Active Assailant Policy

The purpose of this protocol is to provide guidance for the responsibilities for triage, treatment and evacuation of injured individuals following active assailant incidents.
Adopting MCAs will have an "X" under their MCA name. If no "X" is present, the MCA has not approved or adopted the protocol.

Allegan	Barry	Clare	Ionia	Isabella	Kent	Mason
			X			*X*
Montcalm	**Muskegon**	**N. Central**	**Newaygo**	**Oceana**	**Ottawa**	
X	*X*	*X*	*X*		*X*	

Responsibility

1. Unified Command shall determine, in advance when possible, the structure and design of teams intended to function as a Rescue Taskforce (RTF) for the purposes of providing lifesaving interventions for patients within a warm zone and the extraction of those patients.
2. Ambulance personnel are responsible for the transportation of injured individuals and accountability for those injured individuals.
3. Life Support Agencies must provide the MCA with a copy of their approved Active Assailant SOG along with annual license renewal.

Triage

1. When a RTF is active, triage of encountered patients shall entail evaluation of dead/not dead.
2. Primary treatment is for control of major hemorrhage.
3. When a group of patients are encountered, a rapid walk thorough of the group with the intent of recognizing and management of uncontrolled hemorrhage is indicated.
4. RTF teams, when an isolated not-dead patient is encountered, the patient should be evacuated and that RTF should return and continue search, after transfer of the patient to waiting personnel.
5. When groups of patients are encountered, rapid control of hemorrhage is primary. Secondary is to evaluate for the most severely injured patient and requests for additional support from RTF teams. Evacuation subsequently occurs based upon severity of injury.
6. When the RTF drops off a patient at the casualty collection point or the external treatment personnel, a new supply of tourniquets, pressure dressings, etc. should be ready for the crew as an exchange for the patient.

Treatment

1. The primary goal in the treatment area is to, as quickly as possible, facilitate preparation for patient transport to the hospital. If patients are ready to go, and a resource is available, efforts should be made to cycle them out for transport. If there are delays in having available ambulances for transport, the sending of patients should be tiered based upon the triage category.
2. When possible and prudent, the highest priority patients should be transported first.
3. Treatment management should be aimed at minimal level care unless there is no other care or transport preparation to be done. ALS level care should be minimal, if any.

Equipment

1. All licensed life support vehicles must, at a minimum, carry go bags each containing:
    a. Two hemostatic gauze (min. 3" x 48")
    b. 2 rolled gauze
    c. Two pressure dressings
    d. Chest seal – combo pack or two seals
    e. 2 tourniquets – CAT or SAM XT
    f. 1 adult NPA (32 F) and 1 pediatric NPA (24 F)
    g. 2 SALT Triage cards

2. Premade kits with the listed contents are encouraged but not required

Transportation

1. Patients should be sent by ambulance when possible and prudent.
2. Spontaneous use of other vehicles is permissible under exceptional circumstances per MCL §333.20939
3. If patients are transported by vehicles other than an ambulance, or without medical personnel, efforts should be made to provide critical emergency care prior to departure (hemorrhage control, chest seals, etc.) when prudent and possible.