



FOR SECURITY DIRECTORS, EVENT PRODUCERS, CROWD MANAGERS & MUNICIPAL PUBLIC SAFETY COORDINATORS

EVENT SECURITY & VENUE MEDICAL READINESS GUIDE & MASS CASUALTY INCIDENT EMERGENCY ACTION PLAN (EAP)

Operational medical protocols, crowd surge decompression, multi-zone trauma staging and 911 dispatch standards for stadiums, arenas, amphitheaters, festivals and public assembly venues.

PRIMARY FACILITY DATA BLOCK · VENUE BINDER AND SECURITY POST

VENUE / FACILITY NAME

LICENSED MAXIMUM OCCUPANCY

PHYSICAL STREET ADDRESS

PRIMARY EVENT DISPATCH LINE (911 / DIRECT MUNICIPAL)

SECURITY DIRECTOR / PUBLIC SAFETY LEAD

DIRECT PHONE

EFFECTIVE DATE

VENUE MEDICAL OFFICER / LEAD EVENT PARAMEDIC

DIRECT PHONE

ANNUAL REVIEW DATE

FACILITY TYPE

☐

Stadium

☐

Arena

☐

Amphitheater

☐

Festival grounds

☐

Convention center

☐

Theater

Developed under the clinical direction of Marco R. Torres, MD, NRP

Clinician and paramedic educator, flight medic, U.S. Navy veteran, founder of MED-TAC International

Evidence-based prehospital trauma standards · NFPA 3000 · NFPA 101 · OSHA 29 CFR 1910.151 · MARCH · Service-Disabled Veteran-Owned Small Business

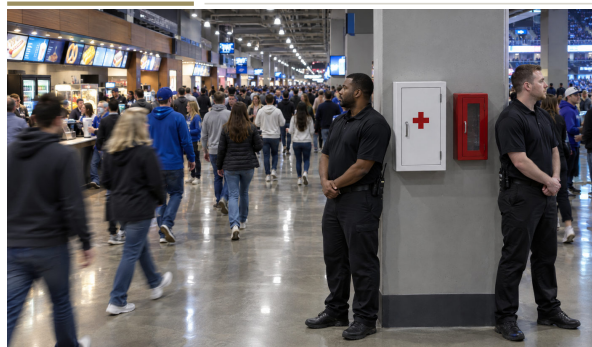
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SECTION 01

Executive summary: the 3-minute dual-threat reality



The concourse at doors: the only responders who can reach a collapse in three minutes are already inside the building. Illustration.

A venue carries two medical risks at once, and they need the same first three minutes. The first is high-frequency and routine: sudden cardiac arrest, exertional heat illness, intoxication and overdose, concourse falls. The second is low-frequency and catastrophic: crowd surge and compressive asphyxia, structural or barrier collapse, blast injury, and hostile violence. Neither waits for the ambulance.

The 180-second physiology. A severed femoral, brachial or carotid artery can bleed a person into irreversible shock in roughly 90 to 180 seconds. In sudden cardiac arrest, the chance of survival falls by about 7 to 10 percent for every minute without defibrillation when no CPR is given, and in the one setting where collapse-to-shock was timed precisely – casino floors under camera – 74 percent survived when the shock came within three minutes and 49 percent when it came later.

90–180 s planning window from an uncontrolled arterial wound to loss of consciousness	7–10% / min fall in cardiac-arrest survival for each minute without defibrillation and no CPR	74% vs 49% survival with a shock inside three minutes versus after, casino AED series	10 min + plan on this from the 911 call to a municipal crew at the patient side inside a full venue
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Why municipal EMS arrives late inside a venue

National median EMS response is 7 to 14 minutes, urban to rural, measured to the curb. Inside a venue the clock keeps running: the rig stops at the perimeter, a gate has to be opened, a marshal has to meet it, and the crew walks a loaded stretcher against pedestrian flow through screening and a packed concourse. Measure it at your own venue during a drill (p. 16); most operators find ten minutes or more before a paramedic touches the patient, and far longer during ingress or egress.

REALITY	WHAT IT LOOKS LIKE	WHO RESPONDS IN MINUTE ONE
High-frequency, routine	Cardiac arrest in a seat; heat collapse in the pit; opioid overdose in a restroom; a fall on the stairs; a laceration at the rail	The nearest usher, guard or supervisor, with the kit on their body and the AED on the wall
Low-frequency, catastrophic	Crowd surge at a barricade; a gate crush at doors; penetrating trauma in the pit; a vehicle into a queue; a blast	The same people, now with a throw bag and a litter, moving casualties to a collection point

CORE TAKEAWAY

In the zero-minute gap the only responders are contract security, ushers, crowd managers and the staged public-access stations. This guide equips and scripts them: what to stage where (Sections 09–10), what to do (03–08), what to say to 911 (11), and how to prove it afterward (13–16).



SECTION 02

Legal due diligence, premises liability and “reasonable care”

A venue operator owes invitees a duty of reasonable care against foreseeable harm. What is foreseeable is not a matter of opinion any more: sudden cardiac arrest, heat illness, overdose and falls happen at every large event, crowd crush has a documented history in every decade, and hostile events at public assemblies are the reason NFPA 3000 exists. The question a plaintiff’s expert asks is not whether the emergency was foreseeable but whether the operator planned, equipped and trained for it.

Three principles courts and insurers apply

PRINCIPLE	WHAT IT MEANS FOR THE VENUE
Foreseeability	Medical emergencies and crowd events in public assembly occupancies are foreseeable as a matter of record. The size of the crowd, the type of event and the venue’s own incident history set the standard the operator is measured against
“We called 911” is not a plan	Post-Astroworld litigation and the crowd-crush cases before it turn on the minutes between collapse and care. When the operator controls the gates, the corridors and the crowd, reliance on a municipal response the operator itself delays is hard to defend
Reasonable care is documented care	A written EAP (pp. 17–18), staff trained in bleeding control and CPR/AED with records (p. 16), AEDs and bleeding stations sited to a standard (pp. 7, 10), a shift-change inspection log (p. 15) and incident documentation (p. 19) are what “reasonable care” looks like on paper. This is evidence, not a guarantee of immunity

Regulatory frameworks this guide is built to

FRAMEWORK	SCOPE	WHAT IT ASKS OF THE VENUE
NFPA 3000	Standard for an Active Shooter / Hostile Event Response (ASHER) Program	Whole-community planning; unified command with law enforcement, fire and EMS; casualty collection, rescue task force integration; public bleeding-control training
NFPA 101	Life Safety Code, assembly occupancies	Egress capacity and maintenance; trained crowd managers (one per 250 occupants where required); life-safety evaluation for large venues
OSHA 29 CFR 1910.151	Medical services and first aid for the workplace	Trained staff and adequate first-aid supplies readily available where no infirmary or clinic is in near proximity
State bleeding-control kit statutes	A growing number of states	Kits in schools, government buildings and some public assembly spaces; verify your state and county – some counties (for example Broward County, FL) add AED and bleeding-kit rules for large facilities
Municipal special-event permits	Fire marshal, police special events, EMS coordinator	Medical plan, crowd manager count, EMS staffing ratio, ingress route and LZ where applicable – the EAP template on pp. 17–18 is written to be submitted

THIS IS NOT LEGAL ADVICE

Good Samaritan protection, duty-to-act rules for contracted security and the standing of a written EAP differ by state. Have venue counsel and the insurer review the completed EAP; put their answers in Section A on p. 17. What this guide gives you is the operational content those reviews expect to find.



SECTION 03

The 60-second rapid bleeding control protocol



Deliberate placement in the concourse: trouser leg cut, tourniquet two to three inches above the wound, clear of the knee. Illustration.

Life-threatening bleeding is the one venue emergency where the first minute is everything and the tools are cheap. The sequence below is written for a guard or usher with the Tier 1 kit on their body and no medical background. It follows MARCH: massive hemorrhage before anything else.

Placement rule. If you can see the wound and you are not under threat, the tourniquet goes on bare skin **two to three inches above the wound, never over a joint**. If the wound is hidden under clothing, there are multiple wounds on the limb, or the scene is still violent, go **high and tight** — proximal third of the limb, over clothing — and convert to deliberate placement once the casualty is at the collection point and the wound is exposed. A tourniquet that stopped the bleeding is never loosened by venue staff; conversion is a medical decision for EMS.

Security action sequence

- 1 **Identify life-threatening hemorrhage.** Spurting or pulsing blood; blood pooling larger than a dinner plate; clothing soaked through; an amputation. Gloves on. Say "major bleed, section ____" on the radio before you touch the casualty.
- 2 **Direct pressure.** Both hands, your weight, straight onto the source while the kit comes out. Pressure is the bridge to everything below, not a substitute for it.
- 3 **Arm or leg — tourniquet.** Place per the rule at left. Pull the strap through and cinch until no more than two fingers fit; twist the windlass until the bleeding stops and the pulse below it is gone; lock the windlass in the clip and secure the time strap. If it still bleeds, place a second tourniquet directly above the first. If it does not hurt, it is not tight enough.
- 4 **Groin, armpit, neck, buttock — pack.** A tourniquet cannot go there. Pack hemostatic gauze into the wound with your fingers, onto the vessel, until the cavity is full; then hold firm direct pressure for a full three minutes by the clock; then anchor with an elastic pressure dressing. Do not pack the chest or abdomen — cover them and get EMS moving.
- 5 **Record the time.** On the tourniquet strap, the casualty's forehead, or your forearm with the marker: "TQ 21:14." Say it to the radio. It travels with the patient to the trauma surgeon.

THE TIER 1 BLEEDING-CONTROL ITEMS, AS SOLD · prices verified on tactical-medicine.com, 25 Sep 2026



C-A-T® Gen 7 tourniquet
North American Rescue · \$28.99



QuikClot Combat Gauze®
Z-Medica · kaolin Z-fold · \$39.99



Celox™ Rapid Z-fold gauze
Celox · chitosan · \$37.95



Emergency Trauma Dressing 4 in.
North American Rescue · \$6.49

WHAT VENUE STAFF DO NOT DO

Loosen or remove a tourniquet. Pack the chest or abdomen. Pull out an impaled object. Move a suspected spinal injury except to escape a threat. Give anything by mouth.





SECTION 04

Crowd surge, crush and compressive asphyxia



Front-of-stage barricade at critical density: the supervisor's view from the platform is where the decision is made. Illustration.

Crowd crush is a physics problem before it is a medical one. Below about four persons per square meter people still choose where they stand. Above five, the crowd behaves as a fluid: a push at the back travels forward as a wave, individuals lose the ability to move their arms, and the pressure at a barrier or a wall can exceed what the chest can withstand. The deaths at Hillsborough, Love Parade and Astroworld were compressive asphyxia in standing crowds, not trampling.

What the supervisor is watching for. Heads bobbing in unison; lateral sway that travels like a wave; the crowd going quiet because people cannot inhale to shout; arms raised over heads; faces at the rail turning gray. Any one of these at the front of a general-admission pit is the trigger for decompression, not a reason to watch longer.

DENSITY	WHAT THE CROWD DOES	SUPERVISOR ACTION
2-3 / m ²	Free movement; people pass each other	Normal operations; monitor ingress flow
4-5 / m ²	Involuntary contact; movement slows to a shuffle; no one can turn around	Stop feeding the area; open secondary lanes; announce
Above 5 / m ²	CRITICAL. Crowd moves as a fluid; shockwaves propagate; individuals lose agency; barrier loads climb	Decompress now: barrier release, reverse-flow lanes, stop the show if the stage is the pull

Decompression protocol

- 1 Barrier relief.** On the first shockwave the barricade supervisor pulls the emergency release pins on the front-of-stage barricade and the lateral perimeter fence sections nearest the pressure. The pins are verified clear on every walkaround (p. 15).
- 2 Reverse-flow channels.** Open the secondary side egress gates and the pit exits so pressure has somewhere to go before the collapse, and stop all ingress into the affected area.
- 3 Stop the pull.** If the stage is the attractor, the show pauses: house lights up, the artist or MC asks the crowd to step back. The security director owns this call and the promoter agrees to it in the EAP before doors.
- 4 Lift-out.** Casualties at the rail come over the barricade to the sterile corridor behind it and onto litters (p. 6) – never back through the crowd.

Compressive asphyxia management

Victims die because the chest wall cannot expand against the load: intercostal muscles and the diaphragm are pinned. Once extricated, a casualty who is not breathing gets immediate rescue breathing and CPR with the AED; one who is breathing goes into the recovery position, is watched for airway blood and vomit, and is kept warm. Anyone compressed for a prolonged period is flagged to EMS for crush syndrome – muscle breakdown that becomes a cardiac and kidney emergency after the pressure is released. Say how long they were pinned in the MIST report.



SECTION 05

Chokepoint extraction and confined-space medical logistics



Two guards carrying a loaded flexible litter through a turnstile bay while a third holds the gate and the crowd back. Illustration.

A wheeled EMS stretcher is 23 inches wide and needs a straight run. A turnstile bay is 32 inches; an arena aisle stair is steeper than any ramp a stretcher can climb; a general-admission pit has no aisle at all. The casualty has to move from where they fell to where the stretcher can reach them, and that move is a venue-staff task with venue-staff equipment.

The equipment standard. Poleless flexible litters rated to 450 lb or more, folded flat and staged at every turnstile bank, every pit barrier section and every first-aid post; a rigid folding drag litter with a first-responder bag at the command post for stairs and long carries. Two guards carry a loaded flexible litter horizontally through a 32-inch bay without stopping; four carry it up stairs with the head uphill.

Medical evacuation corridors

Six-foot sterile corridor behind every stage barricade and along the arena perimeter wall, marked on the floor, kept clear of cases, cable ramps and staff. It is the lift-out lane for the pit and the path to the collection point.

One designated casualty route per zone (p. 10) from the zone to the ambulance loading point, walked by the supervisor before doors and again at every walkaround; a route that needs a key, a code or a forklift is not a route.

Guards own the lane. Spectators who congregate in a corridor are moved before an incident, not during one. A corridor blocked at the moment of need is the finding that ends up in the after-action report.

Litter drills

Every guard on a gate or pit post carries a casualty on a flexible litter at least once a season, through the actual turnstile and up the actual stairs of the post they work. Time it: fall to the corridor in under 60 seconds at the barricade, litter to the ambulance loading point in under four minutes from anywhere in the bowl. Log the times on p. 16.

EXTRACTION LITTERS, AS SOLD · prices verified on tactical-medicine.com, 25 Sep 2026



QuickLitter™ (disposable, 500 lb)
North American Rescue · \$19.00; XL
1,000 lb \$39.99



TacMed™ Phantom Litter (450 lb)
Tactical Medical Solutions · \$64.57
litter only



TacMed™ Foxtrot Litter
Tactical Medical Solutions · \$209.99



Foldable Drag Litter System + responder bag
6:8 Medical · rigid ABS, 78 in. ·
\$399.99

SECTION 06

Sudden cardiac arrest and the 3-minute AED siting standard



Public-access bleeding control station beside the AED: eight vacuum-sealed kits and a litter in a semi-recessed steel cabinet. Product photograph.

Sudden cardiac arrest is the most frequent fatal medical event at sporting events and concerts: exertion, heat, alcohol, the stairs, and a crowd that is older than it looks. Survival is decided by the interval from collapse to the first shock, and that interval is decided by where the AED hangs, not by how good the paramedics are.

The 3-minute standard. Shock delivered within 180 seconds of collapse from any seat, suite, concourse point or back-of-house position. Working backward: someone recognizes the collapse and calls it (30 s), someone reaches the cabinet and returns (the round trip), pads go on (30 s). That leaves about 90 seconds for the round trip, which through a crowded concourse is roughly 200 to 250 feet of walking path from the farthest point the cabinet serves.

Co-locate bleeding control with every AED — one search finds both.

CABINET STANDARD	SPECIFICATION
Spacing	No public position more than 200–250 ft of walking path from an AED; every level, every suite corridor, every back-of-house area with staff; mapped on the EAP floor plan and drilled to the 180-second shock
Cabinet	Surface-mounted or semi-recessed steel, high-visibility, local audible alarm of 85 dB or more with strobe, serialized tamper seal, three-way sign visible down the concourse in both directions
Contents	AED with pre-connected adult pads and pediatric pads or key, spare battery per manufacturer, CPR barrier, shears, razor, towel; bleeding-control station co-located (Tier 2, p. 11); bilingual instruction card
Status	Green readiness indicator checked on every shift-change walkaround (p. 15); pads and battery expiry logged; AED registered with the county and the medical director's program

Recognize and act

- 1 Unresponsive, not breathing normally (gaspings counts). Radio: "cardiac arrest, section ____, AED to me." One person calls 911 with the dispatch script (p. 13).
- 2 Compressions now: center of the chest, at least 2 in. deep, 100–120 per minute, full recoil; no pulse checks.
- 3 AED on arrival: power on, pads on bare dry chest, follow the prompts, clear, shock, resume compressions instantly.
- 4 Continue until EMS takes over; marshal the crew in; MIST report with collapse time and shocks delivered.

AED AND CABINET, AS SOLD - prices verified on tactical-medicine.com, 25 Sep 2026



ZOLL AED Plus complete station
AED + alarmed cabinet + sign · \$1,999.99



Philips HeartStart OnSite AED
Philips · \$1,499.99



Semi-recessed cabinet for bleeding-control packs
North American Rescue · \$209.99



SECTION 07

Active threat and hostile event response under NFPA 3000



A casualty collection point in a loading dock: door down, casualties on litters against the wall, a guard at the corridor. Illustration.

NFPA 3000 exists because the municipal answer to a hostile event — police clear, then fire and EMS enter — leaves the wounded alone for the interval between. The standard asks the venue to plan as part of the whole community: unified command with law enforcement, fire and EMS before the event; casualty collection points designated before the event; and staff trained to stop bleeding and move casualties during it.

Casualty collection points. The security director designates two or more CCPs per zone in structurally protected areas shielded from lines of sight into the public space: freight elevator vestibules, interior service tunnels, loading docks with the doors down, back-of-house corridors with a second exit. Each CCP is marked on the EAP floor plan, stocked from the Tier 3 vault, and known to the police and fire liaisons before doors.

Roles during the event

ROLE	WHO	WHAT THEY DO
Warm-zone escort	Security supervisors paired with the police contact team	Guide the municipal rescue task force (RTF) through the venue by the routes on the EAP; hold doors; call out CCP locations and casualty counts
CCP lead	Senior guard or venue medic at each CCP	Triage on arrival (p. 16 START logic); MARCH on the red casualties; keep the count and the tourniquet times; hand off to EMS with MIST
Movers	Guards with litters	Bring casualties from the last known safe corridor to the CCP; never re-enter the hot zone; the police contact team decides when a space is warm
Gate marshal	Guard in a high-visibility vest at the emergency ingress gate	Opens the gate, clears vehicles and pedestrians, brings rigs to the CCP loading point; the dispatch script (p. 13) names this person

MARCH at the collection point

Massive hemorrhage first: tourniquets on arterial limb bleeds, packing at the junctions, then the next casualty. Airway: recovery position. Respiration: a vented seal on every penetrating wound between neck and navel, front and back. Then reassess what you placed and keep them warm. Tourniquets are not loosened at the CCP.

THROW KITS AND MULTI-CASUALTY BAGS, AS SOLD · prices verified on tactical-medicine.com, 25 Sep 2026



H&H; "Grab and Throw" 6-pack, intermediate
H&H; Medical · six kits · \$349.00



TacMed™ Trauma Station throw kit
Tactical Medical Solutions · w/ chest seal · \$80.03



Crisis Incident Response Kit
North American Rescue · multi-casualty · \$389.99



Public Access individual kit, vacuum sealed
North American Rescue · from \$54.95





SECTION 08

Exertional heat stroke and opioid overdose



Festival cooling station: an immersion tub, ice water, rotating towels and shade behind the medical tent. Illustration.

Outdoor festivals and amphitheaters produce heat casualties in volume: hours of sun, dancing, alcohol, and no shade at the front. The distinction that matters is mental status. Heat exhaustion is a hot, sweaty, tired person who answers questions. Exertional heat stroke is a hot person who is confused, combative, staggering or unconscious — and it is a time-critical emergency whose outcome depends on how fast core temperature comes down, not on how fast the ambulance arrives.

Cool first, transport second. Cold-water immersion is the standard of care for exertional heat stroke; a tub, a stock tank or a tarp taco with ice water at the medical tent brings the core temperature down faster than anything in an ambulance. If the venue's medical staff can cool, the casualty is cooled to a documented target before transport; if they cannot, ice-water towels over the whole body are rotated continuously until EMS takes over.

CONDITION	LOOKS LIKE	VENUE ACTION
Heat exhaustion	Pale, sweaty, weak, headache, cramps; normal mentation	Shade, rest, oral fluids with electrolytes, cooling towels; watch for progression
Exertional heat stroke	Hot; altered mental status — confusion, aggression, collapse; may still be sweating	Call it. Cold-water immersion or continuous ice-water towels now; 911; protect the airway
Opioid overdose	Unresponsive; slow or absent breathing (under 8 per minute); pinpoint pupils; blue lips	Naloxone nasal spray; rescue breaths; recovery position when breathing; 911

Naloxone protocol (per FDA labeling, under the venue medical program)

- 1 Unresponsive with slow or absent breathing and any reason to suspect opioids — fentanyl is in counterfeit pills and stimulants; assume it. 911 and “naloxone to me” on the radio.
- 2 One 4 mg intranasal device, tip in one nostril, plunger pressed fully. Rescue breathing or CPR as trained while you wait.
- 3 No response in 2–3 minutes: second device, other nostril; repeat every 2–3 minutes with a new device while breathing is absent.
- 4 Breathing returns: recovery position, stay with them — naloxone wears off before fentanyl does. Expect agitation and vomiting on reversal; two staff, calm voice, no weight on the chest.

HEAT, OVERDOSE AND AIRWAY SUPPORT ITEMS, AS SOLD • prices verified on tactical-medicine.com, 25 Sep 2026



Naloxone nasal spray, twin pack (4 mg)
MED-TECH Resources • \$33.50



Mylar emergency blanket
MED-TECH Resources • \$1.50



Nasal airway 28 Fr, pre-lubricated
VETRUM • medical program only •
\$4.99

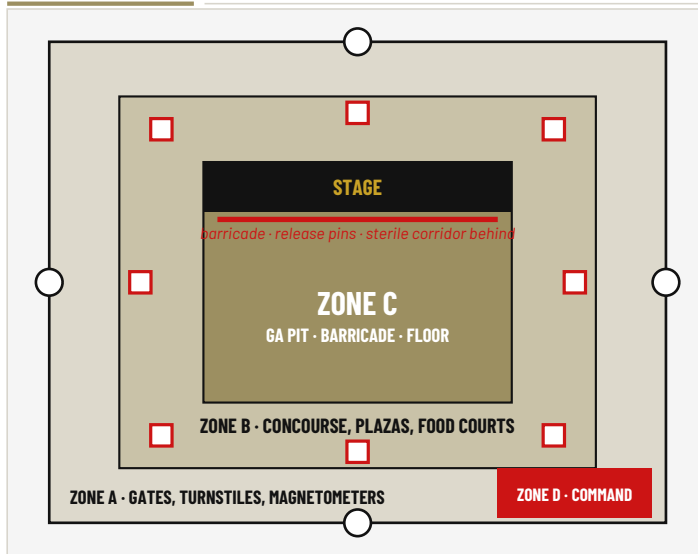


Nitrile exam gloves, wrapped pair
MED-TAC • \$1.00



SECTION 09

The four-zone staging architecture



Four-zone staging map. Scale and shape are schematic; draw your own on the EAP floor plan.

Hardware is staged where the threat is, not where the storeroom is. The four zones below map onto any bowl, shed, tent or fairground; the EAP floor plan (p. 17) marks each zone's kits, AEDs, litters, corridors and collection points by number.

Reading the map. White circles are gates (Zone A); the white-and-red squares are co-located AED and bleeding-control stations on the concourse (Zone B) at 200–250 ft spacing; the red line is the front-of-stage barricade with its release pins and the sterile corridor behind it (Zone C); the red block is security dispatch (Zone D), where the Tier 3 vault lives.

Rule of placement. Every kit is in the zone it serves, mounted or staged in the open, reachable without a key, and checked on the walkaround. A kit in a locked office is not staged.

ZONE	THREAT PROFILE	REQUIRED HARDWARE
A • Entry gates, turnstiles, magnetometers Perimeter	Crowd surge at the chokepoint; perimeter vehicle impact; entry-gate violence; queue heat	Roving security IFAKs on-body (Tier 1); a throw bag per gate bank (4 tourniquets, 4 dressings, 2 vented seals, gloves); a flexible litter per bank; marshal vest and dispatch card at the gate office
B • Main concourse, plazas, food courts Public circulation	Sudden cardiac arrest; falls; lacerations; overdose in restrooms; hostile event	Public bleeding-control station beside every AED at 200–250 ft spacing (Tier 2); three-way signage; a flexible litter in each station; naloxone at guest services and restroom posts
C • GA pit, stage barricades, arena floor High density	Compressive asphyxia; barrier crush; thrown projectiles; heat in the pit	Barricade response bags every 50 ft (tourniquets, dressings, seals, shears); relief-pin tools at every release point; flexible litters every 50 ft; the sterile corridor; cooling towels and water at the pit medical post
D • Security dispatch, first-aid station, command Command	Multi-casualty triage; prolonged holding; resupply; documentation	Tier 3 vault (10–20 severe casualties); spare AED pads and batteries; oxygen and suction under the medical program; naloxone stock; the EAP binder, floor plans, dispatch script, LZ kit and incident forms

MED-TAC planning ratios (minimums; the AED reach standard on p. 7 governs placement)

ITEM	RATIO	20,000-SEAT ARENA
Tier 1 kits	Every response officer; at least one per 250 attendees (the NFPA 101 crowd-manager ratio)	80 kits
Tier 2 stations	One per 1,000 attendees of licensed occupancy; none farther than 200–250 ft of walking path	20, beside 20 AEDs
Throw bags, litters	One of each per gate bank and per 50 ft of pit barrier	8 gates + 120 ft = 11 each
Tier 3 vault	One per venue; two when a collection point is more than a building length from dispatch	2 vaults



SECTION 10

Tier 1 on-body kit and Tier 2 concourse station

Three tiers, one logic: the guard carries what stops one bleed; the concourse station holds what a bystander needs for the next three casualties, beside the AED; the command vault (p. 12) holds what the venue needs when the count reaches double digits. Every device comes from the manufacturer or an authorized distributor with lot traceability.

Tier 1 • Roving security officer on-body trauma kit (belt or vest)

QTY	ITEM	SPECIFICATION
1	Limb tourniquet	Proven windlass device (C-A-T Gen 7 or SOF-T Wide class), authentic, staged per the manufacturer, in a rigid or open-top retention holster reachable by either hand
1	Hemostatic gauze	Kaolin or chitosan Z-fold, vacuum-sealed (QuikClot Combat Gauze or Celox Rapid class)
1	Pressure dressing	4 in. emergency trauma dressing, flat-packed
1	Vented chest seals	Twin pack, compact (HyFin Vent Compact class) – entry and exit
2 pr / 1 / 1	Gloves, shears, marker	Nitrile, chemotherapy-permeation tested (ASTM D6978); 7.25 in. coated trauma shears; mini black permanent marker for the tourniquet time
1	Pouch	Low-profile, tear-open or one-motion flap; no snaps; no retail packaging inside

TIER 1 CONFIGURATIONS AND ITEMS, AS SOLD • prices verified on tactical-medicine.com, 25 Sep 2026



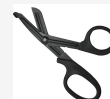
CORE – Compact Officer Response Kit
North American Rescue • C-A-T,
Combat Gauze LE, flat ETD • \$79.99



**MED-TAC Immediate Trauma Kit w/
pouch**
MED-TAC • MOLLE/belt • \$74.95



HyFin® Vent Compact twin pack
North American Rescue • \$12.99



EMT trauma shears 7.5 in.
MED-TAC • \$4.99

Tier 2 • Concourse and plaza wall-mounted public bleeding-control station

QTY	ITEM	SPECIFICATION
1	Cabinet	High-impact polycarbonate or steel wall cabinet, surface or semi-recessed, audible alarm, serialized tamper seal, three-way sign; beside or inside the AED cabinet
4–8	Individual bleeding-control kits	Each: tourniquet, 6 in. emergency trauma dressing, compressed or hemostatic gauze, vented chest seal, gloves, marker, instruction card; vacuum-sealed for shelf life
1	Flexible litter	Poleless, rated 450 lb or more, folded flat
2	Hypothermia blankets	Mylar or reflective survival wrap
1	Instruction card	Laminated, bilingual (English/Spanish), pictorial – tourniquet, packing, seal, AED

TIER 2 STATIONS, AS SOLD • prices verified on tactical-medicine.com, 25 Sep 2026



**Public Access Bleeding Control Station,
8-pack, steel cabinet**
North American Rescue • from
\$699.99



**Public Access Bleeding Control Kit,
nylon**
North American Rescue • from \$69.99



NAR Trauma & First Aid Kit, Class A
North American Rescue • ANSI Z308.1
+ trauma • from \$184.99



TRAMEDIC® Cabinet Kit
Tramedic • 10 sub-kits, 4 tourniquets •
from \$549.00



SECTION 10 • CONTINUED

Tier 3 command mass-casualty response vault

The vault is the venue's answer to the day the casualty count outruns the concourse stations: a hostile event, a barricade collapse, a vehicle into a queue. It lives at security dispatch (Zone D), it is packed to be carried by two people to a casualty collection point, and it is never opened for a routine call — the concourse stations absorb those.

QTY	ITEM	SPECIFICATION
1	Container	Heavy-duty water-resistant medic backpack or wheeled hard case; two-person carry; color-coded internal modules; seal and inventory card on the outside
12	Limb tourniquets	Proven windlass device, authentic; duty black or high-visibility orange
8	Hemostatic gauze	Z-fold, vacuum-sealed
10	Pressure dressings	6 in. emergency trauma dressings
6	Vented chest seal twin packs	Twelve seals
4	Nasopharyngeal airways	28 Fr with lubricant — venue medical program and standing orders only
6	Hypothermia blankets	Mylar or reflective wrap; every trauma casualty, every season
2	Evacuation litters	Heavy-duty poleless litters; plus the rigid drag litter at dispatch for stairs
10 pr	Nitrile gloves	Mixed sizes
4	Medical tape	Heavy-duty 2 in. rolls
1	Triage and documentation	Triage tags or tape (red/yellow/green/black), casualty count board, markers, incident forms (p. 19)
—	Not in the vault	Supplemental oxygen, suction and any medication ride with the venue medical program under its medical director, not in a security-managed cache

Enclosure and staging standard

Location: security dispatch or the command post, on the floor by the door, never on a shelf; a second vault at the far end of a large venue so no collection point is more than one building length from resupply.

Seal and card: serialized tamper seal; an inventory card on the outside with the last audit date, the earliest expiry inside, and the auditor's initials — read on every walkaround without opening the bag.

Climate: indoors, away from heat; hemostatic gauze and chest-seal adhesive degrade in a hot storeroom or a vehicle. Anything staged outdoors at a festival rides in an insulated case and is rotated in.

Drill: the vault is opened, carried to a CCP and repacked at least once a season (p. 16); the drill is when expired items are found.

VAULT CONTAINERS AND TOURNIQUETS, AS SOLD — CONTAINERS SHIP EMPTY; STOCK TO THE TABLE ABOVE · prices verified on tactical-medicine.com, 25 Sep 2026



Tasmanian Tiger Medic Assault Pack MK II
container, sold empty · \$189.00



TacMed™ ARK™ Active Shooter Response Bag
chassis, sold empty · \$266.04



MCI Throw Kit Dispenser System bag
North American Rescue · sold empty · \$379.99



SAM® XT tourniquet
SAM Medical · \$33.99



C-A-T® Gen 7, orange
North American Rescue · \$28.99





SECTION 11

The venue 911 emergency dispatch script

Fill this page before the season, laminate it, and post it at the security console, box office and command post. Under stress the caller reads it top to bottom; the dispatcher gets the address, the gate and the marshal in the first thirty seconds.

"911 Dispatcher, this is calling from ,

located at in .

"Exact GPS coordinates: latitude longitude .

"Nature of emergency:"

☐ Active violence ☐ Crowd surge / crush ☐ Mass medical collapse ☐ Sudden cardiac arrest ☐ Other:

"Estimated casualties: red / immediate, yellow / delayed, green / minor."

"Exact location inside the venue (gate / section / concourse level / stage barricade):"

"Status of the threat:" Controlled / Contained / Active – "On-site interventions so far:"

"Primary emergency ingress: direct fire/EMS units to enter via (gate name / loading dock ramp / road):"

"Marshalling: Security Officer (name) will be at that gate in a high-visibility vest to clear traffic and guide units to the casualty loading zone:"

"Gate lock code / overhead door switch location:"

BEFORE YOU HANG UP

Confirm the dispatcher has the gate and the marshal. Then radio the marshal to the gate, radio the CCP lead with the ETA, and keep this line open on speaker if the dispatcher asks you to. Update the casualty count every five minutes until the first unit is at the patient.

Two more scripts the same people will need

SCRIPT	WHO SAYS IT	WORDS
Gate marshal to the rig	The vest at the emergency gate, on the radio to dispatch and by hand signal to the crew	"Unit ____, gate is open, follow me to the dock – casualties are inside the roll-up door on the left, ____ red, ____ yellow. Tourniquet times are on the tape."
CCP lead to EMS (MIST)	Whoever holds the casualty count, to the first paramedic	"Mechanism: ____ Injuries: ____ Signs: breathing ____, pulse ____, awake / not awake. Treatment: tourniquet ____ at ____ hours, packed ____, seal ____, AED ____ shocks, naloxone ____."



SECTION 12

Helicopter air ambulance landing zone protocol



Night landing zone in an overflow parking lot: four corner beacons, a fifth marking the wind, the security perimeter at 200 ft. Illustration.

Rural amphitheaters, speedways and festival grounds can be an hour by road from a trauma center and twelve minutes by air. The flight crew decides whether to land; the venue decides whether there is somewhere safe to land. The landing zone is chosen and walked with the local air-medical program before the season, written into the EAP with its coordinates, and set up by a security detail that has done it in daylight.

Never approach the aircraft until the crew signals; never from the rear; never aim spotlights, high beams or phone lights at the cockpit; never let anyone chase a hat into the rotor disk.

LZ REQUIREMENT	STANDARD
Size and surface	At least 100 × 100 ft, flat, firm — paved lot or cleared, mowed turf; slope under 5 degrees; no loose gravel, sand or dust that will blind the crew on approach
Obstacles	No overhead wires, light poles, speaker towers, flag poles, tents or stadium cables in the approach and departure paths; report every obstacle within 300 ft to the crew by radio or dispatch
Foreign object debris	Detail sweeps the zone for trash cans, folding chairs, banners, tarps, cones not in use and anything lighter than a person — rotor wash is hurricane-force and lifts it into the blades
Marking	Day: four high-visibility weighted cones at the corners, a flag or smoke for wind if the crew asks, a marshal in a high-visibility vest at the upwind edge, back to the wind, arms up. Night: four weighted beacons at the corners and a fifth upwind; no white light at the aircraft; headlights off or aimed away
Perimeter	Minimum 200 ft sterile perimeter held by security in all directions; no spectators, no vehicles, no media; crowd noise means the perimeter must be physical, not verbal
Communications	Ground contact on the frequency or phone the program specifies; report LZ ready, wind, obstacles, surface, and the patient's condition; the crew may decline the LZ — have the road alternative ready

Patient hand-off at the aircraft

- 1 Casualty packaged on the litter at the perimeter edge, tourniquet time and MIST on tape on the chest, blanket on.
- 2 Crew approaches you; you do not approach the aircraft. Hand over at the perimeter unless the crew directs a carry — then crouched, from the front quarter they indicate, nothing above head height.
- 3 Hold the perimeter until the aircraft is out of sight; log program, tail number and departure time on the incident form (p. 19).

Venue LZ card (complete with the air-medical program before the season)

PRIMARY LZ LOCATION / NAME	COORDINATES	SIZE (FT) / SURFACE	AIR-MEDICAL PROGRAM / GROUND-CONTACT CHANNEL

- ☐ Walked with the air-medical program ☐ Night beacon kit staged at dispatch ☐ Alternate LZ identified





SECTION 13

Shift-change 60-second walkaround

One supervisor, one minute, before doors and at every shift change. The walkaround is the only control that catches a raided cabinet, a dead AED battery or a corridor full of road cases before the incident does. Print a stack; file the completed sheets with the event record — they are the evidence of reasonable care on p. 3.

DATE	EVENT	SUPERVISOR NAME	BADGE / ID

SHIFT ☐ Doors open ☐ Mid-event ☐ Load-out

Inspection checklist

- ☐ **Concourse bleeding stations** — every cabinet inspected; tamper seals intact and serial numbers match the log; zero missing kits; sign visible from both directions
- ☐ **Concourse AED units** — green readiness indicator on every unit; adult and pediatric pads and battery within expiry; cabinet alarm armed
- ☐ **Turnstile throw bags** — present and sealed at every designated ticket-scanning lane and gate bank
- ☐ **Stage barricade response kits** — staged at the rapid-grab points every 50 ft; emergency release pins verified clear and unobstructed
- ☐ **Emergency corridors** — six-foot sterile lanes behind the barricade and along the perimeter wall clear of cases, cable ramps and staging
- ☐ **911 dispatch cards** — present and readable at the security console, box office and command post; coordinates and gate names current
- ☐ **Litters** — flexible litters present and undamaged at gate banks, pit barrier and first-aid posts; rigid drag litter at dispatch
- ☐ **Roving guard on-body kits** — 100 percent of designated response officers carrying a staged tourniquet, gloves and the Tier 1 pouch; spot-check three
- ☐ **Tier 3 vault** — at dispatch, sealed, inventory card current; naloxone stock at guest services and restroom posts
- ☐ **Casualty routes and CCPs** — each zone's route to the ambulance loading point walked; CCP doors unlocked from the inside; loading dock clear

DISCREPANCIES NOTED • CORRECTIVE ACTION TAKEN • TIME CORRECTED

SUPERVISOR SIGNATURE	TIME COMPLETED	REPORTED TO (SECURITY DIRECTOR / MEDICAL OFFICER)





SECTION 14

Annual staff training and practical drill standard

Training standard: every full-time security officer, usher, crowd manager and venue supervisor holds current CPR/AED certification and has completed an instructor-led bleeding-control course, refreshed by a hands-on drill every twelve months and a tourniquet self-application check every quarter — skill measurably decays within six months of a class. Seasonal and contract staff get a bleeding-control and AED orientation before their first shift. Records live in Section F of the EAP.

#	SCENARIO	DRILL FOCUS	PASS STANDARD
1	Sudden cardiac arrest, upper concourse	Recognition; radio call; AED retrieval and first shock; compressions; crowd management around the casualty; EMS marshal	Collapse to first shock under 180 s; 911 connected under 90 s
2	Main-gate crowd surge and barrier collapse	Density recognition; barrier release; reverse-flow lanes; litter extrication through the turnstile; asphyxia triage	Decompression order under 30 s of the first wave; first casualty in the corridor under 60 s
3	GA pit penetrating trauma	Hot-to-warm transition with the police liaison; tourniquet and chest seal; movement to the CCP; RTF escort; MIST hand-off	Tourniquet on under 60 s; casualty at the CCP under 4 min; EMS gate link-up under 180 s of arrival
4	Festival heat-illness cascade	Triage by mental status; cooling-tent operations; ice-water rotation; electrolyte and shade protocol; coordination with on-site medical	Heat-stroke casualty in cooling under 5 min of recognition; core-temperature documentation by medical staff

Evaluation metrics (record on the drill log)

< 30 s scene size-up and radio call from the first responder on post	< 60 s tourniquet applied and locked, time recorded	< 90 s 911 connected and the dispatch script read through the gate line	< 180 s municipal EMS at the gate met by the marshal and moving to the casualty
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Cadence

WHEN	WHAT	WHO
Pre-season	Full-scale exercise with police, fire and EMS: one scenario end-to-end; LZ set-up where applicable; EAP walk-through with the fire marshal	Supervisors; sample of guards, ushers, medical
Quarterly	Tourniquet self- and buddy-application check on post; litter carry through the actual turnstile	Every response officer
Every event / annually	Walkaround and dispatch-script radio check every event; CPR/AED and bleeding-control refresher, EAP re-submission and AED registry update every year	Zone supervisors; all staff; security director

Triage logic for the CCP lead (START). Anyone who can walk is green and goes to the collection area. Of the rest: not breathing after the airway is opened — black; breathing over 30 per minute, no radial pulse or not following commands — red; everyone else — yellow. Reds get MARCH first; the count goes to dispatch every five minutes.



SECTION 15

Master venue EAP template – for the binder and the fire marshal

Complete every field, attach the zone floor plan with kits, AEDs, litters, corridors, CCPs, the emergency ingress gate and the LZ marked, and submit with the special-event permit application. Review annually (date on the cover) and after every incident.

Section A • Venue administrative and legal information

CORPORATE ENTITY / LEGAL OPERATOR

OWNERSHIP / MANAGEMENT COMPANY

GENERAL LIABILITY INSURER

POLICY NUMBER

COUNSEL OF RECORD (GOOD SAMARITAN / DUTY REVIEW)

Section B • Facility physical parameters

TOTAL SQUARE FOOTAGE

LEVELS

SEATING / STANDING CAPACITY

TURNSTILE BANKS / TOTAL LANES

LOADING DOCKS (NAMES)

EMERGENCY INGRESS GATE (NAME / ROAD)

LZ COORDINATES (IF APPLICABLE)

Section C • Primary and secondary hospital directory

FACILITY	NAME	DISTANCE	TRANSPORT TIME	HELIPAD
Level 1 trauma center				
Level 2 / 3 trauma center				
Pediatric hospital				
Burn center / nearest ED				

Section D • Municipal emergency service contacts

AGENCY	CONTACT NAME / TITLE	DIRECT PHONE	RADIO / CHANNEL
Police / sheriff special events unit			
Fire / rescue special operations			
Contract event EMS provider			
Air-medical program (LZ)			
Fire marshal / permitting authority			

SPECIAL CONDITIONS • PYROTECHNICS • WATER FEATURES • TEMPORARY STRUCTURES • MUTUAL-AID AGREEMENTS



SECTION 15 • CONTINUED

EAP template – contact tree, roles and staging register

Section E • Venue internal emergency contact tree

ROLE	NAME	MOBILE	RADIO CALL SIGN
General manager / venue VP			
Director of security			
Venue medical officer / lead paramedic			
Risk management and legal counsel			
Public information officer (PIO)			
Promoter / event producer on site			
Facilities / engineering lead			

Section F • Designee roles and responsibilities matrix

ROLE	RESPONSIBILITY	PRIMARY (NAME)	ALTERNATE (NAME)
Incident commander (venue)	Owens the stop-the-show and decompression calls; unified command with police/fire		
Triage officer / CCP lead	START triage, MARCH, casualty count, MIST hand-off		
Evacuation coordinator	Corridors, litters, routes to the loading point, crowd movement		
Gate marshal	Emergency ingress gate, vest, rig guidance to the CCP loading point		
Dispatch communicator	Reads the 911 script (p. 13); keeps the line; five-minute count updates		
LZ officer	Sets and holds the landing zone (p. 14); ground contact with the aircraft		
Training and records officer	Certification roster, drill log, walkaround file, AED registry		

Section G • Staging register (summary – detail on the floor plan)

ZONE	TIER 1 KITS ISSUED	TIER 2 STATIONS	AEDs	LITTERS	THROW BAGS	CCPs DESIGNATED
A • Gates						
B • Concourse						
C • Pit / floor						
D • Command						

PREPARED BY (NAME, TITLE)	DATE	REVIEWED WITH FIRE MARSHAL / EMS COORDINATOR	DATE	FLOOR PLAN SHEETS





SECTION 16

Post-incident casualty report – Form MTC-EVT-INC

One form per casualty, completed by the staff member who rendered care before the end of shift, countersigned by the security incident commander, filed with the event record and the insurer's incident file. It is the legal record of what was done and when.

Incident overview

DATE	TIME OF INCIDENT	EVENT / ARTIST	SECTION / SEAT / GATE / ZONE
MECHANISM (MEDICAL COLLAPSE · FALL · CRUSH · PENETRATING · ALTERCATION · HEAT · OVERDOSE · OTHER)		DISCOVERED BY (NAME / POST)	

Casualty information

NAME	AGE	SEX	TICKET / SEAT	EMERGENCY CONTACT NOTIFIED (NAME / TIME)

On-site interventions rendered

INTERVENTION	BY (STAFF NAME)	DETAIL	TIME
Tourniquet			
Hemostatic gauze / packing			
Vented chest seal			
CPR / AED			
Naloxone			
Cooling / other			

Transfer of care to municipal EMS

TRANSPORTING AGENCY AND UNIT #	LEAD PARAMEDIC NAME / BADGE	TIME OF TRANSFER	DESTINATION FACILITY
MIST REPORT GIVEN (MECHANISM · INJURIES · SIGNS · TREATMENT) – SUMMARIZE		AIR-MEDICAL TAIL # (IF FLOWN)	

NARRATIVE · WITNESSES · EQUIPMENT USED AND RESTOCK REQUIRED · CORRECTIVE ACTIONS

CARE PROVIDER SIGNATURE	SECURITY INCIDENT COMMANDER CERTIFICATION AND SIGNATURE	DATE





THE AMBULANCE IS AT THE GATE. YOUR STAFF IS AT THE PATIENT.

FREQUENTLY ASKED QUESTIONS

Can contract security officers legally apply tourniquets and hemostatic gauze?

In most U.S. jurisdictions, Good Samaritan statutes and the employer's duty-of-care framework cover trained staff who render bleeding control and CPR/AED in good faith. Statutes vary by state and some condition protection on training; have venue counsel confirm your state's statute and write the answer into Section A of the EAP. This guide is not legal advice.

How do we keep concourse bleeding stations from being stolen or vandalized?

Alarmed wall cabinets with serialized break-away tamper seals: the seal is checked on every shift-change walkaround (p. 15), the alarm deters opportunistic tampering, and nothing stands between a bystander and the kit in a real emergency.

How many bleeding-control stations does a venue need?

MED-TAC planning ratio: at least one Tier 2 station per 1,000 attendees of licensed occupancy, and never more than 200-250 ft of walking path from any public position, placed beside the AEDs. NFPA 3000 requires the program and the plan; it does not set a ratio — the ratio is ours, and the AED reach standard on p. 7 is the binding constraint.

How do we set up Net 30 purchasing for the venue?

Verified government agencies, public institutions and established corporate venue operators can request Net 30 on an institutional purchase order or quote through the logistics portal below; quotes are valid 45 days. All others pay in full at order.

EVENT SECURITY SOLUTIONS HUB: THE THREE-TIER VENUE STANDARD

tactical-medicine.com/pages/event-security-medical-preparedness



B2B QUOTES, BILL-OF-MATERIALS UPLOAD AND INSTITUTIONAL PROCUREMENT

tactical-medicine.com/pages/medical-logistics-rfq-services



CLINICAL DIRECTION

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LEGAL DISCLAIMER

This guide is educational doctrine for venue operators and security personnel and does not replace hands-on training, the venue medical director's standing orders, medical direction, state scope-of-practice or Good Samaritan law, the authority of the fire marshal and permitting agency, or the judgment of trained responders on scene. Naloxone and airway adjuncts are used only under the venue medical program and state law. Standards cited were current when published and change; verify them before relying on them. Nothing here is legal advice. No government endorsement is implied. © 2026 MED-TAC International Corp. Free to share unmodified within your organization; not for resale.

INSTITUTIONAL PROCUREMENT & CONSULTATION DIRECTORY

Bleeding control catalog: tactical-medicine.com/collections/massive-hemorrhage · CPR/AED: tactical-medicine.com/collections/cpr-aed

Event security solutions hub: tactical-medicine.com/pages/event-security-medical-preparedness

Guide download: tactical-medicine.com/pages/event-security-venue-readiness-guide

B2B quote and logistics sourcing: tactical-medicine.com/pages/medical-logistics-rfq-services

Institutional procurement: tactical-medicine.com/pages/institutional-procurement

Direct logistics inquiries: info@tactical-medicine.com · Customer service: (850) 409-9628

Mailing address (correspondence and authorized returns only — not a walk-in location):

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