

Seattle/King County



Multiple Casualty Incident Plan



2017

ACKNOWLEDGEMENTS

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SEATTLE/KING COUNTY MULTIPLE CASUALTY INCIDENT PLAN

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I. EXECUTIVE SUMMARY

King County fire, EMS, and police departments define a Multiple Casualty Incident (MCI) as any time the presence of multiple patients at an incident affects the treatment decisions of individual patients. King County strives to always provide the best care possible to any patient. However, when there are more patients than the resources on scene can adequately take care of, the goal must be to provide the best treatment possible for as many patients as possible. This means that operations must be adjusted to maximize the efficient use of available resources.

The 'Golden Hour' of emergency medicine is a well accepted concept which states that victims of trauma need to have surgery within one hour of the insult or injury to maximize survivability. Therefore, rapid transport to definitive care centers is the best way to increase survivability in an MCI.

This plan seeks to reduce chokepoints, unnecessary actions, and streamline efforts to reduce the time it takes to remove all patients from the scene. This includes:

- using the Sick/Not Sick triage standard to reduce time spent triaging;
- having the first arriving company establish a transportation corridor to ensure a smooth flow of transportation resources;
- establishing geographic divisions in larger incidents to speed triage and extraction;
- scaling patient tracking and documentation with the size and complexity of an incident.

MCI's can be as small as a few patients or as large as hundreds. Flexibility is integrated into this plan to accommodate all sizes of incidents. Issues related to a fractured or geographically challenging incident are also addressed. The federal disaster levels were used to help determine MCI incident sizes and the appropriate protocols for each level.

Agencies should be prepared for a variety of MCI incidents that might occur in their region. Complex Coordinated Attacks (CCA's) will pose logistical hurdles to first responders. It is expected that departments will use this plan to conduct training in order to make their personnel competent in all aspects of MCI responses.

This plan is designed to be shared and integrated with local, state, and federal governmental agencies to ensure coordination and cooperation. During an incident, interagency cooperation will be in accordance with the National Incident Management System (NIMS). This document has been written to be compliant with NIMS, as well as to follow the Incident Command System (ICS). It is understood that based on the size and complexity of any incident, ICS positions may or may not be filled. Throughout this document MCI positions will be named, however ICS designators will not be assigned.

With the emphasis on rapid transport and efficient use of resources, King County Fire, EMS, and police agencies will be ready to handle a Multiple Casualty Incident.

II. PLANNING ASSUMPTIONS

The traditional definition of an MCI is: any incident in which emergency medical services personnel and equipment at the scene are overwhelmed by the number and severity of casualties at that incident. A more specific working definition is: any time the presence of multiple patients at an incident affects the treatment of individual patients.

The priority of an MCI response is to streamline efforts to speed patient transition to definitive care centers.

This plan is scalable to all sizes and complexity levels of MCI responses. Any action that delays the treatment or transport of patients should be modified or eliminated as long as it does not increase the risk to responders.

A transportation corridor needs to be established and secured early in the incident to facilitate rapid patient transport.

King County emergency responders will use the Sick/Not sick model for MCI triage. “Sick” patients will be classified as red. “Not Sick” patients will be classified as yellow or green.

All triage systems produce similar results, resulting in red, yellow, green and striped (black/white) patients. Therefore, when working with other agencies, it does not matter if different triage systems are used.

On scene treatment is dynamic, allowing alteration of treatment protocols to match available resources.

It is generally recognized that similar mechanisms of injury will have corresponding patterns of sick and not sick patients. This allows responders to quickly estimate the patient distribution based on total patient count. Using this assumption allows the first arriving officer to simply state the estimated total number of patients during the initial scene size up, rather than trying to determine the number of red, yellow, and green patients upon arrival. Assuming that approximately 50% of the patients on scene will be red or yellow, this will give a quick guide to the number of resources that should be immediately requested and establish the scope of the incident.

In large-scale MCI incidents, some non-critical patients may attempt to self-extricate or self-transport. This cannot be avoided, but attempts should be made to triage and track all patients at the scene. There is also a law enforcement component to this issue, as these patients are witnesses to the event and may be needed for statements.

MCI responses may need to be adjusted to the configuration and geography of the incident. It may be necessary to create more than one treatment, loading, and transportation area. In these situations, Incident Commanders should consider creating as many Divisions as is necessary. Each Division can be responsible for triaging and treating patients identified in their assigned geographical area. A single Transport Group can support multiple Divisions by managing the ambulance staging area and assigning ambulances to each Division as requested. Each Division can contact the DMCC or this can be assigned to the Transport Group Supervisor. In some large-scale or multi-site scenarios, it may be advantageous to assign a single DMCC coordinator; this limits the number of separate Divisional conversations to the DMCC.

Extraction priorities will be dynamic based on severity, access, and resources. It may be necessary or prudent to remove some yellow patients before red patients. Situations such as extended extraction times, yellow patients blocking the access of red patients, physical barriers, or a shortage of staffing may necessitate altering extraction priorities.

A triage funnel point creates an unnecessary choke point, impeding patient care and will no longer be used.

Deceased patients will not be moved, unless it is necessary to extract a live patient.

The mental stress to the responders during an MCI can cause dramatic adverse effects. Individual agencies are encouraged to develop a program to help care for the emotional and mental health of their staff.

III. DEFINITIONS

Alternate Care Facility (ACF): Location, preexisting or created, that serves to expand the capacity of a hospital in order to accommodate or care for patients when an incident overwhelms local hospital capacity. In an MCI, patients will be triaged and transported to the hospital not the ACF for definitive care.

Ambulance Staging: Designated parking area for patient transport vehicles. Operators and attendants will not leave their vehicles.

Base: Designated parking area for apparatus that are assigned a task or function during an incident.

Colored Flagging: A color coded identification system used to designate medical priority of patients during a Multiple Casualty Incident.

- Red Flagging (immediate)
- Yellow Flagging (delayed)
- Green Flagging (minor)
- Striped (black/white) Flagging (deceased)
- White Flagging (decontaminated/clean patient)

Disaster Medical Control Center (DMCC): The DMCC (also known as Hospital Control) is the hospital responsible for providing patient transport destinations with a coordinated distribution of patients to area hospitals based on patient needs and the hospitals' capabilities. For the purpose of this plan, Harborview Medical Center will be the primary DMCC for King County with Overlake Hospital as the backup.

Extraction: The process of moving patients out of the hot zone to the treatment and transport areas.

Extrication: The process of removing a patient from an entrapment.

Field Treatment Site: Area designated or created by emergency officials for the congregation, triage, medical treatment, holding, and/or evacuation of casualties following a multiple casualty incident.

Field Triage: The process of rapidly categorizing a large number of patients according to their severity of injury in order to prioritize their extrication and/or extraction to the treatment area.

Various forms of triage are used to determine the severity of a patient's injuries and condition. Examples are:

- **ABC Field Triage:** An algorithm which allows for the rapid categorization of patients dependent on the assessment of Awake, Breathing, and Circulation.
- **RPM Triage:** A form of triage that has the first responders evaluate a patient's status based on **R**espirations, **P**ulse, and **M**entation.
- **Sacco Triage:** Triage system which incorporates the Injury Severity Score to define patients according to surgery survivability, not just their basic vital signs.
- **Sick/ Not Sick:** The Sick/Not Sick approach to triage utilizes the EMT's knowledge and experience to rapidly evaluate a patient's physiological status. The sick patient is categorized as Red. The not sick patient is considered Green if they are able to get up and walk on their own, and Yellow if they have injuries preventing moving themselves. (Seattle/ King County 2010 EMT Patient Care Guidelines) It is understood that the Sick/Not Sick model encompasses the ABC, START, RPM, and other triage systems used to determine the patient's severity and transport priority.
- **START Triage:** An acronym for **S**imple Triage and **R**apid Treatment, and is defined as being a method that first responders use to effectively and efficiently evaluate all of the victims during a mass casualty incident

Green Patient Area: An area dedicated for congregation, treatment, and care of patients with minor injuries. Designated as a separate area from Treatment due to the large number of potential patients and the

special considerations they may need, such as: shelter, food and restroom facilities. Depending on the type of incident they may also be considered witness/suspects and require police presence.

Medical Control: Physician direction over pre-hospital activities. Also includes written policies, procedures, and protocols for pre-hospital emergency medical care and transportation.

Multiple Casualty Incident (MCI): An incident resulting from man-made or natural causes with associated illness or injury to a large number of people. The effect is that patient care cannot be provided immediately to all and resources must be managed.

MCI Response: Varied level of resources dispatched to an incident dependent upon the nature of the incident, the number of patients, and their severity of injury.

MCI Unit: A mobile unit which contains large quantities of medical supplies that can be dispatched to a scene of an MCI. MCI units typically treat 50 or more patients.

Medical: Ensures that Triage, Extraction, Treatment, Transportation, Green Patient Area, Medical Staging, and Morgue Team functions are performed; establishes positions as necessary.

Rescue: In larger or more complex incidents Rescue will oversee the extraction and extrication of patients.

Staging: Location where incident personnel and equipment are assigned on an immediately available status.

Treatment Area: The designated area for the collection and treatment of patients.

- Red: an area where patients require immediate assistance
- Yellow: an area where patient injuries are serious (delayed) but not life-threatening
- Green: an area where patients with minor injuries are kept

Unique Identifier: Number preprinted on a band or bracelet to assist in tracking patient throughout the incident from initial entry to final

disposition.

IV. MCI CONCEPT OF OPERATIONS

A. Dispatch

There are four main EMS dispatch centers in King County: Norcom, (Zone 1), Valley Com (Zone 3), the Seattle Fire Alarm Center (Zone 5), and the Port of Seattle, located at SeaTac Airport. Each individual dispatch center has put in place a matrix and/or a run card to activate an MCI and dispatch the proper resources to the scene of the incident. All requests for Mutual Aid are coordinated through the dispatch centers.

B. Initial Report and Size Up

As with any fire or rescue response, the initial company is responsible to give an initial and size-up report. These reports give dispatch and all incoming units a “picture” of what the initial company is seeing.

Upon arrival the initial company officer will broadcast the initial report over the radio, including the following in the report:

- Unit signature
- The location, or corrected location
- Initial basic impression

As soon as possible, the officer will give a size-up report including:

- Briefly describe an impression of the scene, including known hazards
- Cause of the incident if known
- Estimate total number of patients
- Establish the Command Designator and Command Post location
- Designate the Transportation Corridor (see Transportation Corridor)
- Initial actions and assignments
- Base and Staging locations

- Additional resource requests

1. Progress Reports

Progress reports are required any time there is a change of the Incident Commander and every 15 minutes.

The progress reports should include the following:

- Current estimated total patient count
- Update transportation corridor location as needed
- Numbers of red, yellow, green, and striped patients when known
- Number of patients remaining to be extracted
- Number of patients transported
- Progress of hazard mitigation
- Additional Resources needed.

2. Tactical Benchmarks

- All patients extracted.
- All red patients transported
- All patients transported/clear of incident
- Any tactical benchmarks appropriate for hazard mitigation

C. Initial Actions

The initial actions of the first arriving company officer are critical to ensuring a successful outcome. Depending on the size and complexity of the incident, the initial company may be able to fill many roles, or handle only a few assignments.

Critical Initial Company Actions:

- Initial and size-up reports
- Establish and secure the transportation corridor
- Give assignments to incoming units.

Assignments to be handled by initial companies:

- Begin Recon and Triage
- Perform a risk assessment and begin hazard mitigation for the purpose of reducing the immediate danger to patients, rescuers, or the public
- Designate a green patient area and have all green patients move to that location
- Begin extraction and treatment of patients as able.

D. Recon

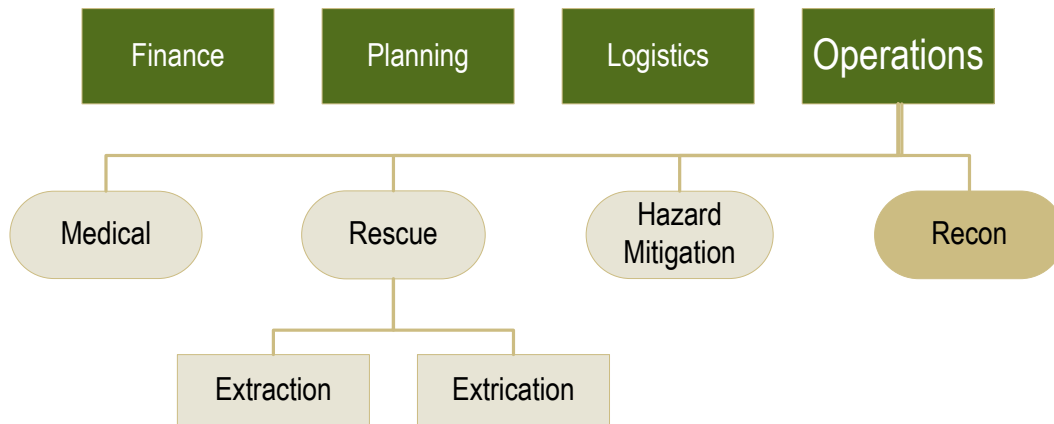
A rapid reconnaissance of the entire MCI site is essential to establish the scope and scale of the incident. Depending on the size and complexity of the incident, this may require a Recon Group consisting of multiple teams. The overriding factor should be speed as opposed to specificity to ensure that the information reaches the IC in a timely manner.

Recon should identify the following:

- Equipment needs
- Levels of PPE that will be required. (Note: Differing levels may be required in different areas.)
- Estimate of the number and condition of patients involved.
- Hazards
- Cause of the incident
- Any physical barriers preventing easy access between areas in the hazard zone. If so, identify areas for multiple treatment and transportation areas.

Recon teams should consider using an elevated platform to help form an overall picture of the incident. This can include nearby buildings, aerial ladders, or geographical highpoints. Helicopters may be considered.

Recon reports directly to Operations.



E. Scene Security

Scene security will be the responsibility of law enforcement, but Fire and EMS personnel must stay alert to potential security issues including but not limited to:

- Secondary Devices
- Crowd control
- Traffic control

The situation may cause the delay of certain operations while law enforcement clears the hazard area. Clear and consistent communication between fire, EMS, and law enforcement is critical to maintain security.

1. Operational Zones

Initial companies need to clearly establish hot, warm, and cold zones. The zones must be clearly communicated to all on-scene responders, including law enforcement. The operational zone locations should be broadcast over the main tactical channel to inform all incoming units even if coordination with law enforcement is handled face to face. Fire scene tape should be used to clearly mark the exclusion zone (outer perimeter) of an incident when possible. Larger sites may need to be secured by law enforcement.

2. Crowd Control

Care must be given to crowd control, but total exclusion of bystanders and volunteers may not be possible or practical. If exclusion is impossible or impractical, attempts should be made to moderate the risk to both bystanders and rescue personnel with the help of law enforcement.

3. Volunteers

MCI incidents may draw civilian volunteers with varying levels of skill and expertise. These volunteers can be helpful if utilized in a safe and organized way, but if they are ignored, they can hinder efforts and increase the risk to both themselves and personnel. Volunteers may be assigned appropriate tasks according to their self-claimed knowledge, skills, and abilities as long as the risks associated with these tasks are minimized. It may be difficult or impossible to verify the claims of expertise by volunteers and care should be taken to place them in supervised roles. It is important to remove or replace volunteers as resources become available.

F. Staging

Two separate staging areas should be considered based on the size and complexity of the MCI. The first staging area should be for personnel or equipment immediately available for use.

There should be a separate Ambulance Staging area that is established for apparatus that will be used to transport patients from the scene to a facility. The Ambulance Staging area may be managed by a private ambulance supervisor with capabilities of communicating to both Transport as well as the staged units. In the Ambulance Staging area, personnel are not to leave their vehicles.

G. Transportation Corridor

The transportation corridor must be established early and clearly communicated by the first arriving company officer during the initial

size-up. The exact street, entry point, exit point, and direction of flow must all be determined and communicated. Law enforcement should be directed to clear and protect the designated corridor; all other apparatus should keep this location clear. Large incidents may require law enforcement to extend the protected corridor all the way to the hospitals.

The first arriving company is responsible for defining and determining a transportation corridor. The corridor must be maintained until law enforcement takes over the security of the corridor. If the initial company cannot commit a member, they will assign the task to another unit from the initial response.

The member controlling the corridor should anticipate requirements for treatment and decontamination areas, and a patient loading area adjacent to the designated corridor.

All apparatus operators must keep the transportation corridor clear.

H. Treatment Area

The patient treatment area will be established in conjunction with the transportation corridor. It should be adjacent to the transportation corridor to facilitate communication, tracking, and patient transfer. If the treatment area and transportation corridor are unable to be co-located, they should be located as close as possible with a clear path between the two and their locations broadcast over the primary tactical radio channel.

The treatment area will be the responsibility of Treatment, typically, a senior ALS member appointed by Medical.

Extracted patients will be delivered directly to the treatment area unless diverted to the transport corridor by Treatment. A funnel point will not be utilized.

Large incidents may necessitate large treatment areas with separate areas and staff for red and yellow patients. Multiple treatment areas with corresponding transportation corridors may be needed. Treatment

needs to request enough staff to handle care for the expected number of patients.

The level of treatment performed in the treatment area may vary according to the situation, but rapid patient stabilization will be the priority. The level of care will be determined by Treatment in accordance with standing orders and/or direction from DMCC.

1. Field Treatment Site

When circumstances dictate that EMS resources must continue to treat patients, Medical should consider establishing a Field Treatment Site (FTS). An FTS may be as simple as extended use of the treatment areas created at the incident or as complex as translocating patients to an Alternate Care Facility that has been opened to EMS. In some cases local agencies and jurisdictions will predetermine where EMS might naturally establish an FTS. Ad-hoc FTSs may be established wherever the IC can rally enough resources to effectively care for patients.

EMS may need to establish an FTS for any of the following reasons:

- Transport resources are inadequate
- Transport cannot keep pace with Extraction
- Number of patients at the incident cannot be handled at hospitals

I. Triage

Triage will not be the responsibility of a single rescuer, but will be a collective and ongoing effort to constantly evaluate patients at every step in the MCI process. The Sick/Not Sick triage standard will be used to evaluate patients.

It is understood that all patients should be triaged. However, depending on the variables of the scene, triage may be accomplished by: a Triage team, Extraction teams, or after safely leaving the area.

Geographic triage allows a member to triage patients in their assigned area and prioritize those patients for extraction.

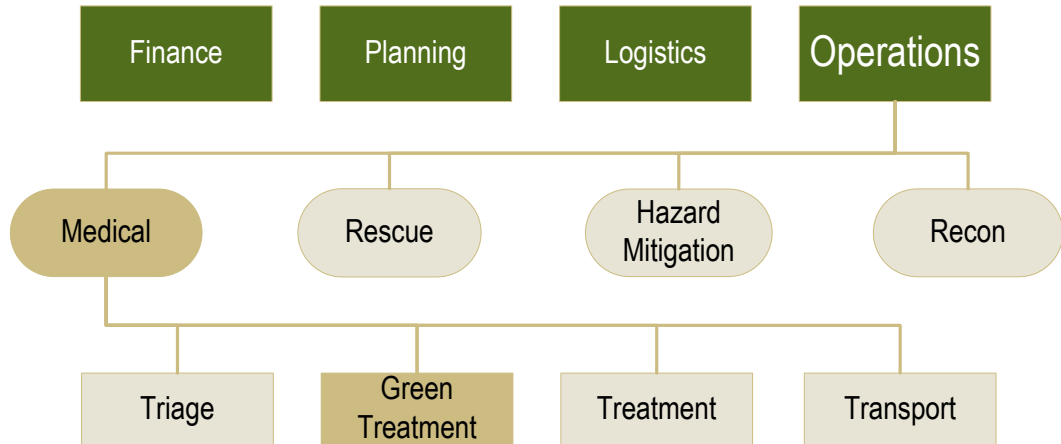
J. Green Patient Area

The Triage Teams at an MCI will direct ambulatory individuals to a designated area of refuge or Green Patient Area. These patients will be initially classified as green patients. As soon as possible, a Green Patient Area Manager should be designated.

The Green Patient Area Manager is responsible for the following:

- Find or create a proper Green Patient Screening Area if one does not already exist
- Liaison with law enforcement
- Medically evaluate all patients, upgrading patients to red or yellow as needed, and moving those patients to the treatment area(s)
- Provide basic medical care
- Contain patients as needed (share responsibility with law enforcement).
- Consider comfort needs such as restroom facilities, water, blankets, etc.
- Provide information as it becomes available to the green patients
- Consider the need for emotional support including the chaplains, family members, or outside counseling support. Many of the green patients may have been separated from friends or family members, and will experience even greater anxiety when dealing with the unknown
- Documentation
- Patient Tracking
- Victim Assistance and Family Reunification

Law enforcement is critical in establishing and maintaining the green patient area. Law enforcement will likely want to interview and document green patients for investigation purposes. Security in the green patient area may be necessary.



K. Communications

A single tactical radio channel may be adequate for a small MCI. Large or complex MCIs may quickly overwhelm a single radio channel, hampering critical communication. The Incident Commander should forecast incidents and with the assistance of dispatch centers, may designate multiple radio channels for the incident. Possible radio channel assignments are:

Operations channel to include:

- Operations
- Recon
- Rescue (May need a separate channel)
- Hazard mitigation groups

Medical channel to include:

- Medical
- Triage
- Treatment
- Transportation

Disaster Medical Control Center channel to include:

- DMCC
- Transportation

Radio communication may be further affected by many factors including:

- Areas of reduced radio signals.
- Damage to radio infrastructure.
- System overload/outages.

V. PATIENT DISPOSITION

A. Rescue

Patient extraction from the hazard zone will be prioritized based on the patient's condition and difficulty of extraction. Rescue may direct extraction in smaller incidents. In larger incidents, Rescue will supervise Extraction as well as Extrication if needed.

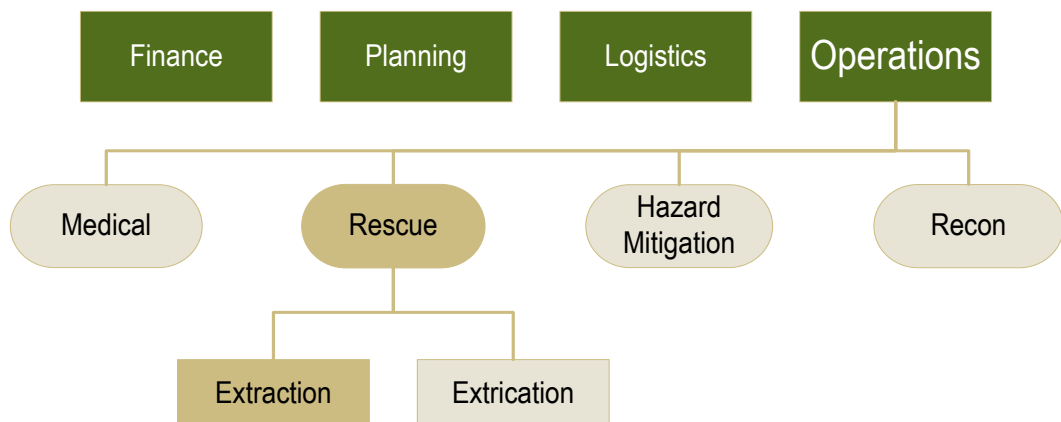
Large or complex incidents may require the hazard zone to be divided into geographical divisions. Supervisors should be alert to recon their assigned area.

Geographical recon includes:

- Number of patients in their area.
- How many of those patients are Red, Yellow, and Striped.
- Extraction needs, including number of patients and complexity.
- Hazards inside their area.

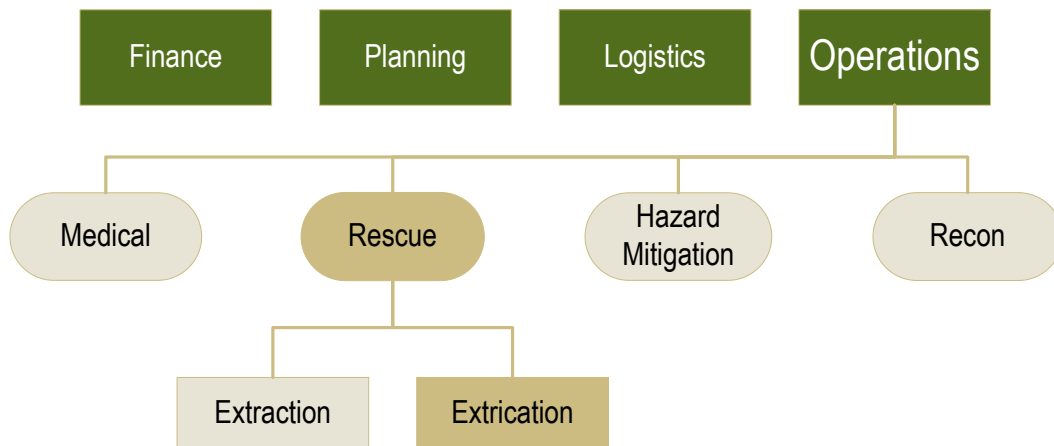
1. Extraction

Extraction teams will be composed of one or more pairs of personnel and will report to Medical or Rescue, depending on incident size, for the purpose of patient removal and delivery to the patient treatment area.



B. Extrication

Disentanglement and technical rescue may be handled by extrication teams under direction of Rescue. When trapped patients are located, the extrication teams will be sent to assist with the technical removal of those patients. Extrication teams must prioritize their operations to remove as many viable patients as possible in the shortest amount of time.



C. Decontamination

Any MCI, natural or intentional, may include the release of hazardous materials (haz-mat). Rescuers will need to evaluate the potential need for a haz-mat response and decontamination procedures. If a haz-mat release is known or suspected, a haz-mat response should be requested if not already dispatched. Primary tasks of the initial companies include: wear the appropriate level of PPE, consider a larger evacuation zone, and start emergency decontamination procedures.

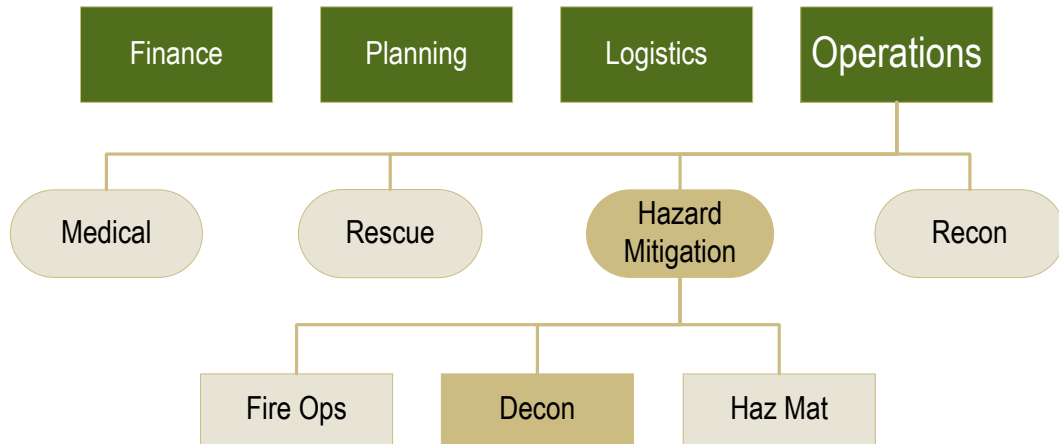
Treatment and/or transport of any patient cannot occur until the patient has gone through emergency decontamination.

It may be difficult to determine in the field if a patient is completely decontaminated, therefore patient contact should be limited to essential procedures in the field and during transport.

Tyvek suits should be used for patients after gross decon when their clothing has been discarded.

Decontamination procedures will occur in the warm zone.

If decontamination procedures are required, the IC must ensure that a large enough footprint has been established for both gross and technical decon.



D. Patient Sheltering

Every attempt should be made to provide shelter for the patients in the patient treatment and green patient areas. The shelter should provide protection from the hazards, weather, media, and the public.

Shelters of opportunity, or existing buildings, should be considered first. Priority will be given to structures with bathroom facilities, running water, and buildings with access that can be easily controlled. If no existing buildings are easily accessible or adjacent to the transportation corridor, then temporary shelters may be used.

Possible temporary shelters include:

- Tents from Decon Units
- Public transportation buses
- MCI bus

When choosing a shelter, the possibility for an expanding incident needs to be considered, ensuring patients are not placed into an existing or future hazard zone.

E. Field Treatment

1. King County Standing Orders for Patient treatment during an MCI

MCI Standing Orders are to be implemented during an MCI. It is understood that communications may be difficult or impossible and it may not be possible to consult medical control prior to providing patient care. MCI standing orders authorize EMS personnel to act pursuant to these orders while on or off duty.

In general, personnel will treat “Red” patients first, “Yellow” patients only as time allows, and “Striped” patients only after assuring that all patients from the red and yellow categories are stabilized. Depending on acuity and number of patients, it may be necessary to transport ALS patients in BLS units without the oversight of ALS personnel.

Harborview Medical Center shall serve as primary DMCC. Overlake Hospital shall serve as back up DMCC.

Individual Medical Incident Report Forms (MIRFs) are not required during an MCI. In addition, no permission is required to “cease efforts”.

If neither primary nor back up DMCC is able to coordinate patient destination, Transport shall notify the receiving hospital of patient numbers and triage status prior to patient transport if possible. Individual transporting units will not routinely communicate to hospitals unless directed to do so.

F. Patient Count and Tracking

Patient count and tracking are important aspects of an MCI, especially when the incident is large and complex. Every effort will be made to count and track every patient that is cared for at an incident. The level of tracking may have to be scaled to an individual incident. Factors such as environment, severity of injuries, hazards, and number of patients will dictate the level of tracking. At no time will these activities be priorities above patient care and transport.

Patient count and tracking will be the responsibility of Transportation in coordination with Treatment. An attempt will be made to attach a unique identifier to each individual patient. Transportation will attempt to keep track of the number of red, yellow, and green patients as they are transported.

Any first responder may be assigned to Transportation as an aide to assist in patient count and tracking.

G. Documentation

1. MIRFS

Patient documentation is important; however documentation should never delay patient care or transport. Individual MIRFs should be attempted at every incident, however, as an incident grows in size and complexity, it may not be possible to complete MIRFs. Incidents may have segments where MIRFs may be completed and other segments where circumstances prevent completion of MIRFs.

2. Unique number with transporting agency

When a patient is received by a transporting unit, personnel will document the unique identifier that is attached to the patient in their agency's MIRF. If a unique identifier has not been assigned to the patient, then the transporting unit's personnel will do so. Every effort will be made to give a copy of the unique identifier to Transport.

H. Transportation

Transportation will assign patients to transporting units as those resources arrive. Constant communication between Transportation and Treatment is important to ensure that patients are ready to be transported.

The preferred method of transport is a BLS ambulance. Larger incidents may require non-traditional assets. If non-traditional assets without emergency signal devices are used, consideration should be

given to using law enforcement escorts to aid during travel. Containing bio-hazardous material in non-traditional assets may be difficult, but tarps, plastic, or other resources should be used to limit the spread of this material.

VI. JOB ASSIGNMENTS

A. Medical

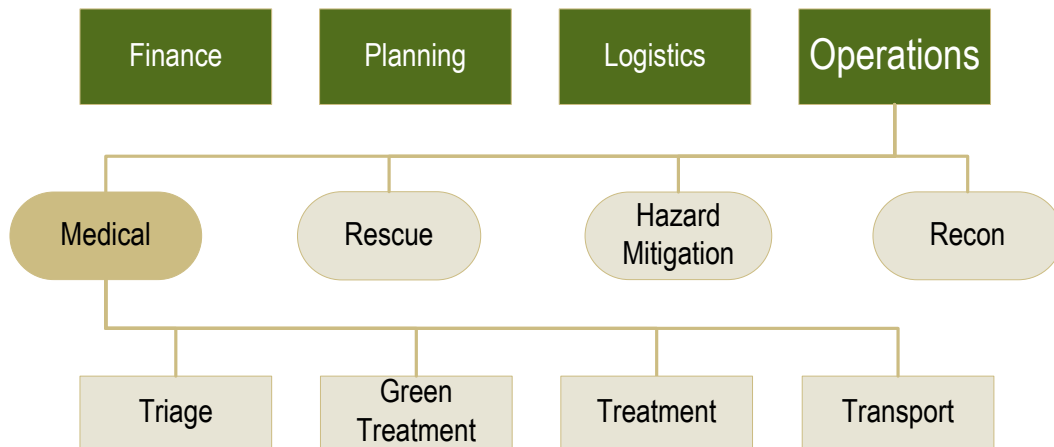
The personnel on the first-arriving Medic unit should be assigned to the roles of Treatment and Transport. The role of Medical Group Supervisor should be assigned to a senior ALS member, ideally an MSO. In cases where the arrival of an MSO is delayed (or where the dynamics of the emergency require earlier assignment of a Medical Group Supervisor), on-scene Medics can be assigned to this position.

Medical is responsible for the following tasks:

- Transportation
- Treatment
- Triage
- Ensure activation of the DMCC
- Green Patient management

Medical may handle most or all of the responsibilities in smaller incidents. Larger or complex incidents will require Medical to be proactive in forecasting the incident and begin assigning roles as soon as possible. Circumstances may dictate a large number of ALS and BLS personnel where:

- ALS personnel need to be prioritized to treatment due to a high patient count;
- Patient removal from the hazard zone will require a large number of BLS personnel and/or complex coordination.



1. Treatment

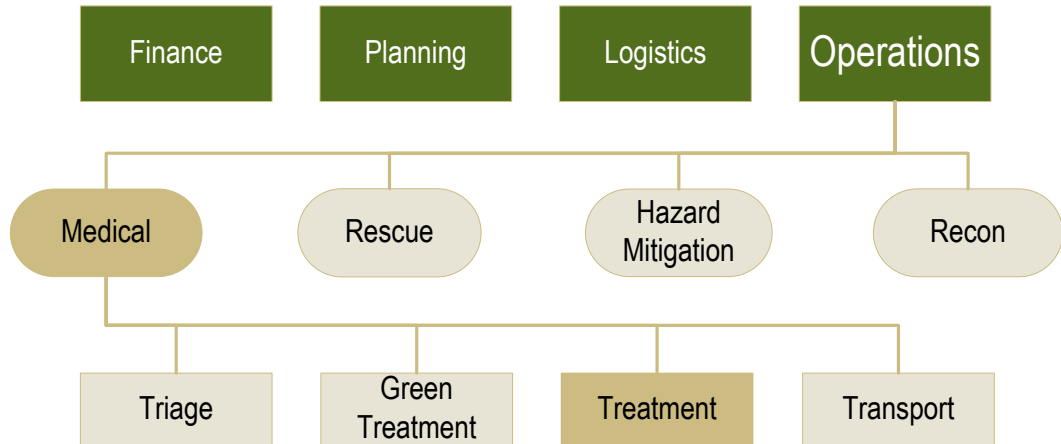
Medical may designate an ALS member to be Treatment. (Note: Smaller incidents may allow Medical to retain this role). Treatment is responsible for the following:

- Receiving patients from Extraction
- Supervising treatment of patients
- Managing Treatment Personnel
- Coordinating with Transportation
- Prioritizing patients for transport

The level of treatment performed in the treatment area may vary according to the situation, but rapid patient stabilization will be the priority. The level of care will be determined by the Treatment Team Leader.

Treatment, with input from Transportation, may elect to have patients delivered directly to the transportation corridor for transport.

Treatment should request adequate personnel and resources to care for the expected number of patients.

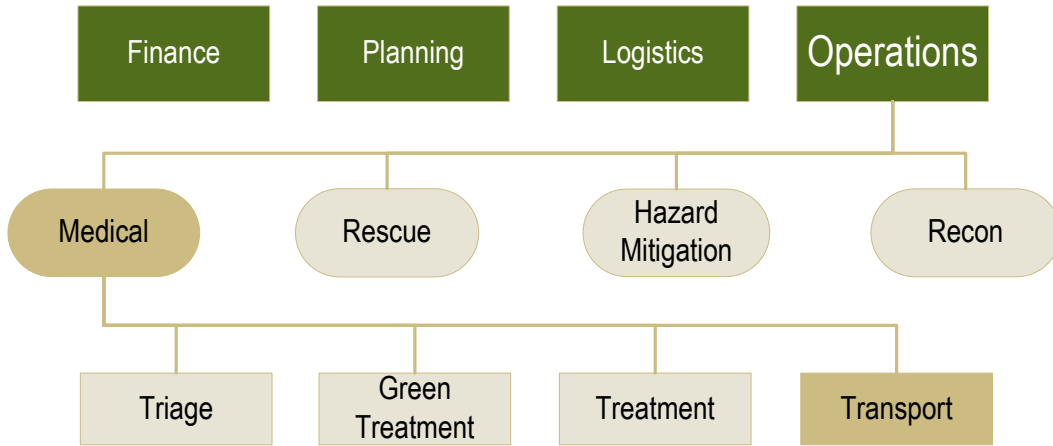


2. Transportation

Transportation should be designated early by Medical. Smaller incidents may allow Medical to retain this role. Transportation should be a senior ALS member capable of performing a wide range of duties including:

- Communication with the DMCC
- Keeping a total patient count of all transported patients (may be delegated to one or more Aides)
- Coordination with Treatment
- Coordination with law enforcement to clear the transportation corridor
- Liaison with transportation resources
- Maintain adequate transportation resources
- Initiate tracking if unique identifier not already assigned

Incidents that require multiple transportation corridors must have multiple personnel assigned to Transport. They may act independently of each other. Transportation may contact the DMCC independently for patient destinations and be responsible for patient count and tracking.



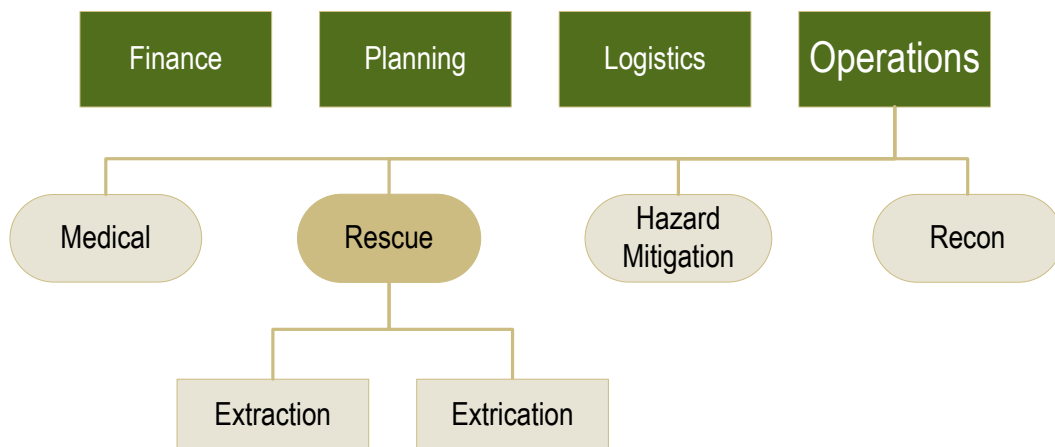
B. Rescue

Rescue shall be considered when:

- ALS staffing needs to be prioritized to patient treatment and transport.
- Any part of patient removal from the hazard zone will require a large amount of BLS resources or skills.

Rescue may be in charge of triage and extraction of all patients from the hot zone into the patient treatment areas.

Technical Rescue Teams will report to Rescue to serve as technical advisors, and participate in extrication as needed.



Appendix A: ZONE MCI RUN CARDS

Zone 5 – Seattle

Dispatch Type Code	Description	Units Sent
MCI Reduced	Multiple Casualty Incident Reduced	2 Engines, 1 Ladder, 1 BC, 1 Aid Car, 2 Medics, DEP1, SAFT2, M44, STAFF10
MCIFUL	Multiple Casualty Incident Full	5 Engines, 2 Ladders, 2 BCs, 2 Aid Cars, 3 Medic Units, MCI1, DEP1, SAFT2, STAFF10, Air 9, M44
MCIHAZ	Multiple Casualty Incident Hazardous Materials	5 Engines, 2 Ladders, 2 BCs, 2 Aid Cars, 3 Medic Units, MCI1, DEP1, SAFT2, Air 9, M44, HazMat Group, E10, L1, B2, A5, HAZ1, STAFF10, Decon Group E27, L7, Decon1
MCIEXP	Multiple Casualty Incident Explosion	5 Engines, 2 Ladders, 2 BCs, 2 Aid Cars, 3 Medic Units, MCI1, DEP1, SAFT2, Air 9, M44, HazMat Group, E10, L1, B2, A5, HAZ1, STAFF10, Decon Group E27, L7, Decon1
MCIWAT	Multiple Casualty Incident Water	5 Engines, 2 Ladders, 2 BCs, 2 Aid Cars, 3 Medic Units, MCI1, DEP1, SAFT2, Air 9, M44, Rescue Group – A14, L7, RESCUE1

MCIRES	Multiple Casualty Incident Rescue	5 Engines, 2 Ladders, 2 BCs, 2 Aid Cars, 3 Medic Units, MCI1, DEP1, SAFT2, Air 9, M44, Rescue Group A14, L7, RESCUE1
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Zone 3 – South King County

Patients	Fire Units	Medics	MSO	Transport	Chiefs
1-10	5 Total Units Aid/Engine/ Ladder	2	1	5 AMB	1
11-20	8 Total Units & 2 MCI Units	3	1	10 AMB	2
21-30	12 Total Units & 1 BLS Strike Team 2 MCI Units 1 Rehab Unit	4	1	15 AMB	3
31-40	16 Total Units 2 BLS Strike Teams 2 MCI Units 1 Rehab Unit	4 1 ALS Strike Team	1	20 AMB 1 Metro Bus	3
41-50	18 Total Units 2 BLS Strike Teams 1 Engine Strike	4 2 ALS Strike Teams	1	25 AMB 2 Metro buses	4

	Team 3 MCI Units 1 Rehab Unit				
50 +	18 Total Units 1 Structural Task Force 2 BLS Strike Teams 1 Engine Strike Team 3 MCI Units 1 Rehab Unit	5 2 ALS Strike Teams	1	30 AMB 2 Metro buses	5
100 +	18 Total Units 1 Structural Task Force 2 BLS Strike Teams 2 Engine Strike Teams 1 EMS Task Force 3 MCI Units 1 Rehab Unit	5 2 ALS Strike Teams	1	35 AMB 2 Metro Busses	5

Zone 1

NorCom utilizes agency specific run cards to dispatch.

Appendix B: ZONE MCI NOTIFICATIONS

Zone 5

- Medic/Portable 55 (ECOM)
- Trauma/M1 MD
- Private Ambulance Providers
- PIO
- MSA
- All MSO's
- Staff Officers

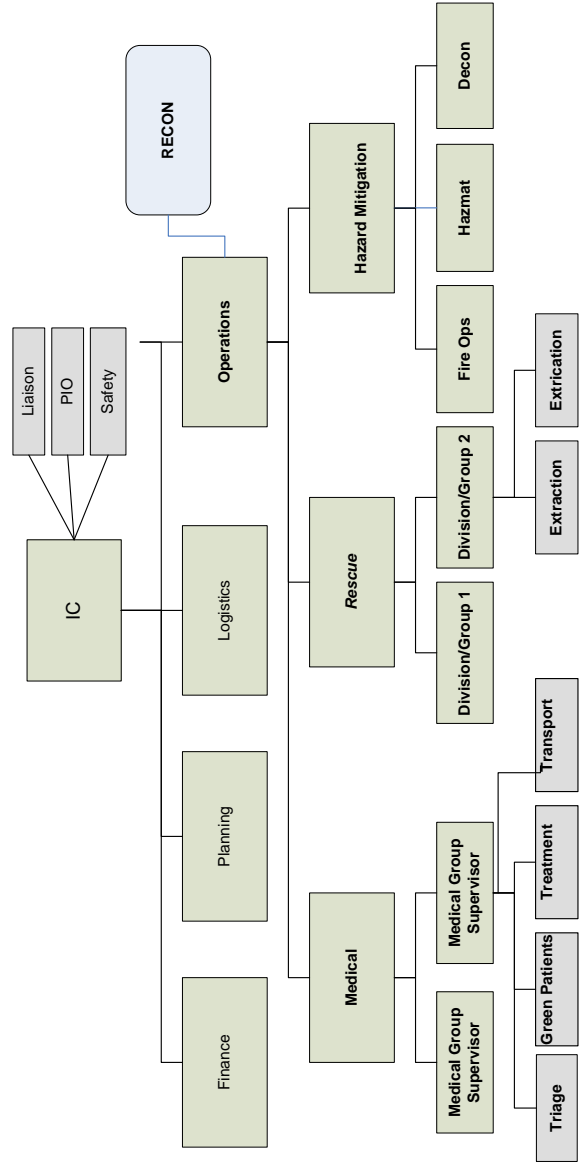
Zone 3

- King County Medic One Command Staff page
- BC page (at level 2)
- Zone 3 PIO (at level 2)

Zone 1

NorCom utilizes agency specific protocols to determine notifications.

Appendix C: Full ICS Chart



This is the org chart for a large scale incident. As with other incidents, multiple roles may be filled by one individual as span of control and need allow. (e.g. Medical Group Supervisor may fill the roles of Green Patient, Treatment and Transport Team Leader. Geography and work volume may alter this.)

THIS CHART IS NOT INTENDED TO IDENTIFY ALL ASPECTS OF ICS AT A LARGE INCIDENT.