



## Standard Operating Guideline

### MCI/IMCI



**Scope:** Sacramento Regional Fire Departments

**Policy Contact:** Sacramento Regional Operations Group

### Table of Contents

01. Guideline	07. Appendix C
02. Definition	08. Appendix D
03. Resources	09. Appendix E
04. Procedure	10. Appendix F
05. Appendix A	11. Appendix G
06. Appendix B	12. Appendix H

### References

- FIRESCOPE. 420-I Field Operations Guide. 2022
- FIRESCOPE. 701-Unified Response to Violence Incidents. 2023
- County of Sacramento EMSA. MCI/Disaster Medical Services Plan. 7500.18
- County of Sacramento EMSA. Multi-Casualty Critique. 7501.04
- County of Sacramento EMSA. Multi-Casualty Incident Plan. 2025
- Incident Response Sacramento Regional SOG
- S.A.L.T. triage. American Journal of Disaster Medicine 2017; 12:27

### 01. Guideline

To provide guidance for operating at a Mass-Casualty Incident or Intentional Mass-Casualty Incident.

### 02. Definition

**2.1 Casualty Collection Point:** A temporary gathering spot for victims prior to being moved to an evacuation zone.

**2.2 Corridor:** A secure path created by law enforcement from the evacuation zone to the victims.

**2.3 Disaster Control Facility (DCF):** The facility responsible for direct medical control and the dispersal of patients during all declared MCI/IMCI incidents. (UC Davis Medical Center)

**2.4 Fox Trot:** A small SKED type device used to move victims from the incident to the casualty collection point.

**2.5 Intentional Mass-Casualty Incident (IMCI); include but is not limited to:**

- Active Shooter events
- Intentional vehicle into crowds
- Bombings
- Mass stabbings

**2.6 Law Enforcement Escort:** Law enforcement officers who maintain security of the indirect threat zone and corridor for Fire and EMS personnel.

**2.7 Litter Team:** Personnel assigned to move victims from one location to another.

**2.8 Mass-Casualty Incident (MCI);** MCI declaration and EMS activation levels follow the Sacramento County MCI Plan (2025):

**\*The Incident Commander (IC) has the authority to declare or cancel an MCI, in accordance with the Sacramento County Multi-Casualty Incident Plan.**

- Level 1: 5- 10 patients
- Level 2: 11- 20 patients
- Level 3: 21- 40 patients
- Level 4 (Catastrophe): 41+ patients

**2.9 Patient:** Any individuals determined by EMS personnel to have a complaint suggestive of an illness/injury or have suffered a mechanism reasonably likely to cause injury, requests evaluation of an illness/injury, and/or in the judgment of EMS personnel, demonstrates a known or suspected illness/injury that requires EMS care.

**2.10 Point of Wound (POW) Kits:** A small bag with basic trauma/bleeding control equipment for IMCI's.

**2.11 Rescue Strike Team:** Consists of multiple Fire Personnel and a

supervisor that operates in a secure corridor established by Law Enforcement Officers, including a liaison from Law Enforcement to join with Rescue Unit Leader (RUL) to aid in real time communications.

**2.12 Rescue Task Force:** Consists of 2-4 Law Enforcement Officers providing force protection for 2-3 Fire Personnel and a supervisor to enter a hostile or threatening environment and provide lifesaving interventions and a secure extraction of a small number of victims.

**2.13 SAC – IT:** Mnemonic used on an MCI/IMCI to accurately communicate triage information.

- S – Sex (gender)
- A – Age
- C – Condition (minimal, delayed, immediate, expectant, deceased)
- I – Injury
- T – Triage tag number (Per EMSA protocols triage tags are only *required* with 21+ patients.)

**2.14 Sort, Assess, Lifesaving Interventions, Treatment/Transport (S.A.L.T):** A standardized and rapid method utilized to sort and categorize people involved in mass casualty incidents.

- Sort
  - Still/Obvious Life Threat- assess 1<sup>st</sup>
  - Wave/Purposeful Movement – assess 2<sup>nd</sup>
  - Walk – assess 3<sup>rd</sup>
- Assess
- Lifesaving Interventions
  - Control major hemorrhage (tourniquet)
  - Open Airway
    - Absent breathing, reposition, reassess, and if still absent- patient is deceased.
  - Chest Seals
  - Peripheral pulse, hemorrhage controlled, obeys commands- patient is delayed.
  - No peripheral pulse, respiratory distress, uncontrolled hemorrhage- patient is immediate.

- Only in an IMCI incident with penetrating trauma will you further subdivide patients by A.C.E
  - Abdominal/pelvic wounds 1<sup>st</sup>
  - Chest wounds 2<sup>nd</sup>
  - Extremity wounds 3<sup>rd</sup>
- Treatment/Transport

**2.15 Scene Clear:** Law Enforcement term meaning the assailant has fled or is subdued.

**2.16 Scene Secure:** Law Enforcement term meaning the ability to return effective fire.

**2.17 Triage:** The screening and classification of sick, wounded, or injured persons to determine priority needs to ensure the efficient use of medical personnel, equipment, and facilities.

### **2.18 Triage Conditions**

- Minimal – requires first aid – walking wounded
- Delayed – delayed care and transport
- Immediate – immediate care and transport needed to survive
- Expectant – severe injury with a very low likelihood of survival
- Deceased – unsalvageable – No CPR

**2.19 Victim:** A person injured during an IMCI that requires bleeding control and extraction

**2.20 Zones:** Various zones established during an IMCI

#### Rescue Task Force

- Hot Zone (Law Enforcement personnel ONLY)
- Warm Zone (relatively safe area)
- Cold Zone (consist of ICP, triage, treatment, transport and staging area)

#### Rescue Strike Team

- Direct Threat Zone (in the line of fire or explosion)
- Indirect Threat Zone (outside of the line of fire or explosion)
- Evacuation Zone (gathering point for victims to be assessed and transported)

### 03. Resources

When an MCI/IMCI is declared, Fire Dispatch will automatically do the following;

- Dispatch 1st alarm MCI/IMCI
- Additional radio channels
  - 1- Command channel
  - 3- TAC channels
- Chief Officer notifications

\* To meet SCEMSA requirements, Incident Commanders may request **notification-only** activation of the DCF for an MCI/IMCI. EMResource is used as the primary MCI notification platform.

#### 3.1 First Alarm Assignment (5-10 patients)

- 3- First Responders
- 4- Ambulances
- 1- Battalion Chief
- 1- EMS Officer

#### 3.2 Second Alarm Assignment (11-20 patients)

- 5- First Responders
- 5- Ambulances
- 2- Battalion Chiefs
- 1- EMS Officer

#### 3.3 Third Alarm Assignment (21-40 patients)

- 5- First Responders
- 5- Ambulances
- 2- Battalion Chiefs

#### 3.4 Fourth Alarm Assignment (41+ patients)

- Type and kind based on specific needs

### 04. Procedure

#### 4.1 Enroute Considerations

- Operational tactics vary based on the law enforcement agency having jurisdiction. Appendix A outlines the Rescue Task Force (RTF)

deployment model historically used by the following agencies: Sacramento County Sheriff's Office (SSO), Folsom Police Department (FPD), Rancho Cordova Police Department (RCPD), and Citrus Heights Police Department (CHPD). Appendix B outlines the Rescue Strike Team (RST) deployment model historically used by: Sacramento Police Department (SPD), Elk Grove Police Department (EGPD), and Galt Police Department (GPD).

- At the time of call attempt to identify the size of the MCI.
- Officers need to make educated decisions based on current information and potential survivability profile.
- There is inherent risk in all rescue operations
- Make every effort to operate in a relatively safe area
- Consider requesting additional resources if the scene is spread over a large geographical area

#### **4.2 First Apparatus – First Alarm**

The first arriving unit identifies the event to dispatch, states actions, and requests additional resources through the tiered MCI/IMCI Response Plan (CAN report).

**\*The Incident Commander (IC) has the authority to declare or cancel an MCI, in accordance with the Sacramento County Multi-Casualty Incident Plan.**

The Captain must ensure that:

- Type of event (MCI/IMCI)
  - Active shooter
  - Vehicle into crowd
  - Bombing
  - Mass stabbing
- State actions
  - Staging
  - Staging with Law Enforcement
  - Engaging with Law Enforcement
- State location
  - Geographical location (address or A,B,C, or D)
- Declare an MCI/IMCI if it meets criteria and type of MCI
  - Medical
  - Trauma

- o Intentional
- Request resources

\*If HazMat is involved it will be a subcategory of one of the three above MCI/IMCI types.

- Example 1:  
“Fire Dispatch, E19 is on scene of an IMCI, Active shooter at 123 Bell Street with multiple victims. E19 is staged in the parking lot on the Alpha side with Law Enforcement. Balance this to a 1<sup>st</sup> alarm Intentional MCI.”
- Example 2:  
“Fire Dispatch, E53 is on scene of an elementary school with multiple sick pediatric patients. Balance this to a 2<sup>nd</sup> alarm Medical MCI.”

#### **4.2.1 (IMCI)**

The Captain should contact Law Enforcement if the assailant or assailants are still active. Identify a COLD/EVAC Zone where victims will be brought to for transport. Depending on the geographical size of the incident there might be more than one COLD/EVAC Zone needed.

#### **4.2.2 (MCI)**

If Law Enforcement states the assailant(s) has fled, been apprehended, or subdued. The Captain should assume command and have his/her crew begin triaging and identifying the number of victims and/or patients.

### **4.3 Second Apparatus – First Alarm**

#### **4.3.1 (IMCI)**

Assailant(s) is still active

- The captain should respond to the COLD/EVAC Zone
- The engineer should spot the rig to provide cover, if possible, without blocking incoming units' ingress or egress.
- The firefighters should prepare equipment to assist with patient care

#### **4.3.2 (MCI)**

No assailant(s)

- Assist with triage or patient care

#### 4.4 Third Apparatus – First Alarm

##### 4.4.1 (MCI/IMCI)

- The captain should respond to the Command Post and assume Medical Group Supervisor (MGS).
- Engineer and Firefighter should assist the MGS by assuming:
  - Medical Communications Coordinator (MCC)
  - Patient Transport Unit Leader (PTUL)

#### 4.5 First Chief Officer – First Alarm

Request Command from the first arriving officer. Name incident, declare MCI/IMCI and confirm traffic plan.

**\*The Incident Commander (IC) has the authority to declare or cancel an MCI, in accordance with the Sacramento County Multi-Casualty Incident Plan.**

##### 4.5.1 Considerations

- Establish unified command with law enforcement
- Confirm if the scene is secure or clear
  - IMCI incidents that have been confirmed as scene clear, will be managed as a normal MCI incident
- Identify the Zones
- Confirm or establish Cold/Evacuation Zone
- Incidents covering a large geographical area may require multiple Cold/Evac Zones and the need for Ground Ambulance Coordinator and Patient Loading Coordinator
- Multi-story buildings may require casualty collection points and litter teams
- Request additional resources, as needed
- Establish appropriate Command structure
- Establish personnel accountability
- Need for family reunification
- Need for PEER Support

#### 4.6 Ambulances – First Alarm

Assigned to assist initial operations based on the following priorities:

- Immediate transport of victims and/or patients

#### **4.7 Air Ambulances- First Alarm**

If an Air Ambulance (Helicopter) is needed refer to FOG Manual, and should be coordinated through the Patient Transportation Unit Leader (PTUL).

#### **4.8 Greater Alarm Assignment**

All resources respond on the assigned Staging channel. Battalion Chiefs and EMS Officers report directly to the ICP. *Refer to Incident Response SOG for more detail.*

## Appendix A

### RESCUE TASK FORCE IMCI/Active Shooter Event Response Procedure

#### Enroute Consideration:

- Have Fire Dispatch gather as much information as possible, victim location, number of victims.
- If unknown number of victims, initiate a 2<sup>nd</sup> Alarm MCI response and provide staging location (upgrade or downgrade as more information is obtained).
- Request additional resources. Examples are, HazMat, Decon unit, Rehab Trailer, Command Trailer.
- Use the FOG Book, and/or Emergency Response to Terrorism Job Aid (ERG)
- Approach the area cautiously; from uphill/upwind if possible. Establish a safe staging area early.
- Park a safe distance from an identified hazard or area that could endanger personnel or equipment. Have situational awareness, use binoculars to identify unusual sights and listen for unusual sounds. Prepare to relocate if odor/cloud/casualties are noted.
- Consider secondary devices, and request Law Enforcement to your area if needed.

#### On-Scene Considerations:

- Establish Command, be prepared to establish/join a Unified Command with Law Enforcement and other agencies. If co-location is not possible, establish liaisons for FD and LE, the liaisons can interact with each other allowing the transfer of information between agencies.
- Initiate an on-scene size-up and hazard risk assessment, continually size up the incident, evaluate hazards and risks. Once the scene is safe to enter verify a 360 has been completed of the scene.
- ASHE considerations: Be on high alert for suspicious individuals, packages, vehicles or potential IEDs. Integrated LE/FD response should include the critical actions contained in the acronym **THREAT** – **T**hreat suppression, **H**emorrhage control, **R**apid **E**xtrication to safety, **A**ssessment by medical providers, **T**ransport to definitive care.
- Direct victims using PA system to a safe area.

- Working with LE, establish Rescue Task Force (Rescue personnel and Law Enforcement personnel formed to make entry into a structure to triage victims and provide lifesaving immediate treatment as needed (i.e., stopping hemorrhage). If an RTF is formed, designate a Triage Unit Leader to communicate with RTF.
- If more than one RTF team, designate the teams as RTF 1, RTF 2, RTF 3 etc....
- If in a building, the RTF should mark the doors with victims count using a grease pencil R=\_\_\_, Y=\_\_\_, G=\_\_\_, B=\_\_\_ (greens should have left the area but may stay to assist with care or supervision).
- Establish an incident perimeter – Request LE to establish safety parameter and establish control zones (Hot, Warm, Cold). Zones in relation to ASHE/MCI
- For contaminated victims – coordinate with HazMat Group Supervisor for decontamination of victims, responders, and equipment to prevent the spread of the hazardous substance.

### **First Apparatus – First Alarm**

- Confirm type of incident (conventional vs Intentional MCI)
- Identify scene security issues (Suspect status, IED's, etc)
- Declare MCI-Trauma with Fire Dispatch
- Determine safe response routes and staging location for incoming units
- Apparatus and all personnel should prepare for immediate response/deployment once the need is determined by Unified Command.
- Maintain mobility to retreat
- Maintain lookouts, communications, escape routes, safety zones (LCES), and situational awareness at all times.

### **Second Apparatus – First Alarm**

- Establish Command if not already done so.
- Triage, Treatment, Transport Areas should be established in the Cold Zone
- Request additional resources as needed

### **First Arriving Chief Officer – First Alarm**

- Establish/Assume Command for Fire/EMS units and contact Law Enforcement Incident Commander.
- Obtain situation briefing.
- Establish Unified Command

- Determine unified objectives
- Establish common communication methods (radios, phone, and/or face-to-face)
- Determine need for Rescue (RTF) or Suppression (STF) Task Forces
- Determine/establish perimeter and control zones (Hot, Warm, Cold) and entry/access control points
- Ensure perimeter/zones are relayed to all personnel
- Request additional resources as needed. Considerations should be given to the following:
  - Fire resources
  - EMS resources
  - Rescue Company
  - Hazardous Material Response Team
  - Support personnel

### **Second Arriving Chief Officer**

- Establish Rescue Group Supervisor and establish RTF staging area
- Ensure RTF(s) are briefed on potential threats and zone boundaries
- Ensure RTF(s) are appropriately equipped with PPE and medical supplies
- Ensure Fire/EMS and LE Officers are appropriately combined to form RTF(s)  
Minimum of two LE Officers (Ideally 3 LE Officers) and two Fire/EMS personnel per RTF (one preferably ALS)

### **Additional Incoming Units**

- Report to Staging

### **RTF Deployment**

- When assigned to do so, the RTF teams will deploy to the Warm Zone for victim treatment/removal
- Command deploys RTF teams by number (i.e. RTF1 and RTF2)
- Teams do not deploy until they have a minimum of two LE personnel as Force Protection
- The first RTF makes an assessment of needs and relays estimated number of victims to Command
- The RTF should consider establishing a Casualty Collection Point (CCP)
- Walking wounded should be escorted/directed to the CCP by LE Officers

- The first two RTFs enter the area and treat as many patients as possible until they run out of equipment or all accessible patients have been reached. RTFs then begin to evacuate the injured
- Treatment within the Warm Zone should be focused on immediate life saving measures such as positioning airways, NPA, occlusive dressings
- Advanced techniques such as needle decompression may be applied at points of cover, the CCP, or treatment areas outside the Warm Zone
- Additional RTFs should be tasked with moving patients from the CCP to the treatment area in the Cold Zone
- Coordination of RTFs should be done through the Rescue Group Supervisor

### **Rescue Considerations**

- Warm Zone should be limited to immediate life saving measures
- Consider establishing a Casualty Collection Points (CCP) in the Warm Zone
- Implement MCI protocol (Treatment/Transport Areas), if needed, in the Cold Zone.
- Provide rapid removal of patients to the designated extraction points
- Consider the need for decontamination of the victims and responders
- Maintain all patient handling/treatment areas as part of the crime scene
- Ambulance personnel should not be utilized for tasks outside of transporting patients.

## Appendix B

### RESCUE STRIKE TEAM IMCI/Active Shooter Event Response Procedure

#### Enroute Consideration:

- Have Fire Dispatch gather as much information as possible, victim location, number of victims.
- If unknown number of victims, initiate a 2<sup>nd</sup> Alarm MCI response and provide staging location (upgrade or downgrade as more information is obtained).
- Request additional resources. Examples are, HazMat, Decon unit, Rehab Trailer, Command Trailer.
- Use the FOG Book, and/or Emergency Response to Terrorism Job Aid (ERG)
- Approach the area cautiously; from uphill/upwind if possible. Establish a safe staging area early.
- Park a safe distance from an identified hazard or area that could endanger personnel or equipment. Have situational awareness, use binoculars to identify unusual sights and listen for unusual sounds. Prepare to relocate if odor/cloud/casualties are noted.
- Consider secondary devices, and request Law Enforcement to your area if needed.

#### On-Scene Consideration:

- Establish Command

#### First Apparatus – First Alarm

The first arriving unit identifies the event to dispatch, states actions, and requests additional resources through the tiered MCI/IMCI Response Plan (CAN report). The Captain must ensure that:

- All victims and/or patients are identified
- Declare an MCI/IMCI if it meets criteria and type of MCI
  - Medical
  - Trauma
  - Intentional

\*If HazMat is involved it will be a subcategory of one of the three above MCI/IMCI types.

- Examples:

“Fire Dispatch, E19 is on scene of an IMCI, Active shooter at 123 Bell Street with multiple victims. E19 is staged in the parking lot on the alpha side with SPD. Balance this to an Intentional MCI 1st alarm.”

“Fire Dispatch, E6 is on scene of an elementary school with multiple sick pediatric patients. Balance this to a 1st alarm Medical MCI and start a second alarm MCI.”

### **(IMCI)**

The captain should attempt to contact law enforcement if the assailant or assailants are still active. Identify an EVAC zone where victims will be brought to for transport. Keep in mind, due to the size of an incident there might be more than one EVAC zone needed.

- The captain should take command if possible and direct incoming units where to gather to form a Rescue Strike Team.
- The Engineer should spot the rig to provide cover, if possible, without blocking incoming units' ingress or egress.
- The firefighters should prepare the Point of Wound (POW) kits and Fox Trots and don grass gear jackets for visibility, identification, and basic personal protection (splash fluids and basic abrasion).
- When the captain is relieved of command by the 1st arriving battalion chief, they should assume Evacuation Unit Leader

### **(MCI)**

If law enforcement states the assailant(s) has fled, been apprehended, or subdued; or if the incident is a medical or trauma the captain should assume command and have his/her crew begin triaging and identifying the number of victims and/or patients.

## **Second Apparatus – First Alarm**

### **(IMCI) Assailant(s) is still active**

- The captain should respond to the EVAC zone and take Rescue Unit Leader (RUL).
- The engineer should spot the rig to provide cover, if possible, without blocking incoming units' ingress or egress.

- The firefighters should prepare POW kits and Fox Trots and don grass gear.
- The engineer and firefighters will report to RUL to form rescue strike teams.

### **(MCI)**

The captain and crew should assist as needed with triage, treatment, and transport.

### **Third Apparatus – First Alarm**

- The captain should respond to the command post and assume Medical Group Supervisor (MGS).
- The firefighters/Engineer should assist the MGS by assuming:
  - Medical Communications Coordinator (MCC)
  - Patient Transport Unit Leader (PTUL)

\*If a truck arrives as part of the first alarm assignment priority will be made to utilize them for specialized knowledge and skills. The Incident Commander will have to request another first responder to back fill the truck. If extrication or specialized skills are not required the truck will assist with triage, treatment, and transport.

### **First Chief Officer – First Alarm**

Request command from the first arriving officer. (That officer will assume Evacuation Unit Leader (EUL) or Triage Unit Leader (TUL) based on the needs of the incident.)

### **Considerations:**

- Establish unified command with law enforcement
- Confirm if the scene is secure or clear.
  - IMCI incidents that have been confirmed as scene clear, will be managed as a normal MCI incident.
- Identify the direct and indirect threat zones.
- Confirm law enforcement escort for the secure corridor.
- Request a law enforcement liaison to join RUL.
- Confirm or establish Evac Zone for IMCI incidents.

- Incidents covering a large geographical area may require multiple Evac Zones and the need for Ground Ambulance Coordinators (GAC) and Patient Loading Coordinator (PLC).
- Multi-story buildings may require casualty collection points and litter teams.
- Request additional resources, as needed
- Establish appropriate command structure
- Establish personnel accountability
- Additional resources for Hospital support
- The need for Behavioral Health Unit
- The need for family reunification

### **First EMS Officer – First Alarm**

Request an assignment from command upon arrival

#### **Considerations:**

- Assist command at the command post
- Assume Medical Group Supervisor
  - Third-in Officer becomes assistant to MGS
- Confirm notification to Disaster Control Facility (UCD)

### **Ambulances – First Alarm**

Assigned to assist initial operations based on the following priorities:

- Immediate transport of victims and/or patients.

### **Air Ambulances**

If an Air Ambulance (Helicopter) is needed refer to FOG Manual, and should be coordinated through the Patient Transportation Unit Leader (PTUL).

### **Greater Alarm Assignment**

All resources respond on the assigned Staging channel. Battalion Chiefs and EMS Officers report directly to the ICP. *Refer to Incident Response SROG for more detail.*

## Position Titles and Responsibilities

### RESCUE STRIKE TEAM

#### Rescue Unit Leader (RUL)

The Rescue Unit Leader leads the Rescue Strike Team from the Evac Zone into the indirect threat zone via the corridor to evacuate victims to the Evac Zone. This position is only used for IMCI incidents.

##### Considerations:

- Assemble and organize the RST with the available on-scene units.
- Meet up with the law enforcement escort.
- Confirm with Law enforcement that there is a secure corridor in the indirect threat zone.
- Lead the RST into the indirect threat zone, always staying in contact with law enforcement escort.
- The RUL is the first fire personnel into the threat zone and the last out.
- Monitor RST's progress and directs members if needed.
- Provides command with CAN reports and updates from the Law Enforcement escort, ideally from a dedicated Law Enforcement Officer Liaison (i.e., Possible number of victims)
- Ensure all fire personnel and alive victims are out of the threat zone before the RUL leaves.

#### Evac Zone Unit Leader (EUL)

The Evac Unit Leader is only assumed in an IMCI incident and will be the first arriving Captain once they are relieved of command by a Battalion Chief or may be appointed by command.

##### Considerations:

- The Evac Zone Unit Leader is a single resource that organizes victims into four categories based on the S.A.L.T. acronym. ●Minimal, Delayed, Immediate, Expectant, Deceased
- If transporting units arrive prior to a Medical Group Supervisor or Transport Unit Leader, the Evac Unit Leader should direct ambulances to transport immediate victims in the following priority: (ACE) 1) Abdomen, 2) Chest Wounds, 3) Extremities.

### **Rescue Strike Teams (RST)**

During IMCI incidents, Rescue strike teams should organize behind the RUL and be equipped with a POW bag and two fox trots.

- When directed, crews should follow the RUL into the indirect threat zone with their Law Enforcement escort with the following priorities for victims as found:
  - Control massive bleeding with tourniquets.
  - Rapid extrication of victims to the evac zone.
  - Identify the dead with a glow stick placed on the deceased body or next to it.
- Crews should stay in the corridor and only operate in secured areas where Law Enforcement is present.
- When all the victims have been moved to the Evac Zone, RST's will transition into assessing and treating the victims while they await transport.

### **Medical Group Supervisor (MGS)**

The Medical Group Supervisor reports to Command or Medical Branch Director, if established. The MGS supervises the Triage Unit Leader, Treatment Unit Leader, Patient Transportation Unit Leader, and Medical Supply Coordinator. The Medical Group Supervisor controls the activities within a Medical Group.

Considerations:

- Confirms MCC and PTUL positions are filled
- Attempt to quickly get a victim and/or patient count including severity
- Identify the need for additional resources (order through IC)
- Develop a traffic plan for ingress and egress
- Ensure Triage, Treatment, and Transport Unit Leaders are identified
- Agency Medical Director to the incident
- Specific vehicles such as busses, vans, or specialty equipment trailers
- Document incident as per county protocol

### **Patient Transport Unit Leader (PTUL)**

The Patient Transportation Unit Leader reports to the Medical Group Supervisor and supervises the Medical Communications Coordinator, and the Ground Ambulance Coordinator. The Patient Transportation Unit Leader is responsible for the coordination of patient transportation and maintenance of records relating to the patient's identification, condition, and destination.

### **Medical Communications Coordinator (MCC)**

The Medical Communications Coordinator reports to the Patient Transportation Unit Leader and establishes communications with the appropriate hospital or other coordinating facility to ensure proper patient destination.

Considerations:

- Maintain Continuous open line with DCF
- Advise DCF of type of MCI and number of patients with proper SAC-IT

### **Ground Ambulance Coordinator (GAC)**

The GAC will be utilized during incidents with a large geographical area of operation and when there is a need for multiple evacuation zones. They will report to the Patient Transportation Unit Leader and manage ambulance egress and ingress.

Considerations:

- There is one GAC per division or evacuation zone.
- The GAC will work alongside the Patient Loading Coordinator (PLC) to ensure proper patient destination is achieved.
- The GAC ensures the right patient is in the right ambulance going to the right hospital.

### **Patient Loading Coordinator (PLC)**

The Patient Loading Coordinator reports to the Treatment Unit Leader and is responsible for coordinating with the Patient Transportation Unit Leader, the transportation of patients out of the Treatment Areas.

Considerations:

- The PLC works within their division/evac zone with the EUL and/or TUL to receive the SAC-IT reports of the patients and will in coordination with the TUL; relay the patient count and each individual patient's SAC-IT details to the PTUL. The PTUL will relay to the PLC the appropriate hospital destination.
- The PLC with the GAC will ensure the right patient is in the right ambulance going to the right hospital.

## Appendix C IMCI/Tools and Guides

### IMCI Tools and Guides

#### “THREAT” acronym

Law Enforcement Stops the killing **FD / EMS stops the dying.**

**T** – Threat Suppression...**Law Enforcement**

**H** – Hemorrhage control

**R** – Rapid

**E** - Extrication

**A** – Assessment

**T** – Transport

#### “SACIT” acronym

For use in IMCI specific incidents to report victim findings in an efficient, standardized format ... supported by an IMCI worksheet at scene and DCF

**S** – Sex...**only Male or Female or best estimation**

**A** – Age... **if unknown best approximation**

**C** – Condition...**only using Minimal/Delayed/Immediate/Expectant/Deceased**

**I** – Injury... **simple Complaint of Abdomen, Chest, or Extremity injury**

**T** – Number ... **complete Triage Tag Number (Per EMSA protocols triage tags are only required with 21+ patients.)**

#### “ACE” acronym

Simplified transport Order for Victims or Patients at an evacuation zone

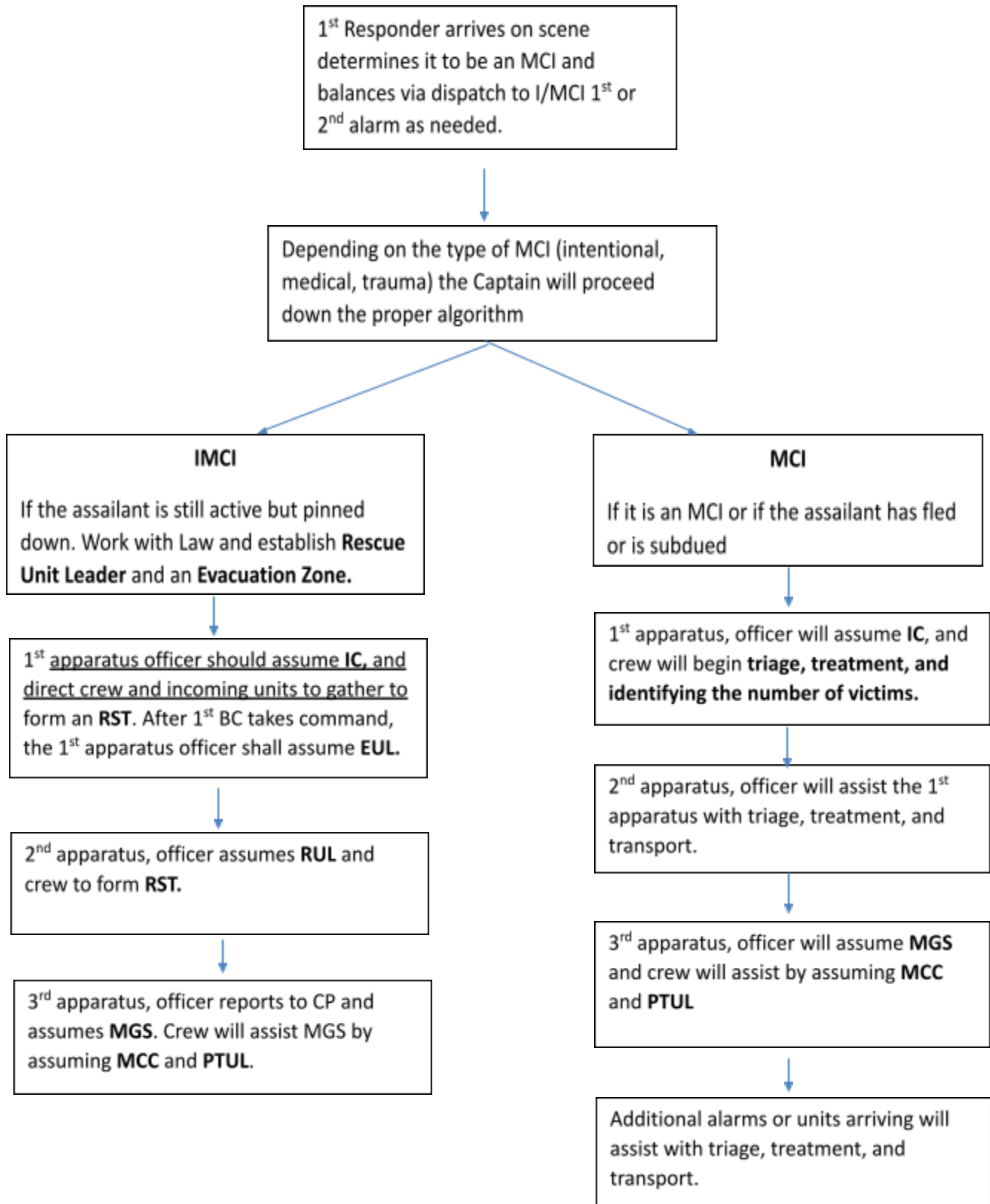
**A** - 1<sup>st</sup> priority- Abdominal wounds, including pelvic cavity

**C** - 2<sup>nd</sup> priority- Chest wounds with or without shortness of breath.

**E** - 3<sup>rd</sup> priority- Extremity injuries.

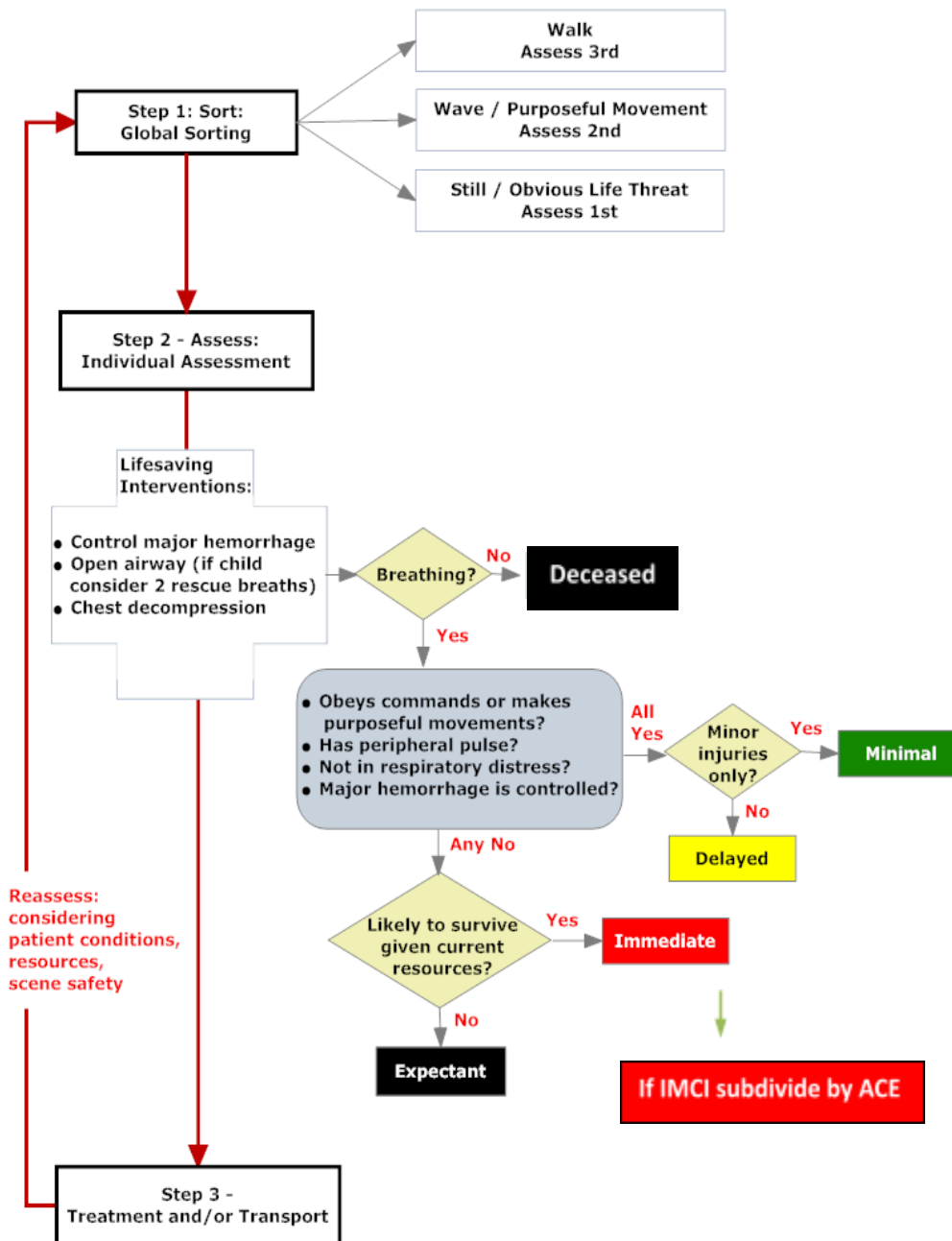
Appendix D

IMCI v MCI Flow Chart



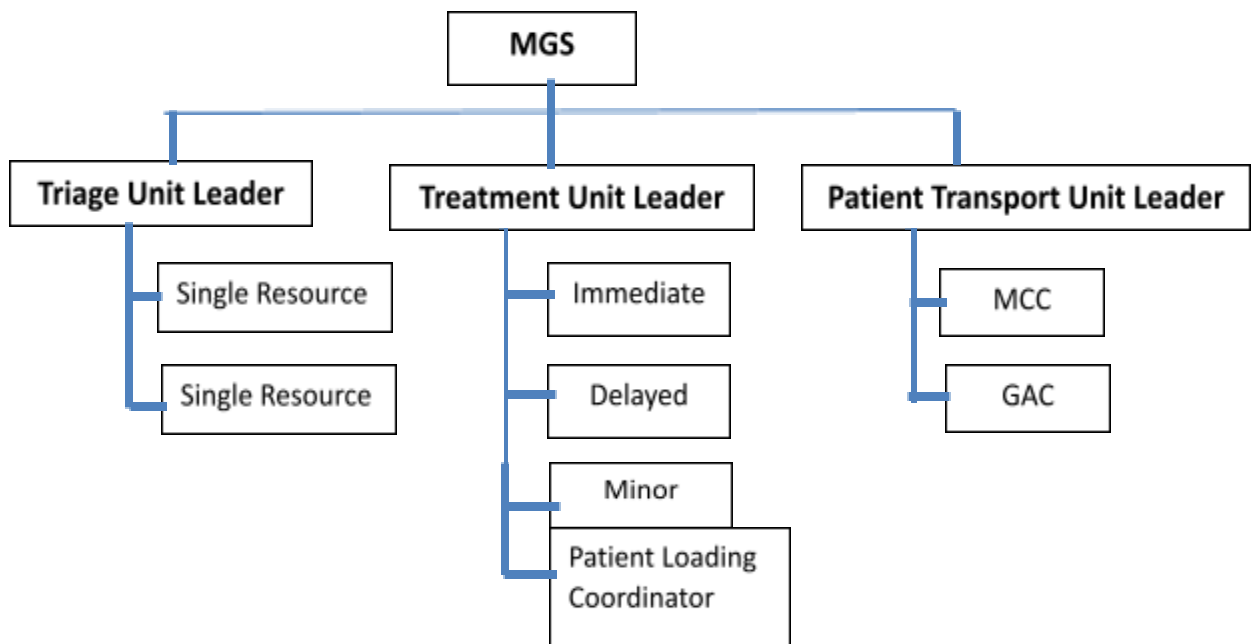
## Appendix E

### S.A.L.T Mass Casualty Algorithm



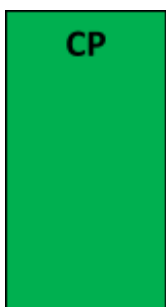
## Appendix F

- **PLC** – talks with EUL or TUL to determine number and type of patients
  - Assists with relaying SAC-IT information to PTUL
  - PTUL documents information and tracks patient/ambulance destinations
- **MCC** – direct communication with PTUL (side by side)
  - Looks at PTUL’s information and talks to DCF to receive hospital destination
  - PTUL will then relay destination to TUL or PLC
- **GAC** – manage ambulance egress/ingress
  - Assure proper patient is loaded into proper ambulances with triage tag (per EMSA protocols triage tags are only required with 21+ patients) and proper destination
  - Request additional ambulances through chain of command (GAC □ MGS □ CMD)



## Appendix G

# Example of Large Area Incident



**IC** - monitor B2 & B4 channels

**MGS** – monitor B4 and supervise MCC & PTUL

**MCC** - communicates with DCF via cell phone and face to face with PTUL

**PTUL** – monitor B9 and face to face with MCC; documents triage information and hospital destinations

**PLC/TUL/EUL** – ascertains # and type of pt's; relays information to PTUL to get hospital destination

Division B

Bravo 7

EVAC Zone/  
Triage-treatment Area

EUL or TUL on B7

PLC/TUL/EUL on B9 (PTUL)



Division D

Bravo 8

EVAC Zone/  
Triage-treatment Area

EUL or TUL on B8

PLC/TUL/EUL on B9 (PTUL)

Appendix H

MCI - Patient Dispersal / Tracking

Page: \_\_\_\_ of \_\_\_\_

Date: \_\_\_\_\_ Incident name: \_\_\_\_\_ Med Grp Sup: \_\_\_\_\_  
 Begin: \_\_\_\_\_ End: \_\_\_\_\_ Location: \_\_\_\_\_ Contact #: \_\_\_\_\_

Pt #	Time	Sex	Age	Immed	Delayed	Minimal	Expectant	Dead	Injury	Triage Tag#	Trauma Triage Criteria	Unit #	Hosp
											Y / N		
											Y / N		
											Y / N		
											Y / N		
											Y / N		
											Y / N		
											Y / N		
											Y / N		
											Y / N		
											Y / N		
<b>TOTAL</b>													

SACIT: Sex/Age/Condition/Injury/Triag Tag#

Revised 8/12/2025

## Signatures


The undersigned Fire Chiefs approve the contents of this document

  
Tilden Billiter (Apr 9, 2026 18:31:46 PDT)

**Tilden Billiter, D/C of Operations  
City of Sacramento Fire Department**

  
Tyler Wagaman (Apr 9, 2026 19:59:47 PDT)

**Tyler Wagaman, D/C of Operations  
Sacramento Metro Fire District**

  
Dan Quiggle (Apr 24, 2026 12:22:44 PDT)

**Dan Quiggle, D/C of Operations  
Cosumnes Fire Department**



**Matt McGee, D/C of Operations  
City of Folsom Fire Department**












# Please Review and sign IMCI Final 2\_26


Final Audit Report

2026-04-27


Created:	2026-04-07
By:	Fire Executive Admin (fireexecadmin@folsom.ca.us)
Status:	Signed
Transaction ID:	CBJCHBCAABAAQHZJIMcgw_FqAVYifYRhWU-a9Jkg3Lj3

## "Please Review and sign IMCI Final 2\_26" History


-  Document created by Fire Executive Admin (fireexecadmin@folsom.ca.us)  
2026-04-07 - 6:36:40 PM GMT
-  Document emailed to Tilden Billiter (jbilliter@sfd.cityofsacramento.org) for signature  
2026-04-07 - 6:38:47 PM GMT
-  Email viewed by Tilden Billiter (jbilliter@sfd.cityofsacramento.org)  
2026-04-10 - 1:15:12 AM GMT
-  Document e-signed by Tilden Billiter (jbilliter@sfd.cityofsacramento.org)  
Signature Date: 2026-04-10 - 1:31:46 AM GMT - Time Source: server
-  Document emailed to Tyler Wagaman (wagaman.tyler@metrofire.ca.gov) for signature  
2026-04-10 - 1:31:49 AM GMT
-  Email viewed by Tyler Wagaman (wagaman.tyler@metrofire.ca.gov)  
2026-04-10 - 2:59:05 AM GMT
-  Document e-signed by Tyler Wagaman (wagaman.tyler@metrofire.ca.gov)  
Signature Date: 2026-04-10 - 2:59:47 AM GMT - Time Source: server
-  Document emailed to danquiggle@cosumnescsd.gov for signature  
2026-04-10 - 2:59:49 AM GMT
-  Email viewed by danquiggle@cosumnescsd.gov  
2026-04-10 - 3:08:58 AM GMT
-  Email viewed by danquiggle@cosumnescsd.gov  
2026-04-24 - 1:32:13 AM GMT
-  Signer danquiggle@cosumnescsd.gov entered name at signing as Dan Quiggle  
2026-04-24 - 7:22:42 PM GMT

 Document e-signed by Dan Quiggle (danquiggle@cosumnescsd.gov)


Signature Date: 2026-04-24 - 7:22:44 PM GMT - Time Source: server

 Document emailed to mmcgee@folsom.ca.us for signature

2026-04-24 - 7:22:48 PM GMT

 Email viewed by mmcgee@folsom.ca.us

2026-04-27 - 3:10:06 PM GMT

 Signer mmcgee@folsom.ca.us entered name at signing as Matt McGee

2026-04-27 - 3:11:31 PM GMT

 Document e-signed by Matt McGee (mmcgee@folsom.ca.us)

Signature Date: 2026-04-27 - 3:11:33 PM GMT - Time Source: server

 Agreement completed.

2026-04-27 - 3:11:33 PM GMT