UNITED NATIONS

International Residual Mechanism for Criminal Tribunals

Case No: MICT-13-38-T

Date: 5 November 2025

Original: English

BEFORE THE TRIAL CHAMBER

Before: **Judge Iain Bonomy, Presiding**
Judge Mustapha El Baaj
Judge Margaret deGuzman

Registrar: **Mr. Abubacarr M. Tambadou**

PROSECUTOR
v.
FÉLICIEN KABUGA

PUBLIC WITH PUBLIC ANNEX

PROSECUTION SUBMISSION OF EXPERT OPINION ON AEROMEDICAL TRANSFERS

The Office of the Prosecutor

Mr. Serge Brammertz
Mr. Rupert Elderkin

Counsel for Félicien Kabuga

Mr. Emmanuel Altit

1. At the most recent Status Conference the Trial Chamber noted that it was deliberating Kabuga's potential transfer to Rwanda.[1] The Prosecution has recently obtained additional information from an aeromedical expert, Dr. Liam Scott, concerning the use of air ambulance flights. Dr. Scott has provided a statement that explains the specific meaning of "Fitness to Fly" criteria, which apply to travel on commercial aircraft and not travel by private air ambulance. Further, Dr. Scott's statement outlines a wide range of measures that can be used in order to move any patient by air ambulance.

2. In order to assist the Trial Chamber in its consideration of the information previously provided by Dr. Muurling, including his assessment that Kabuga could not be declared generally fit to fly, Dr. Scott's explanations of this terminology and his description of the use of private air ambulances may be helpful. Dr. Scott's statement is attached as an annex.

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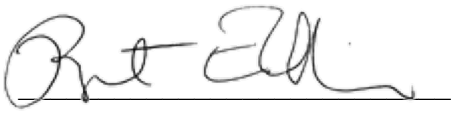

Rupert Elderkin
Senior Trial Attorney

Dated this 5th day of November 2025,
At Arusha, Tanzania

[1] *See Prosecutor v. Félicien Kabuga*, Case No. MICT-13-38-T, T.25 September 2025, pp.2, 16-17.

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ANNEX A

Statement Regarding the Practical Conduct of International Aeromedical Transfers in Private Air Ambulances

Dr Liam Scott

4th November 2025

1. I am Dr Liam Scott, a Consultant in Intensive Care Medicine and Anaesthesia at Southmead Hospital, Bristol, UK. I am also a fixed-wing air ambulance Flight Doctor based at Bristol International Airport, UK. My qualifications are: Bachelor of Medical Science with Honours (BMedSci (Hons), 2007); Bachelor of Medicine and Bachelor of Surgery with Honours (MBChB (Hons), 2009); Fellowship of The Royal College of Anaesthetists (FRCA, 2017); Fellowship of the Faculty of Intensive Care Medicine (FFICM, 2019); and Master of Laws (LLM, 2025). I am fully registered and licensed by the General Medical Council of the UK; my GMC number is 7038820.

2. The comments made in this statement are based upon my experience as a fixed-wing Air Ambulance Flight Doctor; I have worked in this role since 2017. I am routinely involved in the pre-flight assessment, preparation and practical conduct of national and international aeromedical transfers and repatriations. I have conducted numerous aeromedical flights in private air ambulances, travelling to 19 different European or Middle Eastern countries with a wide range of patients, ages and pathologies. These have ranged from fully ambulant, stable patients through to critically-ill, anaesthetised patients requiring ventilation and invasive life-support. I have published a case report describing my emergency management of a deteriorating patient during a complex

international repatriation.[1] I have also coordinated several complex international aeromedical repatriations for foreign patients admitted to my hospital.

3. As a preliminary consideration, it should be noted that 'Fitness to Fly' criteria, such as those published by the International Air Transport Association (IATA),[2] or the medical guidelines often used by physicians and airlines,[3] are only relevant to passengers travelling on commercial flights; they do not apply to patients or passengers transferred in private air ambulances. For commercial flights, Medical Advisors employed by the airlines will provide medical clearance for unwell passengers after assessing the available medical records, health questionnaires or other clinical information. The airline (and ultimately the captain) retains the final authority to allow or deny travel on a commercial flight.

4. In contrast, private air ambulances are not limited by the constraints of commercial aircraft, or the basic medical equipment and capabilities of a commercial cabin crew. Private air ambulances are able to provide bespoke, medically-equipped, clinically-supervised aeromedical transfers that are tailored to the specific requirements of each individual patient.

5. The planning of an air ambulance mission begins with a detailed appraisal by a Medical Operations team of the available medical records, clinical assessments and investigations. An individualised risk assessment is performed, taking into account the patient's specific pathologies and comorbidities, as well as any potential causes for

[1] Scott, L. 'Case Study: PIU repatriation of a fully ventilated patient' (2020) 107 *AirMed & Rescue* 40-42

[2] International Air Transport Association, *Medical Manual* (12th edn, IATA 2020)

[3] Aerospace Medical Association, *Medical Guidelines for Airline Travel* (2nd ed, AMA 2003)

deterioration en route. This assessment will determine many of the key aspects of the transfer, such as: the type and capability of the aircraft used; the number and expertise of the aeromedical crew; the anticipated requirement for specific interventions; the requirement for advanced medical equipment, monitoring or medications; and the requirement for special cabin environments (such as 'sea-level' cabin pressurisation). The patient's current location and the intended destination will be noted, along with their proximity to suitable airfields and any routing considerations or restrictions. Immediately prior to departure, the transferring aeromedical crew will also make their own in-person pre-flight assessment, satisfying themselves that the appropriate planning, stabilisation and preparation has been made.

6. Private air ambulances typically provide a 'bed-to-bed' service. The aeromedical crew collects the patient from their current location, travels with them during the flight and any ground transfers, then delivers them directly to a receiving hospital, care facility or residence. A relative or friend is usually allowed to accompany the patient during the journey. (This may be particularly beneficial, for example, to an elderly patient with dementia, who might be comforted by a familiar presence on a long journey and who is able to help keep them orientated and engaged.)

7. On arrival at the destination, the aeromedical crew provides a detailed handover to the receiving facility, including any specific concerns or interventions during the transfer. They will also usually provide copies of any medical records and investigations, including the aeromedical transfer documentation and vital observations. Any recommendations for ongoing interventions, observations or medications might also be made.

8. Private air ambulances therefore benefit from complete operational and medical control over their transfers. They use dedicated aircraft, determine their own routing and timings, employ experienced aeromedical crews, and provide a full range of specialist medical equipment, medications and interventions. With appropriate planning and preparation, a well-resourced and experienced air ambulance crew is able to transfer essentially any patient, with any disease severity, safely and seamlessly over large distances.[4]

9. There are a number of potential risks inherent to aeromedical transfers, regardless of the age, physiology or comorbidities of the patient. These may include: the physiological effects of travelling in a hypoxic (low oxygen) and hypobaric (low pressure) cabin environment; the physiological effects of acceleration and deceleration; thromboembolic disease; effects of vibration and temperature change; dehydration; lethargy; and 'jetlag'. These risks are mostly predictable, modifiable and transient, and generally last only for the duration of the flight itself. A number of general aviation risks are also applicable to any flight, including turbulence, noise, difficulty with communication, motion sickness, and mechanical aircraft problems.

10. The presence of such risks does not necessarily mean they will materialise, and the vast majority of aeromedical flights are completed successfully and uneventfully. Research demonstrates that the rate of adverse clinical events during air transport with appropriately trained aeromedical crews is similar to (or actually lower) than that observed in hospitals.[5] Indeed, a primary reason for utilising an air ambulance is to

[4] Veldman A, et al. 'Please get me out of here: the difficult decision-making in fit-to-fly assessments for international fixed-wing air ambulance operations.' (2023) 54 *Travel Medicine and Infectious Diseases* 102613

[5] MacDonald R, et al. 'Air medical transport myths.' (2020) 22(s2) *Canadian Journal Emergency Medicine* 55

mitigate risks in order to provide the safest transfer possible. The likelihood of medical complications attributable to flight in practice reflects the nature and severity of the patient's underlying diseases and their overall stability. In general, aeromedical transfers are significantly more risky for critically ill, ventilated patients on life-support than for frail but stable patients with chronic comorbidities.

11. To facilitate a safe and comfortable transfer, a private aeromedical crew can provide: regular monitoring of vital observations; supplemental oxygen; manipulation of cardiovascular or fluid status (in order to attenuate the body's response to acceleration and deceleration); pharmacological and/or physical prophylaxis against thromboembolism; alleviation of the effects of vibration, temperature changes and jetlag; nutrition and hydration; oral or injectable medications; and nursing assistance with toileting and mobilisation.

12. For critically unwell or deteriorating patients, an aeromedical crew may also provide: continuous invasive physiological monitoring; continuous sedation and paralysis; invasive ventilation; regular monitoring of blood samples using a portable blood-gas analyser; active temperature management; anaesthetic peripheral nerve blocks; spinal immobilisation and pressure relieving mattresses; Portable Isolation Units for contagious diseases; a full range of intensive care medications and infusions; and, if required, the capability to provide Advanced Life Support for cardiac or respiratory arrests (including defibrillation, external cardiac pacing, non-invasive ventilation and emergency airway management). These advanced capabilities allow even the most critically ill patients to be transferred by air in relative safety.

13. In summary: given the operational flexibility, aeromedical crew capabilities and clinical resources available during private air ambulance transfers, and with appropriate planning and preparation, it is in principle possible to safely and seamlessly move any patient from any location to any location. The level of medical supervision and intervention required to facilitate a safe aeromedical transfer can be carefully tailored to the specific medical and physiological needs of each individual patient, based upon a comprehensive pre-flight risk assessment.

14. From the limited clinical information available to me, I would anticipate that the intercontinental aeromedical repatriation of an elderly, frail, wheelchair-user with dementia (and other chronic co-morbidities) would be a relatively straightforward and uneventful exercise for an experienced, well-prepared and appropriately-resourced aeromedical transfer team.

15. This statement is true to the best of my knowledge and belief.

Dr Liam Scott
4th November 2025
Bristol, United Kingdom

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