Tactical Combat Casualty Care [TCCC]

Some reminders and information

Almost 90% of all combat deaths occur before the casualty reaches a Medical Treatment Facility (MTF). TCCC not limited to MEDICs and can be adjusted or used by ALL Combatants

Care Under Fire | Tactical Field Care | Tactical Evacuation Care

Tactical Combat Casualty Care [TCCC]

Police Officers and other LEO should be taught its use to save lives in the hot zone

Care Under Fire | Tactical Field Care | Tactical Evacuation Care

Tactical Combat Casualty Care [TCCC]

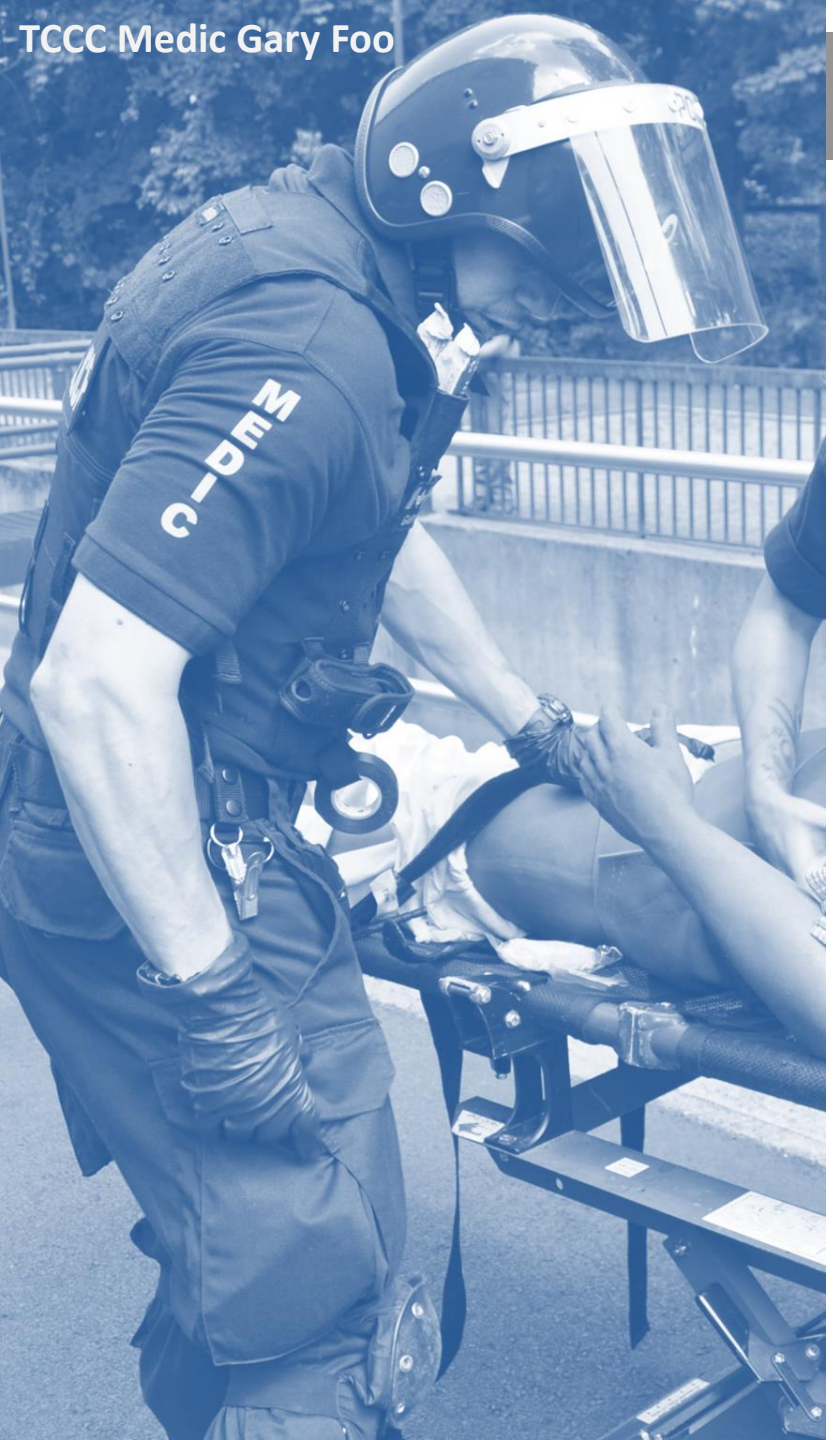
Police Medics could be trained all over the world *(Picture from Riot Police in the UK)*

Care Under Fire | Tactical Field Care | Tactical Evacuation Care

Three Goals of Tactical Combat Casualty Care TCCC

TCCC recognizes this fact and structures its guidelines to accomplish three primary goals:

1. **Treat the casualty**
2. **Prevent additional casualties**
3. **Complete the mission**


TCCC Medic Gary Foo

Three Phases of TCCC

TCCC (AKA “Tee-Triple-Cee”)is built around three definitive phases of casualty care:

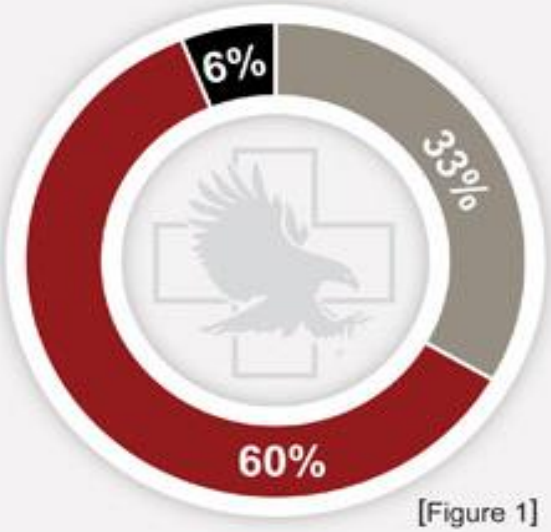
Care Under Fire:
Care rendered at the scene of the injury while both the medic and the casualty are under hostile fire. Available medical equipment is limited to that carried by each operator and the medic.

Tactical Field Care:
Rendered once the casualty is no longer under hostile fire. Medical equipment is still limited to that carried into the field by mission personnel. Time prior to evacuation may range from a few minutes to many hours.

Tactical Evacuation Care (TACEVAC):
Rendered while the casualty is evacuated to a higher echelon of care. Any additional personnel and medical equipment pre-staged in these assets will be available during this phase.

The Target: Preventable Combat Death

Col. Gray hit the nail on the head 85 years ago. Empirical research using data from World War II until today elicited the same conclusion. The overwhelming cause of preventable combat death continues to be extremity hemorrhage (see Figure 1). However, until recently, neither warfighters nor tactical operators were trained or equipped to control the life threatening hemorrhage so common to both operational arenas.



[Figure 1]

Good Medicine in Bad Places

Source Graphic Left: www.narescue.com Source Graphic Right: Gary Foo / Craig Hall DG

The ‘New’ MARCH Protocol

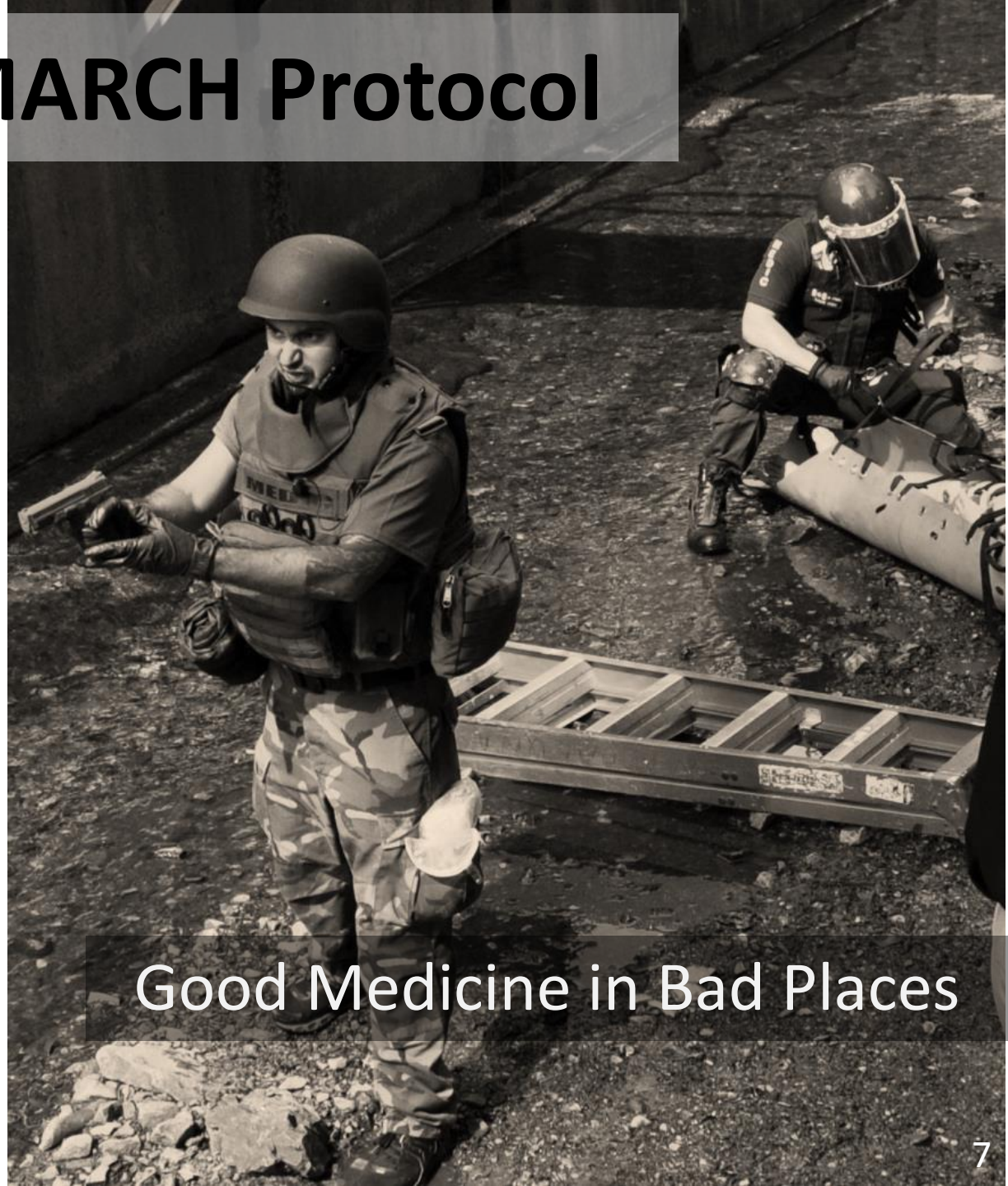
Massive Bleeding
hemorrhage control
(tourniquets hemostatic dressings)

Airway management
(including surgical cricothyroidotomy for TACMED medics)

Respiratory management
(occlusive dressings for open pneumothoraces and needle decompression for tension pneumothoraces)

Circulation
(BIFT) Bleeding control
Intravenous/intraosseous access
Fluid resuscitation (HSD as a volume expander) Tourniquet assessment and removal

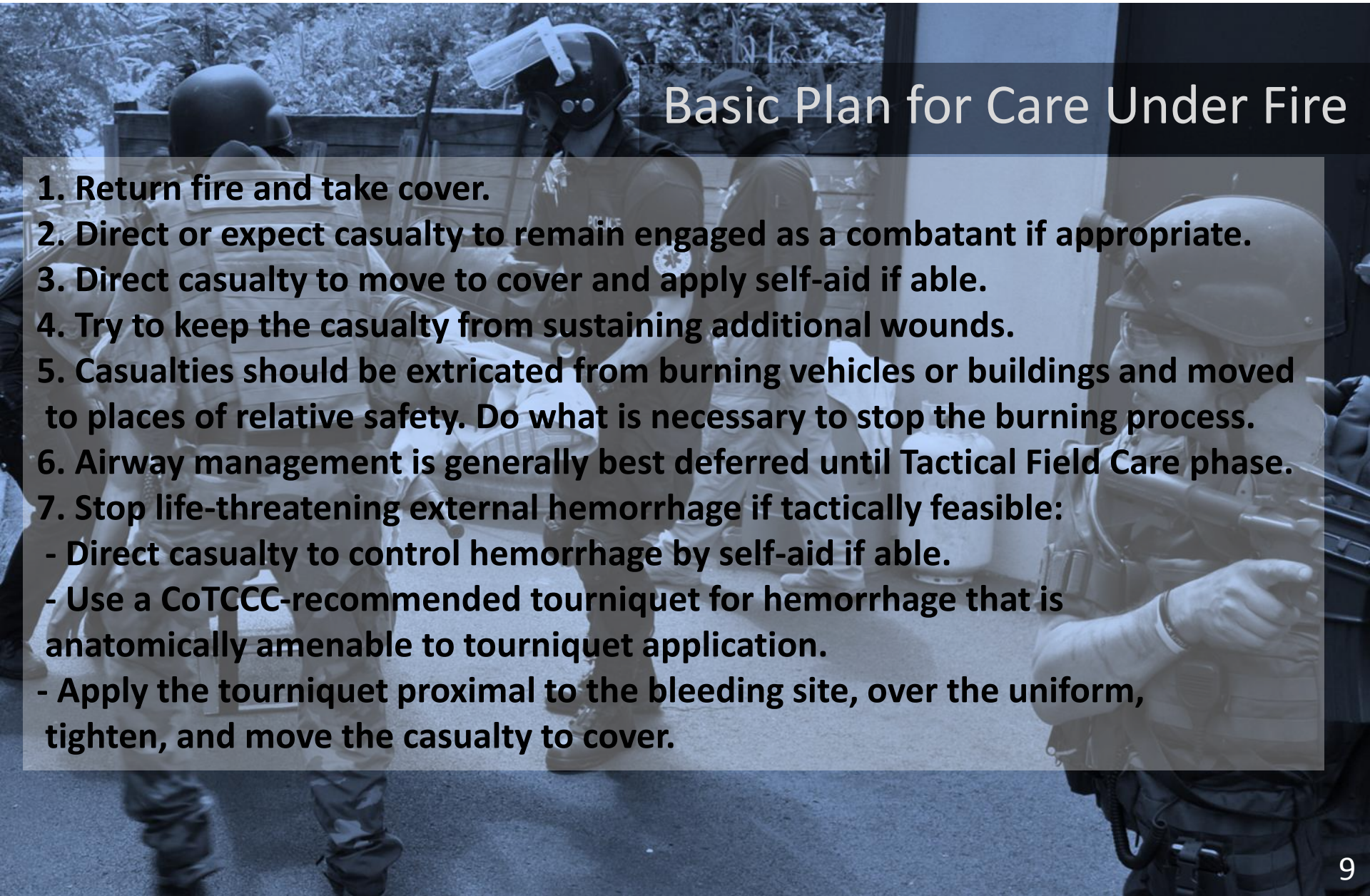
Hypothermia / **H**ead injury



Tactical Combat Casualty Care

Good Medicine in Bad Places

Tactical Combat Casualty Care



Basic Plan for Care Under Fire

1. Return fire and take cover.
2. Direct or expect casualty to remain engaged as a combatant if appropriate.
3. Direct casualty to move to cover and apply self-aid if able.
4. Try to keep the casualty from sustaining additional wounds.
5. Casualties should be extricated from burning vehicles or buildings and moved to places of relative safety. Do what is necessary to stop the burning process.
6. Airway management is generally best deferred until Tactical Field Care phase.
7. Stop life-threatening external hemorrhage if tactically feasible:
   - Direct casualty to control hemorrhage by self-aid if able.
   - Use a CoTCCC-recommended tourniquet for hemorrhage that is anatomically amenable to tourniquet application.
   - Apply the tourniquet proximal to the bleeding site, over the uniform, tighten, and move the casualty to cover.

Tactical Combat Casualty Care

1. Casualties with an altered mental status?
2. Airway Management
3. Breathing
Tension pneumothorax and decompress?
Open and/or sucking chest wounds?
O2 for moderate/severe TBI
4. Bleeding
Assess for unrecognized hemorrhage and control
Expose and clearly mark all tourniquet sites
5. Intravenous (IV) access
6. Tranexamic Acid (TXA)
7. Fluid resuscitation
a. If not in shock:
- No IV fluids necessary
- PO fluids permissible if conscious and can swallow
b. If in shock:
- Hextend, 500-mL IV bolus
- Repeat once after 30 minutes if still in shock.
- No more than 1000 mL of Hextend
c. Resuscitate? Tactical considerations and the risk
8. Prevention of hypothermia
9. Penetrating Eye Trauma
10. Monitoring
11. Inspect and dress known wounds.
12. Check for additional wounds.
13. Analgesia
14. Splint fractures and recheck pulse.
15. Antibiotics: recommended for all open combat wounds
16. Burns
17. Remember to Communicate and reassure the casualty
18. Cardiopulmonary resuscitation (CPR)
19. Documentation of Care

Tactical Field Care

Tactical Combat Casualty Care

The term "Tactical Evacuation" includes both Casualty Evacuation (CASEVAC) and Medical Evacuation (MEDEVAC) as defined in Joint Publication 4-02. Many medical protocols here and a few non-medical. (One of them being the 9 line request)

9 Line MEDEVAC Request

Line 1. Location of the pick-up site.
Line 2. Radio frequency, call sign, and suffix.
Line 3. Number of patients by precedence:
Line 4. Special equipment required:
Line 5. Number of patients:
Line 6. Security at pick-up site:
Line 7. Method of marking pick-up site:
Line 8. Patient nationality and status:
Line 9. NBC Contamination
(or Terrain Description in peacetime)

Booklet by

Gary Foo

The Police Charter www.thepolicecharter.com
DIMERSAR www.DIMERSAR.com

Graphics and Media

www.envisagenow.com/the-importance-of-a-medic-in-a-tactical-team/

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http://www.dailymail.co.uk/sport/football/article-1209050/West-Ham-fans-face-life-bans-hundreds-bloody-rampage-night-shame-Millwall-Upton-Park.html

www.myarmyonesource.com

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