

NATO STANDARD

AMedP-1.10

**MEDICAL ASPECTS
IN THE MANAGEMENT
OF A MAJOR INCIDENT/
MASS CASUALTY SITUATION**

Edition B, version 1

OCTOBER 2021



NORTH ATLANTIC TREATY ORGANIZATION

ALLIED MEDICAL PUBLICATION

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NATO STANDARDIZATION OFFICE (NSO)

NATO LETTER OF PROMULGATION

12 October 2021

1. The enclosed Allied Medical Publication AMedP-1.10, Edition B, Version 1, MEDICAL ASPECTS IN THE MANAGEMENT OF A MAJOR INCIDENT/MASS CASUALTY SITUATION, which has been approved by the nations in the Military Committee Medical Standardization Board, is promulgated herewith. The agreement of nations to use this publication is recorded in STANAG 2879.
2. AMedP-1.10, Edition B, Version 1, is effective upon receipt and supersedes AMedP-1.10, Edition A, Version 1, which shall be destroyed in accordance with the local procedure for the destruction of documents.
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Director, NATO Standardization Office

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RECORD OF SPECIFIC RESERVATIONS

[nation]	[detail of reservation]
FRA	<p>Paragraph 1.3.4: In France, the SMO/MIO establishes the mismatch between the management capabilities and the number of casualties and notifies the MEDDIR. France's approach is that only the MEDDIR confirms this discrepancy regarding available medical capabilities (human and materiel) and declares the MASCAL situation.</p> <p>Paragraph 2.5.1: The Military Health Service's doctrine provides for the medicalization of CBRN casualties before complete decontamination. It enables, in particular, after triage of the casualties and once life-saving first aid has been applied, to preserve the patients' vital functions.</p>
GBR	<p>Reservation 1: the UK will use other modern triage tools (for example MTTP-24) where they have been adopted based on evidence. It is recommended that NATO considers the use of other triage tools.</p> <p>Reservation 2: the UK identifies that AMedP-1.10 does not provide comprehensive guidance for MASCAL scenarios of a significant scale (very high casualty numbers for an enduring period). It is recommended that NATO develops guidance for this scenario.</p> <p>Reservation 3: the UK notes that this AMedP does not fully align with CBRN Major Incident guidelines. It is recommended that NATO seeks to align all guidelines to the all-hazards approach.</p>
HUN	<p>In the HUN TRIAGE cards/casualty tags the designation of T3 category in English is DELAYED (instead of MINIMAL).</p> <p>The color code is the same: green.</p>
USA	<p>1. Paragraphs 5.a-e: The USA military triage categories are: Minimal, Immediate, Delayed, and Expectant. There is no triage category for "Dead" since the purpose of triage is to prioritize casualties for treatment and evacuation.</p> <p>Decedents do not require treatment or medical evacuation. The NATO definition for triage is: "The evaluation and classification of wounded for purposes of treatment and evacuation. It consists of the immediate sorting of patients according to type and seriousness of injury, and likelihood of survival, and the establishment of priority for treatment and evacuation to assure medical care of the greatest benefit to the largest number."</p>

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CHAPTER 1 INTRODUCTION

1.1. PRELIMINARY

The aim of this AMedP-1.10 is to standardize the principles of the medical contribution to the management of a Major Incident or of a Mass Casualty (MASCAL) situation.

Participating nations agree:

1. To employ medical principles applicable to Major Incidents/MASCAL situations.
2. To prepare preparatory medical plans for Major Incidents/MASCAL situations, regularly carry out exercises and provide sufficient manpower and supplies (Ref STANAG 2228 – AJP-4.10(C)).
3. That Major Incident/MASCAL situations are demanding tasks to be dealt with by the Medical/Health Services personnel and/or staff. A joint approach under the responsibility of the respective commander is required to manage the event successfully.
4. That medical and other military personnel should be trained in military acute trauma care and first aid prior to employment in military operations (Ref STANAG 2544 – AMedP-8.12).
5. That providing appropriate and sufficient medical and military capabilities lies within national responsibility.

1.2. DEFINITIONS

The following terms and definitions are used for the purpose of this agreement:

1. **Major Incident:** From a medical point of view, a Major Incident is a critical incident where the number, severity, or type of medical cases to treat, or its location, requires extraordinary resources and procedures.¹
2. **MASCAL situation:** A MASCAL situation is a MI, overwhelming the available medical capabilities and/or capacities despite the employment of extraordinary measures.¹

The latter applies for any number of casualties produced in a relatively short period of time which overwhelms the available medical and logistic support capabilities.

¹ ¹ MI is declared 'bottom up' (for example from the ground) while a MASCAL is declared 'top down' by the Theatre Medical Commander.

3. **EMERGENCY MEDICAL CARE:** Emergency medical care encompasses the critical actions for timely evaluation, resuscitation, stabilization, treatment and transportation of an emergency patient to prevent a loss of life, limb, function and body tissue or to undue suffering. Pre-hospital emergency care is delivered from the point of injury/insult to admission in a secondary health care facility, where critical care and specialist treatment (including surgery) can be provided.

1.3. GENERAL

1. In a Major Incident/MASCAL situation a coordinated response of all staffs and agencies (including civilian resources) involved is required, and management of a Major Incident/MASCAL situation is a Commander's responsibility. Any Major Incident/MASCAL situation should have the total focus of the commander, especially in a humanitarian and disaster response situation and/or medical stability operation.²
2. It is essential that the same principles with respect to the response to the incident apply in both cases with the exception that the categorization as T4 (details given in Para. 2.4 (5)) is implemented in MASCAL situations only. The use of triage category T4 can only be authorised by the Commander or Medical Adviser or Medical Director (MEDAD/MEDDIR). Hence, in a MASCAL situation the principles of treatment at the onset of the medical response may change from one based on the individual needs of each patient to the greatest good for the greatest number.
3. The standardization of principles concerning preparatory planning, personnel training, gear interoperability, categorization, treatment, and evacuation of patients will help considerably in ensuring inter-allied and mutual assistance.
4. If the medical/health service anticipates increased numbers of casualties are likely to exceed the planned medical capability deployed to support the incident, the senior medical officer (SMO) may declare a MASCAL situation. The Joint Operations Centre (JOC) is to inform all personnel that a MASCAL situation has been declared. As referred in AJP-4.10(C) the Patient Evacuation Coordination Cell (PECC) - if implemented - is collocated with or integrated in the Ops-Centre (Tactical Operations Centre (TOC), Joint Operations Centre (JOC) or Combined Joint Operations Centre (CJOC) and is likely to have the best overview of available medical capabilities and hospital capacity. Therefore the coordination of the medical evacuation is a responsibility of the PECC.
5. Medical assets and resources may be re-prioritised to support the MASCAL response which may be initiated via the PECC. The lead for the response may, if appropriate, fall within the C4 of other higher formations or subordinate

² May not be applicable in the SOF setting.

formations/echelons, etc. Early liaison and co-ordination with the CJOC, JOC, TOC at the start of all planning process is essential.

6. Force Protection (FP) measures and other support operations, e.g. air support and Explosive Ordnance Disposal (EOD) and chemical, biological, radiological and nuclear (CBRN) incidents require a rapid, efficient and coordinated response to Major Incident/MASCAL situations.

7. A Major Incident/MASCAL situation required medical material high in quantity but low in diversity.

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CHAPTER 2 DETAILS OF THE AGREEMENT
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2.1. PREPARATORY PLANNING

Plans for Major Incidents/MASCAL situations should be available to all units. Planning should be updated and practiced on a regular basis. Preparation and planning should at least include:

1. Assessment of hazards and risk: Hazards can be classified as military hazards, environmental hazards or a combination of both. Areas of Operations (AOO) are generally characterized by very different existing and potential hazards, including deposits of CBRN agents. Further, specific regions within an AOO can present themselves with higher risks for the same hazards/threats. When, as part of the situation assessment, high-risk regions have been identified, these findings must be taken into account in the overall planning including plans for the event of a Major Incident/MASCAL situation. This includes release of Toxic Industrial Materials (TIM).
2. Identification of resources:
 - a. Available resources: Agencies involved at the scene of a Major Incident/MASCAL situation across the spectrum of operational environments, e.g. IO (International Organisations), NGO (Non-governmental Organisations) and mainly GO (Governmental Organisations) such as military, police, fire fighters and civilian rescue services.
 - b. Equipment needs (personnel/medical): The scale and scope of a medical logistics system will be dependent on the situation. The following will need to be considered:
 - personnel available in the event of a Major Incident/MASCAL situation,
 - familiarity of the deployed unit with its Areas Of Responsibility (AOR) and the measures to be taken when handling Major Incident/MASCAL situation,
 - the formation of Mobile Medical Teams (MMT) and cooperation with a Quick Reaction Force (QRF),
 - the identification and appointment of appropriate key medical personnel, e.g. Medical Incident Officer (MIO), Medical Coordination

Officer (MCO), Triage Officer, Patient Coordination Officer (PCO), and Ambulance Loading Officer (AmbLO),

- pre-establish required medical equipment including medical supplies and resupplies.

c. Evacuation assets

Planned support from other units, including possible Medical Evacuation (MedEvac) and non-medical Casualty Evacuation (CASEVAC) and possible landing sites nearby/in a contaminated and non-contaminated environment.

When planning and executing a Major Incident/MASCAL response threats such as topography and capacity are to be considered.

Isolation capacity and procedures for both quarantine and transportation assets should be foreseen in case of CBRN incidents (infectious agents).

Air transport and ground vehicle transport equipment should be considered contaminated once they have entered the CBRN contamination zone. Appropriate decontamination procedures will be required.

For further information on transportation of CBRN casualties refer to AMedP-7.1 Chapter 15.

d. Re-supply

Transportation used for evacuation could be involved in the re-supply throughout the ongoing Major Incident/MASCAL situation.

3. Responsibilities:

At the scene of a Major Incident/MASCAL situation, there can be a large spectrum of operational environments with many agencies involved.

4. Command and Control (C2) structure:

Deployed organizational structure of the Medical Services and of other staffs and agencies (incl. civilian resources) involved.

5. Communications
 - a. Methods of communication
 - b. Equipment needs including backup systems
 - c. Principles of information exchange procedures, i.e.
 - Declaration of MASCAL situation must be clearly understandable.
 - PACE plan formulation (Primary, Alternate, Contingency, Emergency).
 - 9-LINE in case of MedEvac.
 - METHANE (My call sign, exact location of the incident, Time/type of incident, Hazards in the area, Approach routes/landings sites, Number, nationality and type of casualties, Expected response) request.
6. Organizational aspects
 - a. Management
 - First on Scene
 - Allocation of medical and non-medical assets on the scene
 - Transport and evacuation
 - Medical treatment facilities, e.g. hospitals, clinics
 - b. Levels of Command³
7. Principles of medical management (including Triage)
8. Practical application/exercise
 - a. Identification of and coordination with role players

³ Depending on the situation, corps, division, brigade, battlegroup or unit commanders may operate at either the operational or tactical level. It should be noted that the levels, if they are recognized at all, may be interpreted or applied differently, depending on the situation, by multinational partners and other government departments.

- b. Harmonization with and integration in Standing Operating Procedures (SOP)
- c. Lessons identified and lessons learned.

2.2. TRAINING

1. All military personnel must be trained in first-aid (Ref STANAG 2122). Military Acute Trauma Care should be made available to medical personnel and other military personnel who may take part in operations (Ref STANAG 2544). Medical personnel must be fully conversant on the principles of triage. All medical personnel must also be fully trained in their role within the Medical Unit's Major Incident/MASCAL situation plan.

2. All units should regularly carry out exercises and reviews of their Major Incident/MASCAL situation response plans and procedures. Exercises should be conducted soon after a unit starts its tour of duty and after any significant change in personnel. Before conducting large scale exercises it should be emphasized that personnel are fully conversant with the plans and procedures within those plans, e.g. triage, decontamination, security aspects, etc.

2.3. PRINCIPLES OF MANAGEMENT

1. General

- a. Major Incidents/MASCAL situations, by their nature, are unpredictable. The principles of the functions displayed here represent an ideal management C2 structure. In the real scenario the functions must be assumed by the first personnel arriving at the scene. Full operational ability, depending on the size and the nature of the incident, will be established later.
- b. To manage a Major Incident/MASCAL situation, the following functions have to be in place (CCSCATTTER):
 - Command and Control (C2)
 - Safety
 - Communication
 - Assess
 - Triage

- Treatment
- Transport / Evacuation
- Decontamination (if applicable)
- Exploit
- Recover

2. Command and Control (C2)

Command is vertical within a single service or agency. Control is horizontal across all the services and agencies responding to the scene. The Incident Commander (IC) has the command at the scene. In incidents with military primacy the operations commander (OC) has the overall command. In other incidents, the military may be lending assistance to Host Nation services. Therefore coordination should be made through their command and control construct.

The JOC, CJOC or TOC will have C2 primacy of the MI/MASCAL situation in order to provide the maximum support and output to the incident; the MEDAD/MEDDIR or empowered representative will provide SME input during a MI/MASCAL situation where required.

3. Medical Command and Control

The Medical Incident Officer (MIO) is responsible for coordination with the IC at the site. The MIO has the local on-site command and control of medical operations. Prior to their arrival on the scene, their tasks are generally assumed by the first physician to arrive at the scene. The MIO is responsible for coordination with the IC at the site including the installation of the medical support area, the layout of the triage point, the number, location and nature of areas of treatment, and the evacuation area. The MIO also leads the triage or delegates this important task to an experienced physician or medical department officer.

The Medical Coordination Officer (MCO) is an experienced medical department officer or an experienced rescue medic (senior non-commissioned officer (NCO)). They are responsible at the Tactical Command Post (TCP) for implementing the MIO's assessments and instructions. The MCO maintains continuous contact with the MIO.

4. Safety

Safety is defined as ensuring that the scene is safe by liaison of the IC with Force Protection/Police, EOD, Engineer, and Fire Support if available. The safety assessment must encompass all aspects of the scene incl. extraction of patients. The MIO liaises with the IC for medical purposes.

5. Communication

Secure and restricted communication, both at the scene and from the scene to responsible patient evacuation coordination cells and command posts (always including PECC, TOC) and medical facilities, is crucial to achieve the optimal response. Poor communication is the most common failure identified when the response to Major Incidents/MASCAL situation is reviewed. It is essential that only appropriate, timely and precise information is passed, and dedicated communication links must be established early.

There is a requirement to generate an incident log for the recording of actions.

6. Assess

Assessment is a continual cyclical process for all commanders, who need to assess the on-going situation and determine what resources and actions are required. Assessment must include current and emerging hazards, numbers of casualties, where to obtain additional resources and the possibility of evacuation.

7. Triage

Determining the priority for initial and further treatment or medical evacuation of casualties after a primary survey. This is a dynamic and repeated process. Details on triage are given in Para. 2.4 – “categorization”.

8. Treatment

Treatment is aimed at providing sufficient care to allow the largest number of casualties to arrive to a Medical Treatment Facility (MTF) safely and in as stable a condition as possible. It must therefore be aimed at standard treatment priorities.

9. Transport/Evacuation

Medical Evacuation is the medical contribution to the coordination and conduct of transport of casualties to available MTF. Transport and evacuation means are required for moving casualties from the scene and bringing personnel and equipment to the scene. In principle, all modes of transport (incl. CASEVAC) can be considered dependent on the tactical situation. If the operational and tactical situation allows, a dedicated air transport to the MTF is essential in a MASCAL situation to evenly distribute the workload.

Evacuation of casualties is coordinated by the Patient Coordination Officer (PCO). Ideally the PCO is an experienced medical department officer or an experienced rescue medic (senior NCO) who acts as instructed by persons authorized by the MIO. They are responsible for establishing and maintaining contact between the casualty control process on site and the PECC. The latter decides on the target treatment facilities and the medical evacuation assets required for the casualties. Clear and timely information is decisive in this context. The PCO, who coordinates the evacuation

process, must receive at regular intervals an up-to-date list of the number, category and required special medical treatment of the casualties to be evacuated.

The evacuation coordination area is under the leadership of the Patient Coordination Officer (PCO). The AmbLO is an experienced medical officer or an experienced rescue medic (senior NCO).

10. Exploit

Exploit is the collection and retention of evidence including medical evidence to allow the chain of command to exploit the response of incident.⁴

11. Recover

Recover is the restoration of the response system to the pre-incident state plus the immediate after-action analysis to learn lessons from the incident.

2.4. CATEGORIZATION

1. In any incident involving multiple casualties a process of triage with priorities for treatment and/or transport is needed. Triage is a dynamic process and could take place several times for each casualty. Many factors affect the decision for categorization, and a significant alteration in one of them may allow the patient's category to be altered. The overall situation must be kept under review at all times.

2. Triage should be directed by the best qualified medical personnel available, preferably a medical officer experienced in emergency medicine. In general, the first member of the medical team at the scene will be in charge of triage until additional, more qualified personnel arrive. A colour scheme to identify the triage categories should be in use, to make it easy for the rescue personnel to identify the casualties (Ref Para. 2.4.6).

3. A casualty tag bearing all necessary information, including individual casualty identification number, personal data and findings, diagnoses, triage outcome, required medical treatment and mode of transportation, is applied to all patients prior to transport. Casualty tags may include a colour scheme to define the triage category.

4. Consequently, patients should be separated into 3 streams for further treatment: those at T1/2 for immediate/urgent treatment, those at T3 for minimal treatment and those at T4 for supportive care being separated into different assigned areas.

5. The following triage priorities are to be used for treatment in a Major Incident/MASCAL situation, but it has to be re-emphasized that the use of the triage

⁴ Exploit includes retention of Individual Protective Equipment (IPE) to inform IPE development, detection and retention of evidence of CBRN agent use etc.

category T4 during a MASCAL situation can only be authorized by the commander or MEDAD/MEDDIR.

- a. Immediate Treatment Group (T1)
T1 consists of those requiring immediate life-saving interventions. One of the principles triaging patients as T1 is that they may be converted into T2 with appropriate temporary intervention(s).
- b. Urgent Treatment Group (T2)
T2 consists of those in need of stabilizing treatment, but whose general condition permits delay in surgical or other special medical treatment without unduly endangering life.
- c. Minimal Treatment Group (T3)
T3 consists of those with relatively minor injuries who can effectively care for themselves or who can be helped by first-aid trained personnel.
- d. Expectant Treatment Group (T4)
T4 consists of those who are expected to die given the circumstances of the Major Incident/MASCAL. They will receive appropriate supportive treatment and palliative care.
- e. Dead
Those who are declared dead by a medical professional or with non-survivable injuries and no vital signs.

6. In a multinational Major Incident/MASCAL situation the following colour coding should be in use; T1 Red, T2 Yellow, T3 Green, T4 Blue/White and DEAD White/Black. Further details on triage categories can be found in the Allied Joint Medical Support Doctrine (AJP 4.10(C)).

2.5. SPECIAL PROBLEMS OF CBRN OPERATIONS

1. General

MASCAL situations may occur under CBRN conditions, or perceived CBRN threats, additional problems are superimposed, particularly contamination and/or irradiation of casualties. The initial MMT must be prepared to triage, decontaminate or isolate casualties and, if necessary, apply life-saving first aid. Appropriate protective gear must be available for MMT and casualties. The decontamination process being completed, teams in a “clean” area are to continue the dynamic process of triage and provide treatment prior to transport. For further details refer to STANAG 2461.

2. Radiation/Nuclear

It will not be possible at the time of triage to predict which casualties with thermal or blast injuries will develop radiation sickness. It will not always be possible to determine the dosage of irradiation received by the casualty. Clinical symptoms may suggest that the casualty has received a significant dose, latency has to be considered. Treatment of burns, fractures, blast injuries, shock and radiation units should be taken into account. Treatment of life-threatening conditions has priority over decontamination. The principles of limited time, increasing distance and shielding from the radiation source apply.

3. Biological

The control of epidemics will be of paramount importance under biological conditions. Availability of prophylaxis and treatment, and the importance of good field hygiene are to be considered. Restriction of movement maybe necessary to prevent spreading infectious diseases.

4. Chemical

There will be a need to consider the individual protection of medical personnel and of patients, and to provide collective protection facilities in which patients may be transported and treated. Proportionate decontamination strategies will be necessary, time-consuming and imposing high demands on manpower.

5. Treatment under CBRN conditions

The recommendations of STANAG 2358 are employed to provide optimum care including airway involvement, eye involvement, and skin involvement.

6. Handling and controlling CBRN incidents may be very time-consuming and units should be prepared for possible long term interventions.

2.6. PRINCIPLES OF TRANSPORTATION/MEDICAL EVACUATION

1. Of particular importance is the time, which will elapse before patients receive emergency treatment. Time is critical in the context of categorizing patients as T1. After initial emergency medical or surgical treatment, most T1 cases will be re-categorized. To the rear of the first medical facility, Evacuation priority for T2 cases is, amongst others, dependent on site, time, distance and available means of transportation. In the case of ongoing threats (e.g. hot zone) there will be limited responders allowed within. There will be delays in getting stretchers to the casualties and delays in removing potentially large numbers of casualties.

2. T3 and T4 cases have lower priority for evacuation and should not block the evacuation chain. They can be transported by any appropriate means of transport to the most distant hospitals, saving medical transportation for T1 or T2 casualties. In the interest of economy, available spaces on ambulances or other means of transportation may be filled up with sitting patients of any category in order to relieve pressure on forward medical resources.

3. Ideally, the availability of MedEvac assets must be considered in every operation. In a MI/MASCAL, coordination between the PECC and subordinate units are imperative IOT deploy MedEvac and CASEVAC assets to support MI/MASCAL. Units must understand the risk of deploying their own transportation when required.

As for aeromedical evacuation, the agreements of STANAG 2087 and STANAG 3204 apply.

2.7. MEDICAL SUPPLIES

Stocks of material will be rapidly used up in MASCAL situations. Medical commanders must therefore organize careful control of critical items. Normal re-supply procedures may be too lengthy in such situations. It is therefore essential that nations establish and maintain the capability for providing essential medical materiel for use in an emergency situation involving Major Incident/MASCAL situations. It is advisory to plan and prepare the transport of medical material with means of evacuation returning to the site of the event to evacuate more patients.

2.8. GENERAL SUPPLIES

Nations should prepare contingency plans for the provision of general equipment, not of medical origin, which would be required by the medical services responsible for the care of casualties in a Major Incident/MASCAL situation, e.g. means of ground and air transport, stretchers, blankets, shelters/tents, etc.

ANNEX A RELATED DOCUMENTS

MC 0326/4 - NATO Principles and Policies of Medical Support

STANAG 2228 - Allied Joint Doctrine for Medical Support– AJP-4.10(C)

STANAG 2087 – Forward Aeromedical Evacuation – AAMedP-1.5

STANAG 2122 – Requirement for Training in Casualty Care and Basic Hygiene for all Military Personnel AMedP-8.15

STANAG 2358 – CBRN First Aid Handbook – AMedP-7.2

STANAG 2461 – The Medical Management of CBRN Casualties – AMedP-7.1

STANAG 2542 - Allied Joint Medical Planning Doctrine AJMedP-1

STANAG 2544 - Requirements for Military Acute Trauma Care Training – AMedP-8.12

STANAG 2546 - Allied Joint Medical Doctrine for Medical Evacuation – AJMedP-2

STANAG 3204 - Aeromedical Evacuation – AAMedP-1.1

STANAG 7179 - Planning Guidelines for Fire and Emergency Services Response to Major Fire and Emergency Incidents

ACO DIR 83-1 - Medical Support to Operations

ACO DIR 80-25 - ACO Force Protection

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ANNEX B ABBREVIATIONS

A

AmbLO ambulance loading officer
AOO area of operations

C

C2 Command and Control
C4 Command, Control, Communication and Computers
CASEVAC Casualty Evacuation
CBRN Chemical, Biological, Radiological and Nuclear
CJOC Combined Joint Operations Center

E

EOD Explosive Ordnance Disposal

G

GO Governmental Organisation

I

IC Incident Commander
IO International Organisation

J

JOC Joint Operations Centre

M

MASCAL Mass Casualty
MCO Medical Coordination Officer
MEDEVAC Medical Evacuation
MIO Medical Incident Officer
MMT Mobile Medical Team
MTF Medical Treatment Facility

N

NCO Non-Commissioned Officer
NGO Non-Governmental Organisation

O

OC Operational Commander

P

PCO Patient Coordination Officer
PECC Patient Evacuation Coordination Center
PZ Pick-up Zone

Q

QRF Quick reaction force

S

SMO Senior Medical Officer
SOP Standing Operating Procedures

T

TCCC Tactical Combat Casualty Care
TCP Tactical Command Post
TOC Tactical Operations Centre

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