National Defence / Défense nationale

B-GL-332-009/FP-001

MEDICAL – INSERT

(ENGLISH)

WARNING

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OPI: DAD 6

2000-10-27

Canada

LIST OF EFFECTIVE PAGES

Insert latest changed page; dispose of superseded pages in accordance with applicable orders.

NOTE

The portion of the text affected by the latest change is indicated by a black vertical line in the margin of the page. Changes to illustrations are indicated by miniature pointing hands or black vertical lines.

Dates of issue for original and changed pages are:

Original…..	0	2000-10-27	Ch……..	2
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Zero in Change No. column indicates an original page. Total number of pages in this publication is 44 consisting of the following:

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PART 8 – ARM INSERT

TAM 808 – MEDICAL INSERT

SECTION 1 – COMMAND

808.01 – MEDICAL PLAN

1. The Med Plan will be part of the unit Op O, under Execution after Coord Instr. This plan contains the info reqr for OCs to execute the CO's plan. The format will change given the tac sit but will normally incl the fol:

a. **Med Plan**:

(1) locs;

SER	FACILITY	GR	DTG OPEN/CLOSED
(a)	Fd Hosp		
(b)	BMS		
(c)	1 Pl		
(d)	2 Pl		
(e)	3 Pl		
(f)	4 Pl		
(g)	ACP		
(h)	BRP		
(i)	UMS RCHA		
(j)	UMS Armd Regt		
(k)	UAS AD Regt		
(l)	UMS CER		
(m)	UAS CMBG HQ & Sigs		
(n)	UMS Inf Bn 1		
(o)	UMS Inf Bn 2		
(p)	UMS Inf Bn 3		
(q)	UMS Svc Bn		

(2) holding pol:
  (a) BMS,
  (b) fwd of BMS;

(3) med plan:
  (a) role 1,
  (b) role 2,
  (c) role 3;

(4) evac pol:
  (a) rd,
  (b) air;

(5) pri for cas evac—based on main effort;

(6) patient abandonment:
  (a) bde,

(b) recce sqn;
(7) PW, refugees and civs:
(a) PW,
(b) refugees and displaced people;
(8) med replen;
(9) bde PMed;
(10) dent;
(11) med waste;
(12) GC symbol:
(a) Pers,
(b) Ambs,
(c) Vehs,
(d) Med Facility;
(13) other.

SECTION 2 – INFO OPS

808.02 – COMMUNICATIONS

1. The primary means of comms is the IRIS system. In the case of loss of rad or during EMCON 1 or 2, info will be dispatched by LO, DR or by amb along the evac chain.

808.03 – FIXED CALLSIGNS

HQ	**COMD**		**OPS/SIGS**		**ADMIN**					
	9 9A 9C	CO DCO RSM	9B 9D 9W 0 0A 91 91S 91T	**Ops O** Trg O CO's Planner Main CP Alt CP IC Sigs Sigs Stores LCIS MRT	92 92A	Adjt Admin SEV				
MED COY	**HQ**		**1 PL**		**2 PL**		**3 PL**		**4 PL**	
	19 19A 19C 1D 1G 1H	OC Coy 2IC CSM Bde PMed Bde Pharm SEV Bde Pharm Stores	11 11A 11C 11B 11B1 11B2 11D 11D1 11D2 11E	Pl Comd Pl 2 IC Pl WO 1 Sect 1 Det 2 Det 2 Sect 1 Det 2 Det Pl TCV	12 12A 12C 12B 12B1 12B2 12D 12D1 12D2 12E	Pl Comd Pl 2 IC Pl WO 1 Sect 1 Det 2 Det 2 Sect 1 Det 2 Det Pl TCV	13 13A 13C 13B 13B1 13B2 13D 13D1 13D2 13E	Pl Comd Pl 2 IC Pl WO 1 Sect 1 Det 2 Det 2 Sect 1 Det 2 Det Pl TCV	14 14A 14C 14B 14B1 14B2 14D 14D1 14D2 14E	Pl Comd Pl 2 IC Pl WO 1 Sect 1 Det 2 Det 2 Sect 1 Det 2 Det Pl TCV

AMB COY	**HQ**		**1 PL**		**2 PL**					
	29	OC	21A	Pl Comd	22A	Pl Comd				
	29C	CSM	21B	Amb Det	22B	Amb Det				
			21C	Amb Det	22C	Amb Det				
			21D	Amb Det	22D	Amb Det				
			21E	Amb Det	22E	Amb Det				
			21F	Amb Det	22F	Amb Det				
			21G	Amb Det	22G	Amb Det				
					22H	Amb Det				
DENT PI	**HQ**		**1 SECT**		**2 SECT**					
	39	OC	31A	Dent SEV	32A	Dent SEV				
	39C	Pl WO	31B	Dent SEV	32B	Dent SEV				
SVCS PI	**HQ**		**SUPPLY**		**FOODS**		**TPT**		**MAINT**	
	8	Svcs CP	81	RQ	82	KO	84	IC Tpt	88	URK/IC
	89	Log O	81A	QM Stores	82K	Kitchen	84L	Lift	88B1	Maint
	89C	Svcs Pl	81B	Bulk Stores	82R	Rations	84M	Misc/Dis	88B2	MRT
		WO	81C	QM DP			84P	c	88B3	MRT
								Pod	88C	MRT
									88F	Maint Stores
									88M	FCS MRT
									88P1	Mat Tech
									88P2	SPSS
									88W	SPSS
										Wrecker

SECTION 3 – MANOEUVRE

808.04 – SITE SELECTION

1. **Universal Siting Factors**.
   a. **Msn**. Consider the role/task.
   b. **Aval**. Use of site must be approved by fmn or unit HQ.
   c. **Space**. Sufficient space for facility and expansion.
   d. **Secur**.
   e. **Protection**. If possible, site med facilities within perimeters of def locs.
   f. **Evac Rtes**. Close to main and alt evac rtes or where evac rtes converge.
   g. **LZs**. Site near existing or planned LZs. Caution must be used as these LZs may also be used by the en.
   h. **Bldgs**. : Numerous advantages of occupying bldgs.
   i. **Wtr**. Local water supplies. Consider potability.
   j. Ideal sites will be reasonably level, adequately drained, with bldgs. Also incl hard stand for vehs, internal rtes, LZs and tentage.
   k. **Health Hazards**. To be avoided.
   l. **Met**. Consider shelter from rain and sun and the dir of prevailing winds.
   m. **Comms**. Attempt to estb comms prior to set-up.
   n. **Alt Sites**. An area, not too far from the main site that satisfies as many of the prerequisites possible.
2. **Rear Area Siting Factors**.
   a. **Bldgs**. Aval of existing civ hosps and bldgs, which may be converted for med use.
   b. **Evac Means**. Facilities should be sited in the gen vicinity of landing strips, railways, and inland waterways used for the tpt of patients within theatre.
   c. **Op Inactivity**. Med facilities should be located as far away as possible from the noise and general activity of battle.
   d. **Amenities**. Convalescent centers and to a lesser degree, hospitalization units would be ideally situated where recreational amenities exist eg. swimming pools, sports fields, etc.
   e. **Space**.
   f. **Development**. Keep in mind the availability of space and resources for expansion.
   g. **Utilities**. The reqr for utilities such as water, electricity, heating, sewers, etc.

808.05 – RECCE AND ADVANCE PARTY DRILLS

1. See TAM 101.02 para 2.
2. The fol shall be considered when planning a recce:
   a. threats;

b. time aval;
c. means of tpt;
d. points to be checked;
e. decisions to be made;
f. locs to be visited;
g. rtes into, out of and within area of responsibility;
h. secur reqrs;
i. time of travel;
j. tac signs, critical points; and
k. GR for ln with flanks, supporting fmns, etc.

3. **Recce Party**.
   a. Unit: DCO and dvr with the Svc Bn recce party.
   b. Sub-unit:
      (1) pl comd;
      (2) dvr; and
      (3) two guides/sentries.
   c. Eqpt:
      (1) 24hrs rats per pers;
      (2) marching order;
      (3) smoke grenades;
      (4) tac signs; and
      (5) marking tape.

4. **Adv Party**.
   a. Unit:
      (1) RSM and dvr;
      (2) CSMs;
      (3) dvrs; and
      (4) two guides/sentries per sub-unit.
   b. Sub-Unit:
      (1) Pl comd;
      (2) dvr; and
      (3) two guides/sentries (due to the size of the sub-unit, the recce and adv party will be the same.)

5. **Sweeps**. Given the size of the recce party, a sweep shall be conducted. If the recce party is too small to do an effective sweep, a cursory sweep will be conducted with the adv party completing a detailed sweep upon arr.
   a. sweep of the area for signs of en activity;
   b. post of sentries in the new loc;
   c. detailed recce and area prep, time permitting;
   d. prep of track plan;
   e. layout and signing of new locs;
   f. preparation of def plans;
   g. signing of rtes from rel P to pl area;
   h. provision of guides for reception of main body; and
   i. selection of hel LZ as reqr.

6. **Sequence of Events**. Provide an initial check for site secur and suitability.

a. recce party arrives, determines suitability, does cursory sweep, occupies area;
b. comd verifies posn on map designates RV point;
c. dvr parks under cover in an over watch posn, mans the radio, sketches area diagram, prepares DEPLOYREP;
d. adv party:
    (1) RV with recce party;
    (2) conducts sweep in area determined by Recce/Adv Party Comd, checks for en, booby traps and obs;
    (3) comd sends one pers to the out-rte;
    (4) mark veh/instl posns; and
    (5) comd returns to in-rte;
e. depending on tac sit and time, OC returns to the coy/pl, meets at an RV or meet at the in-rte; and
f. recce of alt site if time permits.

808.06 – OPENING STATION DRILLS (COY/PL)

1. The fol, many of which are concurrent acts, will normally be fol by the main body arr at a new loc:

a. meet guide at RV, co-dvrs dismount;
b. co-dvr guides veh to parking area;
c. park vehs and switch off;
d. once last veh shut off, two mins listening watch;
e. hasty cam all vehs;
f. sweeps:
    (1) DAY:
        (a) sweep 50 m beyond vehs—det comd supervises sweep line; and
        (b) def posns sighted during sweep—pl WO/sect comd;
    (2) NIGHT: no sweep, complete at first light;
g. cam;
    (1) DAY: drape except for duty vehs; and
    (2) NIGHT: hasty only, full cam at first light;
h. Def Posns:
    (1) DAY: assign areas for staff and cas protective trenches, each posn to incl one pers from tmt and holding and;
    (2) NIGHT: areas assigned, firing posts in place, complete range cards and digging at first light;
i. complete range cards, duty sect/det pers go to tailgate ops, holding pers completes protective trenches;
j. once at tailgate, send DEPLOYREP;
k. fwd ambs to supported UMS;
l. erect canvas—duty sect/det;

m. holding set up. If required duty sect/det pers complete protective trenches;
n. concealment—dvrs/co-dvrs:
(1) DAY: full; and
(2) NIGHT: hasty cam only, full cam at first light;
o. sweep LZ;
p. def plans in conjunction with other units in area—OC/pl comd;
q. est rest area (incl latrines)—off duty sect; and
r. prep alt posn as reqr.

808.07 – CLOSING STATION DRILLS

1. The fol tasks, many of which are concurrent, will normally be fol when preparing to leave a loc:

a. receive Wng O to incl NTM;
b. prep for move IAW states of readiness;
c. clear cas on order or on receipt of DEPLOYREP from other med sub-unit;
d. recce party departs;
e. receive orders;
f. sweep area at 15 min NTM to ensure no ident left;
g. send CLOSTAREP to HQ at 5 mins NTM; and
h. sentries wdr as vehs depart.

808.08 – STATES OF READINESS

1. In addition to USOP 108, a med unit will maint op readiness based on the fol:

SER	PROWORD		TIGER	PANTHER	LYNX	COUGAR	MOUSE
	ACTIVITY/NTM	6 HRS	2 HRS	1 HR	30 MINS	15 MINS	5 MINS
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
1	Tmt/Holding	UP	UP	UP	UP	TAILGATE	DOWN
2	Latrine tent	UP	UP	DOWN	DOWN	DOWN	DOWN
3	Sleeping accn	UP	UP	UP	UP	DOWN	DOWN
4	Cam nets	UP	UP	UP	DRAPE	HASTY	DOWN
5	Signs external	UP	UP	UP	UP	DOWN	DOWN
6	Signs internal	UP	UP	UP	UP	DOWN	DOWN
7	Ground stores	UNLOAD	UNLOAD	LOAD	LOAD	LOAD	LOAD
8	Rations	UNLOAD	UNLOAD	LOAD	LOAD	LOAD	LOAD
9	POL/gen	UNLOAD	UNLOAD	LOAD	LOAD	LOAD	LOAD
10	Fd defs	UP	UP	UP	UP	NEUTRALIZE TRIPFLARES	DOWN
11	Sentries	OUT	OUT	OUT	OUT	OUT	OUT
12	Land line	OUT	OUT	OUT	IN RTE	IN RTE	IN
13	Cooking	YES	YES	YES	YES	NO	NO
14	Deliver fresh rations	YES	NO	NO	NO	NO	NO
15	Maint	YES	YES	YES	URGENT	LIMITED	EMERG
16	Rest	YES	YES	YES	YES	YES (DRESSED)	NO

808.09 – CRASH MOVES

1. All facilities must be capable of mov without prior notice. The fol will be used as a guide:
   a. Clear facility of cas immed. Cas may have to be moved with the sub-unit to new loc with accompanying ambs.
   b. No cas will be abandoned unless ordered by the CO.
   c. All eqpt and sups left behind (other than med) not reqr for care of abandoned patients shall be destroyed.
   d. At ni, use white light.
   e. RV pt must be passed to all.

808.10 – DESTRUCTION OF VEHICLES AND EQUIPEMENT

1. In the event that own vehs and eqpt would have to be destroyed, the following principles will be observed:
   a. method of destruction shall achieve such damage to eqpt and essential spare parts that it will be impossible to restore the eqpt to a useable condition in the CZ, wither by repair or cannibalization;
   b. cl eqpt must be destroyed to such a degree as to prevent duplication or revealing the means of op or manufacture;
   c. pri must be given to destruction of cl eqpt and associated docs;
   d. when lack of time and/or stores prevents complete destruction of eqpt, pri is to be given to the destruction of essential parts, and the same parts are to be destroyed on all eqpt;
   e. components of eqpt will be destroyed in the fol pri:
      (1) crypto eqpt;
      (2) engine;
      (3) elec systems, incl comms eqpt;
      (4) wpn systems; and
      (5) suspension incl tires, tracks.

SECTION 4 – PROTECTION

808.11 – GENEVA CONVENTIONS

1. The fol refs shall be held by all sub-units comds and will be used in all ops to provide a source of info pertaining to the four Geneva Conventions (GC):
   a. The Wounded Convention;
   b. Maritime Convention;
   c. PW Convention;
   d. Civ Convention; and
   e. A-JS-007-008/JD-001 The Geneva Conventions of Aug 12, 1949.

2. In addition to providing guarantee of humane tmt of cas taken PW, the “Wounded Convention” also guarantees that captured med pers are extended protection and spec status.

3. **Red Cross**:
   a. **Entitlement to Use Red Cross**:
      (1) **Armed Forces**:
         (a) pers exclusively engaged in the search for, the collection or tpt of or the tmt of the wounded or sick or in the prevention of disease; and
         (b) staff exclusively engaged in sp of a med unit.
      (2) **Civ**:
         (a) pers of Aid Societies who are subj to mil regs; and
         (b) neutral societies under the con of a belligerent provided that they are emp as per roles listed above.
   b. **Display**:
      (1) All pers engaged in performing med and med related duties shall wear on their left arm an armlet marked with a Red Cross, auth by a qualified military auth. In addition, pers must carry a GC Ident Card stating in what capacity the bearer is entitled to protection under the Convention.
      (2) The unit will not normally display the Red Cross unless ordered, as dictated by the tac sit or depending on the applicability of the GCs. It is realized that failure to clearly mark a med unit does not alter the protection afforded by the applicable conventions to med pers and cas after capture. However, such failure would very likely increase the med unit susceptibility to en atk. The Red Cross will be displayed in the fol circumstances.
         (a) displayed on facilities if under atk;
         (b) displayed on ambs only when carrying patients; and
         (c) other vehs will only display a temporary Red Cross if transporting patients.

4. **Implications of Conventions**. The "Wounded Convention" guarantees that med pers are treated with special consideration when both parties to the conflict agree to observe these Conventions as fols:
   a. Fixed estb and mob med units may in no circumstances be attacked.
   b. The protection stated above shall not cease unless these units are sued to commit, outside their humanitarian duties, acts harmful to the en.
   c. Med pers may use arms in their own def or in def of the wounded and sick in their charge.
   d. Pers exclusively engaged in searching for, collecting, tpt or treating wounded and sick, and staff exclusively engaged in the sp of med units are protected pers.
   e. Protected pers who fall into en hands shall be retained only so far as the state of health and the number of PW reqr.

f. Retained pers are not deemed to be PWs although they shall benefit by all the provisions of the “PW Convention”. Additionally, they shall enjoy the fol advantages:
   (1) auth to visit the PWs in labour units and hospitals outside the camp;
   (2) the Sr MO (SMO) retained shall be resp to the military auth of the camp for the professional activity of retained pers;
   (3) retained pers shall be subj to the internal discipline of the camp; however, they shall not be reqr to perform any work outside their med duties; and
   (4) retained pers whose retention is no longer nec in order to ensure that the wounded and sick of friendly captured forces receive adequate med care must be returned ASAP.

808.12 – ACTION ON CAPTURE

1. All pers shall resist capture to the limit of their ability. When capture appears imminent, all unit maps, docs and tech eqpt shall be destroyed. Questioning and interrogation shall be resisted. Pers are only reqr to give their SN, rk, name and DOB. Protection for unit pers is IAW the GCs, described in TAM 808.11.

808.13 – ABONDONMENT OF WOUNDED AND SICK

1. Where it is unavoidable that wounded and sick must be abandoned to the en, med pers and mat shall, as far as the tac sit permits, be left with them to assist in their care. The final decision for the abandonment of the wounded and sick always rests with the tac comd.

808.14 – PERS WPNS

1. Pers wpns issued to unit pers are only for self def and def of facility and patients. Wpns will not be used for off acts; ie. aggressive ptls. This incl all unit sp pers engaged in unit sp activities.

808.15 – BLOCKING APPROACHES TO FORWARD DEFENDED LOCS

1. When in contact with the en and ops are not mob, sub-units will ensure that all rds leading towards the en are blocked and sentries are posted to prevent rd users driving into en posns or minefds.
2. Unit elms will be aware of this drill and obey instr of the sentries.
3. Ambs, if unable to reach destination due to en activity, will info their sub-unit HQ ASAP.

808.16 – FLANK AND BOUNDARY SECURITY

1. It is the responsibility of unit elms to estb and maint close ln with the unit it is supporting or occupying adjacent/same areas. This will be done by ln or rad. In add, the Ops O shall ensure:
   a. def fire on the bdry is satisfactorily coord with the bde svc bn/DISGP if co-loc and the resp for fire protection is exactly defined; and
   b. that arrangements are made for frequent physical contact between units on either side of bdry. The HQ defining the bdry will detail junc pts. Contact will be made at junc pts at least once by day and once by ni.

808.17 – VEHICLE ANTI-AMBUSH DRILLS

1. On contact:
   a. The veh comd of the lead veh will assess the sit and decide whether the packet can proceed without stopping.
   b. If able, the lead veh will proceed at max speed and the remainder of the packet will fol. The sit and loc of the ambush shall be passed soonest to the resp HQ.
   c. If the lead veh is unable to proceed, it will halt. Remaining vehs will also halt while adhering as closely as possible to the travelling veh interval.
   d. Immed upon stopping, the dvr and co-dvr will dismount the veh on the side opposite of the source of en fire. Lead veh comd will order "Dismount Left" or Right and continue with fire orders.
   e. If sit permits, cas will be dismtd from ambs and placed in protected posns.
   f. Pers will return fire. If aval, use smoke to cover wdr.
   g. If possible, the convoy (veh) comd will dispatch someone to go back down the rd on foot to prevent other vehs from entering the ambush.

808.18 – PROTECTION AGAINST AIR ATTACK

1. The unit will practice passive air defence (PAD) unless otherwise ordered.
   a. **PAD**. When attacked by en ac, the fol action shall be taken:

MOBILE	**STATIC**
Leave rd and dispers	Sound alarm
Dvrs leave vehs. Assist amb crews with removing and protecting patients	**Display Red Cross**
Sit permitting, patients will be off-loaded from ambs and placed under cover	Remove patients to protective trenches

MOBILE	STATIC
Report incident to unit HQ by quickest means	All pers not manning essential comms to take cover, and
Vehs to return to rd ASAP after atk	Stop all tfc mov within area or leaving area

b. **Active Air Def**. Dir def action taken to destroy or reduce the effect of en air atk:
   (1) action as per PAD; and
   (2) return fire with all wpns.

SECTION 5 – SUSTAINMENT

808.19 – CASUALTY MANAGEMENT – PRINCIPLES

808.20 – CASUALTY HANDLING

1. The following principles must be applied whenever handling cas:
   a. **Minimum Handling**—unnecessary moving off/on vehicles must be avoided;
   b. **Staging**—not to exceed four hours; and
   c. **Maximum Speed**—to minimize mortality the cas must reach initial tmt destination soonest.
2. Battlefd cas must be managed with attention to both evac and tmt reqr.
3. Not every cas will pass through every role of tmt (i.e. through the UMS/Med Pl/Hosp tmt rte); therefore every med facility shall be prep to accept unexpected cas.

808.21 – MASS CASUALTIES

1. A "Mass Cas" sit is one in which a significant disparity exists between the cas load and the med capabilities aval for its conventional mgt. In such cases all unit pers will be reqr to perform procedures which are not normally in their field of expertise and will be called upon to assume increasing responsibility. Unit resources will be stressed and will necessitate max use of all pers as well as improvisation of shelter and vehs.

808.22 – PRINCIPLES OF MASS CASUALTY HANDLING

1. The basic principles of mass cas mgt are early and continuous triage, rapid evac and standardized care interventions. The fol principles have also been ident:
   a. A change of philosophy—decisions have to be made to do less for some patients in order to be able to treat other cas when there are insufficient pers, eqpt and facilities.
   b. Realistic advance planning—with the aid of past experience one can predict and plan for the approx no and types of cas that will occur in various op sit.

c. Proper use of skills—certain manoeuvres will reduce mortality, early morbidity and long term functional loss. These can be performed quickly by people with relatively limited training and incl:
   (1) relief of airway obstruction; and
   (2) con of hemorrhage by pressure.
d. Do the greatest good for the greatest number of cas.
e. Life takes precedence over organ or limb, and function over anatomical perfection.

808.23 – PLANNING FOR A MASS CASUALTY SITUATION

1. The plan will be coord by the relevant HQ staff who will then liaise with the nec outside agencies. Coord within the med unit is critical so that pers and resources are not wasted or improperly emp. The plan shall incl:
   a. Define each person's role.
   b. Trg of pers to build confidence in their roles:
      (1) Comms;
      (2) log sp;
      (3) emergency care procedures; and
      (4) how the work shall be done under stressful and chaotic conditions.
   c. The responsibilities of the triage offr and criteria for categorization and mgt of cas.
   d. Criteria for con and use of essential med sup items and lists or scales of med mat nec to fulfil the reqr role. The limited pers and mat aval must be used to the max benefit of all cas.
   e. In with civ auth when and where applic and integration of preplanned assistance from outside the CFMS.
   f. Use of unit cargo vehs to augment ambs and aeromedevac resources for cas evac.
   g. A diagram of the flow of patient through the BMS.
   h. Provision of cover for cas awaiting tmt and evac.

808.24 – STAFFING AND DUTIES

808.25 – TRIAGE OFFICER

1. The triage offr at the BMS will:
   a. Triage all cas arr at the BMS, spending no more than one min with each cas, assigning each a pri. Pri 1 and 2 cas will be given triage cards and handed over to a trauma tm ldr with a quick brief on the cas condition. Pri 3 and 4 cas will be ident and handed over to LB for tpt/escort to the facility. Holding areas will be estab as reqr in the event that the trauma bays are full and the cas has to wait. Pri 1 and 2 cas in the holding area will be mon by the triage tm and quickly re-triaged prior to their hand-over to a trauma tm ldr.
   b. Maint con of the external triage area.

c. Be accompanied by a med regulator who will asg unique ident numbers to each cas during triage. The triage offr must be cognizant of the med regulator's presence and ensure that the cas pri is clearly indicated to the med regulator for recording purposes.
d. Have absolute auth in triage. It is essential that C2 be carried out with firm and sound judgment.
e. Dir the activities of the triage tm and decide which procedure is needed for each cas at that level of care.
f. Continually mon each patient's status and pri (e.g. for the trauma bays) as airway and hemorrhage con progress. This function is often delegated to the triage tm mbrs who report to him or her.

2. If the triage offr is the sub-unit's senior offr he or she shall also:
   a. repeatedly re-evaluate, manage, and commit the unit's resources such as drugs, supplies and eqpt; and
   b. continually reassess the unit's ability to sustain momentum, which incl mon the fatigue level of pers, the Pri 1 and Pri 2 backlog, bed aval, the op nec to move the facility or one of its sub-sub elements.

808.26 – COMMAND AND CONTROL

1. The auth to declare a mass cas sit is the responsibility of the sr med pers on site. At the BMS, in the absence of the Bde Surg, the SMO as designated by the Bde Surg is granted final auth.

2. Forewng of all potential mass cas sits is a critical component of maximized med response. Upon receiving an EVACREP, MEDREP or Special Casualty Report (SPECIALCASREP) the CP shall notify the SMO of the nature of the event and known status of the injured. The decision to activate mass cas protocol is then the responsibility of the SMO.

3. If cas arr at the BMS with no wng the SMO shall immed notify the CP of the numbers and med status of all cas. The ident and origin of each cas is to be reported ASAP. If the SMO is declaring a mass cas sit, this must be clearly stated to the CP.

4. After the initial notification of the anticipated large influx of cas, an alert is passed along the chain of comd. Notification of the declaration of a mass cas to all bivouac area pers will be activated by the CP by the fastest possible means. Once a mass cas has been declared comms between the BMS and CP must be maint until the mass cas is declared ended by the SMO.

5. The 2IC Med Coy shall be asg the role and resp of scene contr. Shift supervisors will assume this role until the arrival of the 2IC Med Coy. The Med Coy pl comds shall be assigned the role and responsibility of med regulators. Their primary responsibility is to ident and con the mov of all cas in and out of the BMS. One will be positioned outside the facility in triage, the second inside. Both shall be in constant contact with the scene contr, each other and the CP at all times. The pl comd will assume the role of scene controller when a mass cas is declared at a pl level facility. The BMS coordinator shall main an updated daily roster of all mass cas staffing

assignments. All med pers are resp for reviewing the roster daily to verify their assignments.

6. The SMO will ensure that all areas are manned and prep to recv cas. Throughout the press the SMO will continually reassess the BMS's ability to sustain momentum, specifically, the status of BMS resources, fatigue level of BMS pers, bed avail, and the cas backlog. When BMS resources are fully committed the SMO must request the diversion of add workload to some other med tmt facility. After the first 24 hrs of a mass cas ordeal, the activities of the pers must be decreased by one half to allow their rest and a new rotation must be estab to a sustain a modified but continuous effort.

7. Once the mass cas sit is over, given the tac sit, rest shall be enforced.

808.27 – SUPPORT PERS

1. All pers shall report to the med facility immed upon notification of a mass cas sit. All Med As shall be empl in tmt areas. Non-med pers from HQ and Svcs Pl shall be employed as LB, med facility secur/access con, tfc con, and LZ secur and safety under the C2 of the scene contr.

808.28 – SERVICES PLATOON RESPONSIBILITIES AND DUTIES

1. The Svcs Pl WO is resp for the org and con of the GD pool of pers from Svcs Pl and HQ in a mass cas sit. Duties incl:

   a. **Interior Litter Bearers**. LB assigned to the interior of the BMS are reqr to do the fol tasks:

      (1) Remain in the facility, adjacent to the admin area, until called upon.

      (2) Move cas from the Pri 1 and Pri 2 areas to the Pri 3 or Pri 4 areas.

      (3) Move cas through exit (from Pri 1, 2, and 3) out of facility to designated amb/heli evac veh.

      (4) Ensure that no cas is moved from a Pri 1 or Pri 2 bay without his/her trauma sheet (held by trauma tm recorder and tpt within the facility by LB). As the stretcher passes the med regulating desk toward exit (for evac by road or heli amb).

      (5) Provide, on req, secur for Pri 3 and Pri 4 in holding when en cas are present.

      (6) Tpt pers from Pri 4 holding to the morgue through the rear of the facility. Ensure that the staff in the Pri 4 holding area have recorded all necessary info on a trauma sheet and that the cas has been tagged. Obtain a receipt from the morgue duty pers and place it in the designated in-box at the med regulating desk.

      (7) Help to escort Pri 3 psy cas to the Pri 3P holding area through the designated exit, ensuring that the cas completed trauma sheet is delivered to the med regulating desk prior to escorting the cas out of the facility.

(8) Prior to escorting/tpt any cas through the exit, wait and ensure that all cas departing the BMS are seen and recorded by med regulating rétention, and that all relevant info concerning discharge and destination has been recorded.

b. **Exterior Litter Bearers**. LB assigned to the exterior of the facility are reqr to perform the following tasks:

(1) Move cas from amb to triage, and from triage to a designated pri area within the facility. The triage offr will designate the appropriate Pri area to tpt the cas. The exact loc for each cas in the Pri 1 and 2 areas is indicated by the colour and no on the assigned triage card, as follows:
   (a) red card = Pri 1 and no 1 = bed 1;
   (b) yellow card = Pri 2 and no 2 = bed 2;
   (c) green card = Pri 3 holding area; and
   (d) black card = Pri 4 holding area.

(2) Ensure that the triage card is turned over to the trauma tm recorder when the cas is placed in the designated bed.

(3) Escort walking wounded from triage to the Pri 3 area.

(4) Tpt deferred pers to the Pri 4 area.

(5) Ensure that the triage offr has triaged the cas, and that the med regulator has recorded the cas, before moving the cas into the BMS. The cas must have a number written on their hand or forehead with marker or a patient ident bracelet prior to entrance, indicating that they have been recorded by the med regulator.

(6) After tpt cas to the appropriate area, return backboards, c-collars, blankets, litters, and litter straps which are no longer needed inside the facility to the amb re-sup pt ASAP.

c. **Secur**. Ideally, Sup Techs would be assigned to secur duties due to the reqr for the handling and acct of pers wpns and effects. The specific tasks of secur pers are as fol:

(1) Provide secur at the entrance to the BMS; ensure that only med pers and triaged cas enter the facility. All other pers reqr permission to enter by the SMO and they reqr an escort.

(2) Provide acct procedures for cas pers wpns and belongings as reqr. Cas pers belongings will be gathered by the trauma tm within the facility, placed in plastic bags and labeled with the corresponding cas number. These bags will be gathered and accounting procedures will commence as reqr. All wpns must be removed from the cas prior to entrance into the BMS. Wpns will be labeled with the cas no immed and taken to the QM sect for proper storage.

d. **Traffic Control**. Pers assigned to tfc con will perform the fol functions:

(1) provide tfc con for the BMS LZ and for the emergency veh in and out rtes;

(2) when the same rte is used for the in and the out rte, ensure that ambs entering the bivouac by the in rte have pri over amb exiting the out rte; and
(3) ensure that vehs are stopped as reqr, to allow LB tpt cas from the LZ to the BMS safe passage across any veh rtes.

808.29 – HQ PERSONNEL RESPONSIBILITIES AND DUTIES

1. Upon declaration of a mass cas by the SMO, Ops is resp for info all sub-units and sub-elm of the declaration, and to instruct all pers to report to their respective mass cas duty areas.
2. All pers not gainfully empl in the CP or elsewhere in the unit must report to the Svcs Pl WO, at the front of the BMS, in order to be assigned a task or GD posn. The Svcs Pl WO will designate the first pers from HQ on the scene to staff the morgue.
3. The Ops sect is specifically resp for:
   a. Coord and info the BMS of incoming cas and all cas evac reqs.
   b. Coord BMS evac reqs with the supporting role 3 facility.
   c. Be prep to recv and send a MEDREP for every 10 patients admitted or every hour, whichever is sooner.
   d. Be prep to recv all reqs from outside units for cas info and to deal with all pers requesting to visit cas admitted to the BMS. Due to the nature of a mass cas sit, no visiting privileges, regardless of the rank or posn of the requesting visitor, will be granted until the declaration of mass cas is removed. Cas status or destination will be provided as req by the Ops sect.

808.30 – DENTAL PLATOON RESPONSIBILITIES AND DUTIES

1. Dent pl pers will staff the fol areas of the BMS in a mass cas sit:
   a. **Triage Area**. The Sr Dent O may be designated as the triage offr in a mass cas sit if no MO/MA is aval. Any other Dent Os aval will assist in the triage area with triage and or med regulating as reqr (record cas pers info, relay cas info to the med regulating desk, etc).
   b. **Pri 4 Area**:
      (1) Dent Pl will staff the pri 4 area along with a minimum of one Chap.
      (2) Cas will be transported/escorted to the pri 4 bay by litter-bearers. If the cas has been transported directly from the triage area, ensure that a field trauma form is initiated and the cas pers info is recorded on the form. If the cas is being tpt from any other pri area (Pri 1, 2 or 3), ensure that the previously initiated trauma form is handed over from the LB and that all pers info is recorded on the form.
      (3) Administer aid to the pri 4 deferred cas as directed.

(4) If vital signs can no longer be established, call the SMO to pronounce the cas dead. Ensure that a cas tag is completed (with the cas ident number, name, rank, SN, and del time to morgue) and attached to the cas. Notify med regulating that cas no ___ must be tpt to the morgue so that LB can be dispatched and the med regulators can update the cas register. Ensure that the LB take the receipt for the morgue delivery to the med regulating desk.

808.31 – PREVENTIVE MEDECIN SECTION RESPONSIBILITIES AND DUTIES

1. The PMed section will:
   a. Staff the Pri 3 psy (Pri 3P) cas area.
   b. Ensure these cas do not leave this area and provide supportive care ensuring they are warm and comfortable. If cas become uncooperative and/or violent, restrain them and req add sup from the SMO.

808.32 – CASASUALTY MANAGEMENT - PROCEDURES

808.33 – CASUALTY FLOW

1. The planning process for units at all levels of med support should include a flow diagram. A blow-up of the flow diagram can be used to mon and con the flow of cas through the BMS. This enlarged version will be utilized by the scene contr in conj with a patient ident tag system and dedicated CF 2050 Patient Register (Field) to map the utilization/aval of tmt space and the constant loc of all cas. Coloured pins can designate occupied beds and trauma bays. This diagram can be stationed with the admin desk.
2. All cas will be ident initially in triage by a sequential numbering system. Each cas will have a hosp ID bracelet applied or will be skin marked with indelible marker prior to transfer out of the triage area. Tmt is not to be delayed attempting to obtain full cas ident in triage. As cas are ident their particulars are entered in the dedicated CF 2050 ensuring the original cas ident no corresponds to the pre-numbered line in the CF2050. All pers effects and cas wpns will be tagged with the self-adhesive tags attached to the ident bracelet. The cas loc will then be indicated with a corresponding numbered pin on the flow diagram.
3. It is very important to prevent, as much as possible, reverse cas flow. This will prevent congestion and confusion. Normally cas tfc shall not enter and exit through the same portal.
4. The fol areas shall be considered:
   a. **Triage Area**:
      (1) Adequate space in this area is very importance. Multiple stations consisting of trestles/sawhorse frames should be in place and ready. The triage tm will consist of Dent O(s) and BTLS qualified QL5A Med As.

(2) Only one delegated pers shall conduct triage. Primary assessment and assignment of pri should not exceed 60 seconds per cas. No definitive tmt is done in triage. The triage offr may direct the Med A to provide emergency life saving procedures (opening and maint an airway, continuing mechanical assisted breathing, con major bleeding) until LB are avail to move a cas into a tmt area.

(3) The triage offr will use a card system to asg cas to specific bays in each tmt area. A cas will not be moved into Pri 1or Pri 2 tmt without a card. It is imperative that the card is returned to the triage offr as soon as a cas is moved out of a Pri 1 or Pri 2 bay. The triage offr will not dir another cas to that trauma tm until the card is returned. This will indicate to the triage offr if tmt areas are overwhelmed and high pri cas must remain on the amb to proceed to the next highest ech of care.

(4) If the facility is expected to become overcrowded with cas, it may be necessary to establish a holding area for cas who cannot be treated immed. To ease congestion and confusion, ambulatory cas could be evaluated in this area as well.

b. **Ambulance Resupply/Litter Bearer Area**:

(1) Amb resupply must account for the rapid depletion of litters, splints, and blankets. Every effort possible must be made to return backboards, C-collars, blankets, litters and litter straps which are no longer needed inside the facility to the resupply pt ASAP. This shall be done by the LB as they drop off cas inside the facility.

(2) The amb resupply pt must be sited away from the triage area to prevent congestion. Ambs shall be unloaded and then moved to the resupply pt for eqpt exchange before reentering the evac chain.

(3) Located near the amb resupply pt will be the LB pool under the control of the Svcs Pl WO. These pers from Svcs Pl and HQ will only enter the triage area when ordered by the triage offr to unload cas from ambs and to carry cas into the BMS.

(4) All reqs for GD pers will go through the Svcs Pl WO. Other GD tasks could incl, tfc con, runners, facility secur, and when there is a severe shortage of med pers LB may be reqr to perform basic airway con and apply pressure to bleeding wounds.

c. **Administration Area**:

(1) Med regulators shall:

(a) know the loc of all cas within the facility;

(b) obtain cas SN, rank, name, unit and pri before entering the facility;

(c) know disposn of cas at all times; and

(d) know when, where, and how cas were tpt out of the facility.

(2) Two med regulating pers will staff the triage area. They will obtain and record cas name, rank, pri and bed. They will asg each cas a no; marking the cas in indelible ink to facilitate tracking within and outside the BMS.

(3) Located adjacent to the primary in-rte to the facility it is the ctl pt for all med regulating activities, including cas ident, coord of med evac reqs, human resource mgt, inside secur, and comms with CP. Three pers will man the admin area. Tasks will include manning the comms with the triage tm; recording cas info in the fd register; con the cas loc board to ensure that all cas that leave the facility have had their info recorded, and acting as a runner.

(4) All comms in and out of the facility will go thru the admin area. One pers will be resp for comms between the unit HQ and the BMS. All evac reqs out of the facility will go thru the med regulating offr, who will make the nec arrangements. The MO/MA will inform their area OIC; who will inform the 2IC or the med regulating offr. The req will be logged in and the comms pers will relay it to unit HQ. An ETA, CS, and confirmed destination will come from unit HQ.

(5) A six pers tm will be empl as LB within the facility and will act as runners for the med regulating officer. These pers will move cas to other pri areas as reqr and move cas to evac vehs. They will ensure that cas info, pri card, and destination info (method and CS) is on stretcher before moving cas. Tm ldr will return pri card and ensure that med regulating desk is aware of cas loc.

d. **Trauma Bays (Priority 1)**:

(1) Only resuscitative, life preserving tmt will be carried out in this area. All tmt will be conducted IAW current ATLS/ACLS stds. Any deviation from these guidelines must be auth by the SMO present.

(2) Pri 1 Area will be staffed, ideally, with 1 MO per bay (may cover two bays if accompanied by a PA or QL6A as acting tm ldr of the 2nd bay), 3 Med As per bay (at least 1 BTLS-Advanced qualified), and 1 Med A per 2 bays as runner/GD tasks.

(3) Pri 1 bays will ideally be set-up as per the fol table:

TEAM LEADER	HEAD	UPPER POSN	LOWER POSN	GO-FOR POSN	RECORDER
Obtain report	Stabilize C-spine	Apply collar, Head-blocks, O2	Secure cas	Secure cas	Listen to report with tm ldr
Conduct primary survey	Establish comms Observe airway	Expose upper body; assess or initiate RT IV	Expose lower body	Apply O2 sat monitor, obtain BP; assess or initiate LT IV	Record findings and interventions of primary
Monitor cas status / dir interventions	Assess head	Assess neck / chest / abdomen	Assess pelvis lower / extremities	Apply monitor leads / provide thermal protection	Record findings and interventions of secondary
Assess back	Call logroll	Assist with logroll	Assist with logroll	Assist with logroll	Record findings and interventions of secondary
Consider any other interventions reqr prior to evac / form an evac plan	Ongoing assessment and interventions as dir by tm ldr	Ongoing assessment and interventions as dir by tm ldr	Ongoing assessment and interventions as dir by tm ldr	Ongoing assessment and interventions as dir by tm ldr	Obtain patient ident info as opportunities arise

e. **Priority 2 Area**:
   (1) Only life and limb function preservative tmt will be carried out in this area. All tmt will be conducted IAW current ATLS/ACLS stds. Any deviation from these guide-lines must be auth by the SMO present.
   (2) Pri 2 Area will be staffed with 1 MO per 2 bays, 3 Med As per bay (at least 1 BTLS-Advanced qualified), and 1 x Med A per 2 bays as runner/GD tasks.

f. **Priority 3 Area**:
   (1) All tmt that does not pose any immed threat to loss of life or limb will be carried out in this area. Tmt whenever possible will be carried out in a space where the cas may remain until evac arrangements can be made. (Example: if the cas will reqr a holding bed space awaiting evac, tmt will normally be carried out in that bed).
   (2) All tmt will be conducted IAW ATLS stds. Any deviation from these guidelines must be auth by the SMO present. All MO orders are to be dir thru the Med A IC.
   (3) Area will be equipped as per BMS ward protocols and staffed with 1 Med A (QL5 BTLS-Advanced qualified) per 5 beds.

g. **Priority 4 Area**:
   (1) Care shall be provided for any cas whose injuries are likely to cause death. It must be clear that acute care for these cas is deferred and every effort shall be made to salvage their lives if human and mat resources are aval.
   (2) The palliative care area will be staffed by a QL5A Med A/Dent Tech with Chaps in attendance. This Med A/Dent Tech shall be granted the expanded DMA auth to admin any narcotic analgesic to max dosage prescribed by a MO.
   (3) The deferred care area will be established with direct access to the morgue holding area to avoid moving any deceased through any other tmt / holding area.

h. **Psychiatric Cas Area (Pri 3P)**:
   (1) Ideally, this area is situated away from the BMS to minimize stressors on the cas. Dent pl/PMed pers can provide the staff and the accns for such an area.
   (2) Violent cas may have to be pharmacologically restrained and subsequently mon by the dent/PMed staff. Svcs pers, from the interior or exterior bearer pool, will have to be ident to provide physical restraint until the cas can be sedated.

i. **Helipad/Ambulance Loading Area**:
   (1) ideally, the helipad shall be close enough to the BMS to preclude the need for intermed amb tpt; and
   (2) LZ safety and secur is the responsibility of IC aeromedevac who is to ensure all LB and med pers are properly briefed prior to proceeding toward any ac.

808.34 – ALLIED, CIVILIAN AND ENEMY CASUALTIES

1. All allied tps are entitled to med care.
2. Civ pers will recv only life sustaining care and evac to nearest civ hosp, unless otherwise dir.
3. En cas are entitled to full med care. Normal evac will fol, however, en cas will be guarded by MPs or guards that have arrived with the cas. It is not the resp of the CFMS to guard en cas.
4. In all instances, the unit CP will be advised of all allied, civ and en cas, as per the SPECIALCASREP.

808.35 – DISPOSAL OF PATIENTS' PERSONAL EQUIPMENT AND EFFECTS

1. Patients' eqpt and effects will be tagged to show SN or equivalent, rank, name, unit and country.
2. Eqpt and pers effect will be turned over to the Log O for safekeeping and back to patients on their rtn to duty or evac.
3. Pers effect and eqpt of dec pers is to be turned over to the Svc Bn.
4. The cas pers wpn should have been retained by their unit; however, if this has not been done, the wpn will be taken and secured.
5. Wpns will be made safe and tagged to show SN, rank, unit and a receipt for the wpn given to the patient.
6. Whenever possible wpns will be rtn to the patient's unit. Failing this, wpns will be turned in to the unit QM for rtn to sup system.
7. En patients will be searched. All docs, maps, etc. will be sent to the CP ASAP. All wpns, eqpt and pers gear will be tagged. All tagged items will accompany the en patient upon evac under MP guard and separate cover.

808.36 – PATIENTS RECEIVED WHILE ON THE MOVE

1. Patients recv while on the mov may have to be carried to new loc. Sub-units will not halt to treat without auth.

808.37 – BRIGADE CASUALTY DECONTAMINATION CENTRE (BCDC)

808.38 – GENERAL

1. Med Coy will provide BCDC that will provide detailed decon of CW cas, prior to their entering the BMS.

808.39 – COMMAND AND CONTROL

1. The OPI for the BCDC is OC Med Coy.
2. The pl comd of the on-wheels pl will provide add pers and eqpt to the BCDC.

808.40 – RECCE AND DEPLOYMENT

1. The DCO will recce the area for the BMS and an appropriate area, a min of 1 km downwind of the BMS, for the BCDC. The BCDC will in most cases be co-located with the Bde Decon Centre, established by the bde LBU.

808.41 – SITING

1. The fol shall be considered when siting the BCDC :
   a. **Distance**. Sited at lease 1 km downwind of the BMS (clean area). Should the wind change dir, the BCDC should be far enough away that it will not contam the clean area.
   b. **Overhead Cover**. Imperative for concealment and protection from further atk. Whenever possible, use existing bldgs.
   c. **Rte**:
      (1) dirty in and out rtes to be segregated from the normal evac rte, to prevent pers and eqpt contam;
      (2) clean rte for clean cas must be established to the clean/dirty line for clean cas transfer; and
      (3) clean in and out rtes must be sited to accommodate ambs tpt cas from the BCDC to the BMS or staging area.
   d. **Comms**. Area must be sited so comms can be estb with the unit HQ/BMS.
   e. **Space**. An area large enough to accommodate BCDC.
   f. **Water**. Copious amounts of water are required for decon and pers.
   g. **Contam Control**:
      (1) clean/dirty line to be established with mine tape outside the BCDC; and
      (2) slurry pits to be entrenched at entrance and exit of BCDC.

808.42 – PERS

1. The Med Pl on wheels and Svcs Pl will provide pers as fol:

SER	TASK	MED PERS	NON-MED PERS
(a)	(b)	(c)	(d)
1	**CW sentries**		2
2	LB (dirty (min))		4
3	**Triage (1 MO, nursing offr or PA and 1 Med A)**	2	
4	Reception (1 HCA and 1 Med A)	2	
5	Dirty cas holding	5	
6	Cas decon	1	3
7	Chemical agent monitor (CAM) operator		1

SER	TASK	MED PERS	NON-MED PERS
(a)	(b)	(c)	(d)
8	NBC cas bagging	1	3
9	LB (clean) (min)		4
10	Clean cas holding	5	
11	Clean/dirty line LB (min)		4
12	Sub total	16	17
13	Total pers (1) (2)	33	
NOTE 1: The no of pers will depend on the no of cas, the length of the task and the weather. Pers will reqr frequent rest periods as they will be working in MOPP 3 masked. **NOTE 2**: If non-med pers are not aval, Med Pl staff will have to fill the posns. More frequent rest periods will be reqr.			

808.43 – DUTIES

1. **CW Sentries**. Loc approx 300 m from the BCDC the CW sentries shall:
   a. stop all vehs and assess contam using the three way detector paper and the CAM;
   b. question dvr regarding if cas are contam;
      (1) if cas are clean, dir to BMS; or
      (2) if cas are contam, dir veh to BCDC; and
   c. notify BCDC of incoming contam cas or BMS of clean cas.
2. **Litter Bearers (Dirty)**. Located at amb drop off pt. Confirm if cas are clean or dirty:
   a. **Dirty Cas**. One bearer will spray the back door of the amb with decon spray. Off load the cas into the triage area.
   b. **Clean Cas**. Direct the amb down to the clean/dirty line where the cas will be transferred to an awaiting amb.
3. **Triage**. The triage offr will recv and do the triage of the cas. This will determine the order for decon.
4. **Reception**. The HCA and Med A will maint the reqr med docs, recv reports from CS sentries and send EVACREP/MEDREPS.
5. **Dirty Cas Holding**. The staff will provide necessary tmt and maint med docs for cas awaiting decon.
6. **Cas Decon**. Each mbr of the cas decon tm is numbered from 1 to 4. Duties are as fols:
   a. tm decon their own gloves, forearms and fronts, as well as the edge of the stretcher;
   b. the Med A (1, Tm Ldr) opens the velcro zipper on the cas CW suit and treats the cas as needed;
   c. 2, 3 and 4 decon the areas of the cas CW suit to be cut for removal;
   d. 1 and 2 assisted by 3 and 4:
      (1) pull the cas gloves down about 10 cm;

(2) cut the arms of the CW suit from the wrist to the shoulders and continue each cut to the midline of the suit;
(3) cut along the anterior surface on both legs starting at the feet and working medially to the velcro zipper;
(4) fold back the suit to either side of the cas—care must be taken to ensure the contam portion of the suit or the staff's gloves do not come into contact with the exposed areas of the cas;
(5) 1 and 2 turn back the hood so that the cas head is left lying on it;
(6) 1 and 2 decon the cas hair and mask, taking extra care to decon the ears, eyepieces and behind the canister;
(7) 1 and 2 hold the arms up with the mitted hand while 3 and 4 remove the gloves, cross the arms over on the chest, tuck sleeves under the suit;
(8) 3 and 4 decon, remove and dispose of the boots in the disposal bag—they also ensure the suit is rolled away from the cas;
(9) prior to the cas being removed from the CW suit it will be necessary for the tm to decon the front of their suits, their forearms and gloves;
(10) move the cas to the trestles at the clean/dirty line and will be monitored with a CAM before crossing the clean/dirty line;
(11) the tm ldr on the clean side allocates one mbr to completely unzip the cas bag and hold it open to the receiving station;
(12) the three remaining pers lift the cas, cradling the cas into themselves and place the cas in the CW bag which is then zipped up; and
(13) the cas is then taken by LB to either a collection pt or to amb for tpt to the BMS.

7. **CAM Operator**. Located in front of the clean/dirty line, the operator is resp to ensure that no contam cas cross the clean/dirty line.

8. **NBC Cas Bagging**. Decon cas are placed in a clean NBC cas bag. This will provide a clean environment for the cas.

9. **Litter Bearers (Clean)**. Remove cas from the bagging sta to either the clean cas holding area or to an amb.

10. **Clean Cas Holding**. Pers will provide sustaining med care.

11. **Clean/Dirty Line Litter Bearers**. Two LB will be on the clean side and two on the dirty side, assisted by amb crews. Cas will be transferred across the clean/dirty line from one amb to another. The tm mbrs also maint a strict technique to ensure that the clean/dirty line is not compromised. A CAM will be used to determine if the back of the amb and the cas are clean and to ensure the amb crews do not violate the clean/dirty line.

808.44 – MED RECORDS

808.45 – GENERAL

1. Med records are the dir resp of each med sub-unit and facility thru which the patients are evac.
2. Med records must be complete, legible and accurate. Initiation of med records must not be allowed to delay tmt. However, proper tmt is impossible in the absence of adequate records.
3. Each sub-unit will dev a drill to ensure that:
    a. documentation is carried out concurrently with other patient mgt;
    b. duplication of effort is avoided; and
    c. essential info is not omitted.

808.46 – SECURITY

1. Med info concerning the individual patient is designated PROTECTED B and med records will be handled accordingly.
2. Protected waste must be destroyed by burning. In a field op this destruction is a coy responsibility.

808.47 – DOCUMENTATION

1. The fol doc is reqr in fd ops:
    a. CF 2016 – MED ATTENDANCE RECORD;
    b. CF 2046 – FD MED CARD;
    c. CF 2047 – FD MED ENVELOPE;
    d. CF 2048 – PATIENT EVAC TAG; and
    e. CF 2050 – FD PATIENT REGISTER.
2. The terms "PRISONER OF WAR" or "CIVILIAN" will be clearly marked on the top of any applicable med records in **RED INK**.

808.48 – PATIENT CLASSIFICATION

1. The cl of patients is:
    a. **NON-BATTLE CASUALTY (A)**. Trauma not attributable to cbt. Incl environmental injuries.
    b. **DISEASED (B)**. All cas other than battle cas and non-battle injuries.
    c. **WOUNDED IN ACTION (C)**. Any cas whose condition is attributable to either dir en action or is sustained while engaged in cbt, incl cas with radiation sickness.
    d. **BATTLE STRESS/PSYCHIATRIC (D)**. Those cas suffering from battle fatigue or other psychological problems.

808.49 – DESCRIPTION OF WOUNDS AND INJURIES

1. Causative agents of wounds and injuries will be described as fols:

a. **SA Ammo**: gunshot wound (GSW), e.g. GSW (SA), GSW (HMG),
b. **Shell and Mor**: shell wound (SW), e.g. SW (HE), SW (Mor).
c. **Bombs and Grenades**: bomb wound (BW), e.g. BW (Aerial), BW (Gren).
d. **Mines**: mine wound (MW), e.g. MW (Atk), MW (Booby trap).
e. **Burns**: burns (B), e.g. B (phosphorous) B (Flash), B (Thermal).
f. **Blast**: concussion (Bomb Blast), or fracture of foot (Mine Blast), i.e. injury caused by blast source.
g. **Biological or Chemical**: BW or CW agents, e.g. CW (Choking) or BW (Anthrax).

2. The Intl Cl of Diseases (ICD 9) will be used to describe diseases, injuries, causes of injuries, procedures and causes of death.

808.50 – OPTIONAL MEDICAL DOCUMENTATION

1. The CO may introduce other docs, at times, to improve efficiency. Existing med docs, e.g. those described in CFMOs will be used if they fit the need. The fol considerations apply:
   a. locally reproduced;
   b. scope and application will be limited to the unit; and
   c. once initiated, details of the use will be included in these SOPs.
2. Examples of optional med docs are:
   a. op book to record details of surgery performed;
   b. test and therapy registration forms;
   c. diagnostic records e.g. x-ray, lab;
   d. nursing records;
   e. hosp record card; and
   f. out-patient (sick parade) disposal slip.

808.51 – MAINTAINING MEDICAL DOCUMENTATION

1. In prep and maint med docs, all entries will be made with blue or black ballpoint pen and all entries will be printed to ensure max legibility and permanence.

808.52 – DISPOSAL OF MEDICAL DOCUMENTATION

1. The disposal of the principal med docs used in a theatre of op will be as fols:
   a. **CF 2016**. Med attendance record remains with unit until individual leaves the theatre. It is then rtn to be filed with the individual's CF 2034, Med Envelope.
   b. **CF 2046**. Fd Med Card remains with patient until discharge or evac to a hosp in Canada or in the support base. Completed forms will be placed in the individual's CF 2034, Med Envelope.
   c. **CF 2047**. Fd Med Envelope will be destroyed once the form CF 2046 has been completed and placed in the form CF 2034.

d. **CF 2048**. Patient Evac Tag consists of three parts. The basic tag remains with the patient until he/she reaches the receiving hosp; emb tag is held by the debarkation unit.
e. **CF 2050**. Fd Patient Register has two copies, the original is sent to the force or fmn HQ daily and the duplicate is retained by the med facility.

808.53 – CASUALTY SWEEPS

808.54 – GENERAL

1. A unit or sub-unit, either friendly or en may come under atk and may suffer significant cas that the unit or sub-unit becomes ineffective. The conduct of an effective cas sweep demands the highest degree of C2.

808.55 – FACTORS

1. Factors to be considered in the conduct of a cas sweep incl:
   a. area secure;
   b. terrain;
   c. visibility (night/fog);
   d. manpower aval;
   e. evac resources aval;
   f. no and pri of cas;
   g. comms resources aval; and
   h. proximity to which evac resources can approach the obj.
2. These factors will determine:
   a. length of sweep line;
   b. density of sweep line;
   c. nec of a second sweep;
   d. time reqr to complete the sweep;
   e. the distr of pers between sweep line, staging area, cas collection sec;
   f. special lighting reqrs;
   g. pers reqr for tmt section;
   h. duration cas must be held;
   i. amount of med sups reqr;
   j. evac resources reqr;
   k. siting of CP;
   l. degree of C2 possible; and
   m. time cas must await tmt.

808.56 – PRINCIPLES

1. The fol principles must be applied in cas sweeps:
   a. the area shall be secure if practical;
   b. C2 must be maint;
   c. staging;

d. passage of info;
e. continuity of tmt; and
f. speed.

808.57 – ASSIGNMENT OF PERSONNEL

1. Ideally a cas sweep sit shall be staffed by a Med Pl. Pers are to be asg, within aval resources, as fols:

a. **CP**:
   (1) on Site Commander(OSC) 1 x offr/sr NCO (not involved in cas tmt);
   (2) dvr/Rad Op –1 x NCM (any trade).
b. **Staging area**:
   (1) triage offr—1 x Dent O or MO if aval;
   (2) triage pers—2 x jr Med As to perform life threatening tmt only;
   (3) tmt offr—1 x MO if aval or PA;
   (4) staging Area IC—1 x Med A (sgt/Mcpl);
   (5) tmt pers—sufficient pers to complete med tmt.
c. **Sweep line**:
   (1) sweep line commander (SLC)—1 x sr NCO (any trade); and
   (2) sweep line pers—one half of aval pers (total pers less those allocated to CP and staging area) (any trade).
d. **Cas Collection Sec**. One half of aval pers (total pers less those allocated to CP and staging area) (Med As).

808.58 – DUTIES

1. **On Site Commander**:
   a. assume comd of all pers;
   b. ensure that the OSC CP are readily ident;
   c. recv brief from contact pers on ground;
   d. sends a DEPLOYREP within 1 min of arr;
   e. sends a SITREP within 5 min of arr;
   f. asg pers to the sweep line, cas collection sec, triage and staging area to effect a smooth progression of all tasks;
   g. estb bdrys of the obj;
   h. cfm the area has been secured by the fmn being supported or estb a secur cordon with aid from local fmn;
   i. estb the staging area as close to the obj as ambs can approach;
   j. estb the LZ and CP in close proximity to the staging area;
   k. estb comms with SLC;
   l. attempt to determine the exact no of cas in the obj—sources of info could incl:
      (1) pax manifest obtained through higher HQ or found on cas themselves; and

(2) reports from fmn in area, eye witnesses, a resp pers from among the cas with knowledge of the sit;

m. updates SITREP as reqr; and
n. sends EVACREPs.

2. **Sweep Line Commander**:
   a. form the sweep line;
   b. maint visual contact with sweep line from behind. If short of pers, join the sweep line;
   c. maint rad contact with OSC—send SITREPs as reqr;
   d. clearly ident cas; and
   e. direct able cas to staging area.
3. **Triage Officer**:
   a. triage all cas; and
   b. inform med sect comd of no and pri of cas.
4. **Staging Area Comd**:
   a. supervise tmt and evac of cas;
   b. divide tmt area by priority;
   c. evac cas in order of pri;
   d. prep EVACREP for transmission by OSC; and
   e. keep OSC informed of cas disposns.

808.59 – SEQUENCE OF EVENTS

1. The OSC will establish the CP and bdrys of the sweep area.
2. The SLC will form the sweep line with the aval pers.
3. As the sweep line advances, cas must be clearly ident to the cas collection pers fol the line. Those pers will admin life sustaining care if reqr and tpt cas to the staging area (or if terrain permits have a veh effect pick-up of cas). If cas are ambulatory, they will be dir to mov to the staging area on their own.
4. Upon reaching the obj bdry, the SLC will decide whether a second sweep of the area is reqr.
5. If there are insufficient pers to evac cas to the staging area, the sweep line will retrace its steps collecting cas as it moves.
6. If sufficient pers are aval, a second line may fol the sweep line to provide life sustaining care as reqr and provide a second sweep capability with cas collection pers fol to effect tpt of cas to the staging area.
7. As cas are ident, SITREPs are to be passed by the SLC to the CP which will maint a running total of nos and pri of cas found, staged and evac. This info will be passed by the OSC to higher HQ in the form of EVACREPs, MEDREPs or SITREPs to ensure proper allocation and assignment of evac resources. The med sup sit will likewise be passed to higher HQ.
8. As cas arr in the staging area, the triage offr will triage cas for tmt. The Staging Area Comd will ensure that cas are treated appropriately as per pri of the cas. Cas will be evac in order of pri.

808.60 – EVACUATION

808.61 – FORWARD AEROMEDEVAC

1. Asg pri and prep for evac of cas will be done by the sr med auth on the scene.
2. When prep cas for aeromedevac the fol shall be done:
    a. obtain instr for in-flt care;
    b. ensure adequate med sup for flt;
    c. with crew, supr ld and unld cas;
    d. keep crew info on cas status;
    e. provide med care enroute;
    f. keep cas briefed;
    g. brief recv facility; and
    h. be familiar with config of ac.

808.62 – LAND EVACUATION VEHICLE CAPACITIES

SER	VEHICLE	SEATING CAPACITY	LITTERS	RANGE (KM)	MAX SPEED (KM/H)	CRUISING SPEED (KM/H)
(a)	(b)	(c)	(d)	(e)	(f)	(g)
1	LSVW amb	7	4 (5 max)	320	80	60
2	LSVW TCV	10+1	6+1	320	80	60
3	MLVW	20	12+1 in attendance	320	90	60
4	Bison amb	8-10	4	845	90	60
5	Bison troop carrier	12 to 14	4	845	90	60
6	Snowmobile	Dvr + 1	2 toboggans 1 per (toboggan)	228*	48	10
NOTES * varies with snow conditions. All vehs will travel at a much slower speed than shown above when used to evac patients or under adverse conditions, i.e., cross country, dirt roads, etc.						

808.63 – REPLENISHMENT

808.64 – MEDICAL RESUPPLY

1. Routine demands for med sups may be submitted to Med Coy on a CF 2086 (Med Indent), msg or any aval auth means.
2. Empty ambs returning in the evac chain will normally be used for del of med sups.
3. All demands for Narcotic "N" and Controlled "C" drugs will be sent separately to Med Coy by CF 2086. All demands must be signed by MO or a designated offr or by a PA.
4. "N" and "C" drugs will be issued with 2 copies of CF 2086. Receipt will be ack on 1 copy and a copy returned to Med Coy.
5. All issues must be recorded.

808.65 – REPORTS AND RETURNS

808.66 – DEPLOYMENT REPORT (DEPLOYREP)

1. Sent to the unit HQ when a sub-unit is in loc. (Adapted from FSOPs DEPLOYREP 706.09.)

DEPLOYREP as at		
A1	Loc of reporting HQ/Sub-Unit	
A2	Contact Pt of HQ/Sub-Unit	
A3	Hel LZ of HQ/Sub-Unit	
B	Loc of sub-unit elms	
C	Loc of OP line and fwd elms	
D	Misc	

808.67 – CLOSING STATION REPORT (CLOSTAREP)

1. Sent to the unit HQ when a sub-unit is preparing to move.

CLOSTAREP		
A	DTG of closing	
B	Time of mov	
C	Est time of opening in new loc	
D	GR of new loc	
E	NO of patients moved with sub-unit	

808.68 – MEDICAL REPORT (MEDREP)

1. Sent to inform unit HQ of sub-unit tmt capabilities and domestic sit, permitting the distr of resources to accommodate patient flow and demands for med resup. It also permits analysis of reqs for changes in evac policy.

The MEDREP is submitted NLT 1330 and 0130hrs as at 1200 and 2400hrs by fwd staging facilities and med pls. The MEDREP can also be sent as reqr to inform the unit HQ of heavy action or immed needs.

MEDREP as at:		
A	No of patients seen since last report.	
B	No of patients evacuated beyond the sub-unit since last report.	
C	No of patients returned to their units since last report.	
D	No of patients presently held in the sub-unit.	
E	No of patients who have died within sub-unit care since last report.	
F	Significant expenditure of med material or shortages.	
G	Misc.	

808.69 – MEDICAL DAMAGE REPORT (MEDDAMREP)

1. Sent immed after damage has occurred to a med sub-unit or its supplies.

MEDDAMREP as at:		
A	Sub-unit damaged or destroyed.	
B	DTG damage occurred.	
C	Cause and extenf of damage.	
D	Useable capacity remaining as percentage of normal.	
E	Extent to which damage can be repaired with estimated time to re-activate.	
F	Other info - assistance, eqpt and labour reqr - alternative arrangements made, etc.	

808.70 – SPECIAL CASUALTY REPORT (SPECIALCASREP)

1. The SPECIALCASREP is used to pass info up the chain of comd to info the supported units and fmn about the death or injury of specific pers or certain types of injuries.

SPECIALCASREP as at:				
1	Nature of cas (litter or walking)-			
2	Cas give detail	A	Sr offr	
		B	En offr	
		C	Civ official	
		D	NGO staff	
3	Service No			
4	Rank			
5	Name and Initials			
6	Unit			

SPECIALCASREP as at:				
7	Nationality			
8	Category of cas (incl detail)	A	Non-battle cas	
		B	Diseased	
		C	WIA	
		D	Battle stress/psychiatric	
9	DTG of cas			
10	Evac category (incl detail)	A	Returned to duty	
		B	Evac to other med facility	
		C	Evac to home or holding country	

808.71 – EVACUATION REPORT (EVACREP)

1. Used to report the no and severity of injuries of cas being evac. Also used to req add evac resources.

EVACREP as at:				
1	No of Pri 1 cas (1)			
2	No of Pri 2 cas (1)			
3	No of Pri 3 cas (1)			
4	No of Pri 4 cas (1)			
5	Departure time (local time)			
7	No of evac veh by type	A	med wh amb	
		B	hy wh amb	
		C	armd amb	
		D	non-amb veh	
		E	hel	
7	No of cas awaiting evac (1)			
8	No and type of evac vehs reqr. (1)	A	med wh amb	
		B	hy wh amb	
		C	armd amb	
		D	non-amb veh	
		E	hel	
NOTE (1). Used when req add evac resources.				

808.72 – MEDICAL SITUATION REPORT (MEDSITREP)

See FSOP 706.07

808.73 – MEDICAL SPOT REPORT (MEDSPOTREP)

See FSOP 706.08