

Operational Casualty Risk Tolerance (OCRT) Framework v1.4

A Mission-Adaptive Decision Tool for Special Operations Medicine

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Executive Summary

The **Operational Casualty Risk Tolerance (OCRT) Framework** provides a mission-adaptive, evidence-based approach to casualty management and medical decision-making in Special Operations Forces (SOF) environments. Unlike traditional triage and evacuation protocols, the OCRT matrix explicitly integrates command-assigned risk tolerance levels with clinical assessment, enabling both medics and non-medical team members to make timely, accountable decisions at the point of injury.

Existing systems such as Tactical Combat Casualty Care (TCCC), START, and SALT offer robust guidelines for life-saving interventions and mass casualty triage, but lack the flexibility and operational alignment needed for complex, high-risk, or denied SOF missions. The OCRT framework addresses these gaps by providing a clear, visual decision-making pathway tailored to mission objectives, resource constraints, and evolving tactical realities. It enables rapid alignment between point-of-injury care and mission command intent, reducing decision fatigue, cognitive overload, and potential disconnects between clinical actions and operational priorities.

Key features of the OCRT framework include:

- **Three OCRT levels** reflecting command risk tolerance, briefed pre-mission and adaptable in real time.
- **Integration with existing doctrine** (TCCC, MARCH, AVPU) for initial assessment and intervention.
- **Distributed responsibility**, empowering all team members through training, checklists, and multi-format reference tools.
- **Structured documentation** and after-action review to ensure transparency, legal and ethical accountability, and continuous protocol improvement.
- **Adaptation to mission phase** (infil, action, exfil, consolidation) and multi-casualty situations, with clear criteria for evacuation, on-site management, or return to duty.

Human factors and cognitive science principles are embedded throughout the protocol, supporting usability in high-stress, resource-limited environments. The OCRT matrix also incorporates lessons from resilience engineering, distributed cognition, and the literature on after-event review.

The OCRT framework is recommended for adoption in SOF and allied operational medical environments, with pilot implementation, rigorous feedback cycles, and ongoing adaptation for multinational or coalition operations. The protocol is designed to enhance both survivability and mission effectiveness, establishing a new standard for integrating medical and operational decision-making in high-risk environments.

OCRT Levels and Card Usage Overview

OCRT Levels – Command Assignment Guide

OCRT Level	Definition	Example Mission Priority
Level 1	No loss of life is tolerated. Evacuation prioritized for all but minor injuries.	Hostage rescue with political oversight
Level 2	Moderate risk accepted. Some casualties may return to duty, others evacuated.	Direct action with partial evac capability
Level 3	Mission priority overrides most casualty evacuation.	Deep reconnaissance with no evac window

OCRT Field Cards – Function and Audience

Card	Name	Used By	Purpose
A	Operational (Blank)	Team Leaders, Medics	Mission-specific decisions, real-time use
B	Guided Explanation	Planners, Instructors	Planning, training, and instructional setup
C	Example / Reference	Trainees, QA Officers	Simulation, reference, and best practice

I. Introduction

Special Operations Forces (SOF) operate in environments characterized by volatility, uncertainty, complexity, and ambiguity. Within these contexts, the stakes for casualty management are exceptionally high, and decision-making at the point of injury can determine not only individual survival but also the overall success of the mission. While established protocols, such as Tactical Combat Casualty Care (TCCC), have standardized immediate life-saving interventions, a critical gap remains: the lack of a mission-adaptive, risk-calibrated decision-making matrix that enables rapid, context-aware choices regarding evacuation or return to duty. The concept of Operational Casualty Risk Tolerance (OCRT) addresses this gap by providing a structured, command-driven approach to casualty decision-making, tailored to operational priorities and the evolving phases of the mission. This paper describes the rationale, structure, and implementation pathway for the OCRT framework, evaluates its alignment with real-world SOF needs, and proposes recommendations for future validation and dissemination.

II. Background and Rationale

Review of Existing Triage and Decision-Making Tools

Current SOF medical doctrine relies heavily on Tactical Combat Casualty Care (TCCC), which structures care under fire, tactical field care, and evacuation based on immediate threats to life such as massive bleeding, airway compromise, and shock (Committee on Tactical Combat Casualty Care, 2022). However, TCCC does not incorporate the operational priorities unique to SOF, such as the necessity to preserve force strength during high-risk missions or the decision to return less-injured personnel to the fight when required for mission continuity.

Similarly, civilian mass casualty triage systems such as START (Simple Triage and Rapid Treatment) and SALT (Sort, Assess, Lifesaving interventions, Treatment/Transport), while effective for large-scale incidents, lack adaptability for the small, mobile teams and shifting objectives typical of SOF environments (Romig, 2002; Romig, 2012).

Several SOF units have developed informal quick-reference cards or decision guides based on field experience; however, these lack standardization, may not be evidence-based, and often fail to integrate operational and medical decision-making. No widely adopted tool provides a systematic, mission-calibrated approach to the rapid, high-stakes decision: Should a casualty be evacuated, or can they be treated and returned to duty? The absence of such a tool can lead to indecision, suboptimal care, or unnecessary mission compromise (Endsley, 1995; Lieberman et al., 2005).

Statement of Need

Given these limitations, there is a documented and urgent requirement for a decision matrix that bridges the gap between point-of-injury care and mission command intent. Such a tool should

standardize risk assessment, provide clear operational alignment, and empower all team members, not only medics, to make timely, accountable, and context-aware decisions.

III. Real-World Challenges in SOF Medical Decision-Making

Operational Contexts Unique to SOF Teams

SOF medics and operators function within highly fluid, resource-constrained, and high-risk environments. Teams are frequently isolated, exposed to direct threats, and must adapt to rapidly shifting operational objectives. Access to supplies, evacuation assets, and external support may be limited or unavailable. Mission imperatives, such as stealth, speed, or the necessity to achieve an objective regardless of casualties, often conflict directly with standard medical priorities.

Decision Dilemmas: Evacuate vs. Return to Duty

At the point of injury, medics and team leaders must make critical decisions in seconds: Should a casualty be evacuated, with all the risks and operational disruption that entails, or can the operator be treated in place and continue the mission, even if at reduced effectiveness? The consequences of these decisions are significant. Incorrect judgment can result in preventable morbidity or mortality, mission failure, or degraded team capability. These dilemmas are complicated by the lack of mission-specific guidance in standard medical algorithms.

Impact of Incomplete Information and Shifting Threats

Information at the point of injury is often incomplete or unreliable. Visibility may be poor due to environmental conditions or ongoing combat, and communication with command or supporting elements may be compromised. Enemy actions, terrain, and evolving threats further degrade situational awareness. As a result, decisions must frequently be made with only partial data and under intense time pressure.

Team Dynamics, Leadership Pressures, and Emotional Burden

Operators may underreport or minimize injuries to avoid being removed from critical roles or to support team objectives. Leadership may exert pressure to prioritize mission accomplishment over individual well-being, or, conversely, to avoid risk to personnel at the expense of the mission. Medics face the unique burden of loyalty to their teammates while simultaneously bearing responsibility for operational risk. These psychological and social factors increase the complexity and emotional cost of decision-making in the field.

Environmental and Logistical Constraints

Physical and environmental factors further complicate casualty management. Active combat, need for concealment, hostile terrain, and lack of secure evacuation routes may render timely evacuation impossible. In such scenarios, the ability to optimize on-site care and to make the best possible decision with available resources becomes essential.

Summary

The unique environment of SOF operations demands rapid, high-stakes medical decisions with limited information, shifting priorities, and immense psychological and operational pressure. Existing systems do not adequately support these realities.

IV. The OCRT Matrix: Structure and Core Features

Matrix Structure and User Base

The Operational Casualty Risk Tolerance (OCRT) Matrix is designed as a structured, visual decision-making tool that enables any trained team member, not just the designated medic, to systematically assess casualties and select an appropriate course of action. The matrix uses a stepwise, yes-or-no flowchart format to guide users through injury identification, functional assessment, and risk-based decision points. This format reduces cognitive load, mitigates decision paralysis, and standardizes care under operational stress.

The OCRT matrix and associated field cards are designed to function similarly to existing medical algorithms such as ACLS, TCCC, and PALS. Like those systems, OCRT provides a structured decision-making scaffold for high-stress environments, but is not intended as a rigid checklist or a substitute for clinical judgment.

In training and simulation contexts, OCRT cards serve as the primary tool for internalization. Operators are expected to rehearse, simulate, and review scenarios using OCRT as they would during ACLS mega-codes or TCCC drills. In live operations, the matrix is a guide, not a crutch, supporting clarity and alignment without dictating every action.

This parallel enhances user adoption by leveraging existing mental models and reinforces the purpose of OCRT: to integrate medical and operational priorities through structured decision logic, rather than constraining experienced field judgment.

This matrix provides mission-aligned guidance for managing common battlefield injuries across all three OCRT levels. It incorporates injury severity, anatomical site, functional impact, and field treatment feasibility, enabling fast, accountable decisions under pressure.

Operational Notes

- **Pain management (oral, IM) is permitted** across levels if not impairing cognition or team function.
- **Splinting guidance:** Buddy splints, improvised slings, or wrap-to-body techniques may restore limited function and enable continuation.
- **Decision Override:** When field conditions or command constraints require deviation, the medic/team lead must annotate the decision and rationale on the OCRT card.

Matrix Use Guidance

- **Standard of Care Escalation:** When uncertain, teams are advised to *default upward*, choosing the more conservative response if OCRT interpretation is ambiguous.

- **Matrix is not prescriptive:** Command, medic, or team lead may override based on operational priority, documented as part of the AAR.

See Appendix C for a printable quick-reference matrix with visuals and expanded injury conditions.

Integration of OCRT Levels

Central to the matrix is the integration of OCRT levels, which are established by command as part of pre-mission planning and communicated to all team members:

- **OCRT 1:** No loss of life is tolerated; evacuation is prioritized for all but the most minor injuries.
- **OCRT 2:** Moderate risk is accepted; some casualties may be treated and returned to duty, while severe cases are prioritized for evacuation.
- **OCRT 3:** Mission priority supersedes casualty evacuation; only the most severe, life-threatening injuries trigger evacuation recommendations.

This command-driven structure ensures that all medical decisions at the point of injury are operationally aligned and that there is no ambiguity regarding mission priorities. Teams are empowered to act with confidence, knowing their choices reflect both medical best practice and command intent.

In situations where the OCRT level is unclear, contested, or rapidly changing due to mission realities, the designated team leader or ground force commander is authorized to override or clarify the application of the matrix. This authority must be documented and, where possible, communicated up the chain of command at the earliest opportunity. Final medical decisions in ambiguous cases should be made in consultation between the medic and team leader, reflecting both the operational environment and the current intent of command.

In certain operational contexts, the OCRT framework acknowledges that immediate evacuation may not be feasible or may be incompatible with mission priorities. Under higher OCRT levels, particularly OCRT 3, the operational plan may designate situations in which evacuation is not authorized unless specific clinical thresholds are met. In these cases, the matrix guides teams toward maximizing on-site care, stabilizing the casualty as much as conditions allow, and maintaining operational continuity. This approach does not diminish the importance of casualty care but acknowledges that certain missions require strict prioritization of objective completion when evacuation would introduce unacceptable tactical risk or compromise force survivability at the mission level.

Field Guidance for Non-Evacuation Scenarios

Non-evacuation decisions are mission-driven and must be clearly communicated by command. In situations where evacuation is not authorized or not feasible, the medic and team leader will maximize on-site care, continually reassess the casualty, and document all decisions and their rationale. Documentation should occur in the unit operational log, mission casualty report, or designated electronic medical record system, as directed by the unit's SOPs. This practice ensures transparency, facilitates after-action review, and supports legal and ethical accountability. If conditions change, the potential for evacuation should be re-evaluated as soon as tactically possible. All personnel are expected to advocate for casualty welfare within the constraints of mission objectives.

Pre-Mission Briefing and Mid-Mission Adaptation

Before every mission, the assigned OCRT level and any relevant casualty care protocols are explicitly briefed. This enables all personnel to internalize expectations and protocols before entering the operational environment. Should the tactical situation shift, command can adjust the OCRT level during the mission, ensuring ongoing alignment between evolving risk tolerance and medical decisions.

Pre-Mission Evacuation Planning and Operational Integration

A. Evacuation Mapping by OCRT Level

Pre-mission evacuation planning must explicitly incorporate the assigned OCRT level. This overlay ensures that medical decision-making in the field aligns with operational risk tolerance and logistical realities from the outset.

At the planning stage, mission commanders and medical planners identify:

- **Primary and alternate casualty collection points (CCPs)**
- **Route constraints and evacuation corridors**, accounting for terrain, threat, and timeline
- **Evacuation trigger criteria**, calibrated to the current OCRT level

For example, under **OCRT 1**, all CCPs must support rapid extraction, with no expected delay or tolerance for contingencies. Under **OCRT 3**, evacuation planning prioritizes concealment and mission preservation, with CCPs used only for the most critical clinical thresholds (e.g., airway compromise, massive hemorrhage unresponsive to interventions).

These evacuation overlays are included in the mission packet and are **briefed explicitly to the entire team**. Operators must understand not only where to move casualties, but under what conditions evacuation is authorized, delayed, or denied, based on both **OCRT logic** and **command intent**. Mid-mission changes to OCRT level, if required, are communicated via standard operational channels and documented in the team log or card notation.

B. Integration into SOPs, Briefings, and Mission Documentation

The OCRT framework is inserted into standard operating procedures and mission briefings through a defined structure:

- **Mission Packet Inclusion:**
 - Assigned OCRT level listed on the front page or risk summary section
 - Relevant Field Card (typically the Guided Card B) included as a visual insert
 - Evacuation maps annotated with OCRT-specific decision points
- **Team Briefing Script Addendum:**
 - Statement of OCRT level and rationale
 - Confirmation of evacuation criteria under current OCRT designation
 - Review of 9-Line MEDEVAC usage in conjunction with OCRT logic

Note: The OCRT matrix does *not* replace the standard 9-Line MEDEVAC card. Both tools are to be used in tandem:

- **OCRT** supports the *who/when/why* of evacuation.
- **9-Line** governs the *how/where*.
The continued use of the 9-Line format is mandatory for all evacuation transmissions, regardless of OCRT level.

This dual-tool system ensures that operational alignment and medical logistics proceed in parallel, maintaining interoperability across units and command structures.

Dynamic Adaptation by Mission Stage

The OCRT matrix is not static; it adapts to the evolving phases of the mission:

- **Infiltration (Infil):** Emphasizes stealth and mission integrity; matrix prioritizes rapid self-aid or buddy-aid and may delay evacuation unless absolutely necessary.
- **Staging:** Allows for more comprehensive assessment and possible role reassignment with lower operational risk.
- **Action/Objective:** During direct engagement, the matrix typically prioritizes maintaining team strength, recommending evacuation only for the most severe casualties.
- **Exfiltration (Exfil):** As teams withdraw, evacuation thresholds may change to reflect increased opportunity for extraction or higher risk to remaining personnel.
- **Post-Action/Consolidation:** Matrix directs thorough reassessment and encourages reporting of any delayed symptoms, guiding non-critical casualties toward delayed evacuation as appropriate.

This stage-based approach ensures that the matrix remains contextually relevant and optimally supports decision-making throughout the operational lifecycle.

Team-Wide Empowerment

A core feature of the OCRT matrix is its emphasis on distributed care responsibilities. All team members are trained in basic self-aid and buddy-aid, and the matrix provides clear guidance on when these are sufficient and when escalation to an intervention by the medic or evacuation is indicated. This approach preserves the medic's capacity for the most critical cases, maintains operational tempo, and supports team morale and cohesion.

The OCRT matrix is intended to complement, not replace, existing protocols such as TCCC. The matrix serves as an operational overlay: initial casualty assessment and immediate life-saving interventions should always follow TCCC or unit-mandated procedures. Once life threats are addressed, the OCRT framework is applied to guide subsequent decisions regarding evacuation or return to duty, ensuring that tactical risk tolerance and command priorities are fully integrated with standard care.

Example Application

During a mission with OCRT 2 assigned, a team member sustains an injury. Using the matrix, the team determines that if the airway or breathing is compromised, immediate evacuation is recommended. If the injury is a controlled bleed and the operator remains alert and mobile, the matrix supports patching, monitoring, and returning the operator to duty. Further guidance is provided for other scenarios, always calibrated to the current OCRT level.

OCRT Card System – Templates and Guidance

The effectiveness of the OCRT framework depends in part on consistent card deployment across all phases of planning, execution, and review. To ensure usability, interoperability, and training alignment, a **three-card system** is employed. Each card type supports a specific function within the decision-making lifecycle and can be adapted to unit-specific SOPs and mission complexity.

A. Three-Card Model for Field and Command Use

1. Blank Operational Card (Field Card A)

- **Purpose:** Used pre-mission by command or medical planners to define operational parameters.
- **Key Fields:**
 - Assigned OCRT level
 - Mission ID and phase
 - Pre-identified evacuation points (primary and alternate)

- Tactical constraints or override authority
 - Signature field for command or mission approver
- **Use Case:** Distributed at the mission brief; each team lead or designated medic receives a populated card for reference during the operation.

2. Guided Explanation Card (Field Card B)

- **Purpose:** A version of the card embedded with instructional prompts, ensuring correct and consistent completion during planning.
- **Features:**
 - Step-by-step prompts for each card window (e.g., “Define evac delay tolerance under OCRT 2”)
 - Reminders to align the injury-action matrix to the mission stage
 - Color-coded reference to card version number and date
- **Use Case:** Used by planners, instructors, and QA officers during scenario design and briefing. This card is often included in training packets or SOP manuals.

3. Example/Reference Card (Field Card C)

- **Purpose:** A completed example card that demonstrates best practices under a defined mission scenario.
- **Features:**
 - Pre-filled entries matched to a representative SOF mission
 - Correct application of injury-action matrix
 - Notes section showing command logic behind OCRT assignment
- **Use Case:** Utilized for onboarding, validation drills, or as a just-in-time reference before live missions.

See Appendix A for templates of all three card types.

B. Instruction Sheet for Commanders and Planners

To support consistent field implementation, an accompanying **instruction sheet** provides a concise reference for those tasked with card deployment and team briefing. This document outlines:

- **How to assign the correct OCRT level** based on mission type, risk tolerance, and available assets
- **Steps to populate each card type** and distribute them to relevant personnel
- **Integration guidance for pre-mission briefings**, including scripting suggestions
- **Card versioning and archive requirements**, to support documentation and after-action review

This guide should be printed on the reverse of the Guided Explanation Card (Card B) or distributed as a standalone insert in mission packets. Instructors and unit medical officers are responsible for maintaining current versions and updating instructional content as protocols evolve.

See Appendix B for the OCRT Card Instruction Sheet.

V. Best Practices in Rapid Field Assessment

MARCH Algorithm and Field Assessment Tools

The matrix is built upon established rapid assessment protocols, with the MARCH algorithm as a foundational tool. MARCH, Massive hemorrhage, Airway, Respiration, Circulation, Head injury/Hypothermia, prioritizes the identification and management of the most critical threats to life in the tactical environment (Committee on Tactical Combat Casualty Care, 2022). All team members are trained to recognize and address these elements, ensuring a standardized initial response across SOF units (Committee on Tactical Combat Casualty Care, 2022).

Key Red Flags for Immediate Evacuation

Certain clinical findings, compromised airway, uncontrolled hemorrhage, signs of shock, decreased consciousness, penetrating chest or abdominal trauma, and major burns or fractures—are identified in the matrix as triggers for evacuation or escalation. These criteria are derived from established trauma protocols and adapted for SOF operational needs (Committee on Tactical Combat Casualty Care, 2022). When the operational context and OCRT level allow, these red flags guide prompt action toward higher levels of care.

Criteria for Patch-and-Return to Duty

The matrix also defines criteria under which a casualty may be treated in place and returned to operational duties. Minor lacerations, controlled bleeding, stable musculoskeletal injuries, and injuries with no loss of function are managed on site, with ongoing monitoring and reassessment as conditions permit (Committee on Tactical Combat Casualty Care, 2022).

Tools, Modifiers, and Pre-Mission Review

Assessment is supported by concise checklists, mnemonics (such as AVPU: Alert, Voice, Pain, Unresponsive), and color-coded triage aids, as recommended in advanced trauma care guidelines (Committee on Tactical Combat Casualty Care, 2022). Pre-mission briefings reinforce these standards and ensure that all operators understand both the assessment process and the specific operational modifiers, such as the assigned OCRT level, risk tolerance, and environmental constraints, that will guide their application during the mission.

Multi-Casualty and Resource-Limited Scenarios

When confronted with multiple casualties, the OCRT matrix should be applied sequentially to each casualty, prioritizing those with the most urgent life-threatening conditions in accordance with TCCC triage principles (Committee on Tactical Combat Casualty Care, 2022). If resources are limited and not all casualties can be evacuated simultaneously, the team leader and medic will use the matrix to determine the most critical cases for immediate evacuation, balancing both clinical severity and operational impact. Documentation of triage decisions and rationale is required for accountability and after-action review (Darling et al., 2005; Ellis & Davidi, 2005).

VI. Impact of OCRT-Driven Decisions

Effects on Mission Outcome and Operational Tempo

Decisions guided by the OCRT matrix directly influence both immediate mission effectiveness and overall operational tempo. The matrix provides clarity at the point of injury, allowing teams to maintain operational continuity and minimize disruptions. When evacuation is necessary and aligns with command intent, the process is executed rapidly and with full team awareness. When evacuation is not recommended or approved, resources and personnel remain focused on mission objectives, and the risk of unnecessary mission compromise is reduced.

Team Morale, Trust, and Resilience

The use of a shared, command-endorsed decision matrix fosters transparency and trust within the team. All members understand the rationale for medical decisions, reducing the likelihood of internal conflict, blame, or regret. The ability to participate in casualty management and decision-making supports psychological resilience and reinforces group cohesion.

Documentation, After-Action Review, and Continuous Improvement

A structured matrix enables systematic documentation of casualty decisions, which is critical for after-action reviews (AARs) and long-term process improvement. When decisions are clearly linked to operational guidelines and command-assigned OCRT levels, outcomes can be more objectively assessed, and lessons learned can be readily integrated into future protocols. This structured approach reduces hindsight bias and provides a clear record of adherence to established standards.

Long-Term Operator Health and Retention

By ensuring that medical decisions are both clinically sound and mission-aligned, the OCRT matrix promotes sustainable operator health and supports force retention. Operators who are managed appropriately at the point of injury, balancing immediate mission needs with longer-term health considerations, are more likely to recover fully and return to duty. This approach reduces preventable morbidity, preserves critical human resources, and strengthens overall operational readiness.

VII. Gaps and Needs in Current Practice

Lack of Mission-Specific, Adaptive Tools

Existing casualty management protocols do not provide a mechanism for tailoring medical decisions to the unique risk profiles of individual missions. TCCC, START, and similar algorithms lack the ability to rapidly align field decisions with command-designated operational priorities (Committee on Tactical Combat Casualty Care, 2022; Romig, 2002; Romig, 2012). As a result, teams may default to generic approaches that do not optimize either casualty outcomes or mission success.

Cognitive Overload and Decision Fatigue

In the operational environment, medics and team members are exposed to intense stress, information overload, and the need to make rapid decisions under uncertainty. Without a clear, visual, stepwise process, decision-making can slow, become inconsistent, or default to routine responses that may not be appropriate for the specific mission context. High cognitive load and decision fatigue are well-documented contributors to error and reduced performance in complex, high-stakes settings (Endsley, 1995; Sweller, 1988; Lieberman et al., 2005; Vohs et al., 2008).

Variable Training and Overreliance on Medics

Medical training levels vary across SOF teams, and not all operators possess the same confidence or competence in casualty care. There is a tendency to over-rely on the team medic, which can create single points of failure (Woods & Hollnagel, 2006). A universally accessible decision tool enables all team members to contribute to casualty assessment and management, improving redundancy and resilience (Shattuck & Miller, 2006).

Disconnect Between Point-of-Injury Decisions and Command Intent

A recurring gap is the misalignment between the decisions made at the point of injury and the actual risk tolerance or priorities established by mission command. Without an explicit, easily referenced framework such as OCRT, there is potential for confusion, delays, or actions that inadvertently compromise the mission or operator welfare.

Documentation and Accountability Issues

Many field decisions are made under pressure and are poorly documented, making post-mission review and accountability challenging. This lack of documentation impedes both quality improvement and the ability to defend or refine protocols in light of real-world experience. Robust after-action review and structured documentation are critical for continuous improvement (Darling et al., 2005; Ellis & Davidi, 2005).

Technology and Field Accessibility Concerns

While digital decision aids exist, they are often impractical for use in austere or denied environments. Teams require robust, reliable analog solutions, such as laminated cards or mental checklists, that can function without reliance on technology, power, or connectivity (Norman, 2013).

Summary

The OCRT matrix is designed to address these gaps by providing a mission-specific, adaptable, and universally accessible tool for casualty risk management in SOF operations.

VIII. Human Factors and Implementation

Cognitive, Psychological, and Emotional Impacts on Medics and Teams

Medical decision-making in SOF environments occurs under intense cognitive load. High-threat conditions, time pressure, and rapidly changing tactical situations significantly tax working memory and situational awareness, which increases the likelihood of errors and decision degradation (Endsley, 1995; Sweller, 1988). Research in military psychology demonstrates that sustained exposure to operational stressors impairs cognitive performance, reaction time, and judgment, particularly during prolonged missions or when sleep deprivation is present (Lieberman et al., 2005).

Decision fatigue also contributes to performance decline. Repeated high-stakes decisions draw upon limited cognitive resources, resulting in slower processing, reduced accuracy, and reliance on heuristics rather than deliberate reasoning (Vohs et al., 2008). The OCRT matrix mitigates these risks by providing a structured, stepwise pathway that reduces dependence on memory, narrows the decision space, and supports consistent, repeatable outcomes under pressure (Shattuck & Miller, 2006).

In addition to cognitive demands, medics experience substantial psychological and emotional burden. They balance clinical responsibilities with tactical judgment, team loyalty, and the ethical weight of casualty care. Studies on combat stress emphasize that medics often experience higher emotional strain due to responsibility for life-and-death outcomes, peer expectations, and fear of negative consequences resulting from their decisions (Adler et al., 2005). A shared, command-endorsed matrix distributes this burden, reducing individual pressure and strengthening team resilience.

Group Dynamics and Distributed Responsibility

The effectiveness of small SOF teams depends on cohesion, communication, and redundancy. By training all personnel in OCRT matrix application, responsibility for casualty assessment and decision-making becomes distributed across the team. Distributing responsibility has been shown to reduce single-point failure risk, enhance adaptability, and improve performance in complex operations (Woods & Hollnagel, 2006). Broad team familiarity with the matrix ensures continuity of care even if the designated medic is injured or otherwise unavailable.

Training Requirements and Habit Formation

Successful implementation of the OCRT framework requires structured training cycles that reinforce automaticity and reduce cognitive load during field use. Repeated exposure through scenario-based drills, pre-mission rehearsals, and high-fidelity simulations supports the development of procedural memory and situational fluency (Ellis & Davidi, 2005). Integrating the OCRT matrix into after-action reviews allows teams to evaluate decisions, identify gaps, and refine both individual and collective performance. AARs have been proven to enhance organizational

learning and operational readiness in both military and industrial high-reliability settings (Darling et al., 2005).

Importance of Simplicity, Redundancy, and Accessibility

Human factors research emphasizes that tools intended for high-stress environments must be simple, visually intuitive, and accessible in multiple redundant formats (Norman, 2013). The OCRT matrix adheres to these design principles by using minimal text, clear visual markers, and color-coded pathways. Dissemination through laminated pocket cards, wallboards, digital versions, and mnemonics ensures that the tool remains usable regardless of environmental constraints, technological limitations, or operational tempo.

IX. Simulation, Scenario Integration, and Card Internalization

The OCRT card system is designed for **training internalization**, not live-scene dependence. While laminated cards may be referenced during field operations, optimal performance depends on prior repetition, scenario exposure, and command-level integration.

A. Training and Simulation Doctrine

OCRT cards function analogously to ACLS megacode templates, TCCC trauma lanes, and MARCH sequence drills. Their primary role is to:

- **Anchor muscle memory and team cohesion** through repeated exposure
- **Reinforce OCRT logic in time-constrained scenarios**
- **Drive consistency in evac decisions and risk communication**

Simulation events should include:

- **Mission briefings with assigned OCRT levels**
- **Field card distribution (Blank + Guided) during planning phase**
- **Real-time scenario stressors requiring injury-action mapping**
- **Post-scenario AAR review of OCRT card accuracy and decision alignment**

At least two OCRT-coded simulations should be run per training cycle:

- One at **OCRT 2** (moderate risk, forced decision gate)
- One at **OCRT 3** (mission-first, limited evacuation)

Training must require both medics and non-medical leaders to participate in decision-making, ensuring cross-functional understanding and reducing medic overreliance.

B. Instructor and Team Leader Guidance

Instructors and team leaders are responsible for:

- **Issuing cards during pre-scenario briefings**
- **Monitoring correct application** of injury-action matrix
- **Documenting deviations** from OCRT recommendations and discussing justification
- **Embedding OCRT discussion into AAR**, not treating it as peripheral

When preparing scenarios:

- Cards should be **populated using the Guided Explanation Card (Field Card B)**

- An **Example Card (Field Card C)** should be included in the prep packet for reference
- Team leads should be evaluated on **alignment of actions to the assigned OCRT level**, not just clinical outcome

See Appendix D for a sample instructor checklist and debrief template.

X. Updating, Customizing, and Documenting OCRT Cards

The OCRT card system is designed for iterative evolution in response to operational feedback, mission variance, and doctrinal refinement. This section defines the **standardized update cycle**, **version control policy**, and **documentation requirements** for all card types.

A. Customization and Iterative Update Protocol

OCRT cards may be adapted to reflect:

- Mission-specific constraints (e.g., austere comms, urban density, limited evac)
- Unit-level SOPs or regional policies
- Doctrinal refinements following AAR findings or higher-level guidance

Customization Rules:

- Core structure (e.g., OCRT level definition, injury-action logic, card hierarchy) may not be altered without command approval
- Unit-level adaptations must retain consistent color coding, terminology, and sectioning
- Any modifications require a new **version tag**, recorded on the card and in the mission packet

Versioning Format:

- Format: OCRT-CARD vX.Y.Z
 - X – Major doctrine revision (rare)
 - Y – Training-level update (e.g., new condition added to matrix)
 - Z – Unit-specific customization (e.g., added field for CCP comms node)

Examples:

- v1.0.0 – Original issued card set
- v1.2.0 – Update includes improved rib fracture protocol
- v1.2.3 – Local SOF team added PACE comms checklist to Field Card B

B. Documentation, Archival, and Accountability

During Operations:

- All completed OCRT cards (Field Card A) are treated as part of the mission record
- Card must include:

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- Operator name or call sign
- OCRT level at time of injury
- Action taken, especially if **deviating** from standard matrix
- Signature or initials of decision authority (e.g., TL, Medic, GFC)

Post-Mission AAR Inclusion:

- OCRT cards must be:
 - Scanned or photographed and stored in mission archive folder (e.g., SharePoint)
 - Linked to mission timeline or casualty log for cross-reference
 - Reviewed for **decision consistency**, not just clinical outcome

Retention Periods:

- For training: minimum 6 months for QA cycles
- For live missions: per unit policy, typically 1–3 years or as required by legal/historical standards

See Appendix E for a sample OCRT card archive log sheet and file naming convention.

XII. Matrix Formats and Dissemination

Quick-Reference Card

The primary format for the OCRT matrix is a laminated, waterproof, pocket-sized card. This version employs color-coded pathways, simple icons, and minimal text to allow rapid consultation under all operational conditions. Its compact design ensures accessibility in austere, low-light, or high-stress environments.

Mobile and Digital Aids

Where technology permits, a mobile application or digital decision tool can supplement the physical card. This app version can provide interactive prompts, log decisions, and transmit data to command elements when communications infrastructure allows. However, digital tools are intended as supplements, not replacements, given the limitations encountered in denied or resource-constrained environments.

All digital tools associated with the OCRT matrix must meet operational information assurance requirements and be compatible with unit mission systems (classified or unclassified as appropriate). If technology fails or is unavailable, default to the analog (pocket card) version and verbal dissemination protocols. Teams are responsible for maintaining operational security when transmitting casualty data through digital channels

Mental Checklists and Mnemonics

To further reduce reliance on physical or digital tools, the OCRT matrix is reinforced through the use of memorable mnemonics and mental checklists. This approach enables operators to apply the decision process even if all external aids are lost or inaccessible.

Wallboard and Training Posters

For use in team rooms, pre-mission briefings, and training environments, large-format wallboards and posters present the matrix in a highly visible, easy-to-reference format. These aids support team rehearsal, ensure consistency, and enable collective review during after-action discussions.

Scenario-Based Guides

Scenario cards, either laminated or digital, provide step-by-step guidance for common casualty situations and can be incorporated into field training or used for just-in-time learning before missions.

Integration Into SOPs and Pre-Mission Briefings

The OCRT matrix is embedded within standard operating procedures and reviewed prior to every mission. This integration ensures that all team members understand the assigned OCRT level, assessment criteria, and care protocols relevant to the operation.

Best Practice: Multi-Format Redundancy

Optimal implementation combines multiple formats to maximize reliability, accessibility, and user familiarity. This redundancy ensures that the OCRT matrix is available and actionable under all possible operational scenarios.

XIII. Discussion and Future Directions

Limitations of the Current Framework

While the OCRT matrix offers substantial improvements over existing casualty management protocols, certain limitations should be acknowledged. The framework relies on clear communication of OCRT levels from command and consistent adherence by all team members. In situations where the operational environment changes rapidly, or where command intent is unclear or contested, the matrix may be less effective. Additionally, the matrix's success is contingent upon high-quality, recurrent training and the presence of a robust feedback mechanism for process improvement.

Commanders and medics must be aware that certain casualty management decisions, especially those involving non-evacuation or delayed evacuation, may carry medical-legal and ethical implications. For coalition or multinational missions, local and partner nation laws may differ. In cases of disagreement or ethical uncertainty, escalation to higher command or medical oversight is advised, and all decisions should be clearly documented to ensure post-mission accountability and review.

Possibilities for Mission-Stage Adaptive Decision-Making

An area for further development is the potential for dynamic, mission-stage adaptive decision-making within the OCRT matrix. Incorporating decision branches tailored to specific operational phases, such as infill, staging, objective action, exfiltration, and post-mission consolidation, may further enhance the context sensitivity and practical value of the framework. However, increased complexity must be balanced against the need for simplicity and ease of use, particularly under high-stress conditions. This addition may be best approached as an advanced feature or as part of future pilot studies and validation efforts.

Recommendations for Piloting, Feedback, and Further Study

Initial field deployment of the OCRT matrix should be accompanied by structured feedback from users at all levels, including medics, operators, and command staff. Data from after-action reviews, incident reports, and training exercises should be used to refine decision pathways, clarify ambiguous scenarios, and document best practices. Pilot programs may focus on evaluating the matrix's impact on decision-making speed, accuracy, and team cohesion.

Future research should address the matrix's effectiveness in diverse operational environments, its adaptability to allied or partner force contexts, and its integration with emerging medical and communications technologies. Peer-reviewed publication, presentation at professional conferences, and cross-institutional collaboration are recommended for broadening the evidence base and accelerating adoption.

Legal and Ethical Considerations

In cases of medical-legal or ethical ambiguity, such as when operational directives, medical best practices, or multinational rules of engagement are in tension, consultation with the unit's legal advisor (JAG) or medical director is recommended. This ensures that casualty management decisions are aligned not only with operational priorities, but also with applicable legal standards and ethical frameworks. Such consultation, when possible, should be documented alongside the medical decision record.

Implications for Broader Adoption

The OCRT framework's design principles, clarity, operational alignment, and accessibility, are generalizable to other high-stakes, dynamic environments beyond SOF medicine. Broader adoption may support improvements in casualty management for other military branches, first responder organizations, and disaster response teams. As the tool is further validated, it may serve as a template for mission-tailored decision-making frameworks in related fields.

XIV. Conclusion

The Operational Casualty Risk Tolerance (OCRT) framework offers a mission-adaptive, team-empowering approach to casualty decision-making in Special Operations Forces environments. By explicitly linking point-of-injury management to command intent and operational priorities, the matrix addresses longstanding gaps in traditional triage and evacuation protocols. Its structured design promotes rapid, context-aware decisions, distributes responsibility across all team members, and supports documentation and continuous improvement. While additional validation and refinement are needed, especially regarding integration with dynamic mission stages, the OCRT matrix provides a robust foundation for enhancing both survivability and operational effectiveness in high-risk, complex settings. Broad adoption and further study are recommended to maximize its impact across SOF and related domains.

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Appendix A: Field Card A — Blank

Use: Used by team leaders and medics during operations. Contains no prompts. Filled out per mission by command.

OCRT FIELD CARD A – OPERATIONAL
Mission Name: _____ Mission Identifier: _____ Date and Time: _____ OCRT Level Assigned: ☐ 1 ☐ 2 ☐ 3
CASUALTY COLLECTION
Primary CCP (Casualty Collection Point): _____ Alternate CCP: _____ Evacuation Route Notes: _____
INJURY ACTION LOG <i>(Refer to injury-action matrix for guidance)</i>
Injury 1: _____ Action Taken: _____ Injury 2: _____ Action Taken: _____ Override Notes (if deviating from matrix): _____ Authorized by: _____
LOGISTICS / COMMUNICATIONS
Evacuation Point of Contact: _____ Radio Frequency (Primary): _____ Radio Frequency (Alternate): _____ Signature: _____

Version: OCRT-CARD v1.2.0

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Appendix A: Field Card A — Blank

Use: Used by team leaders and medics during operations. Contains no prompts. Filled out per mission by command.

Appendix B: Field Card B — Guided Explanation Card

Use: Use: Pre-mission planning tool for instructors and command staff. Mirrors Field Card A with embedded guidance for each field.

OCRT FIELD CARD A – OPERATIONAL
Mission Name: <i>Full name of the operation or objective (e.g., “Night Watch,” “Falcon Strike”).</i> Mission Identifier: <i>Internal mission tracking code or ID number used in TOC/ops systems.</i> Date and Time: <i>Planned date/time of execution. Include time zone if relevant.</i> OCRT Level Assigned: ☐ 1 ☐ 2 ☐ 3 <i>Circle or check assigned risk tolerance level: 1 (No loss), 2 (Moderate risk), 3 (Mission-first).</i>
CASUALTY COLLECTION
Primary CCP (Casualty Collection Point): <i>Exact location where casualties will be staged. Use grid, building name, or landmark.</i> Alternate CCP: <i>A backup collection point in case the primary is compromised or unreachable.</i> Evacuation Route Notes: <i>Planned evac path from CCP to pickup site. Note obstacles, risk zones, or alternate paths.</i>
INJURY ACTION LOG <i>(Refer to injury-action matrix for guidance)</i>
Injury 1: <i>Enter expected or probable injury (e.g., “rib fracture,” “minor burn”).</i> Action Taken: <i>Matrix-based action: Evacuate, monitor, return to duty, or override.</i> Injury 2: <i>Enter the second likely or planned-for injury type.</i> Action Taken: <i>Define the pre-authorized or expected response under the current OCRT level.</i> Override Notes (if deviating from matrix): <i>Record any expected deviations from standard action. Include scenario and reasoning.</i> Authorized by: <i>Name, role, or call sign of person who approves override logic.</i>
LOGISTICS / COMMUNICATIONS
Evacuation Point of Contact: <i>Primary individual responsible for triggering evacuation. Include role or callsign.</i> Radio Frequency (Primary): <i>The main communications frequency for casualty movement coordination.</i> Radio Frequency (Alternate): <i>A backup communications channel in case of failure or jamming.</i> Signature: <i>Signature or initials of the planner completing this form.</i>

Version: OCRT-CARD v1.2.0 or the current version assigned by command. Always include version control.

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Appendix C - Page 1: Field Card C — Sample Card

Use: Use: Pre-mission planning tool for instructors and command staff. Mirrors Field Card A with embedded guidance for each field.

OCRT FIELD CARD A – OPERATIONAL
Mission Name: Falcon Strike
Mission Identifier: FS-1125-ZULU
Date and Time: 2025-11-16 / 0430Z
OCRT Level Assigned: ☒ 2 (Moderate risk – casualties may be managed forward or evacuated)
CASUALTY COLLECTION
Primary CCP: Rooftop – Building Bravo, Grid 1349.8920
Alternate CCP: Rear alley courtyard, northeast exit, same grid quadrant
Evacuation Route Notes: Exit via east stairwell, down alley to LZ Hawk; risk: sniper window at grid 1350.8917; fallback route behind comms shed if blocked
INJURY ACTION LOG <i>(Refer to injury-action matrix for guidance)</i>
Injury 1: Rib fracture (TL Alpha)
Action Taken: Splinted. Monitored. Remains in command position with pain control.
Injury 2: <i>Partial-thickness burn (left forearm) – Breacher</i>
Action Taken: Covered. Continue mission. Evacuate only if infection or spread is noted.
Override Notes: If TL Alpha loses mobility, initiate delayed evac via fallback CCP. No override yet triggered.
Authorized by: LT Hale – Ground Command
LOGISTICS / COMMUNICATIONS
Evacuation POC: SSG Grant (Callsign: Raincap)
Radio Frequency (Primary): 155.360 MHz
Radio Frequency (Alternate): 155.400 MHz
Signature: C. Monroe

Version: OCRT-CARD v1.2.0

Appendix C - Page 2: Field Card C — Injury Matrix

Use: Use: Pre-mission planning tool for instructors and command staff. Mirrors Field Card A with embedded guidance for each field.

Injury / Condition	OCRT 1 (Risk Averse)	OCRT 2 (Balanced Risk)	OCRT 3 (Mission Priority)
Capillary Bleed	Patch, return to duty	Patch and monitor	Patch and continue
Venous Bleed	Pressure, patch, observe	Hemostatic agent, continue if sealed	Wrap, reassess every 15m
Arterial Bleed (controlled)	Tourniquet and evac	Secure TQ, evac if distal compromise	Secure TQ, continue if perfusion stable
Superficial Laceration (<2cm)	Evac optional	Patch/glue, monitor	Patch, return to duty
Deep Laceration (muscle visible)	Evac for closure	Dress, evac if reduced function	Pack, pain manage, continue if limb usable
Long Bone Fracture (closed)	Splint + evac	Splint, monitor function, evac if unstable	Splint, pain manage, continue if non-weight bearing
Upper Extremity Fracture (minor)	Evac for imaging	Buddy splint or sling, continue if usable	Secure limb, return with limited function
Lower Limb Fracture (non-weight-bearing)	Splint and evac	Splint, assist with mobility	Splint and move with aid (crutch, buddy carry)
Rib Fracture (non-flail)	Evac for eval	Wrap, monitor vitals	Wrap, continue if breathing stable
Flail Chest Segment	Immediate evac	Priority evac	Evac only if respiratory distress
Mild Concussion (GCS 15)	Evac for neuro eval	Monitor x2hr, restrict from complex tasks	Return to duty if AVPU A/V
Heat Illness (moderate)	Evac + IV fluids	Cool + fluids, evac if no improvement	Cool in place, observe LOC
Smoke Inhalation (mild)	Evac with O ₂	Monitor breath sounds, consider evac	Monitor; evac only if respiratory decline
Abdominal Pain (non-traumatic)	Evac for further eval	Monitor + hydration	Monitor; evac if collapse or guarding
Penetrating Trauma (torso/extremity)	Immediate evac	Evac priority unless non-critical	Treat in place unless ABCs compromised
Blunt Chest Wall Trauma	Evac for imaging	Wrap, monitor O ₂ sats	Field treat, monitor vitals
Eye Trauma (non-penetrating)	Evac for eval	Shield, assess acuity	Shield, continue unless vision impaired
Traumatic Amputation (limb)	Evac with TQ and hypothermia prevention	Evac priority; apply dressing and TQ	Control bleed, hypothermia protocol, evac if able
Burns – Superficial (1st degree)	Evac optional	Cool, hydrate, return to duty	Cool, dress lightly, continue
Burns – Partial Thickness (2nd)	Evac for pain control and infection risk	Dress, monitor for fluid loss	Field dress, manage pain, evac if >10% TBSA
Burns – Full Thickness (3rd)	Immediate evac	Evac priority	Dress + pain management; evac if vitals decline
Facial Trauma (no airway threat)	Evac for imaging	Ice, dress, evac if swelling increases	Continue with wound care, monitor for changes
Facial Trauma (airway involved)	Immediate evac	Airway management + evac	Secure airway in field, evac only if decompensating

Appendix D – Instructor Checklist & AAR Debrief Template

Use: Provided to instructors and scenario planners for use during training simulations and live mission rehearsals involving OCRT-level integration.

Instructor Pre-Simulation Checklist

- OCRT Level assigned and briefed to team
- Field Cards distributed (Blank A + Guided B)
- Scenario injury types selected (must align with injury-action matrix)
- Evacuation points pre-marked on map
- Override trigger discussed with team leads
- Safety and comms protocols reviewed
- Observer assigned for decision tracking

Post-Simulation AAR Template

- **Scenario Code:** _____
- **Date / Time:** _____
- **Instructor Name:** _____
- **OCRT Level Assigned:** ☐ 1 ☐ 2 ☐ 3
- **Total Casualties Simulated:** _____

Evaluation Points:

Category	Satisfactory?	Notes
Injury-Action Match	☐ Yes ☐ No	
Decision Documentation	☐ Yes ☐ No	
Override Used	☐ Yes ☐ No	Justified? _____
Comms Coordination	☐ Yes ☐ No	
Leadership Decision Flow	☐ Yes ☐ No	
Debrief Conducted	☐ Yes ☐ No	Key Insight: _____

Appendix E – Card Archive Log & File Naming Convention

Use: For units or instructors to maintain accountability and retrieval of completed OCRT Field Cards from operations or simulations.

Card Archive Log Sheet (Example Format)

Mission Name	Card Type	OCRT Level	Date	Team Lead	Archived Filename
Falcon Strike	Field Card A	2	2025-11-16	LT Hale	FS-1125ZULU-A_v1.2.pdf
Night Watch	Field Card A	3	2025-10-09	SFC Owens	NW-1009A_v1.2.jpg

Standard File Naming Convention

Format: [MISSION ID]-[CARD TYPE]_v[VERSION].[filetype]

Examples:

- FS-1125ZULU-A_v1.2.pdf (Operational Card A)
- FS-1125ZULU-B_v1.2.docx (Guided Card B)
- NW-1009-C_v1.2.jpg (Example Card C scanned image)

Retention Policy (Suggested)

- **Training Simulations:** Retain minimum 6 months
- **Live Operations:** Retain 1–3 years per unit SOP or legal review policy