

Pre-Hospital MCI/Active Shooter/Hostile Event (ASHE) Response Procedure

PURPOSE

To efficiently triage, treat, and transport victims of mass/multiple-casualty incidents (MCIs). The following protocol is applicable to all multiple-victim situations. This protocol is intended for the everyday MCI when the number of injured exceeds the capabilities of the first-arriving unit as well as for large-scale MCIs.

PROCEDURE

A. The officer of the first-arriving unit will establish Command and:

1. Perform a size-up, estimating the number of victims.
2. Request a Level 1, 2, 3, 4, or 5 response, and request additional units and/or specialized equipment as needed. If the incident is an active shooter/hostile event with unknown victims, request a MCI level 2 response until a count can be determined and then upgrade or downgrade as needed.
3. Identify a staging area.
4. If it is an active shooter/assailant incident or any tactical environment MCI, establish a Unified Command (UC) with Law Enforcement (LE). Consider establishing Liaisons for FD and LE, the Liaisons can interact with each other allowing the transfer of info between agencies. Law Enforcement will make entry with their contact team and provide feedback to the UC. The decision may be made to establish a Rescue Task Force (team of LE officers providing forced protection for rescue personnel). The Rescue Task Force will initiate triage and provide immediate life saving treatment (i.e. hemorrhage control).
5. If the area is deemed safe to enter, direct the remaining crew members and any additional arriving personnel to initiate triage.
6. Triage will be performed in accordance with START or JumpSTART.
Prioritize victims utilizing color-coded ribbons:
Red Immediate care
Yellow Delayed care
Green Ambulatory (minor)
Black Deceased (non-salvageable)
7. Locate and direct the “walking wounded” to one location away from the incident, if possible. These victims need to be assessed as soon as possible. Assign someone to keep the walking wounded together.
8. Active shooter/hostile event considerations: Be on high alert for suspicious individuals, packages, vehicles or potential IEDs. Integrated active shooter/assailant response should include the critical actions contained in the acronym **THREAT**
Threat suppression
Hemorrhage control
Rapid **E**xtrication to safety
Assessment by medical providers
Transport to definitive care

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As additional units arrive, Command will designate the following officers:

1. Triage (Initially the responsibility of the first-arriving officer).
2. Treatment
3. Transport
4. Staging

C. Additional branches/sections may be required depending on the complexity of the incident. These officers may include, but are not limited to:

1. Medical Branch
2. Landing Zone/Heli-spot
3. Extrication
4. Hazardous Materials (hazmat)
5. Rehabilitation
6. Safety
7. Public Information Officer (PIO)
8. Medical Intelligence—to assist with suspected or known WMD (weapons of mass destruction) events for decontamination, antidotes, and treatment.

D. MCI: predetermined response plan.

1. Considerations:

- a. An MCI shall be classified by different levels depending on the number of victims. The number of victims will be based on the initial size-up, prior to triage.
- b. Levels of response will augment the units already on the scene, and units enroute will be included in the assignment. The exception would be in conjunction with a Fire Alarm assignment i.e., a fire with multiple victims may be a Second Alarm with an MCI Level 3 response; this will be two separate assignments).
- c. Command can downgrade or upgrade the assignments at any time.
- d. All units are to respond to the staging area “emergency response” unless otherwise directed by Command.
- e. When announcing an MCI, specify the general category (e.g., trauma, hazardous materials, smoke inhalation).
- e. Any victim meeting trauma transport criteria must be reported to a state-approved trauma center for determination as to transport destination. Trauma transport criteria will be determined during the secondary triage in the treatment phase.
- f. Consider the use of air transport for patients with special needs, private BLS transport units and mass-transit resources for multiple “walking wounded” patients.
- g. Consider the use of mobile command vehicles, medical supply trailers, and communication trailers as needed.
- h. Upon notification of an MCI, Medical Control (Medcom/MRCC) will gather information about each hospital’s capability and relay this information to the Transport Officer or Medical Communication Officer.
- i. On a large-scale incident, consider sending a Hospital Coordinator to each hospital to assist with communications.
- j. Request law enforcement to set up a safety parameter.

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2. Definitions.

- a. **Active Assailant(s) (AA).** An individual or individuals actively engaged in killing or attempting to kill people in a confined and populated area with means other than the use of firearms.
- b. **Active Shooter** – An individual or individuals actively engaged in harming, or attempting to kill people in a populated area with the use of firearm(s)
- c. **Active Shooter Hostile Event Response (ASHER)** - An incident where one or more individuals are or have been actively engaged in harming, killing, or attempting to kill people in a populated area by means such as firearms, explosives, toxic substances, vehicles, edged weapons, fire, or a combination thereof.
- d. **Ballistic Protection Equipment (BPE)** – An item(s) of personal protective equipment (PPE) intended to protect the wearer from threats that could include ballistic threats, stabbing, fragmentation, or blunt force trauma. Minimally consists of ballistic vest, helmet and/or shield.
- e. **Casualty Collection Point (CCP)** – A temporary location used for gathering, triage, medical stabilization, and subsequent evacuation of nearby casualties. Where vehicular access might be limited and is usually occurring in the warm zone. Casualties can be transferred to an ambulance exchange point/loading zone from these locations.
- f. **Complex Coordinated Attack** – Frequently this is done using multiple asymmetric attack modes, such as firearms, explosives, fire, and smoke as weapon and/or vehicle assaults. It will also often involve coordinated and concurrent attacks on multiple locations which will usually require multiple attackers.
- g. **Concealment** – The protection from observation. Anything that prevents direct observation from the threat that might or might not provide protection from the threat.
- h. **Contact Team/Law Enforcement Entry Team** – A team of law enforcement officers tasked with locating the suspect(s) and neutralizing the threat.
- i. **Cover** – The protection from firearms or other hostile weapons.
- j. **Extraction Team/Litter Bearers** – Personnel used to move the injured/uninjured to an area of safety.
- k. **Force Protection (FP):** Is preventive measures taken to mitigate hostile actions in specific areas or against a specific population, those protected by FP can include civilians and unarmed responders.
- l. **Improvised Explosive Device (IED)** – Per the Department of Defense (DOD), it is a device placed or fabricated in an improvised manner incorporating destructive, lethal, noxious, pyrotechnic, or incendiary chemicals and designed to destroy, incapacitate, harass, or distract. An IED may be made with military or nonmilitary components.
- m. **Rescue Task Force (RTF)** – A combination of fire and/or EMS personnel and law enforcement who provide force protection. The RTF could provide the following tasks: threat-based care, triage, and extracting victims to a casualty collection point or other designated location. The law enforcement officers (LEO) are assigned as force protection for this team and should not separate from the fire and/or EMS personnel. There could be instances where the warm zone suddenly becomes a hot zone, and the LEO must immediately respond to that threat to ensure the safety of the team. Based on the scene, number of victims, and available emergency personnel, there could be more than one RTF assigned. RTFs can operate in the warm zone. Once triage and treatment is complete, the RTF can assist with victim movement. The RTF could also have tactical objectives such as breaching, utility control, managing building systems, and fire control. These teams treat, stabilize, and remove the injured in a rapid manner, while wearing Ballistic Protective Equipment (BPE) and under the protection of law enforcement officers.
- n. **THREAT** – Acronym from the Hartford Consensus highlighting the importance of initial actions to control hemorrhaging.
 - T** – Threat suppression
 - H** – Hemorrhage Control
 - RE** – Rapid Extraction to safety
 - A** – Assessment by medical providers

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T – Transport to definitive care

p. **Unified Command (UC)** – An authority structure in which the role of the incident commander is shared by individuals from all responding organizations responsible for the incident, operating together to develop a single incident action plan. During an ASHER incident, Unified Command generally consists of law enforcement, fire, and EMS representatives at a minimum.

q. **Zones as they relate to Active Shooter Hostile Events:** The areas at ASHER incidents within an established perimeter that are designated based upon safety and the degree of hazard.

Hot Zone – Area that has not been cleared by law enforcement personnel, an area where there is known hazard or direct and immediate threat. Rescue Task Force's (RTF's) should NOT be deployed in this area.

Warm Zone – An area where there is the potential for a hazard or an indirect threat to life. Where the perpetrator is not believed to be and is available for entry by a trained RTF to treat victims and extract them to the CCP.

Cold Zone - Areas where there is little or no threat due to geographic distance from the threat or the area has been secured by law enforcement (i.e., the area where fire/EMS may stage to triage, treat, and transport victims once removed from the warm zone).

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PRE-DETERMINED RESPONSE PLAN

MCI Level 1 (5-10 victims)

- 4 ALS Transport Units
- 2 Suppression Units
- 1 Shift Supervisor
- 1 EMS Supervisor

Note - The two hospitals and trauma center closest to the incident will be notified by Medical Control (Medcom or local communications center).

MCI Level 2 (11-20 victims) (any ASHE incident until an accurate victim count can be made)

- 6 ALS Transport Units
- 3 Suppression Units
- 2 Shift Supervisors
- 2 EMS Shift Supervisors

Note - The three hospitals and two trauma centers closest to the incident will be notified by Medical Control (Medcom or local communications center).

MCI Level 3 (21-100 victims)

- 8 ALS Transport Units
- 4 Suppression Units
- 3 Shift Supervisors
- 3 EMS Shift Supervisors
- Command Vehicle
- MCI Trailer
- Operations Chief

Note – The four hospitals and three trauma centers closest to the incident will be notified by Medical Control (Medcom or local communications center). The Warning Point will notify the Emergency Management Agency.

MCI Level 4 (101-1000 victims)

- 5 MCI Task Forces (25 units)
- 2 ALS Transport Strike Teams (10 units)
- 1 Suppression Unit Strike Team (5 units)
- 2 BLS Transport Strike Teams (10 units)
- 2 Mass Transit Buses
- 2 MCI Trailers
- Command Vehicle
- Communications Trailer
- 5 Shift Supervisors
- 3 EMS Shift Supervisors, 1 EMS Chief
- Operations Chief

Note - The 10 hospitals and 5 trauma centers closest to the incident will be notified by

Medical Control. The Warning Point will notify the Emergency Management Agency.

In an ongoing, long-term MCI, the Metropolitan Medical Response System (MMRS) and the State Medical Response Team (SMRT), Medical Reserve Corp (MRC), Florida Advanced Surgical Team (FAST) Disaster Medical Assistance Team (DMAT) may be notified.

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PRE-DETERMINED RESPONSE PLAN

MCI Level 5 (more than 1000 victims)

- 10 MCI Task Forces (50 units)
- 4 ALS Transport Strike Teams (20 units)
- 2 Suppression Unit Strike Teams (10 units)
- 4 BLS Transport Strike Teams (20 units)
- 4 Mass Transit Buses
- 2 Command Vehicles
- 4 Supply Trailers
- Communications Trailer
- 10 Shift Supervisors
- 6 EMS Shift Supervisors
- 2 EMS Chiefs
- 2 Operations Chiefs

Note -The 20 hospitals and 10 trauma centers closest to the incident will be notified by Medical Control. The Warning Point will notify the Emergency Management Agency. In an ongoing, long-term MCI, the MMRS, DMAT, SMRT, MRC, FAST and the International Medical and Surgical Response Team (IMSURT) may be notified.

Strike Team: Five of the same type of units, including common communications and leader.

Task Force: Five different types of units, including common communications and leader.

MCI Task Force: May be two ALS Transport Units, two BLS Transport Units, and one Suppression Unit, including common communications and leader.

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OFFICER RESPONSIBILITIES

A. Command.

1. Established by the first arriving officer. Radio designation "Command."
2. Follow Field Operation Guide (FOG) #1.
3. If ASHE, get briefing from LE, establish a Unified Command and co-locate with LE. Consider establishing Liaisons for FD and LE, the Liaisons can interact with each other allowing the transfer of info between agencies.
4. Remain in a safe, fixed, and visible location, uphill and upwind of the incident.
5. Determine the MCI Level (1, 2, 3, 4, or 5). If unknown victims in an ASHE initiate a MCI level 2 until a count can be determined.
6. Designate a staging area.
7. Assign personnel to perform the functions of Triage, Rescue Task Force, Treatment, Transport, and Staging.
8. Advise the Communications Center of the number of victims and their categories once triage is complete.
9. During large-scale or complex MCIs (e.g., a fire with multiple victims/ASHE), designate a Medical Branch to reduce the span of control.
10. Ensure proper security of the incident site, treatment area, and loading area; also provide for traffic control and access for emergency vehicles, including law enforcement.
11. If the incident is due to a known or suspected weapon of mass destruction (WMD event), refer to WMD FOG #8 and designate a Medical Intelligence Officer to assist with decontamination, antidotes, and treatment of victims.
12. If ASHE incident refer to FOG #9

B. Medical Branch.

1. Radio designation "Medical." Follow FOG #2.
2. Assure Triage, Treatment, and Transport Officers have been established. If established by Command, Triage, Rescue Task Force, Treatment, and Transport will now report to the Medical Branch.
3. Work with Command, and direct and/or supervise on-scene personnel from agencies such as the Medical Examiner's Office, Red Cross, private ambulance companies, and hospital volunteers.
4. Ensure notification of Medical Control (Medcom/MRCC).
5. Ensure proper security of incident site, treatment area, and loading area; also provide for traffic control and access for emergency vehicles, including law enforcement.
6. If the incident is due to a known or suspected WMD, refer to WMD FOG #8 and designate a Medical Intelligence Officer to assist with decontamination, antidotes, and treatment of victims.
7. If ASHE incident refer to FOG #9

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C. Triage Officer.

Reports to Command or the Medical Branch. Supervises the Triage Personnel, Rescue Task Force (RTF) (if needed) Litter bearers and directs Medical Examiner personnel to locate deceased victims

1. Radio designation "Triage", follow FOG #3.
2. Organize the Triage Team to begin initial triaging of victims. Assemble the walking wounded and uninjured in a safe area. Use bullhorns or a public address (PA) system if necessary.
3. Advise Command (or the Medical Branch, if established) as soon as possible if there is a need for additional resources.
4. Coordinate with Treatment to ensure that priority victims are treated first.
5. Ensure that all areas around the MCI scene have been checked for potential victims, walking wounded, ejected victims, and so forth.
6. Maintain security and control of the triage area. Request the assistance of Law Enforcement.
7. If an RTF is formed designate a Triage Aide to communicate with the RTF
8. If more than one RTF team, designate the teams as RTF 1, RTF 2 etc.
9. If in a building the RTF should mark the doors with the victim count using a grease pencil R= __, Y=__ , G=__ , B=__ (greens should have left the area but may stay to assist with care or supervision (i.e., teacher).
10. Report to Command/Medical Branch upon completion of duties for further assignments.

D. Treatment Officer.

Reports to Command or the Medical Branch. Supervises the Treatment Managers of the Red, Yellow, and Green Areas. Coordinates the re-triage and tagging of all victims and the on-site medical care. Directs the movement of victims to the loading area(s).

1. Radio designation "Treatment", follow FOG #4.
2. Consider assigning a Documentation Aide to assist with paperwork.
3. Direct personnel to either begin treatment on the victims where they lay or establish a centralized treatment area.
4. Considerations for a treatment area:
 - a. Capable of accommodating the number of victims and equipment.
 - b. Consider weather, safety, and the possibility of hazardous materials.
 - c. Designate entrance and exit areas, which are readily accessible (funnel points).
 - d. Use appropriate-color tarps if available.
5. On large-scale incidents, divide the treatment area into three distinct areas based on priority. Designate a Treatment Manager for each area (Red, Yellow, Green). The Red, Yellow, and Green Treatment Managers report to the Treatment Officer and are responsible for the treatment and continual re-triaging of victims in their area. The Treatment Area Managers need to notify the Treatment Officer of victim readiness and priority for transportation. Assure that appropriate victim information is recorded
6. Complete a Treatment Log as victims enter the area.
7. Ensure that all victims are re-triaged through a secondary exam and the assessment is documented on a triage tag (Disaster Management System [DMS] - All Risk Triage tag).
8. All red-tagged victims will be transported immediately as transport units become available. These victims should not be delayed in the treatment area.
9. Ensure that enough equipment is available to effectively treat all victims.
10. Establish communications with Transport to coordinate proper transport of the appropriate victims. Direct movement of victims to the ambulance loading areas.
11. Provide periodic status reports to Command/Medical Branch.

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E. Transport Officer.

Reports to Command or the Medical Branch. Supervises the Medical Communication Coordinator and Documentation Aide(s). The Transport Officer is responsible for the coordination of victims and maintenance of records relating to victim identification, injuries, mode of transportation, and destination.

1. Radio designation "Transport", follow FOG #5.
2. Assign a Documentation Aide with a radio to assist with paperwork and communications.
3. Assign a Medical Communication Coordinator to establish continuous contact with Medical Control (Medcom or MRCC).
4. Establish a victim loading area. Advise Staging of the location and direction of travel. Consider requesting law enforcement assistance for ensuring the security of the loading area.
5. Arrange for the transport of victims from the treatment area. Maintain a Hospital Transportation Log #5B. Keep the appropriate section of the triage tag for future documentation.
6. Communicate with the Landing Zone (LZ)/Heli-spot Officer and relay the number of victims to be transported by air. Air-transported victims should be assigned to distant hospitals, unless the victims' needs dictate otherwise (e.g., trauma center, burn unit).

F. Medical Communications Coordinator.

Reports to the Transport Officer and is responsible for maintaining communication with Medical Control to assure proper victim transport information and destination.

1. Radio designation "Communication." Follow FOG #5A.
2. Establish communication with Medical Control (Medcom or MRCC¹). Advise Medical Control of the overall situation (e.g., smoke inhalation, trauma, burns, hazardous materials exposure) and the number and categories of victims. Medical Control will survey area hospitals to determine their capabilities and capacities and then relay this information to the field. Document this information on the Hospital Capability Worksheet #5C and maintain this document for the duration of the incident.
3. When units are prepared to transport, advise Medical Control and supply of the following information:
 - a. The unit transporting.
 - b. The number of victims to be transported.
 - c. Their priority: Red, Yellow, or Green.
 - d. Any victims with special needs (e.g., cardiac, burn, trauma).
4. The Medical Communication Coordinator, in conjunction with Medical Control, will determine the most appropriate facility. Ground-transported victims should be assigned to hospitals on a rotating basis.
5. Once Medical Control receives the information from the Medical Communication Coordinator, Medical Control will notify the appropriate hospital. Transporting units will not contact the individual hospital on their own unless there is a need for medical direction/care outside of protocols.

¹ Medical Resource Coordination Center (MRCC): The MRCC's prime function is to maintain status information—that is, the number of victims and the hospital readiness status to accept victims, to coordinate transportation, and to direct patients to the appropriate hospital during a disaster or other situation characterized by a high demand for medical resources.

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G. Medical Supply Coordinator.

Reports to the Medical Branch and is responsible for acquiring and maintaining control of all medical equipment and supplies.

1. Radio designation “Medical Supply”, follow FOG #6.
2. Assure necessary equipment is available on the transporting vehicle.
3. Provide an inventory of medical supplies at the staging area for use on scene.
4. Assure support vehicles are requested. (Broward County has four MCI supply trailers and Region 7 has three large MCI supply trailers available for use during a large-scale MCI.)

H. Staging Officer.

Reports to Command and is responsible for managing all activities within the staging area.

1. Radio designation “Staging”, follow FOG #7.
2. Establish the location of a staging area and notify the Communication Center to direct any incoming units.
3. Maintain a Unit Staging Log #7A.
4. Ensure that all personnel stay with their vehicles unless otherwise directed by Command. If personnel are directed to assist in another function, ensure that the keys stay with each vehicle.
5. Coordinate with the Transport Officer the designation of a location for victim loading and the best route to the area.
6. Maintain a reserve of at least two transport vehicles. When the reserve is depleted, request additional units through Command.

DOCUMENTATION

- A. The Incident Commander will, at the completion of the incident, coordinate the gathering of all pertinent documentation.
- B. A Post-Incident Analysis (PIA) will be completed.

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Recommended MCI Kits for Responder Vehicles

Each unit should carry an MCI bag. The following items are recommended:

- A. Two (2) triage packs recommend to have:
 1. Four (4) combine dressings
 2. Four (4) 4 × 4's
 3. Gloves
 4. One (1) pediatric face mask
 5. Colored ribbons (Red, Yellow, Green & Black) either rolls or ribbons.
 6. Trauma Tourniquets (2)
 7. Hemostatic Dressing (2)
 8. Chest Decompression Needles (2)
 9. Chest Seals (2)
- B. Fifty (50) triage tags—Disaster Management Systems (DMS) All Risk Triage tags.
- C. Pencils/grease pencils and pens.
- D. Additional tourniquets, hemostatic dressing, chest seals & chest decompression needles (10 of each)
- E. The following MCI FOGs, logs, and associated paperwork for each officer:
 1. Command FOG #1 - White
 2. Medical FOG #2 - Blue
 3. Triage FOG #3 - Yellow
 4. Treatment FOG #4 - Red
 5. Treatment Area Log #4A - Red
 6. Transport FOG #5 - Green
 7. Medical Communication FOG #5A - Green
 8. Hospital Transport Log #5B - Green. (10 logs)
 9. Hospital Capability Worksheet #5C - Green
 10. Medical Supply FOG #6 - Blue
 11. Staging FOG #7 - Orange
 12. Unit Staging Log #7A - Orange
 13. MCI-Contaminated Victim/Terrorist Event FOG #8 – Beige
 14. MCI/ASHE FOG #9 - Beige

MCI SUPERVISOR KIT

- A. Complete vest set with the following identification vests:
 1. White for Command.
 2. Blue for Medical Officer.
 3. Yellow for Triage Officer.
 4. Red for Treatment Officer.
 5. Green for Transport Officer.
 6. Green for Medical Communication Coordinator.
 7. Blue for Medical Supply Officer.
 8. Orange for Staging Officer.
- B. Clipboard which contains paperwork for each officer, pens/pencils/grease pencils, and paper.
- C. EMS Command Board.
- D. Tarp set: red, yellow, green, black tarps.
- E. Patient tracking device/Scanner (if available)
- F. Bullhorn (if available)

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START SYSTEM OF TRIAGE

This procedure is based on the Simple Triage and Rapid Treatment (START) process for adult victims and the JumpSTART adaptation for pediatric victims.

PROCEDURE

- A. Initial triage: Using the START or JumpSTART method (described in the following two sections):
1. Locate and direct all of the walking wounded to one location away from the incident if possible. Assign someone to keep them together (Fire Rescue Department personnel, Law Enforcement officer, or capable bystander).
 2. Begin assessing all non-ambulatory victims where they are found.
 3. Utilize the triage ribbons tied to an upper extremity in a visible location.
 4. Independent decisions should be made for each victim. Do not base triage decisions on the perception of too many reds, not enough greens, and so forth.
 5. If borderline decisions are encountered, always triage to the most urgent priority (e.g., for a Green/Yellow patient, tag as Yellow).
- B. Secondary triage.
1. Performed on all victims during the Treatment phase. If a victim is identified in the initial Triage phase as a Red and transport is available, do not delay transport to perform a secondary assessment.
 2. Utilize a triage tag (Disaster Management System [DMS] All Risk Triage tag) and attempt to assess for and complete all information required on the tag (time permitting). Affix the tag to the victim and remove the ribbon.
 3. The triage priority determined in the Treatment phase should be the priority used for transport. If trauma-related, the trauma transport criteria will be applied to trauma victims during the secondary triage in the Treatment phase.

Remember the mnemonic RPM (Respiration, Perfusion, Mental status). The first assessment that produces a Red stops further assessment. Only correction of life-threatening problems, such as airway obstruction or severe hemorrhage, should be managed during the triage phase. Any major external bleeding should also be controlled at this time. Depending on the victim's injuries (burns, fractures, bleeding), it may be necessary to prioritize as Yellow.

START Modified ADULT (size, + 2° sex characteristics)

Move the Walking Wounded

MINOR

No Respirations after Head Tilt

EXPECTANT

Control Bleeding

Respiratory Distress ↑ 30/min

IMMEDIATE

Perfusion (No Radial Pulse)

IMMEDIATE

Mental Status (unable to follow commands)

IMMEDIATE

Normal RPM, follows commands

DELAYED

Conduct Secondary Triage in the Treatment Phase

FL MCI Levels

MCI Level 1: 5-10 victims

MCI Level 2: 11-20 victims

MCI Level 3: 21-100 victims

MCI Level 4: 100 -1000 victims

MCI Level 5: Over 1000 victims

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JUMPSTART TRIAGE

Physiological differences in children necessitate adaptation of the standard START triage method in children 8 years of age or younger, or in those victims with the anatomical or physiological features of a child in the age group. The same parameters (RPM) are utilized, with the adaptations indicated here.

JumpSTART Modified (Newborn to Appears as Adult*)

Move the Walking Wounded	MINOR
No Respirations <u>and</u> No Peripheral Pulse	EXPECTANT
Respiratory Rate: ↑ 45/min, ↓ 15/min or ↑ Work of Breathing, obvious distress	IMMEDIATE
No Respirations <u>with</u> Peripheral Pulse Give 5 Ventilations via Barrier Device Respirations Resume	IMMEDIATE
No Spontaneous Respirations	EXPECTANT
Control Bleeding	
Perfusion (No Palpable Pulse)	IMMEDIATE
Mental Status* (unresponsive, no localization of painful stimulus)	IMMEDIATE
Normal RPM, mental status normal for age	DELAYED

Conduct Secondary Triage in the Treatment Phase

**Consider developmental level and 2° sex characteristics*

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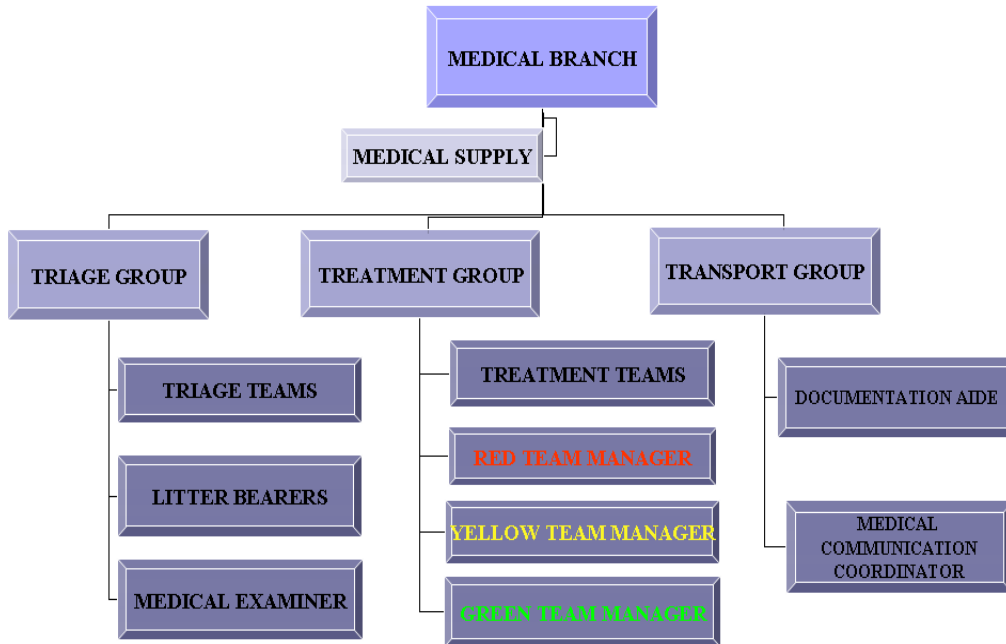
<https://emlrc.org/flpedready/>

Note -Infants who are developmentally unable to walk should be triaged using the JumpSTART algorithm either during initial triage or in the Green area if carried out by a non-rescuer. During triage, if the infant does not fulfill the criteria of a Red victim and has no other outward signs of significant injury; he/she may be triaged as a Green victim.

Note -The START Triage system was developed by Newport Beach Fire Rescue and Hoag Hospital. The JumpSTART Triage system was developed by Dr. Lou Romig.

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MCI Command Structure



ASHE/MCI Command Structure

