

# Tracking Afghanistan VSI/SI Operational Casualties: 8 October 2007 to 30 September 2012

31 January 2013

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## INTRODUCTION

1. This report produces statistical information on patients that were very seriously injured (VSI) or seriously injured (SI) on Operation HERRICK (Afghanistan) between 8 October 2007 (Start of the Defence Patient Tracking System) and 30 September 2012 (latest information available) as listed on the initial Notification of Casualties (NOTICAS) signal. It complements and expands upon the monthly publication of operational casualty and fatality statistics which include counts of Service personnel VSI or SI.
2. This report **does not** include patients that were very seriously ill or seriously ill on Operation HERRICK (Afghanistan) between 8 October 2007 and 30 September 2012 as listed on the initial Notification of Casualties (NOTICAS) signal.
3. This report has been provided in response to the increasing number of requests for information about injured UK Service Personnel. The requests vary from requesting more detail on the injuries sustained to understanding the long-term outcome of those injured.
4. The MOD are committed to making information on Operational Casualties public but have to draw a line between how much information is provided regularly in the public domain and information which compromise operational security of UK Armed Forces Personnel or which risks breaching an individual's right to medical confidentiality. This report along with the quarterly release of the Afghanistan and Iraq Amputation Statistics is supporting the MOD's commitment to release information wherever possible.
5. The findings in this report first focus on the casualty care pathway in theatre in Afghanistan, including admittance to the field hospital, the length of time in the field hospital, how many died of wounds/died as a result of their injuries from non enemy action in the field hospital and how many were aeromedically evacuated to the UK. The report then presents information on the casualty care pathway once they have been returned to the UK. This includes:
  - Where they were initially admitted on return to the UK and the length of time at that first location.
  - If the patient died of wounds/died as a result of their injuries from non enemy action and where they died.
  - Medical locations where the casualties received further specialist treatment.
  - The number of VSI/SI casualties that were amputees.
  - The number of pathways closed and the overall length of the care pathway from initial injury to the date the care pathway was closed (or the date of download from the Defence Patient Tracking System (DPTS) for open pathways).
  - The number of casualties that return to medically fully deployable or medically limited deployable status.
  - The number of casualties who have been discharged from Service.
  - The number of casualties who have been medically discharged from Service.
  - The number of casualties who have registered a claim for compensation and who have been awarded compensation under the Armed Forces and Reserve Forces Compensation Scheme (AFCS).

6. This report **does not** include detailed information on the casualty care pathway for those VSI or SI in Afghanistan on Op HERRICK or Op VERITAS between 7 October 2001 (start of Operations in Afghanistan) and 7 October 2007. This is because this time period predates the set-up of the Defence Patient Tracking System (DPTS) on 8 October 2007. The DPTS was set up to monitor the progress of Armed Forces patients undergoing specialist treatment, to ensure that their care is delivered promptly and coherently, and to coordinate clinical, administrative and welfare aspects of their support. The DPTS was set up as previously this information was not stored centrally and could only be accessed through individual medical records. However, it has been possible for this group of patients to provide some information presented in the final section of this report:
- The number of casualties by NOTICAS listing (VSI or SI).
  - The number of casualties who died of their wounds/died as a result of their injuries from non enemy action.
  - The number of casualties who have been discharged from Service.
  - The number of casualties who have been medically discharged from Service.
  - The number of casualties that return to medically fully deployable or medically limited deployable status.

#### KEY POINTS

7. Between 8 October 2007 and 30 September 2012 there were 547<sup>a</sup> casualties with an initial NOTICAS classification of VSI or SI on Operation HERRICK (294 were VSI, 253 were SI); 512 (94%) of these were the result of hostile action and 35 (6%) were the result of operational accidents. As at 4 December 2012<sup>b</sup>, 49 had died of wounds (48 VSI, one SI), three had died as a result of their injuries from non enemy action (all VSI) and 495<sup>c</sup> casualties had survived their injuries.
8. Of the 547 casualties with an initial NOTICAS classification of VSI or SI on Operation HERRICK between 8 October 2007 and 30 September 2012, 546 were admitted to a field hospital in Afghanistan; one casualty died of their injuries sustained while on decompression training in Cyprus and therefore was not admitted to a field hospital in Afghanistan. The length of stay at the field hospital for the 546 casualties varied between less than a day to seven days, with an average (median) length of stay of one day. Seven patients were discharged from the field hospital and returned to unit in theatre, of which one later returned to the UK on a routine flight to receive treatment. 26 patients died in the field hospital (25 died of wounds, one died as a result of their injuries from non enemy action). The remaining 513 casualties were aeromedically evacuated to the UK for treatment (one of these was initially aeromedically evacuated to the American Hospital in Landstuhl, Germany).
9. As the main receiving unit for military casualties evacuated from an Operational theatre, the Royal Centre for Defence Medicine (RCDM) received 509 of the 513 casualties in the UK (one casualty was treated in Germany initially and upon returning to the UK was then treated at the RCDM). Two patients were returned to their unit to be treated at Primary Health Care, one patient returned to their unit to be treated at Primary Health Care before treatment at a NHS (Independent Sector) hospital and one patient went straight to the Defence Medical Rehabilitation Centre (DMRC).
10. Of the 509 casualties received by RCDM (508 aeromed directly to RCDM and one received by RCDM via Germany): 24 died while receiving treatment in their first inpatient episode (23 died of wounds, one died as a result of their injuries from non enemy action) and 485 survived their first episode at RCDM. Of the 485 casualties who survived their first episode at RCDM: 475 have gone on to either receive further treatment at RCDM or to receive treatment at other specialist care locations; nine completed their first episode at RCDM before returning to unit and having their care pathway closed with no further specialist care required; one went on to receive further treatment at RCDM and DMRC but subsequently died of wounds at home, a year after their initial injury.
11. Of the 495<sup>d</sup> personnel who survived their injuries, 199 (40%) were identified as amputees at 31 December 2012 (the latest amputations data available), 197 (99%) of which were the result of hostile action, two (1%) were the result of operational accidents.

<sup>a</sup> One patient had two separate VSI/SI incidences and therefore has been counted twice in this report totalling 547 personnel.

<sup>b</sup> 4 December 2012 is the date of the data extract from the Defence Patient Tracking System (DPTS) and is used frequently throughout this report.

<sup>c</sup> One patient, who was SI in 2009/10, survived and was returned to duty but later died in an unconnected incident, thus is counted throughout this report as having survived their operational injury.

<sup>d</sup> 547 less the 27 who died in theatre (26 in a field hospital in Afghanistan, one in Cyprus) and the 25 who died in the UK (24 at RCDM, one at home) as at 4 December 2012.

12. As at 4 December 2012, 280 (57%) of the 495 casualties who survived their injuries had closed care pathways, indicating that no further specialist care was required.
13. 34<sup>e</sup> of the 274<sup>e</sup> patients who returned to the UK for treatment in specialist care and survived their injuries with closed pathways had subsequently redeployed on Operation HERRICK and/or Operation TELIC after their care pathway closure date.
14. As at 1 December 2012 (the latest strength data available), 127 (45%) of the 280 personnel who survived their injuries with a closed pathway were no longer in Service. The remaining 368 (153 with closed pathways, 215 with open pathways) remain in Service. Of the 127 no longer in Service:
  - 69 had a closed pathway in the DPTS indicating that no further specialist care was required and had then been discharged from Service.
  - 57 had a closed pathway in the DPTS as a result of leaving Service.
  - One personnel had a closed pathway in the DPTS and was returned to duty after recovering from his injuries then later died in an unconnected incident.
15. As at 31 March 2012 (the latest data for which medical discharge date are available), 50 (39%) of the 127 VSI and SI patients that were no longer in Service had been discharged from Service due to medical grounds. It should be noted that the principal condition leading to discharge may not be related to the VSI/SI injury sustained.
16. As at 1 December 2012 (the latest strength data available), the latest Medical Deployability Standard (MDS) recorded, for the 153 personnel who were still in Service with a closed pathway;
  - 65 were medically full deployable (MFD)
  - 18 were medically limited deployable (MLD)
  - 59 were medically non deployable (MND)
  - 11 had no MDS recorded after their injury in their medical record on the Defence Medical Information Capability Programme (DMICP)
17. As at 30 September 2012, 465 (85%) of the 547 casualties had claimed for compensation under the Armed Forces Compensation Scheme (AFCS). This resulted in a total of 696 claims, which includes multiple and/or additional claims for some individuals. Of the 547 casualties, 52 subsequently died as a result of their injuries and as a result there have been 17 survivors claims<sup>f</sup> registered under the AFCS for these deaths. Currently individuals have up to seven years from the date of their injury to make a claim and as such, the remaining 66 individuals who have yet to claim may still do so in the future.
18. Please note that one of the 547 casualties registered an injury/illness claim and then subsequently died. A survivor's claim was then also registered for this casualty. This individual is therefore counted as both an injury claim and a survivor claim.
19. Of the 465 who claimed under the AFCS for injury/illness, a total of 439 have been awarded compensation for an injury or illness caused by Service. Of the remaining 26 casualties, 25 who registered a claim are still awaiting the outcome of their AFCS claim and one was accepted due to Service but did not meet the minimum tariff level.
20. Of the 17 who made a survivors claim under the AFCS, a total of 16 have been awarded a Survivors Guaranteed Income Payment (SGIP) and one was rejected.

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<sup>e</sup> Excludes Service personnel that returned to unit in theatre after sustaining their injury (VSI/SI) and includes one personnel who redeployed and died in an unconnected incident.

<sup>f</sup> Where death is caused by Service the AFCS provides an income stream known as the Survivor's Guaranteed Income Payment (SGIP). This is payable to the spouse, civil partner or adult dependant for life. Compensation is also paid to eligible children, known as the Child Payment (CP).

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## Data, Definitions and Methods

### Very Seriously Injured (VSI) and Seriously Injured (SI)

21. The VSI and SI categories are defined by Joint Casualty and Compassionate Policy and Procedures. They are not strictly 'medical categories' but are designed to give an indication of the severity of the injury to inform the next of kin and the chain of command.

22. Casualties are listed as VSI and SI in the Notification of Casualty (NOTICAS). NOTICAS is the name for the formalised system of reporting casualties within the UK Armed Forces. It sets in train the MOD's procedure for informing next of kin. The MOD's Joint Casualty and Compassionate Policy and Procedures set out the guidance under which a NOTICAS report is to be raised. NOTICAS takes precedence over all but the most urgent operational and security matters.

23. This report **does not** include patients that were very seriously ill or seriously ill on Operation HERRICK (Afghanistan) between 8 October 2007 and 30 September 2012 as listed on the initial NOTICAS signal.

24. The NOTICAS reports raised for casualties contain information on how serious medical staff in theatre judge their condition to be. This information is used to inform what the next of kin are told. "VSI" and "SI" are the two most serious categories into which personnel can be classified:

- Very Seriously Injured or VSI is the definition used where the injury is of such severity that life or reason is imminently endangered.
- Seriously Injured or SI is the definition used where the patient's condition is of such severity that there is cause for immediate concern, but there is no imminent danger to life or reason.

25. The NOTICAS system is initiated very early in the patient's admission to the field hospital, the classification of a casualty will change as time progresses. The initial signal listing of VSI or SI may in some cases be followed by an updated less serious listing if the case appeared worse on admission than transpires. This report only includes casualties with an initial NOTICAS listing of VSI or SI.

26. The Ministry of Defence publishes the VSI and SI casualty statistics for Operation HERRICK every month. These can be obtained from the DASA website: [www.dasa.mod.uk](http://www.dasa.mod.uk).

### Died of Wounds (DOW) and Died Not Enemy Action (DNEA)

#### Hostile Action

27. *Killed in Action (KIA)*: A battle casualty who is killed outright or who dies as a result of wounds or other injuries before reaching a medical treatment facility.

28. *Died of Wounds (DOW)*: A battle casualty who died of wounds or other injuries received in action, after having reached a medical treatment facility. This only includes those who have died of wounds whilst under the care of Defence Medical Services.

#### Non-Hostile Action

29. *Died on Operations (DOP)*: A casualty who died whilst deployed on, or as a result of operations but was not KIA or DOW. Includes operational accidents, road traffic accidents, assaults, suicides and deaths as a result of natural causes. If the casualty died outright they are classified as Killed Not Enemy Action (KNEA) and if they died of their injuries after reaching a medical treatment facility they are classified as Died Not Enemy Action (DNEA).

### Operations in Afghanistan

#### Operation VERITAS

30. Operation VERITAS is the name for UK operations in Afghanistan which started in October 2001. The UK was involved in Afghanistan alongside Coalition forces, led by the US under Operation Enduring Freedom (OEF), from the first attacks in October 2001.

#### Operation HERRICK

31. Operation HERRICK is the name for UK operations in Afghanistan which started in April 2006. UK Forces are deployed to Afghanistan in support of the UN authorised, NATO led International Security Assistance Force (ISAF) mission.

32. **Operation Panther's Claw** was preceded by several other operations carried out by British and Afghan government forces with the purpose of "taking and holding ground" in Helmand Province prior to the Afghanistan elections in 2009.

#### **Operation TELIC**

33. Operation TELIC is the name for UK operations in Iraq which started in March 2003. There was a drawdown of troops in July 2009 and Operation TELIC finished on 21 May 2011. UK Forces were deployed to Iraq to support the Government's objective to remove the threat that Saddam posed to his neighbours and his people and, based on the evidence available at the time, disarm him of his weapons of mass destruction. The Government also undertook to support the Iraqi people in their desire for peace, prosperity, freedom and good government.

#### **Roulement**

34. A roulement in Afghanistan comprises a six month time period from April to October or October to April. Some of the results in this report are presented by these time periods representing the summer and winter deployments. Each six month time period is assigned a sequential number, the time periods covered by each roulement are:

- HERRICK 4: 15 April 2006 to 14 October 2006
- HERRICK 5: 15 October 2006 to 14 April 2007
- HERRICK 6: 15 April 2007 to 14 October 2007
- HERRICK 7: 15 October 2007 to 14 April 2008
- HERRICK 8: 15 April 2008 to 14 October 2008
- HERRICK 9: 15 October 2008 to 14 April 2009
- HERRICK 10: 15 April 2009 to 14 October 2009
- HERRICK 11: 15 October 2009 to 14 April 2010
- HERRICK 12: 15 April 2010 to 14 October 2010
- HERRICK 13: 15 October 2010 to 14 April 2011
- HERRICK 14: 15 April 2011 to 14 October 2011
- HERRICK 15: 15 October 2011 to 14 April 2012
- HERRICK 16: 15 April 2012 to 14 October 2012

#### **Amputee**

35. An amputee is defined as live UK Service personnel who have an injury coded in the Joint Theatre Trauma Register (JTTR) as Amputation (traumatic), partial or complete, for either upper or lower limbs using the Abbreviated Injury Scale (AIS) Dictionary 2005 (Military Edition), and live UK Service personnel who had a surgical amputation performed either at the field hospital or at a UK hospital (the majority of these will be at the Royal Centre for Defence Medicine). A traumatic or surgical amputation can range from the loss of part of a finger or toe up to the loss of entire limbs. Only amputees with an initial NOTICAS listing of VSI or SI have been included in this report.

#### **Data sources**

36. The information provided in this report includes Naval Service Personnel (includes the Royal Navy and the Royal Marines), Army Personnel including those from the Gibraltar Regiment, RAF Personnel and Reservists.

37. The information has been compiled from a number of sources:

- Notification of Casualty (NOTICAS)
- Field Hospital Admissions from J97 Returns and Operational Emergency Department Attendance Register (OpEDAR)
- The Joint Theatre Trauma Registry (JTTR)
- DMRC Headley Court Prosthetics Database
- DMRC Headley Court Complex Trauma Database
- The Defence Patient Tracking System (DPTS)
- DASA's Mental Health Returns Database
- DASA's Medical Discharge Database
- Compensation and Pension System (CAPS)
- Joint Personnel Administration (JPA)
- Defence Medical Information Capability Programme (DMICP).

38. Detailed information on these datasets and how they were used in this report is contained in **ANNEX A**.

### **Pseudo-anonymisation**

39. Prior to analysis data sources have been linked using a pseudo-anonymisation process. The individual identifiers were stripped from datasets and replaced by a pseudo-anonymiser, generated by an automated sequential numbering system. The key to the system is that it recognises previous occurrences of a given Service number and allocates the same pseudo-anonymiser on each occasion. The pseudo-anonymisation process can only be reversed in exceptional circumstances controlled by the Caldicott Guardian under strict protocols.

### **Statistical Methods**

40. Information on length of stay and length of pathways has been presented as a median average with an inter-quartile range, rather than a mean average and standard deviation as these statistics are affected less by outliers.

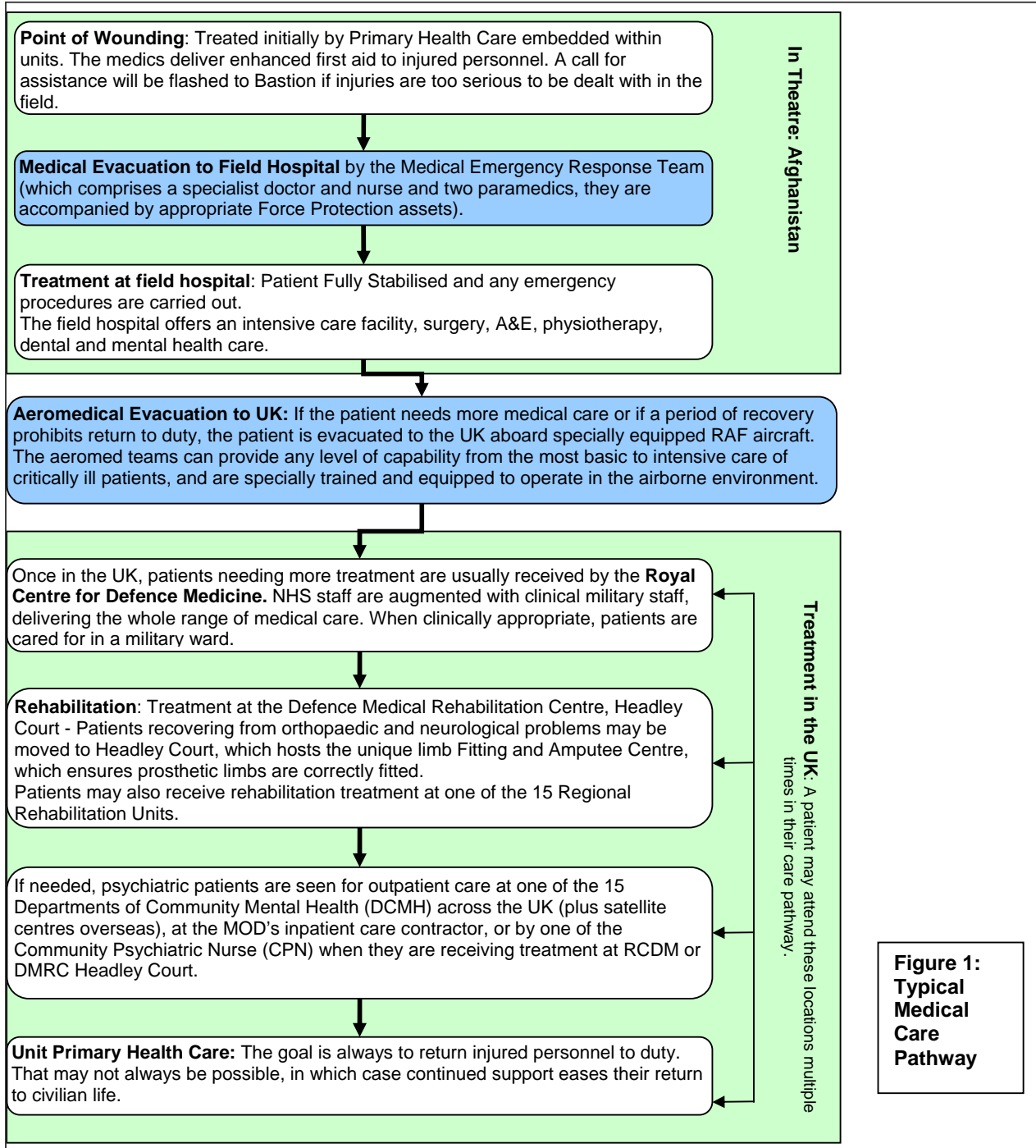
- a. The median is the value in the centre of the data set when they are arranged from smallest to largest.
- b. A quartile is any of three values (first/lower quartile, second quartile (median), third/upper quartile) that divides the sorted (from smallest value to largest value) dataset into four equal parts. The lower quartile is the value that at which 25% of the values in the dataset will be below. The upper quartile is the value that at which 75% of the values in the dataset will be below.
- c. The inter-quartile range is the range in which the middle 50% of the data points fall (i.e. the distance between the lower and upper quartile). The longer the inter-quartile range the wider the spread of data.
- d. An outlier is a value lower than the lower quartile or higher than the upper quartile.

41. The Non-Parametric Mann-Whitney U Test for Independent samples has been used to test if the distribution of length of admission time is different for VSI and SI patients at both RCDM and at DMRC. The same test has also been used to test if the distribution of length of admission time is different for patients with injuries resulting from hostile or non-hostile action at RCDM and to test if the distribution of the number of admissions to DMRC is different for VSI and SI patients.

42. Some of the data sources used in this report are live systems that are constantly being updated. This means figures can occasionally change. Any amendments made since the last release have been indicated by an 'r'.

## Medical Care Pathway

43. **Figure 1** presents an example of a *typical* medical care pathway for a UK Service Personnel VSI or SI whilst on Operation HERRICK.



### Specialist Treatment Locations

44. More detailed information on the Specialist Treatment locations included in this report is contained in **ANNEX B**.

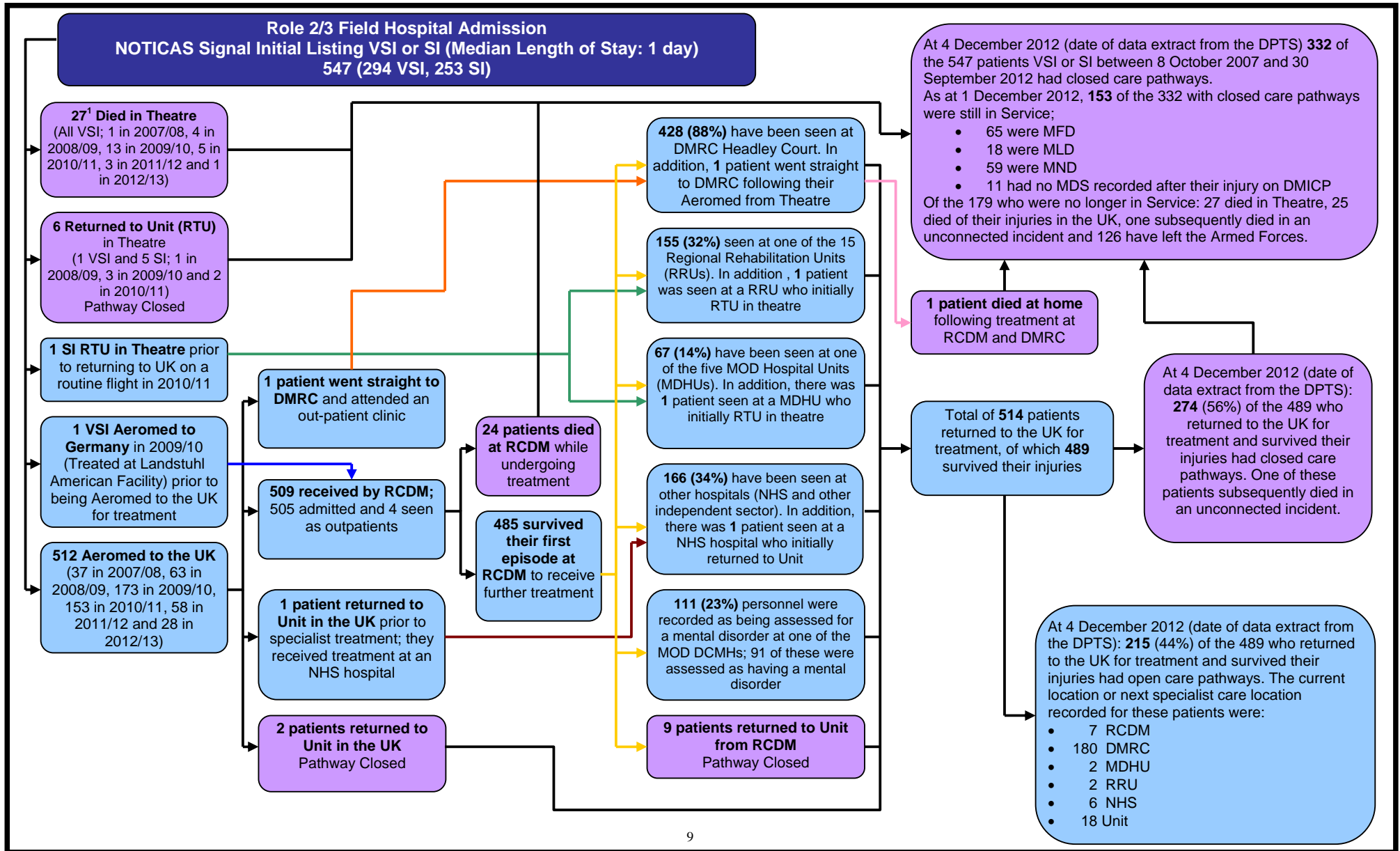
### FINDINGS

45. **Figure 2** presents a summary of the VSI/SI patient treatment pathway for those injured between 8 October 2007 and 30 September 2012.



**Figure 2: Summary of care pathways for VSI/SI casualties, 8 October 2007 – 30 September 2012**

**Colour Key**  
 Blue = Open Care Pathway  
 Purple = Closed Care Pathway



<sup>1</sup>26 died in a field hospital in Afghanistan and one died while on decompression training in Cyprus.

## Number of Personnel Very Seriously Injured or Seriously Injured

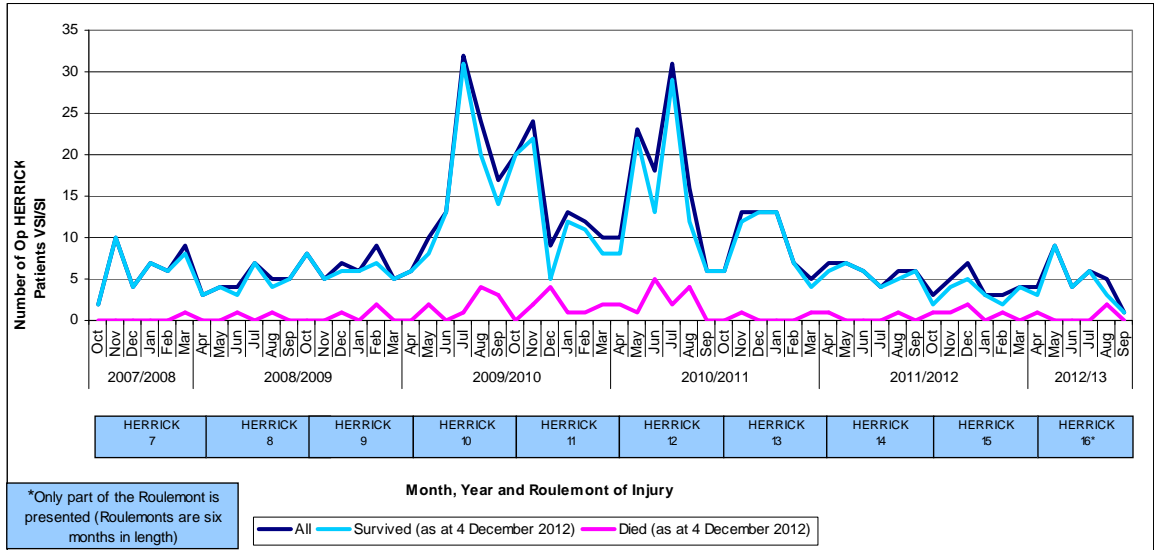
46. Between 8 October 2007 and 31 March 2008, there were 38 casualties with an initial NOTICAS classification of VSI or SI on Operation HERRICK (12 were VSI, 26 were SI); 36 (95%) of these were the result of hostile action, 2 (5%) were the result of operational accidents. As at 4 December 2012, one had died of wounds (one VSI).
47. In 2008/09, there were 68 casualties with an initial NOTICAS classification of VSI or SI on Operation HERRICK (34 were VSI, 34 were SI); 63 (93%) of these were the result of hostile action, 5 (7%) were the result of operational accidents. As at 4 December 2012, four had died of wounds and one had died as a result of their injuries from non enemy action (all VSI).
48. In 2009/10, there were 190 casualties with an initial NOTICAS classification of VSI or SI on Operation HERRICK (114 were VSI, 76 were SI); 179 (94%) of these were the result of hostile action, 11 (6%) were the result of operational accidents. As at 4 December 2012, 20 had died of wounds (all VSI).
49. In 2010/11, there were 161 casualties with an initial NOTICAS classification of VSI or SI on Operation HERRICK (83 were VSI, 78 were SI); 148 (92%) of these were the result of hostile action, 13 (8%) were the result of operational accidents. As at 4 December 2012, 14 had died of wounds and two had died as a result of their injuries from non enemy action (15 VSI, one SI).
50. In 2011/12, there were 61 casualties with an initial NOTICAS classification of VSI or SI on Operation HERRICK (39 were VSI, 22 were SI); 59 (97%) of these were the result of hostile action, 2 (3%) were the result of operational accidents. As at 4 December 2012, seven had died of wounds (all VSI).
51. Between 1 April and 30 September 2012, there were 29 casualties with an initial NOTICAS classification of VSI or SI on Operation HERRICK (12 were VSI, 17 were SI); 27 (93%) of these were the result of hostile action, 2 (7%) were the result of operational accidents. As at 4 December 2012, three had died of wounds (all VSI).
52. This totals 547<sup>g</sup> casualties with an initial NOTICAS classification of VSI or SI on Operation HERRICK between 8 October 2007 and 30 September 2012 (294 were VSI, 253 were SI); 512 (94%) of these were the result of hostile action, 35 (6%) were the result of operational accidents. As at 4 December 2012, 49 had died of wounds (48 VSI, one SI), three had died as a result of their injuries from non enemy action (all VSI) and 495<sup>h</sup> casualties had survived their injuries.
53. Of the 547 VSI/SI casualties, 70 were Naval Service personnel (includes Royal Navy and Royal Marines), 466 were Army personnel and 11 were Royal Air Force personnel.
54. **Figure 3** presents the number of casualties with an initial NOTICAS classification of VSI or SI on Operation HERRICK by month of injury and roulement. The fluctuations seen are largely due to Operational tempo. The rise on HERRICK 10 (summer 2009 tour) was largely due to Operation Panther's Claw and the rise in HERRICK 12 (summer 2010 tour) was largely due to the Operational tempo in the province of Sangin.

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<sup>g</sup> One patient had two separate VSI/SI incidences and therefore has been counted twice in this report totalling 547 personnel.

<sup>h</sup> One patient, who was SI in 2009/10, survived and was returned to duty but later died in an unconnected incident, thus is counted throughout this report as having survived their operational injury.

**Figure 3: Personnel with an initial NOTICAS classification of VSI or SI on Operation HERRICK by month of injury and Roulement, 8 October 2007 – 30 September 2012, Numbers<sup>1</sup>**

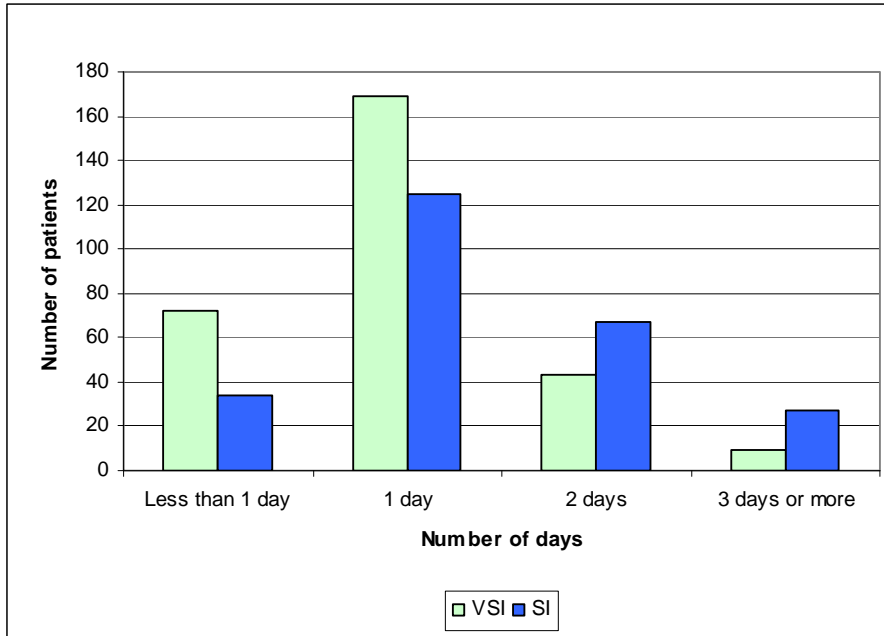


<sup>1</sup>Includes 52 personnel who died of wounds/died as a result of their injuries from non enemy action as at 4 December 2012 and one patient, SI in 2009/10, who survived their operational injury and was returned to duty but later died in an unconnected incident.

**Field Hospital**

55. Of the 547 casualties with an initial NOTICAS classification of VSI or SI on Operation HERRICK between 8 October 2007 and 30 September 2012, 546 were admitted to a field hospital in Afghanistan; one casualty died of their injuries sustained while on decompression training in Cyprus and therefore was not admitted to a field hospital in Afghanistan. The length of stay at the field hospital for these 546 casualties varied from less than one day to seven days, with a (median) length of stay of one day. The length of stay in the field hospital will have been based on individual circumstances, before leaving the field hospital the casualty will have been fully stabilised and any emergency procedures will have been carried out prior to their departure from the field hospital. **Figure 4** presents the length of stay of those admitted to the field hospital.

**Figure 4: Days<sup>1</sup> in field hospital, initial VSI or SI NOTICAS, 8 October 2007– 30 September 2012, Numbers<sup>2</sup>**



<sup>1</sup> Dates into and out of the field hospital are recorded as date only and not date and time, therefore if a patient arrived and departed on the same day this would be recorded as less than a day. If a patient arrived one day and departed the following day this would be recorded as 1 day.

<sup>2</sup> One casualty has been excluded as they died on decompression training in Cyprus and therefore were not admitted to a field hospital in Afghanistan.

56. Although 54% of the 546 casualties were VSI (n=293) compared to 46% SI (n=253) there was a higher proportion of VSI casualties (82%, n =241) who spent less than 2 days in a field hospital, compared to SI casualties (63%, n=159). This reflects the urgency to return VSI casualties back to the UK to receive specialist treatment.
57. 26 (All VSI) of the 546 casualties admitted to a field hospital in Afghanistan subsequently died in the field hospital (25 died of wounds, one died as a result of their injuries from non enemy action).
58. Seven casualties (one VSI and six SI) were treated in the field hospital and then returned to unit in theatre. These casualties may have had conditions that were less serious than originally judged or the treatment may have been readily available in the field hospital and the casualties did not require aeromedical evacuation to the UK. However one of these casualties subsequently returned to the UK on a routine flight and received specialist treatment in the UK.
59. Of the remaining 513 casualties, 512 were returned to the UK for treatment (via an aeromed flight) and one was returned (via an aeromed flight) to the US hospital in Germany for initial treatment for one month and then later returned to the UK for treatment. When patients require aeromedical evacuation they will be given appropriate degrees of Priority so that if the aircraft space is limited the more urgent patients may be evacuated before those with conditions less serious. Of the 513 patients:
  - 310 (60%) were returned as priority 1 – Urgent: These are patients for whom speedy evacuation is necessary to save life or limb, to prevent complication of serious illness or to avoid serious permanent disability. Priority 1 patients will normally be returned to the UK within 24 hours.
  - 124 (24%) were returned as priority 2 – Priority: These are patients who require specialised treatment not available locally and who are liable to suffer unnecessary pain or disability unless evacuated to the UK within 48 hours.
  - 79 (15%) were returned as priority 3 – Routine: These are patients whose immediate treatment requirements are available locally but whose prognosis would definitely benefit by air evacuation on routine flights. Most return to the UK within 3-4 days.

Occasionally patients, particularly those of greater dependency, may wait longer than 7 days in order to maximise fitness to fly and to reduce any risks associated with their movement by air. Such deferment would result from purely clinical considerations.

## **VSI/SI Personnel returned to the UK for treatment**

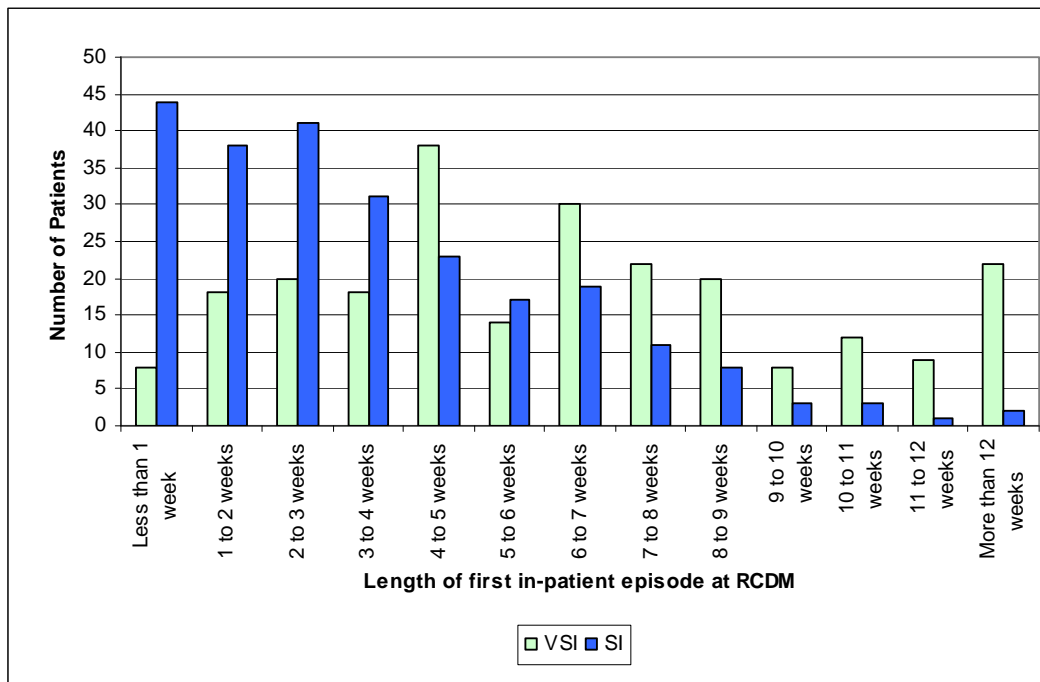
### **First Location of Specialist Care**

60. As the main receiving unit for military casualties evacuated from an operational theatre, the Defence Patient Tracking System (DPTS) recorded that the Royal Centre for Defence Medicine (RCDM) received 509 of the 513 VSI and SI casualties aeromed to the UK for treatment (including one patient aeromed via Germany). Of the 509 patients received by RCDM, 24 died whilst undergoing treatment in their first inpatient episode (23 died of wounds, one died as a result of their injuries from non enemy action). There were four patients recorded on the DPTS as not being received by RCDM:
- Two casualties, one listed as VSI and one listed as SI, were returned to unit, receiving treatment/care at primary health care before having their care pathways closed.
  - One casualty, listed as SI, was returned to unit, receiving treatment/care at primary health care. This casualty was later seen at a NHS (Independent Sector) hospital thus has been included in subsequent sections of this report.
  - One casualty, listed as SI, was aeromed from Op HERRICK and went straight to the Defence Medical Rehabilitation Centre (DMRC) for an outpatient clinic.
61. At RCDM, National Health Service (NHS) staff, augmented with clinical military staff, deliver the whole range of medical care. Serious casualties need and receive advanced levels of care across a wide range of medical disciplines that can only be found in a major trauma hospital. When clinically appropriate, patients are cared for in a military ward.
62. 505 of the 509 casualties received by RCDM were admitted as inpatients. **Figure 5** presents the length of stay for the 480<sup>i</sup> patients who were received by RCDM immediately following their evacuation from theatre and survived their first inpatient episode at RCDM. The length of stay for these patients varied between less than one day (less than one week) and 229 days (32-33 weeks), with an average (median) of 30 days (4-5 weeks), and an inter-quartile range of 34 days (lower quartile of 15 days and an upper quartile of 49 days).

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<sup>i</sup> To avoid skewing the length of first inpatient episode at RCDM, 24 patients have been excluded as they died while undergoing their first inpatient episode at RCDM and one patient has been excluded that initially received treatment at a US hospital in Germany for one month prior to their first inpatient episode at RCDM.

**Figure 5: Length of stay at first inpatient episode at RCDM (weeks), initial VSI or SI NOTICAS, 8 October 2007 – 30 September 2012, Numbers<sup>1,2</sup>**



<sup>1</sup> For the weekly categories, 1 to 2 weeks, for example, includes patients at RCDM for 1 or more weeks but less than 2 weeks.

<sup>2</sup> Graph represents the length of stay for the 480 inpatients received by RCDM immediately following evacuation from theatre who survived their first inpatient episode.

63. The distribution of the length of casualties' first episode as an inpatient at RCDM was significantly different for VSI and SI casualties<sup>j</sup>. The median length of stay of VSI patients (43 days (6 to 7 weeks); inter-quartile range of 34 days (lower quartile of 26 days and an upper quartile of 60 days)) was longer than for SI patients (21 days (2 to 3 weeks); inter-quartile range of 25 days (lower quartile of 11 days and an upper quartile of 36 days)).
64. The distribution of the length of casualties' first inpatient episodes were significantly different for those injured as a result of hostile action and those injured as a result of non-hostile action<sup>k</sup>. The median length of stay of patients injured as a result of hostile action (31 days (4 to 5 weeks); inter-quartile range of 34 days (lower quartile of 16 days and upper quartile of 50 days)) was longer than for patients injured as a result of non-hostile action (10 days (1 to 2 weeks); inter-quartile range of 15 days (lower quartile of 3 days and upper quartile of 18 days)). This is likely to be due to the complexity of conditions suffered by some of the casualties who were injured as a result of hostile action.

### **Subsequent Locations of Specialist Care**

65. As at 4 December 2012 (date of extract from the DPTS), of the 509 patients that were received by RCDM as either an inpatient (n=505<sup>k</sup>) or an outpatient (n=4), 485 survived their first episode. Of the 485 patients who survived their first episode at RCDM:
- 475 have gone on to either receive further treatment at RCDM or to receive treatment at other specialist care locations.
  - Nine patients completed their first inpatient episode at RCDM before returning to unit and having their care pathway closed with no further specialist care required.
  - One patient went on to receive further treatment at RCDM and DMRC, but subsequently died of wounds at home, a year after their initial injury.

<sup>j</sup> Difference in distributions tested using The Mann Whitney U statistic for independent samples at the 5% significance level.

<sup>k</sup> Includes one patient that initially received treatment at a US hospital in Germany for one month prior to their first inpatient episode at RCDM

### ***Royal Centre for Defence Medicine***

66. As at the 4 December 2012 (date of data extract from the DPTS):

- 299 (62%) of the 485 patients had received subsequent treatment as an inpatient or outpatient at **RCDM**, 180 of which were admitted as an inpatient more than once.
- Seven of the 485 patients were receiving treatment at RCDM or were awaiting their next episode at RCDM.

### ***Defence Medical Rehabilitation Centre (DMRC), Headley Court***

67. As at 4 December 2012 (date of data extract from the DPTS), 428 (88%) of the 485 patients have received subsequent treatment at **DMRC** Headley Court. Patients may move straight from their inpatient or outpatient care at RCDM to DMRC or they may have a period of time on sick leave to enable time to heal before starting rehabilitation or they may be seen at one of the Regional Rehabilitation Units before requiring treatment at DMRC.

68. In addition, there was one patient, listed as SI, who was aeromed to the UK and went straight to DMRC for an outpatient appointment.

69. As at 4 December 2012, 180 (37%) of the 486 patients (485 aeromed that survived RCDM and one aeromed straight to DMRC) were currently receiving treatment at DMRC or awaiting their next episode of care at DMRC.

70. All patients attending DMRC are initially seen by a team of experts from different medical fields who together agree on the course of treatment. The team includes specialist medical officers, nurses, fitness instructors, physiotherapists, occupational therapists, speech and language therapists, cognitive therapists and social workers. The team also help prepare the casualties for a gradual return to active duty where possible.

71. Of the 429<sup>1</sup> (428 who were received by RCDM after their aeromed to the UK and one who went straight to DMRC) patients that have attended DMRC:

- 349 (81%) were seen as inpatients<sup>m</sup>, 305 (87%) of which were admitted as an inpatient more than once.
- 409 (95%) were seen as outpatients.
- 131 (31%) were seen as residential patients.

### ***Length of time between Injury and In-Patient Admissions***

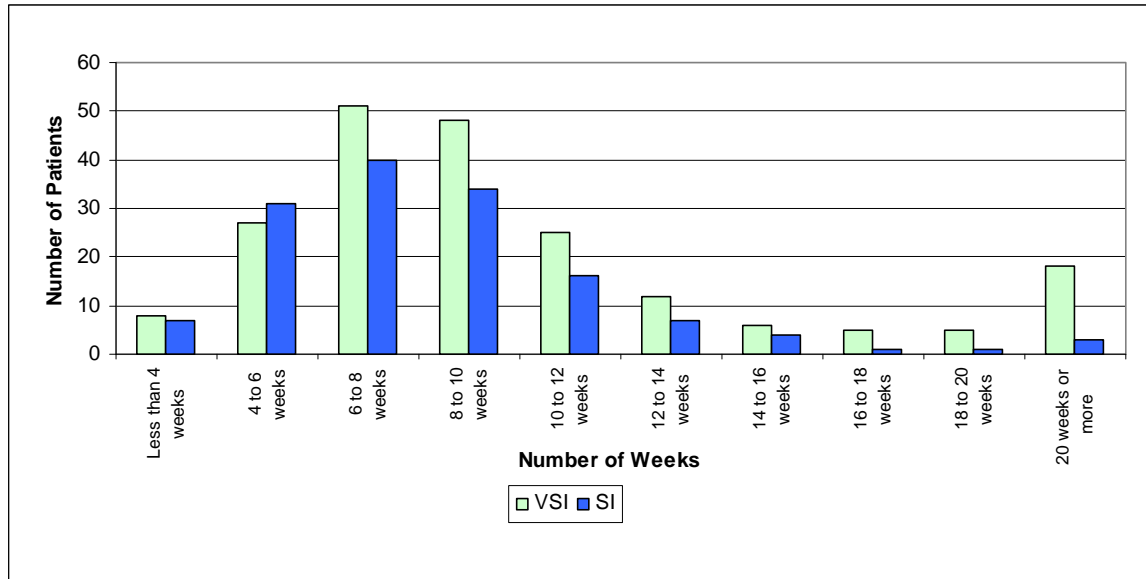
72. **Figure 6** presents the length of time between injury and the first inpatient episode of care at DMRC for the 349 patients who have been treated as an inpatient.

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<sup>1</sup> The total number of patients treated at DMRC will not equal the sum of the number of different patient types because patients can be treated at DMRC as multiple patient types in any one time period.

<sup>m</sup> An inpatient is a patient that has been admitted and allocated a ward bed. A residential patient is a patient that is on a three week-rehab course; they are not allocated a ward bed, but reside in dormitory style accommodation. An outpatient is a non-resident patient attending DMRC for treatment.

**Figure 6: Length of time between injury and first inpatient episode of care at DMRC, initial VSI or SI NOTICAS, 8 October 2007 – 30 September 2012, Numbers<sup>1</sup>**



<sup>1</sup> For the weekly categories, 4 to 6 weeks, for example, includes patients whose time between injury and arrival at their inpatient episode at DMRC is 4 or more weeks but less than 6 weeks.

73. The length of time between injury and first inpatient episode of care at DMRC varied between 12 days (less than 4 weeks) and 873 days (more than 124 weeks), with a median of 59 days (inter-quartile range of 31 days (lower quartile 44 days to upper quartile 75 days)). Therefore the impact of an increase in the number of VSI and SI casualties in theatre may lead to an increasing initial burden on DMRC 8 to 9 weeks after injury.
74. First inpatient admissions at DMRC show the smallest variation in the length of time between injury and admission. There are a few outliers in this data with some patients taking considerably longer than average to arrive at DMRC from their date of injury. Of these outliers, the majority were VSI patients indicating that they may need lengthier specialist care or longer recovery time prior to being admitted for rehabilitation. Subsequent admissions<sup>n</sup> are more variable in nature (with larger inter-quartile ranges) than the first admission:
- On average (median) second inpatient admissions occur 17 weeks after injury, nine weeks after first admission.
  - Third inpatient admissions occur 25 weeks after injury, eight weeks after second admission.
  - Fourth inpatient admissions occur 34 weeks after injury, nine weeks after third admission.
  - Fifth inpatient admissions occur 43 weeks after injury, nine weeks after fourth admission.
  - Sixth inpatient admissions occur 52 weeks after injury, 10 weeks after fifth admission.
  - Seventh inpatient admissions occur 64 weeks after injury, 11 weeks after sixth admission.
  - Eighth inpatient admissions occur 73 weeks after injury, 10 weeks after seventh admission.

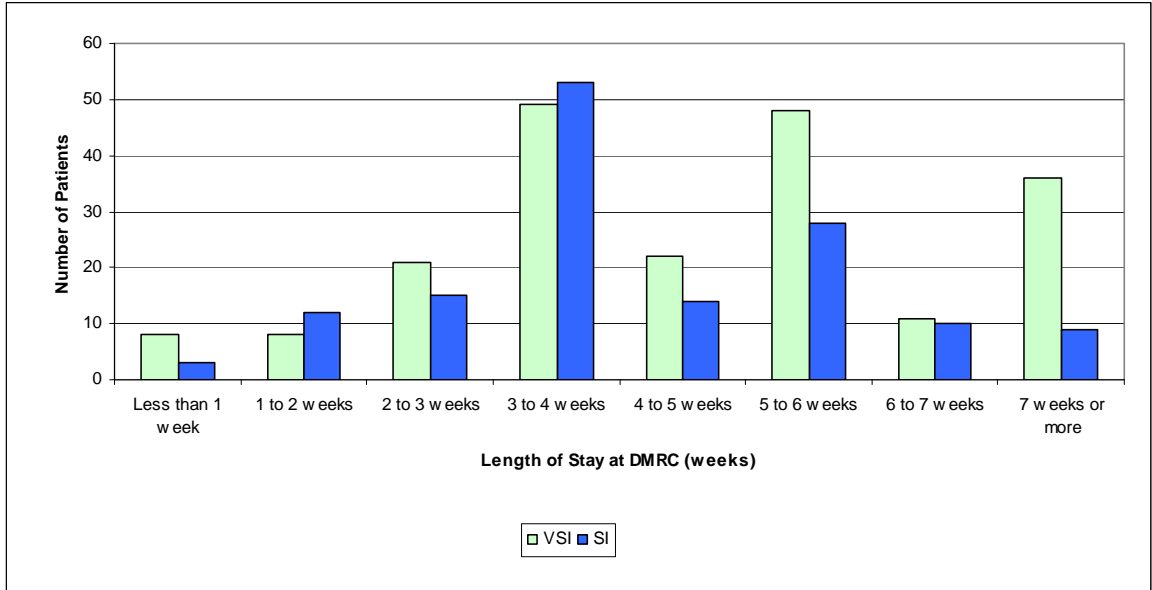
#### *Length of In-Patient Admissions*

75. **Figure 7** shows that the median length of stay of first admission for both VSI and SI inpatients at DMRC was 3 to 4 weeks. Two of the 349 patients treated as an inpatient at DMRC were excluded from analyses as they have not yet been discharged from their first inpatient episode.

<sup>n</sup> Only eight admissions have been shown, however some patients have had more than 10 admissions.



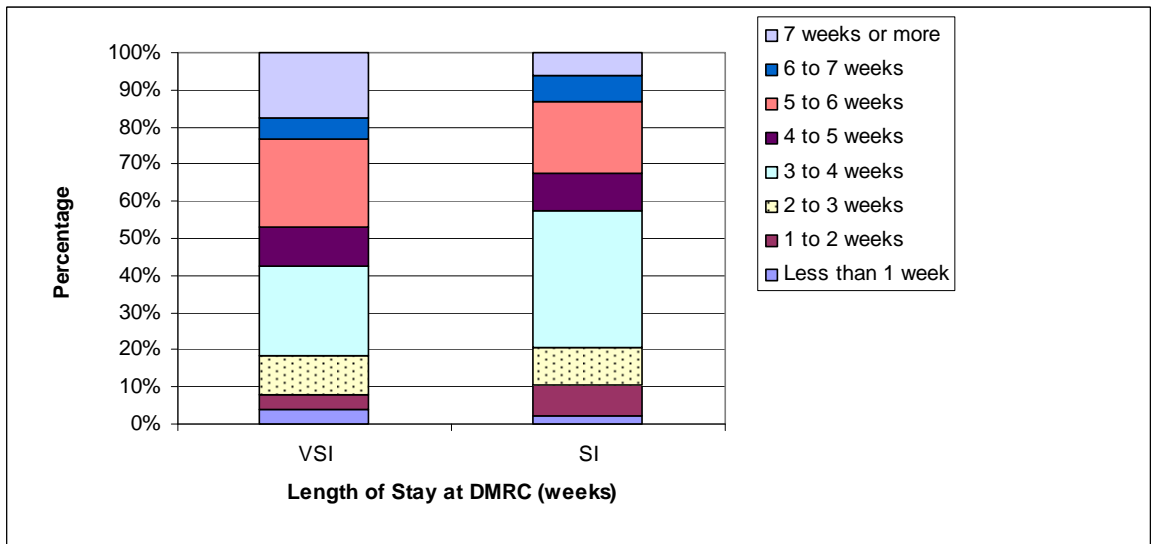
**Figure 7: First In-patient length of stay at DMRC, initial VSI or SI NOTICAS, 8 October 2007 – 30 September 2012, Numbers<sup>1,2</sup>**



<sup>1</sup> For the weekly categories, 1 to 2 weeks, for example, includes patients at DMRC for 1 or more weeks but less than 2 weeks.  
<sup>2</sup> Two of the 349 patients admitted as an inpatient at DMRC have been excluded as they have not yet been discharged from their first episode of care, leaving 347 patients represented in this graph.

76. **Figure 8** shows that the distribution of the length of inpatients first stay at DMRC was significantly different for VSI and SI patients<sup>o</sup>. The median length of stay for VSI patients (31 days, (4 to 5 weeks); inter-quartile range of 18 days (lower quartile of 23 days and an upper quartile of 41 days)) was longer than for SI patients (24 days (3 to 4 weeks); inter-quartile range of 16 days (lower quartile of 22 days and an upper quartile of 38 days)).

**Figure 8: First In-patient length of stay at DMRC, initial VSI or SI NOTICAS, 8 October 2007 - 30 September 2012, Percentage<sup>1</sup>**



<sup>1</sup> Two of the 349 patients admitted as an inpatient at DMRC have been excluded as they have not yet been discharged from their first episode of care at DMRC, leaving 347 patients represented in this graph.

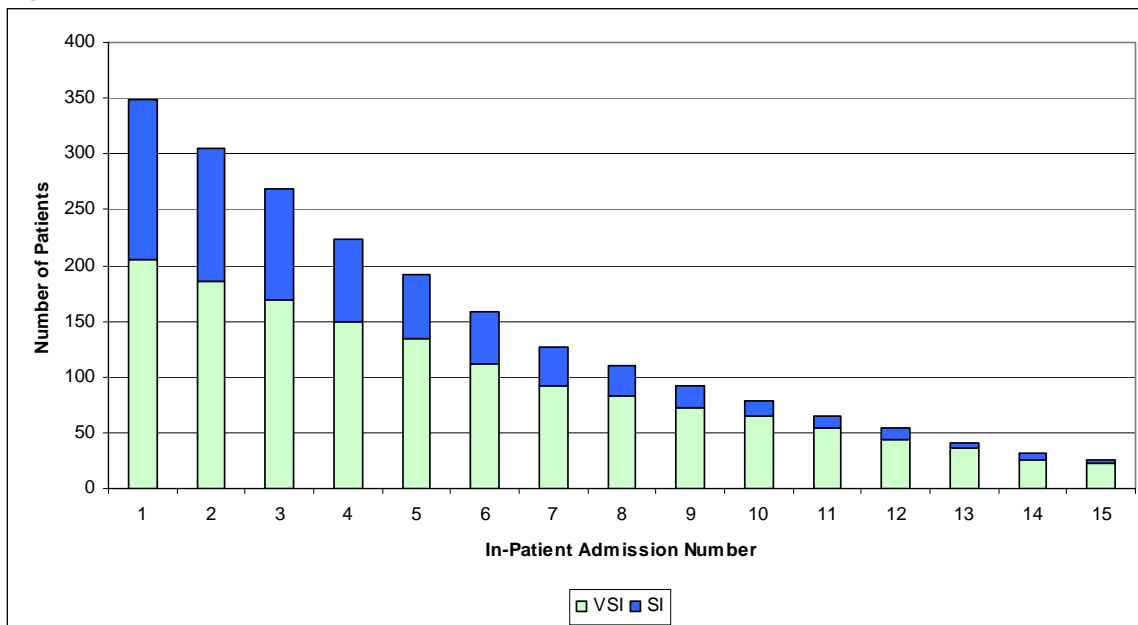
77. On average the first inpatient admission was the longest admission for these 347 patients (349 patients less the two patients not discharged from their first inpatient episode of care) with an average (median) admission length of 29 days. There were some outliers in this data with three patients spending considerably less time than average during their first inpatient admission (less

<sup>o</sup> Difference in distributions tested using The Mann Whitney U statistic for independent samples at the 5% significance level. Two of the 349 patients admitted as an inpatient at DMRC have been excluded as they have not yet been discharged from their first episode of care at DMRC, leaving 347 patients represented.

than two days) and a number of patients spending considerably longer than average during their first inpatient admission (more than 50 days). Both VSI and SI inpatients have extreme outliers surrounding their average length of first inpatient admissions indicating that first inpatient length of stay is dependent on individual circumstances.

78. The median length of stay for each subsequent admission (admission number is incremental, first inpatient episode is admission 1, second inpatient episode is admission 2 etc) is less than the first but remains relatively stable at around 19 days. **Figure 9** presents the number of inpatient admissions by VSI and SI classification. The current maximum number of inpatient admissions is 24 (admissions 16-24 do not appear on the graph due to small numbers). However, these numbers are likely to change as many patients have yet to complete their care pathway.
79. The number of inpatients admitted decreases with every subsequent admission; of the 349 inpatients:
- 305 (87%) went on to have a second admission,
  - 268 (77%) went onto have a third admission,
  - 223 (64%) went on to have a fourth admission,
  - 192 (55%) went on to have a fifth admission,
  - 158 (45%) went on to have a sixth admission,
  - 127 (36%) went on to have a seventh admission
  - 110 (32%) went on to have an eighth admission,
  - 92 (26%) went on to have a ninth admission,
  - 79 (23%) of all first inpatient admissions go on to have ten or more admissions.
80. The distribution of the number of admissions was significantly different for VSI and SI patients<sup>P</sup>. The median number of admissions for VSI patients (six admissions; inter-quartile range of eight (lower quartile of three and an upper quartile of 11)) was higher than for SI patients (four admissions; inter-quartile range of four (lower quartile of two and an upper quartile of six)). This may reflect the more severe injuries that are sustained by VSI patients that require additional inpatient rehabilitation admissions.

**Figure 9: In-Patient Admissions to DMRC, initial VSI or SI NOTICAS, 8 October 2007 - 30 September 2012, Numbers**



**Regional Rehabilitation Units (RRUs)**

81. As at 4 December 2012 (date of data extract from the DPTS):
- 155 (32%) of the 485 patients had received subsequent treatment at one of the 15 **RRUs**. Of these 155; 152 had been seen at multi-disciplinary assessment clinics (MIAC) and 45 had been

<sup>P</sup> Difference in distributions tested using The Mann Whitney U statistic for independent samples at the 5% significance level.

treated on three week rehabilitation courses (24 had been on one rehabilitation course, 17 had been on two rehabilitation courses and four had been on three rehabilitation courses).

- In addition, one patient who was SI and returned to unit in theatre and returned to the UK on a routine flight subsequently received treatment at a RRU. This patient was seen at a MIAC.
- Two of the 486 patients (485 aeromed that survived RCDM and one returned on a routine flight) were currently receiving treatment at a RRU or awaiting their next episode at an RRU.

### **Other Locations**

82. As at 4 December 2012 (date of data extract from the DPTS):

- 67 (14%) of the 485 patients had received subsequent treatment at one of the five **Ministry of Defence Hospital Units (MDHUs)**.
- In addition, one patient who was SI and returned to unit in theatre and returned to the UK on a routine flight subsequently received treatment at one of the five MDHUs.
- Two of the 486 patients (485 aeromed that survived RCDM and one returned on a routine flight) were currently receiving treatment at a MDHU or awaiting their next episode at a MDHU.

83. As at 4 December 2012 (date of data extract from the DPTS):

- 166 (34%) of the 485 patients had received subsequent treatment at **another hospital** (including NHS and Independent Sector Hospitals).
- In addition, one patient who was aeromed from Op HERRICK and returned to unit to receive treatment/care at primary health care subsequently received treatment at a NHS/Independent Sector Hospital.
- Six of the 486 patients (485 aeromed that survived RCDM and one returned on an aeromed, received treatment at unit and later seen at a NHS hospital) were currently receiving treatment at *another hospital* or awaiting treatment at *another hospital*.

84. As at 30 September 2012 (latest date for which mental health data are available):

- 111<sup>q</sup> (23%) of the 485 patients (aeromed that survived RCDM) had been seen for assessment as new patients at one of the MOD's **Departments of Community Mental Health (DCMH)** after their date of injury. Of these 111 personnel, 91<sup>f</sup> were assessed as having a mental disorder. Of the 91 personnel:
  - 80<sup>f</sup> were assessed with a neurotic disorder, of which 24<sup>f</sup> were assessed as having Post Traumatic Stress Disorder (PTSD).
  - Five<sup>f</sup> were assessed with a mood disorder
  - Six<sup>f</sup> were assessed with another mental disorder, this includes those assessed with mental and behavioural disorders due to alcohol.
- Fewer than five of the 485 patients were admitted to the MOD's inpatient contractor for mental health care.
- None of the 485 patients (aeromed that survived RCDM) were currently receiving treatment at a DCMH or awaiting their next episode at a DCMH.

### **Amputees**

85. Of the 495 casualties with an initial NOTICAS classification of VSI or SI on Operation HERRICK between 8 October 2007 and 30 September 2012 who survived their injuries (as at 4 December 2012), 199 (40%) were identified as amputees as at 31 December 2012 (the latest amputations data available). Of these, 197 (99%) were the result of hostile action and two (1%) were the result of operational accidents. The 199 amputees are a subset of those reported in the Quarterly Afghanistan and Iraq Amputation Statistics produced by DASA<sup>f</sup>, and do not match the statistics published in this report for several reasons;

- their injury occurred before 8 October 2007 and the amputation was a surgical amputation that occurred after 8 October 2007;
- their injuries resulted in an initial NOTICAS listing of 'Incapacitating Injury' or 'Unlisted injury' as the injuries were not of such severity that life or reason is imminently endangered (VSI) or of such severity that there is cause for immediate concern, but there is no imminent danger to life or reason (SI) (as some of the amputees include personnel who have lost a finger or toe).

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<sup>q</sup> The numbers presented for mental health have decreased since the previous report was released as the number of new episodes of care for mental health were erroneously presented as opposed to the number of patients seen; it is possible for patients to have more than one new episode of care for more than one mental disorder in a given time period therefore the numbers presented in the previous report were an over count.

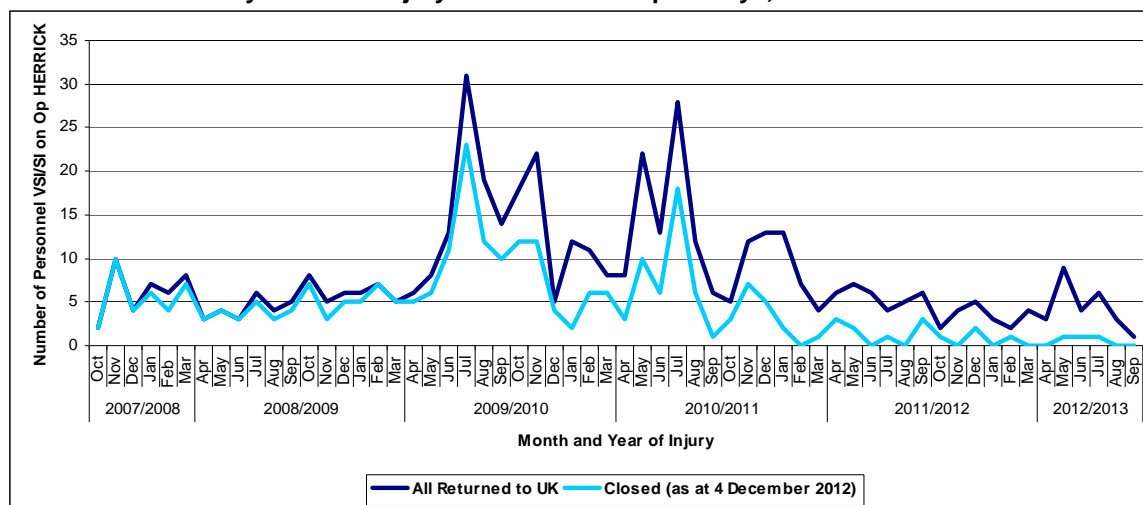
<sup>f</sup> Quarterly Afghanistan and Iraq amputation statistics can be found on the DASA website ([www.dasa.mod.uk](http://www.dasa.mod.uk))

86. As at 4 December 2012, 147 (74%) of the 199 amputees had open care pathways, indicating that they were still receiving specialist care. Of the 199 amputees:
- All had been treated at RCDM (all 199 were seen as inpatients and 125 were seen as outpatients).
  - 197<sup>s</sup> had been treated at DMRC; 196 were seen as inpatients, 197 were seen as outpatients and 49 were seen as residential patients. All 197 patients were seen at more than one type of appointment (inpatient, outpatient and residential).
  - 40 had received treatment at a RRU; all 40 were seen at a multi-disciplinary injury assessment clinic and three were treated on a rehabilitation course.
  - 107 had received subsequent treatment at another hospital (including NHS, Independent Sector Hospitals and Ministry of Defence Hospital Units).

### Care Pathway Length and Closed Pathways

87. As at 4 December 2012 (date of data extract from the DPTS), 332 personnel out of the 547 with an initial NOTICAS listing of VSI or SI had a **closed care pathway**. Of the 332: 27 died in theatre (26 in a field hospital in Afghanistan and one in Cyprus), 25 died in the UK (24 at RCDM and one at home) and 280 survived their injuries.
88. The graphs and commentary produced in this section only include the 489 personnel who returned to the UK for specialist care **and** survived their injuries (as at 4 December 2012). Therefore, the six personnel who returned to unit in theatre and had their pathway closed, the 27 who died in theatre and the 25 who died in the UK were excluded from this section as they would skew the trends presented.
89. **Figure 10** presents the number of personnel returned to the UK for specialist treatment with an initial NOTICAS classification of VSI or SI on Operation HERRICK by month of injury and the number of these personnel with closed pathways as at 4 December 2012. The fluctuations seen are largely due to Operational tempo. The rise on HERRICK 10 (summer 2009 tour) was largely due to Operation Panther's Claw and the rise in HERRICK 12 (summer 2010 tour) was largely due to the Operational tempo in the province of Sangin.

**Figure 10: Personnel with an initial VSI or SI NOTICAS, 8 October 2007 – 30 September 2012, returned to the UK by month of injury and closed care pathways, Numbers<sup>1</sup>**



<sup>1</sup> Figures presented are for the 489 casualties who returned to the UK for treatment and survived their injuries (as at 4 December 2012).

90. As at 4 December 2012 (date of data extract from the DPTS), 215 (44%) of the 489 VSI/SI patients returned to the UK for treatment in specialist care who survived their injuries had open care pathways. The remaining 274 had closed pathways indicating that no further specialist care was required (111 VSI and 163 SI; 33 who were injured between 8 October 2007 and 31 March 2008, 54 who were injured in 2008/09, 109 who were injured in 2009/10, 62 who were injured in 2010/11,

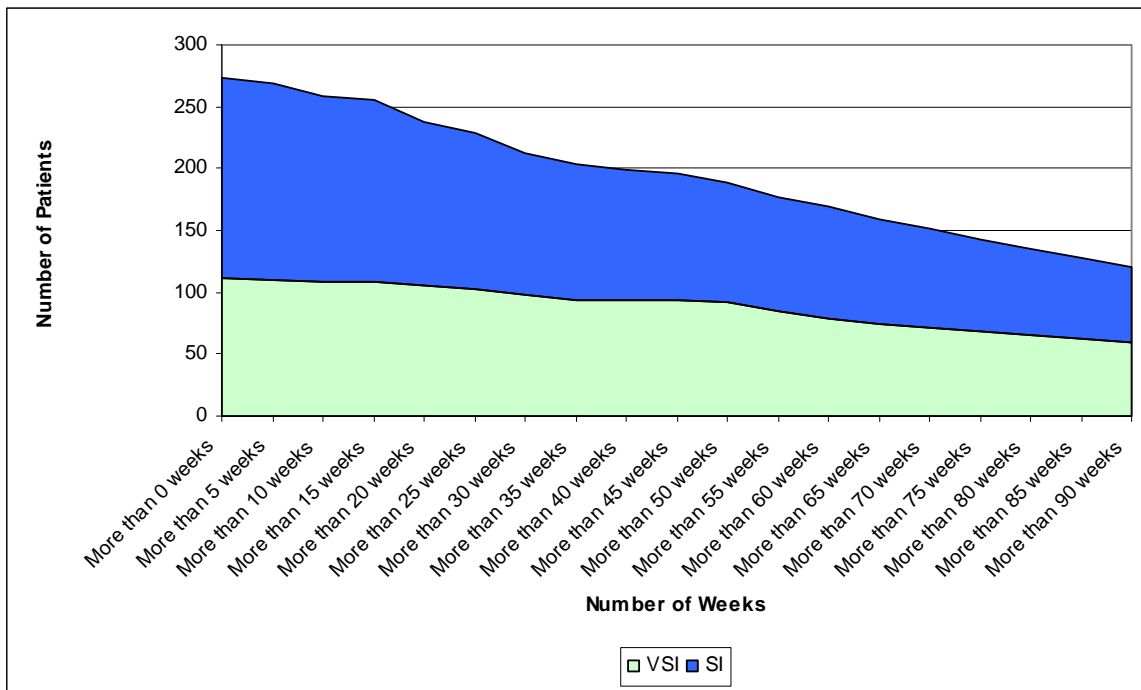
<sup>s</sup> One amputee did not attend DMRC for treatment, this patient instead received treatment for their injuries at RCDM; and one amputee, injured in 2012/13, has yet to attend DMRC for treatment.

13 who were injured in 2011/12 and three who were injured between 1 April 2012 and 30 September 2012). Of the 274 patients;

- One had a new pathway initiated (nine months after the original closed pathway) as a result of their previous injury (SI). Their care pathway is now closed.
- Two who required no further specialist follow-up for a VSI and SI were returned to duty, one later died in an unconnected incident and one was returned via aeromed from Operations for the same injury sustained in the original VSI incident and treated in Primary Health Care (their care pathway is now closed).

91. **Figure 11** presents the length of care pathway as a cumulative frequency graph for the 274 patients who returned to the UK for treatment and survived their injuries with **closed** pathways (as at 4 December 2012), calculated using the time between injury and date of pathway closure. For the patient with a subsequent pathway initiated only the length of time of the initial pathway has been calculated.

**Figure 11: Length of care pathway for closed pathways (weeks), initial VSI or SI NOTICAS, 8 October 2007 – 30 September 2012, Cumulative Frequency**



92. The length of **closed** care pathways<sup>†</sup> varied between 2 days (less than 1 week) and 1,729 days (247 weeks), with an average (median) of 543 days (between 77 and 78 weeks) and an inter-quartile range of 683 days (lower quartile 235 days (between 33 and 34 weeks) and upper quartile 918 days (between 131 and 132 weeks)).

93. Please note, there are some patients with **open** care pathways who were injured at the start of 2008 and thus at 4 December 2012 (date of data extract from the DPTS) these pathways were nearly five years in length.

94. The analysis on length of care pathway is currently limited due to the proportion of those who were VSI/SI on Op HERRICK between 8 October 2007 and 30 September 2012 with closed treatment pathways. This will be updated in future reports to enable a better understanding of the length of time that these patients were under specialist care.

<sup>†</sup> Please note that DASA are aware of data issues with the date care pathways are closed and this is currently in the process of being validated and as such this data should be treated as provisional.

## **Personnel who have Redeployed**

95. As at 1 January 2013 (latest deployment data available), 34<sup>u</sup> of the 274<sup>u</sup> patients who returned to the UK for treatment in specialist care and survived their injuries with closed pathways had subsequently redeployed on Operation HERRICK and/or Operation TELIC after their care pathway closure date.

## **Current Joint Medical Employability Standard (JMES) for Personnel with Closed Pathways**

96. 153 (55%) of the 280 patients who survived their injuries with closed pathways were still in Service on 1 December 2012 (the latest strength data available). The latest Medical Deployment Standard (MDS) as recorded on their medical record in the Defence Medical Information Capability Programme (DMICP) was identified;
- 65 were medically fully deployable (MFD)
  - 18 were medically limited deployable (MLD)
  - 59 were medically non deployable (MND)
  - 11 had no MDS recorded after their injury on their medical record in DMICP

## **Discharged Personnel**

97. As at 1 December 2012 (the latest strength data available), 127 (45%) of the 280 patients who survived their injuries with closed pathways were no longer in Service. The remaining 368 VSI and SI casualties who survived their injuries (153 with closed pathways, 215 with open pathways) remain in Service. Of the 127:
- 69 had a closed pathway in the DPTS indicating that no further specialist care was required and had then been discharged from Service.
  - 57 had a closed pathway in the DPTS as a result of leaving Service.
  - One personnel had a closed pathway in the DPTS and was returned to duty after recovering from his injuries then later died in an unconnected incident.

## **Medically Discharged**

98. As at 31 March 2012 (the latest date for which medical discharge date are available), 50 (39%) of the 127 VSI and SI casualties that were no longer in Service had been discharged from Service due to medical grounds. It should be noted that the principal condition leading to discharge may not be related to the VSI/SI injury sustained on Op HERRICK.
99. Of the 50 medically discharged from Service, Musculoskeletal disorders and injuries was the most common principal cause of medical discharge (40 cases). Other principal causes of medical discharge included blood disorders, clinical and laboratory findings, ear and mastoid process diseases, eye and adnexa diseases and factors influencing health status.
100. If a decision has been taken to medically discharge an individual from the Military the specific Defence Medical Services health team who have been caring for that individual will begin a liaison with appropriate civilian healthcare providers (e.g. General Practitioner / Primary Health Care Team / civil mental health team / NHS Trust) to ensure the transfer of care and patient history takes place.
101. Additionally the MOD have specialist health social workers who manage the individual's wider resettlement issues, liaising with relevant civil agencies such as local housing authorities, financial authorities, service welfare and charitable organisations; again to endeavour that the individual's transfer into the civilian environment is as smooth and as seamless as possible.

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<sup>u</sup> Excludes Service personnel that returned to unit in theatre after sustaining their injury (VSI/SI) and includes one personnel who redeployed and died in an unconnected incident.

## **Armed Forces Compensation Scheme (AFCS)**

### ***Claims registered***

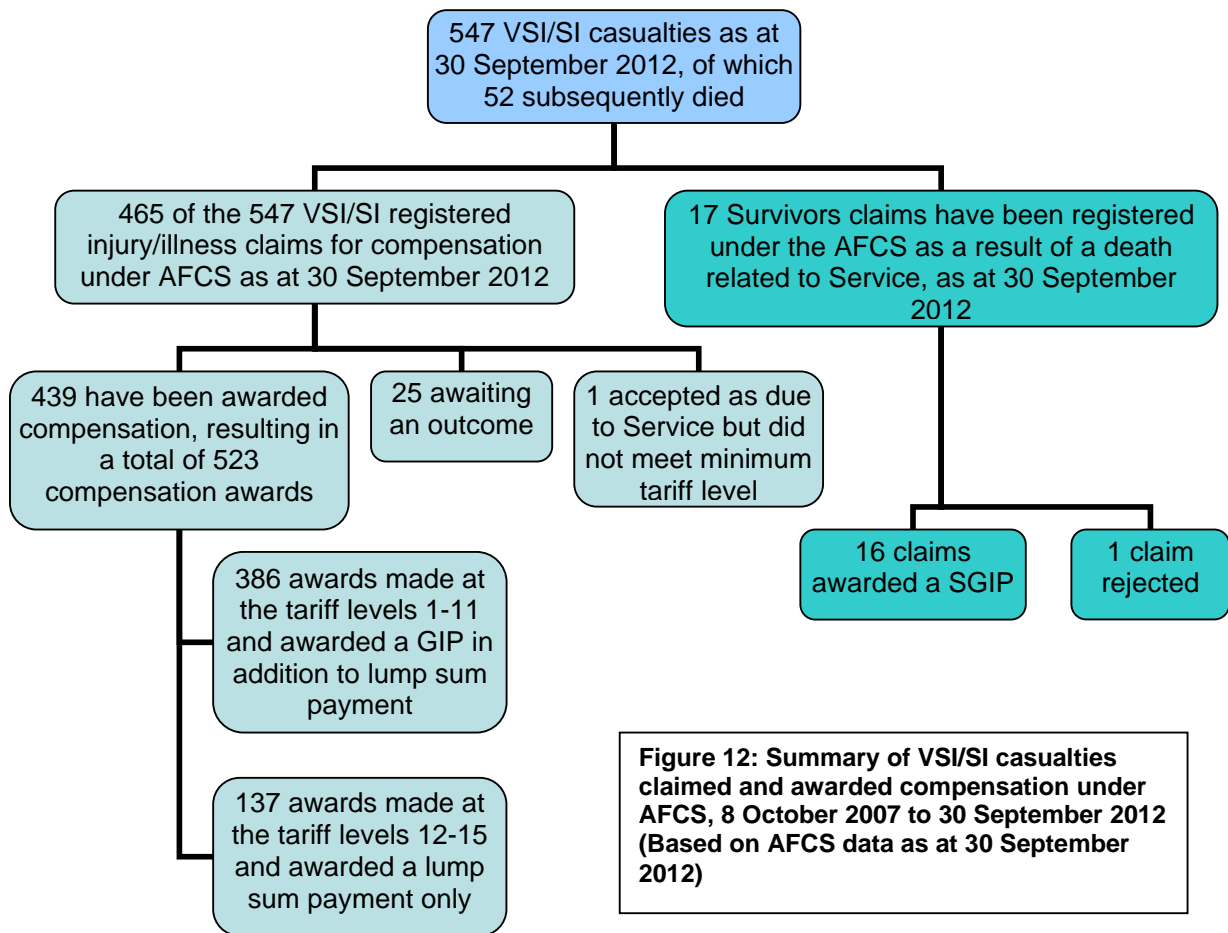
102. As at 30 September 2012 (the latest date for which AFCS data is currently available), 465 of the 547 casualties had registered injury/illness claims under the Armed Forces and Reserve Forces Compensation Scheme (AFCS). These individuals made a total of 696 injury/illness claims, which included multiple and/or additional claims for some individuals.
103. Of the 547 VSI/SI casualties, 52 subsequently died as a result of their injuries. As at 30 September 2012, 17 survivor's claims have been registered under the AFCS as a result of these deaths.
104. There are 66 casualties for which no injury/illness or survivor's claim has been registered (as at 30 September 2012). Currently, individuals have up to seven years from the date of injury to make a claim and as such, further claims may still be registered for these casualties in the future.
105. Please note that one of the 547 casualties registered an injury/illness claim and then subsequently died. A survivor's claim was then also registered for this casualty. This individual is counted in the figures quoted in both paragraphs 104 and 105 and therefore the figures quoted will not sum to the total number of casualties.

### ***Awards made for injury/illness claims***

106. Under the AFCS individuals awarded for an injury/illness claim at tariff levels 1-11 receive a Guaranteed Income Payment (GIP), which is an index-linked, tax-free payment, in addition to their lump sum amount. Individuals awarded at tariff levels 12-15 will receive a lump sum amount only.
107. As at 30 September 2012, 439 of the 465 individuals who have claimed under the AFCS have been awarded compensation for an illness or injury related to their Service. A total of 523 compensation awards were made to these individuals.
108. Of these 523 awards, 386 were made at tariff levels 1-11 and therefore included a Guaranteed Income Payment (GIP) in addition to the lump sum payment. The remaining 137 awards were made at tariff levels 12-15 and included a lump sum payment only.
109. Of the 386 awards including a Guaranteed Income Payment (GIP), 134 awards were made at 100% GIP percentage and therefore received 100% of the tariff amount for all awarded conditions. The two categories of conditions most frequently awarded in these cases were 'injury, wounds and scarring' and 'amputations'.
110. Please note there was one individual where the claimed condition was accepted as being due to Service but did not meet the minimum tariff level (15). This claim was therefore rejected.
111. As at 30 September 2012, there was no outcome recorded on the Compensation and Pension System (CAPS) for the claims of the 25 remaining VSI/SI casualties who had registered injury/illness claims under the AFCS.

### ***Awards made for Survivors claims***

112. Where death is caused by Service the AFCS provides an income stream known as the Survivor's Guaranteed Income Payment (SGIP). This is payable to the spouse, civil partner or adult dependant for life. Compensation is also paid to eligible children, known as the Child Payment (CP).
113. Of the 17 survivors claims registered as at 30 September 2012, 16 were awarded a Survivor's Guaranteed Income Payment and one claim was rejected.



*Notes on AFCS data:*

114. The Armed Forces and Reserve Forces Compensation Scheme (AFCS) came into force on 6 April 2005 to pay compensation for injury, illness or death caused by Service that occurred on or after that date. It replaced the previous compensation arrangements provided by the War Pensions Scheme (WPS) and the attributable elements of the Armed Forces Pensions Scheme.
115. Under the AFCS, compensation payments include a tariff-based tax free lump sum for pain and suffering associated with the injury or illness, the size of which reflects the severity of the injury or illness. There are 15 tariff levels with associated lump sums. For more serious injuries, in addition to the lump sum, a tax-free index-linked income stream known as the Guaranteed Income Payment (GIP) is paid from service termination for life to recognise loss of future earnings due to the injury or illness. Under the AFCS, a claim can be made and awarded while still in Service.
116. Where death is caused by Service the AFCS provides an income stream known as the Survivor's Guaranteed Income Payment (SGIP). This is payable to the spouse, civil partner or adult dependant for life. Compensation is also paid to eligible children, known as the Child Payment (CP).
117. Conditions are assessed against a tariff of injuries table where the lower numerical values (i.e. 1-4) reflect the more severe conditions that are awarded at the highest tariff level. Further details on the scheme can be found at [www.mod.uk/afcs](http://www.mod.uk/afcs)
118. All claims counted in this report occurred after the date of injury. However please note that the claim made under the AFCS may not be attributable to their VSI or SI sustained on Op HERRICK.
119. DASA publish a bi-annual AFCS Official Statistic which can be found on the DASA website ([www.dasa.mod.uk](http://www.dasa.mod.uk)).



## **Discussion and Future Developments**

120. A large proportion of the casualties that had a classification of VSI or SI on the initial NOTICAS signal and survived their injuries still remain in specialist care, with 57% of patients completing their care pathway.
121. To fully understand the length of time that VSI/SI patients are in treatment and the broad long term outcome measures (including the number returned to unit, those medically discharged or those re-deployed), DASA will continue to track the remaining 43% of patients with open pathways and will add subsequent patients with a NOTICAS classification of VSI or SI on Op HERRICK. DASA will update this report every six months.

## **Casualties VSI or SI in Afghanistan on Op HERRICK or Op VERITAS between 7 October 2001 and 7 October 2007**

122. Between 7 October 2001 (the commencement of Op VERITAS) and 7 October 2007 (the day before the start of the Defence Patient Tracking System), there were 93 casualties with an initial NOTICAS classification of VSI or SI on Operations in Afghanistan (49 were VSI, 44 SI); 75 (81%) of these were the result of hostile action, 18 (19%) were the result of Operational accidents.
123. Six of the 93 casualties died as a result of their injuries; three died of wounds, three died as a result of their injuries from non enemy action (all VSI).
124. As at 1 December 2012 (the latest strength data available), 50 (57%) of the 87 casualties with an initial NOTICAS listing of VSI or SI on Operations in Afghanistan between 7 October 2001 and 7 October 2007 who survived their injuries were no longer in Service.
125. As at 31 March 2012 (the latest date for which medical discharge date are available) 31 (62%) of the 50 VSI and SI casualties that survived their injuries and were no longer in Service had been discharged from Service due to medical grounds. It should be noted that the principal condition leading to discharge may not be related to the VSI/SI injury sustained.
126. Of the 31 to have been medically discharged from Service, Musculoskeletal disorders and injuries was the most common principal cause of medical discharge (22 cases). Other principal causes of medical discharge included factors influencing health status, mental and behavioural disorders, nervous system disorders and skin and subcutaneous tissue diseases.
127. 37 of the 87 casualties with an initial NOTICAS listing of VSI or SI on Operations in Afghanistan between 7 October 2001 and 7 October 2007 who survived their injuries were still in Service on 1 December 2012 (the latest strength data available). The latest Medical Deployment Standard (MDS) as recorded on the Defence Medical Information Capability Programme (DMICP) was identified;
  - 16 were medically fully deployable (MFD)
  - Eight were medically limited deployable (MLD)
  - 10 were medically non deployable (MND)
  - Three had no MDS recorded after their injury on DMICP

## Data Sources

### NOTICAS

128. Notification of Casualty (NOTICAS) is the name for the formalised system of reporting casualties within the UK Armed Forces. It sets in train the MOD's next of kin informing procedure. The MOD's Joint Casualty and Compassionate Policy and procedures set out the guidance under which a NOTICAS report is to be raised. NOTICAS takes precedence over all but the most urgent operational and security matters.
129. The NOTICAS reports raised for casualties contain information on how seriously medical staff in theatre judge their condition to be. This information is used to inform what the next of kin are told. "VSI" and "SI" are the two most serious categories into which personnel can be classified:
- Very seriously injured/ill or VSI is the definition we use where the injury/illness is of such severity that life or reason is imminently endangered.
  - Seriously injured/ill or SI is the definition we use where the patient's condition is of such severity that there is cause for immediate concern, but there is no imminent danger to life or reason.
130. The VSI and SI categories are defined by Joint Casualty and Compassionate Policy and Procedures. They are not strictly 'medical categories' but are designed to give an indication of the severity of the injury to inform the next of kin and the chain of command.
131. The NOTICAS was used to identify those personnel whose initial listing was VSI or SI between 7 October 2001 and 30 September 2012. In these figures we have excluded individuals categorised as VSI or SI whose condition was identified to be caused by illness.
132. The number of Service personnel VSI or SI as a result of Op HERRICK is published fortnightly, a fortnight in arrears, and can be found on the DASA website ([www.dasa.mod.uk](http://www.dasa.mod.uk)).

### Aeromed

133. DASA routinely receive aeromedical evacuation records from the Aeromedical Evacuation Control Centre (AECC) at RAF Brize Norton for operations in Afghanistan.
134. Not all Service personnel aeromedically evacuated from Afghanistan will receive specialist medical treatment (i.e. in a hospital, rehabilitation centre or mental health facility) but will be placed under the care of their unit Medical Officer/Medical Centre.

### Field Hospital Admissions from J97 Returns and OpEDAR

135. There is a UK Field Hospital at Camp Bastion where the more seriously ill and injured are treated. This has an intensive care and high-dependency facility, as well as surgical, medical, A+E, physiotherapy, and dental, mental health, x-ray, CT scanner and laboratory facilities.
136. DASA receive information on the patients who are admitted to the UK Field Hospital at Camp Bastion from the J97 Returns. This J97 return also includes those patients admitted to the following two locations:
- The HQ of Multinational Brigade (South) in Kandahar also maintained a Field Hospital which provides support for ISAF and Coalition personnel. This facility includes additional capabilities to that of the Role 2 including specialist diagnostic resources and specialist surgical and medical capabilities.
  - In Kabul, UK Personnel may be admitted to either the French or Greek Field Hospital. There is also a US facility which provides physiotherapy and dentistry. In total, the UK deploy some 300 medical staff to support the operation.
137. DASA also receive information on admissions and attendances at the UK Field Hospital at Camp Bastion from the Operational Emergency Attendance Register (OpEDAR)).
138. These two data sources have been used to report on length of stay in the field hospital and outcome from that admission.

139. Whilst most of the data is captured via drop down menus, some fields, including diagnosis, are free text, thus the quality of medical information captured is variable.
140. The OpEDAR system records all patients who have attended or have been admitted through the A&E department of a UK Operational hospital. The treatment classification broadly groups the data by injury treatment type. OpEDAR captures information at the initial assessment. It is possible for this to change over the course of treatment or for a patient to have multiple conditions; however, this information is not captured.

#### Amputation Data

141. The VSI/SI casualties in Afghanistan between 8 October 2007 and 30 September 2012 were linked with amputation data which are compiled from five sources:

- The Joint Theatre Trauma Register (JTTR), which commenced during 2003 to improve the care of the seriously injured patient from the point of injury to the point of discharge from hospital treatment.
- The Complex Trauma Database managed by the Defence Medical Rehabilitation Centre, Headley Court which commenced in June 2008 to record information on patients receiving inpatient care on the complex trauma ward.
- The Prosthetics Database managed by the Defence Medical Rehabilitation Centre, Headley Court which commenced in June 2006 to record information on patients fitted with a prosthetic limb(s).
- The Defence Patient Tracking System (DPTS) which commenced on 8 October 2007. The DPTS was set up to enable the capture of tracking data for aeromedically evacuated patients at the place where healthcare is being delivered along the care pathway.
- UK Service personnel who have sustained a partial or complete limb amputation as a result of injuries on Op HERRICK and Op TELIC prior 1 April 2006 have been identified from the dataset used to compile the following research paper: Dharm-datta, S; Etherington, J.; Mistlin A. & Clasper J, 2011, Outcome of amputees in relation to military Service, Journal of Bone and Joint Surgery - British Volume, Vol 93-B, Issue SUPP\_1, 52.

142. A live UK Service personnel is defined as an amputee if they have an injury coded in the JTTR as Amputation (traumatic), partial or complete, for either upper or lower limbs using the Abbreviated Injury Scale (AIS) Dictionary 2005 (Military Edition), and live UK Service personnel who had a surgical amputation performed either at the field hospital or at a UK hospital (the majority of these will be at the Royal Centre for Defence Medicine). A traumatic or surgical amputation can range from the loss of part of a finger or toe up to the loss of entire limbs.

143. Live personnel are defined as either those undergoing treatment at Camp Bastion Field Hospital or the Royal Centre for Defence Medicine (RCDM) or those being discharged from hospital after receiving treatment for the injuries that resulted in an amputation(s).

144. The data from the JTTR is cross referenced with the Complex Trauma Database, the Prosthetics Database and the DPTS. Doctors may recommend and/or patients may elect to have an amputation at any point during their care pathway, thus any additional live UK Service personnel identified as an amputee from these data sources have been included in this report.

145. The number of amputations sustained as a result of Op HERRICK are released on a quarterly basis, one month in arrears, on the DASA website ([www.dasa.mod.uk](http://www.dasa.mod.uk)).

#### Defence Patient Tracking System (DPTS)

146. The DPTS was set up to monitor the progress of Armed Forces patients undergoing specialist treatment in the UK to ensure that their care is delivered promptly and coherently, and to coordinate clinical, administrative and welfare aspects of their support. The DPTS was set up as previously this information was not stored centrally. This data source has therefore been used to track the VSI/SI casualties through their specialist care pathway.

147. The DPTS is not a medical or welfare record system; medical records are held on the Defence Medical Information Capability Programme (Primary Health Care) and by the National Health Service (Secondary Health Care); welfare records are held in single Service welfare databases. The DPTS is not an authoritative record of personnel and demographic details, these details are held on Joint Personnel Administration system.
148. The number of patients treated at RCDM and DMRC as a result of Op HERRICK are released on a monthly basis, one month in arrears, on the DASA website ([www.dasa.mod.uk](http://www.dasa.mod.uk)).

#### Medical Discharge Data

149. Medical discharges are the result of a number of specialists (medical, occupational, psychological, personnel, etc) coming to the conclusion that an individual is suffering from a medical condition that pre-empts their continued service in the Armed Forces. Statistics based on these discharges do not represent measures of true morbidity or pathology. At best they indicate a minimum burden of ill-health in the Armed Forces. Furthermore, the number and diversity of processes involved with administering a medical discharge introduce a series of time lags, as well as impact on the quality of data recorded.
150. The information on cases was sourced from electronic personnel records and manually entered paper documents from medical boards. The primary purpose of these medical documents is to ensure the appropriate administration of each individual patient's discharge. Statistical analysis and reporting is a secondary function.
151. Although Medical Boards recommend medical discharges they do not attribute the principal disability leading to the board to Service. A Medical Board could take place many months or even years after an event or injury and it is not clinically possible in some cases to link an earlier injury to a later problem which may lead to a discharge. Decisions on attributability to Service are made by the Service Personnel and Veterans' Agency.
152. The number of UK Service personnel medically discharged from the Armed Forces by financial year is released annually on the DASA website ([www.dasa.mod.uk](http://www.dasa.mod.uk)). Medical discharge data for 2012/13 are currently being validated and will be available from July 2013.

#### Mental Health Returns

153. DASA receive and collate mental health returns covering all new episodes of care of Service Personnel to the MOD's Departments of Community Mental Health (DCMHs) for outpatient care, and new admissions to the MOD's inpatient care contractor. DASA also receive data from four mental health posts located in medical centres, attached to a DCMH, staffed by mental health nurses and operating in the same way as a DCMH; seeing and treating personnel referred for specialist care with suspected mental health disorders. Throughout this report the term DCMH included these four mental health posts.
154. DCMH staff record the initial mental health assessment during a patient's first appointment, based on presenting complaints. The information is provisional and final diagnoses may differ as some patients do not present the full range of symptoms, signs or clinical history during their first appointment. The mental health assessment of condition data were categorised into three standard groupings of common mental disorders used by the World Health Organisation's International Statistical Classification of Diseases and Health-Related Disorders 10th revision (ICD-10).
155. Records submitted were excluded from the main analysis if they were duplicates or repeat attendances in the same episode of care. Civilian or non-UK military personnel are not covered by this report.
156. A rigid pseudo-anonymisation process, and other measures preserving patient confidentiality, has enabled full verification and validation of the DCMH returns, importantly allowing identification of repeat attendances.
157. This data source has been used to identify the VSI/SI patients that have attended a DCMH or inpatient care contractor as a new referral after the date of their injury.

158. The number of Service personnel referred to the MOD's DCMHs for outpatient care, and new admissions to the MOD's inpatient care contractor are released on a quarterly basis, three months in arrears, on the DASA website ([www.dasa.mod.uk](http://www.dasa.mod.uk)).

#### Compensation and Pension System (CAPS)

159. The Compensation and Pension System (CAPS) holds the data regarding the Armed Forces and Reserve Forces Compensation Scheme (AFCS). The AFCS came into force on 6 April 2005 to pay compensation for injury, illness or death attributable to Service that occurred on or after that date. It replaced the previous compensation arrangements provided by the War Pensions Scheme and the attributable elements of the Armed Forces Pensions Scheme.

160. Under the AFCS, compensation payments include a tariff-based tax free lump sum for pain and suffering associated with the injury or illness, the size of which reflects the severity of the injury or illness. There are 15 tariff levels with associated lump sums. For more serious injuries, in addition to the lump sum, a tax-free index-linked income stream known as the Guaranteed Income Payment (GIP) is paid from service termination for life to recognise loss of future earnings due to the injury or illness. Under the AFCS, a claim can be made and awarded while still in Service.

161. Where death is caused by Service the AFCS provides an income stream known as the Survivor's Guaranteed Income Payment (SGIP). This is payable to the spouse, civil partner or adult dependant for life. Compensation is also paid to eligible children, known as the Child Payment (CP).

162. Conditions are assessed against a tariff of injuries table where the lower numerical values (i.e. 1-4) reflect the more severe conditions that are awarded at the highest tariff level. Full details of the tariff can be found at <http://www.veterans-uk.info/pdfs/afcs/tariff.pdf>.

163. All claims counted in this report occurred after the date of injury. However please note that the claim made under the AFCS may not be attributable to their VSI or SI sustained on Op HERRICK.

164. Please note that figures for multiple conditions awarded by tariff percentage have not been provided in this latest update of AFCS figures. As a result of the 2010 AFCS Review a number of improvements have been made to the scheme, including changes to the way in which compensation is awarded to individuals suffering multiple injuries from a single incident. These changes have been introduced to ensure that the most seriously injured individuals receive the most compensation, and that every injury sustained in a single incident will receive some compensation. Therefore presenting information by tariff percentage is no longer relevant to the rules of the scheme.

165. SPVA are currently revisiting historic cases to apply the new scheme rules and at present this information is being recorded offline. Once information on changes to awards has been migrated to the Compensation and Pension System (CAPS) DASA will investigate reporting figures based on the new scheme rules.

166. The number of claims registered and awarded under the AFCS are reported on a quarterly basis, three months in arrears, on the DASA website ([www.dasa.mod.uk](http://www.dasa.mod.uk)).

#### Joint Personnel Administration (JPA)

167. JPA (the Armed Forces personnel system) has been used to identify if the Service personnel remains in Service and to identify if an individual has been re-deployed once their care pathway is complete (using JPA move and track).

#### Defence Medical Information Capability Programme

168. DMICP is the source of electronic, integrated healthcare records for primary healthcare and some MOD specialist care providers. This source has been used to obtain an individuals medical deployability status (MDS) after injury, which provides an indication of their Medical Deployability status. Once downgraded, Service personnel will be assessed as Medically Fully Deployable (MFD), Medically Limited Deployable (MLD) or Medically Non-Deployable (MND).

## Specialist Treatment Locations

### Hospital Treatment

#### *The Royal Centre for Defence Medicine (RCDM)*

169. Since 2001, the Royal Centre for Defence Medicine (RCDM), based at the University Hospital Birmingham Foundation Trust (UHBFT), has been the main receiving unit for military casualties evacuated from an operational theatre. In the Birmingham area, military patients can benefit from the concentration of five specialist hospitals (including the new Queen Elizabeth Hospital) to receive the appropriate treatment. The Queen Elizabeth Hospital is at the leading edge in the medical care of the most common types of injuries (e.g. polytrauma) our casualties sustain, and the majority of casualties will be treated there, but others may be transferred to another hospital (in Birmingham or elsewhere) if that is where the best medical care can be given.

#### *Ministry of Defence Hospital Units (MDHUs)*

170. There are five Ministry of Defence Hospital Units (MDHUs) where Defence Medical Services personnel work alongside civilian colleagues in NHS hospitals. As well as contributing to the care provided by these hospitals, they gain the depth and range of experience necessary to be able to administer first class treatment when deployed on Operations. When clinically appropriate, military patients are kept together and treated by military staff at these units. They are located at: Deriford, Frimley Park, Peterborough, Portsmouth and Northallerton.

#### *National Health Service (NHS) and Independent Sector Hospitals*

171. Patients may also receive treatment at other NHS hospitals or independent sector hospitals. This may occur if the patient requires treatment at a particular specialist unit or to be nearer their home.

### Rehabilitation

172. If military patients require further rehabilitation care following initial hospital treatment, they may be referred to the Defence Medical Rehabilitation Centre (DMRC) at Headley Court in Surrey, which provides advanced rehabilitation and includes inpatient facilities. Less serious cases may go on to one of MOD's 15 Regional Rehabilitation Units (RRUs) in the UK and Germany, which provide accessible, regionally based assessment and treatment, including physiotherapy and group rehabilitation facilities.

### Psychiatric Treatment

173. Psychiatric patients in the UK Armed Forces are seen for outpatient care at one of the 15 Departments of Community Mental Health (DCMH) across the UK, at the MOD's inpatient care contractor, or by one of the Community Psychiatric Nurse (CPN) when they are receiving treatment at RCDM or DMRC Headley Court. Patients may also receive treatment at one of four mental health posts located in medical centres, attached to a DCMH, staffed by mental health nurses and operating in the same way as a DCMH; seeing and treating personnel referred for specialist care with suspected mental health disorders. Throughout this report the term DCMH included these four mental health posts.

174. Mental health services are configured to provide community-based mental health care in line with national best practice, providing assessment and treatment consistent with the guidelines and standards set by the National Institute for Health and Clinical Excellence and the National Service Frameworks.

175. The DCMHs are staffed by Community Mental Health Teams comprising psychiatrists and mental health nurses based on the catchment area population of the DCMH, with access to clinical psychologists and mental health social workers.

176. Until 1st March 2009, inpatient care has been provided regionally in specialised psychiatric units under a contract with the Priory Group. In November 2008 it was announced that the South Staffordshire and Shropshire NHS Foundation Trust network (in partnership with 5 other Foundation Trusts and one NHS Scotland Trust) has been awarded a three year contract for the provision of inpatient mental health services. The transfer of inpatient care from Priory Group occurred from 1st March 2009, at which point Priory Group ceased to admit patients. To ensure appropriate

procedures were in place by 1st March 2009, selected patients were admitted to the South Staffordshire and Shropshire NHS Foundation Trust network from January 2009.