

Initial Approach (Phase 1)	
<b>1. PPE</b>	
The Incident Commander and Team members adopted appropriate levels of PPE when approaching the scene.	5
The Incident Commander or Team members entered the risk area with minor PPE deficiencies.	3
The Incident Commander or Team members entered the risk area with multiple or significant PPE deficiencies.	0
<b>2. Scene protection</b>	
Appropriate controls were implemented to protect the scene and respond to the potential fire risk.	5
Deficiencies in control measures impacted on-scene safety, exposing the working area to unnecessary risks.	3
No scene controls were implemented, leaving the working area unprotected.	0
<b>3. Safety instructions to the team</b>	
The Incident Commander provided explicit instructions, prioritised actions and prevented unauthorised access to the risk area.	5
The Incident Commander's instructions were delayed or unclear and needed clarification.	3
Team members self-deployed or ignored instructions and entered the risk area without approval.	0
<b>4. Safe approach</b>	
The Incident Commander and Teams approached the risk area and were controlled, safe, and without delay. Team members only entered when authorised, and immediate risks were identified and mitigated.	5
The Incident Commander or Teams approach exposed them to minor hazards or was delayed.	3
The Incident Commander or Teams approach was unsafe, overlooking significant hazards.	0
<b>5. 360° Evaluation</b>	
The Incident Commander performed a complete survey without delay, identifying all the immediate hazards.	5
The Incident Commander performed a mechanical/adequate survey, or overlooking minor hazards, or there were delays or an incomplete 360 visualisation of the scene.	3
The Incident Commander's assessment was poorly executed, overlooking significant hazards.	0
<b>6. Patient(s) Information</b>	
Within the context situation, information was obtained about the number of patients, their position, and their level of consciousness within timeframes that were not detrimental to their health or welfare.	5
Information about the number of patients, their position, and their level of consciousness was obtained but with delays or minor omissions.	3
Critical information about the number of patients, their position, or their level of consciousness was overlooked, causing detriment to the patient's health or welfare.	0
<b>7. Level of entrapment</b>	
The patient(s) level of entrapment was correctly identified, preventing delays in planning and patient(s) extrication.	5
The patient(s) level of entrapment was correctly identified, but with delays that impacted planning and patient(s) extrication.	3
The patient(s) level of entrapment was not identified, resulting in significant delays, a change to plans and an impact on the patient's welfare.	0
<b>8. Vehicle survey</b>	
OTHER vehicles were subject to a complete interior survey; assessed for impactive hazards. Vehicle data sheets were used if accessible. The luggage compartment was checked, and vehicle batteries were disconnected subject to the need to operate electrical items and accessibility. All hazards were identified, and risks were removed, isolated or mitigated.	5
All vehicles were assessed, minor hazards were overlooked, or the level of risk was not adequately reduced.	3
Not all vehicles were assessed, significant hazards were overlooked, or the level of risk was not reduced.	0
<b>9. Access to the Patient(s)</b>	
The Incident Commander identified access points to the patients(s) and considered egress options for responders.	5
Access points were identified, but with slight delays or less impactive options were available.	3
There were significant delays in gaining access to the patient, impacting their health and welfare	0
<b>10. Interior space</b>	
Initial space was created, maximising access and room for the Medic to provide patient care. Space was appropriately adapted to support extrication pathways and minimise manual handling risk.	5
Minimum initial space was created to support access and room for the Medic. Space was partially adapted to support extrication pathways and minimise manual handling risk.	3
Insufficient or no interior space was created, impacting access, patient care and extrication pathways.	0
<b>11. Scenario status</b>	
The Incident Commander declared the scene safe when appropriate and shared relevant information that was identified during the scene survey.	5
The Incident Commander declared the scene safe and shared information, but the information had to be clarified or excluded minor points.	3
The Incident Commander failed to declare the scene safe or did not share critical information.	0
<b>12. Management priorities</b>	
The Incident Commander identified and managed all initial priorities logically, gaining access to the patient quickly and safely.	5
The Incident Commander identified and managed all initial priorities, but out-of-sequence or unnecessary actions delayed access to the patient.	3
The Incident Commander overlooked key priorities, or there were significant delays or actions were unsafe.	0
<b>13. Communication with Medic</b>	
During the initial approach, the Incident Commander maintained effective two-way communication with the Medic.	5
Communication with Medic needed to be clarified or more bi-directional.	3
Communication with the Medic was limited.	0
<b>14. Communication with Technical team</b>	
During the initial approach, the Incident Commander maintains effective two-way communication with the Technical team.	5
Communication with the Technical team needed to be clarified or more bi-directional.	3
Communication with the Technical team was limited.	0

## Plans (Phase 2)

### 15. Plan communication with Medic

The IC contacts and agrees on plan(s) with the Medic once the primary assessment has been performed and without delay	15
Communication with the Medic was delayed or incomplete, impacting planning and progress.	10
Communication with Medic was without primary information about patient(s) conditions, impacting planning decision.	5
The IC does not consider information from the Medic in order to decide the plan(s)	0

### 16. Plan Communication With Technical Team

Risk and Patient(s) information was exchanged to provide a shared situational awareness. The patient's clinical needs, condition, extrication pathways, and plans were discussed. Technicians have the opportunity to provide input into the extrication plan(s).	15
Risk and Patient(s) information was exchanged to improve situational awareness but with slight delays. The patient's clinical needs, condition, extrication pathways, and plans were partially discussed. Technicians provide input into the extrication plan(s).	10
Risk and Patient(s) information was partially exchanged to improve situational awareness. The patient's clinical needs, condition, extrication pathways, and plan(s) were partially discussed. Technicians do not provide input, or their ideas are very ambitious regarding plan(s).	5
Minimal or no information was shared, or the Technical team had no planning input due to authoritarian command.	0

### 17. Plan(s) communication

The plans were communicated clearly with team members without delays. All planning briefings reflected a patient-centred extrication, considering their welfare and clinical needs.	15
The plan(s) were communicated clearly with team members with slight delays. All planning briefings reflected a patient-centred extrication, considering their welfare and clinical needs.	10
The plan(s) were communicated with team members with delays, or the patient(s) clinical needs were not included in the team briefing.	5
The plan(s) were communicated with team members with significant delays, or planning did not factor in the clinical needs of all patient(s).	0

### 18. Appropriate selection of plans

All plans reflected the clinical needs of the patient(s). Consideration was given to Immediate, Emergency and Full plan(s), and they were applied appropriately.	20
All plans reflected the clinical needs of the patient(s) but did not consider changes in the patient(s) condition, or one of the plan(s) is ambiguous	10
Not all plans reflected the clinical needs of the patient(s), or other options were more viable.	5
Plans did not reflect the needs of the patient(s).	0

### 19. Planning objectives and priorities

Planning and priorities reflected the triage of the patients, and clear objectives were identified, exchanged and understood.	20
Planning and priorities reflected the triage of the patient(s), and clear objectives were identified, and exchanged but confirmation of understanding was not confirmed.	10
Planning reflects the triage of patient(s), but priorities or objectives were unclear.	5
Planning did not reflect the triage of patient(s), or priorities or objectives were not provided.	0

### 20. Vehicle type.

Planning considered the functionality of seats, safety systems, glass, vehicle type, and body construction.	15
Planning considered the functionality of seats, safety systems, glass, vehicle type, and body construction with minor omissions.	10
Planning considered the functionality of seats, safety systems, glass, vehicle type, and body construction with moderate omissions.	5
Planning overlooked vehicle components that had a detrimental impact on extrication pathways.	0

### 21. Patients and resources.

Planning considered the available resources, number of casualties, level of entrapment, injuries, triage, casualty size and physical needs.	15
Planning overlooked minor details that led to slight delays in the extrication of patients.	10
Planning overlooked essential details that led to extensive delays in the extrication of patients.	5
Planning did not consider critical factors that led to the implementation of alternative plan(s), caused delays and had a negative impact on the patient(s).	0

### 22. Impact on patient

Plan(s) were patient-focused and provided pathways that minimised the impact on the patient(s) condition and injuries. The space created was ample for the patient's and team's needs. Consideration was given to the need for immediate or rapid extrication.	15
Plan(s) were patient-focused and provided pathways that minimised the impact on the patient(s) condition and injuries. The space created was adequate but could be improved. Consideration was given to the need for immediate or rapid extrication.	10
The execution of the plan(s) was not fully focused on the patient's condition and could have resulted in some injury to the patient due to the limited space created.	5
Plans were not patient-centred, with actions detrimental to their health and well-being.	0

### 23. Plan(s) progression

Activities were coordinated, logical and simultaneous. Potential issues were considered and acted on, preventing delays. Plans were reviewed and updated if required.	20
Activities were coordinated, logical and simultaneous. Potential issues were considered and acted on but with minor delays. Plans were reviewed and updated if required.	10
Activities were coordinated, logical and simultaneous; some sporadic simultaneous activities. Plans were not reviewed and updated when needed with slight discrepancies. Unforeseen or slow corrections created minor delays.	5
Activities were uncoordinated, out of sequence or protracted. Delays were created by indecision by the Incident Commander.	0

### 24. Patient(s) extrication

The final creation of the space is of adequate size to accommodate removal of the patient. Adequate protection was provided, and the extraction method is performed without sudden movements. Patient in a safe place outside the vehicle	20
The final space creation was adequate, with some difficulties during the extrication process. Suitable protection was provided, but with minor failures, the extrication method reflected the patient's injuries/condition. <b>The patient is in the process of extrication, or the extrication device is in position.</b>	10
The final creation of the space was not adequate, with adverse movements to the patient during the extraction process. Adequate protection was not provided during extraction. Precipitous extraction or board going into the vehicle.	5
The final creation of the space was inadequate or has not been completed. The board does not go into the vehicle; therefore, the extraction does not start.	0

## Command and Control (During the Process)

<b>25. Dynamic Risk Assessment</b>	
The scene was reassessed throughout; all hazards were identified and reported, risks were considered, and controls were implemented without delays.	5
The scene was reassessed throughout; not all hazards were identified or reported, or controls were implemented with delays.	3
The scene was not reassessed, or controls were not introduced to mitigate significant risks.	0
<b>26. Positioning</b>	
The Incident Commander maintained good positioning throughout the incident. The Commander is always in the best position to control all major actions.	5
The Incident Commanders' positioning was intermittent.	3
The Incident Commander's positioning was inadequate or inappropriate.	0
<b>27. Control of techniques and tools</b>	
Incident Commander ensured that all technical actions were completed without delay, supported the objectives of the extrication plans and were completed safely, systematically and efficiently.	5
There were some minor delays to technical actions, with some deviation from the plan's objectives, or there were slight issues with safety or simultaneous actions.	3
There were delays to technical actions, with deviation from the plan's objectives, or there were significant issues with safety or simultaneous actions	0
<b>28. Control momentum</b>	
The Incident Commander controlled the momentum of operations and maintained the appropriate speed, ensuring continuous progression.	5
The Incident Commander was inconsistent in controlling the momentum and speed, which impacted progression.	3
The Incident Commander allowed the Technical Team to dictate the control and pace of operations.	0
<b>29. Command &amp; Control</b>	
The Incident Commander had overall command and control of the situation throughout the rescue (the Incident Commander conveyed authority, security and confidence in their work).	5
The Incident Commander lost command and control of the scene situation occasionally.	3
The Incident Commander lost command and control of the scene situation.	0
<b>30. Team welfare</b>	
The Incident Commander considers hydration, fatigue - including tool rotation, the weight of equipment, vehicle components and working in a confined working environment.	5
Incident Commander does not act at the appropriate time to rotate tool operations, or the Technical Team does it on their own.... Handling of heavy objects was performed with physical hazards.	3
Incident Commander did not consider the welfare of the Technical team; with minimal team rotation, or heavy objects (guardrails, tree trunks, etc.) lifted with little thought to the operator.	0
<b>31. PPE control</b>	
Incident Commander controlled and promoted the use of PPE throughout without failures or delays	5
There were minor failures or delays in the use of PPE or RPE. (respiratory protective equipment)	3
There were significant failures or delays in the use of PPE or RPE that impacted the safety of team members or patients.	0
<b>32. Stabilisations / Lifting</b>	
The Incident Commander oversaw lifting operations or stabilisation checks. They were timely and did not impact the patient's welfare.	5
The Incident Commander oversaw lifting operations and stabilisation checks. There were slight delays, impact on the patient or they were not completed at a logical time.	3
The Incident Commander did not oversee lifting operations or stabilisation checks. There was significant delays or substantial impact on the patient.	0
<b>33. Risk Control</b>	
Incident Commander created a safe working area and controlled all hazards without delay or failure.	5
The Incident Commander focused on creating a safe work area and ensured that most scene hazards were controlled or there were delays.	3
The Incident Commander overlooked significant or numerous hazards, failing to introduce controls.	0
<b>34. Tidy and safe work area</b>	
The work area was tidy and safe throughout the rescue.	5
The work area was sufficiently tidy and safe but with slight deficiencies.	3
The work area was chaotic, unsafe or adding unnecessary risk to the working area.	0
<b>35. Resource Management</b>	
Incident Commander managed and coordinated all resources. Decisions made promptly and efficiently (one step ahead) to ensure maximum use of resources, equipment, procedures.	5
The Incident Commander managed and coordinated resources but lost control or made poor decisions occasionally.	3
There was no control or coordination of resources.	0
<b>36. Motivation</b>	
The Incident Commander motivated and encouraged or calmed down the team all times at the correct moments, ensuring a positive momentum all the time	5
The Incident Commander motivated and encouraged or calmed down the team sometimes but was not consistent.	3
The Incident Commander did not motivate, calm down or encourage the team	0
<b>37. Confidence in the team</b>	
The Incident Commander demonstrated full confidence in their team.	5
The Incident Commander provided teaching or made some corrections, demonstrating some confidence in the team.	3
The Incident Commander had limited trust in the team, providing excessive teaching or corrections.	0
<b>38. Hands-on</b>	
The Incident Commander occasionally assisted where needed, and focus was maintained on activities.	5
The Incident Commander assisted when necessary but occasionally lost focus, losing control of the scene.	3
The Incident Commander assisted excessively, constantly focused on specific actions, losing vision and control of the scene.	0

## Command and Control (During the Intervention)

39. Patient(s) condition	
The Incident Commander received (or searched for) sufficient information about the patient's condition without delays	5
The Incident Commander receives (or searches for) sufficient information about the patient's condition but with delays.	3
The Incident Commander was not concerned with receiving (or searching for) information about the patient's condition	0
40. Warnings	
The Incident Commander monitored safety warnings (noises, movements, etc.) to the medic and patient throughout the incident without delays.	5
The Technical team gave safety warnings, but some were missed or delayed.	3
The patient received no warning due to failures in team communication	0
41. Patient's safety and well-being	
The Incident Commander monitored the patient's safety and well-being, ensuring adequate protection throughout the rescue.	5
The Incident Commander showed some concern for the patient's safety and well-being, with slight shortcomings or delayed corrections.	3
The Incident Commander had little concern for the patient's safety and well-being.	0
42. Coordination with Medic	
The Incident Commander coordinated activities with the Medic to collectively influence actions and outcomes (initial approach, access, plan selection, patient extrication).	5
The Incident Commander coordinated sufficiently with the Medic; some were not at the appropriate time.	3
The Incident Commander did not coordinate with the Medic.	0
43. Clear instructions to the team	
Instructions to the team were clear, concise, and personalised, with confirmatory responses without delay.	5
Instructions were clear but not personalised or with delay.	3
Instructions were not given by the Incident Commander or were ignored or misunderstood by the team, or there was no confirmatory response.	0
4. Communication with Technical team	
Communication with the Technical team was always effective and two-way, with appropriate body language and tone.	5
Communication was adequate, with slight lapses.	3
There was little communication with the Technical team during the rescue or there was not confirmatory response	0
45. Patient's condition	
The Incident Commander received information about the patient's condition and injuries at the appropriate time (on the initial approach, after primary assessment, followed by regular updates).	5
The Incident Commander received information about the patient's condition and injuries, but it was incomplete or done at inappropriate or delayed times.	3
No information about the patient's condition or significant injuries was received.	0
46. With Medic	
Communication with the Medic was effective and two-way at all times; it continued throughout to ensure a <b>patient-centred rescue</b> .	5
Communication with the Medic was adequate, with some minor lapses	3
There was very little or no communication with the Medic during the rescue.	0
PHASE 3: EXTRICATION	
47. Patient handover	
The Incident Commander identified the extrication phase (phase 3) and passed control of patient handling and extrication to the Medic. The Commander remained in overall control of the rescue.	10
The Incident Commander identified the extrication phase, but there was confusion about who controlled the extrication or movements.	5
The Incident Commander did not identify the extrication phase. There was no control of the extrication or movements, or the extrication phase was not reached.	0