1st Medical Battalion, 1st Marine Logistics Group
Bravo Company, 1st Platoon
Camp Pendleton, California

From: Company Commander, Bravo Company, 1st Platoon, 1st Medical Battalion
To: All 1st Platoon, Bravo Company Personnel

Subj: STANDARD OPERATING PROCEDURE FOR MASS CASUALTY (MASCAL) EVENTS, 1ST PLATOON, BRAVO COMPANY, 1ST MEDICAL BATTALION

Ref: (a) MCRP 4-11.1F, Health Service Support Operations

Encl: (1) Personnel Billet and MASCAL Role Matrix
(2) Personnel Flex Matrix

1. Purpose. To establish standard procedures for 1st Platoon, Bravo Company, 1st Medical Battalion (hereinafter "the Platoon") in the event of a mass casualty (MASCAL) event in its Role 2 (R2) configuration. This SOP applies to trauma MASCAL events, disease non-battle injury (DNBI) surge/outbreak events, and chemical, biological, radiological, and nuclear (CBRN) mass casualty scenarios.

2. Cancellation. None.

3. Action. All 1st Platoon, Bravo Company personnel shall comply with the provisions of this SOP.

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Company Commander, Bravo Company
1st Medical Battalion, 1st Marine Logistics Group

STANDARD OPERATING PROCEDURE
MASS CASUALTY (MASCAL) EVENTS

1st Platoon, Bravo Company, 1st Medical Battalion

1. PURPOSE

This Standard Operating Procedure (SOP) establishes doctrinal procedures for the management of mass casualty (MASCAL) events at a United States Marine Corps (USMC) Role 2 (R2) medical treatment facility operated by 1st Platoon, Bravo Company, 1st Medical Battalion. This SOP governs trauma MASCAL events, DNBI/public health surge events, and CBRN mass casualty scenarios. Blood product management during MASCAL events is governed by a separate SOP (Reference (e)).

2. SCOPE

2a. This SOP applies to all assigned and attached personnel of 1st Platoon, Bravo Company, 1st Medical Battalion operating in an R2 construct.

2b. This SOP is self-contained and does not require nesting under a higher-echelon operation order. In deployed or exercise contexts, this SOP should be read in conjunction with relevant Annex Q and the supported unit's OPORD.

3. DEFINITION OF MASCAL

3a. A MASCAL event is declared when the number or acuity of casualties exceeds the sustained treatment capacity of the R2 facility as determined by the Senior Medical Officer, Triage Officer, or Surgical Team. Declaration is a clinical judgment that may be based on any combination of the following factors:

- The rate of casualty arrival prevents timely sorting and treatment under routine operations.
- Available personnel, supplies, or equipment are insufficient to meet immediate needs.
- Absolute casualty numbers: MASCAL should be strongly considered when simultaneous casualties exceed the doctrinal R2 treatment capacity as outlined in Reference (a) (nominally 18 casualties per operational period under surge conditions). Exceeding this threshold is presumptive grounds for declaration.
- Any single event generating 10 or more casualties simultaneously constitutes presumptive MASCAL conditions and shall prompt immediate triage officer assessment.

3b. MASCAL declaration is a medical determination. The declaration is immediately reported to the Officer-in-Charge (OIC), who notifies higher headquarters and requests concurrence for divert status or expedited resupply and evacuation as appropriate.

4. TRIAGE METHODOLOGY

4a. The Platoon uses the START (Simple Triage and Rapid Treatment) algorithm as its primary triage system. All personnel in clinical roles shall be trained and current in START triage prior to deployment or exercise.

4b. Triage Categories. The four operational triage categories are:

Category	START Criteria	Tag Color	Location	Reassessment Interval
IMMEDIATE	RR >30 or <10; cap refill >2s; cannot follow commands	RED	Shock Trauma Platoon / FRSS	Continuous until stabilized
DELAYED	RR 10–30; cap refill ≤2s; follows commands; significant injury	YELLOW	Shock Trauma Platoon / Casual Collection	Every 30 min
MINIMAL	Walking wounded; minor injuries; capable of self-care	GREEN	Holding – Minimal Zone	Every 60 min
EXPECTANT	Unsurvivable injuries given available resources; massive resource requirement	BLACK/GRAY	Holding – Expectant Zone (separated from Minimal)	Every 15 min; upgrade if resources available

4c. Triage is a dynamic, ongoing process. Patients shall be re-triaged at the intervals specified above. Any patient whose condition changes shall be re-tagged and repositioned accordingly.

4d. Expectant patients shall be physically separated from Minimal patients within the Holding area. A minimum distance of 15 feet between cohorts is preferred. Expectant patients shall receive comfort care and reassessment at 15-minute intervals. Upgrade of Expectant patients to Immediate or Delayed is authorized at any time if resources permit.

5. TRIAGE LEADERSHIP AND OFFICER ROLES

5a. The Primary Triage Officer shall be the senior available Emergency Physician or the senior available surgeon.

5b. The Triage Officer physically stations at the point of patient entry (triage area) and continuously drives the triage process, directing personnel assignments and managing patient flow. The Triage Officer does not perform definitive treatment during active MASCAL unless no other provider is available.

5c. The secondary Emergency Physician leads the Shock Trauma Platoon, directing resuscitation and stabilization of critically injured patients.

5d. The Anesthesiologist moves forward to the triage area upon MASCAL declaration and provides airway management and vascular access as required. The Anesthesiologist returns to FRSS upon notification that the first operative case is being prepared. If no operative case materializes, the Anesthesiologist remains forward as a resuscitation asset.

5e. The Family Medicine Physician leads the Holding area, overseeing the Minimal and Expectant patient populations. The Family Medicine Physician shall not be pulled from Holding unless all Immediate-category patients are stabilized and no further triage surge is anticipated.

5f. The Dental Officer shall serve as the Repeat Triage Officer and Patient Administrator. The Dental Officer circulates among all triage categories, verifying tag accuracy, reassessing patient status, and maintaining the patient tracking log in coordination with Medical Regulator. Dental Techs assist with litter bearing and patient flow.

6. PERSONNEL FLEXING AND MINIMUM MANNING

6a. Upon MASCAL declaration, personnel from FRSS, Holding, and Dental sections shall flex to augment the triage area As detailed in Enclosure 2, which governs flex assignments and minimum manning requirements.

6b. The OIC in coordination with the Senior Medical Officer has authority to modify flex assignments based on the specific MASCAL scenario. Deviations from the above matrix shall be documented in the SITREP.

7. MASCAL DECLARATION AND NOTIFICATION CHAIN

7a. MASCAL is declared by the Senior Medical Officer, Triage Officer, or Surgical Team upon meeting criteria in paragraph 3. Declaration is immediately communicated to the OIC.

7b. The following notification sequence shall be followed:

Step	Who Notifies	Who Receives	Required Actions / Information
1	Senior Medical Officer / Triage Officer / Surgical Team	OIC	MASCAL declared; current casualty count; triage status; resource status; recommend divert or resupply
2	OIC	Higher Headquarters (C2 unit)	MASCAL declaration; request concurrence for divert; request MEDEVAC/resupply if indicated; provide LACE report
3	OIC / OPS O	Adjacent Role 1 / Role 2 units	Divert status (if approved); capacity constraints; redirect casualty flow
4	OPS O / Comms	Higher HQ (ongoing)	Periodic SITREP every 30 min until MASCAL stand-down; patient status updates
5	Senior Medical Officer	OIC	MASCAL stand-down criteria met; recommend termination
6	OIC	Higher HQ	MASCAL terminated; lessons learned; resupply requirements

7c. Divert Status. The R2 facility may recommend divert status (ceasing or limiting acceptance of additional casualties) to higher headquarters when treatment capacity is critically exceeded. Divert status requires concurrence from higher headquarters prior to implementation. Higher headquarters may represent any C2 element exercising operational control over the Platoon, including but not limited to RCT Surgeon, BDE Surgeon, or MAGTF Surgeon. The medical team may implement temporary divert while awaiting higher headquarters response only if patient safety is immediately compromised.

7d. A LACE report format (Liquids, Ammunition, Casualties, Equipment) adapted for medical logistics shall be used when requesting resupply from higher headquarters. At minimum, the following shall be reported: number and category of casualties, blood product status (per Reference (e)), critical supply deficiencies, and MEDEVAC requirements.

7e. SITREPs shall be submitted every 30 minutes to higher headquarters throughout the MASCAL event, until stand-down is declared.

8. PHYSICAL LAYOUT AND PATIENT FLOW

8a. Upon MASCAL declaration, the R2 facility activates the MASCAL configuration. Physical layout adjustments shall be completed within 15 minutes of declaration.

8b. Patient Flow Sequence:

(1). CASUALTY ARRIVAL: Ambulatory patients report to triage entry point; litter patients are offloaded by Dental Techs, FMT litter teams, and ambulance crew.

(2). PRIMARY TRIAGE: Triage Officer and FMT team conduct START triage at entry; patient tagged and directed to appropriate treatment area.

(3). IMMEDIATE TREATMENT BAY: Secondary EM Physician leads resuscitation; Anesthesiologist provides airway/vascular access; Emergency Nurse and PA support.

(4). DELAYED TREATMENT AREA: PA and IDC (if assigned) manage delayed patients; FMTs provide ongoing monitoring and interventions.

(5). FRSS (OPERATIVE): First Surgeon, Second Surgeon, Anesthesiologist (upon return), CC Nurse, and Surg Techs manage operative cases.

(6). HOLDING – MINIMAL ZONE: Family Medicine Physician and Holding team manage ambulatory, self-care patients; reassess at 60-minute intervals.

(7). HOLDING – EXPECTANT ZONE: Physically separated from Minimal zone; Family Medicine Physician oversees; nursing and FMT support; reassess at 15-minute intervals.

(8). REPEAT TRIAGE: Dental Officer circulates continuously, reassessing all zones and updating patient tracking log.

(9). MEDEVAC STAGING: Ambulance crew and FMTs (#53–56) prepare patients for evacuation; Med Reg coordinates patient movement documentation.

8c. Ancillary services (Lab, Radiology, Pharmacy) operate in support mode throughout the MASCAL event. Point-of-care testing is preferred to minimize transport. Radiology shall prioritize portable studies in the Immediate Treatment Bay.

9. DISEASE NON-BATTLE INJURY (DNBI) AND PUBLIC HEALTH SURGE

9a. A DNBI surge event occurs when the rate of illness presentations exceeds routine sick call capacity or when an outbreak of a potentially communicable illness is identified. Preventive Medicine Representative conducts ongoing surveillance and reports to the Senior Medical Officer.

9b. The following workflow governs DNBI surge and outbreak events:

Phase	Lead	Actions	Threshold / Criteria
SURVEILLANCE	Prev Med Rep (#52)	Ongoing illness tracking; report to Fam Med Physician and OPS O daily	Any cluster of ≥3 similar presentations within 24 hrs triggers formal investigation
OUTBREAK DECLARATION	Senior Medical Officer	Declare outbreak; notify OIC; OIC notifies Higher HQ; coordinate with Prev Med	≥10% of unit strength with similar illness OR any confirmed high-consequence pathogen
COHORT ISOLATION	Fam Med Physician + Holding team	Establish illness cohort in Holding; separate from trauma patients; assign dedicated FMTs	Symptomatic personnel isolated from unit; asymptomatic exposed personnel monitored

CASE MANAGEMENT	Fam Med Physician + Nurses	Oral/IV rehydration; electrolyte replacement; symptom management; daily reassessment	Admission criteria: signs of dehydration, altered status, inability to maintain oral intake
CONTACT TRACING	Prev Med Rep	Identify exposure source; map case distribution by time/place/person; report to Higher HQ	Submit DNBI SITREP to Higher HQ within 4 hrs of outbreak declaration; daily updates
RETURN TO DUTY	Fam Med Physician	Afebrile x 24 hrs; tolerating oral fluids; no active diarrhea/vomiting; cleared by provider	Document RTD in medical record; report aggregate numbers to OPS O for readiness tracking
STAND-DOWN	Senior Medical Officer + OIC	No new cases x 48 hrs; all contacts cleared; outbreak cause identified; notify Higher HQ	Debrief Prev Med findings; submit outbreak report; lessons learned to unit

9c. Cohort Isolation. Ill patients shall be cohorted in the Holding area, physically separated from trauma patients. A dedicated entrance and exit for DNBI patients shall be established when practicable. FMTs assigned to DNBI cohort shall not cross-cover trauma patients during an active outbreak without PPE change.

9d. Enteric illness surge (e.g., diarrheal disease outbreak) shall prompt immediate coordination with the supported unit's S4 and Preventive Medicine assets for water source testing, food service inspection, and environmental assessment.

9e. The DNBI SOP does not require MASCAL declaration; however, if DNBI surge simultaneously degrades operational readiness or overwhelms treatment capacity in conjunction with trauma operations, the Senior Medical Officer may declare MASCAL and activate this SOP in full.

10. CBRN MASS CASUALTY PROCEDURES

10a. A CBRN MASCAL modifies standard trauma MASCAL procedures to account for contamination control, PPE requirements, and decontamination lane operations. The CBRN Marine, when assigned to the Platoon T/O, is the primary CBRN resource. In the absence of a CBRN Marine, the OIC designates a CBRN-trained collateral duty officer.

10b. CBRN MASCAL Workflow:

Phase	Responsible	Actions	Key Considerations
ALERT	OIC / Triage Officer	Don PPE; alert CBRN Marine; establish hot/warm/cold zones; suspend non-CBRN intake	PPE Level per agent; notify Higher HQ immediately; activate decon SOP
DECON SETUP	CBRN Marine (#74) + UT (#62–65)	Establish decon lane; mark dirty/clean boundary; prepare water source and decon solutions	Wet decon preferred; minimum 2-person decon teams; traffic control

DIRTY TRIAGE	Triage Officer + FMTs (PPE)	Conduct life-saving interventions in hot zone only (airway, hemorrhage control); primary triage using modified START	No definitive care in dirty zone; minimize personnel; document agent if known
DECON TRIAGE	Anesthesiologist + EM Physician (warm zone)	Airway management and vascular access at decon lane exit; re-triage post-decon	Airway interventions may be required prior to full decon; prioritize chemical agent casualties
CLEAN TREATMENT	Full STP + FRSS (cold zone)	Standard MASCAL triage and treatment protocols apply post-decon	Confirm decon complete before transfer to clean zone; equipment decon required
DOCUMENTATION	Dental Officer + Med Reg	Record agent, exposure time, decon time, treatment given in hot zone	CBRN patient cards supplement standard triage tags; report to higher HQ

10c. PPE Requirements. Minimum PPE for CBRN MASCAL is Mission Oriented Protective Posture (MOPP) Level 4 in hot and warm zones until agent identification and hazard assessment are complete. PPE may be downgraded on order of the Senior Medical Officer in coordination with the CBRN Marine.

10d. Modified START Triage for CBRN. In the hot zone, triage is limited to life-saving interventions only: airway positioning, hemorrhage control with tourniquet, and gross decon if indicated. Full START triage is conducted post-decon in the warm/cold zone.

10e. Antidote and Pharmaceutical Management. CBRN-specific antidotes (e.g., Mark 1/NAAK kits for nerve agent) shall be staged at the decon lane entry. Pharmacy Tech (#51) coordinates with the Senior Medical Officer for antidote draw and administration protocol.

10f. Higher headquarters shall be notified immediately upon CBRN MASCAL declaration. A CBRN-specific SITREP shall include: suspected agent, number of exposed personnel, decon status, and medical resources required.

11. COMMUNICATIONS

11a. Internal communications during MASCAL shall be managed by the Transmission Chief and Radio Operators . A dedicated internal net for medical operations shall be established at MASCAL declaration.

11b. The OPS O (#4) coordinates external communications with higher headquarters. All SITREPs shall be transmitted in standard Navy/Marine Corps format.

11c. Patient tracking data shall be maintained by Medical Regulator and backed up by the Dental Officer patient log. Data shall be reconciled prior to each SITREP.

12. BEHAVIORAL HEALTH SUPPORT DURING MASCAL

12a. The Psychiatric Provider and Behavioral Health Technician shall monitor staff performance and acute stress reactions during prolonged MASCAL events. Staff rotation and rest shall be implemented by the SEL when operationally feasible.

12b. Combat and Operational Stress Control (COSC) principles shall be applied. Personnel exhibiting signs of acute stress reaction shall be relieved from patient care responsibilities when a replacement is available, assessed by the Psychiatric Provider, and returned to duty as rapidly as clinically appropriate.

13. TRAINING REQUIREMENTS

13a. All clinical personnel shall complete START triage refresher training no less than annually.

13b. The Platoon shall conduct a MASCAL exercise no less than semi-annually, incorporating both trauma and DNBI scenarios. CBRN MASCAL shall be exercised annually when CBRN assets are available.

13c. After-action reviews (AAR) shall be conducted following all MASCAL exercises and actual events. Lessons learned shall be submitted to the Company Commander and incorporated into the next SOP review.

14. SOP REVIEW AND CURRENCY

14a. This SOP shall be reviewed annually or upon significant change to unit T/O, mission, or higher-echelon doctrine. The Medical Officer of the Day is responsible for initiating annual review.

14b. Temporary amendments may be authorized by the OIC and shall be incorporated into the next full SOP revision.

15. RECORDS

15a. MASCAL event logs, patient tracking records, and SITREPs shall be retained in accordance with applicable Navy and Marine Corps records management policy.

15b. A MASCAL After-Action Report shall be completed within 72 hours of MASCAL stand-down and submitted to the Company Commander.

Enclosure (1) Comprehensive billet and MASCAL role matrix

#	Billet / Description	Section	MASCAL Primary Role
1	OIC	COC	MASCAL Declaration Authority; Notify Higher HQ
2	SEL	COC	Command continuity; support OIC notification chain
3	LPO	HQ	Logistics coordination; resupply/MEDEVAC requests
4	OPS O	HQ	Operational coordination; SITREP generation
5	Med Reg	HQ	Patient tracking, MED REG; documentation control

7	General Surgeon	FRSS	FRSS operative care; MASCAL triage lead (alt)
8	Gen Surgeon / Ortho	FRSS	FRSS operative care
9	Anesthesiologist	FRSS	Forward triage: airway mgmt & vascular access until first OR case
10	CC Nurse	FRSS	FRSS critical care; flex to triage Immediate area as needed
11	IDC (if assigned)	FRSS	FRSS support or triage flex
12	Surg Tech	FRSS	FRSS support; flex to triage on declaration
13	Surg Tech	FRSS	FRSS support; flex to triage on declaration
14	Field Med Tech	STP	STP / primary triage support
15	Emergency Physician	STP	PRIMARY TRIAGE OFFICER (Lead)
16	Emergency Physician	STP	SECONDARY TRIAGE OFFICER / Immediate treatment lead
17	Emergency Nurse	STP	Immediate treatment area; IV access, stabilization
18	Physician Assistant	STP	Triage / Immediate treatment support
19	IDC (if assigned)	STP	Triage / treatment support
20–31	Field Med Techs (12)	STP	Triage runners, litter bearers, treatment assist, vitals
32	ERC Nurse	ERCS	ERC resuscitation support
33	Field Med Tech	ERCS	ERC tech support
34	Fam Med Physician	Holding	Leads Holding: oversees Minimal & Expectant; reassessment
35	Primary CC Nurse 1960	Holding	Holding senior nurse; Expectant monitoring
36	Nurse 1910	Holding	Holding nursing support; Minimal care
37–44	Field Med Techs (8)	Holding	Flex to Triage (4) or remain Holding (4) per MASCAL status
45–47	Adv Lab Techs (3)	Ancillary	POC labs: iSTAT, CBC, type & screen support
48–50	Adv Rad Techs (3)	Ancillary	Portable X-ray, FAST augment support
51	Pharmacy Tech	Ancillary	Medication draw; controlled substance tracking
52	Prev Med Rep	Ancillary	DNBI/outbreak surveillance; cohort ID; public health
53–54	Motor Vehicle Operators	Ambulance	MEDEVAC/ambulance coordination; patient movement

55–56	Field Med Techs	Ambulance	Ambulance crew; patient movement
57	Psychiatric Provider	CST	BH triage; stress reaction management in prolonged MASCAL
58	BHT	CST	BH support; staff acute stress monitoring
59	Dental Officer	Dental	Repeat triage; patient administrator; tag verification
60–61	Dental Techs (2)	Dental	Litter bearing; patient flow assist; documentation support
62–65	UT / Operator	Utility	Facility setup; generator; water; shelter
66–72	Comms (7)	Comms	Internal/external comms; SITREP transmission
73	BMET	BMET	Equipment readiness; ventilator / monitor support
74	CBRN Marine*	CBRN	Decon lane setup; dirty/clean side management (*when assigned)

Enclsure 2: Flex Staffing Pattern for MASCAL

Source Section	Personnel Flexed	Flex Destination	Minimum Manning Retained
FRSS	Anesthesiologist Surg Techs, CC Nurse	Casualty Collection Point / Shock Trauma Platoon	Min: 1 Surgeon + 1 Surg Tech for first OR case; Anesthesiologist returns on first case
Holding	4 x corpsmen, Dental Techs	Triage litter bearing / patient flow	Min: Fam Med Physician + CC Nurse + 4 FMTs remain for Expectant/Minimal care
Dental	Dental Officer	Repeat triage / patient admin	Dental Techs support litter bearing and documentation
CBRN (if assigned)	CBRN Marine	Decon lane / dirty-clean boundary	Sole billet; maintain decon lane throughout CBRN MASCAL
CST/BH	BHT	Staff stress monitoring / patient flow assist	Psych Provider (#57) available for BH triage surge
Ambulance	FMTs (#55–56) + Drivers (#53–54)	Patient movement / MEDEVAC staging	Retain minimum 1 crew for ongoing MEDEVAC missions