAVY—1.
 C. RAAF—2.
 D. CIVILIAN—1.
 4. CLINICAL DETAILS AND PROPOSED DMF FORWARDED AT REF A.
 5. AECO ACTION—VALIDATED BY SMO DAR.
 6. POINT OF CONTACT—SQNLDR PHILLIPS 323 CSS (08) 7472 9553.
 7. GENERAL INFORMATION—NIL.

Notes

- (a) **Message format.** The message instructions are to use the word 'TABULATE' and the message title is to include the words 'AME TASKING'. The message is to conform to the following sequence.
- (b) Item 1—**approval.** Approval/disapproval with reasons if disapproved and suggested alternatives.
- (c) Item 2—**tasking details.** Unit tasked with the AME mission, recommended team composition and responsibilities.
- (d) Item 3—**flight details.** Flight number, departure date, ETD and ETA and other relevant flight plan details as indicated.
- (e) Item 4—**originating medical facility (OMF).** Pick-up airfield(s) or OMF.
- (f) Item 5—**departure/in-transit/terminal airfields.** Details of route.
- (g) Item 6—**load summary.** Total number of patients, number of litter patients and number in each class, number of walking patients including 2C with the number in each class and the number of special patients (note any changes to REQUEST message).
- (h) Item 7—**personnel summary.** Numbers of patients by parent Service and number of civilian patients.
- (i) Item 8—**destination medical facility (DMF) summary.** List all DMF with total number of patients and totals in each class.
- (j) Item 9—**aeromedical evacuation coordinating officer (AECO) action.** Details of AECO validation.
- (k) Item 10—**point of contact.** Details of point of contact at OMF or airfield.
- (l) Item 11—**loading times.** Estimated time for loading at pick-up airfields.
- (m) Item 12—**special instructions.** Any other information including requirements for distinguishing aircraft in accordance with law of armed conflict.

EXAMPLE AEROMEDICAL EVACUATION TASKING MESSAGE

131730Z JUL96
 FROM: HQAC AUST Notes:
 TO: JFHQ ALSP To (1) Requesting HQ/Unit
 3HOSP (2) Unit being tasked
 HQALG with AME
 INFO: HQJFA (3) Aircraft supplier
 ADHQ
 COMAUSNAVSUP
 MHQAUST
 LHQAUST
 LOG COMD MELBOURNE
 SIC KSV
 544/SHO
 SECURITY CLASSIFICATION
 PRECEDENCE
 TABULATE
 SUBJ: **AME TASKING**
 A. JFHQ ALSP SIC KSV 230/AECC DATED 13 JUL97(NOTAL)
 B. JFHQ ALSP SIC ABA/KSV 231/AECC DATED 13 JUL 97 (NOTAL)
 1. REF A REQUEST APPROVED.
 2. TASKING DETAILS:
 A. CO 3HOSP IS TO PROVIDE AME TEAM, INCL SURG AND ANEAS, AND IS RESP FOR ALL
 ADMIN ASPECTS TO EXECUTE AME.
 3. FLIGHT DETAILS:
 A. C130 FLIGHT ATO 071 RIC-TDL-DAR-RIC-ADL A/PORT-RIC.
 ETA AMSDAR 151530Z JUL97.
 4. OMF: 321ABW
 5. DEPARTURE/INTRANSIT/TERMINAL AIRFIELDS/S—AMSRIC/ADELAIDE AIRPORT
 6. LOAD SUMMARY:
 A. TOTAL—8.
 B. LITTER—1 (C2A-1).
 C. WALK—7 (C1C-2, C3A-4, C3B-1).
 7. PERSONNEL SUMMARY:
 A. ARMY—4.
 B. NAVY—1.
 C. RAAF—2.
 D. CIVILIAN—1.
 8. DMF SUMMARY:
 A. ROYAL NORTH SHORE HOSP—1 (C3B-1).
 B. 1 FD HOSP (REAR)—2 (C3A-2).
 C. HMAS PENGUIN—1 (C3A-1).
 D. CONCORD HOSP—1 (C1C-1).
 E. 3HOSP—2 (C1C-1, C3A-2).

Notes

- (a) **Message format.** The AME REQUEST message format is similar to those used for TRANSREQ, TRANSAR and TRANSLAND messages. The message instructions are to include the word 'TABULATE' and the message is to be drafted using the following numeric sequence as shown in subsequent notes.
- (b) Item 1—**medical facility.**
- Originating medical facility (OMF); pick-up point grid reference, departure, in-transit, and/or terminal airfields (departure/in-transit/terminal airfields used in strategic AME request).
 - Delivery point grid reference or terminal airfield (if the destination medical facility (DMF) has been identified by the appropriate regulating headquarters).
 - AME aircraft options—specify potential for fixed-wing or rotary wing aircraft and/or aircraft type.
 - Proposed date time group (ZULU) of pick-up (tactical AME only) or proposed arrival time (strategic AME only).
 - Communication frequencies (tactical AME only).
 - Callsigns (tactical AME only).
- (c) Item 2—**load summary.** Total number of patients, number of litter patients and number of walking patients by class.
- (d) Item 3—**personnel summary.** Parent organisation of patients by parent Service.

- (e) **Item 4—details of individual patients.** When indicated, the following details are to be provided for special patients only on tactical AME request messages. These details are to be provided for all patients on strategic AME request messages.
- Personal details including age and sex when indicated, eg in the case of civilian patients;
 - Diagnosis, onset date and brief notes on present condition.
 - An outline of special management required during the flight, on arrival at the terminal airfield or at the DMF.
 - Movement precedence.
 - Subsequent personal details are to be recorded in prefix order.
- (f) **Item 5—aeromedical evacuation coordinating officer (AECO) action.** Indicate if the request has been validated by an AECO.
- (g) **Item 6—point of contact.** Indicate a point of contact within the OMF or joint force headquarters requesting the AME.
- (h) **Item 7—general information.** This section contains any information of a general nature relating to the flight, including numbers of passengers and/or accompanying personnel.

EXAMPLE AEROMEDICAL EVACUATION MOVE MESSAGE

140430Z JUL96
 FROM: 3HOSP(tasked unit)
 TO:321CSW
 1 FD HOSP (REAR)—all RAAF bases along flight route.
 HMAS PENGUIN
 4MC UNIT
 304CSW—DMF
 322CSW
 HQALG
 INFO:HQAST
 ADHQ
 JFHQ ALSP
 COMAUSNAVSUP
 MHQAUST
 LHQAUST
 HQAC AUST
 LOG COMD MELBOURNE
 SIC KSV
 SECURITY CLASSIFICATION
 PRECEDENCE
 TABULATE
 145/CO
 SUBJ: AME MOVE. MISSION NUMBER RIC 25/92
 A. JFHQ ALSP SIC ABA/KSV 236/AECC OF 14 JUL96
 1. FLIGHT DETAILS—FLIGHT ATO 071 DEPARTING AMSRIC 150900ZMAY92. ROUTE REMAINS
 RIC—TDL—DAR—RIC—ADL A/PORT—RIC.
 2. AME TEAM—1 SURG, 1 ANAES, 2 NURS, 1 MEDASST; OIC—SQNLDR DUFFY.
 3. LOAD SUMMARY:
 A. TOTAL—8.
 B. LITTER—1 (C2A-1).
 C. WALKING—7 (C1C-2, C3A-4, C3B-1).
 4. PERSONNEL SUMMARY:
 A. ARMY—4.
 B. NAVY—1.
 C. RAAF—2.
 D. CIVILIAN—1.
 5. DMF SUMMARY:
 A. ROYAL NORTH SHORE HOSP—1 (C3B-1).
 B. 1 FD HOSP (REAR)—2 (C3A-2).
 C. HMAS PENGUIN—1 (C3A-1).
 D. CONCORD HOSP—1 (C1C-1).
 E. 3HOSP—2 (C1C-1, C3A-2).
 F. ROYAL ADELAIDE HOSP—1 (C2A-1).
 6. CLINICAL DETAILS OF PATIENTS WILL BE FORWARDED SEPARATELY.

Notes

- (a) **Message format.** Message instructions are to include the word 'TABULATE' and the message title is to be the words 'AME MOVE' followed by the appropriate mission number. The message is to be set out in the following sequence.
- (b) Item 1—**flight details.** Flight number, departure date, ETD and ETA and other relevant flight plan details as indicated.
- (c) Item 2—**AME team.** Personnel details of the team or of recommended staffing levels and details of special team equipment carried or recommended.
- (d) Item 3—**load summary.** Total number of patients, number of litter patients and number in each class, number of walking patients to include class 2C with the number in each class and the number of special patients.
- (e) Item 4—**personnel summary.** Parent organisation—numbers of patients by parent Service, a breakdown by officers and other ranks and the numbers of civilian patients with an indication of their status, sex and age as relevant, and an identification of patients by cross reference to personnel messages.
- (f) Item 5—**destination medical facility (DMF) summary.** A list of all DMF showing total number of patients and total numbers in each class.

- (g) Item 6—**details of special patients.** When indicated, the following details are to be provided for each special patient:
- personal details including age and sex when indicated eg in the case of civilian patients;
 - class;
 - DMF;
 - diagnosis, onset date and brief notes on present condition;
 - reason for classification;
 - movement priority to DMF;
 - estimation of fitness for on move from terminal airfield to DMF;
 - an outline of any special management required on arrival at the terminal airfield or at the DMF if not already indicated; and
 - any request for a report on condition on arrival or after.
- (h) Item 7—**general information.** This section contains any information of a general nature relating to the flight including numbers of passengers and, if considered appropriate, personal details.

**EXAMPLE AEROMEDICAL EVACUATION REQUEST AND CLINICAL
DETAILS MESSAGE**

132005Z JUL97
FROM: JFHQ ALSP
TO: HQAC AUST
INFO: HQAST
SIC ABA/KSV
231/AECC
SECURITY CLASSIFICATION
PRECEDENCE
TABULATE
MEDICAL-IN-CONFIDENCE
SUBJ: **AME REQUEST AND CLINICAL DETAILS**
A. JFHQ ALSP 230/AECC OF 13 JUL97
1. FURTHER TO REF A, FOL CLINICAL DETAILS ARE PROV:
A. 245678 PTE O.W. HURTE 3 RAR. GSW ABDOMEN 12 JUL. PARAPLEGIC. HAD SPLENECTOMY,
NEPHRECTOMY, COLOSTOMY. L2-L3 LAMINECTOMY. ON POVEY FRAME. GENERAL
CONDITION STABLE. PROPOSED DMF: ROYAL ADELAIDE HOSP. CLASS-2A. ESTIMATE FIT
FOR IMMEDIATE ONMOVE FROM RIC.
B. A244222 SGT B. BLUNT 486SQN. DEPRESSION. DMF: 3HOSP. CLASS-1C.
C. 145678 MAJ I.M. GREEN 5/7RAR. MILD PSYCHOSIS. DMF: CONCORD. CLASS-1C.
D. MR U. WALLY. AGE: 36 YRS. DOD COMPUTER PROGRAMMER. INVERSION INJURY TO
RIGHT ANKLE FROM SPORTING INCIDENT. DMF: ROYAL NORTH SHORE HOSP. CLASS-3A.
E. 274589 CPL T. BONE 5/7RAR. LEFT KNEE INJURY. DMF: 1 FD HOSP (REAR). CLASS-3A.
F. 77989 CAPT Z. O'MALLEY 3RAR. TORN ANTERIOR CRUCIATE LIGAMENT. DMF: 1 FD HOSP
(REAR). CLASS-3A.
G. A7847902 AC B. HUMBLE 303 CABW. LACERATION TO RIGHT GREAT TOE. DMF: 3HOSP.
CLASS-3A.
H. R934986 AB R. WETT HMAS PENGUIN. HEAT RASH. DMF: HMAS PENGUIN. CLASS-3B.

EXAMPLE AEROMEDICAL EVACUATION DEPART MESSAGE

```
251830Z JUL96
FROM:321CSW (departing airfield)
TO:3HOSP
1 FD HOSP (REAR)—all RAAF Bases along flight route
HMAS PENGUIN
4 MC UNIT
304CSW—DMF
322CSW
HQALG
INFO:HQAST
ADHQ—all HQ
JFHQ ALSP
COMAUSNAVSUP
MHQAUST
LHQAUST
HQCAUST
LOG COMD MELBOURNE
SIC KSV
236/AECC
SECURITY CLASSIFICATION
PRECEDENCE
TABULATE
SUBJ: AME DEPART. MISSION NUMBER RIC 25/92
ATO 071.
151730Z JUL96
CHANGES.
C3A-1 CMM DMF 1 FD HOSP (REAR) OFFLOADED.
C3A-1 CMM DMF 3 RAAF HOSP ADDED.
```

Note

- (a) **Message format.** The message instructions are to include the word 'TABULATE' and the message title is to be the words 'AME' followed by the appropriate mission number. The message is to be set out in the following sequence.
- Item 1—the flight number of the aircraft.
 - Item 2—the actual time and date of departure (in ZULU).
 - Item 3—confirmation of information contained in AME MOVE message or details of any changes.

PRINCIPLES FOR SELECTION OF PATIENTS FOR TACTICAL AND STRATEGIC AEROMEDICAL EVACUATION

Introduction

1. This annex outlines broad principles to be applied in the selection of patients for tactical and strategic aeromedical evacuation (AME) and is published for general information only. The annex is not intended to provide a detailed guide to the selection and pre-flight preparation of patients for Royal Australian Air Force (RAAF) medical officers (MO) who are to refer to instructions and information issued separately by the Surgeon General Australian Defence Force.
2. There are no absolute contra-indications to the evacuation of patients by air provided that the factors outlined in [paragraphs 3. to 5.](#) are assessed in relation to each patient. Each case is to be judged on its merits by a RAAF MO trained and experienced in AME, in the light of the advantage to the patient of transfer and the possible harmful effects of the flight. In emergencies it may be necessary to take a reasoned risk.

General physiopathological stresses

3. The principal environmental changes in-flight which require consideration, regarding their effect on patients, result from changes in barometric pressure with changes of altitude and comprise:
 - a. changes in the volume of the air or gas in any body cavity,
 - b. the decrease of the partial pressure of oxygen, and
 - c. changes in the density of the air.
4. Other environmental factors of flight which are to be considered include:
 - a. accelerative forces, including turbulence;
 - b. changes in temperature and humidity; and
 - c. noise and vibration.

Factors other than general physiopathological stresses

5. Factors additional to those outlined in [paragraphs 3. and 4.](#) which require consideration include:
 - a. the availability of a trained AME team to provide in-flight care, and the necessary equipment;
 - b. aspects relating to facilities in the aircraft such as control of cabin environment (especially temperature and humidity), general facilities for AME such as loading and unloading, litter fixation and toilet and feeding facilities; and
 - c. aspects relating to the proposed flight such as expected weather conditions, total duration, the duration of each stage and the medical and general facilities available at departure, enroute and terminal airfields and destination medical facilities.

Patients not normally to be airlifted

6. Notwithstanding the general guidance outlined in [paragraph 2.](#), the types of patients to be transferred by aircraft only if there is no possible alternative are:
 - a. patients in the infectious stage of a serious communicable disease;
 - b. patients whose general condition is so poor that they are unlikely to survive the flight;
 - c. pregnant persons whose pregnancy has extended beyond the 34th week; and
 - d. patients involved in diving operations in the last 48 hours, or patients suffering from decompression sickness, unless sea level pressurisation is available.

Selection of patients suffering from communicable diseases

7. When the airlift of patients suffering from a communicable disease is essential, Aeromedical Evacuation Coordinating Officers (AECOs) are to take such steps as are necessary to ensure that there is no risk to the health of other personnel aboard the aircraft.

Patients requiring special consideration

8. Types of patients requiring special consideration in selection and pre-flight/in-flight medical management are:

- a. neuropsychiatric patients classified class 1A,
- b. patients suffering from certain cardiovascular diseases,
- c. patients suffering from severe anaemia,
- d. patients suffering from certain respiratory diseases,
- e. patients suffering from certain gastrointestinal diseases,
- f. patients with conditions in which quantities of gas are confined in body cavities such as pneumothorax and ileus,
- g. patients with severe ocular and cranial injuries,
- h. patients who have recently undergone abdominal or thoracic surgery, and
- i. patients with fractures of the maxilla and/or mandible with fixed dental splints.

CLASSIFICATION OF PATIENTS FOR TACTICAL AND STRATEGIC AEROMEDICAL EVACUATION

1. Patients selected for tactical and strategic aeromedical evacuation are to be classified into classes 1–4 as follows:
 - a. **Class 1**—neuropsychiatric patients. These include:
 - (1) **Class 1A.** Neuropsychiatric patients who are frankly disturbed and inaccessible and require the use of restraint equipment, sedation and close supervision are to be classified class 1A. These patients are to be treated as litter patients.
 - (2) **Class 1B.** Neuropsychiatric patients who do not usually require the use of restraint equipment and are not at the moment mentally disturbed but may react badly to air travel or commit acts likely to endanger themselves or the safety of the aircraft and its occupants are to be classified class 1B.
 - (3) **Class 1C.** Neuropsychiatric patients who are cooperative and have proved reliable under specialist observation are to be classified class 1C. These patients are normally to be considered as walking patients.
 - b. **Class 2**—litter (stretcher) patients other than neuropsychiatric. These include:
 - (1) **Class 2A.** Patients who are unable to move about of their own volition in any circumstances are to be classified class 2A.
 - (2) **Class 2B.** Patients who in an emergency will be able to move themselves are to be classified class 2B.
 - (3) **Class 2C.** Patients whose medical condition would benefit from carriage on a litter during flight but who may be handled as walking patients during loading and unloading procedures, during transport between terminal and destination medical facilities and during their stay in staging facilities, are to be classified class 2C. Use of class 2C is particularly applicable to long-range flights. However, the classification is to be based on the condition of individual patients and is not to be used to ensure carriage on litters when this is merely a matter of general comfort in aircraft where seating is considered inadequate. In this circumstance the provision of litters for use throughout the flight or on a rotational basis is a matter for arrangement by, and at the discretion of, the aeromedical evacuation coordinating officer, or in accordance with specific directives.
 - c. **Class 3**—sitting patients other than neuropsychiatric. These include:
 - (1) **Class 3A.** Sitting patients, including handicapped persons, who may need medical or nursing attention enroute and who, in an emergency, would require assistance to escape.
 - (2) **Class 3B.** Sitting patients who may need medical or nursing attention enroute and who would be able to escape unassisted in an emergency.
 - d. **Class 4**—passenger class. Patients who need no medical treatment enroute and are physically able to travel unattended are to be classified class 4.

RESPONSIBILITIES OF MEDICAL FACILITIES INVOLVED IN TACTICAL AND STRATEGIC AEROMEDICAL EVACUATION

Responsibilities—originating medical facility

1. **Notification of patients.** For each patient awaiting aeromedical evacuation (AME), medical authorities of the originating medical facility (OMF) are to notify the appropriate Royal Australian Air Force aeromedical evacuation coordinating officer (AECO) of:
 - a. personal details;
 - b. diagnosis;
 - c. date airlift is required or date on which patients are expected to be fit for AME;
 - d. clinical details; and
 - e. Destination medical facility (DMF) (if known).
2. **Documentation.** OMF are responsible for the preparation of patients' personal medical records.
3. **Special medical supplies.** When necessary, OMF are to provide any special medical supplies required for treatment during the flight.
4. **Transportation and loading.** OMF are responsible for delivery of the patients to the intransit medical facility at the departure airfield. In some circumstances they may also be required to assist with the loading of aircraft under the direction of the AECO.
5. **Provision of guards.** OMF are responsible for arranging the provision of guards to accompany any prisoner patients, if necessary.

Responsibilities—departure aeromedical evacuation facilities

6. AECO at departure AME facilities are to:
 - a. advise OMF of procedures regarding the selection, classification and movement priority of patients and of other relevant general arrangements, and maintain close liaison with the appropriate authorities at such facilities;
 - b. undertake required pre-flight procedures;
 - c. ensure AME teams are staffed in accordance with the principles described in [chapter 5—'Triage, evacuation and regulation'](#);
 - d. inform all authorities involved in each mission; and
 - e. ensure the personal medical records of patients and patient evacuation tags are properly prepared.

Responsibilities—aeromedical evacuation staging facilities and terminal aeromedical evacuation facilities

7. AECO at aeromedical evacuation staging facilities (ASF) are to:
 - a. supervise loading, unloading and transportation of patients;
 - b. provide medical care to patients;
 - c. maintain personal records;
 - d. make the necessary arrangements regarding the next leg of the AME flights;
 - e. replenish medical supplies required by the AME team;

- f. evaluate the patients' fitness for the next leg of the AME flight and arrange the treatment or disposal of those off-loaded on medical grounds and the notification of appropriate authorities;
- g. be responsible for the care of patients' personal belongings and any personal items of value;
- h. arrange accommodation for the AME team;
- i. arrange the provision of supplies for in-flight feeding; and
- j. liaise with the authorities at the DMF, when located at a terminal airfield or whenever necessary.

Responsibilities—destination medical facility

8. Medical authorities of DMF are to:

- a. provide assistance, when required, with the unloading of patients under the direction of the AECO;
- b. provide a representative to accept patients, their baggage and personal medical records;
- c. transport patients to the destination medical facility, when required; and
- d. provide reports, when requested, on the condition and management of special patients after admission.

ORGANISATION AND CAPABILITIES OF AN AUSTRALIAN DEFENCE FORCE MEDICAL REGULATING OFFICE

Manning of an Australian Defence Force medical regulating office

1. The officer-in-charge of the Australian Defence Force medical regulating office (ADFMRO) is to be of MAJ(E) rank, preferably a medical officer (MO). If this appointment is not filled by a MO, or a MO is not on the staff of the medical regulating office, an Australian Defence Force (ADF) MO is to be appointed and promulgated as 'medical officer adviser' to the ADFMRO.
2. Other staff of the ADFMRO are to comprise representatives with maritime, land and air experience, preferably of CAPT(E) rank. These officers should have the following prerequisite experience:
 - a. health services (sea, field or air deployment) experience;
 - b. staff officer experience;
 - c. spreadsheet analysis experience; and
 - d. attended a Joint Health Planning Course.
3. Noncommissioned officer (NCO) clerical support of three personnel is required to enable, as a minimum, two staff per watch during 24-hour operation of the ADFMRO. The staffing of the ADFMRO will be operation dependent and can be adjusted as required in each circumstance. Service specific NCO staff are not required, although a spread of environmental expertise is desirable.

Roles and responsibility of an Australian Defence Force medical regulating office

4. The role of the ADFMRO is to:
 - a. identify and arrange destination medical facility (DMF) within the Australian support area (ASA) for all casualty evacuation from the joint force area of operations (JFAO);
 - b. liaise with Headquarters Air Command for the provision of strategic aeromedical evacuation (AME);
 - c. arrange and coordinate patient movement along the air, sea and land lines of communication within the ASA;
 - d. arrange and coordinate reception for surface, sea and air transport of patients to a DMF on exit from the AME system;
 - e. coordinate the ongoing administrative support within the ASA single Service support commands and personnel support organisations;
 - f. track all casualty/patient movement within the ASA until return to unit status is achieved;
 - g. maintain a patient tracking database;
 - h. monitor the available ADF and civilian bed status;
 - i. report daily statistics of admissions, discharges and transfers to the Surgeon General Australian Defence Force office; and
 - j. act as point of contact for all inquiries from next of kin regarding patients.

Medical regulating process

5. The medical regulating process is flow charted in [appendix 1](#).

Medical regulating status reports

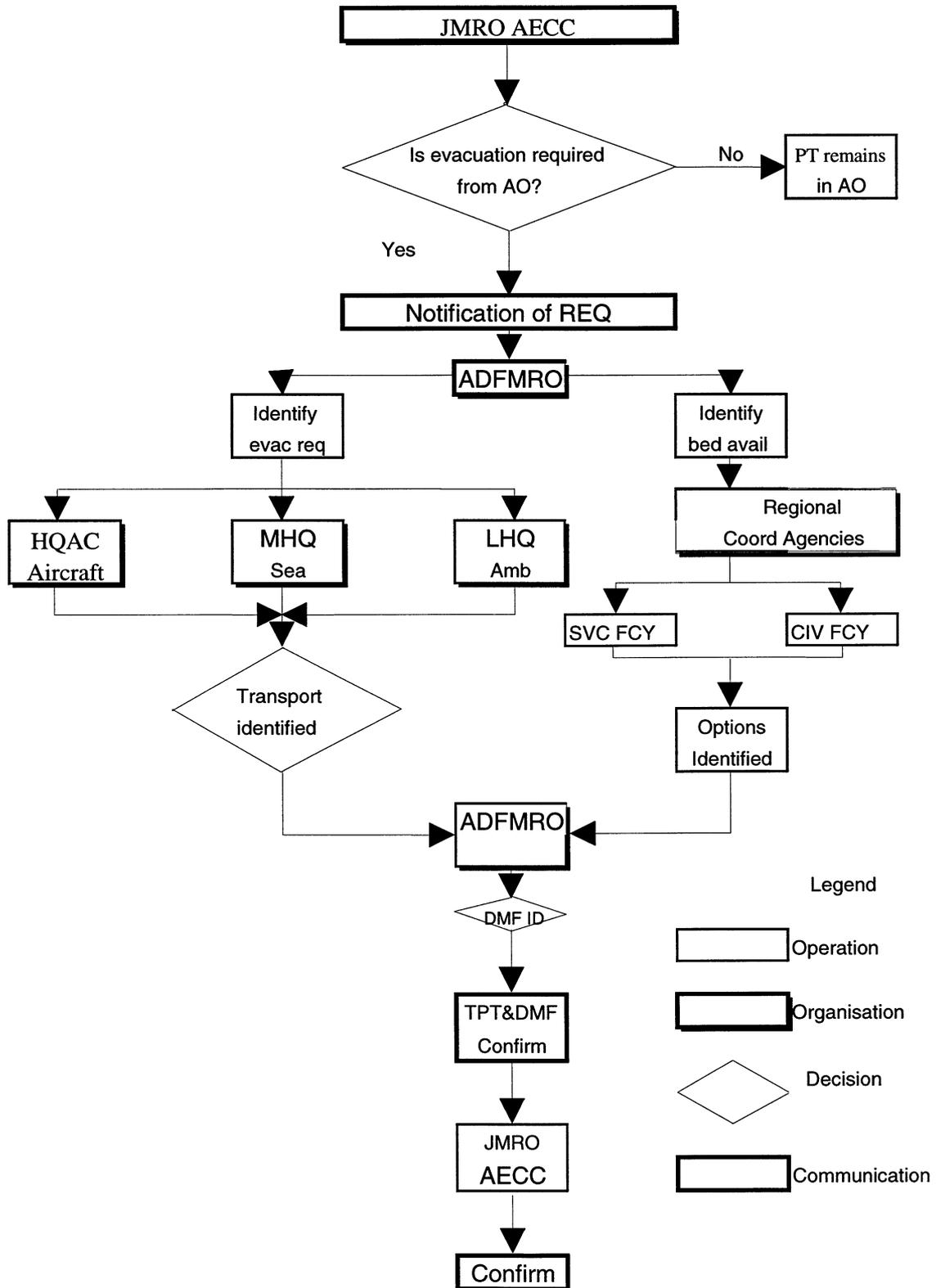
6. The ADFMRO should be prepared to provide individual and collective medical regulating/patient status reports as required. The frequency of the reports will be dependent upon the operation and will be advised in the health support planning process. The reports will indicatively contain as a minimum:

- a. the total number of casualty evacuations from the JFAO,
- b. the total number of casualties currently in Service and civilian hospitals/facilities,
- c. the total number of casualty evacuations sent on convalescence/sick leave, and
- d. the total number of casualties returned to active duty.

Appendix:

1. [Medical regulating process](#)

MEDICAL REGULATING PROCESS



CHAPTER 6

COMMAND, CONTROL AND COMMUNICATIONS

General

6.1 Australian Defence Force Publication (ADFP) 1—*Doctrine* describes the doctrine and philosophy of command and control of Australian Defence Force (ADF) operations. Details of the command and control organisation of the joint and joint force headquarters (JFHQ) are also included.

6.2 The joint health planning process is described in [chapter 3—‘Australian Defence Force health planning’](#).

Command and control methods

6.3 The direct and component methods of command are described in ADFP 1.

6.4 Health services representation in joint and JFHQ is described in [chapter 2—‘Health support capabilities’](#). In a deployed joint task force headquarters (JTFHQ), there will be a joint health staff irrespective of the method of command and control. The size of the joint health staff will vary with the size and function of the JTFHQ. It will work closely with the J1 and J4 staff. The Joint Force Commander (JFC) will appoint an appropriate officer from the joint health staff as the joint force health adviser (JFHA). In certain circumstances, a commander joint task force health services (CJTfHS) may be appointed. The JFHA or CJTfHS will have primary responsibility to the senior joint administrative officer, but will retain the right of direct access to the JFC. Where the component method of command and control is employed, health service advisers and staff are also to be included on component headquarters (HQ). The roles of the joint health staff are to:

- a. provide advice to the JFC and other joint staffs on the provision of health support;
- b. prepare health support plans;
- c. exercise technical control over the provision of health support in the joint task force area of operations (JTFAO);
- d. provide casualty regulation within the JTFAO; and
- e. liaise with appropriate authorities regarding casualty evacuation from the JTFAO to the support area.

Command and control terminology

6.5 Command and control terms used in ADF operations are defined in ADFP 1 and in the glossary of this ADFP.

Status of command and control of health service units

6.6 Command of single Service health support units, elements or agencies within a JTFAO will normally be exercised by a single Service commander, who may also be responsible for providing support to other Services.

6.7 Single Service health service units or HQ assigned to a joint force will be assigned under a degree of operational authority or a support measure. In certain circumstances, a JFC may appoint a CJTfHS as a subordinate commander to exercise the appropriate degree of operational authority over health service assets assigned to the joint task force (JTF).

6.8 Where appropriate, a JFC or CJTfHS may assign a health service sub-unit or unit of one Service under a degree of operational authority of a health service unit of another Service. For example, Air Commander Australia may assign an aeromedical evacuation staging facility under operational control or tactical control of a field hospital for which it is performing the aeromedical staging function. Similarly, an element of a preventive medicine company could be placed in direct support of an air transportable hospital for a specific vector control task.

6.9 The command and control arrangements applying to health service units and agencies in a JTF must be those that facilitate the primary role of providing effective and efficient health support to the operation. Because of the interdependent nature of the treatment and evacuation processes, close liaison will be necessary between health service commanders, single Service components and their staffs.

6.10 Technical control of health support activities in a JTFAO will normally follow the command levels and be exercised through health service advisers and staff at each level.

Medical liaison

6.11 Close liaison up and down lines of technical control, and between health service units, will be necessary to ensure the effectiveness and continuity of treatment and evacuation. In many circumstances, liaison will be informal.

6.12 In certain circumstances, it may be appropriate to formally appoint medical liaison officers to provide specialist advice and coordination assistance to a commander. Principles for the employment and duties of liaison officers are detailed in ADFP 1. In combined operations, medical liaison officers could be used to facilitate interoperability in the provision of health support.

Medical communications

6.13 In most circumstances, requirements for medical communications will be met through access to operational and administrative links in strategic, operational and tactical level communications networks. However, in other circumstances, particularly at the tactical level, dedicated medical communications may be necessary to facilitate casualty evacuation and casualty regulation.

6.14 The use of secure communications by medical facilities or evacuation transport may be limited by the application of international humanitarian law, [chapter 10—‘Medical aspects of the law of armed conflict’](#) provides further details.

Medical reports and returns

6.15 Medical reports and returns to be used in joint operations are detailed in [annexes A to D](#). They are:

- a. casualty situation report—CASSITREP;
- b. medical situation report—MEDSITREP;
- c. medical spot report—MEDSPOTREP; and
- d. health intelligence report—HEALTHINTREP.

6.16 The requirement for medical reports and returns will be included in standing operating procedures (SOP). Requirements for specific operations as well as timings for submission are to be detailed in the health support plan for the operation.

6.17 The security classifications to be used in medical reports and returns are to be determined through consultation with the operations/intelligence staff and the policy is to be detailed in SOP, the health support plan for the operation and appropriate administrative instructions.

Annexes:

- A. [Casualty situation report](#)
- B. [Medical situation report](#)
- C. [Medical spot report](#)
- D. [Health intelligence report](#)

CASUALTY SITUATION REPORT

1. Purpose of casualty situation report (CASSITREP): To inform medical staff at tactical and operational level headquarters of the casualty situation within a health service unit.
2. Security Classification:
3. SIC: PPJ
 - a. DTG of release.
 - b. Report as at (DTG).
 - c. Health service facility.
 - d. Patients remaining from previous reporting period.
 - e. Battle casualties admitted (total).
 - (1) Priority one.
 - (2) Priority two.
 - (3) Priority three.
 - f. Non-battle casualties admitted (total).
 - (1) Priority one.
 - (2) Priority two.
 - (3) Priority three.
 - g. Discharged (total).
 - (1) Returned to unit.
 - (2) Transferred to military facilities.
 - (3) Transferred to civilian facilities.
 - (4) Deceased.
 - h. Patients held at time of report ($D + E + F - G$).
 - i. Patients awaiting evacuation (total).
 - (1) Litter.
 - (2) Walking.
 - j. Outpatients treated but not admitted.
 - k. Waiting time for initial wound surgery.
 - l. For units with aeromedical evacuation (AME) teams:
 - (1) Number of AME missions during reporting period.
 - (2) Number of AME missions planned for next reporting period.
 - (3) Number of AME teams out of area and expected return dates.

MEDICAL SITUATION REPORT

1. Purpose of medical situation report (MEDSITREP): To inform medical staff at operational and strategic level headquarters of the health service situation in an area of operations or support area.
2. Security classification:
3. SIC: PPJ
 - a. DTG of release.
 - b. Report as at (DTG).
 - c. Medical evacuation status:
 - (1) Name of unit/org¹.
 - (2) Number of patients treated since last report.
 - (3) Number of patients admitted since last report.
 - (4) Number of patients evacuated since last report.
 - (5) Number of patients returned to duty since last report.
 - (6) Number of patients died since last report.
 - (7) Number of patients presently held.
 - (8) Number of patients awaiting evacuation.
 - d. Hospital status:
 - (1) Name of unit/org¹.
 - (2) Number of operational beds².
 - (3) Number of available beds³.
 - (4) Significant personnel shortages.
 - (5) Significant major equipment deficiencies.
 - e. Medical logistic situation:
 - (1) Significant shortages of medical and dental (class 8) supply items.
 - f. Mass casualty situation:
 - (1) Cause.
 - (2) Location (name/grid reference).
 - (3) Number of casualties.
 - (4) Unit(s) affected.

1 Identity of reporting unit.

2 Beds supported by personnel and equipment to provide treatment appropriate to unit role.

3 Beds that are operational and NOT occupied by patients.

- g. Epidemic situation:
- (1) Disease.
 - (2) Location (name/grid reference).
 - (3) Number of patients.
 - (4) Unit(s) affected.
- h. Remarks.

MEDICAL SPOT REPORT

1. **Purpose:** To inform health staff of specific incidents that have resulted in or are likely to result in significant casualties, or other incidents of a health nature which are likely to attract higher staff, public, political or media attention. MEDSPOTREP do not replace NOTICAS or other incident reports. MEDSPOTREP should be sent by IMMEDIATE message with privacy markings of STAFF-IN-CONFIDENCE or MEDICAL-IN-CONFIDENCE as appropriate. The dispatch of the message should not be delayed while full details are collected. Additional detail should be sent when available.

Format:

SIC: PPJ

FROM:

TO:

INFO:

SECURITY CLASSIFICATION

IMMEDIATE

SUBJ: MEDSPOTREP

- A. Map reference (if appropriate).
 - 1. MEDSPOTREP Number.
 - 2. DTG of incident.
 - 3. Location of incident:
 - A. Place.
 - B. Geographic name.
 - C. Lat/long or grid ref as appropriate.
 - 4. Incident details:
 - A. Type of incident.
 - B. Diagnosis.
 - C. Numbers affected.
 - 5. Remarks.

HEALTH INTELLIGENCE REPORT

1. Purpose of health intelligence report (HEALTHINTREP): To inform medical staff at tactical, operational and strategic headquarters of the health and environmental situation in the area of interest.
2. Security classification (with caveats as required).
3. Precedence.
4. SIC: P3A
 - a. DTG of release.
 - b. Report as at (DTG).
 - c. Source of information.
 - d. General information (detail on topography, climate, water sources, coordinates, etc).
 - e. Socio-economic information (demographic factors, social factors, political factors, economic factors).
 - f. Public health information (water supply and potability, sanitation, pollution, vector control, food handling, electricity, etc).
 - g. Insect, plant and animal hazards.
 - h. Military trauma hazards (unconventional weapons systems).
 - i. Diseases of military importance (endemic diseases, attack, case fatality rates and general importance).
 - j. Civilian health services (organisation and administration, civil defence/disaster relief, quality of civil health care).
 - k. Military health services (ORBAT, medical logistics, quality of health care).
 - l. Civilian and military health facilities (capacity, availability, access, facilities, services, etc).
 - m. Medical materiel (production capabilities, stockpiles, etc).
 - n. Medical training, research and development.
 - o. Health aspects of port calls (medical entry requirements, screening, quarantine, water supplies garbage and sewerage arrangements, health and sanitation of port, diseases, and medical facility arrangements).

CHAPTER 7

HEALTH SUPPORT IN THE SUPPORT AREA

General

7.1 Support areas are those areas which contain concentrations of human resources, industrial potential and sources of food and raw materials. For operations in the Australian theatre, the Australian support area (ASA) will normally include that portion of the Australian continent which is outside the joint task force area of operations (JTFAO) and, in certain circumstances, may be within another area of operations.

7.2 During operations, single Services will continue to provide the range of health support they provide in non-operational circumstances. However, because of the demands on treatment and evacuation services in the support area made by casualties evacuated from the JTFAO, and the need to avoid duplication of services, planning and execution of health support in the support area will normally be conducted on a joint basis.

Support area capabilities

7.3 Single Services will continue to provide level one, two, three, and in certain circumstances, level four medical support to Australian Defence Force (ADF) elements remaining in the support area. In certain cases, there will be a need to expand health support capabilities as additional forces are raised, trained and equipped. There will also be a requirement to provide alternative health support for those forces remaining in the support area whose normal complement of health support has been deployed in an operational role to the joint force area of operations (JFAO). Where operations are mounted direct from the support area, for example strategic air strike operations, functions performed by health support elements will be similar to those performed in the JFAO.

7.4 Comprehensive level five support will be provided in the support area. This includes a full range of highly specialised medical and surgical facilities in major civilian hospitals. The capabilities of such facilities to accept casualties returning from the JFAO will need to be established in advance, and access to them regulated. Such access will be coordinated with State, Territory and Commonwealth health authorities. It will be normal to identify more than one level five facility capable of dealing with each of the major specialties, eg burns, neurosurgery, facio-maxillary, microsurgery, plastic surgery, etc. Level five support will include research assistance provided by ADF facilities such as the Royal Australian Navy School of Underwater Medicine, the Army Malaria Research Unit and the Royal Australian Air Force Institute of Aviation Medicine. High level advice and research assistance may also be available from civilian research institutions.

7.5 Surface evacuation and aeromedical evacuation (AME) within the support area will be provided by both civilian and military transport.

Support area health planning

7.6 An appropriate authority will normally be appointed to prepare and execute a joint health support plan for the support area. This could be Commander Australian Theatre, one of the Service chiefs, the Surgeon General Australian Defence Force (SGADF) or other appropriate commanders. That authority will appoint a senior medical officer (SMO) for the support area. A joint planning group will be convened as required by the SMO to prepare the support area plan. The Theatre Health Planning Group (THPG) is chaired by the senior Headquarters Australian Theatre health representative (J07) and includes health service representatives from the three environmental command headquarters, SMOs from northern command and deployed joint force headquarters and the Head of the Joint Health Support Agency. Other representatives will participate as required. Joint health planning procedures in the ASA are comprehensively detailed in Health Policy Directive 818—*Joint Health Planning Procedures in the Australian Support Area* issued by the SGADF.

7.7 The support area health plan will identify arrangements for treatment, hospitalisation, patient tracking, research, convalescence and rehabilitation, and for AME, surface evacuation and casualty regulation to, and within the support area. It will include arrangements for support along the lines of communication and identify financial planning and funding aspects.

7.8 An example of a medical operational order which details a support area medical plan is at [annex A](#).

Execution of support area health plan

7.9 The authority appointed to prepare and execute the support area health plan will include a joint health staff who will coordinate the execution of the plan with appropriate single Service and civilian agencies.

7.10 Casualty regulation to and within the support area is a major function of the joint health staff. Where appropriate, the casualty regulating function could be delegated to another appropriate authority, eg Headquarters Air Command.

Annex:

A. [Medical operation order—support area medical plan](#)

MEDICAL OPERATION ORDER—SUPPORT AREA MEDICAL PLAN

RESERVED

CHAPTER 8

HEALTH SUPPORT TO OPERATIONS IN NORTHERN AUSTRALIA

General

8.1 This chapter identifies considerations in planning for and provision of, health support during low-level conflict in northern Australia.

8.2 Within the land area of operations (AO) the focus is likely to be on independent brigade operations with each having a comparatively large tactical area of responsibility. During low-level operations, much of the civilian population and civil infrastructure is likely to remain in the joint task force area of operations (JTFAO). Within the maritime AO, surface combatants and other vessels are likely to be deployed in small groups with the focus on coastal defence, protection of shipping, mine countermeasures and patrolling. Air activity will be focused towards surveillance and enforcement of an air defence identification zone (ADIZ) where established.

Casualties

8.3 Battle casualties (BCas) should be low and sporadic but could occur with little or no warning across a wide expanse of a JTFAO, including the maritime AO. Specific incidents may produce BCas surges. Non-battle casualties (NBCas) will exceed BCas in most circumstances, and the climatic extremes of the north will exacerbate this situation. Minor injuries and illnesses, if untreated, can rapidly develop into more serious medical problems.

Treatment capabilities

8.4 All combat and combat support units in a JTFAO require organic level one medical support. In certain situations, level one support may be enhanced to provide a capability to provide stabilising care and hold small numbers of casualties pending evacuation to level two or level three facilities. Advance trauma life-support skills will be appropriate in such circumstances.

8.5 Levels two and three facilities will be deployed to provide optimum health care and should reflect the casualty estimate. The dispersed nature of operations and the probable lack of level three treatment capability will complicate the provision of initial wound surgery within acceptable time frames. The capability to provide initial wound surgery or surgical resuscitation to combat forces operating remote from major troop concentrations must exist. Within the land AO, this may require the attachment of forward surgical teams to brigade administrative support battalion medical companies or field ambulances, or in certain circumstances, deployment of fly away surgical teams to level one facilities. The parachute surgical team is likely to be used to provide a level three support to airborne operations. An afloat medical facility providing level three care will normally be deployed in the maritime AO to support offshore operations. Level three facilities should also include an increased medical (as distinct from surgical) capability. Royal Australian Air Force (RAAF) medical facilities located at RAAF airfields for which Army elements are providing vital asset protection would normally provide levels two and three support to those Army forces.

8.6 Australian Defence Force (ADF) level four facilities will not normally be deployed to a JTFAO. Where level four care is required within the JTFAO, it will normally be provided by utilising existing civilian facilities. Casualties requiring level four and level five care will usually be evacuated to the support area.

8.7 Holding policies for the JTFAO in low-level conflict are likely to be greater than for other operations.

Casualty evacuation

8.8 Aeromedical evacuation (AME) will be the preferred means of evacuation for BCas and NBCas of all priorities. The phases of the AME chain will be less distinct than in other operations. While Army will provide forward AME to combat forces in the land AO using primarily rotary wing, the dispersion of forces and the availability of airstrips and landing grounds in the north, which are capable of taking fixed-wing aircraft, may enable use of RAAF aircraft (staffed with RAAF AME teams) with greater range and airspeed operating in the forward AME role. The Royal Australian Navy will have primary responsibility for forward AME in maritime operations.

Civil health infrastructure

8.9 Civil health infrastructure should be used whenever possible to complement ADF health support. However, the widespread distribution and variable nature of civilian health care facilities may limit their utility and they are unlikely to be able to expand their services to meet the needs of the ADF. However, they should be considered during the health planning process and utilised where practical. Such utilisation could range from access to a single specific service, collocation and sharing of major resources to total ongoing reliance on a civilian facility or service.

CHAPTER 9

HEALTH SUPPORT IN A NUCLEAR, BIOLOGICAL AND CHEMICAL ENVIRONMENT

Introduction

9.1 Scope. Nuclear, biological and chemical (NBC) defence includes the plans, methods, procedures, facilities, materiel and training required to establish the measures necessary to mitigate the effect and facilitate operational recovery from the effects of hostile attacks involving nuclear weapons, and chemical and biological agents. Joint doctrine on NBC operations is provided in Australian Defence Force Publication (ADFP) 15—*Operations in a Nuclear, Biological and Chemical Environment*. Joint health doctrine on NBC operations is provided in ADFP 713—*Health Aspects of Nuclear, Biological and Chemical Defence*. The scope of medical support in NBC operations will include:

- a. provision of advice on prophylactic measures and the impact of NBC operations on the individual,
- b. administration of certain prophylactic measures,
- c. development of regimes for immediate treatment of NBC casualties, and
- d. provision of subsequent treatment and evacuation services.

9.2 Problems. NBC operations pose particular problems that will impact differently on health support from conventional operations. During NBC operations:

- a. casualty rates are likely to be much higher than from conventional operations, particularly where personnel are unprotected or drills are not efficiently performed;
- b. injury patterns will be different—for example:
 - (1) chemical weapons will produce a range of signs and symptoms not previously seen;
 - (2) nuclear explosions will produce a high proportion of casualties with burns;
 - (3) radiation sickness will be seen for the first time;
 - (4) biological weapons may produce infectious disease epidemics not normally encountered in a military setting, as well as disease patterns unusual in civilian medical practice;
 - (5) certain biological agents may produce new diseases; and
 - (6) the combination of NBC and conventional injury will produce casualty types not previously seen, and which will often produce complex, specific handling and management problems;
- c. indirect casualties will occur—for example:
 - (1) equipment and weapon handling accidents from fatigue and performance degradation;
 - (2) pharmacological incapacitation from inappropriate use of antidotes, heat illness resulting from wearing of individual protective equipment (IPE); and
 - (3) psychiatric illness resulting from the sense of isolation experienced when wearing IPE;

- d. treatment and evacuation tasks will need to be capable of themselves continuing to function in a threat environment requiring:
 - (1) wearing of IPE with its limitations on examination and treatments;
 - (2) radiation protection by deployment within structures providing appropriate protection;
 - (3) the decontamination of casualties; and
 - (4) the provision of areas of collective protection with treatment facilities; and
- e. problems will apply when the use of NBC weapons is threatened, and not just after actual use.

Training

9.3 Army is responsible for training health services personnel in medical aspects of NBC defence in consultation with Royal Australian Navy, Royal Australian Air Force and Emergency Management Australia. Training will be both individual and collective. The latter is to include casualty management procedures, use of collective protection and contamination control (including casualty decontamination). Individual training for health services personnel is to include training of:

- a. medical officers and nursing officers in the clinical management of NBC casualties,
- b. health service officers in the provision of medical support in NBC operations, and
- c. other ranks in appropriate health aspects of NBC operations.

Health support considerations

9.4 Health support to a deployed force in a NBC environment will be essentially the same as for conventional operations, details for which are given in [chapter 4—'Health support to a deployed force'](#). Planning of health support for NBC operations will be carried out in accordance with [chapter 3—'Australian Defence Force health planning'](#). However, the following specific considerations will apply to the planning for and provision of health support in an NBC environment:

- a. The operating procedures at each level of care will need to be modified to take into account problems outlined in [paragraph 9.2](#) above.
- b. Increased casualty rates may require assignment of additional health support units to a joint force area of operations and augmentation of the staff of existing units at each level of care.
- c. If the conventional triage system becomes unworkable, the priorities for treatment and evacuation detailed in chapter 5, [paragraph 5.4](#) may need to be modified. A mass casualty system may need to be implemented.
- d. The numbers of casualties and the requirement for decontamination may mean that initial wound surgery is not always possible within the time frames detailed in chapter 5, [paragraph 5.6](#).
- e. Contamination will affect evacuation routes and interfere with the operation of evacuation vehicles and aircraft.
- f. There will be a requirement for greater quantities of and different types of medical stores.
- g. While casualty decontamination will occur as far forward as possible, all level two and level three facilities are to be capable of establishing and operating a casualty decontamination centre.
- h. Level two and three medical facilities should be capable of continuing to function when themselves threatened or directly affected by NBC operations. They will therefore require a collective protection capability.

- i. Advice to commanders on the physiological implications of operating in IPE will be an important function for medical officers.
- j. Health services officers will need to be aware of ongoing developments and research in NBC operations to ensure that appropriate adjustments can be made to prophylactic measures, treatment techniques and procedures.

CHAPTER 10

MEDICAL ASPECTS OF THE LAW OF ARMED CONFLICT

INTRODUCTION

General

10.1 The law of armed conflict (LOAC) has an immediate and practical relevance to the provision of health support in operations. The Australian Defence Force (ADF) is required to adhere to international conventions which have been ratified by the Australian Government. Many LOAC provisions will have a direct impact on ADF health services.

10.2 At all levels of command, there is a statutory duty to ensure that the provisions of LOAC are observed. Commanders are to draw on their legal advisers for advice on the impact of LOAC on the provision of health support.

10.3 Noncombatants. Along with chaplains, health staff are designated as 'noncombatants' and any use of weapons by these personnel, except in self-defence or to protect patients in their care, contravenes the LOAC. Restrictions applying to hospital ships are mentioned in chapter 2, [paragraph 2.16b](#). In the field, health support units are **not** to be placed on the defensive perimeter but rather totally within or totally outside any position. Health units located within the area of operations but outside a defended position should be declared and marked in accordance with the Geneva Conventions and Protocols.

10.4 At the strategic level, the application of certain aspects of LOAC will almost certainly be subject to political direction which will be detailed in operational instructions or orders issued by Australian Defence Headquarters. Depending on the nature of political direction, commanders may have some latitude in the application of LOAC in specific operations. This will most often involve decisions as to whether or not certain treatment facilities or evacuation transport, particularly in forward areas, are to be declared and marked, and so seek protection from enemy attack. Such declaration in certain circumstances may be impractical, prejudice operational success or increase the prospect of further casualties. Commanders may therefore be required to balance these considerations against the benefits that declaration and protection may provide in terms of unimpeded evacuation and treatment of casualties.

Geneva Conventions and Protocols

10.5 In the treatment of enemy prisoners of war (EPW), protection of medical and auxiliary personnel, and the marking and protection of medical units and transport, the ADF is governed by the provisions of the Geneva Conventions of 1949, and its two additional protocols. One of the principal aims of the conventions and the protocols is to establish a humane regime for the treatment of civilians, the sick, wounded, shipwrecked and EPW.

10.6 Geneva Conventions. The four Geneva Conventions of 12 August 1949 are:

- a. Geneva Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of the Armed Forces in the Field;
- b. Geneva Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of the Armed Forces at Sea;
- c. Geneva Convention Relative to the Treatment of Prisoners of War; and
- d. Geneva Convention Relative to the Protection of Civilian Persons in Time of War.

10.7 Protocols additional to the conventions. The two protocols which were adopted in 1977 are:

- a. Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of International Armed Conflicts (Protocol I); and
- b. Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II).

Application of the conventions and protocols

10.8 The first three conventions apply to the protection of members of armed forces (ie to combatants who are wounded, sick, shipwrecked or captive), and to noncombatants who are engaged in treating the sufferings of the former. Such noncombatants may be members of the medical services (doctors, dentists, pharmacists, nurses, stretcher-bearers, etc), may belong to the administrative staff of medical establishments, or may be chaplains. The fourth convention is essentially concerned with the protection of civilian persons in the power of a country involved in an international armed conflict. It may refer to persons who happen to be of the enemy state or to an entire population of an occupied territory.

10.9 The Geneva Conventions are now binding and it is generally accepted that their fundamental provisions have the force of custom and are therefore binding on the whole international community. These conventions call for the respect and protection, in times of armed conflict, without discrimination, of all persons who do not take any active part in the hostilities.

10.10 Since the adoption of these conventions in 1949, the number of armed conflicts has increased, more and more civilians have suffered the effects of ever deadlier weapons, and methods of guerilla warfare have been widely employed. Moreover, most of these conflicts have not taken place between two or more States; they have flared up within the State itself, the result of clashes of rival factions, or between dissidents or liberation movements in opposition to the established government. In view of such situations, two additional protocols to the Geneva Conventions of 1949 were first drafted, then adopted by a Diplomatic Conference on 8 June 1977 and finally ratified by Australia on 5 June 1991. The two protocols are complementary to the four conventions as a whole. Protocol I is applied in the case of international armed conflicts, whilst Protocol II is complementary to article 3 common to all four conventions and is applicable to the non-international armed conflicts. The essential purposes of these protocols are to ensure better protection for the entire civilian population during armed conflicts.

Emblems

10.11 Under the Geneva Conventions and the additional protocols, the distinctive emblem is a Red Cross or Red Crescent on a white background. In the event of armed conflict, use of the emblem is authorised for medical and religious personnel, both military and civilian, who are recognised as such by the party to which they belong; the same applies for medical units and establishments and medical means of transport, equipment and materiel. In such cases it is a protective sign; the persons and objects displaying it must not be attacked, but on the contrary, they must be respected and protected. The National Red Cross Societies are permitted to use the emblem; they are entitled to display it both in peace and in time of armed conflict when engaged in humanitarian activities to designate persons and property belonging to them. In such circumstances the distinctive emblem does not confer the protection of the Geneva Conventions and additional protocols.

PROTECTION PROVIDED BY THE CONVENTIONS AND PROTOCOLS

General

10.12 The conventions and protocols provide for the protection of medical and associated personnel, fixed and mobile medical units of armed forces, and medical transports. This section further defines the entitlement to claim protection, describes the circumstances under which such protection may be claimed or forfeited, and outlines the requirements for identifying personnel, facilities and transport claiming protection.

Medical and associated personnel

10.13 General. The first Geneva Convention determines the status, nature, and protection afforded to the armed forces medical personnel in the field: the second convention for armed forces at sea. A clear distinction is made between personnel who are entitled to the protection of the convention at all times, and those protected only when engaged in the performance of certain duties. The protection of civilian medical and associated personnel is covered by the fourth convention. Civilian medical personnel are categorised as persons who are either regularly and solely engaged in the operation and administration of civilian hospitals, who are protected at all times, or employed incidentally in the operation of hospitals, who are protected only when performing such duties.

10.14 Armed forces personnel entitled to full protection. Protection for armed forces personnel are as follows:

- a. Personnel who are entitled to use the Red Cross emblem and enjoy its full protection at all times are:
 - (1) medical personnel exclusively engaged in the search for, or the collection, transportation and treatment of the wounded or sick; or in the prevention of disease (the term 'medical' includes 'dental');
 - (2) staff exclusively engaged in the administration of medical units;
 - (3) chaplains attached to armed forces; and
 - (4) personnel of national Red Cross societies and those of other voluntary aid societies (who are duly recognised and authorised by the Government), and recognised relief societies of neutral countries placed under a belligerent's control provided that, in each case, personnel of such societies are:
 - (a) employed on the same duties as those shown in [sub-subparagraphs \(1\) and \(2\)](#); and
 - (b) subject to military laws and regulations.
- b. All the personnel mentioned in [subparagraph a.](#) must wear on the left arm a water-resistant armband bearing the Red Cross emblem, issued and stamped by the military authority. They should also carry a special identity card bearing the Red Cross emblem and showing at least the surname and given names, date of birth, and rank and Service number of the bearer. The card should state in what capacity the bearer is entitled to the protection of the conventions and should also bear the photograph, signature and thumb-print of the owner. It should be embossed with the stamp of the military authority. Personnel from relief societies from neutral countries should have the card issued before their departure. Red Cross armbands and identity cards are available within the ADF under Defence stock number:
 - (1) 7530-66-107-1096—ID Card for Medical Staff and Chaplains;
 - (2) 7530-66-107-1095—ID Card for Medical Assistants/Nurses;
 - (3) 8455-66-103-3745—Brassard Summer Weight Geneva; and
 - (4) 8455-66-012-3887—Brassard Winter Weight Geneva.
- c. Personnel designated in [subparagraph a.](#) who fall into the hands of the enemy shall not be deemed prisoners of war (PW) and shall be detained only in as far as the state of health, the spiritual needs and the number of PW require. They are, nevertheless, entitled to all the benefits of the third Geneva Convention relative to the treatment of PW. While retained by the enemy to provide care for the PW. These personnel:
 - (1) are subject to the laws and regulations of the enemy and the internal discipline of the camp in which they are retained,
 - (2) exercise their functions in accordance with their professional etiquette,
 - (3) may not be compelled to carry out any work other than that concerned with their duties,
 - (4) may visit working detachments and hospitals, and
 - (5) have access to military and medical authorities and correspondence facilities (this applies to senior medical officers and chaplains only).

10.15 Armed forces personnel entitled to part-time protection. Members of the armed forces specially trained to perform medically-related duties only when the need arises are also entitled to the protection of the conventions. However, this protection is only afforded when they are actually carrying out these duties and come into contact with the enemy. This provision would apply to stretcher-bearers involved in the search for or collection, transportation or treatment of the wounded or sick. Personnel carrying out these duties should wear a white armband on the left arm but only while carrying out medically-related duties. The armband should have a miniature Red Cross in its centre and should be issued and stamped by the military authority. The members should carry the normal military identity documents which should also specify what special training they have received, the temporary character of the duties they are carrying out, and their authority for wearing the armband. The members are PW if captured by the enemy. They may, however, be employed on medical duties as the need arises.

10.16 Civilian personnel entitled to full protection. Persons regularly and solely engaged in the operation and administration of civilian hospitals, including the personnel engaged in searching for, transporting or caring for wounded and sick civilians, the infirm and maternity cases, are entitled to the use of the Red Cross and its full protection in all circumstances. In occupied territory and in zones of military operations, these persons, while carrying out their duties, should wear a water-resistant armband on the left arm, marked with the Red Cross emblem, issued and marked by the State. They should also carry an identity card certifying their status, bearing the photograph of the holder and embossed with the stamp of the responsible authority. The management staff of each hospital should maintain an up-to-date list of such personnel and hold it at the disposal of the competent national or occupying authorities.

10.17 Civilian personnel entitled to part-time protection. Persons who are incidentally engaged in the operation and administration of civilian hospitals are entitled to the protection of the conventions, but only while they are actually performing such duties. They should wear a similar armband to the persons referred to in [paragraph 10.15](#) when performing their duties and carry a similar identity card which should state the duties on which they are employed. The military authorities may appeal to the charity of the civilian inhabitants to voluntarily collect and care for the wounded and sick. Persons responding to this appeal should be granted the necessary protection and facilities by both the military authorities originally appealing and the enemy, should they take or retake control of the area in question. The protection and facilities to be provided, however, will depend upon the prevailing circumstances. Nevertheless, such protection would not normally involve the right to display the Red Cross emblem, either on the premises sheltering the wounded and sick, or on the armband worn by such voluntary medical personnel.

10.18 Medical treatment of EPW. When sick, wounded or shipwrecked combatants are captured they become EPW and are entitled to the protection that that status affords. In particular, they are to be afforded necessary medical care. If medical supplies, personnel or facilities are inadequate to treat all the sick and wounded then medical assistance is to be provided strictly on the basis of medical triage. That is, the most in need of medical treatment are to be given priority and no regard is to be paid to the nationality of the patient. Security of EPW during and after treatment is required. Security personnel will be assigned as part of the joint force EPW plan in accordance with [paragraph 10.27](#).

Medical facilities and medical transport

10.19 Armed forces medical units and establishments:

- a. **Protection.** Fixed establishment and mobile medical units of the medical services of the armed forces, Red Cross and other authorised relief societies, and recognised relief societies of neutral countries may not, under any circumstances, be attacked and are at all times to be respected and protected by the parties to the conflict. If these establishments and units fall into the hands of the enemy, their personnel should be free to pursue their duties if the enemy has not ensured the necessary care of the wounded and sick. Article 23 of the first convention provides for the parties to the conflict to establish in their own territory and if the need arises, in occupied territory, hospital zones and localities so organised as to protect the wounded and sick from the effects of war. Protocol I invites the parties to the conflict to notify each other of the locations of their fixed medical units.

- b. **Loss of protection.** The protection to which these establishments and units are entitled ceases if they are used to commit, outside their humanitarian duties, acts harmful to the enemy. This protection, however, ceases only after a due warning has been given which, in all appropriate cases, states a reasonable time limit and after such warning has remained unheeded. Some examples of harmful acts are:
- (1) sheltering unwounded combatants or fugitives in a hospital;
 - (2) making a medical establishment or unit a depot for arms and ammunition;
 - (3) setting up a military observation post in such establishments/units; or
 - (4) deliberately placing a medical unit in such a position as to prevent an enemy attack, or to shield military objectives from attack.
- c. **Special conditions.** The following five conditions, specifically detailed in the first convention, are not considered as depriving a medical unit or establishment of protection, and are not, therefore, acts harmful to the enemy where:
- (1) the personnel of the unit or establishment are armed with light individual weapons and use these arms in their own defence or in that of the sick and wounded in their charge;
 - (2) in the absence of armed orderlies, the unit or establishment is protected by a picket or by sentries, or by an escort;
 - (3) small arms and ammunition taken from the wounded and sick, which have not yet been handed to the proper service, are found in the unit or establishment;
 - (4) personnel and materiel of the veterinary service are found in the unit or establishment, without forming an integral part thereof; and
 - (5) the humanitarian activities of medical units and establishments, or of their personnel, extend to the care of civilian wounded or sick.
- d. **Activity of captured medical unit.** Where it is unavoidable that wounded and sick should be abandoned to the enemy, medical personnel and materiel should, as far as military considerations permit, be left with them. While the wounded and sick who fall into the hands of the enemy will be EPW, medical personnel left with them are not so deemed, but if retained, continue to carry out their medical duties on behalf of EPW. Following the capture of a complete medical unit or establishment, there is a period when the various elements cannot be split up, and that is while the wounded and sick in the unit or establishment, or those in the neighbourhood, have need of their assistance. Apart from the change of authority, the unit or establishment will continue to function as it was before capture. The status quo remains in force until the enemy is in a position to make complete arrangements for the necessary care of the wounded and sick.
- e. **Buildings and materiel.** The materiel and stores of medical establishments and units may not be intentionally destroyed. The materiel of captured armed forces medical units is to be reserved for the care of wounded and sick in the captured formation, or failing this, the materiel will be reserved for other wounded and sick. The buildings, materiel and stores of armed forces fixed medical establishments remain subject to LOAC; they become war booty if captured but they may not be diverted from their purpose if they are providing care for wounded and sick personnel. Nevertheless, commanders of forces in the field may make use of them in case of urgent military necessity but only when necessary arrangements have been made for the welfare of the wounded and sick of such captured establishments.
- f. **Property of aid societies.** The real and personal property of aid societies which are entitled to the privileges of the convention shall be regarded as private property. Except in cases of urgent necessity and only after the welfare of the wounded and sick has been ensured, the right of requisition recognised for belligerents by the laws and customs of war will not be exercised.

- g. **Marking.** Medical units and establishments and their stores, buildings, and equipment should, with the consent of the military authorities, be marked with the Red Cross emblem and fly both the Red Cross flag and their national flag. Captured medical units may only fly the Red Cross flag. The distinctive emblem is to be as large as appropriate under the circumstances, may be lighted or illuminated, may be made of materials rendering it recognisable by technical means of detection and should be displayed on a flat surface or on flags visible from as many directions and as far away as possible. Protocol I also provides for medical units to aid recognition by using distinctive signals.

10.20 Armed forces medical transport. Vehicles or other forms of transport used to move the wounded and sick or medical equipment, should be marked with the Red Cross emblem and may also use a flashing blue light. They are protected in the same way as mobile medical units. If such transports or vehicles are captured, they are subject to the laws of war on the condition that the enemy, in all cases, must ensure the care of the wounded and sick.

Armed forces medical aircraft

10.21 Article 36 of the first convention specifies that medical aircraft exclusively employed for the removal of the wounded and sick, as well as the transport of medical personnel and equipment must fly, at heights, times, and on routes specifically agreed upon between the belligerents concerned. However, under Additional Protocol I medical aircraft flying in combat zones are protected as soon as they are recognised as such. Medical aircraft flying over areas physically controlled by an enemy or over areas where it is not clear who has control may be ordered to land to permit inspection. Such medical aircraft must bear, clearly marked, the Red Cross emblem together with the national colours on their lower, upper and lateral surfaces. Dedicated medical aircraft may also be equipped with a flashing blue light, details of which are contained in chapter 1 to annex 1 to Protocol I. No other aircraft are to use this light. Identification may also be assisted through use of a distinctive radio signal.

10.22 Medical aircraft are not to be armed, except for personal light weapons which may be carried for self-protection or protection of patients and must obey every summons to land but the aircraft with its occupants may continue its flight after examination. In the event of involuntary landing in enemy or enemy occupied territory, the wounded and sick as well as the crew will become PW. Medical personnel on board are to be treated in accordance with the regulations described in [paragraph 10.14c](#).

10.23 Medical aircraft of belligerents may, after giving previous notice to which there is no objection, fly over neutral territory, land in case of necessity or use it as a port of call. Such aircraft may disembark wounded and sick with the consent of the local authorities. The wounded are to be detained by the neutral state until the close of hostilities unless an agreement to the contrary has been made between the neutral state and the belligerents. Medical aircraft are not to be used to collect or transmit intelligence data nor carry any equipment for such purposes. In certain specific circumstances detailed in Protocol I, temporary medical aircraft may use distinctive signals without displaying the distinctive emblem.

10.24 Hospital ships. Hospital ships are built or equipped specially and solely to assist the wounded, sick and shipwrecked, to treat them and to transport them. They may be military hospital ships or ships used by national Red Cross or other officially recognised relief societies of the belligerent or neutral countries. Hospital ships must be painted white on all exterior surfaces, must display one or more dark Red Crosses on each side of the hull and on the horizontal surfaces, and must make themselves known by hoisting a white flag with a Red Cross, their national flag, and if they belong to a neutral country, also the flag of the belligerent whose direction they have accepted. They may also employ a flashing blue light. They may not possess or use secure communications. Merchant vessels which have been converted into hospital ships cannot be put to any other use for the duration of hostilities. Hospital ships may not in any circumstances be attacked or captured and at all times are to be respected and protected provided that their names and descriptions have been notified to the belligerents ten days before they are employed.

10.25 Civilian hospitals. Belligerents are at all times to respect and protect civilian hospitals organised to give care to the wounded and sick, the infirm and maternity cases. All civilian hospitals must be issued with certificates, by the states that are parties to a conflict, stating that they are civilian hospitals and that the buildings which they occupy are not used to commit acts harmful to the enemy. Civilian hospitals forfeit the protection of the Convention if they are used to commit acts harmful to the enemy. They must, however, be given a warning, nominating a reasonable time limit. Protection ceases if the warning is unheeded after the limit. The fact that sick or wounded members of the armed forces are nursed in these hospitals, or the presence of small arms and ammunition taken from such personnel and not yet handed to the proper service, are not considered to be acts harmful to the enemy. The hospitals should be clearly marked with the Red Cross emblem but only if so authorised by the state.

10.26 Civilian medical transport. Convoys of vehicles or hospital trains on land, or specially provided ships at sea, conveying wounded and sick civilians, the infirm and maternity cases, are entitled to the same protection under the Conventions as civilian hospitals. With the consent of the state, they should be marked by displaying the Red Cross emblem. This protection does not extend to normal civil ambulance vehicles, except on occasions when they are used for transport by convoys. Aircraft exclusively employed for the removal of wounded and sick civilians, the infirm and maternity cases, or for the transport of medical personnel and equipment, are entitled to the same protection and are governed by the same regulations as apply to armed forces medical aircraft described in [paragraph 10.10](#).

PLANNING

10.27 A number of considerations are likely to be prominent in planning for the application of LOAC to ADF operations. At the strategic level, there will be a need to establish the position of the other party to the conflict in relation to the Geneva Conventions and their protocols with a view to establishing the degree to which the protection of medical personnel, facilities and transport is likely to be respected. Communication with the other party on this and other matters will be through a protecting power or an international humanitarian organisation such as the International Committee of the Red Cross. This means of communications will be used to exchange details on casualties, details of locations of medical facilities and where appropriate, hospital zones, sea areas used by hospital ships, routes to be used by evacuation transport and specific identifying signals applicable to the operation.

10.28 Given political and strategic guidance, commanders and their staffs at the operational and tactical levels will need to address such issues as:

- a. the location of medical facilities in relation to other military units and facilities;
- b. which of those facilities are to be declared and seek protection;
- c. the extent to which guards or pickets may be assigned to those units;
- d. weapons that may be carried in these units;
- e. the arrangements for guarding PW casualties in medical facilities;
- f. the extent to which mobile medical facilities in forward areas are declared and for what phases of an operation;
- g. whether or not all surface evacuation transport is to be marked; and
- h. the extent to which aircraft are to be dedicated to the aeromedical evacuation (AME) role, marked and thereby claim protection.

10.29 In relation to strategic AME, the option of providing suitable civilian aircraft dedicated to the role, marked and protected and flying along declared flight paths, may be the best solution in view of the limited availability of Royal Australian Air Force airframes. In the maritime environment, the options of providing level three medical support afloat using a dedicated hospital ship operating in declared zones and without the advantages of access to secure communications will have to be weighed against the advantages of providing such support further forward in non-dedicated ships with unrestricted movement using secure communications to monitor casualty occurrence.

References

10.30 This chapter should be read, as appropriate, in conjunction with the following references:

- a. Australian Defence Force Publication (ADFP) 37—*Law of Armed Conflict*.
- b. *The Geneva Conventions of August 12, 1949* (second) revised edition, (Geneva, July 1950).
- c. *Commentary on the Geneva Conventions* published by Jean S. Pictet for the International Committee of the Red Cross, 1952.
- d. *The Doctor in the Geneva Conventions of 1949* (extract from the *Revue Internationale de la Croix Rouge*, February and March 1953).

- e. *Unit Guide to the 1949 Geneva Conventions for the Protection of War Victims* (modified for Australia) (reprinted 1969).
- f. *Protocols Additional to the Geneva Conventions of 12 August 1949* (Geneva, 1977).
- g. *The Military Medical Officer and the Geneva Conventions* by Olivier Servais, published by the International Committee of Military Medicine and Pharmacy, 1988.

CHAPTER 11

HEALTH SUPPORT TO OTHER CONTINGENCIES

General

11.1 Doctrine in this Australian Defence Force Publication (ADFP) generally applies to provision of health support during substantial, conventional conflict. The provision of health support to operations in northern Australia is addressed in [chapter 8—'Health support to operations in Northern Australia'](#) while nuclear, biological and chemical (NBC) operations are covered in [chapter 9—'Health support in a nuclear, biological and chemical environment'](#).

11.2 The doctrine is equally adaptable to a range of other contingencies that might involve the Australian Defence Force (ADF). These include:

- a. United Nations (UN) peace support operations;
- b. ADF evacuation operations;
- c. Defence Assistance to the Civil Community (DACC); and
- d. Defence Force Aid to the Civil Power (DFACP).

Peace support operations

11.3 An ADF contingency plan exists for deployment of an ADF contingent for duty with a peace support force. Planning considerations for peace support operations are detailed in ADFP 9—*Joint Planning*.

11.4 Health planning. Health planning will be generally in accordance with [chapter 3—'Australian Defence Force health planning'](#) of this ADFP. The senior medical officer of the headquarters (HQ) responsible for mounting the Australian Service contingent (ASC) is to prepare the health support plan for the ASC, including coordination of support from other commands. The Australian Service contingent reconnaissance party should include a health adviser to assess hazards and facilities in the ASC area of operations (AO) and advise the commander Australian contingent (COMASC) on arrangements for health care and casualty evacuation.

11.5 Support arrangements. The health support arrangements for the ASC will vary according to its composition, the AO and the UN support arrangements. Formed units of the ASC will deploy with integral level one medical support, whereas small contingents, eg observers, will be reliant on UN arrangements for level one care. Levels two, three and four medical support will be arranged by the UN, either through the provision of a national contingent specifically for that purpose, or through the host nation health care infrastructure.

11.6 Casualty evacuation. Evacuation of casualties within and out of the AO will be the responsibility of the UN. The requirement for subsequent evacuation of ASC casualties to Australia will be determined by the mission HQ in conjunction with COMASC. The UN will normally accept financial responsibility for the repatriation of casualties to home countries employing UN identified means. Where national considerations determine that other means of evacuation are more appropriate, the cost of evacuation will normally be an Australian responsibility. Where the ADF is required to provide strategic aeromedical evacuation (AME), this will be a Headquarters Air Command (HQAC) responsibility. The mounting HQ for the operation would normally perform the casualty regulation function, although in certain circumstances this may be more appropriately performed by HQAC.

Evacuation operations

11.7 ADF doctrine for evacuation operations is detailed in ADFP 43—*Evacuation Operations* and ADF contingency plans. These operations will normally involve the evacuation of Australian nationals and other approved persons from a foreign country. They are likely to involve combined planning and execution and are classified as follows:

- a. **Services assisted evacuation (SAE).** SAE operations are conducted when a host nation is capable of providing and guaranteeing the security of the evacuees and the ADF elements involved. ADF assistance is likely to be limited to communications, transport and movement, and medical support.

- b. **Services protected evacuation (SPE).** SPE operations are conducted when a host nation is incapable of, or unable to guarantee the security of the evacuation. In these circumstances, forces will be deployed with the necessary resources to effect the evacuation and provide protection.

11.8 Health planning. Health planning for SAE and SPE will generally be in accordance with [chapter 3](#). The mounting authority is to ensure that a health support plan is prepared for the commander of the evacuation force. The plan should cover support to both ADF members and civilian evacuees.

11.9 Support arrangements. The evacuation force will normally include appropriate levels one, two and three medical support and evacuation capabilities. The scope of health support included in the force will need to take into account the requirement to medically screen and treat civilian evacuees of varying ages, sex and medical condition.

Defence assistance to the civil community

11.10 DACC is defined as provision of Defence resources for the performance of tasks which are primarily the responsibility of the civil community. Defence resources include personnel, equipment, stores, supplies and facilities, and expenditure from Defence outlay on administration, personnel support, equipment operation, repair and maintenance. ADF policy and procedures for DACC are detailed in ADFP 44—*Civil Military Cooperation* and Defence Instructions (General) OPS 05-1—*Defence Assistance to the Civil Community*.

11.11 The utility of military medicine results in it being a common form of assistance requested, both during civil emergencies/disasters, and for other significant community events. This assistance can be provided in Australia or overseas.

11.12 Contingency planning. Contingency plans exist which provide for a response to a range of circumstances in which assistance may be sought. These include the following:

- a. **Plan AUSAID**—prepared by Emergency Management Australia (EMA) in conjunction with AUSAID to meet requests from other countries for Australian physical and technical assistance following a disaster of any type.
- b. **ASP EVERGREEN**—covers ADF assistance to the civil community for a major natural disaster or civil emergency in Australia.
- c. **ASP CARAVEL**—covers ADF assistance to neighbouring countries following major natural disasters or civil emergencies.
- d. **ASP TOSCA**—covers ADF assistance to EMA to prepare for the possible re-entry of nuclear space debris and to support operations resulting from the impact of nuclear space debris on Australian territories.

11.13 Plan AUSAID, ASP EVERGREEN and ASP CARAVEL identify a range of medical capabilities that the ADF could be requested to provide. These are:

- a. AME teams provided by the Royal Australian Air Force (RAAF);
- b. supplementary medical teams including triage and surgical teams provided by Army;
- c. major medical facilities ashore, field ambulances, field hospitals or elements thereof provided by Army;
- d. major medical facilities afloat provided by Navy;
- e. medical stores provided by Army; and
- f. public health services including health inspectors, preventive medicine elements and vaccination teams provided by Army.

11.14 Other ADF health support capabilities may be appropriate to disaster relief operations in certain situations. For example, a Royal Australian Navy afloat medical facility may be appropriate to support offshore contingencies or in remote areas along the Australian coast. RAAF health support units may also be appropriate where there is a requirement to evacuate casualties, by air, from a disaster area. The actual capabilities tasked to support any particular contingency will be driven by the nature of assistance requested by EMA, and determined by the Australian Defence Headquarters. Under ASP TOSCA, health support to the Australian space debris emergency search team will be based initially on an Army level two facility, augmented as necessary with appropriate specialist services, eg preventive medicine, surgical support and casualty decontamination, and a medical officer competent in radiobiology.

11.15 The health support arrangements for ADF personnel involved in DACC tasks will vary with the circumstances. However, all ADF contingents deployed on disaster relief/civil emergency tasks should include integral level one support. Levels two and three support to the contingent will normally be provided from civilian sources. In disaster situations where civil health support has been destroyed or substantially damaged, it may be necessary to deploy ADF health support assets to provide levels two and three support.

11.16 Within the AO casualty evacuation will be the responsibility of the contingent commander using ADF or civilian resources. Strategic AME of ADF casualties to or within Australia will normally be coordinated by Air Commander Australia.

Defence Force aid to the civil power

11.17 DFACP is the term used to describe the provision of ADF aid to supplement law enforcement measures undertaken by the Federal and/or State/Territorial governments and their responsible authorities, within the terms of the Constitution, existing legislation and common law, in situations where there is a likelihood that members of the ADF may be required to use force. Force may differ in degrees from deliberate acts of minor physical contact or restraint to the use of weapons or other means to cause death or injury.

11.18 Tasks for which members of the ADF may be called out could range from an assault on a location occupied by terrorists through to more general assistance to the police in protecting the public. Examples of possible tasks are:

- a. recovery of hostages held by terrorists;
- b. recovery of offshore oil and gas installations held by terrorists;
- c. recovery of aircraft, ships and land vehicles (including trains) held by terrorists;
- d. recovering of buildings and installations occupied by terrorists;
- e. cordon;
- f. area and/or building search;
- g. control of public movement; and
- h. picketing and guarding.

11.19 Health support requirements for counter-terrorist (CT) operations are detailed in ADFP 45—*Special Operations* and supporting plans. Health support planning for CT operations will generally be in accordance with [chapter 3](#). ADFP 44 provides guidance on Defence Force aid to the civil power.

11.20 Health support to offshore contingencies will be more complex, and where detailed support arrangements are not in place there will be a requirement for Headquarters Special Operations (HQSO) to liaise closely with the Surgeon General Australian Defence Force to ensure appropriate treatment and evacuation resources are identified, and that appropriate medical countermeasures are adopted.

CHAPTER 12

AUSTRALIAN DEFENCE FORCE HEALTH TRAINING

General

12.1 Individual and collective training to develop and maintain the operational health support capabilities outlined in this Australian Defence Force Publication (ADFP) will be conducted on both a joint and single Service basis.

Individual training

12.2 Individual training is a continuing process involving formal courses and on-the-job experience. Its aim is to prepare Australian Defence Force (ADF) health services personnel to perform health support functions in appropriate operating environments.

12.3 Prior to and during operations, there will be a requirement to conduct individual health training specific to the operation. This will be conducted in accordance with operational directives, orders and instructions. This training could involve specialised clinical training for ADF health services personnel, as well as first-aid and health training for all members of the deploying force. It may need to be concentrated to meet operational deployment programs.

12.4 During operational and non-operational circumstances, the ADF health facilities in the support area provide a critical medium for obtaining clinical experience essential to the performance of health support functions in operational environments.

Collective training

12.5 Collective training exercises provide the opportunity for practicing and evaluating operational health support capabilities and procedures.

12.6 During joint exercises, every opportunity should be taken to practice joint health support doctrine contained in this ADFP. Such exercises will normally include simulated casualty situations.

12.7 While collective joint health training will normally be conducted as part of collective joint exercises, it may be more appropriate in certain circumstances to conduct joint medical exercises to practice specific aspects of operational health support. These exercises would be planned and coordinated at the operational level by the Theatre Health Planning Group, details of which are given in [chapter 3—'Australian Defence Force health planning'](#).

CHAPTER 13

MANAGEMENT OF HEALTH INFORMATION

General

13.1 Effective management of health information on operations is essential for purposes of health planning. This ensures that health support is effective and facilitates the highest possible quality of care to individuals. Health information can broadly be classified as follows:

- a. Information recorded for the purposes of individual medical or dental management and typically included on computerised or hard copy medical and dental records is known as individual health information.
- b. Information that embraces health intelligence and the monitoring of the health support system is collective health information.

13.2 Health intelligence provides crucial information for health support planning. The health intelligence cycle is detailed in [chapter 3—‘Australian Defence Force health planning’](#). Medical reports and returns outlined in [chapter 6—‘Command, control and communications’](#) also provide input to the health planning process and facilitate the ongoing management of health support on operations. Requirements for clinical reporting (eg reporting of certain infectious diseases) are detailed in Surgeon General Australian Defence Force health policy directives, single Service instructions and standing operating procedures.

Health documentation

13.3 Health documentation provides a record of individual health assessment and treatment during Australian Defence Force (ADF) service. Such documentation is crucial for individual clinical care, ensuring ADF personnel are employed in accordance with their medical fitness, and medico-legal purposes such as compensation or repatriation benefits.

13.4 The personnel medical (PM) series of forms is utilised by the ADF for documenting individual health care and health assessment. While this series contains a number of forms that are in tri-Service usage, the majority are designed for single Service use. Health documentation is currently compiled, managed, stored and retrieved in accordance with single Service record-keeping policies and procedures. These policies and procedures are detailed in:

- a. ABR 1991—*Royal Australian Navy Health Services Manual*;
- b. Directorate of Medical Services—Army (DMS–A) administrative and technical instructions; and
- c. Royal Australian Air Force health service circulars.

13.5 Health documentation during operations will be in accordance with single Service instructions. The documents used are to be those of the Service operating the facility, regardless of the Service of the casualty. However, Form PM 377—*Field Medical Report* is to be used for all casualties treated in the field. Within treatment facilities, health documents are to be raised and maintained in accordance with the policy of the Service operating the facility. However, disposal of such documents is to be in accordance with the single Service health documentation policy, eg disposal of documents raised by a field hospital on a Royal Australian Navy member is to be in accordance with Navy policy.

Public information and the media

13.6 During operations there is likely to be intense public and media interest in casualties and their management. Perceptions so gained will be influential in developing and sustaining public and political confidence in the ADF. Information which demonstrates that ADF casualties are rapidly and effectively treated and evacuated will be an important part of the public information policy for the operation. Within a joint force area of operations (JFAO), an ADF media support unit under command of the Joint Force Commander will have responsibility for public information, with Director-General Public Information having responsibility for the technical direction of the public information strategy. Any requirement for control of casualty information will be identified in the public information strategy and promulgated at appropriate levels in operation orders/instructions.

Patient tracking

13.7 Effective and efficient systems for patient tracking are to be implemented both in the JFAO and the support area. Accurate up-to-date information on the whereabouts of patients in the treatment and evacuation chain will be essential for casualty regulation purposes, and to meet public expectations and political requirements.

CHAPTER 14

AUSTRALIAN DEFENCE FORCE HEALTH LOGISTICS

General

14.1 While health support is itself part of the broader logistics process, there are specific aspects of material policy and procedures that are critical to providing and maintaining health support in joint operations. These include supply of medical and dental materiel, repair and maintenance of medical and dental equipment and supply of blood and blood products.

14.2 Within a joint logistic framework, every effort must be made to economise and promote efficiency by using standardised and compatible equipment, pooling resources and using single Service management for 'common user' logistic support. Single Service logistic management (SSLM) is the process by which one Service, by agreement with others, has sole responsibility for supply of a commodity, maintenance or repair of an equipment, or provision of a service, in support of the Australian Defence Force (ADF). Army has SSLM responsibility for supply and maintenance of medical and dental materiel within the ADF.

14.3 Health logistics support within a deployed force is made more difficult by the nature of the commodities involved. Blood and certain pharmaceutical items need to be transported and stored within specified temperature ranges to maintain their efficacy. Medical and dental equipment, particularly that found at level two and level three medical facilities, can be technically complex, susceptible to the effects of climate and movement, and difficult to repair.

Supply of medical and dental materiel

14.4 Australian Defence Force Publication (ADFP) 703—*Management Procedures for Medical and Dental Materiel* describes the operations and organisation of the ADF medical and dental supply system, and sets out the policy and procedures for the efficient SSLM of the system. Amplifying single Service policy is contained in the following references:

- a. Royal Australian Navy (RAN)—Naval Supply Manual 2 (Australian Book of Reference 4)—*Manual of Stores Management in HMA Ships and Establishments*;
- b. Army—*Manual of Equipment Accounting (MEMA)*; and
- c. Royal Australian Air Force—Defence Instructions (Air Force) PERS 54–15—*Provision of Medical Aids*.

14.5 SSLM (Army) and single Service responsibilities as they affect supply of medical dental materiel on operations are as follows:

- a. SSLM (Army):
 - (1) financial programming for allocation of funds for, and acquisition of, medical and dental supplies;
 - (2) provision of medical and dental supplies to the ADF; and
 - (3) quality assurance and quality control requirements for medical and dental materiel held by Army supply agencies.
- b. Single Services (Navy, Army and Air Force):
 - (1) control and maintenance of medical and dental materiel in health service units,
 - (2) demanding medical and dental materiel for Army supply agencies, and
 - (3) forecasting requirements for medical and dental supplies.

14.6 As SSLM, Army is responsible for provision, receipt, storage and issue of medical and dental materiel on operations. Within the joint task force area of operations (JTFAO), Army field supply companies and supply battalions have primary responsibility. Each of these has a medical and dental stores element, including one or more pharmacists. Within the support area, the medical and dental supply function is performed by elements of Army logistic battalions. Details are provided in ADFP 703. Levels two and three medical facilities within a JTFAO normally include a pharmacist and appropriate medical and dental stores personnel. The holdings of medical and dental supplies within supply agencies and health service units within a JTFAO will be largely determined by the casualty estimate and will be detailed in medical plans at all appropriate levels. The outline system for supply of medical and dental materials on operations is shown in [annex A](#).

14.7 Medical and dental supplies are usually obtained by health service units submitting single-item demands to supporting Army supply units. Where operational circumstances dictate, demands can be submitted in message form. For designated items with readily forecast requirements, periodic bulk demands may be utilised. Replenishment of stock at all levels is based on forecast usage. Certain drugs or pharmaceuticals, and other items that could be expensive or in short supply, may be subject to control by health service staff at a joint force headquarters and/or subordinate headquarters (HQ). Requirements of this sort are to be specified in the medical plan. Health service units are generally responsible for collecting medical and dental supplies from supporting supply agencies. Where practicable, medical and dental supplies can be delivered on returning surface and air evacuation transport. Where civil infrastructure remains intact within the JTFAO, local procurement of certain medical and dental items may be possible.

Repair and maintenance of medical and dental equipment

14.8 Army is responsible for the inspection, repair and modification of medical and dental equipment for the three Services under SSLM. Within an area of operations, repairs to medical and dental equipment will normally be carried out by tradesmen of the Royal Australian Electrical and Mechanical Engineers (RAEME) from appropriate Army workshops. Where appropriate civil infrastructure remains in place, contract repair may be utilised. Within the support area, maintenance responsibilities will be discharged by Support Command Australia, usually through period contracts with civilian agencies.

14.9 Levels of repair used by Army for maintenance of equipment are:

- a. Operator maintenance which comprises those functions which are the responsibility of a unit, ship or base in regard to the equipment which it holds. It consists of cleaning, preserving, lubricating and adjusting (front panel only), non-technical inspection and minor servicing as required in accordance with relevant procedures contained in the user handbook supplied with each equipment. Where appropriate these actions should be recorded in equipment record books.
- b. Unit repair consists of minor inspection, fault-diagnosis and repair tasks which can be carried out in situ by a tradesman permanently attached to that unit, eg confirmation of failures reported by the equipment operator, electrical or mechanical adjustments to bring the equipment into specification, diagnosis of defective subassemblies or accessories or minor repair using generally available hand tools, simple general purpose test equipment and, in some cases, a limited range of 'fast-moving' repair parts, accessories or subassemblies. In units without tradesmen on establishment, these repairs form part of the field repair tasks.
- c. Field repair consists of performance testing, detailed defect diagnosis and the repair or replacement of defective assemblies, modules, accessories or components within the constraints of available tools, test equipment, repair parts, etc and the complexity and portability of the equipment. It may be carried out in a RAEME workshop or civilian trade repair agency or in situ by a tradesman sent forward from such a workshop or agency.
- d. Base repair consists of all maintenance tasks beyond the capability or capacity of field repair agencies. It includes the repair of backloaded assemblies and subassemblies and repair and overhaul of complete equipment. In the context of medical and dental equipment, all base repairs will normally be carried out through trade repair resources.

14.10 Policy and procedures for repair and maintenance of medical and dental equipment are detailed in ADFP 703, chapter 7.

Supply of blood and blood products

14.11 Reliable provision of appropriate stocks of blood and blood products is essential for the delivery of high quality health care on operations.

14.12 Blood and blood products required by the ADF on operations may include:

- a. whole blood;
- b. red cell concentrates;
- c. platelet concentrates; and
- d. plasma components and derivatives including:
 - (1) immunoglobulin;
 - (2) anti-D immunoglobulin; and
 - (3) clotting factors (competent concentrates or fresh frozen plasma).

14.13 On operations, level three and level four health facilities will require blood. Level one and level two facilities routinely use blood substitutes. However, exceptions include a RAN ship with a medical officer (MO) embarked and a level two facility supporting a specific operation or from which delays in casualty evacuation are expected.

Supply sources

14.14 The Australian Red Cross Blood Transfusion Service (ARCBTS) is likely to be the primary source of supply of blood and blood products on operations. The specific ARCBTS source will normally be that closest to the area of need. Supply will be the responsibility in the first instance of the ARCBTS director in the State or Territory where the ARCBTS facility is located. Where that facility cannot satisfy the ADF requirement, the request will be relayed by that director to the medical director national headquarters ARCBTS, or to another ARCBTS director as appropriate. On operations, it may be necessary for the ADF to supplement this from its own resources.

14.15 ADF health facilities may collect from local ADF donors to supplement existing stocks during surge usage. Where necessary, Army will be responsible for the establishment of a central blood bank to meet ADF requirements. Alternatively, blood and blood products may be temporarily held at a medical supply company in the support area for forwarding to the JTFAO. In certain operational situations outside Australia, it may be necessary to make arrangements for the provision of screened blood and blood products from indigenous civilian or allied military sources. A central blood bank established by the ADF on operations would provide similar screening of blood to that of the ARCBTS. Blood obtained from local donors to meet an emergency or surge situation and not subject to ARCBTS screening will be screened for HIV, HBV and HCV. Service personnel who are deployed, or at short notice may be deployed, for activities where emergency blood transfusions may be required are to be tested for HIV and hepatitis B/C infections.

14.16 Where the ADF has a requirement for blood or blood products from the ARCBTS, a request is to be made by an appropriate ADF MO to the director of the ARCBTS in the State/Territory where the requirement exists.

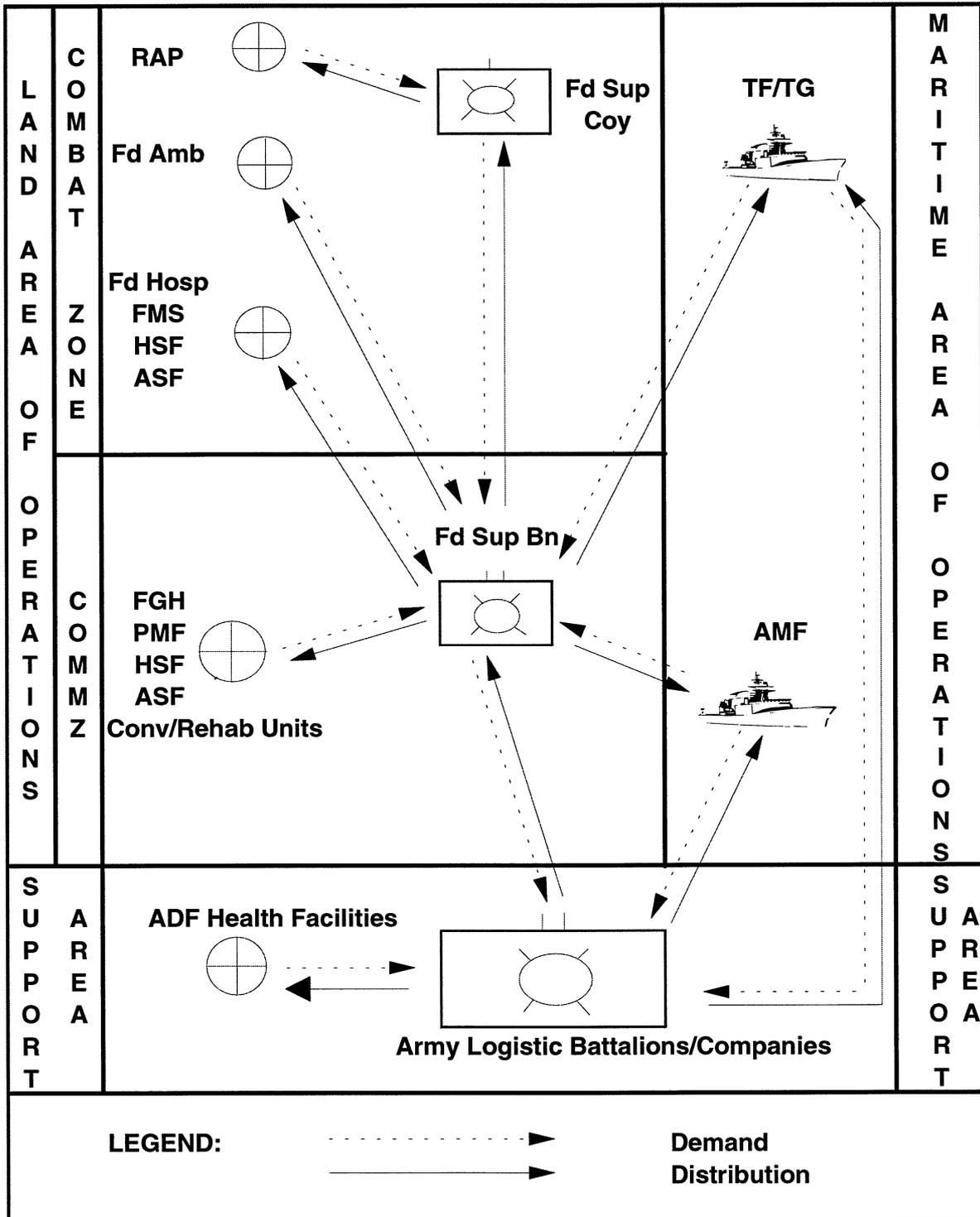
14.17 The ADF is responsible for the collection of blood and blood products from ARCBTS and distribution to the appropriate ADF health facility other than where the ARCBTS agrees to deliver to a transfer point, eg a medical supply company in the support area or an airport. Within a JTFAO, distribution of blood is the responsibility of health services staff at appropriate HQ, in close consultation with air movements and logistics staff. A system for demand and distribution of blood on operations is shown in [annex B](#). The normal means for transport of blood and blood products, other than for local distribution, is to be air. Casualty evacuation aircraft may be used for distribution of blood under the provisions of the Geneva Conventions. Mobile blood fridges are to be used where necessary to maintain quality of blood and blood products during distribution.

14.18 Where the ADF established a central blood bank, blood and blood products will be stored in accordance with ARCBTS guidelines. Support area health facilities with operating theatres may maintain a blood bank to meet routine requirements. Such facilities are to ensure that blood and blood products are stored under optimal conditions so that they do not become contaminated or haemolysed. Within a JTFAO, there will be a requirement for storage of blood and blood products in the pathological sections of level three and level four facilities, and in certain circumstances, on RAN ships. The type of blood and blood products used depend on the laboratory facilities available. Appropriate refrigeration must be available for safe storage of blood (4–6 degrees C). Specific technical requirements for storage of blood and blood products are detailed in ADFP 710—*Blood Banking Methods Manual*.

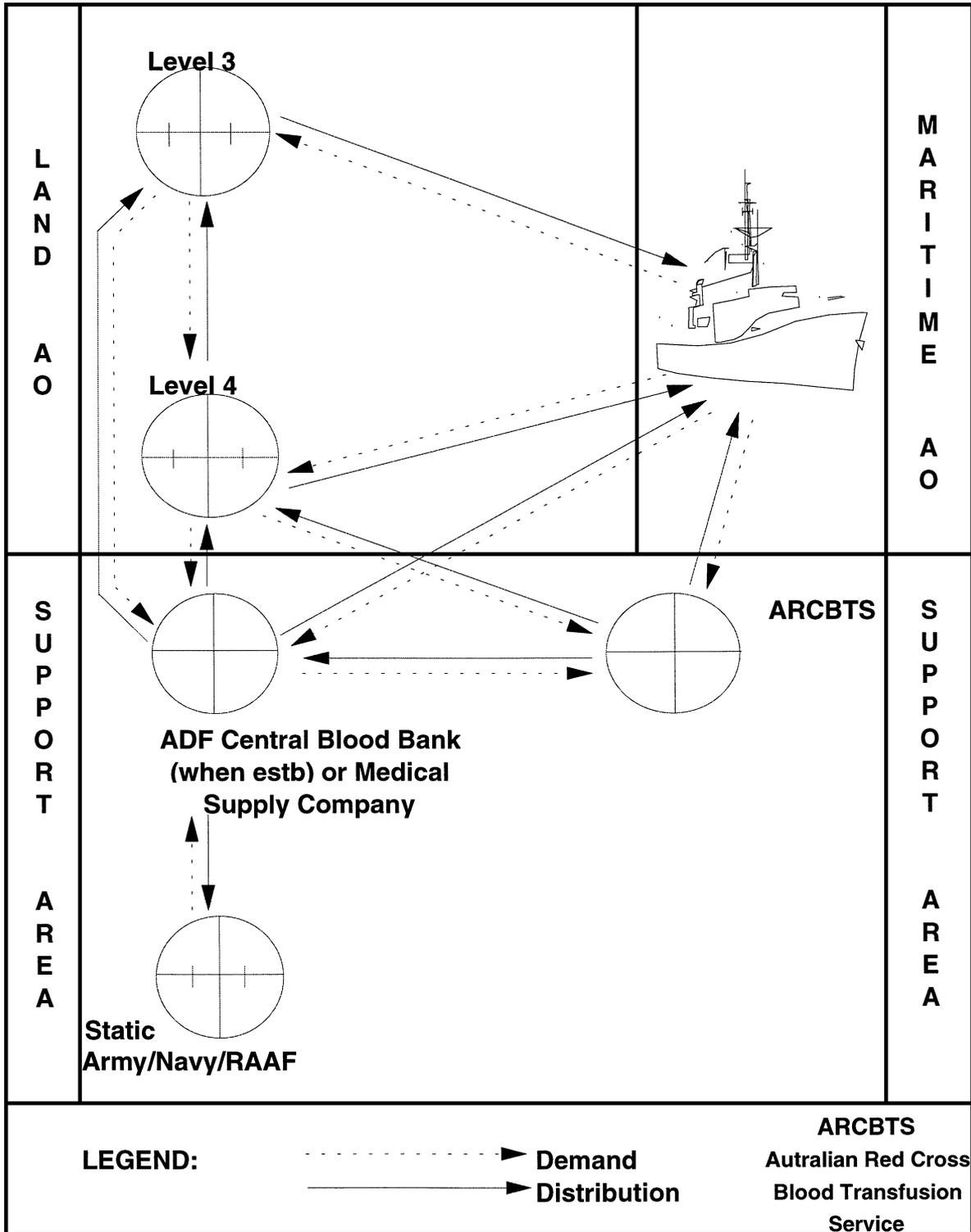
Annexes:

- A. [Outline system for supply of medical and dental materiel on operations](#)
- B. [Supply of blood on operations](#)

OUTLINE SYSTEM FOR SUPPLY OF MEDICAL AND DENTAL MATERIEL ON OPERATIONS



SUPPLY OF BLOOD ON OPERATIONS



CHAPTER 15

ASSOCIATED REFERENCES

Combined

- 15.1** The combined references are:
- a. Quadripartite Standardisation Agreements;
 - b. Quadripartite Advisory Publications;
 - c. Air Standardisation Coordinating Committee Air Standards; and
 - d. Air Standardisation Coordinating Committee Advisory Publications.

Joint

15.2 **Australian Defence Force Publication (ADFP) series (operations)**—listed at page ix.

15.3 **ADFP 700 series (health):**

- a. ADFP 702—*Immunisation Procedures*;
- b. ADFP 703—*Management Procedures for Medical and Dental Materiel*;
- c. ADFP 708—*Military Surgery Manual*;
- d. ADFP 709—*Casualty Treatment Regimes*;
- e. ADFP 710—*Blood Banking Methods Manual*;
- f. ADFP 711—*Transfusion Manual*;
- g. ADFP 713—*Health Aspects of Nuclear, Biological and Chemical Defence*; and
- h. ADFP 714—*Operational Stress Management*.

15.4 **Defence Instructions (General) DI(G):**

- a. DI(G) OPS 03–1—*Special Aeromedical Evacuation*;
- b. DI(G) PERS 16–7—*Surgeon General Australian Defence Force Health Policy Directives*;
- c. DI(G) PERS 16–9—*Prevention of Heat-related Illness and Injuries*; and
- d. DI(G) PERS 19–3—*Occupational Health and Safety Radio-Frequency Radiation Hazards (RADHAZ)*.

15.5 **Surgeon General Australian Defence Force health policy directives (HPD):**

- a. HPD 002—*Health Aspects of Handling Chemical Warfare Agents: Nerve, Oedemagen, and Vesicant Agents*;
- b. HPD 056—*Asbestos Related Diseases*;
- c. HPD 125—*Health Intelligence*;
- d. HPD 151—*Wound Ballistics*;
- e. HPD 212—*Documentation, Reporting and Notification of HIV Infection in Members of the ADF*;
- f. HPD 213—*Hepatitis B Virus Infection*;

- g. HPD 214—*Infection Control Procedures for Health Care Personnel in Blood Borne Diseases due to Hepatitis B Virus, Hepatitis C Virus and Human Immunodeficiency Virus*;
- h. HPD 215—*Malaria*;
- i. HPD 217—*Hepatitis C*;
- j. HPD 224—*Notification of Infectious Diseases*;
- k. HPD 412—*Australian Defence Force Levels of Health Support in Operations—Dental Implications*;
- l. HPD 504—*Australian Defence Force Nursing Policy—Infection Control*;
- m. HPD 703—*Blood Supply*;
- n. HPD 821—*Operational Health Activities of International Interoperability Programs*; and
- o. HPD 801—*Aeromedical Evacuation Terminology*.

15.6 Miscellaneous—Australian Defence Force Consolidated Index of Therapeutic Items.

Single Service

15.7 Royal Australian Navy:

- a. Australian Book of Reference 1991—*Royal Australian Navy Health Services Manual* (volumes 1 and 2).

15.8 Army:

- a. Manual of Land Warfare (MLW) 1.1.6—*Logistics in Support of Operations*;
- b. MLW 1.5.1—*Staff Duties in the Field*;
- c. MLW 1.5.2—*Aide Memoire*;
- d. MLW 1.5.2—*Aide Memoire* (interim);
- e. MLW 2.1.1—*The Employment of the Health Services*;
- f. MLW 2.3.1—*First Aid*;
- g. Royal Australian Army Medical Corps (RAAMC) Corps Training Note 1.1—*The Theory and Practice of Army Health*; and
- h. RAAMC Corps Training Note 2.1—*Field Surgery Handbook*.

15.9 Royal Australian Air Force:

- a. Defence Instructions (Air Force) (DI(AF)) PERS 51-1—*The Function, Objectives and Roles of the Health Services*;
- b. DI(AF) PERS 56-7—*Mosquito Borne Disease Control*;
- c. DI(AF) PERS 57-1—*Aeromedical Evacuation*;
- d. DI(AF) PERS 57-3—*Approvals for Use of Aeromedical Evacuation Equipment*;
- e. DI(AF) PERS 58-5—*Base Aeromedical Services*; and
- f. DI(AF) PERS 59-1—*Operational Health Support*.

GLOSSARY

administration

The management and execution of all military matters not included in tactics and strategy; primarily in the fields of logistics and personnel management.

aeromedical evacuation

The movement of patients under medical supervision to and between medical treatment facilities by air transportation.

aeromedical evacuation control centre

The control facility established in a headquarters by the commander of an air transport organisation, air force, or air command. It operates in conjunction with the command movement control centre and coordinates overall medical requirements with airlift capability. It also assigns medical missions to the appropriate aeromedical evacuation elements in the system and monitors patient movement activities.

aeromedical evacuation coordinating officer

An officer of an originating, intransit or destination medical facility/establishment who coordinates aeromedical activities of the facility/establishment.

aeromedical evacuation operations officer

An officer of the airlift force or command who is responsible for activities relating to planning and directing aeromedical evacuation operations, maintaining liaison with medical airlift activities concerned, operating an aeromedical evacuation control centre, and otherwise coordinating aircraft and patient movements.

aeromedical evacuation system

A system which provides:

- a. control of patient movement by air transport;
- b. specialised medical attendants and equipment for in-flight medical care;
- c. facilities on or in the vicinity of air strips and air bases for the limited medical care of intransit patients entering, en route, via, or leaving the system; and
- d. communication with destination and en route medical facilities concerning patient airlift movements.

aeromedical staging facility

A medical unit operating transient patient beds located on or in the vicinity of an emplaning, or deplaning air base or airstrip that provides reception, administration, processing, ground transportation, feeding and limited medical care for patients entering, transiting through or leaving an aeromedical evacuation system.

appreciation of the situation

A logical process of reasoning by which a commander considers all circumstances affecting the military situation and arrives at a decision as to the course of action to be taken in order to accomplish the mission.

battle casualty

Any casualty incurred as a direct result of hostile action, sustained in combat or relating thereto, or sustained going to or returning from a combat mission.

casualty

Any person who is lost to the organisation by reason of having been declared dead, wounded, injured, diseased, interned, captured, retained, missing, missing in action, beleaguered, besieged or detained.

casualty regulation

The process that directs the casualty to the medical facility best able to cope with the condition in terms of medical speciality required and the availability of treatment capability.

collection agency

In intelligence usage, an organisation or individual engaged in collecting information.

combat zone

1. That area required by combat forces for the conduct of operations.
2. The territory forward of the Army group rear boundary. It is divided into:
 - a. the forward combat zone, comprising the territory forward of the Corps rear boundary; and
 - b. the rear combat zone, usually comprising the territory between the Corps rear boundary and the Army group rear boundary.

communications zone

Rear part of the theatre of operations (behind but contiguous to the combat zone) which contains the lines of communications, establishments for supply and evacuation, and other agencies required for the immediate support and maintenance of the field forces.

direct support

The support provided by a force not attached to, or assigned under a degree of operational authority of the supported force, which may be withdrawn only with the agreement of the supported force or direction of superior authority. Detailed planning and tasking remain with the supporting force's parent command. The support provided is to include the provision of advice, liaison and communications.

forward aeromedical evacuation

The phase of evacuation which provides airlift for casualties between points within the battlefield, from the battlefield to the initial point of treatment, and to subsequent points of treatment within the combat zone (ASCC AIR STD 61/79).

health intelligence

Knowledge resulting from the collection and processing of all available civil and military medical, environmental and biotechnological information, and which is immediately or potentially significant to military planning and operations.

holding policy

The maximum time for which casualties or patients are to be held in deployed medical facilities.

information

In intelligence usage, unprocessed data of every description which may be used in the production of intelligence.

intelligence

The product resulting from the processing of information concerning foreign nations, hostile or potentially hostile forces or elements, or areas of actual or potential operations. The term is also applied to the activity which results in the product and the organisations engaged in such activity.

joint

Connotes activities, operations, organisations, etc in which elements of more than one Service of the same nation participate.

lines of communications

All the land, water and air routes that connect an operating military force with one or more bases of operations, and along which supplies and reinforcements move.

logistics

The science of planning and carrying out the movement and maintenance of forces. In its most comprehensive sense, those aspects of military operations which deal with:

- a. design and development, acquisition, storage, movement, distribution, maintenance, evacuation and disposition of materiel;
- b. movement, evacuation and hospitalisation of personnel;
- c. acquisition or construction, maintenance, operation and disposition of facilities; and
- d. acquisition or furnishing of services.

major fleet units

Vessels defined as major fleet units are aircraft carriers, fleet replenishment vessels, destroyer tenders, guided missile destroyers, guided missile frigates, destroyer escorts, designated training ships, landing ships heavy, and hydrographic and oceanographic research vessels.

minor war vessel

Vessels defined as minor war vessels are mine countermeasures vessels, patrol boats, landing craft heavy, survey motor launches, and craft of opportunity.

noduff

The term used during exercises and training to denote a real incident rather than exercise play.

non-battle casualty

A person who is not a battle casualty, but who is lost to the organisation by reason of disease or injury, including persons dying from disease or injury, or by reason of being missing where the absence does not appear to be voluntary or due to enemy action or to being interned.

operational command

The authority granted to a commander to assign missions or tasks to subordinate commanders, to deploy units, to reassign forces, and to retain or delegate operational and/or tactical control as may be deemed necessary. It does not of itself include responsibility for administration or logistics. May also be used to denote forces assigned to a commander.

operational control

The authority delegated to a commander to direct forces assigned so that the commander may accomplish specific missions or tasks which are usually limited by function, time or location; to deploy units concerned, and to retain or assign tactical control of those units. It does not include authority to assign separate employment of components of the units concerned. Neither does it, of itself, include administrative or logistic control.

single Service management

The process by which one Service accepts the responsibility for supply, engineering and maintenance management, as applicable, of an item of supply, a commodity group or an equipment system in common use by two or more Services on behalf of the others.

strategic aeromedical evacuation

That phase of evacuation which provides airlift for patients out of the area of operations.

support area(s)

Those areas which contain concentrations of manpower, industrial potential and sources of food and raw materials.

tactical aeromedical evacuation

That phase of evacuation which provides airlift for patients within the area of operations.

tactical control

The detailed and usually local direction and control of movements or manoeuvres necessary to accomplish missions or tasks assigned.

technical control

The specialised or professional guidance and direction exercised by an authority in technical matters.

triage

The evaluation and classification of casualties for purposes of treatment and evacuation. It consists of the immediate sorting of patients according to type and seriousness of injury, likelihood of survival, and the establishment of priority for treatment and evacuation to assure medical care of the greatest benefit to the largest number.

ACRONYMS AND ABBREVIATIONS

ACAUST	Air Commander Australia
ADIZ	air defence identification zone
ADFP	Australian Defence Force Publication
ADHQ	Australian Defence Headquarters
AECC	aeromedical evacuation control centre
AECO	aeromedical evacuation coordinating officer
AEOO	aeromedical evacuation operations officer
AES	aeromedical evacuation system
AS	Australian Services
ASAP	as soon as possible
ASP	Australian Service plan
AME	aeromedical evacuation
AMF	afloat medical facility
AMO	air movements officer
AO	area of operations
APG	administrative planning group
APM	ANZUS Planning Manual
ARCBTS	Australian Red Cross Blood Transfusion Service
ASC	Australian Contingent (used in a United Nations context)
ASDEST	Australian space debris emergency search
ASCRP	Australian Service Contingent Reconnaissance Party
ASF	aeromedical evacuation staging facility
ATH	air transportable hospital
ATHC	air transportable health centre
ATOC	air transport operations centre
BASB	brigade administrative support battalion
BCas	battle casualty
BDS	battle dressing station
bn	battalion
CA	concentration area
cas	casualty
casevac	casualty evacuation
CASSITREP	casualty situation report
CCP	casualty collection post
CISM	critical incident stress management
CJFHS	Commander Joint Forces Health Services
CMONSC	Command Medical Officer Naval Support Command
COMAST	Commander Australian Theatre
COMNORCOM	Commander Northern Command
COOP	craft of opportunity
coy	company
CSR	combat stress reaction
CSS	combat support squadron
CSSD	central sterile supply department
CSW	combat support wing
CT	counter-terrorist
commZ	communications zone
CZ	combat zone
DACC	Defence assistance to the civil community
DFACP	Defence Force aid to the civil power
DIO	Defence Intelligence Organisation
DMF	destination medical facility
DTG	date time group
DZ	drop zone/dropping zone

elm	element
EOS	emergency operating station
EMA	Emergency Management Australia
en	enemy
EPW	enemy prisoners of war
FAP	first aid post
FAST	fly away surgical team
fd amb	field ambulance
fd hosp	field hospital
FGH	forward general hospital
FIRST	field integrated resuscitation and surgical team
FMS	field medical station
FOB	forward operating base
FSB	forward support base
FST	forward surgical team
fw	fixed wing
fwd	forward
HBV	hepatitis B virus
HCV	hepatitis C virus
HEALTHINTREP	health intelligence report
HI	health intelligence
HIV	human immunodeficiency virus
HQ	headquarters
HQAC	Headquarters Air Command
HQAST	Headquarters Australian Theatre
HQNORCOM	Headquarters Northern Command
HQSO	Headquarters Special Operations
HSF	Health Services Flight
ICRC	International Committee of the Red Cross
IHL	international humanitarian law
IMF	intransit medical facility
IPG	Immediate Planning Group
IWS	initial wound surgery
JAPG	joint administrative planning group
JFAO	joint force area of operations
JFAOC	joint force air operations centre
JFC	Joint Force Commander
JFHA	joint force health adviser
JFHQ	joint force headquarters
JHQ	joint headquarters
JLS	joint logistics staff
JOP	joint operational plan
JPAS	joint personnel and administrative staff
KIA	killed in action
LCAUST	Land Commander Australia
LHQ	Land Headquarters
LOAC	laws of armed conflict
loc	location
LofC	lines of communication
LPA	amphibious transport
LZ	landing zone

MCAUST	Maritime Commander Australia
mech fd amb	mechanised field ambulance
medasst	medical assistant
Med Coy	medical company
MEDSITREP	medical situation report
MEDSPOTREP	medical spot report
MEZ	maritime exclusion zone
MFU	major fleet unit
MHQ	Maritime Headquarters
MIA	missing in action
MO	medical officer
MSST	maritime surgical support team
MWV	minor war vessel
NBC	nuclear, biological and chemical
NBCas	non battle casualty
NO	nursing officer
NOK	next of kin
NORCOM	Northern Command
OMF	originating medical facility
pax	passengers
PCRf	primary casualty reception facility
PMF	port medical facility
PST	parachute surgical team
PTI	physical training instructor
PW	prisoner of war
RAAF	Royal Australian Air Force
RAAFSR	RAAF specialist reserve
RAEME	Royal Australian Electrical and Mechanical Engineers
RAN	Royal Australian Navy
RAP	regimental aid post
RMO	regimental medical officer
RW	rotary wing
SAE	Services assisted evacuation
SAR	search and rescue
SDENTO	senior dental officer
SGADF	Surgeon General Australian Defence Force
SHO HQAC	Senior Health Officer Headquarters Air Command
SHO	senior health officer
SME	squadron medical element
SMET	ship's medical emergency team
SMO	senior medical officer
SMT	stress management team
SOP	standing operating procedure
SPE	Services protected evacuation
SSLM	single Service logistics management
STUFT	ship taken up from trade
SU	support unit
TAOC	tactical air operations centre
TAC	Tactical Air Command
TACP	tactical air control party
THPG	theatre health planning group
UN	United Nations
WIA	wounded in action
XP	exchange point