5 May 2026

MEMORANDUM

From: HM2 (FMF) Garcia, Adrian Anthony, USN
To: All Concerned

Subj: UKR ESCORT PROGRAM OVERVIEW REPORT

1. This correspondence provides a summarized overview of the escorted Ukrainian Medical Training Team at Strensall, York, England and at Camp Jomsberg, Lipa, Poland as a Temporary Duty Assignment (TDY) from 28 Apr 26 to 02 May 26. The information reflects key observations I noted from staff and students and should not be interpreted as a verbatim record.

2. The following are focus points of at Land Medical Team Centre (LMTC), Strensall, England:

a. Decedent Affairs and Joint Trauma Registry. The Ukrainian (UKR) Medical Training Team expressed strong interest in how LMTC incorporates current battlefield injuries and medical conditions into its courses. LMTC explained that course updates are not made immediately following new developments; instead, changes must first go through a peer-review process unless an urgent operational requirement demands otherwise. LMTC also emphasized that much of their curriculum was created based by Deployed Medicine and data from the Joint Trauma Registry (JTR), which they use to track injuries and develop representative patient profiles for training. The UKR medical team noted that they are attempting to update their own JTR but face significant challenges. Many casualties cannot be recovered promptly or at all making it difficult to accurately determine causes of death and use that information for training and medical improvements. They also requested guidance on establishing a Decedent Affairs program. Their primary goal is to ensure fallen personnel can be properly accounted for and returned home with dignity, as they currently lack a formal system to support this process.

b. Accountability for Pushing Through Students. The UKR team asked how LMTC determines whether a student successfully completes a course. Specifically, they wanted to understand who decides whether an incorrectly performed or medical intervention such as a needle decompression constitutes a partial pass or a complete failure during an individual assessment. They also questioned how LMTC handles borderline academic results, such as a student missing the required passing score by 0.01%. LMTC explained that several steps are taken before making any final determination. First, the student is given an opportunity to remediate. They are then privately asked whether any personal issues may be affecting their performance. Instructors and the class leader also provide their assessments of the student's overall capability and professionalism. LMTC then contacts the student's gaining command to determine whether the individual meets local operational requirements and to coordinate opportunities for future remediation if needed. Taking all factors into account, the Officer in Charge or Commanding Officer makes the final pass/fail decision and assumes full responsibility for that outcome. Based on all available information, the student is placed into one of four performance categories:

(1) Blue – above the standard.

(2) Green – meeting the standard.

(3) Amber – below the standard.

(4) Red – not meeting the standard.

3. The following are unique informative findings from Land Medical Team Centre (LMTC), Strensall, England:

a. Instructor Removal During Student Test Out. LMTC has fully transitioned to a training model that removes instructors from the immediate environment during final medical evaluation scenarios. Instead, the facility now operates on a "dumb mannequins, smart devices" approach. All major testing areas are equipped with 360-degree cameras capable of recording and transmitting audio, while instructors monitor and control the scenario remotely. They manage every environmental and medical cue—including speakers, temperature changes, vital-sign monitors, electrocardiogram displays, smoke machines, and other simulation tools from a separate control room. This setup allows students to immerse themselves completely in the scenario without direct instructor prompting. After the evolution is complete, the class reconvenes to review recorded footage, observe each other's performance, and receive an individually structured debrief.

b. Mannequin Molds are made on Site. LMTC trains a wide range of medical personnel, from individual providers in courses like the Platoon Combat Medic (PCM) program to full company sized role two medical teams. Supporting this broad spectrum of training requires a substantial amount of medical simulation equipment. To meet these demands efficiently, LMTC maintains on site acrylic molding capabilities that allow them to produce and replenish many of their anatomical training components, such as replacement brains or rib structures. These anatomical models are essential for enabling students to perform realistic medical interventions, for example, fractured ribs for practicing cardiac massage or skull and brain components for drilling burr holes.

3. The following are focus points of course concerns and findings at Operation Legio in Camp Jomsberg, Lipa, Poland:

a. Camp Jomsberg Facilitation Needs. After speaking with several personnel stationed at Camp Jomsberg in support of Operation Legio, it was noted that they are experiencing challenges that require additional support. One issue raised involves cultural differences in instructional expectations between UKR instructors and other partner nation instructors. Some UKR instructors expressed concern that students were given too much freedom in how they conducted themselves during the course for example, using recreational facilities such as the student lounge (equipped with a TV, couches, and a small troop store) or maintaining a relaxed posture in the classroom. In contrast, other instructors emphasized that while high stress training environments are necessary at times, students also need opportunities to decompress in order to effectively absorb and retain the material being taught.

b. Staff and Students seen at Medical. Medical staff reported that they typically treat between 100 and 200 patients per day during morning and afternoon walk in sick call, with the daily average being approximately 170 patients. The primary complaints vary depending on the phase of training. During indoctrination week, most cases involve upper respiratory symptoms, while later phases of the course see an increase in musculoskeletal injuries.

c. Hourly Time Allotment and Staff to Student Ratio. The UKR medical team asked who determines the required instructor to student ratios for different modalities and class types within the same course. They also wanted clarification on who sets the standard for the number of instructional hours assigned to each topic for example, why massive hemorrhage receives 20 hours while eye trauma receives 4 hours. LMTC explained that the course package they were provided already included these specifications within the classroom requirements.

d. Dental Facilities Needed. Another issue identified at Camp Jomsberg is the lack of a dedicated dental facility with appropriate staffing. Current medical personnel reported that, while they could repurpose one of their medical treatment rooms for dental procedures, they do not have the required dental providers or dental assistants to deliver those services. Currently, the process for handling dental emergencies involves transporting UKR students off site to another camp, with the hope that walk in dental services are available that day. This creates delays in care and disrupts training schedules.

4. The following are unique informative findings from Operation Legio in Camp Jomsberg, Lipa, Poland:

a. Class and Operation Statistics. Both Operation Legio and LMTC reported a recurring issue, when a class returns to UKR to complete their test out, no follow on statistics are being shared through official channels. This gap in reporting revealed a broader problem. Host nations conducting PCM do not have a centralized platform to communicate with one another or to upload key data such as pass rates, class challenges, program updates, or curriculum modifications made to meet mission requirements. As a result, each nation is effectively running its own version of the PCM program. This leads to repeated issues being rediscovered and addressed independently, causing unnecessary delays and preventing the timely sharing of solutions that could improve efficiency across all training sites. Current efforts are being made to consolidate all host nations PCM programs into one central area such as Sky Blue teams where accesses wouldn't cause too much of a strain on management from different nationalities.

b. Course Critique Data Collection. Instructors reported that they rely heavily on strong lead instructors and class leaders to maintain course improvements. The current method for collecting course critiques is informal feedback is passed verbally from students to class representatives and then to instructors. While this allows for real time adjustments and reinforcement for the next class, it does not create a documented record of why changes were made or how those changes evolved over time. Without a formal system to track modifications and their rationale, the same issues may resurface, especially during periods of instructor turnover, leading to repeated corrections and inconsistent course development.

c. Need for Instructors. Staff reported that they have the capacity to support additional courses, however, they require more instructors and linguists to do so. Without the addition of new personnel to assist with teaching they would not be able to support another course as they are already operating at their maximum workload. Camp infrastructure such as sleeping areas, classrooms, and shower facilities can be expanded to accommodate increased training demands if additional courses are scheduled. However, staff noted that they do not know which organization or nation they should contact to request the additional instructors needed to meet these requirements.

d. Course Material Hand Outs. Operation Legio consistently produces high quality, informative classroom materials tailored to issues identified in previous classes. These reference guides cover a wide range of topics, from antibiotic administration to calculating total body surface area for burns. However, this material is typically created within the two weeks leading up to each course, and there is no centralized system for storing, sharing, or updating these resources. As a result, valuable instructional products are not archived for future development or cross-site use.

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A. A. GARCIA
MED TRNG/ADMIN NCO