XIV. MULTIPLE CASUALTY MEDICAL PLAN

A. Purpose

Designed to enhance the Incident Command System and facilitate effective scene management during multiple casualty incidents. In addition, this Medical Operations component is designed to interface with the operations and organization detailed in the Unified San Diego County Emergency Services Organization Operational Area Emergency Multi-Casualty/Disaster Plan known as Annex D.

B. Goal

To rapidly and effectively triage multiple victim incidents while providing appropriate treatment and transportation to local emergency facilities or casualty collection points (CCP).

To transport off scene any trauma center candidate within 10 minutes from the arrival of the transport unit, unless delayed by extrication or rescue.

To identify the resources at the Local, State and Federal level available to the Incident Commander and the process of activation.

C. Emergency Response Levels

1. Multi-Patient Incident (MPI)

   a. Incident with nine (9) or less patients where at the discretion of the Transportation Group Supervisor activation of Annex D is not necessary. Expansion of the incident is not anticipated and Department resources can effectively manage the incident.

   b. Initial response of one (1) First Responder and one (1) ALS transport unit unless upgraded by Fire/Medical Dispatch based upon information received from the reporting party.

   c. Incidents where victims are believed to be trapped will receive a First Alarm Rescue assignment to include one (1) Battalion Chief, one (1) First Responder, one (1) Truck Company one (1) Heavy Rescue Unit and one (1) ALS Transport Unit.

d. The scope of the incident may require additional resources to assist with patient assessment, stabilization, loading and driving upon request by the Incident Commander. A general rule of one (1) ALS or BLS transport unit for every two (2) patients and one (1) First Responder unit for every three (3) patients can be used to maintain adequate resources dependent upon the severity of the victims.

2. Medical Multi-Casualty Incident (MCI)

a. Incidents with ten (10) or more victims that require the activation of Annex D as deemed necessary by the Patient Transportation Group Supervisor. In situations where the Incident Commander has early recognition or knowledge without an assigned Patient Transportation Group Supervisor, the Incident Commander may chose to alert or activate Annex D.

b. An incident that has the potential to escalate or will require the resources of multiple EMS agencies.

c. An incident with less than ten (10) victims who are identified as moderate or immediate status that require the activation of Annex D to facilitate access to the most appropriate medical facility as deemed necessary by the Transportation Group Supervisor.

d. Medical Multi-Casualty Response of one (1) Battalion Chief, three (3) First Responders, one (1) Truck Company, one (1) Heavy Rescue Unit, two (2) ALS transport units, two (2) BLS transport units, one (1) Aeromedical unit on standby or dispatched, one (1) Medical Supervisor and Duty Medical Support.

e. The scope of the incident may require additional resources to assist with patient assessment, stabilization, loading and driving upon request by the Incident Commander. A general rule of one (1) ALS or BLS transport unit for every two (2) patients and one (1) First Responder unit for every three (3) patients can be used to maintain adequate resources dependent upon the severity of the victims.

D. <u>Alert/Activation of Annex D</u>

1. Alert**:**

Alert for Annex D shall be announced upon report of an event or potential event that is suspected (but unconfirmed) to constitute a multi-casualty incident which

exceeds the capabilities of the immediately available emergency response contingent, or the patient care capabilities of proximate medical facilities.

2. Activation**:**

Activation of Annex D shall be declared under the following conditions:

a. A confirmed event has occurred that is a multi-casualty incident which exceeds the capabilities of the immediately available responding emergency contingent, or the patient care capabilities of the proximate medical facilities.

b. An event is imminent, or has occurred, of such magnitude in a populated area that extensive casualties are inevitable, i.e. structure collapse, major transportation emergency, hazardous materials release.

c. Notification from authority that a disaster, local or general, is imminent or has occurred, which requires mobilization of the emergency organization and indicates the expectation that extensive casualties will result.

3. Responsibility

The alert or activation of Annex D is the responsibility of the Transportation Group Supervisor, or designee, and requires notification to the Incident Commander upon Alert or Activation.

The Incident Commander will notify Fire Communications that Annex D has been alerted or activated, advise of the magnitude of the incident and request any additional resources.

Fire Communications will notify the Sheriff's Communication Center of the alert or activation and request resources which cannot be provided by the Department or through Mutual or Automatic Aid.

4. Purpose:

The purpose of Annex D is to facilitate the rapid movement of patients from the incident to appropriate facilities based upon patient status and is controlled by the Medical Communications Coordinator.

5. Procedure:

Alert or Activation of Annex D can be determined by the need to move critical patients off scene in an expeditious manner with minimum delay for communications. The Transportation Group Supervisor or designee (Medical Communications Coordinator) will contact the Base Hospital assigned to the Engine Company district in which the incident occurred. Upon activation of Annex D the following policies are in effect:

a. All Paramedic standing orders are in effect during the triage, treatment and transportation phase of the event.

b. Only one Base Hospital will be contacted throughout the entire event. The Transportation Group Supervisor or designee (Medical Communications Coordinator) is responsible for contact and control of radio communications with the assigned Base Hospital. In circumstances where transporting units have exhausted their standing orders and require further patient treatment, contact can be made by the transporting unit to the Base Hospital contacted by the Transportation Group Supervisor.

c. Transportation Group Supervisor or designee assigns patients to area hospital beds based upon the status of the patient and hospital resources.

d. Information required for reporting patient information to the base hospital will consist of the initial overall scene and the following:

1) Patient Number.
2) Patient Status (Immediate, Delayed, Minor).
3) Transport Destination.
4) Unit Transporting Patient.
5) Estimated Time of Arrival of Patient at receiving facility.

e. Documentation of each patient will be completed by the transporting paramedic or EMT.

f. The overall incident will be documented by the Transportation Group Supervisor and will include, at a minimum, the following:

1) Location of Incident.
2) Type of Incident, i.e. structure fire, hazardous materials incident, vehicle accident.
3) Units assigned to the incident for the purposes of patient care or transportation of victims.

4) Transport destination and unit assignment of victims.
5) Number of patients released or pronounced dead on scene.

E. Non Annex D MPI Reporting

1. Purpose

The purpose of Non Annex D, MPI reporting, is to expedite the movement of patients off scene of a MPI incident by limiting the required reportable information to the Base Hospital.

2. Notification

Notification of a Multiple Patient Incident (MPI) will be made by the Patient Transportation Group Supervisor to the Incident Commander. There is no requirement for further notification.

3. Procedure

The Patient Transportation Group Supervisor, or designee, shall establish contact with their assigned Base Hospital or the Trauma Hospital within the trauma catchment area of the incident, if indicated.

a. All Paramedic standing orders are in effect during the triage, treatment and transportation phase of the event.

b. Only one Base Hospital will be contacted throughout the entire event.

c. The Transportation Group Supervisor or designee (Medical Communications Coordinator) is responsible for contact and control of radio communications with the assigned Base Hospital.

d. In circumstances where transporting units have exhausted their standing orders and require further patient treatment, contact can be made by the transporting unit to the Base Hospital contacted by the Transportation Group Supervisor.

4. The Patient Transportation Group Supervisor, or designee, shall:

a. Not delay transport of the acute status patient to obtain radio report information. Acute status or “scoop and haul” patient reports can be given in the Annex D format to facilitate rapid transportation.

b. Advise the Hospital of the overall mechanism, location and number of patients.

c. Advise the hospital that the abbreviated or "short" report format will be used.

d. Report the following for each patient:
   1) Patient Number
   2) Age
   3) Mechanism (individual for the patient)
   4) Sex (Gender)
   5) Chief Complaint
   6) Abnormal Findings
   7) Treatment Rendered
   8) Transport by / where / ETA

e. Documentation of each patient will be completed by the transporting paramedic.

f. The overall incident will be documented by the Transportation Group Supervisor and will include, at a minimum, the following:
   1) Location of Incident.
   2) Type of Incident, ie structure fire, hazardous materials incident, vehicle accident.
   3) Units assigned to the incident for the purposes of patient care or transportation of victims.
   4) Transport destination and unit assignment of victims.
   5) Number of patients released or pronounced dead on scene.

F. Roles and Responsibilities

1. First in ALS First Responder Unit

a. The Captain assumes the role of Incident Commander, requests additional resources as needed and assigns crew members to mitigate any hazard as necessary. The Incident Commander should prioritize the establishment of the following ICS Positions:

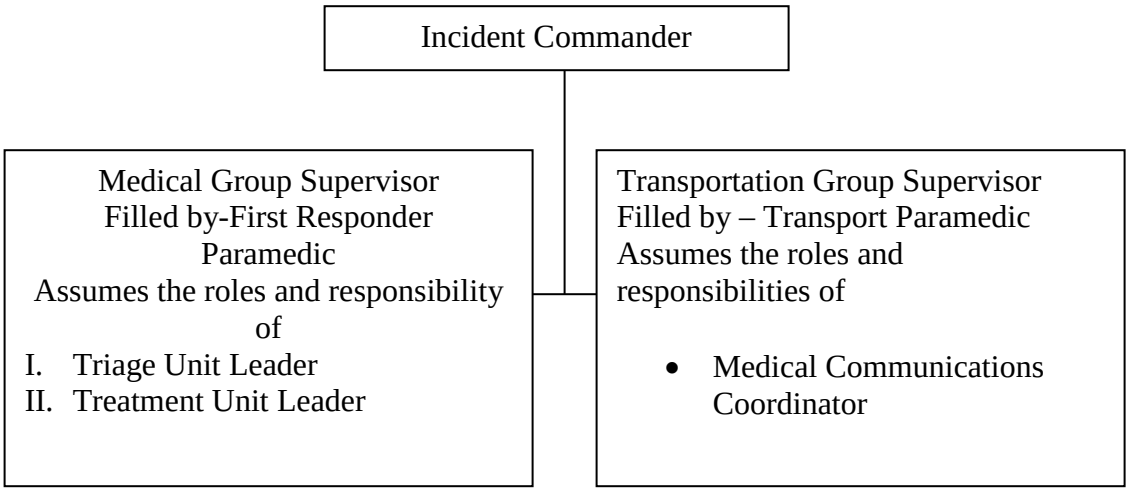
   1) Medical Group Supervisor
   2) Patient Transportation Group Supervisor
   3) Triage Unit Leader
   4) Medical Communications Coordinator
   5) Ambulance Staging Manager

6) Treatment Unit Leader

b. Unless otherwise assigned by the Incident Commander, the first in paramedic First Responder will assume all roles and responsibilities of Medical Group Supervisor until reassigned by the Incident Commander.

c. Unless otherwise assigned by the Incident Commander, the first in transport paramedic will assume all roles and responsibilities of Transportation Group Supervisor until reassigned by the Incident Commander.

Initial ICS Structure



2. Expanded Incident Roles and Responsibility

a. **Multi-Casualty Branch Director** (Call sign "Med Branch") – Reports to the Operations Section Chief and is responsible for the overall direction of the Medical Branch. Directly supervises the Medical Group Supervisor and Transportation Group Supervisor. Responsible for the implementation of the Incident Action Plan within the Branch. This includes the direction and execution of branch planning for the assignment of resources within the Branch. The Incident Commander assumes the role of Multi-Casualty Branch Director if unassigned.

Duties:

1) Obtain briefing from the Operations Section Chief
2) Review established Group/Division assignments for effectiveness of current operations and modify as needed.
3) Provide recommendations/input to Operations Section Chief for the Incident Action Plan.
4) Supervise Branch activities.
5) Update Operations Section Chief on activities and needs of the Branch.
6) Maintain unit log.

b. **Medical Group Supervisor** – (Call sign "Med Group") Reports to the Multi-Casualty Branch Director and establishes command and control of the activities within the Medical Group in order to assure the best possible triage and treatment of patients during a multi-casualty or multi-patient event.

Duties:

1) Receive briefing from Multi-Casualty Branch Director or Operations Section Chief and participates in planning activities of the Medical Branch.
2) Establish and Supervise Medical Operations within the Medical Group. Insure sufficient personnel and resources to effectively handle triage and treatment of victims.
3) Assume roles and responsibilities of the Triage Unit Leader, Treatment Unit Leader and Morgue Manager until otherwise assigned.
4) Establish communications and coordination with Patient Transportation Group Supervisor. Confirms alert or activation of Annex D and the need for Casualty Collection Points.
5) Assign Triage and Treatment Unit Leaders. Fill any requests for additional personnel requirements under the Medical Group to include:

    a) Triage Personnel
    b) Morgue Manager
    c) Treatment Dispatch Manager
    d) Immediate Treatment Manager
    e) Delayed Treatment Manager
    f) Minor Treatment Manager

6) Designate treatment areas and consider isolation of Morgue and Minor Treatment Areas from the Immediate and Delayed Treatment Areas.
7) Request additional resources through the Multi-Casualty Branch Director. In situations where the Multi-Casualty Branch Director has not been assigned, resources are requested through Operations Section Chief or through the Incident Commander. Examples of additional resources required to handle the triage and treatment needs inlcude (medical caches, triage teams, treatment teams, litter bearers, etc.)
8) Coordinate Medical Supply needs with the Medical Supply Coordinator through the Incident Commander.
9) Direct or supervise on-scene personnel from other agencies directly involved with the triage and treatment of victims such as the Medical Examiners Office, Red Cross, Law Enforcement, Ambulance Companies, County Health Personnel and Hospital Personnel.
10) Ensure security within the Medical Group to include ingress and egress of personnel and victims from the Medical Group to the Transportation Group, Casualty Collection Point or Morgue.
11) Upon completion of Triage and movement of victims into Treatment Areas, assures reassignment of Triage personnel within the Medical Group.
12) Maintain Unit Log.

c. **Patient Transportation Group Supervisor – (**Callsign "Transportation Group") Reports to the Multi-Casualty Branch Director and establishes command and control of the activities within the Transportation Group in order to assure the most effective way to track and transport casualties from the incident while considering the impact on local area resources.

Duties:

1) Receive briefing from Multi-Casualty Branch Director or Operations Section Chief and participates in planning activities of the Medical Branch.
2) Establish and Supervise Medical Operations within the Transportation Group. Insure sufficient personnel and resources to effectively handle communications, record keeping and transportation of injured.
3) Assume roles and responsibilities of the Medical Communications Coordinator, Amublance Staging Manager, Air Ambulance Coordinator and Ground Ambulance Coordinator until otherwise assigned.

4) Establish communications and coordination with Medical Group Supervisor. Confirms alert or activation of Annex D and the need for Casualty Collection Points.
5) Assign Medical Communications Coordinator, Ambulance Staging Manager, Air Ambulance Coordinator, and Ground Ambulance Coordinator. Fill any requests for additional personnel requirements under the Transportation Group.
6) Request additional resources through the Multi-Casualty Branch Director. In situations where the Multi-Casualty Branch Director has not been assigned, resources are requested through Operations Section Chief or through the Incident Commander. Examples of resources required to handle the tranportation needs of the incident include (ambulance drivers, scribes, litter bearers).
7) Coordinates with Ambulance Staging Manager on the needs and mode of transportation.
8) Coordinate loading of patients with the Treatment Dispatch Manager.
9) Control ambulance and bus loading activities including ingress and egress of apparatus. Maintain victim transportation disposition to include; number of patients transported, destination of patients, unit transport identification, and status of patients. Victims under age 18 should be tracked by first and last name to assist the IC or Public Information Officer (PIO) with family notification issues.
10) Coordinate Aeromedical Transportation through the Air Ambulance Coordinator. Determine landing location and request first responder to facilitate landing area.
11) Ensure security within the Transportation Group to include ingress and egress of personnel and victims from the Medical Group to the Transportation Group or Casualty Collection Point.
12) Upon completion of Transport, perform final tally of patients with the Medical Communications Coordinator and hospital.
13) Maintain Unit Log.

d. **Staging Manager** – (Call sign "Staging") Reports to the Incident Commander and is responsible for maintaining sufficient resources of ground and air transportation resources on scene.

Duties:

1) Supervise the Air/Ground Ambulance coordinator and delegate the responsibility of filling ambulance requests from the Transportation Group Supervisor.

2) Request transportation resources as identified by the Transportation Group Supervisor through the Incident Commander.
3) Advise the Incident Commander when resources assigned to staging fall to a level of 1 ALS ambulance and 1 BLS ambulance.
4) Separate ALS and BLS transportation resources to aid in ease of assignment.
5) Maintain crews with transportation unit until requested by the Transportation Group Supervisor or by the Medical Group Supervisor.
6) Provide an inventory of medical supplies available at ambulance staging area for use at the scene. Notify IC of available Equipment Pool for delivery to Medical Group Supervisor.
7) Maintain a Unit Log.

e. **Triage Unit Leader** – (Call sign "Triage") Reports to the Medical Group Supervisor and assumes responsibility of coordinating triage management of casualties.

Duties:
1) Obtain briefing from Medical Group Supervisor.
2) Develop organization sufficient to handle assignment.
3) Assign Triage Personnel to assure rapid assessment of all victims using the "START" Triage System.
4) Prioritize Immediate victims for transportation or coordination to treatment area or casualty collection point (CCP).
5) Coordinates movement of patients with the Treatment Unit Leader from the triage area to appropriate treatment/CCP areas.
6) Brief and coordinate incoming triage teams.
7) Maintain security and control of the triage area.
8) Update Medical Group Supervisor on the number and serverity of casualties by category, number of Dead on Scene (DOS), and any medical resources or personnel needs for triage purposes.
9) Maintain Unit Log.

f. **Triage Principles**

1) Triage Categories:

Category 1:	IMMEDIATE	Patient requires Immediate care and transportation.

Category 2:	DELAYED	Patient requires definitive care but transportation can be delayed.
Category 3:	MINOR	Patient requires an assessment and minor treatment but may not require transportation.
Category 4:	DECEASED	Patient has been assessed and is determined to be non-viable.

2) Category Definitions:

Patients are placed into one of four categories using the START (Simple Triage and Rapid Treatment) triage method of evaluation with the nemonic R.P.M. (Respirations, Perfusion, and Mental Status).

a) Category 1 - IMMEDIATE patients who can not ambulate from the scene on their own power have the following indicators:

Respiration: rate greater than 30, or, apneic patients who have return of spontaneous breathing once the airway is open.
Perfusion: capillary refill greater than 2 seconds or the absence of a peripheral pulse with a pulse present at the carotid.
Mental Status: patient is unconscious or does not follow simple commands or appears disoriented and confused.

b) Category 2 - DELAYED patients who can not ambulate from the scene on their own power and have the following indicators:

Respiration: normal respiration rate.
Perfusion: no delay in capillary refill, patient has a palpable peripherial pulse.
Mental Status: patient follows commands and appears oriented.

(c) Category 3 - MINOR patients who can ambulate from the scene on their own power when asked to move to another location. Patients must maintain the following indicators in the MINOR treatment area of their status will be upgraded:

Respiration: normal respiration rate.
Perfusion: no delay in capillary refill, patient has a palpable peripheral pulse.
Mental Status: patient follows commands and appears oriented.

(d) Category 4 - DECEASED victim or victims who will most likely die shortly from the injuries. Patients must meet the following criteria:

Respirations: absent or agonal respirations not relieved by opening the airway.
Perfusion: pulseless or a weak carotid pulse in the presence of absent respirations not relieved by opening the airway.
Mental Status: unconscious and unresponsive

g. **Multi-Casualty Disaster Tag**

In order to assign the patient to the appropriate treatment area, triage tags will be utilized by triage teams.When marking the patient during the initial triage of victims, the victim will be marked with a black felt marker on the hand or forhead to indicate the patient number. When multiple triage teams are used the Triage Unit Leader will supervise the all triage operations and assign triage numbers/procedures to each team. For example, if two teams are used, one team will be assigned even numbers for marking patients and the other team will use odd. When multiple teams are used, an engine company or truck company will be assigned as a team leader and their engine or truck number will proceed the patient number. For example, Engine 1 would use E1-1, E1-2, and so on.

Each patient will also be tagged with a triage tag. Listed below are recommendations for the use of triage tags during the course of the incident:

1) The left and right corners on the tag are yellow in color with perforated lines for ease of detachment. The corners will contain the same number as the card. These corners can be detached and

used anytime the patient is re-triaged or moved/transported. Once torn from the tag, the corner should remain with the triage personnel for purposes of documenting what patient was assessed by which crew member.

2) Area is available on the tag to record initial vital signs, time, injuries and other data as needed. If bandage and dressing is used to cover the injury, the description can be circled or documented on the card referencing the injured site.

3) At the bottom of the tag are 4 perforated patient status indicators. After evaluation of the patients using START triage, the status of the patient shall be left on the tag as the last or lowest indicator. For example, if the patient is IMMEDIATE status, the triage crew member will remove the MINOR and DELAYED status indicators showing IMMEDIATE as the last or lowest indicator with DECEASED attached above.

4) If the patient meets the MINOR category, leave all indicators attached. As patients status deteriorates, the indicators may be removed and the status of the patient upgraded. If the status is changed during re-triage in the treatment area, the patient shall be moved to the appropriate treatment area, or morgue if appropriate, for upgrade in transportation from scene.

5) If the patient status improves, remove the remaining tags on the card and add an additional card with the updated patient status. Leave the original card in place for purposes of patient information and triage tracking.

h. **Treatment Unit Leader** – (Call sign "Treatment") Reports to the Medical Group Supervisor and assumes responsibility for coordinating treatment and preparation for transportation of casualties.

Duties:

1) Obtain briefing from Medical Group Supervisor.
2) Develop organization sufficient to handle assignement.
3) Direct and supevise Treatment Dispatch Manager, Immediate Treatment Manager/Area, Delayed Treatment Manager/Area, Minor Treatment Manager/Area, CCP.
4) In the absences of the Treatment Dispatch Manager, establish communications and coordination with Patient Transportation

Group Supervisor or designee (Medical Communications Coordinator.

5) Coordinate movement of patients from the Triage Area to Treatment Areas with Tirage Unit Leader.
6) Coordinate the deployment of medical resources and utilization of hospital response teams with the Medical Group Supervisor.
7) Maintain security, control, re-triage and assessment of casualties within the casualty loading areas.
8) Direct movement of patients to ambulance loading areas.
9) Give periodic updates to the Medical Group Supervisor.
10) Maintain unit log.

i. **Medical Communications Coordinator** – (Call sign "MedCom") Reports to the Patient Transportation Group Supervisor and is responsible for communications with Medical Control.

Duties:

1) Obtain briefing from the Patient Transportation Group Supevisor.
2) Establish communications with the assigned base hospital or trauma center.
3) Determine and maintain current status of hospital availability and capability.
4) Receive basic patient information and injury status from Treatment Dispatch Manager.
5) Communicate hospital availability to Treatment Dispatch Manager.
6) Coordinate patient destination with assigned base hospital.
7) Perform final tally with base hospital.
8) Maintain appropriate records.

j. **Treatment Dispatch Manager** – (Call sign "Treatment Dispatch") Reports to the Treatment Unit Leader and is responsible for the coordination with the Transportation Group Supervisor of patient movement from triage and treatment areas onto transport units.

Duties:

1) Obtain briefing from Treatment Unit Leader and Medical Communications Coordinator.
2) Establish communications with the Immediate, Delayed, and Minor Treatment Managers.
3) Establish communications with the Patient Transportation Group Supervisor.
4) Verify patient prioritization for transportation.

5) Advise Medical Communications Coordinator of patient readiness and priority for transport.
6) Coordinate transportation of patients with Medical Communications Coordinator.
7) Assure appropriate patient tracking information is recorded to include patient number, status, transport unit and destination. Patients who are less than 18 years old should have their first and last name recorded to assist the PIO and the IC with family identification.
8) Coordination ambulance loading and destination assignment with the Treatment Manager and ambulance personnel.

k. **Medical Supply Officer** – (Call sign "Supply") Reports to the Medical Group Supervisor and is responsible for the acquisition and distribution of medical equipment and supplies.

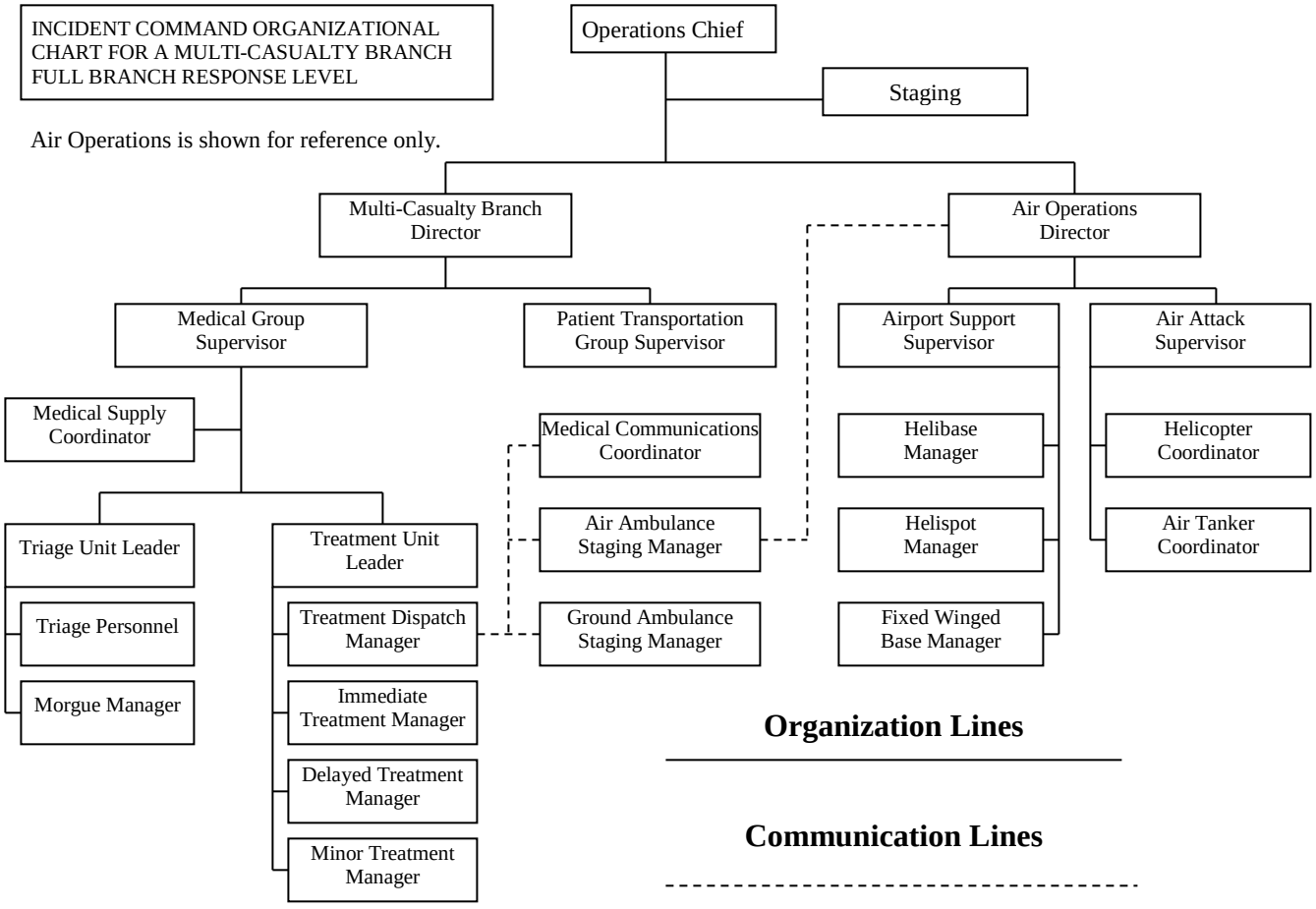
Duties:
1) Obtain briefing from the Medical Group Supervisor.
2) Acquire, distribute, and maintain status of medical equipment and supplies within the Medical Group/Division.
3) Request additional medical supplies to include medical caches.
4) Distriubute medical supplies to Treatment and Triage Units.
5) Maintain Unit Log.

l. **Air/Ground Ambulance Coordinator** – (Call sign "Ambulance Staging Manager") Reports to the Patient Transportation Group Supervisor and works directly under the Staging Manager. The Air/Ground Ambulance Coordinator is responsible for supervision and management of air and ground ambulance resources in the Staging area as directed by the Staging Manager.

Duties:
1) Working with the Staging Manager, establish appropriate staging areas for ambulances based upond level of medical service, i.e., ALS, BLS, CCT.
2) Establish and maintain routes of travel for transport units throughout the incident.
3) Establish and maintain communications with the Air Operations Branch Director.
4) Establish and maintain communications with the Treatment Dispatch Manager and Medical Communications Coordinator.
5) Provide Ambulances upon request from Treatment Dispatch Manager or Medical Communications Coordinator.

6) Maintain records as to the number of, status and type of resources in the ambulance, bus and air staging areas.
7) Assure that necessary ambulance equipment is available in the ambulance for patient needs during transport.
8) Establish liaison with ambulance agencies and law enforcement to facilitate smooth and secure operation of ambulance receiving, staging, movement, loading and transport of victims off scene of the incident.
9) Request additional resources from the Staging Manager to maintain a minimum of one ALS and one BLS ambulance in ambulance staging. Notify the Staging Manager when Air and Bus resources are depleted.
10) Provide an inventory of medical supplies available at ambulance staging area for use at the scene. Notify IC through the Staging Manager of available Equipment Pool for delivery to Medical Group Supervisor.

G. FULL BRANCH - MULTI CASUALTY RESPONSE



H. EXPANISION OF INCIDENT BEYOND LOCAL RESOURCES

In the event of a local or regional disaster, additional resources will be required for prolong operations and mitgation of the incident. The incident commander will identify and request additional resources through the Fire Communications Center (FCC). FCC will make all necessary contacts for resources which cannot be obtained through automatic or mutul aid. Incidents which may require resources greater than the capacity of loal resources will be classified by the County as a Level II or Level III Disaster Response.

1. Level II Disaster

   a. Moderate to severe disaster wherein local resources are not adequate and mutual aid will be required on a regional or statewide basis. The City of San Diego's EOC (Emergency Operations Center) is activated.

   b. The County of San Diego will proclaim a LOCAL EMERGENCY and a STATE OF EMERGENCY may be proclaimed.

   c. County EOC (Emergency Operations Center) is activated and requests for state mutual aid are made by the Regional Disaster Medical/Health Coordinator.

2. Level III Disaster

   a. Major disaster that overwhelms resources in or near the impacted area and requires extensive state and/or federal resources.

   b. LOCAL EMERGENCY and a STATE OF EMERGENCY will be proclaimed and a Presidential Declaration of an EMERGENCY or MAJOR DISASTER will be requested.

I. Local, State and Federal Responsibility/Resources

1. County Emergency Medical Services (EMS)

   a. Coordinate disaster medical operations within the operational area.

   b. Coordinate the procurement and allocation of medical resources required to support disaster medical operations.

c. Develop and organizes a system for staffing and operation of Casualty Collection Points (CCP) and disaster support areas.

d. Request and responds to requests from the Regional Disaster Medical/Health Coordinator for disaster assistance.

e. Develop and maintains a capability for identifying medical resources, transportation, and communication services within the operational area.

f. Maintain liaison with the coordinators of other emergency functions such as communications, fire and rescue, health, law enforement and traffic control, transportation, care and shelter, etc.

g. Coordinate and provides support to medical activities at the scene.

h. Assist with contacting and the coordination of Critical Incident Stress Management.

i. Critical Incident Stress Management Team (CISMT)

Prolonged rescue efforts, multiple-day emergency operations, and single event "critical incident" exposures are typical encounters during multi-casualty and medical disasters. On-scene defusing and post-incident debriefing are available from the San Diego County CISMT. Request for CISMT support can be made via Sheriff's Communications Center or the County EMS Duty Officer.

2. State Medical Mutual Aid

The State of California is divided into six mutual aid regions. The San Diego County Operational Area is in Region VI which also includes the Mono, Inyo, San Bernardino, Riverside and Imperial Operational Areas. In the event local medical resources are unable to meet the medical needs of disaster victims, the Operational Area may request assistance from neighboring jurisdictions through the Regional Disaster Medical/Health Coordinator or Office of Emergency Services (OES) regional office. The Regional Coordinator coordinates the provision of medical resources to the Operational Area and the distribution of casualties to unaffected areas as conditions permit. In addition, a Medical Mutual Aid Plan exists in Region VI and all counties in Region VI have signed this plan and the Medical Mutual Aid Agreement. If a state response is indicated, the Regional Coordinator functions are subsumed under the overall State medical response.

a. The State Shall:

1) Respond to requests for resources from the operational area.
2) Coordinate medical mutual aid within the State.
3) Coordinate the evacuation of injured persons to medical facilities throughout the State.
4) Assist the operational area in recovery efforts.

b. Mutual Aid Implementation

The following information is required for disaster medical mutual aid requests.

1) The number, by triage category, and location of casualties.
2) The location and helicopter accessibility of CCP's.
3) Land route information to determine which CCP's may be evacuated by ground transportation.
4) The resource needs of the affected areas.
5) Location, capabilities, and patient evacuation needs of operational medical facilities in and around the affected area.

c. Information is considered at the Operational Area EOC and provided to the Regional Coordinatore who transmits it to the Emergency Medical Services Authority (EMSA) Staff at the Sate Operations Center (SOC).

The Regional Coordinator shall:

1) Coordinate the acquisition and allocation of critical public and private medical and other resources required to support disaster medical care operations.
2) Coordinate medical resources in unaffected counties in the Region for acceptance of casualties.
3) Request asisstance from the Emergency Medical Services Authority (EMSA) and/or State Department of Health Services (DHS), as needed.

3. Federal Government

a. As shortfalls occur in the State resources, Federal agencies make their resources available, coordinated by the Federal Emergency Management Agency (FEMA).

In a major disaster, the National Disaster Medical System may be activated and patients from the Operational Area would be sent to other counties and states for treatment.

b. Federal Military

1) Provide support such as supplies, equipment, helicopters, and sites for disaster support areas.
2) Provide air/sea lifts.

c. Other Federal Resources

1) Metropolitan Medical Strike Team – (MMST) a federally funded medical, law enforcement, hazardous materials and explosive ordinance team comprised of local resources which responds to acts of terrorism associated with biological, chemical or nuclear weapons producing mass casualties. MMST is requested through the local federal representatives such as the area FPB coordinator.

2) Urban Search and Rescue Team – (USAR) a federally funded team controlled by FEMA. USAR responds to major disasters such as earthquakes, tornados, and terrorist activities in which severe damage is inflected to the infrastructure of the municipality.

3) Disaster Medical Assistance Team (DMAT) a federally funded team controlled by FEMA. DMAT teams are comprised of local doctors, nurses, and paramedics who respond to disasters across the nation providing field hospitals and patient care where local area hospitals are overwhelmed with victims from natural and manmade disasters. DMAT is requested through the local federal representative.