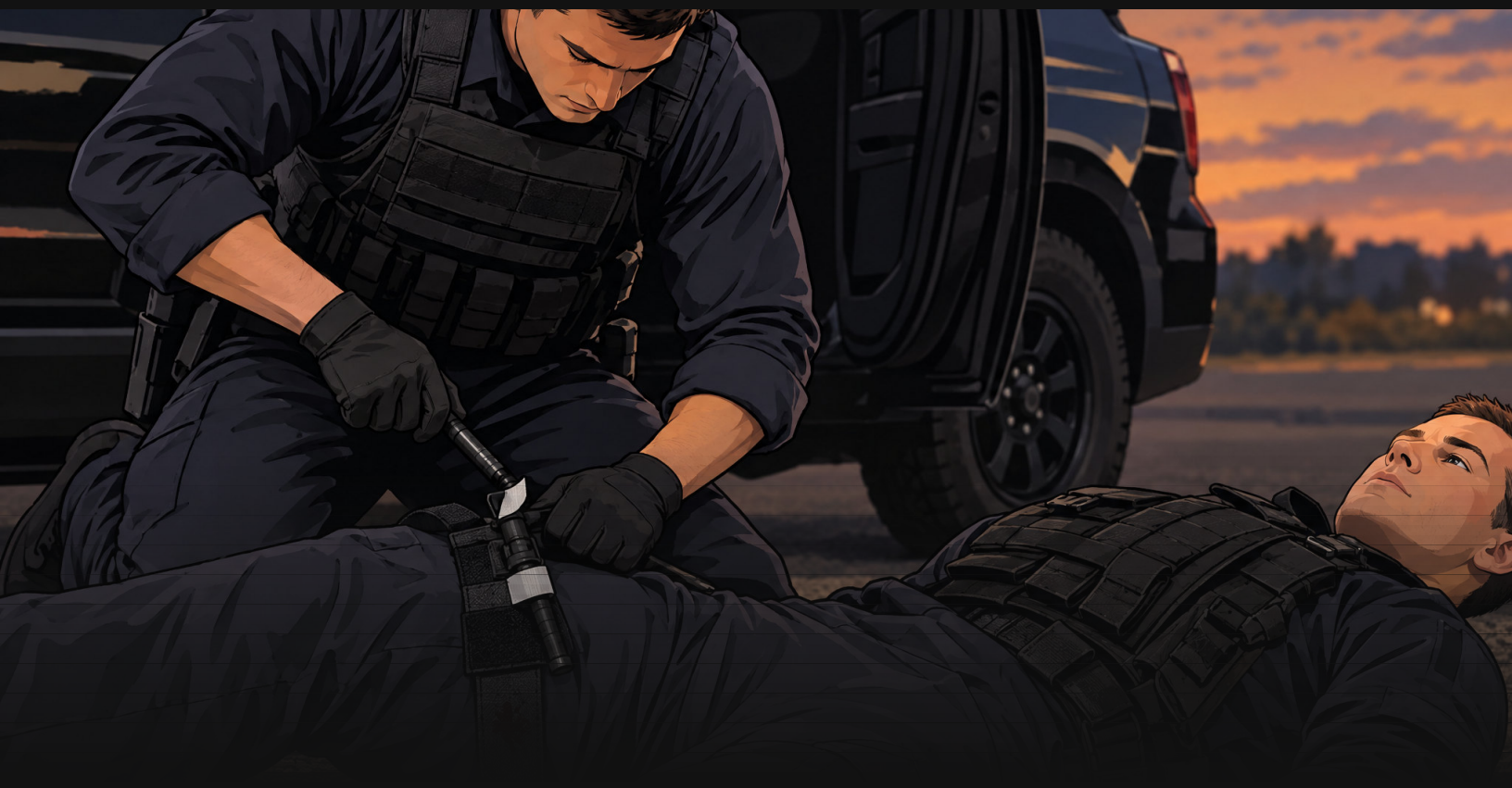


LAW ENFORCEMENT · FOR POLICE CHIEFS, SHERIFFS, ACADEMY DIRECTORS & TACTICAL SUPERVISORS

TACTICAL MEDICAL READINESS AUDIT
FOR LAW ENFORCEMENT

A Defensible Agency Self-Assessment for Police Chiefs, Sheriffs, and Training Leadership

"Doctrine Before Gear. Competency Before Equipment. Accountability Always."

6	36	12	30/60/90
AUDIT SECTIONS	SCORED ITEMS	POINTS PER SECTION	DAY ACTION PLAN

Marco R. Torres, MD, NRP — physician and medical educator, U.S. Navy veteran, founder of MED-TAC and ALKEONHealth.com

Medical SME Veteran-Led · Evidence-based prehospital trauma standards · Interactive scoring with an auto-calculated readiness index

Service-Disabled Veteran-Owned Small Business (SDVOSB) | SAM Registered | CAGE: 9VFL3 | UEI: YU3ZMJ44REA5 | Kits Assembled in the USA

EXECUTIVE SUMMARY

The gap before EMS is the patrol officer's problem

On a shooting, a stabbing, a crash, or a workplace injury, the first person at the side of the casualty with equipment and authority is a patrol officer. Emergency medical services arrive later, and on the calls that matter most, an active threat, the ambulance stages until law enforcement declares the scene safe enough to enter. During that gap, the officer is the definitive care provider, and the only interventions that count are the ones the officer carries, has practiced, and is authorized to perform.

< 3 min
A transected femoral artery can produce fatal blood loss in under three minutes. Nothing that arrives later helps.

7 → 14 min
Median EMS response time in a study of 1.7 million U.S. activations: about 7 minutes overall, about 14 minutes in rural areas, and nearly 1 in 10 rural calls waited close to 30 minutes.

30–40%
of trauma deaths are caused by hemorrhage, the leading cause of preventable death after injury.

90% vs 10%
Survival when a tourniquet was applied before the onset of shock, versus after, in the largest combat tourniquet study.

Sources: Kauvar 2006; Mell 2017; Kragh 2009. Full references on page 35.

What this audit measures

Whether the agency can deliver evidence-based prehospital trauma care during that gap, and prove it. Six sections cover the things that decide the outcome in order of leverage: **doctrine and medical direction** (Section 1), **the kit on every officer** (Section 2), **the kit in every vehicle and its survival in the trunk** (Section 3), **training that survives stress and time** (Section 4), **the joint response with fire and EMS** (Section 5), and **the debrief, data, and support that turn incidents into improvement** (Section 6). Each section has six scored items on a 12-point scale and a printable tool the agency can put to work the same week.

Why leadership, not the training sergeant, owns this

Every item in this audit is a policy decision, a budget line, or a supervisory habit before it is a medical skill. Tourniquets on belts are a procurement decision. Semiannual drills are a scheduling decision. Standing orders are a medical-direction agreement the chief signs. The training sergeant can run the drill; only command can make the program exist, fund it, and defend it when a family's attorney asks what the agency knew and when.

The core tenet

Doctrine Before Gear. Competency Before Equipment. Accountability Always. Gear without doctrine is inventory. Doctrine without competency is paper. Both without accountability are what a plaintiff's expert finds in discovery. This audit scores all three.

EXECUTIVE SUMMARY

Who uses this audit, and how to read the result

ROLE	WHAT YOU GET FROM IT
Chief / Sheriff	A defensible record of the agency's trauma-care program, a prioritized gap list, and a 30/60/90-day plan that fits a budget cycle and a council briefing.
Training commander / academy director	A skills standard with timed benchmarks, a drill cadence that beats skill decay, and a scorecard the state training board will recognize.
Patrol and tactical supervisors	Inspection logs, vehicle inventories, and a thermal protocol that keep the kit on the belt and in the cruiser usable.
Medical director / EMS partner	A scope-of-practice checklist, standing-order template, and joint rescue task force SOP outline to sign and file.
Grants and procurement staff	The documentation package a grant audit asks for: component specifications, vendor data, training records, inspection logs.

How to read your result

Section-level results matter more than the total. A strong overall index can hide a zero on medical direction or on the duty kit, and those are the items an expert witness reads first. The four critical items (1.2b, 2.1a, 2.3a, 4.1a) cap the agency at the middle tier whatever the index says, because an agency cannot be called defensible while its officers carry unauthorized devices, uninspected kits, or no standing orders.

What changed in Revision 2.0

Statutory landscape (pages 4–5): the federal trauma-kit standards for Byrne JAG-funded purchases enacted in December 2025, and the duty-of-care framework that applies to officers and to people in custody.

Cruiser thermal management (Section 3): staged inspection and rotation protocols for hydrogel chest seals and hemostatic dressings that spend the summer in a trunk.

Fentanyl and naloxone doctrine (Section 4): the current toxicology position on incidental exposure, and what officers should actually carry, wear, and do.

Body-worn camera documentation and evidence preservation (Section 1): a workflow that protects the case without delaying hemorrhage control.

30/60/90-day corrective action pathway (Section 7): a leadership roadmap for closing doctrine, procurement, and training gaps inside one quarter.

EVIDENCE	WHAT IT MEANS FOR THE AGENCY	AUDITED IN
Hemorrhage is the leading cause of preventable death after injury	Tourniquets and hemostatic gauze on every officer, and the authority to use them	Sections 1, 2
EMS arrives in minutes; on active threats it stages until the scene allows entry	Officer self-aid and partner aid, vehicle kits, and a rescue task force agreement	Sections 2, 3, 5
Trauma skills decay measurably inside six months	Semiannual practical drills and timed, stress-loaded evaluation	Section 4
Vehicle interiors exceed the storage ranges printed on medical adhesives	Thermal management, rotation, and inspection for fleet kits	Section 3

STATUTORY MANDATES & 2026 LEGAL LANDSCAPE

The Improving Police CARE Act: what it does and does not do

The Improving Police CARE Act (introduced as S. 1595 and H.R. 5864 in the 119th Congress) was enacted in December 2025 as part of the National Defense Authorization Act for fiscal year 2026. It amends the Edward Byrne Memorial Justice Assistance Grant (JAG) program, the largest federal source of general criminal justice funding for state and local agencies, in three ways that matter to this audit.

PROVISION	WHAT IT REQUIRES	WHAT IT MEANS FOR YOUR AGENCY
Trauma kits as an eligible JAG use	Confirms that trauma kits and related training are an allowable use of Byrne JAG funds.	You can fund standardized duty and vehicle kits, and the training to use them, from an existing grant stream instead of a new budget line.
Minimum performance standards	Directs the Bureau of Justice Assistance to publish minimum standards for trauma kits purchased with JAG funds, built around bleeding-control supplies: tourniquets, bandages or dressings, non-latex gloves, scissors, and printed instructions.	Kits bought with federal money must meet the published standard, and the agency must be able to show component-level compliance at audit.
Best practices for training, deployment, and maintenance	Directs BJA to publish optional best practices for training officers to use the kits and for deploying and maintaining them in vehicles and facilities.	The best practices become the reasonable-agency benchmark even where they are not mandatory. Sections 2, 3, and 4 of this audit are built to that benchmark.

Mandate or eligibility standard?

The Act does not order every agency in the country to buy trauma kits. It sets the standard for kits bought with federal grant money and creates a published federal benchmark for what a trauma kit is, how officers are trained on it, and how it is maintained. That distinction cuts both ways. An agency that never touches JAG money is not bound by the purchase standard. Every agency, however, will be measured against the published best practices the next time a casualty outcome is litigated, because a national benchmark is exactly what a reasonable-agency argument is built on.

Budget defense: how to use it

Map your duty and vehicle kit specification (page 35) to the component categories the statute names, and keep the vendor invoice that lists each component and manufacturer.

Cite the Act, the JAG eligibility, and the BJA standards in the justification memo for the kit line and the training line. Attach this audit's Section 2 and Section 4 scores as the needs statement.

Keep the training records, quarterly inspection logs (Section 2 printable), and vehicle inventories (Section 3 printable) together. That package is what a grant monitor asks for.

Check the BJA publication status of the performance standards and best practices before each procurement cycle; the statute set a deadline in 2026, and the published text controls.

Statutory references: Improving Police CARE Act, S. 1595 / H.R. 5864 (119th Congress), enacted through the FY2026 National Defense Authorization Act; Edward Byrne Memorial Justice Assistance Grant Program, 34 U.S.C. § 10151 et seq. Confirm current text at congress.gov and bja.ojp.gov.

STATUTORY MANDATES & 2026 LEGAL LANDSCAPE

Duty of care: where agency exposure actually lives

No single federal statute says a patrol officer must apply a tourniquet. The exposure is assembled from several sources, and each one is answered by a section of this audit.

SOURCE OF DUTY	WHAT IT SAYS	AUDITED IN
People in custody (Fourteenth and Eighth Amendment claims under 42 U.S.C. § 1983)	Deliberate indifference to the serious medical needs of a detainee or arrestee is a constitutional violation. An officer who has the equipment and the training, and does not act, is the fact pattern these cases turn on.	Sections 1, 2, 6
State EMS statutes and standing orders	Which interventions a non-EMS officer may perform, and under whose authority, is set by state law and the agency's medical director. Acting outside it is unprotected; having no medical direction at all is the larger exposure.	Section 1
Good Samaritan and public-duty doctrines	Vary by state; generally protect good-faith care but rarely protect an agency that issued equipment it never trained anyone to use.	Sections 1, 4
Employer obligations (OSHA 29 CFR 1910.151; state plans)	Employers must ensure prompt first aid and adequate supplies where medical care is not near. Officers are employees before they are responders.	Sections 2, 3
Published national benchmarks	BJA trauma-kit standards and best practices; NFPA 3000 for active shooter and hostile event response programs; state training-board standards.	Sections 2–5
Duty to the public and to partners	The reasonable-agency standard: what comparable agencies write, issue, train, and document. The published benchmarks above define "comparable."	All

What a defensible program looks like in discovery

Plaintiffs' counsel will request the policy, the standing orders, the training records, the inspection logs, the purchase records for the devices, and the body-worn camera footage. A defensible agency produces each one from a file, and they agree with each other. The printables in this audit exist so that those files exist.

Documentation the agency should be able to produce within one business day

	RECORD	WHERE THIS AUDIT BUILDS IT
☐	Signed operational medical policy with review dates	Section 1 printable
☐	Medical direction agreement and standing orders	Section 1 printable
☐	Component specification and vendor invoices for issued devices	Page 35; Section 2
☐	Quarterly kit inspection logs by officer	Section 2 printable
☐	Vehicle kit inventories and thermal logs	Section 3 printable
☐	Training records with timed skill results	Section 4 printable
☐	Joint rescue task force SOP and exercise after-action reports	Section 5 printable
☐	Medical after-action reviews and intervention data	Section 6 printable

This page describes exposure in general terms for planning purposes. It is not legal advice. Agency counsel and the medical director should review the policy, standing orders, and retention decisions.

HOW TO CONDUCT THE AUDIT

Score what exists today, from evidence

The audit takes a small team about half a day if the records exist and about two days if they have to be found. The second case is itself a finding.

Who completes it

Audit lead: a command-level owner (deputy chief, division commander, or chief deputy) who can direct records requests and sign the result.

Training commander for Sections 4 and 5; **patrol and fleet supervisors** for Sections 2 and 3; **the medical director or EMS liaison** for Sections 1 and 6.

Grants or procurement staff to assemble the documentation package as the audit runs.

Rules of evidence

Score from what you can produce, not from what you believe. A policy that exists in a captain's head is a PARTIAL. A drill that happened but was not recorded is a PARTIAL. A device that cannot be traced to an authorized source is a NO. If you cannot show it, you cannot defend it, and the score should say so.

Sequence

STEP	ACTION	OUTPUT
1	Read pages 2–7. Agree on the rating definitions before scoring anything.	Shared standard
2	Pull the records list on page 5. Note which ones do not exist.	Records inventory
3	Physically inspect a sample of duty kits and vehicle kits. Open them. Check lots and dates.	Inspection sample
4	Score each section from the evidence. Use N/A only where the item cannot apply.	Section scores
5	Complete the matrix (page 32), the gate check and sign-off (page 33).	Index and tier
6	Build the 30/60/90-day plan (page 34). Assign an owner and a date to every 0 and 1.	Action plan
7	Brief command. Set the re-audit date. File the audit with the records it references.	Program record

Digital or print

Each item has four rating buttons: YES, PARTIAL, NO, and N/A. In Adobe Acrobat or another reader that runs form calculations, the points, section subtotals, applicable maximums, percentages, the readiness index, and the tier fill in automatically. On paper, circle the rating and add the points by hand using the legend on page 7.

SCORING METHODOLOGY

Four ratings, twelve points per section, one index

RATING	POINTS	MEANING
YES	2	Fully institutionalized: written in policy, resourced, and verifiable from records or a physical check.
PARTIAL	1	Informal, unwritten, or inconsistently executed across shifts, units, or precincts.
NO	0	Missing or non-functional.
N/A	—	Does not apply to the agency's jurisdiction or mission (for example, no K-9 unit). Removed from the section maximum; not a way to skip a hard item.

Section score

Each section has six items and a maximum of **12 points**. Items rated N/A are removed from the maximum, so a section with one N/A is scored out of 10. The section percentage is the subtotal divided by the applicable maximum.

SECTION RESULT	POINTS (OF 12)	PERCENT	WHAT IT MEANS
DEFENSIBLE	10–12	83–100%	Mature, documented, verified. Sustain and re-audit annually.
MODERATE	6–9	50–82%	Capability exists but is informal or uneven. Formalize policy, standardize gear, and record what you already do.
HIGH LIABILITY EXPOSURE	0–5	Below 50%	Missing or non-functional. Requires immediate ground-up restructuring with command ownership.

Readiness index and tiers

The readiness index is the sum of all section subtotals divided by the sum of all applicable maximums, times 100. With no N/A items the maximum is 72 points. The index uses the same three bands as the sections.

Critical-item gate. Four items are marked CRITICAL ITEM: **1.2b** (standing orders for the interventions officers carry), **2.1a** (a standardized, agency-issued duty kit on every officer), **2.3a** (quarterly logged inspection), and **4.1a** (initial hands-on qualification). A NO on any of them caps the agency at MODERATE regardless of the index, and the tier field says why.

Scoring honesty

The audit is only useful if the numbers are true. Score the agency you have, not the one in the strategic plan. A low score is a budget argument, a training calendar, and a policy draft. A falsely high score is a liability with a date on it.

SECTION 1 · DOCTRINE

1 AGENCY-LEVEL DOCTRINE, POLICY & MEDICAL DIRECTION

An agency treats the wounded the way its policy says it will. Without written doctrine and a medical director behind it, every officer improvises, and every improvisation is discoverable.

6 AUDIT ITEMS · MAXIMUM 12 POINTS · SCORING ON PAGE 10



Why it matters

The agency with a written policy, a named medical director, and standing orders can show a jury exactly what it authorized and trained. The agency without them is asked why an officer with a tourniquet on the belt had no authority to use it, or why one without a tourniquet was sent to a shooting. Every other section of this audit rests on this one.

SECTION 1 · STANDARDS

Agency-Level Doctrine, Policy & Medical Direction

1.1 Written operational medical policy

A formal SOP defines the care phases (direct threat, indirect threat, evacuation), delineates officer self-aid, partner aid, and the triage of bystanders and suspects, and is reviewed by executive command every year.

1.2 Dedicated medical direction and scope of practice

A designated operational medical director (a physician or an authorized EMS medical authority) signs standing orders for sworn non-EMS personnel covering tourniquets, hemostatic gauze, pressure dressings, chest seals, and naloxone, inside the state emergency medical statute and the jurisdiction's duty-of-care framework.

1.3 Chain of custody and legal documentation

Interventions are documented on body-worn camera and in the incident record. Evidence is preserved when clothing is cut or a suspect is treated. Incidents are tracked in a format the EMS partner and the agency records system can both read.

Standing orders: what each intervention needs behind it

INTERVENTION	STANDING ORDER MUST STATE	EVIDENCE THE AUDITOR LOOKS FOR
Limb tourniquet	Indication (life-threatening extremity bleeding), placement, time marking, no field removal	Signed order; training record per officer
Hemostatic gauze and packing	Indication (junctional or deep wounds not controlled by a tourniquet), hold time, no removal	Signed order; flowing-trainer drill record
Pressure dressing	Indication and reassessment	Signed order
Vented chest seal	Indication (penetrating chest/back), entry and exit, burping, monitoring	Signed order; drill record
Intranasal naloxone	Indication (hypoventilation), dose, repeat interval, monitoring, EMS notification, disposal	Signed order; expiration tracking
Care of persons in custody	Same interventions apply; document and hand off; evidence preserved without delaying care	Policy section 1.3; BWC review sample

NOTES

SECTION 1 · SCORING

Agency-Level Doctrine, Policy & Medical Direction

#	SECTION 1 — AUDIT ITEM	YES	PART.	NO	N/A	PTS
1.1a	A written operational medical policy exists that defines the care phases (direct threat / indirect threat / evacuation) and who treats whom: self-aid, partner aid, bystanders, and suspects in custody.	○	○	○	○	
1.1b	The policy carries an executive signature dated within the last 12 months, and every sworn member has acknowledged it in training records.	○	○	○	○	
1.2a	A designated operational medical director is named in writing, with a signed agreement that defines their authority over protocols, training, and quality review.	○	○	○	○	
1.2b	Standing orders for sworn non-EMS personnel cover tourniquets, hemostatic gauze, pressure dressings, vented chest seals, and naloxone, and cite the state EMS statute and immunity provisions that apply. CRITICAL ITEM	○	○	○	○	
1.3a	The documentation SOP requires the tourniquet time, interventions, and handoff to be narrated on body-worn camera and entered in the incident report, and the agency can retrieve them.	○	○	○	○	
1.3b	An evidence-preservation workflow exists for cutting clothing, treating suspects, and handling projectiles or fragments, and it states that hemorrhage control is never delayed for evidence.	○	○	○	○	
	SECTION 1 SUBTOTAL · APPLICABLE MAXIMUM		/			

SECTION RESULT	
	DEFENSIBLE 83–100% · MODERATE 50–82% · HIGH LIABILITY EXPOSURE below 50%

Gaps to close

ITEM	GAP TO CLOSE	OWNER	DUE

SECTION 1 · PRINTABLE TOOL

Operational medical policy: required elements checklist

Use this as the outline for the policy, or as the review checklist for the one you have. Every element maps to an audit item.

	POLICY ELEMENT	ITEM
☐	Purpose, scope, and definitions: direct threat, indirect threat, evacuation phases	1.1a
☐	Priorities of care: self-aid, partner aid, bystanders, suspects in custody	1.1a
☐	Authorized interventions and the standing order that authorizes each	1.2b
☐	Medical director: name, authority, review responsibilities, agreement on file	1.2a
☐	Equipment standard: issued kit contents, wear location, prohibited personal devices	2.1a, 2.2b
☐	Inspection cadence, replacement cache, and expiration management	2.3a, 2.3b
☐	Documentation: body-worn camera narration, incident report fields, tourniquet time	1.3a
☐	Evidence preservation during care: clothing, projectiles, photographs, never delay hemorrhage control	1.3b
☐	Training standard and cadence, with timed benchmarks	4.1a, 4.1b, 4.2a
☐	Opioid exposure and naloxone protocol	4.3a, 4.3b
☐	Joint response: rescue task force SOP reference and casualty collection points	5.1a, 5.1b
☐	After-action review, data tracking, peer support activation	6.1a, 6.2a, 6.3a
☐	Annual executive review with signature and date	1.1b

Medical direction agreement: minimum contents

	CLAUSE
☐	Identity and credentials of the medical director; authority under the state EMS statute
☐	Interventions authorized for sworn non-EMS personnel, by name, with contraindications
☐	Training required before authorization, and the refresher interval
☐	Quality review: which incidents are reviewed, by whom, and how findings return to training
☐	Naloxone: indication, dose, repeat interval, monitoring, and disposal
☐	Term, renewal, and the process for protocol changes

SECTION 2 · OFFICER GEAR

2 INDIVIDUAL OFFICER MEDICAL GEAR & DUTY STANDARDIZATION

The kit on the belt is the only kit that is always at the scene. It has to be the same kit on every officer, in the same place, with authentic devices inside.

6 AUDIT ITEMS · MAXIMUM 12 POINTS · SCORING ON PAGE 14



Why it matters

Counterfeit and expired tourniquets fail under load; a published 2024 case report documented a counterfeit windlass fracturing during evacuation. A kit that is not on the officer is not at the scene. Standardization is what lets a partner find the tourniquet on a downed officer in the dark.

SECTION 2 · STANDARDS

Individual Officer Medical Gear & Duty Standardization

2.1 Standardized duty IFAK configuration

Every sworn officer carries an agency-issued kit with identical contents verified by clinical performance: an authentic windlass or ratcheting limb tourniquet, hemostatic gauze with a proven clotting agent (kaolin or chitosan), a pressure dressing with an integrated occlusion pad, vented chest seals in a two-pack, nitrile exam gloves, trauma shears, and a permanent marker.

2.2 Ambidextrous accessibility and wear location

The agency prescribes where the kit rides (duty belt center-back, vest front, or drop mount). Every officer can deploy the tourniquet with either hand, without looking, in 20 seconds. Uninspected personal medical devices are prohibited.

2.3 Inspection and expiration management

Supervisors inspect every kit quarterly for seal integrity, heat and UV damage, and expiration, and log it. Expended or expired items are replaced the same shift from a precinct cache.



Tourniquet placement standard for training and evaluation: on bare skin, two to three inches above the wound, never over a joint; high and tight only under threat or when the source is hidden. Second tourniquet side-by-side if bleeding continues. Illustration.

SECTION 2 · SCORING

Individual Officer Medical Gear & Duty Standardization

#	SECTION 2 — AUDIT ITEM	YES	PART.	NO	N/A	PTS
2.1a	Every sworn officer carries an agency-issued IFAK with the standard contents: authentic windlass or ratcheting tourniquet, hemostatic gauze (kaolin or chitosan), pressure dressing, two vented chest seals, nitrile gloves, trauma shears, permanent marker. CRITICAL ITEM	○	○	○	○	
2.1b	Tourniquets and hemostatic gauze are purchased only from the manufacturer or an authorized distributor, lot numbers are recorded at intake, and a counterfeit check is part of receiving.	○	○	○	○	
2.2a	The wear location is standardized, and every officer has demonstrated a blind, either-hand tourniquet deployment in 20 seconds or less within the last 12 months.	○	○	○	○	
2.2b	Personally purchased medical devices are prohibited unless inspected and listed on a written approved-equipment list.	○	○	○	○	
2.3a	Quarterly supervisor inspections check seal integrity, heat/UV damage, and expiration dates, and are logged by officer and kit serial. CRITICAL ITEM	○	○	○	○	
2.3b	A replacement cache at every precinct lets an officer swap an expended or expired item before the next shift, without a purchase request.	○	○	○	○	
	SECTION 2 SUBTOTAL · APPLICABLE MAXIMUM		/			

SECTION RESULT	
	DEFENSIBLE 83–100% · MODERATE 50–82% · HIGH LIABILITY EXPOSURE below 50%

Gaps to close

ITEM	GAP TO CLOSE	OWNER	DUE

SECTION 2 · PRINTABLE TOOL

Quarterly duty kit inspection log

One row per officer per quarter. Supervisors initial. Any NO in the last three columns triggers a same-shift swap from the precinct cache and a note in the remarks.



Quarterly inspection: the duty kit laid out item by item, the supervisor working the checklist, the pouch checked for seal integrity and heat damage before it goes back on the belt. Illustration.

OFFICER / ID	KIT SERIAL	SEAL OK	CONTENTS OK	IN DATE	LOT LOGGED	SUPV.	DATE

Remarks and swaps

ITEM SWAPPED · REASON · CACHE LOCATION · INITIALS

SECTION 3 · FLEET

3 PATROL VEHICLE STAGING, FLEET EQUIPMENT & THERMAL MANAGEMENT

The cruiser is the second echelon of care and the worst place to store medical adhesives. Every marked unit needs the same kit, in reach, and protected from the trunk.

6 AUDIT ITEMS · MAXIMUM 12 POINTS · SCORING ON PAGE 18



Why it matters

Closed vehicles in sun reach interior temperatures far above ambient within an hour, and hydrogel chest seals and hemostatic dressings carry storage ranges that a summer trunk exceeds daily. The vehicle kit also carries what the belt cannot: multiple tourniquets, packing gauze, a litter.

SECTION 3 · STANDARDS

Patrol Vehicle Staging, Fleet Equipment & Thermal Management

3.1 Fleet standardization

A standard trauma response kit rides in every marked unit where the driver can reach it. Multi-casualty bleeding-control bags with multiple tourniquets and packing gauze, plus compact litters, are assigned to designated units.

3.2 Thermal shelf-life management

Closed vehicles reach interior temperatures far above the storage ranges printed on hydrogel chest seals and hemostatic dressings. A written protocol names where kits are staged, how they are shielded, and when they are rotated and inspected.

3.3 Specialty elements: K-9 and tactical units

K-9 handlers carry a canine trauma loadout and train with the unit veterinarian. Breaching and tactical teams stage eye and burn adjuncts and extended-capability kits.



The trunk in summer: convenient staging, hostile storage. Insulate, rotate, log. Illustration.

SECTION 3 · SCORING

Patrol Vehicle Staging, Fleet Equipment & Thermal Management

#	SECTION 3 — AUDIT ITEM	YES	PART.	NO	N/A	PTS
3.1a	Every marked unit carries a standard vehicle trauma kit, inventoried to a fixed list, staged where the driver can reach it without leaving the vehicle (headrest, seatback, or console).	○	○	○	○	
3.1b	Designated units carry a multi-casualty bleeding-control bag (multiple tourniquets, packing gauze, dressings) and a compact drag or soft litter.	○	○	○	○	
3.2a	A written thermal management protocol exists: manufacturer storage ranges on file, cabin-versus-trunk staging rule, seasonal inspection, and replacement triggers.	○	○	○	○	
3.2b	Trunk-staged kits are in an insulated case, on a rotation schedule, with a temperature log or indicator that supervisors check.	○	○	○	○	
3.3a	K-9 handlers carry a canine trauma loadout (sized tourniquet, dressings, muzzle) and have trained with the unit veterinarian in the last 12 months.	○	○	○	○	
3.3b	Tactical, breaching, and specialty units stage rigid eye shields, burn dressings, and extended kits matched to their mission profile.	○	○	○	○	
	SECTION 3 SUBTOTAL · APPLICABLE MAXIMUM		/			

SECTION RESULT	
	DEFENSIBLE 83–100% · MODERATE 50–82% · HIGH LIABILITY EXPOSURE below 50%

Gaps to close

ITEM	GAP TO CLOSE	OWNER	DUE

EVIDENCE REVIEWED / NOTES

SECTION 3 · PRINTABLE TOOL

Vehicle kit inventory and thermal log

One sheet per unit, kept with the vehicle file. The thermal columns are the evidence for items 3.2a and 3.2b.

UNIT #	KIT LOCATION	CASE TYPE	LAST FULL INVENTORY	INSPECTED BY

ITEM	QTY	LOT	EXP.	STORAGE RANGE (MFR)	OK
Tourniquets (windlass or ratcheting)					
Hemostatic gauze					
Pressure dressings					
Vented chest seals (pairs)					
Compressed gauze					
Nitrile gloves					
Trauma shears / marker					
Survival blanket					
Naloxone (intranasal)					
Soft or drag litter					
Multi-casualty bag (if assigned)					

Trunk temperature log (indicator or logger)

DATE	AMBIENT	TRUNK / CABIN	ABOVE MFR RANGE?	ACTION	INITIALS

Rotate any adhesive-based item that has spent a summer above the manufacturer's storage range, whether or not it looks intact. Adhesive failure is discovered on the casualty.

SECTION 4 · TRAINING

4 TRAINING REALISM, STRESS INOCULATION & SKILLS SUSTAINMENT

A skill that was demonstrated once at the academy is not a skill the officer has tonight. Trauma skills decay in months and survive only under rehearsed stress.

6 AUDIT ITEMS · MAXIMUM 12 POINTS · SCORING ON PAGE 22



Why it matters

A prospective study of bleeding-control course graduates found that six months after training, 39% failed the tourniquet skill test and 26% could not control life-threatening bleeding on the trainer. Skills decay in months. Only a cadence beats that, and only stress-loaded evaluation proves it.

SECTION 4 · STANDARDS

Training Realism, Stress Inoculation & Skills Sustainment

4.1 In-service training cadence

Recruits complete 8 to 16 hours of hands-on trauma qualification. Every sworn member repeats practical drills at least every six months, and medical care is built into live-fire, shoot-house, and use-of-force simulator training instead of taught in isolation.

4.2 Objective evaluated competencies

Self-application of a tourniquet under stress in under 30 seconds; wound packing on trainers with flowing fluid, not static foam; low-light and one-handed skills with weapon retention.

4.3 Opioid reversal and responder safety doctrine

An evidence-based fentanyl exposure protocol that retires the passive-skin-contact myth while preparing for real aerosol and ingestion hazards, with intranasal naloxone standing orders and dosing.



Self-application under stress: one hand, weapon retained and pointed safely, timed. Illustration.

SECTION 4 · SCORING

Training Realism, Stress Inoculation & Skills Sustainment

#	SECTION 4 — AUDIT ITEM	YES	PART.	NO	N/A	PTS
4.1a	Every recruit completes 8 to 16 hours of hands-on trauma qualification before solo patrol, and the record is on file. CRITICAL ITEM	○	○	○	○	
4.1b	Every sworn member completes a practical trauma drill at least every 6 months, and medical care is integrated into firearms, defensive tactics, or simulator training at least once a year.	○	○	○	○	
4.2a	Officers are timed on self-application of a tourniquet under stress: under 30 seconds, either hand, one-handed, in low light. Results are recorded.	○	○	○	○	
4.2b	Wound packing is trained and tested on trainers with active fluid flow; chest seal application and recovery positioning are part of the drill.	○	○	○	○	
4.3a	The fentanyl exposure protocol follows current toxicology guidance: nitrile gloves, hand washing with soap and water, no routine respirator, N95 or P100 only for visible powder or aerosol, naloxone only for hypoventilation.	○	○	○	○	
4.3b	Intranasal naloxone is carried on the officer or in the vehicle kit under a standing order with dosing, repeat timing, and post-dose monitoring, and expirations are tracked.	○	○	○	○	
	SECTION 4 SUBTOTAL · APPLICABLE MAXIMUM		/			

SECTION RESULT	
	DEFENSIBLE 83–100% · MODERATE 50–82% · HIGH LIABILITY EXPOSURE below 50%

Gaps to close

ITEM	GAP TO CLOSE	OWNER	DUE

EVIDENCE REVIEWED / NOTES

SECTION 4 · PRINTABLE TOOL

Skills scorecard and naloxone protocol card

Timed evaluation record for one officer. Benchmarks are the audit standard; the medical director may set stricter ones.

SKILL	BENCHMARK	TIME / RESULT	PASS	EVALUATOR	DATE
Self-application, tourniquet, dominant hand	≤ 30 s, bleeding stopped				
Self-application, non-dominant hand	≤ 30 s				
Blind deployment from wear location	≤ 20 s, either hand				
Partner tourniquet, low light	≤ 45 s, 2–3 in above wound, not on a joint				
Wound packing, flowing trainer	Cavity filled, 3-min hold, no bleed-through				
Vented chest seal, front and back	Seal on both wounds, burp demonstrated				
Recovery position and reassessment	Correct side, airway open, recheck stated				
Intranasal naloxone	Indication stated, dose given, monitoring stated				

Opioid exposure and naloxone: protocol card

SITUATION	DO	DO NOT
Powder or residue on a surface or a person	Nitrile gloves. Avoid touching your face. Wash exposed skin with soap and water. Bag evidence per policy.	Do not use alcohol-based sanitizer on exposed skin (it can increase absorption). No respirator is needed for routine contact.
Visible airborne powder or an aerosolizing task	N95 or P100 respirator, eye protection, gloves. Limit personnel.	Do not rely on a surgical mask for airborne powder.
A responder becomes symptomatic	Assess for objective hypoventilation (slow or absent breathing, unresponsive). Give intranasal naloxone 4 mg; repeat in 2–3 minutes if no response. Call EMS. Monitor; effects can recur.	Do not give naloxone for anxiety, dizziness, or a racing pulse. Those are not opioid toxicity.
A subject or bystander overdoses	Same naloxone protocol. Rescue breathing if trained. Recovery position when breathing. Hand off to EMS.	Do not leave a reversed patient unattended; naloxone can wear off before the opioid does.

Consistent with the American College of Medical Toxicology position statement on occupational opioid exposure (updated 2025). Local medical direction governs dosing.

SECTION 5 · INTERAGENCY

5 INTERAGENCY COORDINATION, UNIFIED COMMAND & RESCUE TASK FORCE

The casualty in the warm zone is reached by a rescue task force or not at all. That capability exists only if it was written, rehearsed, and radio-tested with the fire and EMS partners beforehand.

6 AUDIT ITEMS · MAXIMUM 12 POINTS · SCORING ON PAGE 26



Why it matters

On an active threat, fire and EMS stage until law enforcement can escort them into the warm zone. Without a written rescue task force agreement, a shared channel, and pre-designated casualty collection points, the casualties wait for the scene to be fully cleared, and the survivable ones become the unsurvivable ones.

SECTION 5 · STANDARDS

Interagency Coordination, Unified Command & Rescue Task Force

5.1 Rescue task force interoperability

A written joint SOP between the agency and fire/EMS governs warm-zone extraction under ballistic escort: entry criteria, roles, PPE, and communications. Plain language replaces department-specific codes. Casualty collection points are pre-designated for priority facilities.

5.2 Joint live-action exercises

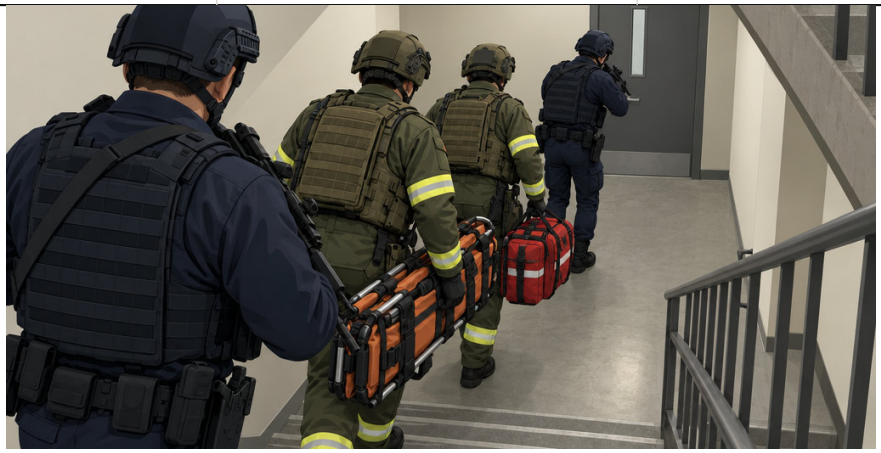
A full-scale joint active-threat or mass-casualty exercise runs at least annually with local fire apparatus and EMS. Radio interoperability is tested across primary and mutual-aid channels.

5.3 Public access bleeding control coordination

Officers know where school, government building, and community bleeding-control stations are and what is in them, and they can integrate public-access kits and bystanders during a mass-casualty incident.

The zone model both agencies must share

ZONE	THREAT	WHO OPERATES	MEDICAL ACTION
Hot (direct threat)	Active, unmitigated	Law enforcement contact teams only	Self-aid and partner aid only; move casualties toward the warm zone when the threat allows
Warm (indirect threat)	Mitigated, not eliminated	Rescue task force: fire/EMS medical element under law enforcement escort	Bleeding control, chest seals, airway positioning, triage, extraction to a casualty collection point
Cold	No threat	Unified command, EMS, hospitals	Full assessment, treatment, transport



A rescue task force stacks up a stairwell in the warm zone: law enforcement escort front and rear, the fire/EMS medical element with litter and bag between them. Illustration.

SECTION 5 · SCORING

Interagency Coordination, Unified Command & Rescue Task Force

#	SECTION 5 — AUDIT ITEM	YES	PART.	NO	N/A	PTS
5.1a	A signed joint rescue task force SOP with fire/EMS defines warm-zone entry criteria, team composition, ballistic escort, PPE, and communications.	○	○	○	○	
5.1b	Plain language is the standard on joint incidents, and casualty collection points are pre-designated and mapped for schools, government buildings, and other priority facilities.	○	○	○	○	
5.2a	A full-scale joint active-threat or mass-casualty exercise with fire apparatus and EMS took place in the last 12 months, and the after-action report is on file.	○	○	○	○	
5.2b	Radio interoperability across primary and mutual-aid channels was tested with fire/EMS in the last 12 months and the results were corrected.	○	○	○	○	
5.3a	Public-access bleeding-control stations in the jurisdiction are mapped, and officers know the locations and contents.	○	○	○	○	
5.3b	Officers are trained to integrate public-access kits and trained bystanders during a mass-casualty incident, using triage tags or marking compatible with the EMS partner.	○	○	○	○	
	SECTION 5 SUBTOTAL · APPLICABLE MAXIMUM		/			

SECTION RESULT	
	DEFENSIBLE 83–100% · MODERATE 50–82% · HIGH LIABILITY EXPOSURE below 50%

Gaps to close

ITEM	GAP TO CLOSE	OWNER	DUE

EVIDENCE REVIEWED / NOTES

SECTION 5 · PRINTABLE TOOL

Rescue task force SOP outline and casualty collection point register

Check each element as it is written into the joint SOP with fire and EMS. The register below is the evidence for item 5.1b.

	RTF SOP ELEMENT
☐	Zone definitions (hot / warm / cold) and who declares transitions
☐	Entry criteria for fire/EMS into the warm zone under law enforcement escort
☐	Team composition: minimum escort, medical element, PPE (ballistic vest and helmet for fire/EMS)
☐	Communications: shared talk group, plain language, casualty count and location format
☐	Casualty collection point selection, marking, and security
☐	Triage and tagging method shared by both agencies
☐	Extraction: litters, vehicles, ambulance exchange point
☐	Unified command position and the medical branch reporting line
☐	Training and exercise cadence, and the after-action review owner

Casualty collection point register

FACILITY	PRIMARY CCP	ALTERNATE CCP	AMBULANCE EXCHANGE	MAP ON FILE	REVIEWED

EXERCISE DATES · PARTNERS · AFTER-ACTION OWNER

SECTION 6 · OPERATIONS & QI

6 OPERATIONS, INCIDENT DEBRIEFING & QUALITY IMPROVEMENT

What the agency learns from its last casualty decides how the next one goes. Debriefs, data, and peer support are the difference between a program and a purchase.

6 AUDIT ITEMS · MAXIMUM 12 POINTS · SCORING ON PAGE 30



Why it matters

The agencies whose outcomes improve are the ones that review every casualty event, measure tourniquet times and handoffs, feed the findings into training, and take care of the officers who did the work. The same data is what wins the grant and defends the budget line.

SECTION 6 · STANDARDS

Operations, Incident Debriefing & Quality Improvement

6.1 Structured medical after-action reviews

A formal medical debrief happens within 72 hours of any duty-related casualty event. It is separated from internal-affairs and disciplinary processes so people report what actually happened.

6.2 Data tracking and quality assurance

The agency tracks tourniquet application times, hemostatic use, hospital handoffs, and outcomes where available, and uses the data to justify grant applications and budget requests.

6.3 Officer mental health and critical incident stress management

Peer support and psychological first aid are mandatory after traumatic pediatric events and line-of-duty injuries, with a policy and a roster that work at 0300.



The 72-hour medical debrief: the sergeant, the EMS partner, the body-worn camera footage, the device in evidence, the form. Illustration.

SECTION 6 · SCORING

Operations, Incident Debriefing & Quality Improvement

#	SECTION 6 — AUDIT ITEM	YES	PART.	NO	N/A	PTS
6.1a	A medical after-action review is completed within 72 hours of any duty-related casualty event using a standard template, and the review is on file.	○	○	○	○	
6.1b	Medical after-action reviews are decoupled from internal affairs and discipline by written policy, and their findings feed the training calendar.	○	○	○	○	
6.2a	The agency centrally tracks tourniquet application times, hemostatic use, chest seal use, naloxone doses, and hospital handoff times.	○	○	○	○	
6.2b	Operational medical data has been used in the last 24 months to support a grant application or a budget request, and the documentation package is retained.	○	○	○	○	
6.3a	A peer support or psychological first aid activation is mandatory after traumatic pediatric events and line-of-duty injuries, with a roster reachable around the clock.	○	○	○	○	
6.3b	An annual re-audit date is set, and the previous audit's corrective actions were briefed to command with status.	○	○	○	○	
	SECTION 6 SUBTOTAL · APPLICABLE MAXIMUM		/			

SECTION RESULT	
	DEFENSIBLE 83–100% · MODERATE 50–82% · HIGH LIABILITY EXPOSURE below 50%

Gaps to close

ITEM	GAP TO CLOSE	OWNER	DUE

EVIDENCE REVIEWED / NOTES

SECTION 6 · PRINTABLE TOOL

Medical after-action review form

Complete within 72 hours of any duty-related casualty event. This is a medical quality review, not a disciplinary document; policy should say so on the form.

FIELD	ENTRY
Incident number and date / time	
Casualty type (officer, suspect, civilian) and mechanism	
First officer at side (time)	
Interventions and times (tourniquet, packing, seal, naloxone)	
EMS arrival and handoff time	
Hospital destination and outcome (if known)	
Body-worn camera reviewed by (medical director / designee)	

REVIEW QUESTION	FINDING	ACTION / OWNER
Was the right intervention chosen and performed to standard?		
Was the equipment present, in date, and did it function?		
Was the tourniquet time captured and communicated?		
Did the handoff to EMS include mechanism, injuries, signs, treatments?		
What should change in policy, equipment, or training?		

Peer support activated? [ ] Yes [ ] No [ ] Not indicated Reviewed by: _____ Date: _____

Intervention data tracker (item 6.2a)

INCIDENT #	DATE	INTERVENTION	TIME APPLIED	EMS HANDOFF	OUTCOME / FOLLOW-UP

SECTION 7 · MATURITY SCORING RUBRIC

Your readiness index

Section subtotals and applicable maximums carry over automatically in form-capable readers. On paper, copy each subtotal and maximum from its scoring page.

SEC.	SECTION	POINTS	MAX	%	RESULT
1	Agency-Level Doctrine, Policy & Medical Direction				
2	Individual Officer Medical Gear & Duty Standardization				
3	Patrol Vehicle Staging, Fleet Equipment & Thermal Management				
4	Training Realism, Stress Inoculation & Skills Sustainment				
5	Interagency Coordination, Unified Command & Rescue Task Force				
6	Operations, Incident Debriefing & Quality Improvement				
	TOTAL				

READINESS INDEX		AGENCY TIER	

Index = total points ÷ total applicable maximum × 100. With no N/A items the maximum is 72.

Agency tiers

TIER	INDEX	COMMAND ACTION
DEFENSIBLE	83–100	Sustain. Close remaining PARTIALs, file this audit with the program records, re-audit in 12 months, and brief the governing body.
MODERATE	50–82	Formalize and standardize inside 90 days: policy, medical direction, issued gear, inspection, and the drill calendar. Re-score at day 90.
HIGH LIABILITY EXPOSURE	Below 50	Command decision required now. Interim medical directive, gear audit, and procurement within 30 days. Counsel briefed.

SECTION 7 · CRITICAL-ITEM GATE & SIGN-OFF

Gate check and validation

A NO on any critical item caps the agency at MODERATE regardless of the index. Tick each item once it is confirmed at PARTIAL or better with evidence on file.

	ITEM	CRITICAL CAPABILITY
☐	**1.2b**	Standing orders exist for every intervention officers carry
☐	**2.1a**	A standardized, agency-issued duty kit is on every sworn officer
☐	**2.3a**	Duty kits are inspected quarterly and the inspections are logged
☐	**4.1a**	Every recruit completes hands-on trauma qualification before solo patrol

Section heat map

Any section below 50% is a priority for the 30/60/90-day plan even when the index is DEFENSIBLE.

1 DOCTRINE	2 OFFICER GEAR	3 FLEET	4 TRAINING	5 INTERAGENCY	6 OPS & QI

Validation and sign-off

ROLE	NAME	DATE
Audit lead (name, rank)		
Training commander		
Medical director / EMS medical authority		
Chief / Sheriff		
Agency counsel (reviewed)		
Re-audit date		

COMMAND NOTES

SECTION 7 · CORRECTIVE ACTION PATHWAY

The 30 / 60 / 90-day plan

Work the gaps in the order that reduces exposure fastest: doctrine and directive first, then standardized gear, then sustainment and the joint response. Re-score at day 90 so command sees the trend, not a snapshot.

PHASE	FOCUS	ACTIONS	ITEMS
30 DAYS	Doctrine and directive	Promulgate an interim operational medical directive. Name the medical director and sign the agreement. Issue standing orders for the interventions officers already carry. Run a 100% duty-belt gear audit and pull every unauthorized or expired device.	1.1a, 1.2a, 1.2b, 2.1b, 2.2b
60 DAYS	Standardization and procurement	Replace unauthorized personal gear with the issued standard. Procure standardized duty IFAKs, vehicle kits, and multi-casualty bags from a manufacturer or authorized distributor with lot documentation. Install the precinct replacement cache. Write the thermal protocol and start the logs.	2.1a, 2.3a, 2.3b, 3.1a, 3.1b, 3.2a, 3.2b
90 DAYS	Sustainment and interagency	Complete department-wide timed skills evaluations. Run a joint rescue task force tabletop with fire and EMS and set the full-scale exercise date. Stand up the after-action template and the data tracker. Set the annual re-audit date and re-score.	4.1b, 4.2a, 4.2b, 5.1a, 5.2a, 6.1a, 6.2a, 6.3b

Priority gap list

#	GAP (SECTION / ITEM)	OWNER	DUE	DONE
1				
2				
3				
4				
5				
6				
7				
8				

DIRECT AGENCY QUOTING: RFQ AND BILL-OF-MATERIALS UPLOAD
tactical-medicine.com/pages/medical-logistics-rfq-services ›

GOVERNMENT CONTRACTING AND PROCUREMENT SOLUTIONS
tactical-medicine.com/pages/government-procurement-solutions ›

PROCUREMENT SPECIFICATIONS

Component performance specification for agency solicitations

Use these as salient characteristics. They describe clinical function and field performance, not a brand, and they map to the component categories named in the federal trauma-kit standard.

COMPONENT	SALIENT CHARACTERISTICS	QTY / OFFICER	QTY / VEHICLE
Limb tourniquet	Windlass or ratcheting mechanical advantage; single-hand application; time-tag; purchased from the manufacturer or an authorized distributor with lot traceability; no counterfeits	1	2–4
Hemostatic gauze	Kaolin- or chitosan-impregnated gauze, z-folded, sterile, in a vacuum-sealed pouch	1	2
Pressure dressing	4 in or 6 in elastic trauma dressing with an integrated non-adherent pad and closure bar	1	2
Vented chest seal	Hydrogel-adhesive occlusive dressing with a one-way vent, two-pack (entry and exit); storage range documented	1 pair	2 pairs
Nitrile exam gloves	Powder-free, medical-grade; specify ASTM D6978 permeation testing where the agency wants documented fentanyl resistance	2 pairs	6 pairs
Trauma shears and marker	7.25 in shears; permanent marker for tourniquet time	1 each	1 each
Compressed gauze	Sterile, vacuum-packed, for packing and dressing	—	2
Intranasal naloxone	4 mg per device; two devices; storage per label	Per policy	2
Litter	Compact soft or drag litter rated for a loaded adult	—	1
Multi-casualty bag	Multiple tourniquets, packing gauze, dressings, seals, gloves, marker; assigned units	—	Designated
Kit container	Labeled, sealed with a serialized tamper indicator; printed instruction card inside	1	1

National standards and references

1. Improving Police CARE Act, S. 1595 / H.R. 5864, 119th Congress; enacted through the FY2026 National Defense Authorization Act, December 2025. Edward Byrne Memorial Justice Assistance Grant Program, 34 U.S.C. § 10151 et seq.
2. Kauvar DS, Lefering R, Wade CE. Impact of hemorrhage on trauma outcome. *J Trauma.* 2006;60(6 Suppl):S3–S11.
3. Mell HK, Mumma SN, Hiestand B, et al. Emergency medical services response times in rural, suburban, and urban areas. *JAMA Surg.* 2017;152(10):983–984.
4. Kragh JF Jr, Walters TJ, Baer DG, et al. Survival with emergency tourniquet use to stop bleeding in major limb trauma. *Ann Surg.* 2009;249(1):1–7.
5. Weinman S. Retention of tourniquet application skills following participation in a bleeding control course. *J Emerg Nurs.* 2020;46(2):154–162.
6. Lagazzi E, et al. Limb hemorrhage control failure with a counterfeit tourniquet. *J Spec Oper Med.* 2024;24(3):67–69.
7. American College of Medical Toxicology. Position statement: preventing occupational opioid exposure to emergency responders (2025 update; original 2017 with the American Academy of Clinical Toxicology).
8. McLaren C, Null J, Quinn J. Heat stress from enclosed vehicles. *Pediatrics.* 2005;116(1):e109–e112.
9. NFPA 3000, Standard for an Active Shooter/Hostile Event Response (ASHER) Program. OSHA 29 CFR 1910.151.

About the author. Marco R. Torres, MD, NRP, is a physician and medical educator, a U.S. Navy veteran, and the founder of MED-TAC International and ALKEONHealth.com, with 15 years in tactical medicine as a flight medic, as a paramedic, and in high-threat protection operations, and 7 years teaching EMS.

MED-TAC INTERNATIONAL

CLOSE THE GAPS BEFORE THE NEXT CALL.

Send us your completed audit or your bill of materials. MED-TAC International Corp. builds and sources agency trauma programs to the standard in this audit: standardized duty IFAKs, vehicle kits, multi-casualty bags, K-9 loadouts, and training equipment, with line-item quotes and the vendor documentation a grant audit asks for.

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