Mass Casualty Incident (MCI)

I. PURPOSE:

A. The establishment of these procedures is designed to provide an organized, coordinated and expandable resource management approach to be utilized by the numerous public and private agencies who each play a vital role in the successful mitigation of a multi-casualty incident.

II. DEFINITION

A. The M.C.I. defined - a multi-casualty incident (M.C.I.) is any incident where the numbers of injured people, in combination with the types and severity of their injuries, overwhelms the initial responder's abilities to provide adequate pre-hospital emergency medical care.

III. OPERATIONS

A. The I.C.S. Multi-Casualty Branch is designed to be expandable, with modules designed to provide the necessary organizational framework for as few as five patients on up into the hundreds.

 Refer to the Fire Service Field Operations Guide ICS 420-1 Chapter 14 MCI definitions and position checklist.

B. It is critical that the first on-scene emergency unit recognize that an M.C.I. exists and include this in the size up. A shift in operational modes from the routine to the M.C.I. is paramount.

C. Timely and appropriate resource requests by the Incident Commander through a central ordering point also needs to occur early-on.

D. The Special Response Unit (SRU) (A-III-1) should be requested as soon as possible.

IV. COMMAND CONSIDERATIONS

A. Multi-Casualty Incident as they differ from a Routine Trauma Call:

1. Unfamiliar Situation

    a) Multi-patient events are not common for the majority of us.

2. Number of Patients

a) Can overwhelm first responders

b) Increased ratio of patients to rescuers

3. Increased Resources Required

    a) Additional manpower, possible call-backs needed

    b) Overhead needed

    c) Specialized apparatus/equipment

    d) Specialized technicians

4. Can Overtax Normal Available Resources

    a) Medical supplies

    b) Ambulances

    c) Fire and rescue units

    d) Police officers

    e) Dispatch capabilities

    f) Hospital resources

5. Roles and Responsibilities Change

    a) First-in unit should not become committed to patient treatment

    b) Triage mode utilized

    c) Leadership roles can be filled by a variety of people

    d) Crews can be split up and mixed

6. Multi-Agency Responses Increase

    a) Can use different terminology

    b) Different equipment

    c) Different radio frequencies

7. The Need to Work Closely with Multi-Agencies

    a) Can get away with it on smaller incidents, but not on larger incidents

b) Over-ordering of equipment, supplies, duplication of efforts, etc.

8. Use of a Common Tactical Radio Net

9. Medical Communication Procedures Change

a) Necessary to appoint a medical communications coordinator

b) Need to ascertain and constantly monitor hospital bed status

10. Duration of Incident is Longer and More Involved

a) Need for rehab area and rotation of crews becomes more important

b) Emotional impact and critical incident stress factors increased due to duration, involvement and number of patients.

c) Need for support services increase

d) Red Cross involvement

e) Blankets, cots, lighting, food, etc.

11. Need to Clearly Identify Leadership Positions, Command Post Location, Treatment Areas and Other Special Functions Areas

a) Multi-agencies present

b) May not be familiar with all personnel at scene and need to easily identify personnel and locations of events at scene

12. Crowd Control can become a Problem

13. Media Control can become a Problem

a) Need for a P.I.O.

b) Designated area

14. Personnel staging can be required

a) Larger incidents

15. Equipment/Apparatus Staging can be required

a) Ambulance staging separate from fire equipment Staging

b) Equipment and medical supplies cache needed

V. IMPLEMENTATION LEVELS OF THE MULTI-CASUALTY BRANCH

A. The degree to which the structural framework of the I.C.S. /M.C.I. is implemented will depend on the type and scope of the incident encountered.

1. Initial Response

   a) Any medical emergency which can be handled with the normal first responding units capabilities.

2. Reinforced Response

   a) (5 to 15 patients) This type of incident would exceed normal first response capabilities, but generally would not require mutual aid resources.

3. Multi-Leader Response

   a) (16 to 50 patients) This level of implementation would generally require the assistance of local mutual aid resources.

4. Multi-Group Response

   a) (51 plus patients) This level of implementation would generally require the assistance from county-wide mutual aid resources and perhaps outside of county resources such as ambulances.

5. Full Branch Response

   a) This implementation level would be warranted when the patient load exceeds the ability of the Multi-Group level for such reasons as span-of-control, logistics or geography. The formation of multiple medical divisions under one branch organization may be required to deal with an emergency of this scope and nature.

VI. MCI INCIDENT PRIORITIES

A. Triage

1. Timely triage of patient using START Triage system (See T-XII-1 Triage)

B. Treatment

1. Appropriate and timely treatment with the realization that the level of care possible may not be the same as that provided in the initial response mode due to the sheer numbers involved.

C. Transportation

1. Rapid transport of a properly packaged and ideally stabilized patient to an appropriate receiving facility.

D. Establishing Medical Communications Coordination's (Med Comm)

1. Designation of a properly trained and equipped individual who can coordinate the incident medical communications.

E. Documentation

1. Each assigned position responsible for a specific area within the organization framework should document activities utilizing a Unit Log I.C.S. 214.

F. It must be kept in mind that although all levels have the same basic priorities, incident specifics and initial resource limitations may necessitate that individuals fulfill more than one role in the incipient stages.