



LAW ENFORCEMENT · FOR PATROL OFFICERS, FIELD TRAINING OFFICERS & SHIFT SUPERVISORS

PATROL OFFICER TRAUMA GUIDE

DOCTRINE FOR THE FIRST 60 SECONDS OF A MEDICAL EMERGENCY

The kit on your belt is the only one that matters in the first minute. What to carry, where to carry it, how to use it on yourself and your partner, and how to hand off to EMS.

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

60 s

THE WINDOW THAT DECIDES IT

MARCH

ONE SEQUENCE, EVERY SCENE

12-pt

FILLABLE IFAK AUDIT

1 card

PRINTABLE QUICK REFERENCE

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

Evidence-based prehospital trauma standards · Clinician-founded, veteran-led

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



BEFORE YOU READ

A note from the author

I have spent fifteen years in tactical medicine as a flight medic, as a paramedic, and in high-threat protection operations, and seven years teaching EMS. The most reliable predictor of whether a wounded officer lives has not been the trauma center, the helicopter, or the paramedic. It has been whether someone standing there — often the wounded officer — put a tourniquet on in the first minute. This guide is written around that fact: short on theory, long on what to carry, where, and what to do with it. It repeats itself on purpose, because repetition is what makes the placement rule automatic when your hands are shaking.

Reading is foundational; training is operational. Take this to your training officer, run the drills in Section 11, and audit your kit with Section 06 before your next shift. — **Marco R. Torres, MD, NRP**, physician and medical educator, U.S. Navy veteran, founder of MED-TAC International and ALKEONHealth.com

CONTENTS

Thirteen sections, one card

01	Why this guide exists The first 60 seconds and who is actually on scene	3
02	MARCH for patrol One sequence for self-aid, partner aid, and the MCI	4
03	The 60-second window Belt, cruiser, plainclothes and TEMS configurations; the mistakes; three scenarios	5
04	Self-application under stress One-handed technique and the weekly drill	8
05	Buddy application and partner down Cover, contact, carry, care	10
06	The department kit audit The 12-point IFAK audit, expiration log and procurement pathways	11
07	Tourniquet doctrine Placement, second tourniquet, what never comes off	13
08	Junctional hemorrhage and wound packing Where a tourniquet cannot go	14
09	Chest trauma and vented seals Entry, exit, and the tension you are watching for	15
10	The MCI hand-off Triage, MIST, and documentation under stress	16
11	Training cadence Weekly, monthly, quarterly, annually	17
12	Quick reference card Print it, laminate it, put it in the pouch	18
13	Sources What this doctrine rests on	19



SECTION 01

Why this guide exists

Three things kill wounded people who could have lived: bleeding from a limb, a hole in the chest, and an airway that closes. All three are addressable in the first minutes by someone on scene with the right tools and the right training. On most law enforcement scenes that someone is the patrol officer, because EMS is still downrange and will not enter until the scene is secured. In the landmark military analysis of potentially survivable deaths, roughly nine in ten were from hemorrhage, and many of them from wounds a tourniquet or packing could have controlled. Nothing about a gunshot wound changes when it happens on a traffic stop instead of a patrol base.

90–180 s planning window from an uncontrolled arterial extremity wound to loss of consciousness	7–14 min median EMS response, urban to rural, in the national registry — after the scene is declared safe	~90% of potentially survivable trauma deaths in the military series were from hemorrhage	< 3 s belt to in-hand for a duty tourniquet — the number your pouch has to hit
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The central claim

The kit on your belt is the only kit that matters in the first sixty seconds. The cruiser trunk is in another zip code during that minute; the EMS rig is staged around the corner waiting for “scene secure”; the trauma bay is a helicopter ride away. Everything downstream depends on what happens in the first minute, and in the first minute the only equipment that exists is what you are wearing. If your tourniquet is in the trunk, your tourniquet is not your tourniquet.

How the guide is organized

By patrol scenario, not by clinical category: what to carry (Section 03), what to do when you are the casualty (04), when your partner is (05), how to audit the kit the department issued (06), the three interventions that do the work (07–09), and how to hand off when EMS arrives or when there are more casualties than officers (10). Section 11 is the training cadence, Section 12 is a card for the pouch, Section 13 is the evidence.

WHAT THIS GUIDE DOES NOT REPLACE

Hands-on, instructor-led training in tactical casualty care, delivered or sponsored by your agency, under your medical director’s standing orders. This guide is the doctrine you bring to that training and the reference you keep afterward. It is not a substitute for it.

Terminology

Tourniquet means a proven windlass or ratcheting limb tourniquet, purchased from the manufacturer or an authorized distributor, with lot traceability. **Hemostatic gauze** means a kaolin- or chitosan-impregnated packing gauze. **Vented chest seal** means an occlusive dressing with a one-way vent. **High and tight** means as high on the limb as possible, used when the wound is hidden or you are under fire. **Deliberate placement** means two to three inches above a visible wound, on bare skin, never over a joint. The difference between the last two is Section 07.



SECTION 02

MARCH for patrol

MARCH is the order in which things kill. Massive hemorrhage first, because an arterial bleed ends a life in minutes; airway second, because an obstructed airway ends one in a few more; then respiration, circulation, and hypothermia. It is sequential, not simultaneous: you finish M before you touch A. Under stress your brain wants to fix what looks worst, which is rarely what is killing the patient fastest. The sequence is the discipline that overrides that.

LETTER	WHAT YOU ARE LOOKING FOR	WHAT A PATROL OFFICER DOES
M Massive hemorrhage	Bright, pulsing, or pooling blood from a limb; blood soaking through clothing at the groin, armpit, or neck	Limb: tourniquet. Junctional: pack with hemostatic gauze and hold pressure. Do not move on until it is controlled
A Airway	Snoring, gurgling, silence in an unconscious patient; blood or vomit in the mouth	Conscious: let them sit up. Unconscious and breathing: recovery position, chin away from the chest. NPA only if trained and authorized by your medical director
R Respiration	Penetrating wound to the chest or back between the neck and the navel; entry and exit	Vented chest seal on every hole; watch for worsening breathing and burp the seal if it develops
C Circulation	Pale, cool, sweaty skin; confusion; weak or absent radial pulse; the tourniquet you already placed	Reassess every tourniquet and dressing; lay the patient flat; note the signs of shock for the hand-off
H Hypothermia / head	A trauma patient losing heat, in any weather; a head injury with altered mentation	Blanket or reflective wrap on every trauma patient, even in July – cold blood does not clot; keep the head-injured patient from being moved roughly

Three patrol-specific rules

Threat before treatment. MARCH starts when the threat is suppressed or you are behind cover. Under fire the only medical act is a tourniquet on a limb, and only if it can be done without leaving the fight.

Reassess, do not just apply. A tourniquet loosens as tissue compresses; a dressing soaks through. C in MARCH is where you go back and check M.

Say what you did. "Tourniquet, left thigh, 1432." To the patient, to your partner, to the radio. It is the start of the MIST hand-off in Section 10.

The card in Section 12 carries MARCH in a form that fits the pouch. Laminate it. The point is not to read it on scene; the point is to have read it a hundred times before.

SECTION 03

The 60-second window: what to carry and where



The issued belt IFAK, opened: Individual Patrol Officer Kit (IPOK), Combat Gauze configuration – C-A-T, 4 in. flat trauma dressing, Combat Gauze LE, gloves. \$95.99; the \$47.99 variant carries plain S-rolled gauze and no hemostatic agent. Product photograph.

Belt real estate is finite. The belt carries hemorrhage control and nothing else; everything that does not stop bleeding in the first minute moves to the cruiser or a cargo pocket. The minimum viable belt load is one tourniquet in an open-top or elastic sleeve on the support side, so the strong hand can cross-draw it if the support arm is hit and the support hand can draw it if the strong arm is, plus a compact IFAK and a marker.

Time it. Belt to in-hand, either hand, under three seconds. A snap-closure pouch fails that test; so does a tourniquet still in retail packaging. Stage it per the manufacturer's instructions, strap routed, windlass secured, ready to go over a limb in one motion.

What does not belong on the belt: a second tourniquet (cruiser or cargo pocket), a nasopharyngeal airway (cruiser, only under standing orders), a reflective blanket (cruiser), and anything that turns the IFAK into a bag.

BELT ITEM	QTY	SPECIFICATION
Tourniquet	1	Proven windlass tourniquet (C-A-T Gen 7, SOF-T Wide, or SAM XT class), authentic, staged; support-side, open-top or elastic retention
Hemostatic gauze	1	Kaolin or chitosan, Z-fold, vacuum-sealed; in the IFAK
Pressure dressing	1	4 in. emergency trauma dressing or compressed gauze
Vented chest seals	2	Entry and exit – a twin pack, or two single-seal packages
Gloves	1 pair	Nitrile, chemotherapy-permeation tested (ASTM D6978), sized to your hands
Shears	1	Trauma shears, not utility shears; on the IFAK or the belt
Marker	1	Permanent marker, black, in the IFAK; writes the time on the tourniquet and casualty card

THE BELT LOAD, ITEM BY ITEM • prices verified on tactical-medicine.com, 25 Sep 2026



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



QuikClot Combat Gauze® LE
Teleflex • kaolin Z-fold
• \$38.99



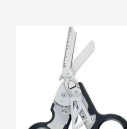
HEMUGUARD® 4 in.
6:8 Medical • pressure
bandage • \$7.95



Sentinel™ Chest Seal
Safeguard • vented, one
per pack • \$18.99



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



6-in-1 trauma shears
MED-TAC • \$29.99

SECTION 03 • CONTINUED

Cruiser, plainclothes and TEMS configurations



Patrol Vehicle Trauma Kit (North American Rescue), opened: tourniquets, dressings, seals and airway in labeled sleeves. \$199.00 basic; \$239.99 with Combat Gauze. Product photograph.

The cruiser kit is for the patient who survived your sixty-second response and now needs care while EMS approaches, and for the second and third casualties. It rides where the driver can reach it without opening the trunk: a seat-back organizer, the passenger floorboard, or a headrest mount. The trunk is for the multi-casualty case, never for the only kit.

Heat. A closed vehicle runs about 40°F above ambient within an hour. Chest-seal adhesives and gloves die in a summer trunk; hemostatic gauze packaging delaminates. The cabin kit lives in the driver's air conditioning; anything in the trunk rides in an insulated case and rotates every twelve months.

CRUISER ITEM	QTY	NOTES
Tourniquets	3	One on the belt plus three in the cruiser: four total, enough for a partner-down plus bystander scene
Hemostatic gauze	2	Packing for the junctional wound the belt gauze could not finish
Vented chest seal twin packs	2	Four seals
Pressure dressings	2	4 in. and 6 in.
Nasopharyngeal airway	1	28 Fr with lubricant, only under your medical director's standing order
Reflective blanket	1	Every trauma patient, every season
Shears, gloves, marker	1 / 4 pr / 1	Duplicates of the belt items
MARCH card	1	Laminated; Section 12

ISSUED CONFIGURATIONS AND CRUISER ITEMS · prices verified on tactical-medicine.com, 25 Sep 2026



CORE – Compact Officer Response Kit
North American Rescue · \$79.99



Rapid Access Pouch – Bleeding Control Kit w/ TMT
MED-TAC · \$44.99 black; \$54.99 OD, coyote, Multicam



NPA kit – 6 sizes, 22-32 Fr
MED-TAC · standing order required · \$19.99



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

Plainclothes and investigators. Plainclothes officers face violence without a duty belt. The answer is a concealed tourniquet – ankle rig, appendix pouch, or inside-the-waistband sleeve – plus a low-profile IFAK in the bag that goes everywhere the officer goes. The drill in Section 04 is run from the concealed position, not from a belt the officer does not wear.

Tactical EMS and tactical teams. Operators carry hemorrhage control externally staged on the plate carrier (tourniquet on the front, IFAK at the side or in a kangaroo pouch), a second tourniquet on the belt reachable by either hand, and a team bag in the stack or the truck with multi-casualty capacity and airway adjuncts. Junctional tourniquets and needle decompression belong to the medic under medical direction, not to the patrol officer.



SECTION 03 • CONTINUED

Common configuration mistakes, and three scenarios to pre-visualize

MISTAKE	WHY IT FAILS	FIX
Tourniquet in the trunk	It is a hundred feet away and behind a liftgate during the only minute that counts	One on the belt, always; the cruiser carries the spares
Strong-side only	The strong arm is the one that gets hit while it is holding the pistol	Support-side carry, reachable by either hand; drill the cross-draw
Snap-closure pouch	Snaps are slow under stress and impossible with a wounded hand	Open-top, elastic sleeve, or hook-and-loop flap; time it under three seconds
Training tourniquet on duty	Blue or marked trainers have been cycled hundreds of times; the windlass and strap are worn	Trainers train; a new, authentic duty tourniquet goes on the belt
Counterfeit or marketplace tourniquet	Fakes snap at the windlass or slip at the clip under arterial pressure	Manufacturer or authorized distributor only, with lot traceability; the agency inspects and lists approved devices
One tourniquet, no backup	Thigh wounds routinely need a second tourniquet side by side; partners and bystanders need their own	Three in the cruiser; a second in a cargo pocket if you are far from the car
No marker	The cheapest item in the kit is the one most often missing, and the tourniquet time goes with the patient	A black permanent marker in the IFAK, tested quarterly — they dry out in vehicle heat

Three scenarios to pre-visualize

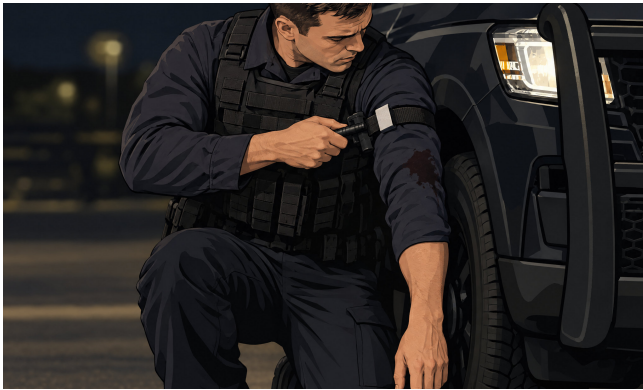
Pre-visualization is free training. Run each of these in your head before the shift until the sequence is automatic.

- 1 Solo officer, traffic stop turned violent.** You take rounds during a felony stop; you are hit in the thigh; the suspect vehicle has fled; you are alone and the radio works. Announce shots fired and your location. Tourniquet high and tight on the thigh while still in the seat — the wound is under a uniform and you are still in the fight. Drive to a collection point if the car will move; hold cover with the tourniquet on if it will not. Write the time on the tourniquet.
- 2 Two-officer call, partner down.** Your partner is hit in the upper arm on a domestic call; the threat is contained. Cover, then contact: move your partner behind cover, expose the wound, tourniquet two to three inches above it on bare skin — you can see the wound, so this is deliberate placement, not high and tight. MARCH. Write the time. Request EMS with the wound location and tourniquet status.
- 3 Public venue, active-threat aftermath.** Threat neutralized, multiple casualties, you are the first patrol unit before the rescue task force arrives. Radio the RTF. Triage: walking wounded to a collection point; tourniquets only on arterial extremity bleeds, not on venous or superficial wounds; chest seals on penetrating chest wounds; TQ time on every tourniquet and casualty card; hand off to fire/EMS with the numbered list.



SECTION 04

Self-application under stress



One-handed self-application: support hand on the windlass, tourniquet high on the wounded arm, behind the engine block. Illustration.

When the officer is the patient, the tourniquet goes on one-handed, by someone in pain, tunnel-visioned, and often still under threat. It is mechanically different from buddy application and it has to be drilled separately. The wounded arm is usually the dominant arm; the drill is run with the support hand, from the belt position you actually carry.

Placement when you are the patient. You are under fire, or the wound is under a sleeve you cannot see through: high and tight, as high on the limb as possible, over the uniform. Once you are behind cover and the fight is over, reassess it and leave it on for EMS — conversion is a medical decision (Section 07) — and add a second tourniquet beside it if bleeding continues.

One-handed upper-extremity application (wounded arm)

- 1 Draw the tourniquet with the uninjured hand. Open the loop wide enough to pass over the hand and forearm of the wounded arm.
- 2 Pass the loop over the wounded arm and slide it up the limb. Under fire or with the wound hidden: as high on the upper arm as it will go. With the wound visible and the threat gone: two to three inches above the wound on bare skin, never over the elbow.
- 3 Pull the free end of the strap through the buckle and tight with the uninjured hand until no more than two fingers slide under it.
- 4 Turn the windlass with the uninjured hand until the bleeding stops and the distal pulse disappears. It will hurt; that is correct.
- 5 Lock the windlass in its clip and secure the strap tail and time strip over it.
- 6 Write the time on the tourniquet's time strip with the marker: "TQ 1432." Say it on the radio.

Lower-extremity self-application (wounded leg)

If both hands work, two-handed application on the thigh is faster and preferred. One-handed thigh application is drilled for the case where an arm is also wounded: pass the loop under and around the thigh, seat it high if the wound is hidden or you are still in the fight, tighten by pulling the strap with whichever hand works, turn and lock the windlass. In the seat of a patrol car the tourniquet goes on before you unbuckle; you move to cover with it on.

SECTION 04 • CONTINUED

The self-application drill protocol

The drill is short because the drill has to happen. Five minutes a week beats a two-hour course once a year that is never reinforced; the six-month skill-decay data in Section 11 is the reason. Use a dedicated training tourniquet of the same model as your duty device; never drill with the duty tourniquet.

DRILL	WHAT YOU DO	STANDARD
Weekly • 5 minutes	Sit belted in the driver seat. On a mental “shots fired,” draw the trainer with the support hand and apply it one-handed to your own thigh. Release, re-stow, repeat with the other hand on the other leg	Under 30 seconds from trigger to locked windlass, either hand; belt to in-hand under 3 s
Weekly • add-on	Once a month, run the same drill in low light and once after a sprint or a set of push-ups	Same time standard under physical stress
Monthly • 15 minutes	Squad briefing: one officer self-applies, a partner observes and critiques placement, tightness, time written. Reverse roles. Two reps each	Placement per Section 07; time written and spoken
Quarterly • 2–4 hours	Full IFAK on a hemorrhage simulator: packing on a flowing trainer, chest seal on a torso, self- and buddy-application under stress, partner drag to cover	Instructor-evaluated; recorded in the training file
Annually • 1–2 days	Agency-sponsored, instructor-led tactical casualty care course, scenario-based, under the medical director’s standing orders	Certificate on file; recruits before solo patrol

What the observer checks

Placement. High and tight only when the scenario calls for it (hidden wound, under fire); otherwise two to three inches above the wound on bare skin, never over a joint.

Tightness. Strap pulled to two fingers before the windlass turns. Most failed applications are strap slack, not windlass turns.

Occlusion. Bleeding stopped and distal pulse gone on the trainer; on a live drill, the officer reports the pulse.

Lock and secure. Windlass in the clip, tail and time strip over it.

Time. Written and spoken. “TQ 1432, left thigh.”

Reassess. The officer states when the next check happens: on arrival at cover, and again at the hand-off.

Log the times. A sergeant who can show a year of weekly drill times for every officer on the shift has a training record that holds up in an after-action review; a sergeant who cannot has an opinion.

SECTION 05

Buddy application and the partner-down scene



Deliberate placement: clothing cut away, tourniquet two to three inches above the visible wound, clear of the knee. Illustration.

Buddy application is two-handed, fast, and usually done on someone who can tell you where it hurts. The hard part is not the tourniquet; it is the sequence around it. **Cover, contact, carry, care.** Suppress or contain the threat. Get to the partner. Move the partner to cover if the scene is not safe where they fell. Then treat.

Placement. With the wound visible, cut or tear the clothing away and place the tourniquet two to three inches above the wound on bare skin, never over the knee or elbow. If you cannot see the wound and cannot expose it, or you are still taking fire, go high and tight over the clothing and leave it on for EMS.

- 1 **Cover.** Do not approach a downed partner under fire. Suppress, conceal, and only then move.
- 2 **Contact.** Announce yourself. An altered or apparently unconscious officer often still hears you.
- 3 **Carry.** If the scene is not safe, drag the partner to cover by the vest drag handle or belt before any treatment; the exception is a tourniquet that can go on in the seconds before the drag without exposing you.
- 4 **Care.** MARCH. Tourniquet or packing first. Say what you are doing as you do it: "Tourniquet, left thigh, above the wound."
- 5 **Document.** Time on the tourniquet and casualty card, in marker: "TQ 1432." 24-hour time. EMS reads it on arrival.
- 6 **Hand off, do not hand over.** A structured MIST report (Section 10) to EMS; you leave when they say they have the patient.



The drag to cover: drag handle, pistol hand free, tourniquet already on. Illustration.

The partner drag

Every duty vest should have a rated drag handle; every officer should have dragged a partner-weight mannequin by it. Crouch, grip the handle, keep the pistol hand free, and move backward with your legs, not your back. On pavement a belt or the seat-belt webbing works when there is no handle. A conscious partner pushes with the heels.

SECTION 06

The department kit audit

Most issued patrol IFAKs were built years ago by someone who is no longer there, from whatever was on the shelf. Audit yours before the next shift. The most common gaps: an older-generation or counterfeit tourniquet, compressed gauze with no hemostatic agent, a non-vented or single chest seal, no marker, and hemostatic gauze or seals that expired two years ago.

The 12-point patrol IFAK audit

OFFICER / UNIT

DATE

KIT SERIAL / ISSUE

#	ITEM AND STANDARD	OK	FAIL	EXPIRES
1	Tourniquet on the belt — proven windlass or ratcheting device, current generation, authentic source with lot traceability, staged, support-side, open-top retention	☐	☐	
2	Backup tourniquets — three in the cruiser or one in a cargo pocket; same model as the belt device	☐	☐	
3	Hemostatic gauze — kaolin or chitosan, Z-fold, vacuum package brick-hard, within shelf life	☐	☐	
4	Pressure dressing — 4 in. or 6 in. emergency trauma dressing or compressed gauze, packaging intact	☐	☐	
5	Vented chest seals — twin pack, vented, foil intact, within shelf life; upgrade non-vented seals at restock	☐	☐	
6	Nasopharyngeal airway — 28 Fr with lubricant, cruiser kit, standing order on file	☐	☐	
7	Trauma shears — dedicated medical shears, sharp, rust-free	☐	☐	
8	Nitrile gloves — two pairs minimum, your size, supple, ASTM D6978	☐	☐	
9	Permanent marker — black, in the IFAK, writes on the first stroke	☐	☐	
10	Reflective blanket — cruiser kit; every trauma patient	☐	☐	
11	MARCH card — laminated, in the IFAK or cruiser kit (Section 12)	☐	☐	
12	Pouch and retention — IFAK opens one-handed; tourniquet draws under 3 s either hand; no snap closures; no heat damage	☐	☐	

Any **FAIL** on items **1, 3, 5** or **9** is a same-shift fix: swap from the precinct cache or buy the item on the way in. The rest go on the squad request through the supervisor (page 12).

FINDINGS • LOT NUMBERS • ITEMS REPLACED



SECTION 06 • CONTINUED

Expiration tracking and procurement pathways

ITEM	SHELF LIFE	WHAT DEGRADES	ACTION
Hemostatic gauze	Printed date, typically 3–5 years from manufacture	Packaging integrity; the agent tolerates heat better than the laminate	Replace at date; replace early if the vacuum is lost
Vented chest seal	Printed date, typically 3–5 years	Adhesive tack, fast in heat	Replace at date; 12 months in an unconditioned vehicle
Pressure dressing / compressed gauze	Printed date	Sterility	Replace at date
Tourniquet	No printed date on most; manufacturers recommend inspection and retirement	UV and heat embrittle the windlass and clips; hook-and-loop wears	Inspect quarterly; retire to training at any cracking, fading, salt, or after any use
Nasopharyngeal airway	Printed date where present	Material cracking; lubricant dries	Inspect annually
Nitrile gloves	Printed date	Heat and ozone stiffen the film	Replace annually in a vehicle
Marker	1–2 years in a vehicle	Dries out in heat	Test quarterly; replace at the first faint stroke

Kit expiration log

ITEM	LOT #	EXPIRES	LOCATION	REPLACED ON	INIT.

Three procurement pathways

PATH	WHO FIXES WHAT	HOW
1 • Personal	You fix your kit. Fastest; lowest leverage	Buy the failed items from an authorized source before the next shift; keep the receipt and lot for the audit
2 • Squad	The supervisor fixes the shift	Attach the audit sheets to a supply request; the training officer consolidates and orders through normal channels
3 • Agency	Procurement standardizes the force	Same kit, same place, every officer: a clinician-led supplier builds the standard, documents the lots, and ships the precinct cache. Net 30 for verified government agencies and public school districts; quotes valid 45 days

AGENCY QUOTES: BILL-OF-MATERIALS UPLOAD AND DEPARTMENT STANDARDIZATION

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



SECTION 07

Tourniquet doctrine



Deliberate placement: two to three inches above the visible wound, on bare skin, above the elbow, never on it. Illustration.

The tourniquet is the single most effective piece of equipment on the belt, and the one most often placed wrong. The rule has two halves and officers are taught only one of them.

Deliberate placement — the wound is visible and you are not under fire: on bare skin, **two to three inches above the wound**, never over a joint. A forearm wound gets the tourniquet on the forearm above it if there is room, otherwise on the upper arm above the elbow; a calf wound gets it above the calf wound, otherwise above the knee.

High and tight — the wound is hidden under clothing, there are multiple wounds on the limb, or you are still in the fight: as high on the limb as possible, over the clothing, as fast as it goes on. At cover, reassess it and leave it on for EMS — conversion is a medical decision — and add a second tourniquet beside it if bleeding continues.

RULE	STANDARD
Which device	A proven windlass or ratcheting limb tourniquet (C-A-T Gen 7, SOF-T Wide, SAM XT class), bought from the manufacturer or an authorized distributor with lot traceability. Improvised straps, ratchet straps and bands fail under arterial pressure. Marketplace “tourniquets” are counterfeited at scale
How tight	Strap to two fingers, then windlass until the bleeding stops and the distal pulse is gone. If it does not hurt, it is not tight enough
Second tourniquet	If bleeding continues with the first fully tightened, place a second directly above the first, side by side. Thigh wounds need this often. Do not loosen the first to “try again”
Never over a joint	Knee, elbow, wrist, ankle: the vessels are protected by bone and the device cannot occlude them
What never comes off	A patrol officer does not release or loosen a tourniquet, ever. Conversion is a medical decision made by EMS or the receiving facility. Write the time and hand off
Time	On the tourniquet’s time strip and the casualty card: “TQ HHMM.” Say it on the radio. Reassess at cover and at hand-off

DEVICES THE RULE ALLOWS, AS SOLD · prices verified on tactical-medicine.com, 25 Sep 2026



C-A-T® Gen 7 — parts named
North American Rescue · single routing buckle · \$28.99



C-A-T® Gen 7 staged for the pouch
strap routed, windlass secured, red tip out



SAM® XT
SAM Medical · auto-locking buckle · \$33.99

A tourniquet placed correctly and left alone is safe for the two hours it takes to reach a surgeon almost everywhere in the United States. A tourniquet placed too loose, too low, or over a knee is the one that ends up in the after-action review.



SECTION 08

Junctional hemorrhage and wound packing



QuikClot Combat Gauze®, Z-folded, feeding from the gloved hand one fold at a time — the leading edge is what goes onto the vessel. Product photograph.

The groin, the armpit, the neck and the buttock are where a tourniquet cannot go and where large vessels sit close to the surface. Junctional wounds killed a meaningful fraction of the potentially survivable casualties in the military series, and they kill officers hit below the vest or above it. The patrol answer is wound packing with hemostatic gauze and sustained direct pressure; junctional tourniquet devices belong to EMS and the tactical medic.

Where you pack: groin, armpit, neck (with care for the airway), buttock, and any limb wound where a tourniquet has failed or cannot be placed. **Where you do not pack:** the chest and the abdomen — seal the chest, cover the abdomen, and get EMS.

Wound packing sequence

- 1 Expose the wound. Cut clothing away. Find the source: the point that is pumping or welling fastest.
- 2 Take the hemostatic gauze in your gloved hand. Aim the leading edge at the source, not at the hole.
- 3 Pack deep and hard, with your fingers, feeding gauze straight down onto the vessel until the cavity is full and gauze mounds above the skin. Use a second packet if the first runs out; do not stop to look.
- 4 Apply firm, focused direct pressure over the packed wound with both hands and hold for a full three minutes by the clock (ten with plain gauze). Do not peek at ninety seconds; releasing early restarts the bleed and wastes the agent.
- 5 After three minutes, release slowly and watch. If it re-bleeds, pack more gauze on top and hold for another three minutes.
- 6 Secure with a pressure dressing over the packed wound. Write the time. Do not remove packing — ever; that is the surgeon's job.

PACKING GAUZE (STEPS 2-3) AND PRESSURE DRESSINGS (STEP 6) · prices verified on tactical-medicine.com, 25 Sep 2026



QuikClot Combat Gauze®
Teleflex · kaolin, 3 in. x 4 yd ·
\$39.99



Ready Gauze™ compact Z-fold
6:8 Medical · plain packing
gauze · \$3.95



OLAES® Modular Bandage 4 in.
Tactical Medical Solutions ·
\$7.26



HEMGUARD® 4 in.
6:8 Medical · targeted
pressure · \$7.95



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

Training this skill. Packing cannot be learned from a page. It needs a trainer with a wound cavity and flowing fluid, so the officer learns what “gauze on the vessel” feels like and how long three minutes of pressure is. The quarterly session in Section 11 exists mostly for this and for chest seals.



SECTION 09

Chest trauma and vented seals



HyFin® Vent seal centered over a penetrating chest wound, vent channels facing out, adhesive seated on wiped skin. Product photograph.

A penetrating wound between the neck and the navel, front or back, can let air into the chest with each breath. Two things follow: an open pneumothorax that stops the lung working, and, if air builds under pressure, a tension pneumothorax that pushes on the heart and the good lung. The seal stops air going in; the vent lets it out. That is why vented seals are preferred. A non-vented seal is acceptable if you watch the patient and burp it.

Entry and exit. Gunshot wounds are often through-and-through. Sweep the back and the sides with a gloved hand; every hole gets a seal, which is why the pack has two.

Chest seal sequence

- 1 Expose the chest and back. Cut, do not pull — you are looking for the second hole.
- 2 Wipe the skin around the wound dry with gauze. Blood, sweat and dirt defeat the adhesive.
- 3 Peel the seal and center it over the wound at the end of an exhalation. Press from the center outward to seat the adhesive.
- 4 Find and seal the exit wound the same way.
- 5 Watch the patient: worsening breathing, rising anxiety, a chest that stops moving on one side. If it develops, lift one edge of the seal to burp trapped air, then reseal.
- 6 Position: the conscious patient sits up or lies on the injured side if it helps them breathe. Say what you found and did in the MIST report.

WHAT THE PATROL OFFICER DOES NOT DO

Needle decompression is a medical procedure performed by personnel within their scope of practice under medical direction. The patrol officer seals the holes, watches for tension, burps the seal, and gets EMS moving. That is the whole job, and it saves the patient.

VENTED SEALS (PREFERRED) · prices verified on tactical-medicine.com, 25 Sep 2026



Sentinel™ Chest Seal

Safeguard Medical · dual vent, one per pack · \$18.99



HyFin® Vent twin pack

North American Rescue · entry and exit · \$15.99



HyFin® Vent Compact twin pack

North American Rescue · belt IFAK size · \$12.99

Heat kills seals: a seal that summered in a trunk will not hold on wet skin. Belt seals live in the officer's climate; cruiser seals are inspected quarterly and rotated every twelve months regardless of the printed date.



SECTION 10

The MCI hand-off: triage, MIST, documentation



Casualty number on the forehead, tourniquet on the arm, the next casualty already in view. Illustration.

EMS arrives with no context. Your thirty-second report decides triage priority, transport destination, and the next hour of the patient's care. The format is **MIST**: Mechanism, Injury, Signs, Treatment. It is the same report for one patient on a domestic call and for the sixth patient at a venue. Practice it out loud in the drill.

Hand off, do not hand over. You stay with the patient until EMS says they have care. You give the tourniquet time. You do not leave the tourniquet time in your head.

MIST	WHAT YOU SAY	EXAMPLE
M Mechanism	How the patient was wounded; weapon if known	"GSW, handgun, one round."
I Injury	Where, how bad, controlled or not	"Left thigh, arterial, controlled."
S Signs	Mental status and what you can see of circulation	"Awake, talking, pale, radial pulse present."
T Treatment	What you did and when	"Tourniquet left thigh at 1432; second tourniquet at 1436; blanket on."

Multi-casualty triage before the rescue task force arrives

- Sort.** "Anyone who can walk, come to me." Walkers are assessed last; send them to a collection point with an officer.
- Sort.** "Anyone who can hear me, wave or move." Those who wave are assessed next. Those who do not move are assessed first.
- Assess** the still casualties first, one by one: breathing, arterial bleeding, signs of life.
- Lifesaving intervention only.** For each immediate patient, the single highest-yield act – tourniquet, airway position, or chest seal – then move to the next. No full MARCH on anyone until everyone has been touched.
- Hand off** the numbered list to fire/EMS when the rescue task force arrives; they own treatment and transport order from there.

Documentation under stress

Tourniquet time on the tourniquet and the casualty card: "TQ HHMM." Wound location on the body in marker if it is not obvious (a packed groin, a seal under a shirt). Adjustments as "TQ-2 HHMM." In a multi-casualty scene, number casualties in the order you treated them: "1," "2," "3" on the forehead and the card. The marker is the cheapest item in the kit and the one that preserves the most downstream medical decision-making. Carry it.

SECTION 11

Training cadence: what actually keeps the skill

Skill decay is measured, not guessed. In a prospective study of bleeding-control course graduates, roughly four in ten could not correctly apply a tourniquet six months after certification. A card in the pouch does not fix that. Only repetition does, and the repetition has to be cheap enough to survive contact with a patrol schedule.

CADENCE	TIME · COST	CONTENT	RECORD
Weekly	5 min · \$0	One-handed self-application in the driver seat, either hand, timed. Monthly variants: low light; after exertion	Time in the officer's own log
Monthly	15 min · \$0	Scenario in the squad briefing; self- and buddy-application with observer critique; MIST out loud	Sergeant's briefing log
Quarterly	2–4 h · low	Full IFAK on simulators: flowing-fluid packing, chest seal on a torso, partner drag, stress inoculation (post-exertion, low light, timed)	Training file, instructor-evaluated
Annually	1–2 days · agency	Instructor-led tactical casualty care course, scenario-based, under the medical director's standing orders; recruits before solo patrol	Certificate on file

Making it stick

The drill uses the real carry. Belt, vest, ankle rig — whatever the officer actually wears. A drill from a table teaches the wrong draw.

Trainers train. A dedicated training tourniquet of the duty model; the duty device is never cycled.

Observers score placement. The most common error is not speed; it is a tourniquet over the knee or two inches too loose.

Say the report. Every drill ends with the MIST out loud and the time written. The hand-off is a skill that decays like the rest.

Log it. The training record is the agency's defense in an after-action review and the officer's proof of competence. Weekly times, monthly scenarios, quarterly evaluations, annual certificates.

Recruits before solo patrol. Eight to sixteen hours of hands-on trauma qualification before the first solo shift; the practical drill every six months thereafter.

If you train one layer of this cadence, you are ahead of most officers in service. If you train all four, you are the officer the wounded one hopes is on the call.



SECTION 12

Quick reference card

Print this page, cut on the outer rule, fold once, and laminate it. It fits the IFAK pouch and the visor. It is not for reading on scene; it is for reading a hundred times before.

MARCH M Massive hemorrhage — tourniquet or pack. Finish before A. A Airway — conscious: sit up; unconscious: recovery position; NPA only if trained, on standing orders. R Respiration — vented seal on every chest hole; watch for tension; burp. C Circulation — reassess every TQ and dressing; lay flat; note shock. H Hypothermia — blanket on every trauma patient, every season.	TOURNIQUET Deliberate: wound visible, no fire — 2–3 in. above the wound, bare skin, never over a joint. High and tight: wound hidden or under fire — as high as possible, over clothing; leave on for EMS. Strap to two fingers, windlass until the bleeding stops and the pulse is gone. Second TQ directly above the first if it still bleeds. Never loosen. Never remove. Write “TQ HHMM” on the TQ and the card. Say it on the radio.
WOUND PACKING Groin, armpit, neck, buttock, failed-TQ limb. Aim the gauze at the source; pack deep with fingers until it mounds. Both hands, firm pressure, 3 full minutes (plain gauze: 10). No peeking. Re-bleed: pack more on top, 3 more minutes. Pressure dressing over. Never remove.	CHEST SEAL Neck to navel, front and back — find the exit. Wipe dry. Center the vented seal, press from the middle out, on exhalation. Worsening breathing: lift an edge, burp, reseal. Vented preferred. Non-vented: watch and burp.
MIST HAND-OFF M Mechanism — how, weapon if known. I Injury — where, how bad, controlled? S Signs — mental status, pulse, skin. T Treatment — what you did, when. Stay until EMS says they have the patient.	TRIAGE • DOCUMENT Assess the still first, then “wave or move,” then “walk to me.” One lifesaving act per immediate patient, then the next. “TQ HHMM” on the TQ and card; casualty number on the forehead. Cover • contact • carry • care. Threat before treatment.

Belt minimum: 1 tourniquet (support side, open-top, under 3 s either hand) • 1 hemostatic gauze • 1 pressure dressing • 1 vented seal twin pack • gloves • shears • marker. **Cruiser:** 3 tourniquets • 2 gauze • 2 seal packs • 2 dressings • blanket • NPA on standing orders • card. **Weekly drill:** 5 minutes, either hand, timed. **Audit:** Section 06 before the next shift.

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SECTION 13

Sources and further reading

This guide follows evidence-based prehospital trauma standards as adapted for law enforcement, and MED-TAC doctrine on tourniquet placement. The evidence behind the numbers:

CLAIM	SOURCE
Hemorrhage causes roughly nine in ten potentially survivable trauma deaths	Eastridge BJ et al. Death on the battlefield (2001-2011). J Trauma Acute Care Surg 2012;73(6 Suppl 5):S431-S437
Prehospital tourniquets save lives; a second tourniquet is often needed on the thigh	Kragh JF et al. Survival with emergency tourniquet use to stop bleeding in major limb trauma. Ann Surg 2009;249(1):1-7; Kragh JF et al. J Trauma 2008;64(2 Suppl):S38-S50
Median EMS response ~7 min urban, ~14 min rural	Mell HK et al. Emergency medical services response times in rural, suburban, and urban areas. JAMA Surg 2017;152(10):983-984
Bleeding-control skills decay: ~40% failed tourniquet application at 6 months	Weinman S. Retention of tourniquet application skills following participation in a bleeding control course. J Emerg Nurs 2020;46(2):154-162
Closed-vehicle temperature rise of ~40°F within an hour	McLaren C, Null J, Quinn J. Heat stress from enclosed vehicles. Pediatrics 2005;116(1):e109-e112
Hemostatic gauze storage at or below 77°F	Manufacturer instructions for use (kaolin hemostatic dressing)
Glove permeation testing	ASTM D6978, Standard Practice for Assessment of Resistance of Medical Gloves to Permeation by Chemotherapy Drugs
Grant-funded law enforcement kit components	Improving Police CARE Act, S. 1595 (119th Congress), enacted via the FY2026 NDAA
Recruit and in-service training standards	MED-TAC Tactical Medical Readiness Audit for Law Enforcement, MTC-RA-001 Rev 2.0

Companion MED-TAC documents

Tactical Medical Readiness Audit for Law Enforcement (MTC-RA-001 Rev 2.0) — the 36-item agency self-assessment; Section 4 is the training standard this guide's cadence is built to.

Vehicle Trauma Readiness & Fleet Staging Standard (MTC-VTR-001) — the cruiser kit in detail: cabin reach, trunk heat, three tiers.

How to Spot a Counterfeit Tourniquet — the visual guide behind audit item 1.

Improving Police CARE Act briefing — what a grant-funded kit must contain and how to document it.

Doctrine statement. Tourniquet placement in this guide follows the MED-TAC rule: two to three inches above a visible wound on bare skin, never over a joint; high and tight only when the wound is hidden or the officer is under fire, then left in place for EMS. Where an agency's medical director directs otherwise, the medical director's protocol governs.



THE BELT KIT IS THE ONLY KIT THAT MATTERS IN MINUTE ONE.

ABOUT MED-TAC INTERNATIONAL

MED-TAC International Corp. is a clinician-founded, veteran-led, Service-Disabled Veteran-Owned Small Business that builds and sources tactical medical equipment and training for law enforcement, fire and EMS, military, and prepared civilians. Founder Marco R. Torres, MD, NRP, a physician and medical educator, has fifteen years in tactical medicine as a flight medic, as a paramedic, and in high-threat protection operations, and seven years teaching EMS. He is a U.S. Navy veteran and the founder of ALKEONHealth.com. Doctrine: DOCTRINE BEFORE GEAR. Every kit is sourced from the manufacturer or an authorized distributor with lot traceability.

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<https://tactical-medicine.com/pages/law-enforcement-trauma-kits>



DEPARTMENT QUOTES, NET 30 AND GOVERNMENT CONTRACTING

<https://tactical-medicine.com/pages/government-procurement-solutions>



LEGAL DISCLAIMER

This guide is educational doctrine for sworn personnel and does not replace hands-on training, the agency's standing medical orders, medical direction, state scope-of-practice law, or the judgment of trained responders on scene. Interventions beyond bleeding control require standing orders. Standards cited were current when published and change; verify them before relying on them. No government endorsement is implied. © 2026 MED-TAC International Corp. Free to share unmodified within your agency; not for resale.

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