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Emergency Support Function # 8 (Public Health and Medical Services) Annex

Thurston County Comprehensive Emergency Management Plan (CEMP)

THURSTON COUNTY
WASHINGTON
SINCE 1852

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Prepared By:

Joint-Primary Agencies

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In Partnership With:

Supporting Agencies & Organizations:
Thurston-Mason Behavioral Health Organization
Thurston County Coroner's Office
Disaster Medical Control Center
Providence St. Peter Hospital and Family of Clinics
Capital Medical Center and Family of Clinics

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Record of Changes

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1. Introduction

1.1 Purpose

This document is a supporting annex of the Thurston County Comprehensive Emergency Management Plan (*base plan*) and serves to establish policies and procedures for the effective countywide coordination of necessary public health and medical services capabilities in the event of a human, technological, or natural caused disaster. Primary and supporting agencies, their general responsibilities, and critical disaster response activities related to public health and medical services are identified herein and serve as a reference for executive officials, Emergency Coordination Center (ECC) staff and incident commanders to coordinate delivery of public health and medical services resources and capabilities during incident response.

1.2 Scope

Emergency Support Function #8 – Public Health and Medical Services (ESF #8) coordinates medical resource support when local agencies and/or organizations exceed their capacity to provide medical services due to either an increase in patient numbers or limitations in personnel and medical resources during an emergency or disaster. During emergencies, communities and healthcare providers may implement crisis standards of care.

This annex is applicable regardless of the implementation of crisis standards of care. Public Health and Medical Services (e.g. patient movement, patient care, behavioral healthcare) and support to human services (e.g. addressing individuals with disabilities and those with access and functional needs) are delivered through surge capabilities that augment public health, medical, behavioral, and veterinary functions through health professionals and pharmaceuticals. These services can include the distribution and delivery of medical countermeasures, equipment and supplies, and technical assistance.

ESF #8 also focuses on the health and safety of responders in addition to the public and disseminates public health information and education on protective actions related to exposure to health threats or environmental threats.

As part of incident response operations at the ECC, ESF #8 coordinates information and resources to directly support effective delivery of the following core capabilities: Public Health, Behavioral, Healthcare, and Emergency Medical Services, and Fatality Management Services. Through intersecting activities with other support functions, ESF #8 provides general support to the following additional core capabilities: Planning, Operational Coordination, Environmental Response, Health and Safety, On-Scene Security, Protection and Law Enforcement. Core capabilities are derived from the *National Preparedness Goal* and further described in the *base plan*. Displayed below is a summary of the primary and supported core capabilities identified for ESF #8.

Primary Response Core Capabilities	
Public Health, Healthcare, and Emergency Medical Services	Provide lifesaving medical treatment via Emergency Medical Services and related operations and avoid additional disease and injury by providing targeted public health, medical, and behavioral health support and products to all affected populations.
Fatality Management Services	Provide fatality management services, including decedent remains recovery and victim identification, and work with local, state, tribal, territorial, insular area, and Federal authorities to provide mortuary processes, temporary storage or permanent internment solutions, sharing information with mass care services for the purpose of reunifying family members and caregivers with missing persons/remains, and providing counseling to the bereaved.
Environmental Response/Health and Safety	Conduct appropriate measures to ensure the protection of the health and safety of the public and workers, as well as the environment, from all hazards in support of responder operations and the affected communities
Critical Transportation	Aids in medical surge support, including patient movement and evacuation as necessary.
Logistics and Supply Chain Management	Aids in the procurement of certain medical countermeasures and works to secure assets from the Strategic National Stockpile (SNS) for immediate public health, medical, or veterinary use.
Supporting Core Capabilities	
Public Information and Warning	Deliver coordinated, prompt, reliable, and actionable information to the whole community through the use of clear, consistent, accessible, and culturally and linguistically appropriate methods to effectively relay information regarding any threat or hazard, as well as the actions being taken, and the assistance being made available, as appropriate.
Operational Coordination	Establish and maintain a unified and coordinated operational structure and process that appropriately integrates all critical stakeholders and supports the execution of Core Capabilities.
On-Scene Security, Protection, and Law Enforcement	Ensure a safe and secure environment through law enforcement and related security and protection operations for people and communities located within affected areas and also for response personnel engaged in lifesaving and life-sustaining operations.
Situational Assessment	Provide decision makers with decision-relevant information regarding the nature and extent of the hazard, any foreseeable cascading effects, and the status of the response.

Not all Critical Tasks are the requirement of ESF #8, due to the collaborative nature of response and the ESF structure; successful Core Capabilities execution may be the shared responsibility of multiple ESFs. For example, ESF #4 (Firefighting) shares significant responsibilities with ESF #8

to provide Emergency Medical Services (EMS) based on how the EMS system in Thurston County is organized.

1.3 Laws & Policy Guidelines

RCW 70.05 (Local Health Departments, Boards, Officers – Regulations) grants authority to the County Health Officer or designee to implement measures as necessary to control communicable disease exposure or contamination of food, water, and environmental resources.

RCW 68.50 (Human Remains) and RCW 36.24 (County Coroner) provides the Thurston County Coroner with independent authority in all cities/towns and all incorporated and unincorporated areas of Thurston County with exclusive jurisdiction over human remains in all unnatural or unlawful civilian deaths; persons who come to their death suddenly when in apparent good health without medical attendance within the 36 hours preceding death; and all unclaimed bodies.

WAC 246-500 (Handling of Human Remains) includes guidelines that funeral directors, embalmers, medical examiners, coroners, healthcare providers, and others directly handling or touching human remains must follow, in addition to guidelines around the management of human remains in refrigerated storage and transportation protocols. The local Health Officer may impose additional requirements for the handling, care, transport, or disposition of human remains or suspend the requirements of this chapter.

RCW 18.73 (Emergency Medical Care and Transportation Services) directs all Thurston County mutual-aid emergency medical responders to operate under the authority of a local Medical Program Director.

RCW 70.02 (Medical Records) requires that patients and other qualified entities have access to healthcare records to inform their healthcare decisions, protect the health of the public, and more, but records must be disclosed appropriately and in appropriate circumstances, as noted in the RCW.

WAC 246.100 (Communicable Diseases) outlines responsibility of every healthcare provider to provide adequate instruction on control measures to prevent the spread of disease to patients, caretakers, and others. Healthcare providers must also cooperate with public health authorities during investigation of suspected or confirmed cases of notifiable conditions or communicable diseases and during outbreaks. The local Health Officer establishes plans, policies, and procedures for instituting emergency measures necessary to prevent the spread of communicable disease or contamination, conduct investigations, and institute disease control and contamination control measures. A state or local Health Officer within their jurisdiction may issue orders for medical examination, testing, and/or counseling as well as orders to cease and desist specific activities.

Local Policy (Thurston County Emergency Medical Program Direction Patient Care Protocols and Patient Care Procedures) Thurston County Medic One, Emergency Medical Responders, Emergency Medical Technicians (EMT), and Paramedics who provide emergency medical assistance in Thurston County shall operate under the current Thurston County Emergency Medical Program Direction Patient Care Protocols and Patient Care Procedures.

Local Policy (Thurston County Public Health & Social Services Role as Local Health Authority) Thurston County Public Health & Social Services (TCPHSS) will provide guidance to the County, agencies, and individuals on basic public health principles involving safe drinking water, food sanitation, personal hygiene, and proper disposal of human waste, garbage, and infectious or hazardous waste.

Local Policy (Providence Saint Peter Hospital Role as the Disaster Medical Coordination Center) Region 3 Healthcare Preparedness Response Plan states that during an MCI, patient transport is directed through the Disaster Medical Coordination Center (DMCC) and all Region 3 hospitals may receive MCI patients. Providence St. Peter Hospital is the DMCC for Region 3, including Thurston County.

1.4 Situation

1.4.1 General Overview

Thurston County's critical healthcare infrastructure includes two major hospital systems: Providence-Swedish and MultiCare, which provide essential medical services and support during emergencies. Basic Life Support (BLS) and Advanced Life Support (ALS) services are managed by Thurston County Medic One. During emergencies, patient transportation and emergency medical services are coordinated in conjunction with ESF #8 Public Health and Medical Services to ensure comprehensive medical support and effective patient care.

1.4.2 Hazard Impacts to Public Health and Medical Services

Section 1.6.2 of the base plan contains a summary assessment of all significant hazards that threaten Thurston County. Of those hazards identified, the following have been assessed to have the most significant impact requiring coordination of ESF #8 capabilities:

Hazard	Impact Statement / Description
Epidemic	• Potential for overwhelm of Thurston County medical facilities and services requiring coordination of casualties. • Disruptions to the availability of emergency response resources and personnel. • Medical disaster may require the triage and treatment of large numbers of individuals (surge), which has direct impact on healthcare facilities. • Disasters may produce urgent need for behavioral health crisis management for impacted community and response personnel.

	• Potential for increased need in procurement of medical and non-medical countermeasures, medical supply shortages. • Disasters may produce issues with fatality management, storage considerations, and overwhelm of our Coroner's Office resources.
Severe Weather	• Potential for overwhelm of Thurston County medical facilities and services requiring coordination of causalities. • Medical disaster may require the triage and treatment of large numbers of individuals (surge), which has direct impact on healthcare facilities. • Disruption of sanitation services and facilities, loss of utilities, massing of people in shelters may cause increased potential for illness and disease spread. • Disasters may produce issues with fatality management, storage considerations, and overwhelm of our Coroner's Office resources.
Mass Violence/Terrorist Attack	• Potential for overwhelm of Thurston County medical facilities and services requiring coordination of causalities. • Medical disaster may require the triage and treatment of large numbers of individuals (surge), which has direct impact on healthcare facilities. • Disasters may produce urgent need for behavioral health crisis management for impacted community and response personnel. • Disasters may produce issues with fatality management, storage considerations, and overwhelm of our Coroner's Office resources.
Hazardous Materials Release	• Infrastructure impacts such as damage to bridges or roads may limit the ability to transport staff, patients, or supplies throughout the region. • Potential for overwhelm of Thurston County medical facilities and services requiring coordination of causalities. • Medical disaster may require the triage and treatment of large numbers of individuals (surge), which has direct impact on healthcare facilities. • Public health threats to food, water, and personal health. Short supplies, disruption to healthcare and other services, potable water issues. • Damage to manufacturing facilities, waste processing and disposal facilities, sewer lines, water distribution systems, and secondary hazards could result in toxic environmental and public health hazards to the public and response personnel.

	• Disruption of sanitation services and facilities, loss of utilities, massing of people in shelters may cause increased potential for illness and disease spread. • Disasters may produce urgent need for behavioral health crisis management for impacted community and response personnel. • Potential for increased need in procurement of medical and non-medical countermeasures. • Certain HazMat incidents may require urgent need for decontamination and subject matter expertise. • Disasters may produce issues with fatality management, storage considerations, and overwhelm of our Coroner's Office resources.
Earthquake, Flood, Landslide, Wildfire	• Infrastructure impacts such as damage to bridges or roads may limit the ability to transport staff, patients, or supplies throughout the region. • Potential for overwhelm of Thurston County medical facilities and services requiring coordination of causalities. • Disruptions to the availability of emergency response resources and personnel. • Thurston County hospitals, clinics, nursing homes, pharmacies, and other medical and health care facilities may be severely structurally damaged, destroyed, or rendered unusable. • Public health threats to food, water, and personal health. Short supplies, disruption to healthcare and other services, potable water issues. • Damage to manufacturing facilities, waste processing and disposal facilities, sewer lines, water distribution systems, and secondary hazards could result in toxic environmental and public health hazards to the public and response personnel. • Disruption of sanitation services and facilities, loss of utilities, massing of people in shelters may cause increased potential for illness and disease spread. • Disasters may produce urgent need for behavioral health crisis management for impacted community and response personnel. • Disasters may produce issues with fatality management, storage considerations, and overwhelm of our Coroner's Office resources.

1.4.3 Whole Community

While emergencies and disasters may vary in size and significance, the population, diversity, multi-jurisdictional environment, and concentration of critical infrastructure in Thurston County can magnify their impacts. These emergencies and disasters take a "Whole Community"

approach, in which an effective decision-making and resource management structure among medical and health service providers is critical to successfully addressing the consequences of emergencies and disasters.

Section 1.7.2 of the *base plan* further describes considerations for the whole community across all county agencies to include those within ESF #8.

1.5 Planning Assumptions

In addition to the planning assumptions listed in the base plan, the ESF-8 plan annex is based on the following additional assumptions:

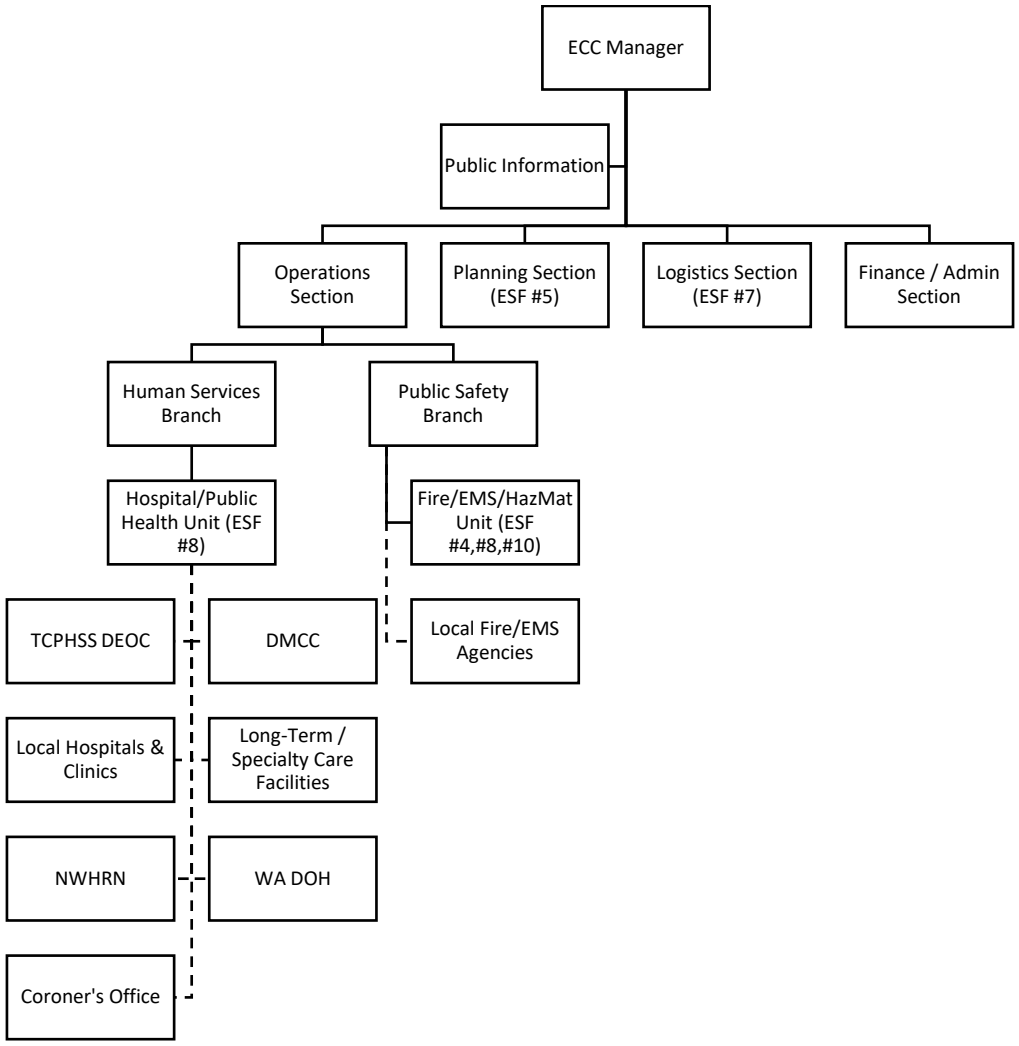
- Natural, technological, and biological emergencies or disasters can overwhelm county health and medical facilities and services requiring emergency coordination of resources.
- All hospitals, nursing homes, and licensed residential care settings and certified facilities have evacuation plans to alternate locations per regulatory requirements.
- Hospitals, long-term care facilities, other inpatient and outpatient facilities, and pharmacies may rely on existing emergency service contracts with appropriate vendors for medical equipment, pharmaceuticals, linens, and other day-to-day supplies.
- If medical personnel are unable to report to their designated work location should report to the nearest health care facility or follow directions from the Continuity of Operations (COOP) program and plan of the parent organization.
- All EMS, healthcare, and the Coroner's Office should have redundant/backup communications and information systems in the event of disrupted services.
- Health and medical facilities and supporting infrastructure may be severely impacted, reducing capability and resources which may result in an increase of disease or injury.
- Disruption of sanitation services and facilities, loss of power, and massing of people in shelters may increase the potential for disease and injury and require an increase in surveillance.
- People with access and functional needs, and those disproportionately impacted individuals or populations may have a variety of medical conditions and will include people who require specialized medical support. All individuals whose health degrades during the response and/or recovery operation may require additional medical support.
- Individuals with access or functional needs along with medical needs may include people from congregate settings (such as group homes, nursing homes), individuals under medical home care requiring a nursing caregiver, and individuals from hospitals.
- Contamination of food and water supplies may increase the potential for disease and injury.
- Availability of medical care personnel may be limited due to injury, illness, personal concerns/needs, or limited access to work locations.

- The damage and destruction caused by an emergency or disaster will produce urgent needs for mental health crisis counseling and spiritual support for disaster victims and emergency response personnel.
- Health and medical agencies may require physical protection of their staff, facility, and its contents following the emergency.
- Thurston County medical systems (emergency medical, public health and related services) will restore operations during the recovery period as soon as possible and within the limitations and capabilities of county government following the emergency or disaster.
- Public health assessments of food, water, and sanitation to ensure safety of the public's health will be conducted.

2. Organization

2.1 ESF-8 Organizational Structure

ESF #8 is organized under the Human Services Branch of the Operations Section within the ECC. During incidents requiring enhanced Emergency Medical Services (EMS) resource coordination with fire districts, ESF #8 staff may also be organized under the Public Safety Branch of the Operations Section as the Firefighting/EMS/HazMat Unit. If branches are not established within the Operations Section, ESF #8 reports directly to the Operations Section Chief. Through the Operations Section / Branches, ESF #8 coordinates with other ESFs and ECC Command and General staff as necessary to ensure public health and medical service support is synchronized with countywide emergency support efforts. Within ESF #8, the primary agencies (Thurston County Public Health and Social Services, Thurston County Emergency Management and Thurston County Medic One) coordinate with state/regional health authorities and networks, mass local hospitals, clinics, and EMS providers, long-term / skilled care facilities, and the county coroner's office as necessary to support countywide public health and medical service activities during emergencies.



2.2 ESF-8 Agencies & Organizations

Local agencies that coordinate ESF-8 support are identified under one of two categories: primary or supporting. Definitions of each can be found under section 2.3.2 of the base plan.

Primary Agencies
Thurston County Public Health & Social Services (TCPHSS)
Thurston County Emergency Management (TCEM)
Thurston County Medic One
Supporting Agencies
Thurston-Mason Behavioral Health Organization (TMBHO)
Thurston County Coroner's Office (TCCO)
Disaster Medical Control Center (DMCC)
Providence St. Peter Hospital and Family of Clinics
Capital Medical Center and Family of Clinics
Thurston County Sheriff's Office (TCSO)
Northwest Healthcare Response Network (NWHRN)
Washington Department of Health (WA DOH)

3. Concept of Operations

3.1 General

TCPHSS is the lead agency for incidents requiring coordination by ESF #8 primary and supporting agencies. TCEM is the lead agency for staffing, equipping, and operating the ECC to include coordinating requirements for ESF #8 staff within the ECC. Both TCEM and TCPHSS maintain 24-hour on-call duty officers and serve as points of contact to request ESF #8 activation. Once activated, ESF #8 becomes the central hub for coordinating information and requests for public health and medical service support during incidents.

Incident response will be guided by each of the ESF #8 partners and their response plans in close coordination with ESF #8 staff. ESF #8 staff will in-turn ensure coordination and situational awareness updates are shared between all ESF #8 response partners.

Under the legal authority granted to Local Health Officer under RCW 70.05, TCPHSS will establish and lead an appropriate incident command structure for the healthcare system and to provide effective decision making and resource coordination during execution of ESF #8 activities. The specific command structure may vary depending on the type of incident, threat and risk posed, jurisdictions involved, suspected criminal activities, and legal responsibilities and authorities of participating agencies. Partner agencies within the healthcare system are expected to follow the principles of NIMS and ICS when coordinating countywide public health and medical service response with TCPHSS and ESF #8.

ESF #8 staff may collaborate with local, state, tribal, and federal governmental agencies, as well as community-based organizations to assure an effective and efficient response. Public/private

partnership will be leveraged to improve situational awareness, increase availability of resources, and to speed recovery efforts. Activities aimed at restoring health and medical services to pre-event status is the desired end state for ESF #8 activities.

3.2 Activation of Public Health & Medical Services ESF #8

Request to activate ESF #8 may be made by public safety agencies and/or hospitals to the ECC Manager or ECC Duty-Officer when an incident has, or is anticipated to, overwhelm local healthcare and dispatch systems such as a mass casualty incident, mass fatality incident, and/or DMCC activation.

Request to activate ESF #8 may also be made by TCPHSS to the ECC Duty-Officer when a public health emergency has, or is anticipated to, exceed the capabilities of TCPHSS and local healthcare systems to manage such as a disease outbreak, food borne or environmental hazard, bioterrorism hazard or other environmental, natural, man-made, technical health hazard.

ESF #8 activation may also be requested by the ECC Manager to TCPHSS when the ECC staff have determined a need for enhanced coordination of public health and medical services support as part of an all-hazards response.

When the Thurston County ECC or other ECC's are activated, TCPHSS will coordinate staffing the appropriate ESF #8 representative(s), or their partners, as needed.

TCPHSS will designate an ESF 8 Coordinator to coordinate decision making and resource coordination during emergencies and disasters. They will assign appropriate staff to ESF 8 functions in the Thurston County ECC and other local EOCs as needed and, will ensure a liaison will be assigned to support the local/county ECC with primary incident jurisdiction, when requested.

Healthcare organizations will utilize WATrac to assist with the coordination of emergency room bed capacity, resources, and communication during an emergency event if able. WATrac is the incident management software system for Washington State, is provided by the WA State Dept of Health and is administered by the Northwest Healthcare Response Network (NWHRN), which supports coordinating regional communications, Patient Tracking for emergency events, as well as reporting on bed availability throughout the region and the state.

3.3 Critical Public Health & Medical Services Response Tasks

To achieve effective disaster response, ESF-8 coordinates information and resources among primary and supporting agencies to support critical response tasks. The critical tasks identified below align with ESF-8's primary core capabilities and serve as a foundation to develop intermittent objectives during disaster response to re-establish or re-stabilize community lifelines.

#	Critical Task Description	Responsible Agencies
Public Health, Healthcare, and Emergency Medical Services		
1	Coordinate provision of mental health services for members of the public and/or critical incident stress-debriefing for responders as requested	Thurston-Mason Behavioral Health
2	Employ all-hazards surveillance systems to monitor the health of the general and medical needs population, as well as that of response workers, and identify emerging trends and provide public health recommendations related to the disaster	TCPHSS
3	Institute disease control measures consistent with Washington State Law, TCPHSS Department Policies and Procedures, and sanitary codes, and recommended Washington State Department of Health, and Centers for Disease Control and Prevention guidelines	TCPHSS
4	Investigate, control, and survey for communicable diseases to identify health hazards and monitor disease trends.	TCPHSS
5	Identify and coordinate procurement of pre-hospital medical resources to resupply field units with consumable medical supplies as necessary	Medic One
6	Conduct internal damage assessments of healthcare systems and facilities, determine status of patients, personnel, communication capabilities, utilities, and essential resources and relay information to the ECC through ESF #8 staff.	DMCC
7	Coordinate resources to support pre-hospital triage and treatment, patient tracking, distribution, and patient return.	Medic One
8	Coordinate resources to support inpatient hospital care, outpatient services, behavioral healthcare, medical needs sheltering, pharmacy services, and dental care to victims with acute injury/illnesses or those who suffer from chronic illnesses/conditions.	TCPHSS
9	Provide support to laboratory diagnostics and through the Laboratory Response Network (LRN) provides a mechanism for laboratories to access additional resources when the capabilities or capacity have been exceeded	TCPHSS
10	Coordinates with other local agencies and/or regional partners to utilize civilian volunteers during times of medical surge, including those deployed through the Medical Reserve Corps	TCPHSS
11	Coordinate resource support for triage, patient treatment, and patient movement.	Medic One DMCC
12	Implement, as necessary, isolation and quarantine measures as well as medical countermeasure and vaccine point of distribution operations (e.g., mass prophylaxis).	TCPHSS

#	Critical Task Description	Responsible Agencies
Critical Transportation		
13	Coordinate transportation of seriously ill or injured patients and medical needs populations from point of injury or casualty collection points in the impacted area to designated reception facilities.	Medic One
14	Coordinate patient movement in or out of Thurston County and Region 3 (Grays Harbor, Lewis, Mason, Pacific, and Thurston Counties).	DMCC Providence St. Peter Hospital
15	Provide resources to assist in the movement of at-risk/medically fragile populations to shelter areas and with the sheltering of the special medical needs population that exceeds the local capacity.	Medic One Fire/EMS Agencies
16	Coordinate private vendor medical transportation (ground and air) support to assist in the movement of patients.	Medic One
17	Provide resources to on-scene incident command(s) as necessary to support medical evacuation of seriously ill or injured patients.	Medic One Fire/EMS Agencies
Environmental Response/Health and Safety		
18	Coordinate measures for vector control, examination of food and water supplies for contamination, and compliance of emergency sanitation standards for disposal of garbage, sewage, and debris	TCPHSS
19	Assessment of environmental contamination and public health risk from hazardous materials spills	TCPHSS WA DOE (ESF #10)
20	Provide technical assistance to incident command(s) and ECC staff, to include conducting exposure assessments and risk management to control health hazards for response workers and the public.	TCPHSS
21	Assist in assessing potable water, wastewater, solid waste disposal, and other environmental health issues related to public health in establishments holding, preparing, and/or serving food, medical facilities, as well as examining and responding to public health effects from contaminated water.	TCPHSS
22	Coordinate with ESF #11 to ensure the safety, security, and defense of federally regulated foods.	TCPHSS
23	Provide advice to private industry regarding the safety and efficacy of drugs; biologics (vaccines and other medical countermeasures); medical devices (including radiation emitting and screening devices); and other products that may have been compromised during an incident.	TCPHSS WA DOH

#	Critical Task Description	Responsible Agencies
Fatality Management Services		
24	Coordinate investigations into cause and manner of death resulting from emergency or disaster.	Coroner
25	Coordinate identification and proper handling and disposition of the dead, registering of deaths at the TCPHSS Vital Records Office.	Coroner
26	Coordinate information and notification about deceased individuals to family members.	Coroner
27	Coordinate support to local mortuary services as needed. Request supplemental assistance for identification, movement, storage, and disposition of the dead if local resources are exceeded.	Coroner
28	Coordinate with ESF #8 to provide behavioral health support to families of victims during the victim identification mortuary process	Coroner
29	Coordinate temporary interment of human remains when permanent disposition options are not readily available.	Coroner
Logistics and Supply Chain Management		
30	Support medical resource needs, facilitation of healthcare related mutual aid, coordination of patient tracking and activation of healthcare clinical and policy leadership groups to inform the healthcare organizations and the health department	NWHRN
31	Determine the need for procurement and transportation of equipment, pharmaceuticals, and medical supplies; diagnostic supplies; radiation detection devices; and medical countermeasures including assets through DOH of from the Strategic National Stockpile (SNS); in support of immediate public health, medical and veterinary response operations	TCPHSS
32	Coordinate with regional health administrators and NWHRN to ensure the safety, availability, and logistical requirements of blood, blood products and tissue.	TCPHSS Medic One DMCC Local Hospitals
Operational Coordination		
33	Coordinate with primary, support, and partner agencies to effectively make decisions, provide situational awareness, and support resource management.	TCPHSS
34	Coordinate mutual aid with neighboring jurisdictions' (Pierce, Grays Harbor, Mason, Kitsap, and Lewis counties) emergency medical services for ALS and BLS services should response requirements exceed capabilities of local EMS system.	Medic One

#	Critical Task Description	Responsible Agencies
Public Information and Warning		
35	Provide public health, behavioral health, disease, and injury prevention information to public information officers that can be transmitted to members of the public and responders who are in or near affected.	TCPHSS PIO (ESF #15)
36	Gathers information on healthcare impacts and other healthcare related situational awareness, reports to TCPHSS and other LHJs in the region	NWHRN
37	Support ESF #15 and the Joint Information Center (JIC) in the release of general medical and public health response information to the public.	TCPHSS

3.5 Supporting Activities

3.5.1 Prevention and Protection

TCPHSS supports prevention and protection through day-to-day operations as the local health authority for the county. Activities include ongoing surveillance and monitoring of endemic and emerging diseases and enforcement of environmental and health regulations to prevent illness, injury, and protect public health.

3.5.2 Mitigation

TCPHSS is a participate in hazard mitigation planning facilitated by TCEM. Both TCEM and TCPHSS coordinate with local healthcare providers to assess vulnerabilities to critical infrastructure in the healthcare sector and implement mitigation measures to reduce vulnerabilities as resources permit. See the *Hazards Mitigation Plan for the Thurston Region* for details on the county's mitigation initiatives.

3.5.3 Recovery

ESF #8 maintains an active role during the transition to long-term recovery until a Recovery Task Force is established to coordinate the health and social services recovery support function (See the Thurston Region Disaster Recovery Framework). ESF #8 recovery activities include, but are not limited to:

- Identifying impacted populations with access and functional needs to ensure tailored services during recovery efforts.
- Coordinating and disseminating public health guidance and messaging to the public and relevant partners during recovery.
- Coordinating employment of medical volunteers, such as the Medical Reserve Corps, to support recovery effort.

3.6 Preparedness Activities

TCPHSS, TCEM, and Medic One coordinate with ESF #8 support agencies to support planning, organization, equipping, training, and exercise activities to build and sustain ESF #8 response capabilities. ESF #8 preparedness activities include, but are not limited to:

- Identifying and pre-designate Points of Dispensing (POD) sites.
- Public education campaigns on public health emergency preparedness
- Providing relevant emergency preparedness and response training.
- Identification of EFS #6 primary and support agency training needs as part of the county's integrated preparedness planning.
- Coordinating with local healthcare agencies and organizations to pre-position essential supplies (PPE, vaccine storage etc.) to ensure quick response during public health emergencies.
- Organizing collaborative drills and exercises, focused on responding to public health emergencies.
- Continuously improving the TCPHSS emergency response plans and associated annexes, involving relevant partners and stakeholders in planning process
- Maintaining a response-ready Medical Reserve Corps (MRC)

4. Responsibilities

4.1 Thurston County Emergency Management (Joint-Primary Agency)

TCEM has primary responsibility for activating, staffing, and equipping the ECC to include ESF #8. TCEM is responsible for coordinating all necessary support with the TCPHSS and Medic One to ensure the success of ESF #8 operations. Responsibilities include, but are not limited to:

- Coordinate with TCPHSS Departmental Operations Center (DOC) when activated.
- Coordinate multi-organization/agency support to ESF #8 with neighboring jurisdiction emergency management organizations.
- Coordinate logistics support for health emergencies.
- Open Joint Information Center (JIC) as needed.
- Provide situational awareness on behalf of ESF #8 to the State Emergency Operations Center
- Coordinate with the Disaster Action Council (DAC) for VOAD support to ESF #8.

4.2 Thurston County Public Health & Social Services (Joint-Primary Agency)

TCPHSS has significant authorities and responsibilities as the county's local health authority under RCW 70.05. The Thurston County Public Health Officer will make reasonable efforts to obtain voluntary compliance to public health orders (such as isolation and quarantine) but has the authority to impose involuntary detention when necessary. The county health officer may invoke the powers of police officers and sheriff's deputies to enforce orders given to preserve public health (Chapter 70.05 RCW). Additional responsibilities include, but are not limited to:

- Coordinating with primary, support, and partner agencies to effectively make decisions, provide situational awareness, and support resource management during an incident.
- Assisting with public health, medical, and recovery efforts within the county
- Supporting other joint-primary and supporting agencies with related activities

- Acting as necessary to maintain public health and sanitation supervision within the county.
- Taking actions to prevent and control the spread of emergent, communicable, and infectious diseases.
- Providing information about the source, nature, prevention, and intervention of communicable disease and disability and the preservation, promotion, and improvement of public health in the county
- Promoting the public's health by developing and issuing public health educational & emergency materials in multi-languages and accessible formats
- Instituting disease control measures consistent with Washington State Law, TCPHSS Department Policies and Procedures, sanitary codes, and recommended Washington State Department of Health and Centers for Disease Control and Prevention guidelines
- Ensuring all facilities operating under ESF 6 and ESF 8 meet public health standards.
- Determining the need for and requests pharmaceuticals and medical supplies from the DOH and the SNS
- Managing the use and distribution of state and federal pharmaceutical and medical assets acquired from DOH and the SNS
- Providing consultation guidance and technical assistance regarding disease control and prevention methods
- Recruiting, training, and deploying the Thurston County Medical Reserve Corps (MRC)
- Providing oversight of potable water supply
- Coordinating with the Thurston-Mason Behavior Health Organization for disaster behavioral health response
- Informing the County Commissioners, Emergency Management, the Thurston County Board of Health, ESF 8 partners, healthcare providers, community partners, and the public about health conditions, warnings, and prevention/intervention information

4.3 Thurston County Medic One (Joint-Primary Agency)

Medic One is the lead agency for providing pre-hospital emergency medical services to the residents of Thurston County. Responsibilities include, but are not limited to:

- Providing training, equipment, supplies, and medical oversight for first responders.
- Serving as an advocate for efficient and effective emergency medical services, ensuring delivery of medical care that is consistent with professionally recognized standards.
- Assuring quality care management to ensure professional and public accountability for medical care provided within the TC EMS system.
- Managing all Thurston County EMS assets and other EMS asset response and recovery efforts.
- Collaborating with NWHRN and DMCC regarding patient tracking and surge.
- Coordinating with State DOH/EMS officials regarding out-of-area EMS certification credentials.
- Requesting designated disaster ambulance coordination as needed.

- Collaborating with other pre-hospital entities regarding altered scope of practices, alternative standards of care, alternate transport mechanisms, and alternate receiving facilities.
- Advocating for safety and protection of EMS personnel (adequate sleeping periods, food and hydration, PPE, immuno- or chemoprophylaxis, if needed.
- Providing quality assurance and medical oversight of prehospital patient care.
- Acting as a liaison between Public Health, Hospital, Fire Agencies, and EMS personnel.

4.4 Thurston County Coroner's Office (Coroner)

The Coroner has jurisdiction over bodies of all decedents (RCW 68.50.010). Investigation into the cause and manner of death resulting from an emergency or disaster is the domain of the Coroner with jurisdiction over all human remains resulting from the emergency or disaster and the responsibility of communicating information about the decedents to family members. Responsibilities include, but are not limited to:

- Coordinating support to local mortuary services as needed. Local funeral home staff may assist in the transportation of human remains from an emergency or disaster scene at the discretion of the coroner.
- Requesting assistance if local resources for investigations or transportation of decedents are overwhelmed.
- Identifying deceased persons within Thurston County when death results from an emergency or disaster and registering deaths at the TCPHSS Vital Records Office.

4.5 Thurston-Mason Behavioral Health Organization (TMBHO)

Thurston-Mason Behavioral Health Organization is the lead agency for response to community behavioral health needs, and responder behavioral health needs, during emergencies and disasters as appropriate and as resources are available. Mental health services and/or critical incident stress-debriefing will be coordinated as needed through the Thurston-Mason Behavioral Health Organization (TMBHO) as resources are available.

4.6 Thurston County Sheriff's Office (TCSO)

TCSO is the lead agency for ESF #13 (Public Safety, Security, and Law Enforcement) with responsibility to provide law enforcement assistance to ESF #8 as necessary to carry out public health and medical service support activities. Responsibilities within the scope of ESF #8 include, but are not limited to:

- Providing movement control support (traffic control, flow, etc.) to facilitate efficient and expedient ingress and egress from response sites. ESF #1 through TCPW should be activated if TCSO is unable to provide the necessary resources at the time (See ESF #1 – Transportation Annex).
- Assisting the County Health Officer with enforcement of lawful orders issued in accordance with the provisions of RCW 43.20.050(4) and 70.05.120.

4.7 Providence St. Peter Hospital and Family of Clinics/Disaster Medical Control Center (DMCC)

Providence St. Peter's Hospital is designated as the Disaster Medical Control Center (DMCC) for the Thurston region. Responsibilities within the scope of ESF #8 include, but are not limited to:

- Ensuring management and alternates are available to provide patient movement and coordination in the event of a mass casualty incident or hospital evacuation.
- Conducting internal damage assessments of their facilities to determine status of patients, personnel, communication capabilities, utilities, and other essential resources. They will relay this information to TC ECC, TCPHSS, other relevant partners including NWHRN.
- Transferring primary DMCC responsibilities to the DMCC alternate when necessary
- Providing patient care according to hospital policy. Expand patient care to alternate sites as directed by the Hospital Incident Command Center
- Managing and train medical care personnel and caregivers to respond appropriately to emergent events, along with the use and wear of PPE and standard precautions.
- Receiving notification of disaster situation and initiate appropriate disaster response plan(s)
- Receiving incoming patients
- Providing medical care
- Making assessment of hospital capabilities and damages

4.8 Northwest Healthcare Response Network (NWHRN)

NWHRN coordinates with healthcare organizations, EMS agencies and local partners related to healthcare response and recovery strategies and tactics to include patient movement and patient tracking. NWHRN will coordinate with TCPHSS within the ESF 8 structure and with the local/county EOCs Coordinate healthcare situational awareness and healthcare and local response partners. Additional responsibilities include, but are not limited to:

- Coordinating healthcare resource requests, including facilitation of healthcare mutual aid/healthcare resource sharing and support local EOCs if requested.
- Coordinating community patient movement and patient tracking with local healthcare partners.
- Coordinating healthcare policy and clinical partners to support response.
- Providing WATrac support to partner entities when requested.

4.9 Capital Medical Center and Family of Clinics

Capital Medical Center and Family of Clinics maintain responsibility of their operations, patients, staff, and facilities as healthcare providers. Responsibilities within the scope of ESF #8 include, but are not limited to:

- Receive notification of disaster situation and initiate appropriate disaster response plan(s).
- Receive incoming patients.
- Provide medical care.
- Make assessment of hospital capabilities and damages.

5. Resource Requirements

5.1 Local Resource Inventory

Thurston County has several volunteer groups that could aid in ESF 8 activities, including the Medical Reserve Corps (MRC) and others. Much of the assistance that would be required during public health or medical emergencies require technical expertise and appropriate credentials. We have many faith-based and community-based groups that help in providing and distributing resources to the community. TCPHSS has robust education, outreach, and translation services abilities.

Medical transportation resources include prehospital Advanced Life Support services (Tumwater FD, Olympia FD, Lacey Fire District #3), and Basic Life Support transport agencies, Lacey Fire District, Olympia FD, West Thurston Regional Fire Authority, Southeast Thurston Regional Fire Authority, South Thurston Fire & EMS, East Olympia Fire Department, South Bay Fire Department, McLane-Black Lake Fire Department, Griffin Fire Department, Bald Hills Fire Department, Olympic Ambulance, AMR, Northwest Ambulance.

5.2 Resource/Capability Gaps

Thurston County has resource and capability gaps that may be filled either with volunteer groups, acting on current MOUs, and/or by requesting aid from the Department of Health or other governmental agencies. Gaps include staffing and training needs, lack of technical expertise and equipment in certain subjects including HAZMAT and radiological incidents, storage, and stockpiling capabilities, adequate CPOD sites, healthcare infrastructure and a growing population, and more. County agencies are working to address these resource and capability gaps as part of continuous improvement.

5.3 Mutual Aid

5.4 State & Federal Aid

WA DOH assists with disease/suspicious substance identification through the State Public Health Laboratory, coordinates response actions with other jurisdictions, supports coordination of local partners with state and federal response, may assist with procurement/receiving of certain state assets related to public health and medical response, and provides radiological monitoring, analysis, and assessment assistance and expertise.

6. Supporting Plans & Procedures

6.1 State & Regional

6.1.3 Puget Sound Regional Catastrophic Disaster Coordination Plan and Annexes

Dating back to March 2008, a team consisting of representatives from eight counties in the Puget Sound Region of Washington State (Island, King, Kitsap, Mason, Pierce, Skagit, Snohomish and Thurston counties) and their associated cities, as well as State, federal and Tribal partners has worked in partnership to establish a Puget Sound Regional Catastrophic Disaster Coordination Plan and Annexes. The Medical Surge Resource Management, Pre-Hospital Emergency Triage and Treatment, and Victim Information and Family Assistance Center Annexes all support ESF #8 activities.

6.2 Local

6.2.1 Public Health Emergency Response Plan (PHERP) and Annexes

Operational plans and annexes detailing Thurston County Public Health & Social Services response for emergencies including Surveillance and Epidemiology Plan; Disaster Behavioral Health Plan; Crisis Emergency Risk Communication Plan; Environmental Health Response Plan; Isolation and Quarantine Plan; Family Assistance Center Plan; Medical Countermeasures Plan. These plans are designed as TLP:AMBER (Limited disclosure, restricted to participants' organization and its clients) and subject to control by TCPHSS.

6.2.2 Thurston County Multiple Casualty Incident (MCI) Plan

This plan is designed to ensure coordination and cooperation during an incident in which emergency medical services personnel and equipment at the scene are overwhelmed by the number and severity of casualties at the incident.

6.3 References

Northwest Healthcare Response Network (2024) *Healthcare Emergency Operations Plan*. URL: https://nwhrn.org/plans-and-tools/

7. Terms & Definitions

Isolation – separating a person known or believed to be infected with a communicable disease and potentially infectious from those who are not infected to prevent spread of the communicable disease.

Quarantine – separating a person believed to have been exposed to a communicable disease, but not yet symptomatic, from others who have not been exposed to prevent the possible spread of the disease.

Medical Countermeasures (MCMs) – FDA-regulated products (biologics, drugs, devices) that may be used in the event of a potential public health emergency stemming from a terrorist attack with a biological, chemical, or radiological/nuclear material, or a naturally occurring emerging disease.

Medical Reserve Corps (MRC) – a national network of volunteers, organized locally to improve the health and safety of their communities.

Community Point of Distribution (CPOD) – a location where the public can pick up life-sustaining commodities following a disaster or emergency.

8. Attachments

Attachment 1 – Thurston County Multiple Casualty Incident (MCI) Plan, 2023

Attachment 2 – Thurston County Public Health Emergency Response Plan (PHERP) **TLP:AMBER**

Attachment 3 – Thurston County Family Assistance Center (FAC) Plan (under development)

2023

Thurston County Multiple Casualty Incident (MCI) Plan

MEDICAL PROGRAM DIRECTOR: LARRY FONTANILLA, JR., MD

REVISION NOV. 2023

CONTENTS

LETTER OF AUTHORITY

Thurston County Multiple Casualty Incident (MCI) Plan 2023

LETTER OF AUTHORITY

The original MCI Plan was described in 1990 at the express direction of the Thurston County MCI Committee.

The 2017, 2018, 2020 and this current 2023 revision of this MCI Plan were directed by the Thurston County Operations Committee, to be completed over the course of the last year. This MCI plan and its component parts exist under the authority of Thurston County Emergency Medical Services Operations Committee and the Thurston County Medical Program Director, whose members maintain the exclusive rights of review and revision.

_____
Chair Thurston County EMS Operations Committee

_____(date)

_____
Thurston County Medical Program Director

_____(date)

Introduction and Acknowledgements

The first Thurston County Multiple Casualty Incident (MCI) Plan was described in 1990. Revisions were completed on October 5, 2017, October 31, 2018, and again on September 3, 2020. This completed edition with revisions is being published and distributed in November of 2023. Several changes have arisen based on additional research, a number of MCI experiences, and post-incident analysis. This document is the result of that review and revision. The personnel who participated in this work are provided below.

The document should be considered a "work-in-progress" that will benefit from regular review and, when pertinent, revision.

Representatives Listed Here

EXECUTIVE SUMMARY

Thurston County Fire, EMS, and Law Enforcement agencies define a Multiple Casualty Incident (MCI) as any time the presence of multiple patients at an incident affects the treatment decisions of individual patients. Thurston County strives to always provide the best care possible to any patient. However, when there are more patients than the resources on scene can adequately take care of, the goal must be to provide the best treatment possible for as many patients as possible. This means that operations must be adjusted to maximize the efficient use of available resources.

The "Golden Hour" of emergency medicine is a well-accepted concept which states that victims of trauma need to have surgery within one hour of the insult or injury to maximize survivability. Therefore, rapid transport to definitive care centers is the best way to increase survivability in an MCI.

The plan seeks to reduce unnecessary actions and streamline efforts to reduce the time it takes to remove all patients from the scene. This includes:

- Using the Sick/Not Sick triage patient care protocol standard which encompasses the SALT/RPM triage system utilizing color coded surveyors tape;
- Having the first arriving company establish a transportation corridor to ensure a smooth flow of transportation resources;
- Establishing geographic divisions in larger incidents to speed triage and extraction;
- Scaling patient tracking and documentation with the size and complexity of an incident.

MCI's can be as small as a few patients or as large as hundreds. Flexibility is integrated into this plan to accommodate all sizes of incidents. Issues related to a fractured or geographically challenging incident are also addressed. The federal disaster levels were used to help determine MCI incident sizes and the appropriate protocols for each level.

This plan is designed to be shared and integrated with local, state, and federal governmental agencies to ensure coordination and cooperation. During an incident, interagency cooperation will be in accordance with the National Incident Management System (NIMS). This document has been written to be compliant with NIMS, as well as to follow the Incident Command System (ICS). It is understood that based on the size and complexity of any incident, ICS positions may or may not be filled. Throughout this document MCI positions will be named; however, ICS designators will not be assigned. With the emphasis on rapid transport and efficient use of resources, Thurston County Fire, EMS, and Law Enforcement agencies will be ready to handle an MCI.

PLANNING ASSUMPTIONS

The traditional definition of an MCI is: any incident in which emergency medical services personnel and equipment at the scene are overwhelmed by the number and severity of casualties at that incident. A more specific working definition is any time the presence of multiple patients at an incident affects the treatment of individual patients.

The priority of an MCI response is to streamline efforts to speed patient transition to definitive care centers.

This plan is scalable to all sizes and complexity levels of MCI responses. Any action that delays the treatment or transport of patients should be modified or eliminated as long as it does not increase the risk to responders.

A transportation corridor needs to be established and secured early in the incident to facilitate rapid patient transport.

Thurston County emergency responders will use the Sick/Not Sick model for MCI triage. "Sick" patients will be classified as red. "Not Sick" patients will be classified as yellow or green. Other triage types may be used if approved by the Thurston County Medical Program Director (MPD).

All triage systems produce similar results, resulting in red, yellow, green and black (deceased) patients. Therefore, when working with other agencies, it does not matter if different triage systems are used.

On scene treatment is dynamic, allowing alteration of treatment protocols to match available resources.

It is generally recognized that similar mechanisms of injury will have corresponding patterns of sick and not sick patients. This allows responders to quickly estimate the patient distribution based on total patient count. Using this assumption allows the first arriving officer to simply state the estimated total number of patients during the initial scene size up, rather than trying to determine the number of red, yellow, and green patients upon arrival. Assuming that 50% of the patients on scene will be red or yellow, this will give a quick guide to the number of resources that should be immediately requested and establish the scope of the incident.

Extrication priorities will be dynamic based on severity, access, and resources. It may be necessary or prudent to remove some yellow patients before red patients. Situations such as extended extrication times, yellow patients blocking the access of red patients, physical barriers, or a shortage of staffing may necessitate altering extrication priorities.

A choke point to the treatment area will be used to upgrade or down grade triaged patients coming in from the hot zone. Deceased patients will not be moved, unless it is necessary to extract a live patient.

The mental stress to these responders during an MCI can cause dramatic adverse effects. All agencies are encouraged to develop a program to help care for emotional and mental health of their staff including the use of defusing techniques and Critical Incident Stress Management.

DEFINITIONS

Alternative Care Facility (ACF): Location, preexisting or created, that serves to expand the capacity of a hospital in order to accommodate or care for patients when an incident overwhelms local hospital capacity. In an MCI, patients will be triaged and transported to the hospital not the ACF for definitive care.

ALS/BLS Transport Staging: Designated parking area for patient transport vehicles. Operators and attendants will not leave their vehicles.

Apparatus Level I Staging: Staging at incident address, a block away or otherwise in the immediate area.

Apparatus Level II Staging: Staging away from incident, usually at a set location with other apparatus.

Ballistic Vest: Worn on the torso and is often called a bulletproof vest. This item of personal armor helps absorb the impact and reduce or stop penetration to the body from firearm-fired projectiles- and shrapnel from explosions. The vest would also carry triage tags, colored surveyors tape, scissors and other lifesaving equipment such as tourniquets while entering a "warm zone" during violent incidents such as an active shooter scenario.

Casualty Collection Point (CCP): A specific Warm Zone location with security measures to assemble nearby casualties and provide Indirect Threat Care.

Color Identifiers Canopies: E-Z Up color-coded canopy system to be used in the Treatment area during a Multiple Casualty Incident.

Color Identifiers (Triage Belt/Surveyors Tape/Triage Tags/Tarps): A color coded identification system used to designate medical priority of patients during a Multiple Casualty Incident.

- Red (immediate)
- Yellow (delayed)
- Green (minor)
- Black (deceased)

Decontamination (Decon): To decontaminate a person or persons in accordance with the Thurston County Hazardous Materials/Weapons of Mass Destruction Operating Guidelines. Joint Base Lewis McCord Fire and Emergency Services has a 300 person decontamination trailer. Regionally, decontamination resources are available on site at MultiCare Capital Medical Center (CMC), Providence St. Peters Hospital (PSPH) and Providence Centralia Hospitals (PCH).

Disaster Medical Control Center (DMCC): The DMCC (also known as Hospital Control) is the Hospital responsible for providing Transport with a coordinated distribution of patients to area hospitals based on patient needs and the hospital capabilities. For the purpose of the plan, Providence St. Peter Hospital will be the primary DMCC for Thurston County.

Extraction: The process of moving patients out of the hot zone to the treatment and transport areas.

Extrication: The process of removing a patient from an entrapment.

Field Treatment Site: Area designated or created by emergency officials for the congregation, triage, medical treatment, holding, and/or evacuation of casualties following a multiple casualty incident.

Field Triage: The process of rapidly categorizing a large number of patients according to their severity of injury in order to prioritize their extrication and/or extraction to the treatment area. Various forms of triage used to determine the severity of a patients injuries and condition. Examples are:

- **Sick / Not Sick:** The Sick/Not Sick approach to triage utilizes the EMT's knowledge and experience to rapidly evaluate a patient's physiological status. The sick patient is categorized as Red. The not sick patient is considered Green if they are able to get up and walk on their own, and Yellow if they have injuries preventing moving themselves. It is understood that the Sick/Not Sick model encompasses the **SALT/RPM** Triage used to determine the patient's severity and transport priority.

- **SALT / RPM Triage:** An acronym for Sort, Assess, Lifesaving Interventions, and Treatment and Transport, and is defined as being a method that first responders evaluate a patient's status based on Respirations, Pulse, and Mentation during a multiple casualty incident.

Green Patient Area: An area dedicated for congregation, treatment, and care of patients with minor injuries. Designated as a separate area from Treatment due to the large number of potential patients and the special considerations they may need such as shelter, food and restroom facilities. Depending on the type of incident they may also be considered witness/suspects and require police presence.

Green Patient Manager: A functional IMS position designed to manage the green patients at an MCI.

Medical Direction: Physician direction over pre-hospital activities. Also includes written policies, procedures, and protocols for pre-hospital emergency medical care and transportation.

Medical Program Director (MPD): This position is certified by and appointed by the Washington State Department of Health and operates under the direction and protection of the state. In this role, the MPD is responsible for the education, certification, and quality assurance for the care provided by all emergency medical services in Thurston County. Thus, all emergency medical services personnel in Thurston County work under his/her state license.

Medical Group/Branch: Ensures that Triage, Extraction, Treatment, Transportation, Green Patient Area, Medical Staging, and Morgue Team functions are performed; establish positions as necessary.

Medical Staging: An area established to maintain medical supplies, personnel and equipment. The Medical staging Area will not be necessary at all incidents, when it is indicated, Medical will assign a Medical Staging Manager.

Multiple Casualty Incident (MCI): An incident resulting from man-made or natural causes with associated illness or injury to a large number of people. The effect is that patient care cannot be provided immediately to all and resources must be managed.

MCI Bag: An MCI Bag contains equipment necessary to respond rapidly and to provide effective management during a multiple casualty event.

MCI Response: Varied level of resources dispatched to an incident dependent upon the nature of the incident, the number of patients, and their severity of injury.

MCI Unit: A mobile unit, which contains large quantities of medical supplies that can be dispatched to a scene of an MCI.

Operational Zones (Hot, Warm, Cold, Exclusion): Operating zones that define areas of an incident and provide for a safe working area for responders. These Zones are also used in response to Thurston County Fire/EMS Response to Large – Scale Violent Incidents involving threats or acts of violence in cooperation and coordination with responding Law Enforcement Agencies as found in Appendix "I" Definitions.

> The Hot Zone: will be considered a higher risk area, and should be restricted to personnel who have donned appropriate PPE, have the appropriate training, e.g. Haz-

Mat, SORT teams and have an assigned task at their training level within this area.

The Warm Zone: is the transition area between the Hot and Cold Zones and will contain any decontamination procedures. This area should be restricted to personnel who have donned appropriate PPE, have the appropriate training, e.g. Haz-Mat, SORT teams and have an assigned task at their training level within this area.

The Cold Zone: will contain all Emergency services activities not involved in Hot or Warm Zones. This includes the Treatment area, Transportation Corridor, Command Post and Staging areas.

The Exclusion Zone: will be the outside limit of the Cold Zone. The public and media will be located outside the Exclusion Zone. Small incidents will allow scene tape to be used to physically designate the Exclusion Zone. Law Enforcement should be used in larger incidents to secure the Exclusion Zone.

Personal Protective Equipment (PPE): Refers to protective clothing, helmets, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection. The hazards addressed by protective equipment include physical, electrical, heat, chemicals, biohazards, and airborne particulate matter.

Recon: The act of gathering information to support the operation or function being performed.

Rescue Group/Branch: In larger or more complex incidents Rescue Branch will oversee Groups/Teams for the extraction and extrication of patients.

Special Operations Rescue Team (SORT): SORT is a Multi-Disciplinary Technical Rescue Team made up of Rescue Tech Level Firefighters from multiple fire agencies within Thurston Co., WA.

Staging: Location where incident personnel and equipment are assigned on an immediately available status.

Treatment Area: The designated area for the collection and treatment of patients.

- **Red:** an area where patients require immediate assistance
- **Yellow:** an area where patient injuries are serious (delayed) but not life-threatening
- **Green:** an area where patients with minor injuries are kept

Triage Belt: A unique belt designed for use within the triage system. It utilizes four colors of survey tape to categorize patients during the sifting and sorting process.

Unique Identifier: Uniquely numbered barcode label (STATBAND®) bracelet to assist in tracking patient throughout the incident from initial entry through chokepoint to final disposition.

MCI CONCEPT OF OPERATIONS

DISPATCH

TCOMM 911 (Thurston 911 Communications) is the answering point and dispatch center for all law enforcement, fire services, and Medic One in Thurston County. TCOMM dispatch center has put in place a matrix and/or a run card to activate an MCI and dispatch the proper resources to the scene of the incident. All requests for MCI upgrades and Mutual Aid are coordinated through dispatch. A dispatcher or the Incident Commander (IC) can call an MCI incident. If the dispatcher calls for one, they will notify the IC to let them know why. For both the dispatcher and the IC, the following are the guidelines for calling an MCI:

Patients	Fire Units	Medic Units	Aid Units	Transport	Command Officer
MCI – 1 (1st Alarm) 1-6 Pts.	3 Engines	2	3	All Private Ambulance Companies	1
MCI – 2 (2nd Alarm) 7-12 Pts.	6 Engines 1 MCI Trailer (TFD)	4 Out of County ALS Units	6	All Private Ambulance Companies	2
MCI – 3 (3rd Alarm) >12 Pts.	9 Engines 1 MCI Trailer (FD6)	6 Out of County ALS Units	All Available	All Private Ambulance Companies	3

INITIAL REPORT AND SIZE UP

As with any fire or rescue response, the initial company is responsible to give an initial CAN (Conditions, Actions and Needs) report. These reports give dispatch and all incoming units a "picture" of what the initial company is seeing.

Upon arrival the initial company officer will broadcast the initial report over the radio, including the following in the report:

- Unit identifier
- The location, or corrected location

- Initial basic impression

As soon as possible, the officer will give a size-up report including:

- Briefly describe an impression of the scene, including known hazards
- Cause of the incident if known
- Estimate total number of patients
- Establish the Command Designator and Command Post Location
- Designate the Transportation Corridor (see Transportation Corridor)
- Initial actions and assignments
- Staging locations
- Additional resource requests

PROGRESS REPORTS

Progress reports are required any time there is a change of the Incident Commander and every 10 minutes.

The progress reports should include the flowing:

- Current estimated total patient count
- Update transportation corridor location as needed
- Numbers of red, yellow, green, and black (deceased) patients when known
- Number of patients remaining to be extracted
- Number of patients transported
- Progress of hazard mitigation
- Additional resources needed

TACTICAL BENCHMARKS

- All patients extracted
- All red patients transported
- All patients transported/clear of incident
- Any tactical benchmarks appropriate for hazard mitigation

INITIAL ACTIONS

The initial actions of the first arriving company officer are critical to ensuring a successful outcome. Depending on the size and complexity of the incident, the initial company may be able to fill many roles, or handle only a few assignments.

Critical Initial Company Actions:

- Initial and size-up reports
- Establish and secure the transportation corridor
- Give assignments to incoming units (to include staging)

Assignments to be handled by initial companies:

- Begin Recon and Triage, as soon as possible
- Perform a risk assessment and begin hazard mitigation for the purpose of reducing the immediate danger to patients, rescuers, or the public
- Designate a green patient area and have all green patients move to that location
- Begin extraction and treatment of patients as able

RECON

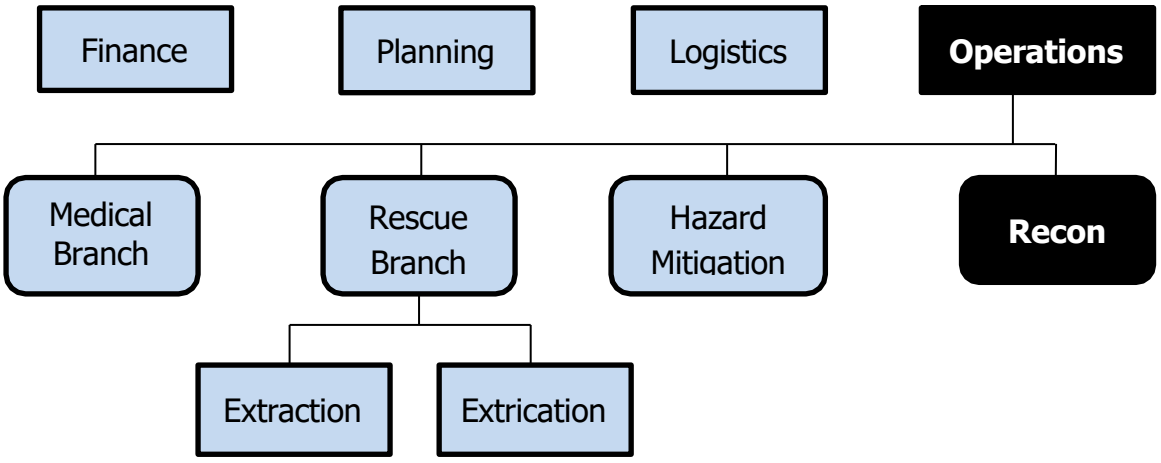
A rapid reconnaissance of the entire MCI site is essential to establish the scope and scale of the incident. Depending on the size and complexity of the incident, this may require a Recon Group consisting of multiple teams. The overriding factor should be speed as opposed to specificity to ensure that the information reaches the IC in a timely manner.

Recon should identify the following:

- Equipment needs
- Levels of PPE that will be required. (Note: Differing levels may be required in different areas.)
- Estimate the number and condition of patients involved so that the appropriate MCI response can be initiated through the IC
- Hazards
- Cause of the incident
- Any physical barriers preventing easy access between areas in the hazard zone. If so, identify areas for multiple treatment and transportation areas

Recon teams should consider using an elevated platform to help form an overall picture of the incident. This can include nearby buildings, aerial ladders, or geographical highpoints. Helicopters may also be considered for Recon. If helicopters are being considered, Recon should evaluate any restrictions to landing zone locations. Additionally, consider the possibility of implementing temporary flight restrictions to news helicopters and other aircraft that may be operating over the emergency scene.

Recon reports directly to Operations (example below).



SCENE SECURITY

Scene security will be the responsibility of law enforcement, but Fire and EMS personnel must stay alert to potential security issues including but not limited to:

- Secondary Devices
- Crowd control
- Traffic control

The situation may cause the delay of certain operations while law enforcement clears the hazard area. Clear and consistent communication between Fire, EMS, and Law Enforcement is critical to maintain security.

OPERATIONAL ZONES

Initial companies need to clearly establish appropriate operational zones for the incident. The zones must be clearly communicated to all on-scene responders, including law enforcement. The operational zone locations should be broadcast over the main tactical channel to inform all incoming units even if coordination with law enforcement is handled face to face. Fire scene tape should be used to clearly mark the exclusion zone (outer perimeter) of an incident when possible. Larger sites may need to be secured by law enforcement.

The following list outlines the zones that should be established:

The Hot Zone: will be considered a higher risk area, and should be restricted to personnel who have donned appropriate PPE, have the appropriate training, e.g. Haz-Mat, SORT teams and have an assigned task at their training level within this area.

The Warm Zone: is the transition area between the Hot and Cold Zones and will contain any decontamination procedures.

The Cold Zone: will contain all emergency services activities not involved in Hot or Warm Zones. This includes the Treatment area, Transportation Corridor, Command Post and Staging areas. Other stakeholder entities such as Thurston County Public Health, emergency management will be allowed in this area depending on the incident and need.

The Exclusion Zone: will be the outside limit of the Cold Zone. The public and media will be located outside the Exclusion Zone. Small incidents will allow scene tape to be used to physically designate the Exclusion Zone. Law Enforcement should be used in larger incidents to secure the Exclusion Zone.

CROWD CONTROL

Care must be given to crowd control, but total exclusion of bystanders and volunteers may not be possible or practical as victims of the incident may have been separated from friends, or family members, and will experience even greater anxiety when dealing with unknown.

If at all possible, reunification may help in this effort as needed or appropriate. If exclusion is impossible or impractical, attempts should be made to moderate the risk to both bystanders and rescue personnel with the help of law enforcement.

VOLUNTEERS

MCI incidents may draw civilian and professional volunteers with varying levels of skill and expertise. These volunteers can be helpful if utilized in a safe and organized way, but if they are ignored, they can hinder efforts and increase the risk to both themselves and personnel.

Volunteers may be assigned appropriate tasks according to their self-claimed knowledge, skills, and abilities as long as the risks associated with these tasks are minimized. It may be difficult or impossible to verify the claims of expertise by volunteers and care should be taken to place them in supervised roles. It is important to remove or replace volunteers as resources become available.

STAGING

Three separate staging areas should be considered based on the size and complexity of the MCI. The first staging area should be for personnel or equipment immediately available for use.

There should be a separate Transportation Staging area that is established for apparatus that will be used to transport patients from the scene to a facility. The transportation Staging area may be managed by a private ambulance supervisor with capabilities of communicating to both Transport as well as the staged units. In the Transportation Staging area, personnel are not to leave their vehicles.

TRANSPORTATION CORRIDOR

The transportation corridor must be established early and clearly communicated by the first arriving company officer during the initial size-up. The exact street, entry point, exit point, and direction of flow must all be determined and communicated. Law enforcement will clear and protect the designated corridor; all other apparatus should keep this location clear. Large incidents may require law enforcement to extend the protected corridor all the way to the hospitals.

The first arriving company is responsible for defining and determining a transportation corridor. The corridor must be maintained until law enforcement takes over the security of the corridor. If the initial company cannot commit a member, they will assign that task to another unit from the initial response.

The member controlling the corridor should anticipate requirements for treatment and decontamination areas, and a patient loading area adjacent to the designated corridor.

All apparatus operators must keep the transportation corridor clear.

TREATMENT AREA

The patient treatment area will be established in conjunction with the transportation corridor. It should be adjacent to the transportation corridor to facilitate Communication, tracking, and patient transfer. If the treatment area and transportation corridor are unable to be co-located, they should be located as close as possible with a clear path between the two and their locations broadcast over the primary tactical radio channel.

The treatment area will be the responsibility of TREATMENT, typically, a senior ALS member appointed by MEDICAL.

Extracted patients will be delivered directly to the treatment area through a choke point unless diverted to the transport corridor by Treatment.

Large incidents may necessitate large treatment areas with separate areas and staff for red and yellow patients. Multiple treatment areas with corresponding transportation corridors may be needed. TREATMENT needs to request enough staff to handle care for the expected number of patients that may be present.

The level of treatment performed in the treatment area may vary according to the situation, but rapid patient stabilization will be the priority. The level of care will be determined by TREATMENT in accordance with Thurston County EMS Standing Orders, Policies, Procedures, Guidelines and/or direction from DMCC / Hospital Control.

FIELD TREATMENT SITE

When circumstances dictate that EMS resources must continue to treat patients, Medical should consider establishing a Field Treatment Site (FTS). An FTS may be as simple as extended use of the treatment areas created at the incident or as complex as translocating patients to an Alternate Care Facility that has been opened to EMS. In some cases local agencies and jurisdictions will predetermine where EMS might naturally establish an FTS. Ad-hoc FTSs may be established wherever the IC can rally enough resources to effectively care for patients.

EMS may need to establish an FTS for any of the flowing reasons:

- Transport resources are inadequate
- Transport cannot keep pace with Extraction
- Number of patients at the incident cannot be handled at hospitals

TRIAGE

Triage will be dynamic, but will be a collective and ongoing effort to constantly evaluate patients at every step in the MCI process. The Sick/Not Sick triage standard will be used to evaluate patients.

It is understood that all patients should be triaged. However, depending on the variables of the scene, triage may be accomplished by: a Triage team, extraction teams, or after safely leaving the area.

Geographic triage allows a member to triage patients (sifting and sorting) in their assigned area and prioritize those patients for extraction utilizing color coded surveyors tape.

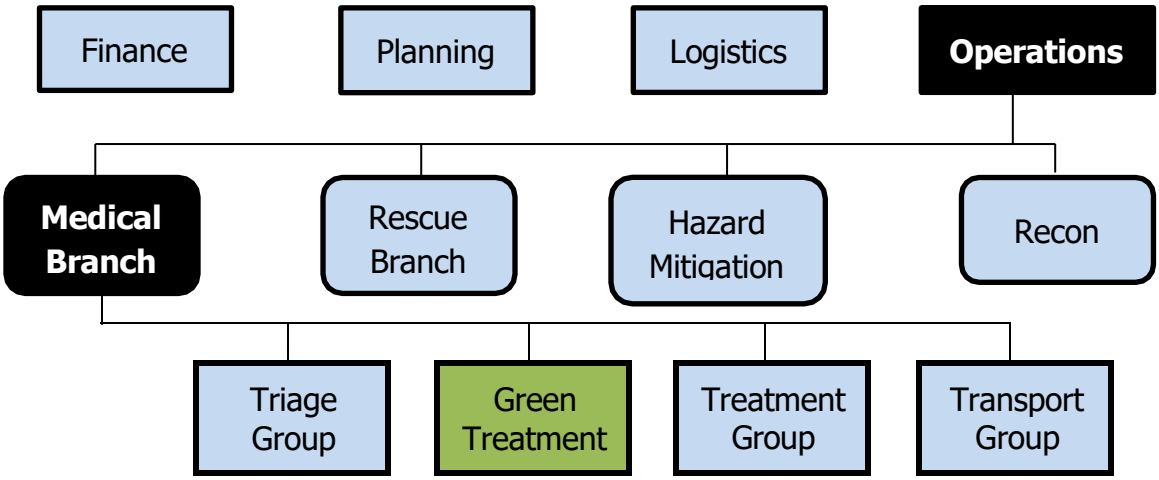
GREEN PATIENT AREA

The Triage Team(s) at an MCI will direct those that can walk to a designated area of refuge, or Green Patient Area. These patients will be initially classified as green patients. As soon as possible, a Green Patient Area Manager should be designated.

The Green Patient Area Manager is responsible for the following:

- Find or create a proper Green Patient Screening Area if one does not already exist and tag each of the Green Patients as green. Green patients will be included in the overall patient count
- Liaison with law enforcement
- Medically evaluate all patients, upgrading patients to red or yellow as needed, and moving those patients to the treatment area(s)
- Provide basic medical care
- Contain patients as needed (share responsibility with law enforcement)
- Consider comfort needs such as restroom facilities, water, blanket, etc.
- Provide information as it becomes available to the green patients
- Consider the need for emotional support including the chaplains, family members, or outside counseling support. Many of the green patients may have been separated from friends, or family members, and will experience even greater anxiety when dealing with unknown
- Documentation
- Patient Tracking
- Victim Assistance and Family Reunification
- Coordinate transportation of the green patients to the appropriate facility for treatment or family reunification (Emergency responder should accompany green patients during transport)

Law enforcement is critical in establishing and maintaining the green patient area. Law enforcement will likely want to interview and document green patients for investigation purposes. Security in the green patient area may be necessary.



COMMUNICATIONS

A single tactical radio channel may be adequate for a small MCI. Large or complex MCIs may quickly overwhelm a single radio channel, hampering critical communication. Therefore, maintain radio discipline as required. The Incident Commander should forecast incidents and with the assistance of the dispatch center, may designate multiple radio channels for the incident. Possible radio channel assignments are:

Operations channel to include:

- Operations
- Recon
- Rescue (May need a separate channel)
- Hazard mitigation groups

Medical channel to include:

- Medical
- Triage

- Treatment
- Transportation

Disaster Medical Control Center (Hospital Control) to include:

- Establishing communications from scene to DMCC/Hospital Control via cell phone
- Transportation

Radio communication may be further affected by many factors including:

- Areas of reduced radio signals
- Damage to radio/cell tower infrastructure
- System overload/outages

PATIENT DISPOSITION

RESCUE

Patient extraction from the hazard zone will be prioritized based on the patient's condition and difficulty of extraction. In larger incidents, Rescue will supervise Extraction as well as Extrication if needed.

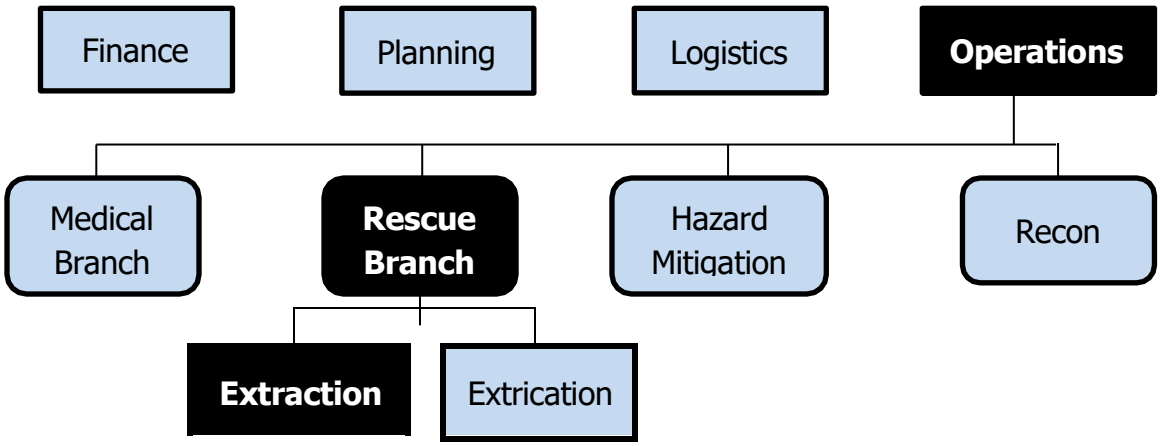
Large or complex incidents may require the hazard zone to be divided into geographical divisions. Supervisors should be alert to recon their assigned area.

Geographical recon includes:

- Number of patients in their area
- How many of those patients are Red, Yellow, and Black (deceased)
- Extraction needs, including number of patients and complexity
- Hazards inside their area

EXTRACTION

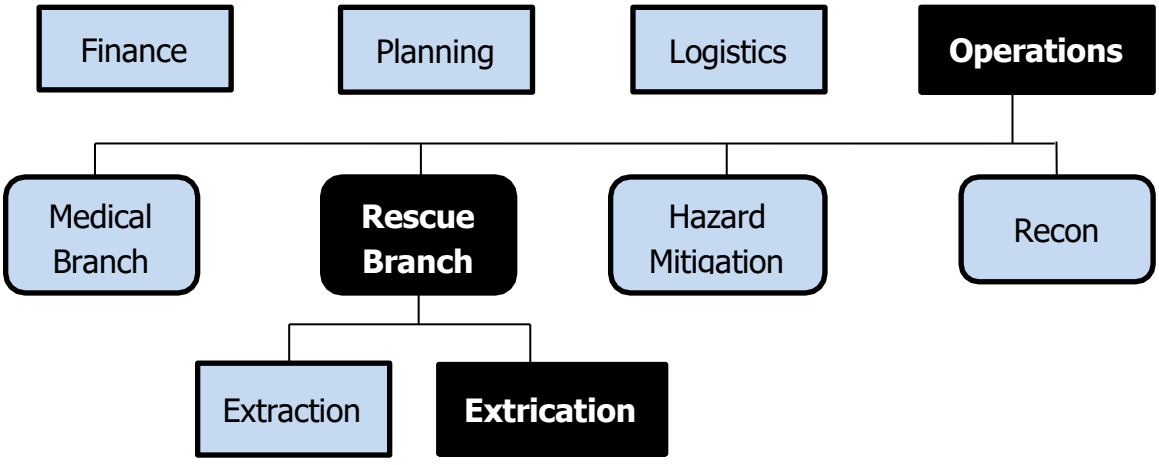
Extraction teams (litter carriers) will be composed of one or more pairs of personnel and will report to Medical or Rescue, depending on incident size, for the purpose of patient removal (harvesting) and delivery to the patient treatment area.



EXTRICATION

Disentanglement and technical rescue may be handled by extrication teams under direction of Rescue. When trapped patients are located, the extrication teams will be sent to assist with the technical removal of those patients. Extrication teams must prioritize their operations to remove as many viable patients as possible in the shortest amount of time.

In smaller incidents it is appropriate for litter-bearers to be assigned to Medical versus their own group under Operations.



DECONTAMINATION (DECON)

Any MCI, natural or intentional, may include the release of hazardous materials (haz-mat). Rescuers will need to evaluate the potential need for a haz-mat response and decontamination procedures. If a haz-mat release is known or suspected, a haz-mat response should be requested if not already dispatched. Primary tasks of the initial companies include wearing the appropriate level of PPE, considering a larger evacuation zone, and starting emergency decontamination procedures.

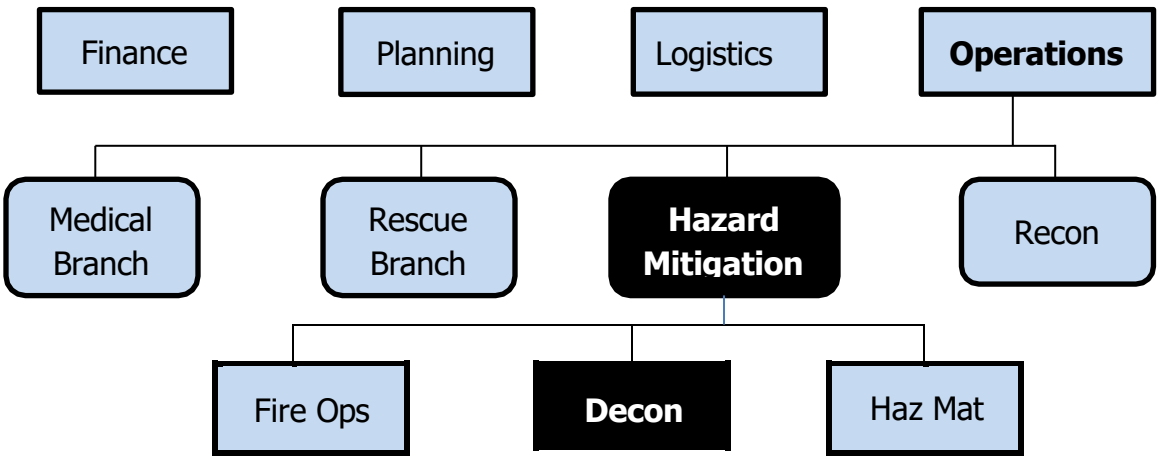
Treatment and/or transport of any patient cannot occur until the patient has gone through emergency decontamination.

It may be difficult to determine in the field if a patient is completely decontaminated, therefore patient contact should be limited to essential procedures in the field and during transport.

Tyvek suits should be used for patients after gross decontamination when their clothing has been discarded.

Decontamination procedures will occur in the warm zone.

If decontamination procedures are required, the IC must ensure that a large enough footprint has been established for both gross and technical decontamination.



PATIENT SHELTERING

Every attempt should be made to provide shelter for the patients in the patient treatment and green patient areas. The shelter should provide protection from the hazards, weather, media, and the public.

Shelters of opportunity, or existing buildings, should be considered first. Priority will be given to structures with bathroom facilities, running water, and buildings with access that can be easily controlled. If no existing buildings are easily accessible or adjacent to the transportation corridor, then temporary shelters may be used.

Possible temporary shelters include:

- Tents from Decontamination Units
- Public / School transportation
- MCI Bus (if available)

When choosing a shelter, the possibility for an expanding incident needs to be considered, ensuring patients are not placed into an existing or future hazard zone.

FIELD TREATMENT

In general, personnel will treat "Red" patients first, "Yellow" patients only as time allows, and "Black" (deceased) patients only after assuring that all patients from the red and yellow categories are stabilized. Note: Deceased patients will not be moved, unless it is necessary to extract a live patient. Depending on acuity and number of patients, it may be necessary to transport ALS patients in BLS units without the oversight of ALS personnel.

Providence St. Peter Hospital shall serve as the primary DMCC (Hospital Control). Once contact has been made with Hospital Control the connection shall not be disconnected.

Transport shall notify the receiving hospital of patient numbers and triage status prior to patient transport if possible. Individual transporting units will not routinely communicate to hospitals unless directed to do so.

PATIENT COUNT AND TRACKING

Patient count and tracking are important aspects of an MCI, especially when the incident is large and complex. Every effort will be made to count and track every patient that is cared for at an incident. The level of tracking may have to be scaled to an individual incident. Factors such as environment, severity of injuries, hazards, and number of patients will dictate the level of tracking. At no time will these activities be priorities above patient care and transport. Both the Triage and Treatment Group Supervisors will have patient tracking boards to attach uniquely numbered barcode sticker to.

Patient count and tracking will be the responsibility of Transportation in coordination with Treatment. An attempt will be made to attach a unique identifier to each individual patient. Transportation will attempt to keep track of the number of red, yellow, and green patients as they are transported utilizing the Transport Unit Patient Log.

Any first responder may be assigned to Transportation as an aide to assist in patient count and tracking.

DOCUMENTATION

ELECTRONIC PATIENT CARE REPORTING (EPCR)

Patient documentation is important; however, documentation should never delay patient care or transport. Individual ePCRs should be attempted at every incident, however, as an incident grows in size and complexity ePCRs may not be reasonable to complete. Incidents may have segments when ePCRs may be completed and other segments that circumstances prevent usage of ePCRs. At a minimum, a photograph of all patient tracking, command and control boards, MCI position sheets (Job Aides) shall be taken and filed with the incident report or official record. Consider taking a picture of the patient with their tag by their face.

UNIQUE NUMBER WITH TRANSPORTING AGENCY

When a patient is received by a transporting unit, personnel will document the unique identifier that is attached to the patient onto their agency's ePCR. If a unique identifier has not been assigned to the patient, then the transporting unit's personnel

will do so. Every effort will be made to give a copy of the unique identifier to Transport.

TRANSPORTATION

TRANSPORTATION will assign patients to transporting units as those resources arrive. Constant communication between TRANSPORTATION and TREATMENT is important to ensure that patients are ready to be transported.

Larger incidents may require non-traditional assets. If non-traditional assets without emergency signal devices are used, consideration should be given to using law enforcement escorts to aid during travel. Containing bio-hazardous material in non-traditional assets may be difficult, but tarps, plastic, or other resources should be used to limit the spread of this material.

If a Green patient is not transported e.g. the patient has been reunified with friends or family, their name should be documented on the Transport Unit Patient Log.

JOB ASSIGNMENTS

MEDICAL

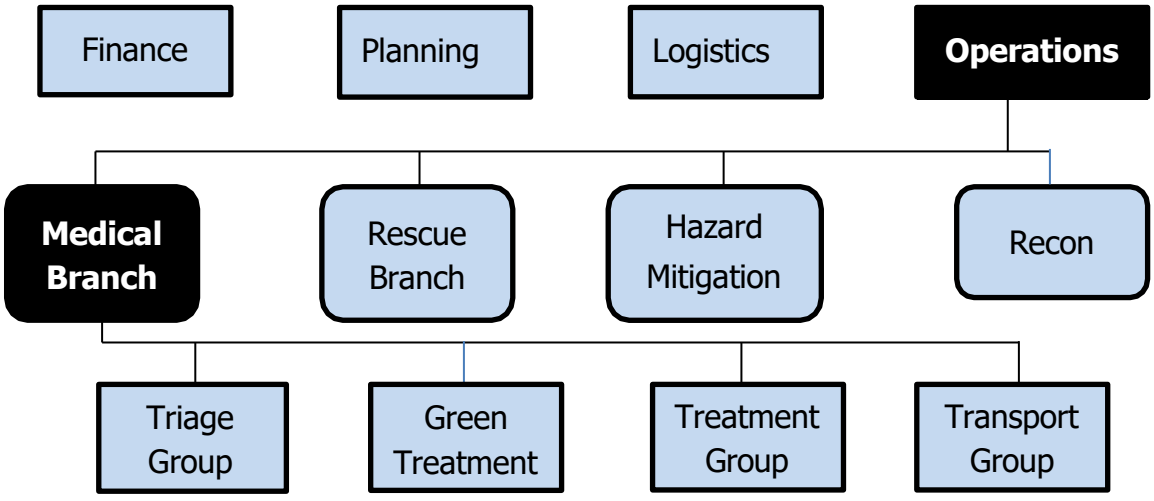
One of the first arriving ALS members should assume the role of Medical. The role of Medical, while initially filled by one of the first arriving ALS members, should be assumed by a senior ALS member, likely a Medical Services Officer (MSO), when possible. Intimate knowledge of the plan is necessary for MEDICAL.

MEDICAL is responsible for the following tasks:

- Transportation
- Treatment
- Triage
- Consider activation of the DMCC (Hospital Control)
- Green Patient management

MEDICAL may handle most or all of the responsibilities in smaller incidents. Larger or complex incidents will require Medical to be proactive in forecasting the incident and begin assigning roles as soon as possible. The use of Aides or Assistants will be needed particularly in complex incidents. Circumstances may dictate a large number of ALS and BLS personnel where:

- ALS personnel need to be prioritized to treatment due to a high patient count;
- Patient removal from the hazard zone will require a large amount of BLS personnel and/or complex coordination.



TREATMENT

Medical may designate an ALS member to be TREATMENT. (Note: Smaller incidents may allow Medical to retain this role). Treatment is responsible for the following:

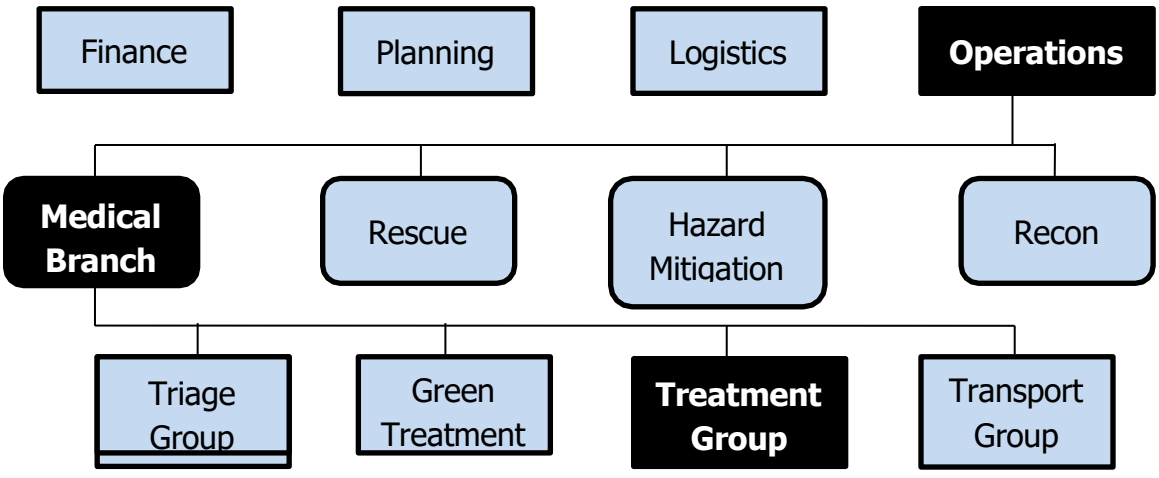
- Receiving patients from Extraction
- Placing bar code sticker on patient tracking board
- Supervising treatment of patients
- Managing Treatment Personnel
- Coordinating with Transportation
- Prioritizing patients for transport

The level of treatment performed in the treatment area may vary according to the situation, but rapid patient stabilization will be the priority. The level of care will be determined by the Treatment Team Leader.

TREATMENT, with input from TRANSPORTATION, may elect to have patients delivered directly to the transportation corridor for transport.

TREATMENT should request adequate personnel and resources to care for the expected number of patients.

The use of Aides or Assistants will be needed particularly in complex incidents.



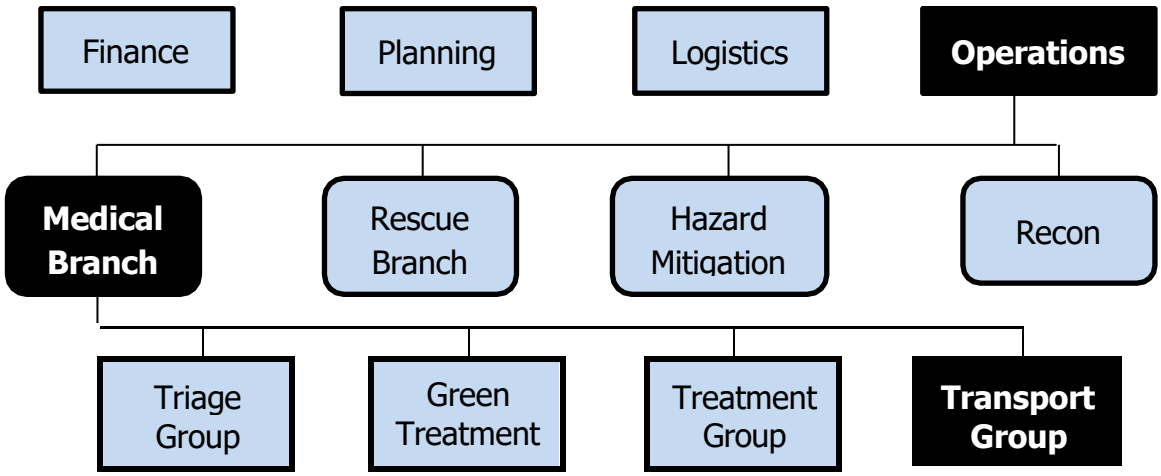
TRANSPORTATION

TRANSPORTATION should be designated early by MEDICAL. Smaller incidents may allow MEDICAL to retain this role. TRANSPORTATION should be a senior ALS member capable of performing a wide range of duties including:

- Communication with DMCC (Hospital Control)
- Keeping a total patient count of all transported patients (may be delegated to one or more Aides)
- Coordination with Treatment
- Coordination with law enforcement to clear the transportation corridor
- Liaison with transportation resources
- Maintain adequate transportation resources
- Initiate tracking if unique identifier not already assigned by placing bar code sticker on transport log

Incidents that require multiple transportation corridors must have multiple personnel assigned to Transport. They may act independently of each other. Transportation may contact the DMCC (Hospital Control) independently for patient destinations and be responsible for patient count and tracking.

The use of a Transportation Group Aide will be needed particularly in complex incidents.



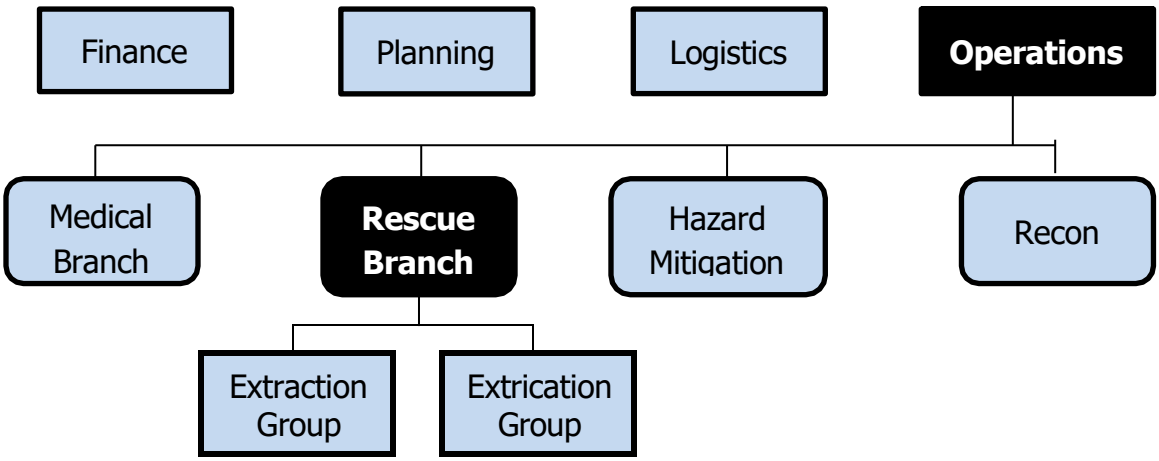
RESCUE

Rescue should be considered when:

- ALS staffing needs to be prioritized to patient treatment and transport
- Any part of patient removal from the hazard zone will require a large amount of BLS resources

Rescue may be in charge of triage and extraction of all patients from the hot zone into the patient treatment areas.

Technical Rescue Teams will report to Rescue to serve as technical advisors and participate in extrication as needed.



APPENDIX A: MCI RUN CARDS

Thurston County Run Cards for MCI

Patients	Fire Units	Medic Units	Aid Units	Transport	Command Officer
MCI – 1 (1st Alarm) 1-6 Pts.	3 Engines	2	3	All Private Ambulance Companies	1
MCI – 2 (2nd Alarm) 7-12 Pts.	6 Engines 1 MCI Trailer (TFD)	4 Out of County ALS Units	6	All Private Ambulance Companies	2
MCI – 3 (3rd Alarm) >12 Pts.	9 Engines 1 MCI Trailer (FD6)	6 Out of County ALS Units	All Available	All Private Ambulance Companies	3

Note: Consider the following if MCI is larger than MCI – 3. The request for the resources below would be attained through TCOMM.

- Out of County Structural Task Forces
- Out of County Engine Strike Teams
- Out of County EMS Task Forces
- Out of County ALS Strike Teams
- SORT Team
- Haz-Mat Team & Decontamination for up to 300 (JBLM F&ES)
- Mass Casualty Unit (JBLM)

APPENDIX B: MCI NOTIFICATIONS

- Medic Units (TCOMM)
- Disaster Medical Control Center (Hospital Control) Providence St. Peter Hospital (From the Scene)
- Private Ambulance & BLS Transport Providers (TCOMM)
- PIO (Host Agency / Delegated)
- All MSO's (TCOMM)
- Chief Officer Notification (TCOMM)
- Predetermined Out of Area ALS Strike Team, EMS Task Force, Engine Strike Team, Structural Task Force (TCOMM)
- Intercity Transport and School District Buses (TCOMM)
- MCI Units, Trailers etc. (TCOMM)
- SORT (TCOMM)
- Haz-Mat (TCOMM)
- Thurston County Coroner's Office (TCOMM)
- Thurston County Emergency Management (TCOMM)
- Thurston County Public Health (TCOMM)
- Thurston County Chaplain Notification (TCOMM)

APPENDIX C: MCI SITE PLAN AND JOB AIDES

THURSTON COUNTY MEDIC ONE

MASS CASUALTY INCIDENT SITE PLAN

ALS UNIT INSTRUCTIONS

ARE YOU THE FIRST-ARRIVING ALS UNIT?

YES - GO TO PAGE 2

NO - GO TO PAGE 9

BLS UNIT INSTRUCTIONS

ARE YOU THE FIRST-ARRIVING BLS UNIT?

YES - GO TO PAGE 2

NO - GO TO PAGE 10

FIRST FIRE DEPARTMENT BLS/ALS UNIT ON SCENE

INCIDENT COMMAND INITIAL INSTRUCTIONS

- ☐ Provide "windshield' scene size-up

INITIAL SIZE-UP

- ☐ Describe the scene (What do I have?)
- ☐ Advise of safety concerns for incoming units
- ☐ Assure safety of work area; mitigate hazards
- ☐ Describe your initial actions (What am I going to do?)

SIZE-UP UPDATE

- ☐ Request additional resources: First (MCI-1), Second (MCI-2), Third Alarm (MCI-3)
- ☐ Establish staging location
- ☐ Establish and Maintain Transportation Corridor
- ☐ Perform 360° scene survey
  - ☐ Direct placement of Loading Area
  - ☐ Establish Transportation Corridor
- ☐ Assign positions and brief subordinates:
  - ☐ Medical Branch Director
  - ☐ Triage Group Supervisor

MEDICAL BRANCH INITIAL INSTRUCTIONS

- First arriving Medic Unit Officer or BLS Company Officer becomes Medical Branch Director (Page 3)
  - Driver becomes Triage Group Supervisor (Page 4)

MEDICAL BRANCH DIRECTOR

MEDICAL BRANCH DIRECTOR

SUPERVISOR

- Operations Section Chief or Incident Commander

RESPONSIBILITIES

- Medical Operations at an incident

TASKS

- ☐ Don GREEN ICS vest
- ☐ Obtain Job Aide Board
- ☐ Receive briefing from supervisor
- ☐ Assure safety of work area; mitigate hazards
- ☐ Relay size-up to DMCC Hospital (PSPH ED) 360.491.8888 or 360.438.6666.
- ☐ Type of incident
- ☐ Estimated patient census (estimated number of patients only)
- ☐ Special situations (WMD, decontamination, burns, etc.)
- ☐ Assign positions and brief subordinates
- ☐ Triage Group Supervisor (Page 4)
- ☐ Treatment Group Supervisor (Page 5)
- ☐ Transportation Group Supervisor (Page 6)
- ☐ Direct layout of the Treatment area at location determined by supervisor
- ☐ Direct placement of Medical Supply Area
- ☐ Responsible for medical documentation of incident

FIRST ARRIVING MEDIC UNIT OFFICER OR BLS COMPANY OFFICER MAY ASSUME THIS POSITION

TRIAGE GROUP SUPERVISOR

TRIAGE GROUP SUPERVISOR

SUPERVISOR

- ☐ Medical Branch Director

RESPONSIBILITIES

- ☐ Develop and deploy Triage Team(s) for sifting and sorting utilizing surveyors tape
- ☐ Develop and deploy Harvesting Team(s)
- ☐ Secondary round of triage
- ☐ Focused exam of each patient at choke point
- ☐ Assign Triage Group Supervisor Aide

TASKS

- ☐ Don RED ICS vest
- ☐ Obtain Job Aide Board
- ☐ Receive briefing from supervisor
- ☐ Assure safety of work area; mitigate hazards
- ☐ Supervise initial SALT triage sifting and sorting
- ☐ Advise personnel to provide initial triage with surveyors' tape
- ☐ Establish Triage Choke Point at location determined by supervisor
- ☐ Remain at Choke Point until harvesting complete
- ☐ Conduct secondary exam for each patient
- ☐ Determine RED or YELLOW treatment for each patient
- ☐ Ensure all patients receive Triage Tag at Choke Point
- ☐ Retrieve Triage Tag sticker at Choke Point and place on Triage Tracking Board

DRIVER OF FIRST-ARRIVING ALS UNIT MAY ASSUME THIS POSITION

TREATMENT GROUP SUPERVISOR

TREATMENT GROUP SUPERVISOR

SUPERVISOR

- Medical Branch Director

RESPONSIBILITIES

- Supervise Treatment area(s)
- Coordinate vehicle load makeup with Transport Group Supervisor

TASKS

- ☐ Don BLUE ICS vest
- ☐ Obtain Job Aide Board
- ☐ Receive briefing from supervisor
- ☐ Assure safety of work area; mitigate hazards
- ☐ Establish and staff Treatment Area(s) at location determined by supervisor
  - ☐ RED - Immediate
  - ☐ YELLOW - Delayed
  - ☐ GREEN - Walking wounded
- ☐ Develop and supervise Treatment Teams from available personnel; request additional personnel through supervisor
- ☐ Maintain Treatment Area medical supply inventory; request additional supply resources through supervisor

OFFICER OF SECOND-ARRIVING ALS UNIT MAY ASSUME THIS POSITION

TRANSPORT GROUP SUPERVISOR

TRANSPORT GROUP SUPERVISOR

SUPERVISOR

- ☐ Medical Branch Director

RESPONSIBILITIES

- ☐ Development of Transport Loads
- ☐ Coordinate vehicle load makeup with Treatment Group Supervisor
- ☐ Supervise Loading Teams
- ☐ Obtain hospital destinations from DMCC (PSPH ED) 360.491.8888 or 360.438.6666

TASKS

- ☐ Don YELLOW ICS vest
- ☐ Obtain Job Aide Board
- ☐ Receive briefing from supervisor
- ☐ Assure safety of work area; mitigate hazards
- ☐ Assign Transport Group Supervisor Aide (Page 7)
- ☐ Establish and staff Patient Loading Area at location determined by supervisor
- ☐ Maintain Transportation Corridor
- ☐ Request transport vehicles from Staging Area Manager
- ☐ Coordinate with Treatment Group Supervisor to develop transport unit loads
- ☐ Assure hospital destinations are obtained from DMCC (PSPH ED) 360.491.8888 or 360.438.6666
- ☐ Communicate destination information to transport vehicles
- ☐ Collect and deliver transport unit/patient logs to supervisor

TRANSPORT GROUP SUPERVISOR AIDE

TRANSPORT GROUP SUPERVISOR AIDE

SUPERVISOR

- ☐ Transport Group Supervisor

RESPONSIBILITIES

- ☐ Assist Transport Group Supervisor

TASKS

- ☐ Receive assignments from and assist Transport Group Supervisor
- ☐ Don YELLOW ICS Job Aide Vest
- ☐ Obtain Job Aide Board
- ☐ Possible tasks include:
- ☐ Communicate with DMCC Hospital (PSPH ED) 360.491.8888 or 360.438.6666
- ☐ Complete transport unit Patient Logs
- ☐ Communicate transport destinations to transport units
- ☐ Communicate with Staging Area Manager to request transport resources to move into transport area
- ☐ Maintain Transportation Corridor

STAGING AREA MANAGER

STAGING AREA MANAGER

SUPERVISOR

- Operations Section Chief or Incident Command

RESPONSIBILITIES

- Maintain appropriate levels of transport, treatment and other resources

TASKS

- ☐ Don STAGING ICS vest
- ☐ Receive briefing from supervisor
- ☐ Assure safety of work area; mitigate hazards
- ☐ Develop Staging Area within line-of-sight of Loading Area along Transportation Corridor
- ☐ Maintain Transportation Corridor

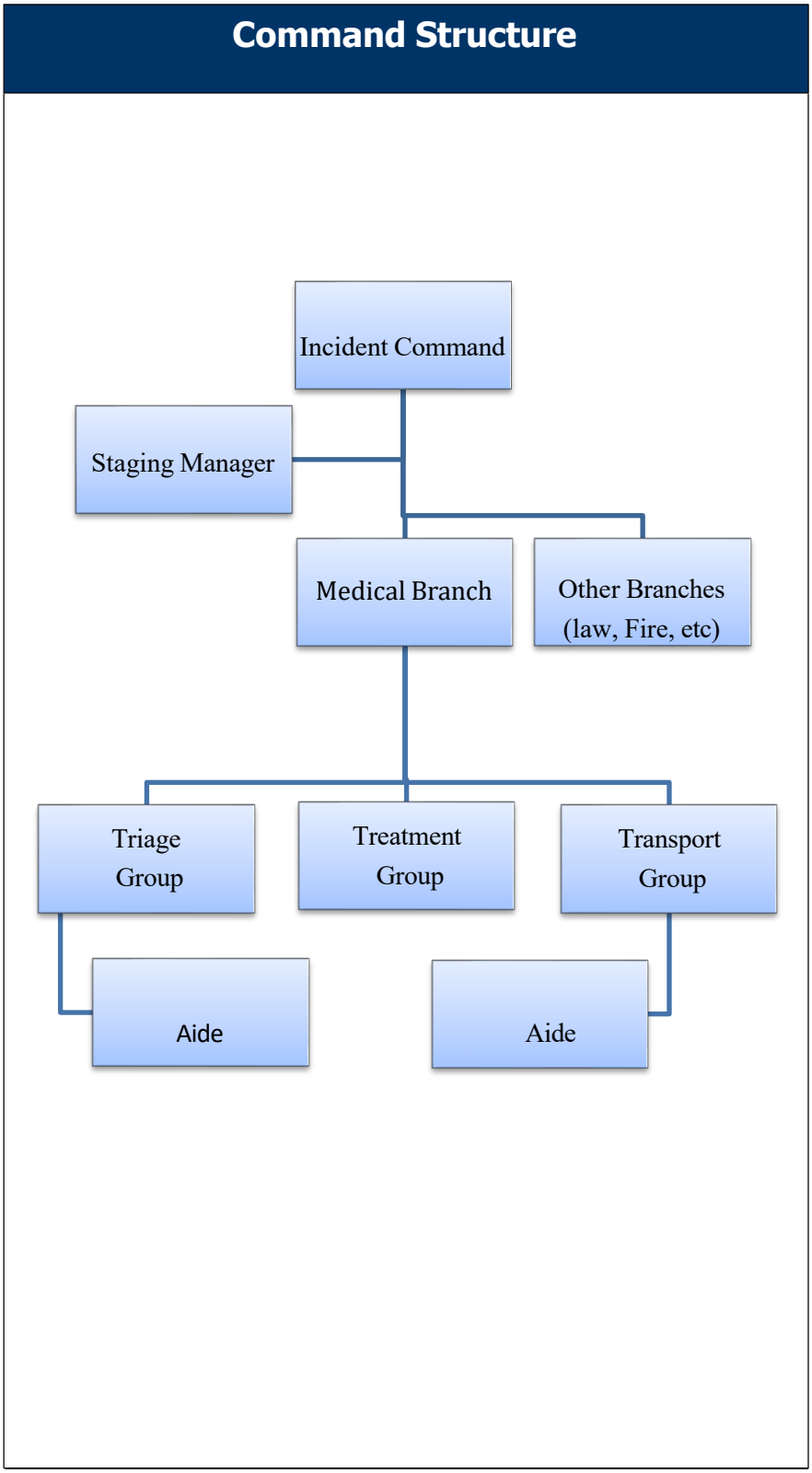
ALS Unit Instructions

- First two Thurston County ALS transport units should proceed directly to the Casualty Collection Point
- Other ALS resources should respond directly to Staging Area
- Check in with Staging Area Manager immediately

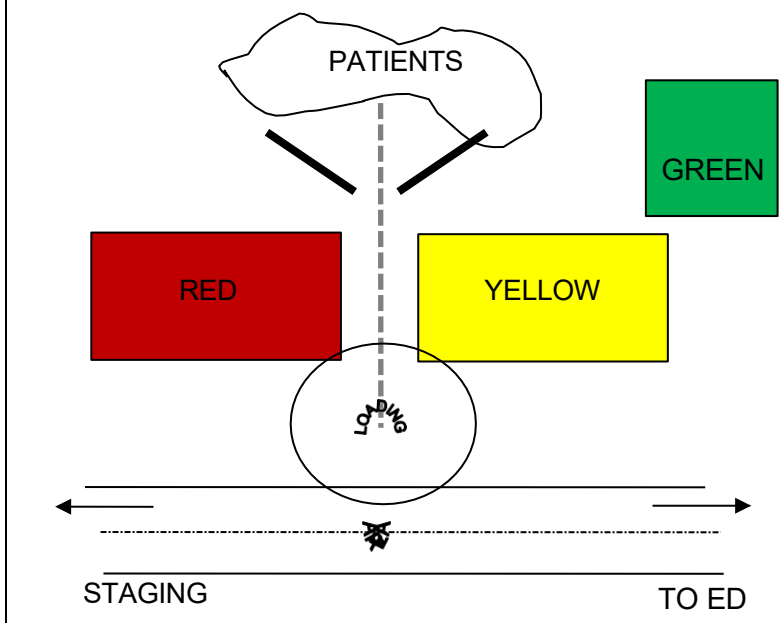
BLS Unit Instructions

- Check in with Staging Area Manager immediately
- If you arrive with a transporting unit, remain with that unit after reporting to Staging Area Manager
- Personnel will remain in Staging until deployed by Staging Area Manager

Command Structure



TREATMENT AREA SCHEMATIC



Maintain Transportation Corridor

RESOURCE ALLOCATION

MCI – 1	
1-6 PATIENTS	3 Engines
	3 FD Aid Units
	2 ALS Transport
	All PVT Amb

MCI – 2	
7 - 12 PATIENTS	3 Engines
	3 FD Aid Units
	2 ALS Transport
	4 ALS Units
	TFD MCI Trailer

MCI – 3	
>12 - 18 PATIENTS	3 Engines
	3 FD Aid Units
	2 ALS Transport
	6 ALS Units
	FD6 MCI Trailer

Incident Name	**Prepared By** (Name & Position)
	Date **Time**

Map/Sketch Include maps drawn here or attached, showing the total area of operations, the incident site/area, overflight results, trajectories, impacted shorelines or other graphics depicting situational and response status.

UNIT LOG – ICS 214

Time	Major Events

Prepared By *(Name & Position)*

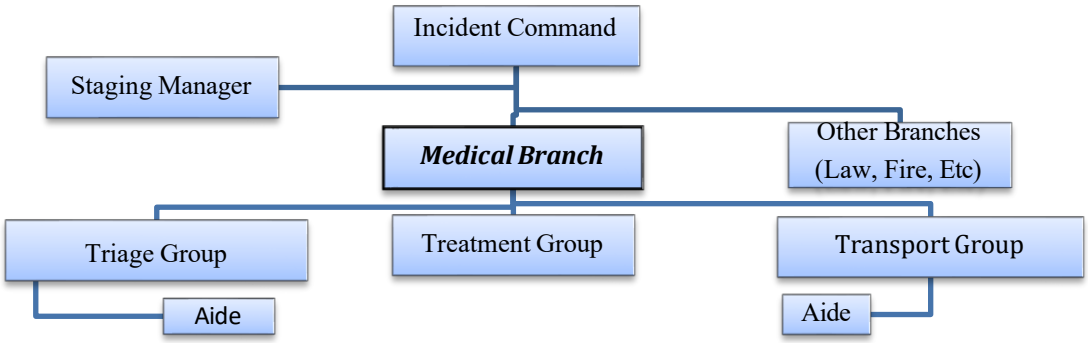
NOTES

MEDICAL BRANCH DIRECTOR

SUPERVISOR: ***OPS SECTION CHIEF or INCIDENT COMMANDER***

INCIDENT COMMAND	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
MEDICAL BRANCH DIRECTOR	*YOUR NAME*
Channel 1 2 3 4 5 6 7 8	***Phone***
TRIAGE GROUP SUPERVISOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
TREATMENT GROUP SUPERVISOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
TRANSPORT GROUP SUPERVISOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**

INCIDENT COMMAND STRUCTURE



STRATEGY

1) Life Safety – Responders and Civilians
2) Incident Stabilization
3) Property Conservation
4)
5)

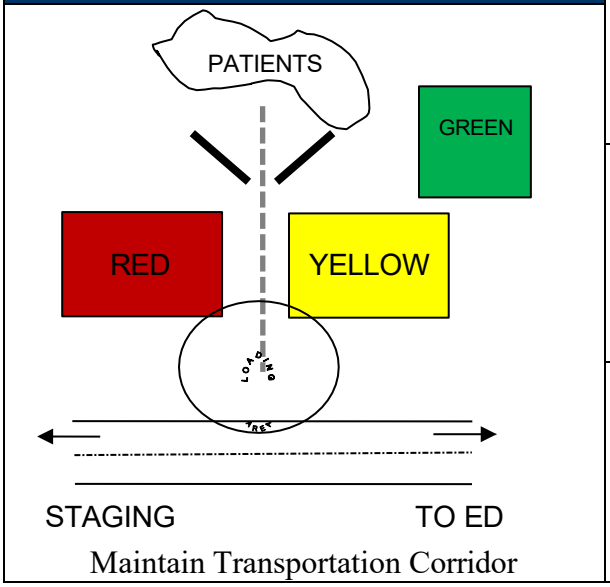
MEDICAL BRANCH ASSIGNED RESOURCES

Resource Name	Type	ETA	Assignment
	E A M		
	E A M		
	E A M		
	E A M		
	E A M		

MEDICAL BRANCH DIRECTOR TACTICS

- ☐ Don GREEN ICS vest & obtain Job Aide Board
- ☐ Receive briefing
- ☐ Contact DMCC (PSPH) 360.491.8888 or 360.438.6666
- ☐ Type of incident
- ☐ Estimated patient census
- ☐ Special situations (WMD, decontamination, etc.)
- ☐ Consider span-of-control
- ☐ Triage Group Supervisor *Name*:
- ☐ Treatment Group Supervisor *Name*:
- ☐ Transportation Group Supervisor *Name*:
- ☐ Direct Treatment Area
  - ☐ Direct Loading Area
  - ☐ Direct RED and YELLOW Treatment Areas
  - ☐ Direct Triage Choke Point
  - ☐ Direct GREEN Treatment Area
- ☐ Direct location of Medical Supplies
- ☐ Receive actual patient census from Triage Group Supervisor
- ☐ Monitor Critical Success Factors

TREATMENT AREA SCHEMATIC



Maintain Transportation Corridor

1-6 PATIENTS	**MCI – 1**
	3 Engines
	3 FD Aid Units
	2 ALS Transport
	All PVT AMB
7-12 PATIENTS	**MCI – 2**
	3 Engines
	3 FD Aid Units
	2 ALS Transport
	4 ALS Units
	TFD MCI Trailer
>12 PATIENTS	**MCI – 3**
	3 Engines
	3 FD Aid Units
	2 ALS Transport
	6 ALS Units
	FD6 MCI Trailer

MEDICAL BRANCH DIRECTOR CRITICAL SUCCESS FACTORS

- ☐ Receive briefing from Incident Command
- ☐ Evaluate and mitigate for all hazards
- ☐ Maintain communications with Incident Command
- ☐ Maintain communications with subordinates
- ☐ Maintain span-of-control
- ☐ Maintain awareness of resource status
  - ☐ Triage Group Supervisor
  - ☐ Treatment Group Supervisor
  - ☐ Transportation Group Supervisor
- ☐ Maintain awareness of subordinate progress toward objectives
  - ☐ Triage
    - ☐ SALT Triage (Sift & Sorting completed – all patients)
    - ☐ Establish Triage Choke Point; provide 2° triage & tag
    - ☐ Appoint Triage Group Aide
    - ☐ Supervise Harvesters
  - ☐ Treatment
    - ☐ Establish RED, YELLOW, GREEN Treatment Areas
    - ☐ Ensure adequate treatment resources
    - ☐ Ensure adequate levels of medical supplies
    - ☐ Coordinate transport unit loads with Transport Group
  - ☐ Transport
    - ☐ Establish Loading Areas
    - ☐ Appoint Transport Group Aide
    - ☐ Ensure communications: Aide and DMCC
    - ☐ Coordinate transport unit loads with Treatment Group
    - ☐ Document patient disposition

NOTES

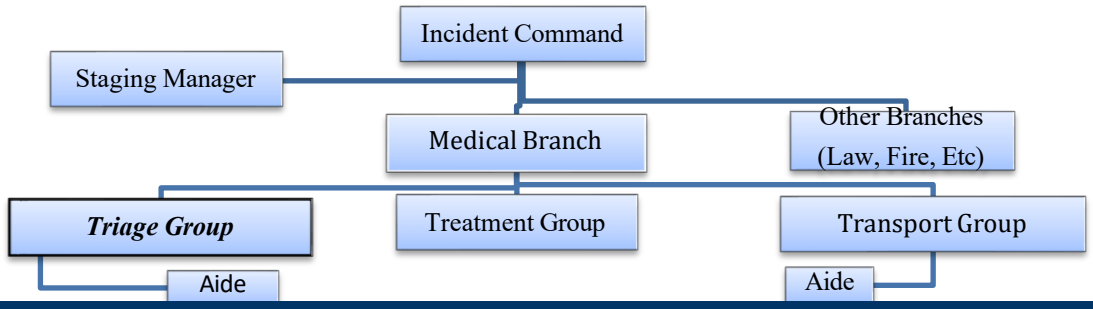
UNIT LOG – ICS 214	
Time	**Major Events**
Prepared By *(Name & Position)*	

TRIAGE GROUP SUPERVISOR

SUPERVISOR: ***MEDICAL BRANCH DIRECTOR***

INCIDENT COMMAND	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
MEDICAL BRANCH DIRECTOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
TRIAGE GROUP SUPERVISOR	*YOUR NAME*
Channel 1 2 3 4 5 6 7 8	***Phone***
TREATMENT GROUP SUPERVISOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
TRANSPORT GROUP SUPERVISOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**

INCIDENT COMMAND STRUCTURE



STRATEGY

6) Life Safety – Responders and Civilians
7) Incident Stabilization
8) Property Conservation
9)
10)

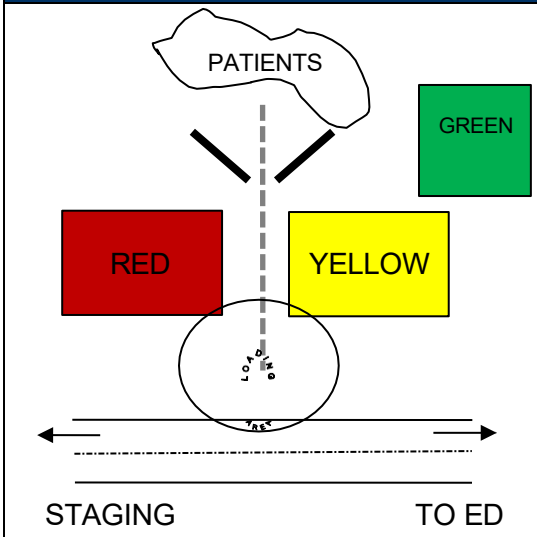
TRIAGE GROUP ASSIGNED RESOURCES

Resource Name	Resource Type	ETA	Assignment
	E A M		
	E A M		
	E A M		
	E A M		
	E A M		
	E A M		

TRIAGE GROUP SUPERVISOR TACTICS

- ☐ Don RED ICS vest & obtain Job Aide Board
- ☐ Receive briefing
- ☐ Assure safety of work area; mitigate hazards
- ☐ Brief subordinates
- ☐ Appoint Triage Group Aide
- ☐ Ensure Triage by harvesters (Sifting and Sorting of Patients)
  - ☐ Ensure all patients receive appropriate colored surveyors' tape Red patients harvested first, if possible
- ☐ Establish Choke Point
  - ☐ Conduct focused exam for each patient
  - ☐ Confirm RED or YELLOW treatment for each patient
  - ☐ Ensure all patients receive Triage Tags at Choke Point
  - ☐ Retrieve Triage Tag sticker at Choke Point and place on Triage Tracking Board
  - ☐ Remain at Choke Point until harvesting complete
- ☐ Ensure availability of sufficient harvesters, boards, litters
- ☐ Monitor Critical Success Factors

TREATMENT AREA SCHEMATIC



Maintain Transportation Corridor

	MCI – 1
1-6 PATIENTS	3 Engines
	3 FD Aid Units
	2 ALS Transport
	All PVT AMB
	MCI – 2
7-12 PATIENTS	3 Engines
	3 FD Aid Units
	2 ALS Transport
	4 ALS Units
	TFD MCI Trailer
	MCI – 3
>12 PATIENTS	3 Engines
	3 FD Aid Units
	2 ALS Transport
	6 ALS Units
	FD6 MCI Trailer

TRIAGE GROUP SUPERVISOR CRITICAL SUCCESS FACTORS

- ☐ Receive briefing from Medical Branch Director
- ☐ Evaluate and mitigate for all hazards
- ☐ Maintain communications with Medical Branch Director
- ☐ Maintain span of control/Assign Triage Group Aide
- ☐ Triage/Harvester Team #1 *Ldr Name:*
- ☐ Triage/Harvester Team #2 *Ldr Name:*
- ☐ Triage/Harvester Team #3 *Ldr Name:*
- ☐ Maintain awareness of subordinate progress toward objectives
- ☐ Triage Team(s)
  - ☐ SALT Triage completed – all patients tagged
  - ☐ Accurate patient census determined
- ☐ Harvester Team(s)
  - ☐ RED patients harvested first, if possible
  - ☐ Four rescuers per patient
- ☐ Provide Secondary Triage
- ☐ Establish Choke Point
- ☐ Conduct brief exam of each patient

NOTES

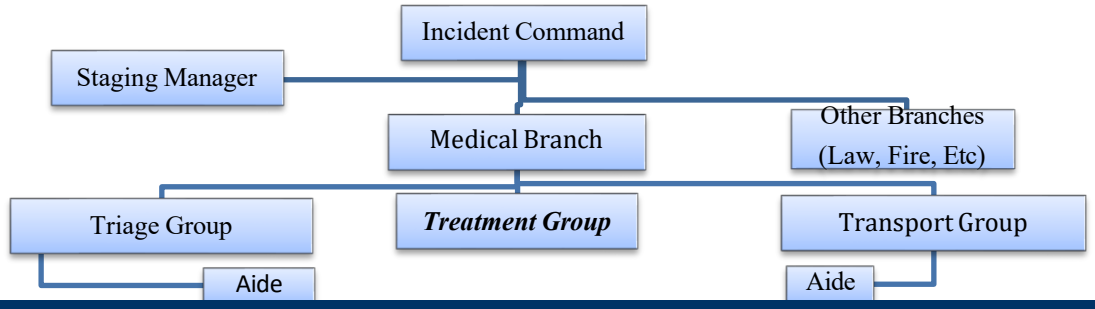
UNIT LOG – ICS 214	
Time	**Major Events**
Prepared By (Name & Position)	

TREATMENT GROUP SUPERVISOR

SUPERVISOR: *MEDICAL BRANCH DIRECTOR*

INCIDENT COMMAND	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
MEDICAL BRANCH DIRECTOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
TRIAGE GROUP SUPERVISOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
TREATMENT GROUP SUPERVISOR	*YOUR NAME*
Channel 1 2 3 4 5 6 7 8	***Phone***
TRANSPORT GROUP SUPERVISOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**

INCIDENT COMMAND STRUCTURE



STRATEGY

11) Life Safety – Responders and Civilians
12) Incident Stabilization
13) Property Conservation
14)
15)

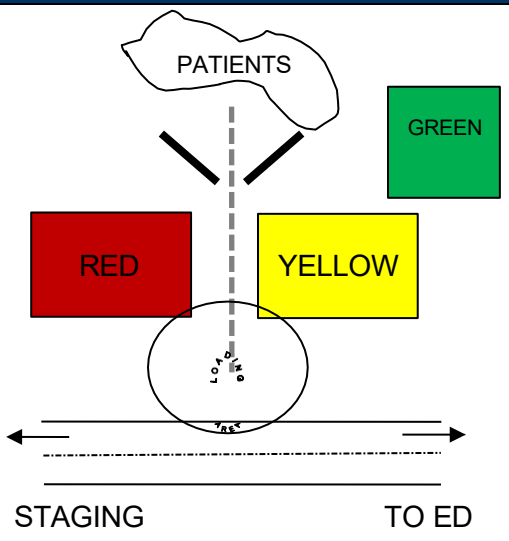
TREATMENT GROUP ASSIGNED RESOURCES

Resource Name	Resource Type	ETA	Assignment
	E A M		
	E A M		
	E A M		
	E A M		
	E A M		
	E A M		

TREATMENT GROUP SUPERVISOR TACTICS

- ☐ Don BLUE ICS vest & obtain Job Aide Board
- ☐ Receive briefing
- ☐ Assure safety of work area; mitigate hazards
- ☐ Set up and staff Treatment Areas
  - ☐ RED *Ldr Name:*
  - ☐ YELLOW *Ldr Name:*
  - ☐ GREEN *Ldr Name:*
- ☐ Ensure adequate medical supplies
- ☐ Ensure adequate treatment personnel
- ☐ Coordinate with Transport Group Supervisor for development of patient loads
- ☐ Monitor Critical Success Factors

TREATMENT AREA SCHEMATIC



Maintain Transportation Corridor

1-6 PATIENTS	**MCI – 1**
	3 Engines
	3 FD Aid Units
	2 ALS Transport
	All PVT AMB
7-12 PATIENTS	**MCI – 2**
	3 Engines
	3 FD Aid Units
	2 ALS Transport
	4 ALS Units
	TFD MCI Trailer
>12 PATIENTS	**MCI – 3**
	3 Engines
	3 FD Aid Units
	2 ALS Transport
	6 ALS Units
	FD6 MCI Trailer

TREATMENT GROUP SUPERVISOR CRITICAL SUCCESS FACTORS

- ☐ Receive briefing from Medical Branch Director
- ☐ Evaluate and mitigate for all hazards
- ☐ Maintain communications with Medical Branch Director
- ☐ Maintain communications with subordinates
- ☐ Maintain span-of-control
- ☐ Maintain awareness of resource status
  - ☐ RED Treatment Team
  - ☐ YELLOW Treatment Team
  - ☐ GREEN Treatment Team
- ☐ Maintain awareness of subordinate progress toward objectives
- ☐ Treatment Team(s)

☐ Ensure adequate medical supplies

☐ Ensure adequate numbers of providers

- ☐ Arrange transport for RED patients first, if possible

NOTES

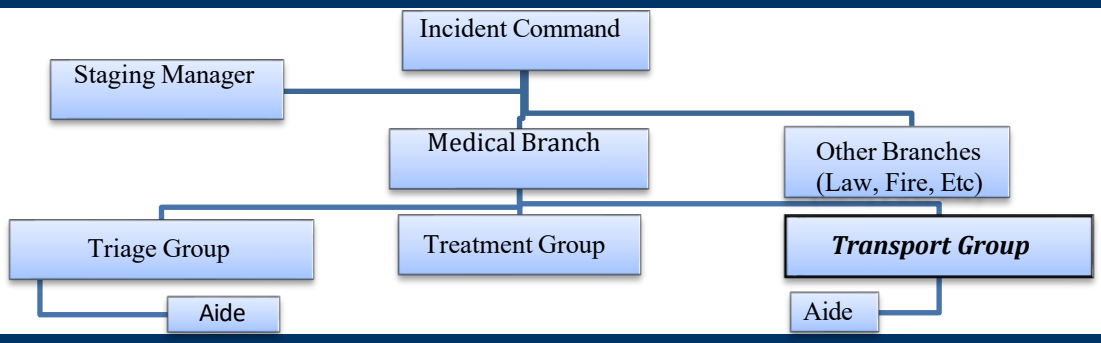
UNIT LOG – ICS 214	
Time	**Major Events**
Prepared By *(Name & Position)*	

TRANSPORT GROUP SUPERVISOR

SUPERVISOR: ***MEDICAL BRANCH DIRECTOR***

INCIDENT COMMAND	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
MEDICAL BRANCH DIRECTOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
TRIAGE GROUP SUPERVISOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
TREATMENT GROUP SUPERVISOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
TRANSPORT GROUP SUPERVISOR	*YOUR NAME*
Channel 1 2 3 4 5 6 7 8	***Phone***
TRANSPORT GROUP AIDE	*NAME*
Channel 1 2 3 4 5 6 7 8	***Phone***

INCIDENT COMMAND STRUCTURE



STRATEGY

1) Life Safety – Responders and Civilians
2) Incident Stabilization
3) Property Conservation
4)
5)

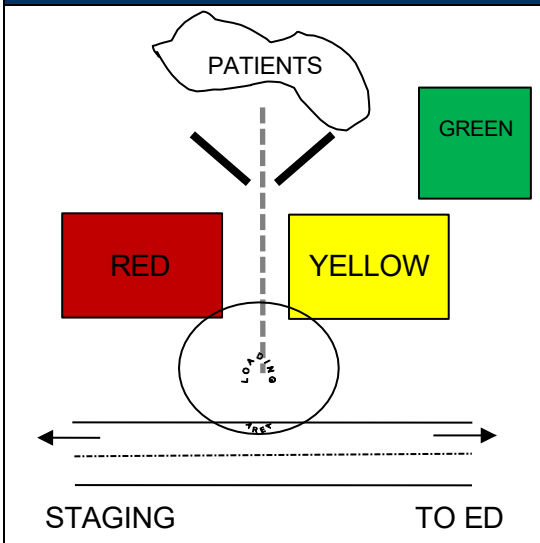
TRANSPORT GROUP ASSIGNED RESOURCES

Resource Name	Resource Type	ETA	Assignment
	E A M		
	E A M		
	E A M		
	E A M		

TRANSPORT GROUP SUPERVISOR TACTICS

- ☐ Don YELLOW ICS vest & obtain Job Aide Board
- ☐ Receive briefing
- ☐ Establish Loading Area
  - ☐ Flat, level, paved/Maintain Transportation Corridor
  - ☐ Well-lit (consider auxiliary lighting)
  - ☐ Allows loading and departure without turnaround
- ☐ Appoint Transport Group Aide
- ☐ Direct Aide to contact and maintain an open communications line with PSPH DMCC, 360.491.8888 or 360.438.6666.
- ☐ Ensure adequate Loading Teams
- ☐ Ensure adequate numbers of transport vehicles
- ☐ Order 1 transport vehicle per 2 patients, RED or YELLOW
- ☐ Plan for transport of GREEN patients (e.g., bus)
- ☐ Coordinate with Treatment Group Supervisor for development of patient loads
- ☐ Maintain transport unit logs, deliver to Medical Branch
- ☐ Monitor Critical Success Factors

TREATMENT AREA SCHEMATIC



Maintain Transportation Corridor

1-6 PATIENTS	**MCI – 1**
	3 Engines
	3 FD Aid Units
	2 ALS Transport
	All PVT AMB
7-12 PATIENTS	**MCI – 2**
	3 Engines
	3 FD Aid Units
	2 ALS Transport
	4 ALS Units
	TFD MCI Trailer
>12 PATIENTS	**MCI – 3**
	3 Engines
	3 FD Aid Units
	2 ALS Transport
	6 ALS Units
	FD6 MCI Trailer

TRANSPORT GROUP SUPERVISOR CRITICAL SUCCESS FACTORS

- ☐ Receive briefing from Medical Branch Director
  - ☐ Evaluate and mitigate for all hazards
  - ☐ Maintain communications with Medical Branch Director
  - ☐ Maintain communications with subordinates
  - ☐ Maintain span-of-control
  - ☐ Identify Loading area/Maintain Transportation Corridor
  - ☐ Maintain awareness of resource status
    - ☐ Transport GS Aide *Name:*
    - ☐ Loading Team *Name:*
  - ☐ Maintain awareness of subordinate progress toward objectives
  - ☐ Aide
    - ☐ Consult with DMCC for destination of each load
    - ☐ Process all patients one load at a time
  - ☐ Loading Team(s)
    - ☐ Attempt to mix (1) RED, (1) YELLOW per load
  - ☐ Transport Vehicles
    - ☐ Ensure sufficient numbers on scene or enroute
    - ☐ Coordinate with Treatment for makeup of each load
- ☐ Maintain records of patient disposition

NOTES

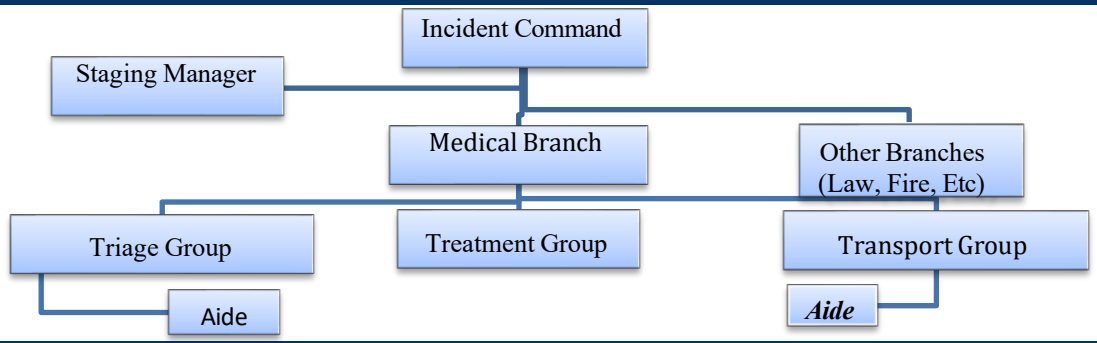
UNIT LOG – ICS 214	
Time	**Major Events**
Prepared By *(Name & Position)*	

TRANSPORT GROUP SUPERVISOR
AIDE

SUPERVISOR: ***TRANSPORT GROUP SUPERVISOR***

INCIDENT COMMAND	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
MEDICAL BRANCH DIRECTOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
TRIAGE GROUP SUPERVISOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
TREATMENT GROUP SUPERVISOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
TRANSPORT GROUP SUPERVISOR	*NAME*
Channel 1 2 3 4 5 6 7 8	**Phone**
TRANSPORT GROUP AIDE	*YOUR NAME*
Channel 1 2 3 4 5 6 7 8	***Phone***

INCIDENT COMMAND STRUCTURE



STRATEGY

1) Life Safety – Responders and Civilians
2) Incident Stabilization
3) Property Conservation
4)
5)

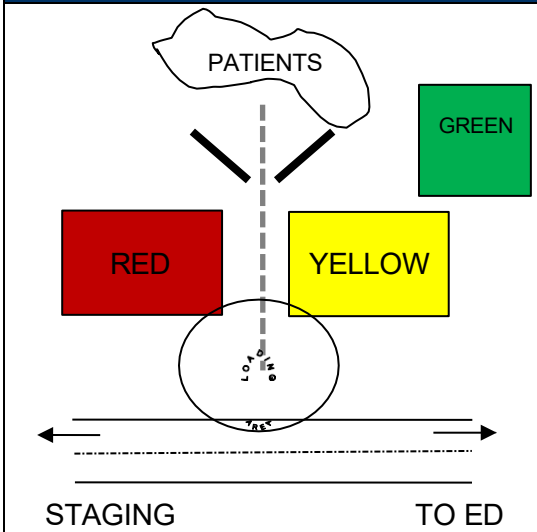
TRANSPORT GROUP ASSIGNED RESOURCES

Resource Name	Resource Type	ETA	Assignment
	E A M		
	E A M		
	E A M		
	E A M		

TRANSPORT GROUP SUPERVISOR AIDE TACTICS

- ☐ Receive assignments from and assist Transport Group Supervisor
- ☐ Don YELLOW ICS Job Aide Vest
- ☐ Obtain Job Aide Board
- ☐ Possible tasks include:
- ☐ Contact and maintain an open communications line with PSPH DMCC, 360.491.8888 or 360.438.6666
- ☐ Complete transport unit Patient Logs
- ☐ Communicate transport destinations to transport units
- ☐ Maintain Transportation Corridor
- ☐ Communicate with Staging Area Manager to request transport resources to move into transport area
- ☐ Other tasks as assigned by Transport Group Supervisor:
  - ☐
  - ☐
  - ☐

TREATMENT AREA SCHEMATIC



Maintain Transportation Corridor

1-6 PATIENTS	**MCI – 1**
	3 Engines
	3 FD Aid Units
	2 ALS Transport
	All PVT AMB
7-12 PATIENTS	**MCI – 2**
	3 Engines
	3 FD Aid Units
	2 ALS Transport
	4 ALS Units
	TFD MCI Trailer
>12 PATIENTS	**MCI – 3**
	3 Engines
	3 FD Aid Units
	2 ALS Transport
	6 ALS Units
	FD6 MCI Trailer

TRANSPORT GROUP AIDE CRITICAL SUCCESS FACTORS

- ☐ Receive briefing from Transport Group Supervisor
  - ☐ Evaluate and mitigate for all hazards
  - ☐ Maintain communications with Transport Group Supervisor
  - ☐ Maintain communications with DMCC for destination of each load
  - ☐ Process all patients one load at a time
  - ☐ Maintain communications with Loading Team(s)
  - ☐ Maintain Transportation Corridor
- ☐ Maintain records of patient disposition for transport

NOTES

UNIT LOG - 214	
Time	**Major Events**
Prepared By *(Name & Position)*	

APPENDIX D: TRANSPORT UNIT PATIENT LOG

Transport Unit Patient Log			
Unit ID #:			Destination: FACILITY NAME
TAG #	**AGE / SEX**	**SEVERITY**	**INJURIES – List RED Patients First**
1	Age M F	☐ Red ☐ Yellow ☐ Green	Always list RED Patients First
2	Age M F	☐ Red ☐ Yellow ☐ Green	
3	Age M F	☐ Red ☐ Yellow ☐ Green	
4	Age M F	☐ Red ☐ Yellow ☐ Green	

THIS PAGE TO BE RETAINED BY TRANSPORT UNIT

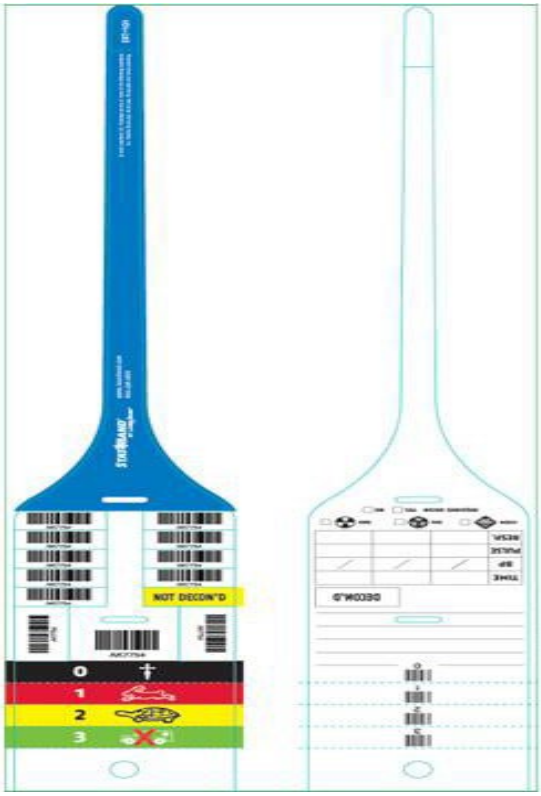
Transport Unit Patient Log			
Unit ID #:			Destination: FACILITY NAME
TAG #	**AGE / SEX**	**SEVERITY**	**INJURIES – List RED Patients First**
1	Age M F	☐ Red ☐ Yellow ☐ Green	Always list RED Patients First
2	Age M F	☐ Red ☐ Yellow ☐ Green	
3	Age M F	☐ Red ☐ Yellow ☐ Green	
4	Age M F	☐ Red ☐ Yellow ☐ Green	

RETURN THIS DUPLICATE FORM TO TRANSPORT GROUP SUPERVISOR

APPENDIX E: TRIAGE TAGS

STAT BAND FROM LASER BAND

Front Back



This all-in-one wristband and triage tag with uniquely numbered barcode labels enables responders to quickly and accurately identify, record and track the injured at the scene of an emergency.

Product Features:

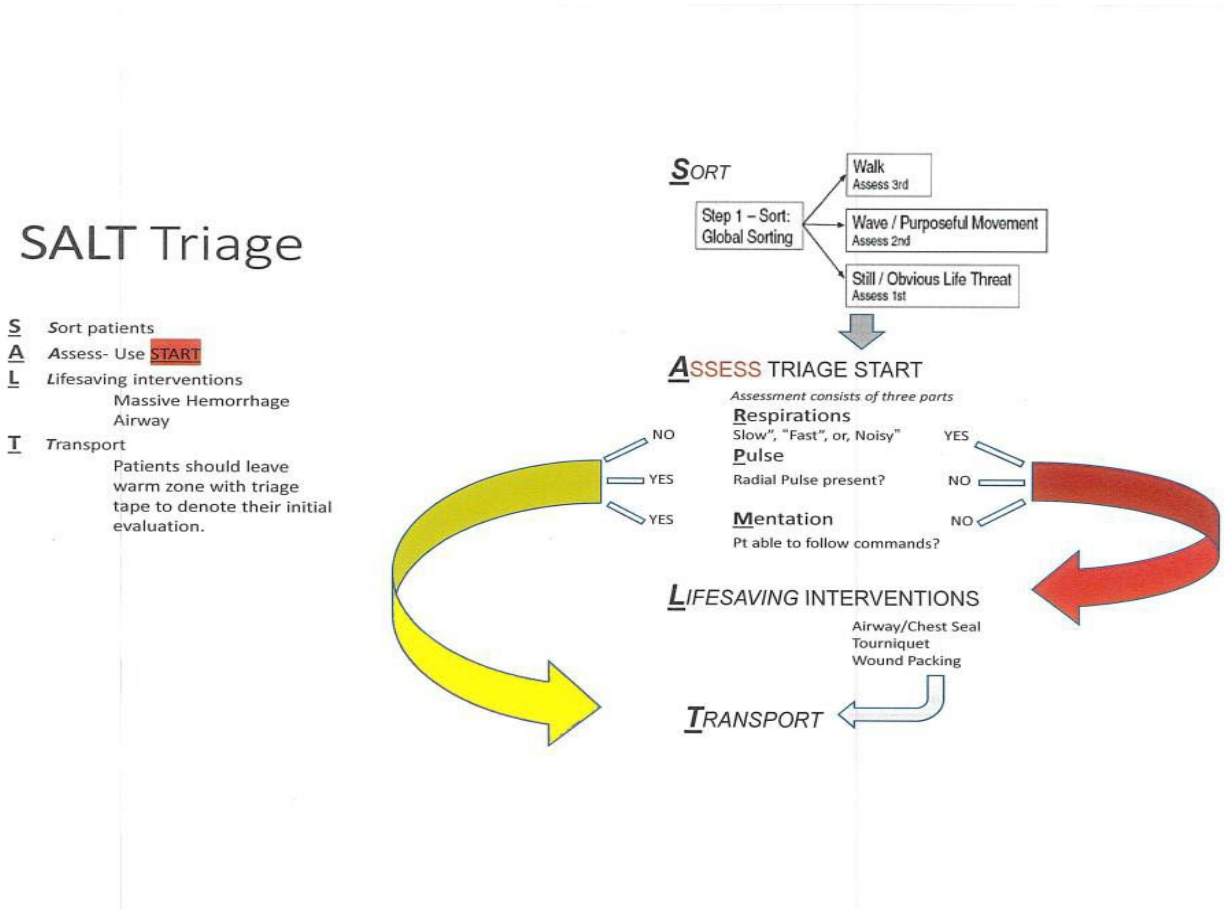
- Advanced water and abrasive-resistant material to withstand the harsh conditions of an emergency response environment far better than traditional paper and string tags.
- One piece fastening system that ensures wristband tags go on quickly and stay on until they are no longer needed.
- Uniquely and sequentially numbered alpha numeric digits and Code 128 barcodes pre-printed on each tag and label for quick and accurate identification and tracking of people, pets and personal belongings.
- Easy clip-on belt fastener enables that allows first responders both hands free to do their jobs.

Product Specifications:

- 17.5” x 3” wristband tag/writable area on back for recording vital signs, haz-mat exp. & Pt. notes
- 11 glove/glass-ready and uniquely numbered/barcoded labels
- 3 Tear-off labels with specific triage status color and barcode

APPENDIX F: SALT/RPM TRIAGE ALGORITHM CHARTS

SALT Triage



R.P.M. TRIAGE

<u>**R**espirations</u>

BREATHING ABSENT – OPEN AIRWAY

BREATHING – RED

NOT BREATHING – BLACK

BREATHING PRESENT

FAST, SLOW OR NOISY – RED

OTHERWISE CONTINUE….

<u>**P**ulse</u>

RADIAL PULSE ABSENT – RED

OTHERWISE CONTINUE….

<u>**M**entation</u>

CAN'T WIGGLE FINGERS AND TOES – RED

OTHERWISE – YELLOW

APPENDIX G: TRIAGE GROUP SUPERVISOR PATIENT TRACKING BOARD

TRIAGE GROUP SUPERVISOR PATIENT TRACKING BOARD

#	Circle M/F	IMMEDIATE	DELAYED	MINOR
1	M/F			
2	M/F			
3	M/F			
4	M/F			
5	M/F			
6	M/F			
7	M/F			
8	M/F			
9	M/F			
10	M/F			
11	M/F			
12	M/F			
13	M/F			
14	M/F			
15	M/F			

NOTES:

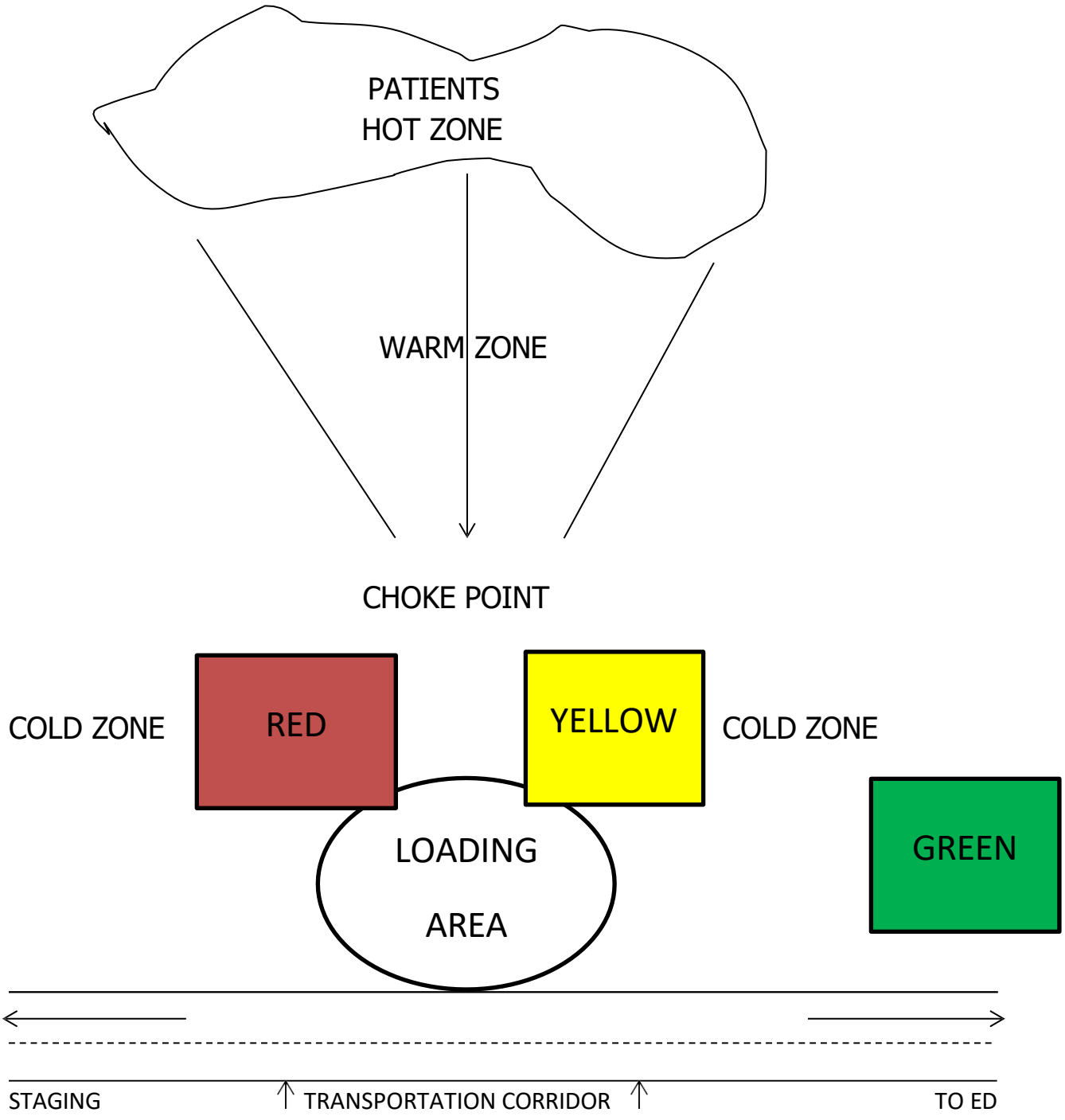
APPENDIX H: TREATMENT GROUP SUPERVISOR PATIENT TRACKING BOARD

TREATMENT GROUP SUPERVISOR PATIENT TRACKING BOARD

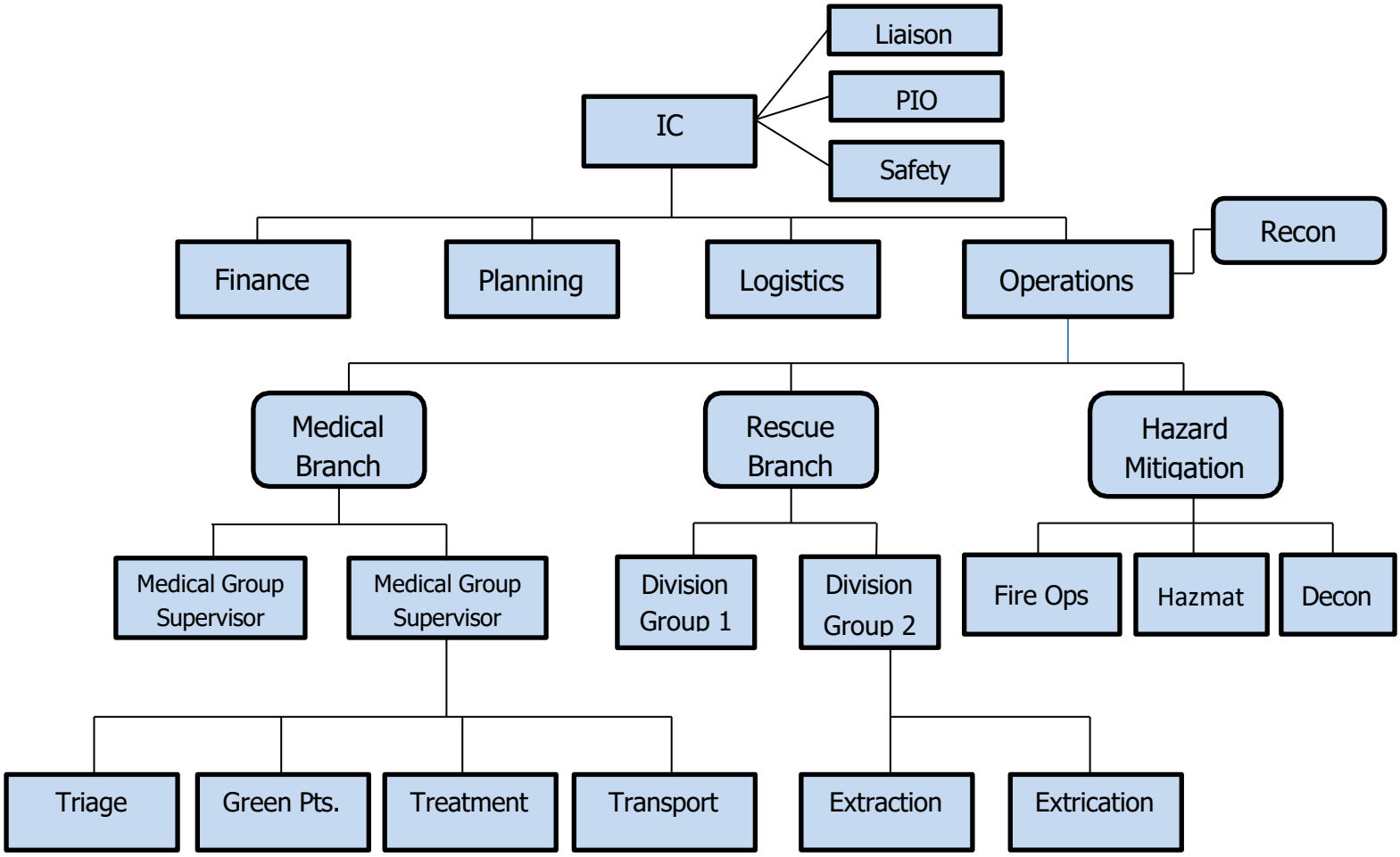
#	Circle M/F	IMMEDIATE	DELAYED	MINOR
1	M/F			
2	M/F			
3	M/F			
4	M/F			
5	M/F			
6	M/F			
7	M/F			
8	M/F			
9	M/F			
10	M/F			
11	M/F			
12	M/F			
13	M/F			
14	M/F			
15	M/F			

NOTES:

APPENDIX I: TREATMENT AREA SCHEMATIC (EXAMPLE)



APPENDIX J: FULL ICS CHART



This is the org chart for a large scale incident. As with other incidents, multiple roles may be filled by one individual as span of control and need allow. (e.g. Medical Group Supervisor may fill the roles of Green Patient, Treatment and Transport Team Leader. Geography and work volume may alter this).

THIS CHART IS NOT INTENTED TO IDENTIFY ALL ASPECTS OF ICS AT A LARGE INCIDENT.

APPENDIX K: BALLISTIC VEST EXAMPLE THAT MAY BE USED FOR RESPONSE TO LARGE-SCALE VIOLENT INCIDENTS WITHIN THE "WARM ZONE."

The following items are an example but not limited to the equipment that may be kept within the Ballistic Vest.

- Triage Tags (optional)
- CAT Tourniquets
- Israeli Bandages
- Sharpie Pen (permanent maker works also and can be easily erased with alcohol)
- Scissors
- Chest Seals
- IV Needles
- Colored Surveyors Tape (Red, Yellow, Green, Black)

APPENDIX L: MCI BAG & CONTENTS

Inventory

(A plasticized checklist of the below items will be provided in each MCI Bag)

- Medical Branch Director Vest & Job Aide Board/Sharpie Pens
- Triage Group Supervisor Vest & Job Aide Board/Sharpie Pens
- Treatment Group Supervisor Vest & Job Aide Board/Sharpie Pens
- Transport Group Supervisor Vest & Job Aide Board/Sharpie Pens
- Transport Group Supervisor Aide Vest & Job Aide Board/Sharpie Pens
- Triage Belt with Red, Yellow, Green, Black & White Striped Surveyors Tape
- Triage Group Supervisor Patient Tracking Board/Sharpie or Grease Pen
- Treatment Group Supervisor Tracking Board/Sharpie or Grease Pen
- Green, Yellow, Red & Black Tarps
- Fire Line Tape for Choke Point
- Triage Tags
- Transport Unit Logs (double layer write in the rain) 50+ logs

APPENDIX M: E-Z UP COLOR CODED CANOPY SYSTEM

APPENDIX N: ACTIVE SHOOTER / THREAT INCIDENT MANAGEMENT – C3 PATHWAYS

Purpose: To guide Law Enforcement/Fire/EMS agencies in their responses to incidents involving threats or acts of violence in cooperation and coordination with responding law enforcement agencies.

Scope: Any incident requiring law enforcement intervention to render the scene safe f or entry of Fire/EMS personnel and where the potential for multiple casualties reasonably exists.

Response Guidelines:

1. Initial Response

   a. Resource requests should be initiated through TCOMM by the first-due Officer In Charge (OIC) based on available dispatch information to include appropriate Level of MCI and any specialized resources based on hazard type.

   b. A Level 1 Staging area should be designated and communicated to TCOMM and all responding Fire/EMS units at a distance and location which provides adequate separation, shielding, and capacity for the initial response package.

      i. Special consideration should be given to the possibility of secondary and diversionary threats.

      ii. Level 2 Staging at a greater distance and capacity should be considered for second and subsequent MCI alarm responses.

   c. The first arriving Fire/EMS unit will initiate the Incident Command System and direct the actions of subsequent units. Any transfers of the Incident Commander responsibilities will be clearly identified and transmitted to Dispatch and all assigned units.

d. Unified command should be sought and established with the primary law enforcement agency as soon as is practical and prior to any intervention by Fire/EMS units. All personnel and activities will be managed utilizing the Incident Command System.

2. Unified Response

a. The unified command will conduct an assessment to identify the type, number, location, and associated risks of the known and potential hazard types. Mitigation strategies will be jointly developed based on the risk assessment and available resources. These strategies are address in the Active Shooter Incident Management Checklist that follows. Should FIRE/EMS personnel be trained in Rescue Team operations, the following strategies and formations will be deployed:

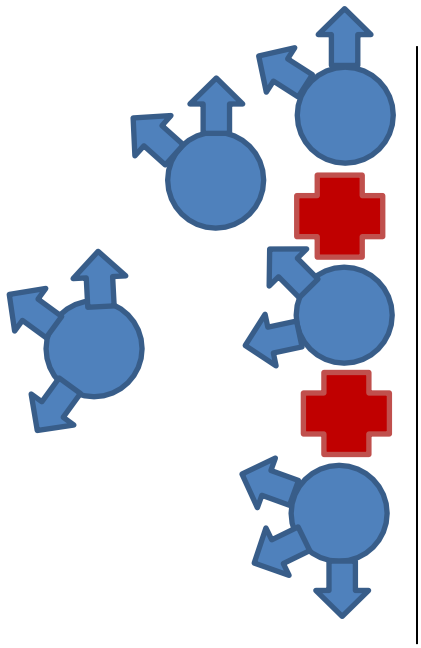
1. Rescue Team Deployment: to "warm zone" areas from where the identified threat(s) have been isolated or removed and a risk analysis leads to a reasonable belief that viable victims exist and that Team deployment would increase the probability of survival.

2. Rescue Teams will don and maintain all designated personal protective equipment, remain intact as a team, and in constant communication with their supervision throughout any deployment.

3. Methods and direction of team movement and communication (e.g. Diamond Formation, Power T, and radio frequencies) will be clearly identified prior to Rescue Team deployment.

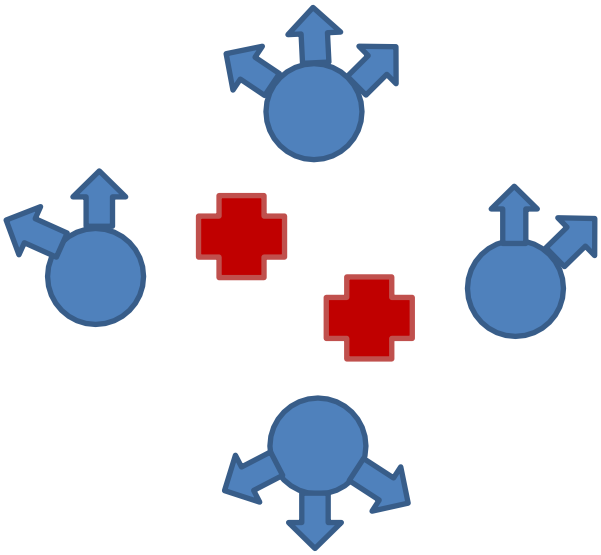
4. The activities of the Rescue Team will be focused on the rapid assessment and triage of victims. Interventions will be limited to those necessary for immediate stabilization of life or limb. Rescue Teams may convert to the role of Extraction Teams based on need, capability, and in coordination with supervision.

RESCUE TEAM



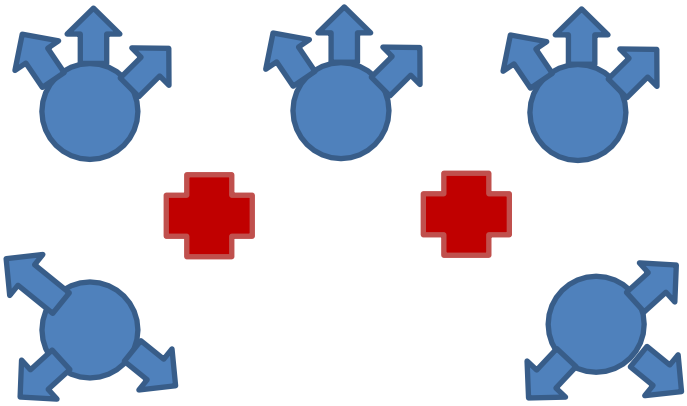
MOVEMENT IN HEAVY HEAD, NEXT TO WALL

RESCUE TEAM



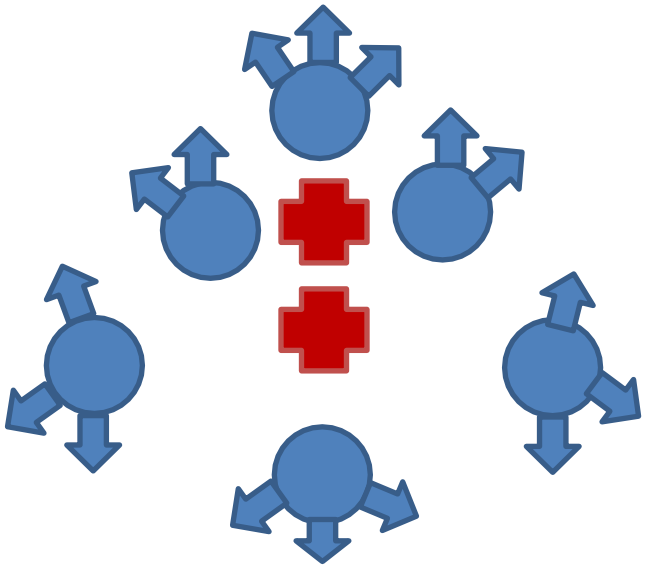
MOVEMENT IN DIAMOND FORMATION

RESCUE TEAM



MOVEMENT IN "T" FORMATION

RESCUE TEAM



MOVEMENT IN WEDGE FORMATION

HELP GUIDE

ACTIVE SHOOTER
INCIDENT MANAGEMENT CHECKLIST

A **VALIDATED CHECKLIST**

FOR **INTEGRATED RESPONSE** OF

LAW ENFORCEMENT AND **FIRE/EMS**

WARNING! Rev 3.0 July 2019

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Godfrey, William M., & Agan, David C. (2015-2019). ***Active Shooter Incident Management Checklist: Help Guide***. Otterbacher, R., Ferrara, J., & Jimenez, A. (Eds.). Orlando, FL: C3 Pathways, Inc.

Disclaimer and Warning

Readers are **CAUTIONED** that the statements contained herein may not be relevant or appropriate for their agency or region. Any new procedure or procedural change should be **validated locally PRIOR TO ADOPTION**. Use of the Active Shooter Incident Management Checklist REQUIRES AUTHORIZATION and WRITTEN PERMISSION. The Active Shooter Incident Management Checklist is the Copyrighted work of C3 Pathways, Inc. There is NO CHARGE to use the Checklist (yes, IT IS A **FREE Checklist**; no cost), BUT you must receive WRITTEN PERMISSION from C3 Pathways to use it. Please read the About section on page 1 for more information and see the actual Copyright Clearance form for full details and language at **http://c3.cm/asc**.

REVISION HISTORY

Checklist

0.1	26 Nov 2013	Alpha

Original

0.2	01 Dec 2013	Alpha

Formatting and grouping

0.3	02 Dec 2013	Alpha

- Reformatted to aviation checklist standards
- Added page 2 (second side)
- Added Intelligence/Investigative Section
- Added ICS Org Chart illustration
- Added Staging sub checklist
- Changed "SA" to "Situational Awareness"
- Changed to "5th Man" terminology
- Added titles, warnings, and other elements

0.4	04 Dec 2013	Beta 1 for testing

- Fixed reference to 5th Man in follow-on steps
- Changed permission reference in Rescue Task Force sub checklist from "Warm Zone" to "Inner Perimeter"

0.5	16 Dec 2013	Beta 2 for testing

- Changed "Call COMMAND" to "Communicate with COMMAND"
- Changed First LE Supv "Assign STAGING" to "Assign STAGING manager"
- Added item "Prioritize assignments as directed" to STAGING sub checklist

1.0	28 Jan 2014	Initial Release

- Changed primary font from Helvetica (Sans) to Gill Sans
- Increased primary font size
- Increased font size on first character of all cap text
- Validation completed

1.1	13 May 2014	Content Change

- Terminology change from "Contact Group" to "Tactical Group"
- Changed Rescue Task Force "permission to enter inner perimeter" from Law Enforcement Branch to Tactical Group

1.2	11 Nov 2014	Content Addition and Change

- Added new **Improvised Explosive Device (IED)** sub checklist
- Changed terminology from victim(s) to casualty(ies)
- Changed terminology from Danger Zone to Hot Zone
- **Intelligence/Investigations** sub checklist: moved to main page, deleted checklist items, added 2 checklist items related to information handling
- **5th Man** sub checklist: Added designation checklist item
- **Contact Team** sub checklist: Added Establish CCP checklist item
- **Triage** sub checklist: Added collocate checklist item, get CCP(s); Changed evacuate casualties to coordinate evacuation
- **Transport** sub checklist: Added establish ambulance exchange point; Changed establish loading zone to if needed

1.3	15 Oct 2015	Content Addition and Change

- **Intelligence/Investigations** sub checklist: Added Reunification Group and Separate radio channel checklist items
- **LE 2nd-4th arriving** sub checklist: Changed Form-up to Link-up, Move-to-Contact Team to Contact Team
- **Improvised Explosive Device (IED)** sub checklist: Changed Moving-to-Contact to Contact
- Added Reunification Group box to org chart
- Changed †Target staffing footnote EMS to Medical

2.0	12 Feb 2018	Content Deletion, Addition, and Change

- **START HERE** primary checklist
  - LE "5th Man" sub checklist: Changed item Get situational awareness to Request additional resources
  - Second LE Supervisor sub checklist: Added item Assign LEAD PIO to establish JOINT INFORMATION CENTER
  - First FD/EMS Supervisor sub checklist: Changed item Check in at Command Post to Go to COMMAND POST; deleted item Get briefing (verbal)
- **Law Enforcement** primary checklist
  - **LAW ENFORCEMENT BRANCH** sub checklist: deleted Support RESCUE TASK FORCE
  - **TACTICAL GROUP** sub checklist: Added item Prioritize 1Threat, 2Rescue, 3Clear; Changed items Update Hot Zone and Inner Perimeter to Update Hot and Warm Zones, Report areas suitable for rescue efforts to Update casualty information to Triage Group
  - **CONTACT TEAM** sub checklist: Changed item Suppress threat to Contain or neutralize threat
  - **INTELLIGENCE SECTION** sub checklist: Changed item Synthesize and disseminate information to Brief COMMAND, added item Coordinate with Communications Center
- Changed **Intelligence/Investigations** primary checklist to a sub checklist and moved under Law Enforcement primary checklist
  - **Common** primary checklist
  - **Staging** sub checklist: Deleted Separate radio channel; changed Keep list of resources to Check-in and list resources
  - Added **LEAD PIO (JOINT INFORMATION CENTER)** sub checklist
- **Fire/EMS Primary Checklist**
  - **MEDICAL BRANCH** sub checklist: Changed item Declare MCI level to Request additional resources; moved item Co-locate with LAW ENFORCEMENT BRANCH after Assign TRANSPORT GROUP; deleted item Separate radio channel
  - **TRIAGE GROUP** sub checklist: Changed item Establish RESCUE TASK FORCE to Stand-up RESCUE TASK FORCE and moved after Get Briefing (verbal); deleted If possible from Co-locate with TACTICAL GROUP; added item Deploy RESCUE TASK FORCES
  - **RESCUE TASK FORCE** sub checklist: Changed items Get briefing (verbal) to Assemble team and equipment, Coordinate casualty evacuation to Ambulance Exchange Point(s) to Coordinate casualty evacuation; deleted items Gather equipment, Get permission to enter Inner Perimeter from TACTICAL GROUP; added items Notify TACTICAL when deploying, If not done, establish Casualty Collection Point(s), Identify Ambulance Exchange Point and confirm with TACTICAL;
  - **TRANSPORT GROUP** sub checklist: Added items Co-locate with Tactical Group, Transport casualties from Ambulance Exchange Point(s); added item Separate radio channel; deleted items If Casualty Collection Point(s), consider how to evacuate, Establish Ambulance Exchange Point(s), If needed, establish Loading Zone;
- Added Joint Information Center box to org chart
- Updated address and Copyright years

3.0	01 Jul 2019	Content Deletion, Addition and Change

- **START HERE primary checklist**
  - **LE First arriving** sub checklist: Added item Radio ID : CONTACT 1
  - **LE 2nd-4th arriving** sub checklist: Deleted item Form CONTACT TEAM; Changed item Communicate with COMMAND to Communicate with CONTACT 1
  - **LE "5th Man"** sub checklist: Deleted item Designate First LE as CONTACT 1; Added item Radio ID: TACTICAL
  - **First LE Supervisor** sub checklist: Changed item Designate "5th Man" as TACTICAL GROUP to Set COMMAND POST location
- **Law Enforcement** primary checklist
  - **INTELLIGENCE SECTION** sub checklist: Changed name from INTELLIGENCE SECTION to INTELLIGENCE / INVESTIGATIONS SECTION; Changed Consider REUNIFICATION GROUP to Consider REUNIFICATION BRANCH; Changed order of items

Checklist

- **COMMON** primary checklist: Changed name from COMMON to MULTI-DISCIPLINE
  - **LEAD PIO (JOINT INFORMATION CENTER)** sub checklist: Added item Announce Reunification site when authorized
  - Added new **REUNIFICATION BRANCH** sub checklist
  - Added new **REUNIFICATION SERVICES GROUP** sub checklist
  - Added new **REUNIFICATION ACCOUNTABILITY GROUP** sub checklist
  - Added new **REUNIFICATION ASSEMBLY GROUP** sub checklist
- **Improvised Explosive Device (IED)** primary checklist
  - **DISCOVERY or DETONATION** sub checklist: Changed item Announce "IED [location]" and move clear to Announce "Bomb Cover" or "Bomb Go"; Added items Maintain 540^0 scan, NEVER TOUCH Bombs, Bombers are Bombs
  - **CONTACT and RESCUE** sub checklist: Changed item Mark and bypass to Mark (Chem Lights) and bypass
  - **EXPOSED VICTIM RESCUE** sub checklist: Changed VICTIM to SURVIVOR; Changed item Direct victim movement explicitly to Direct survivor movement explicitly
  - **NO VICTIMS THREATENED** sub checklist: Changed VICTIM to SURVIVOR
- **ICS Org Chart Illustration:** Deleted item REUNIFICATION GROUP; Added items REUNIFICATION BRANCH, REUNIFICATION STAGING, REUNIFICATION SERVICES GROUP, REUNIFICATION ACCOUNTABILITY GROUP, REUNIFICATION ASSEMBLY GROUP; Changed item INTELLIGENCE SECTION to INTEL / INVESTIGATIONS SECTION
- Updated Copyright year

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Help Guide

1.0	30 Jan 2014	Initial Release

Original

1.1	13 May 2014	Checklist Change

- Terminology change from "Contact Group" to "Tactical Group"
- Changed Rescue Task Force "permission to enter inner perimeter" from Law Enforcement Branch to Tactical Group

1.2	11 Nov 2014	Checklist and Content Change

- Updated to Checklist rev 1.2
- Added new Improvised Explosive Device (IED) section
- Updated and changed Abbreviations, Glossary of Terms, and Reference List
- Added, updated content to match Checklist rev 1.2 changes
- Typographical, formatting and editorial corrections

1.3	15 Oct 2015	Checklist and Content Change

- Updated to Checklist rev 1.3
- Added explanation to RTF Ambulance Exchange Point checklist item, Consider Reunification Group checklist item
- Updated and changed Abbreviations, Glossary of Terms, and Reference List
- Added, updated content to match Checklist rev 1.3 changes
- Typographical, formatting and editorial corrections

2.0	12 FEB 2018	Checklist and Content Change

- Updated to Checklist rev 2.0
- Added, updated content to match Checklist rev 2.0 changes
- Added definition of Complex Coordinated Attack (CCA)
- Typographical, formatting and editorial corrections

3.0	01 Jul 2019	Checklist and Content Change

- Updated to Checklist rev 3.0
- Added, updated content to match Checklist rev 3.0 changes
- Changed Improvised Explosive Device (IED) section 5 to include updated information to match checklist changes
- Typographical, formatting and editorial corrections

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About the Active Shooter Incident Management Checklist

A Validated Active Shooter Checklist

The Active Shooter Incident Management Checklist is designed for basic complexity through moderate complexity Active Shooter Events in a generic approach suitable for most communities. However, the Checklist will not be suitable for ALL communities. Each agency must evaluate if this Active Shooter Checklist is appropriate for their community, their staffing, and their risk.

In June 2013, C3 Pathways published a document on Active Shooter Incident Management Best Practices based on observations from a series of Active Shooter training exercises conducted at the University of North Florida (UNF). In large part, we developed the document because what we thought we knew to be true about Active Shooter Response and Active Shooter Incident Management turned out to be untrue. Perhaps a better way to say it would be that we discovered, quite by accident, that there were better ways to manage Active Shooter Events than what we thought "we knew to be true."

This realization caused our team to start over at the beginning and question everything. Along the way, we discovered a number of things. An important first step was building an accurate model of a typical Active Shooter Event, which we did based largely on the incredible research work of ALERRT - the Advanced Law Enforcement Rapid Response Training program at Texas State University. We also spent a tremendous amount of time looking at how to integrate the law enforcement and EMS response to an Active Shooter Event (ASE) and approaches to the incident management of Active Shooter Events. We did this work starting from scratch without assumptions, and specifically without the assumption that a rapid Unified Command was the best approach. What we observed from the UNF exercises suggested that early Unified Command slowed the response, which after all is what started us down this road.

The Active Shooter Incident Management Checklist is the culmination of our work thus far. The Active Shooter Incident Management Checklist has been validated for design, content, format, and usability.

Four separate validations were conducted on the Active Shooter Incident Management Checklist prior to publication. Three validations focused on design (e.g. font, size, etc) and format (layout, groupings, etc) based on aviation emergency checklist design and usability, human factors engineering, and evaluative methodologies. The final validation focused on content, the logical order of items, and usability based on feedback from 121 responders who used the Active Shooter Incident Management Checklist in live Active Shooter training exercises. Information about the validation processes are in the published validation document available for review.

There is still much more work to be done. Checklists are living items that must be periodically reviewed, updated, and improved -- especially through user feedback and actual experience. There is additional information available on our web site to aid in understanding the Active Shooter Incident Management Checklist concepts and how to use the Checklist.

WARNING!

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We have automated the Copyright Clearance process on our web site at **http://c3.cm/asc**. You simply fill out the form, provide some information, agree to several important things, click the submit button, and the system will automatically generate a certificate of WRITTEN PERMISSION for you to use the Active Shooter Incident Management Checklist. The key things we require you to agree to include (but not limited to):

- formal review and adoption of the Checklist by agency policy prior to issuing it for use,
- formal training on the Checklist for all responders who might use it,
- providing direct feedback to us if the Checklist is used in an actual Active Shooter Event,
- and agree to waive liability.

Please see the actual Copyright Clearance form for full details and language at **http://c3.cm/asc**. The printable written certificate includes all the language agreed to and associated requirements. Please feel free to contact us should you have questions or need assistance with the Active Shooter Incident Management Checklist.

We sincerely hope you never have to use the Checklist in real life.

ACTIVE SHOOTER INCIDENT MANAGEMENT CHECKLIST

Improvised Explosive Device (IED)

DISCOVERY or DETONATION
- [ ] Announce "Bomb Cover" or "Bomb Go"
- [ ] Secondary threat scan (device, 5ft, 25ft)
- [ ] Maintain 540° scan
- [ ] NEVER TOUCH Bombs
- [ ] Bombers are Bombs

CONTACT and RESCUE
- [ ] Consider threat to life and alternate route
- [ ] Mark (Chem Lights) and bypass
- [ ] Provide security element if possible

EXPOSED SURVIVOR RESCUE
- [ ] Direct survivor movement explicitly
- [ ] View area for secondary threats
- [ ] Establish narrow cordon in/out of area
- [ ] Provide Direct Threat Care only
- [ ] Evacuate to standoff / Isolate / Barricade

FROM RADIO SAFE DISTANCE (300ft or standoff)
- [ ] Report IED location, description, size
- [ ] Report action taken
- [ ] Request Bomb Squad

NO SURVIVORS THREATENED
- [ ] View area for secondary threats
- [ ] Reposition personnel to safe standoff
- [ ] Report impact to assignment and priority
- [ ] Cordon off 360° device kill zone
- [ ] Control cordon security awaiting Bomb Squad

Standoff Distance[1]

IED	Size	Minimum with Cover	Preferred
Pipe Bomb	5 lb	70 ft	1200 ft
Suicide Bomber	20	110	1700
Briefcase/Suitcase	50	150	1850
SUV / Van	1000	400	2400

[1]See Help Guide and DHS reference for IMPORTANT information.

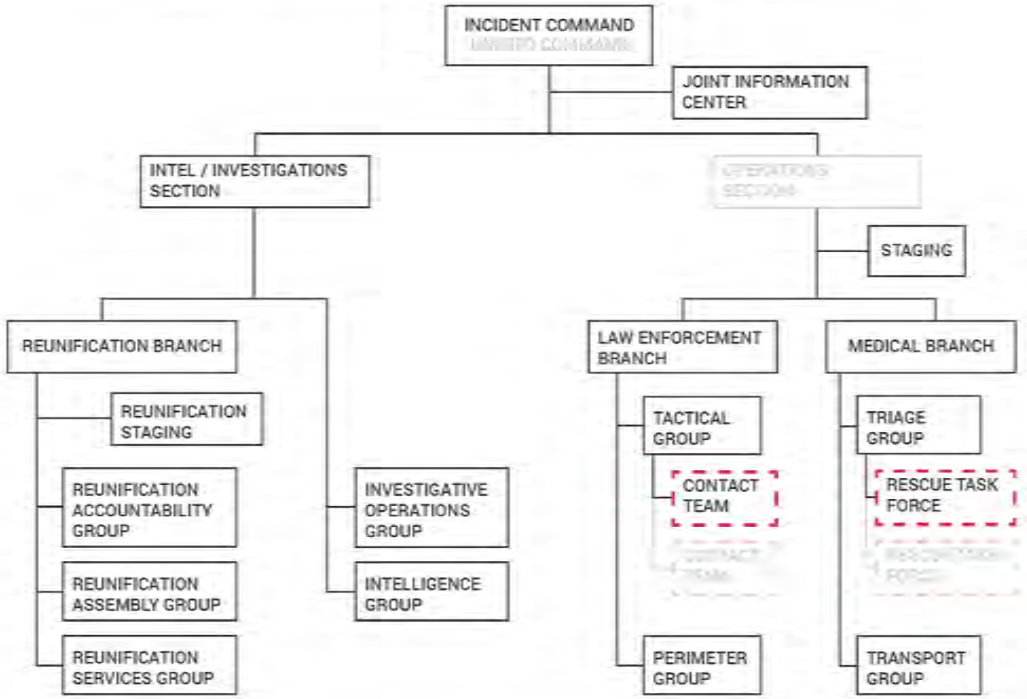

Fig 1. Active Shooter Incident Command Organizational Chart

WARNING! Rev 3.0 7/2019

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START ON OTHER SIDE

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START HERE

LE First arriving
- [ ] Size up report
- [ ] Identify Hot Zone
- [ ] Establish COMMAND (mobile)
- [ ] Radio ID: CONTACT 1
- [ ] Engage

LE 2nd-4th arriving
- [ ] Communicate with CONTACT 1
- [ ] Link-up

LE 5th arriving (5th Man)
- [ ] Radio ID: TACTICAL
- [ ] Get briefing (verbal)
- [ ] Assume COMMAND
- [ ] Set STAGING location
- [ ] Request additional resources
- [ ] Assign more CONTACT TEAMs

First LE Supervisor
- [ ] Get briefing (verbal)
- [ ] Assume COMMAND
- [ ] Set COMMAND POST location
- [ ] Assign STAGING manager
- [ ] Assign PERIMETER GROUP
- [ ] Assign MEDICAL BRANCH to FD/EMS

Second LE Supervisor
- [ ] Get briefing (verbal)
- [ ] Assume COMMAND
- [ ] Request additional resources
- [ ] Designate First LE Supervisor as LAW ENFORCEMENT BRANCH
- [ ] Assign INTELLIGENCE SECTION
- [ ] Assign LEAD PIO to establish JOINT INFORMATION CENTER

First FD/EMS Supervisor
- [ ] Go to COMMAND POST
- [ ] Request MEDICAL BRANCH assignment

Law Enforcement

LAW ENFORCEMENT BRANCH
- [ ] Get briefing (verbal)
- [ ] Co-locate with MEDICAL BRANCH
- [ ] Coordinate with INTELLIGENCE SECTION

TACTICAL GROUP
- [ ] Coordinate CONTACT TEAM(s)
- [ ] Prioritize 1Threat, 2Rescue, 3Clear
- [ ] Update Hot and Warm Zones
- [ ] Update casualty information to Triage Group

CONTACT TEAM
- [ ] Contain or neutralize threat
- [ ] Update location as moving
- [ ] Report casualty locations, numbers
- [ ] Establish Casualty Collection Point(s)

PERIMETER GROUP
- [ ] Separate radio channel*
- [ ] Establish INNER PERIMETER
- [ ] Establish OUTER PERIMETER

INTELLIGENCE / INVESTIGATIONS SECTION
- [ ] Get briefing (verbal)
- [ ] Separate radio channel*
- [ ] Coordinate with Communications Center
- [ ] Collect incoming information, tips, leads
- [ ] Brief COMMAND
- [ ] Consider REUNIFICATION BRANCH
- [ ] Assign INVESTIGATIVE OPERATIONS GROUP
- [ ] Assign INTELLIGENCE GROUP

*[illegible] assigned BRANCH / COMMAND channel

†[illegible]

Fire / EMS

MEDICAL BRANCH
- [ ] Get briefing (verbal)
- [ ] Request additional resources
- [ ] Assign TRIAGE GROUP
- [ ] Assign TRANSPORT GROUP
- [ ] Co-locate with LAW ENFORCEMENT BRANCH
- [ ] Consider TREATMENT GROUP

TRIAGE GROUP
- [ ] Get briefing (verbal)
- [ ] Stand-up RESCUE TASK FORCE(s)
- [ ] Co-locate with TACTICAL GROUP
- [ ] Get operable areas, routes, and Casualty Collection Point location(s)
- [ ] Deploy RESCUE TASK FORCE(s)

RESCUE TASK FORCE†
- [ ] Assemble team and equipment
- [ ] Notify TACTICAL when deploying
- [ ] If not done, establish Casualty Collection Point(s)
- [ ] Rapidly assess casualties
- [ ] Report counts to TRIAGE GROUP
- [ ] Identify Ambulance Exchange Point and confirm with TACTICAL
- [ ] Coordinate casualty evacuation

TRANSPORT GROUP
- [ ] Get briefing (verbal)
- [ ] Co-locate with TACTICAL GROUP
- [ ] Determine routes
- [ ] Separate radio channel*
- [ ] Get Hospital capacity count
- [ ] Transport casualties from Ambulance Exchange Point(s)
- [ ] Target 3 per ambulance (1ea Red/Yel/Grn)
- [ ] Distribute to Hospitals
- [ ] Keep Transport Log

Multi-Discipline

STAGING
- [ ] Check-in and list resources
- [ ] Give resources assignment, location, and channel
- [ ] Prioritize assignments as directed
- [ ] Maintain minimum resources as directed

LEAD PIO (JOINT INFORMATION CENTER)
- [ ] Establish JOINT INFORMATION CENTER
- [ ] Establish Media Staging Area
- [ ] Clear all messaging and releases with COMMAND
- [ ] Announce Reunification site when authorized

REUNIFICATION BRANCH
- [ ] Get briefing (verbal)
- [ ] Select Reunification Location
- [ ] Location approved by INTELLIGENCE SECTION
- [ ] Notify DISPATCH of Location Not for public release
- [ ] Assign REUNIFICATION STAGING MANAGER
- [ ] Request additional resources
- [ ] Assign SERVICES GROUP
- [ ] Assign ACCOUNTABILITY GROUP
- [ ] Assign ASSEMBLY GROUP
- [ ] Notify INTELLIGENCE SECTION when ready to announce Location to public

REUNIFICATION SERVICES GROUP
- [ ] Assign Set-up Unit
- [ ] Assign Law Enforcement Unit
- [ ] Assign Transportation Unit
- [ ] Assign Medical Unit
- [ ] Establish Family Assistance Center

REUNIFICATION ACCOUNTABILITY GROUP
- [ ] Assign Accountant Unit
- [ ] Assign Checker Unit
- [ ] Assign Greeter Unit
- [ ] Assign Reunifier Unit
- [ ] Assign Exit Control Unit

REUNIFICATION ASSEMBLY GROUP
- [ ] Assign Class Leader Unit
- [ ] Assign Nutritional Support Unit
- [ ] Consider Entertainment Unit

SECTION 1

START HERE

The START HERE panel is the entry point to the Checklist

A critical step in effectively managing an incident is to obtain situational awareness quickly. Delay in gaining situational awareness will contribute to confusion, disorganization, and may negatively impact the outcome.

It is unreasonable to expect the first arriving unit to take out a checklist and begin checking boxes during an active shooter event (ASE). But during training and practice these Checklist Items can and should be committed to memory, which in turn should drive predictable, measured responses.

The **START HERE** panel is the entry point to the Checklist.

LE FIRST ARRIVING

[ ] Size up report - Information overload is common. Often this information is unclear, imprecise or simply wrong. The first arriving law enforcement officer must perform a size up of the situation. This is a mental exercise that is taught and practiced by the vast majority of agencies. What to say, how to say it and what is critical and what isn't in highly charged and stressful environments can only be learned with practice.

[ ] Identify Hot Zone - Immediately identify the area of threat in order to reduce additional exposure to danger and clearly state this over the radio to inform all that will follow you. The communications center must rebroadcast this information. Clearly communicate the Hot Zone boundaries to the general public in the vicinity. This is paramount to lower the risk of surprise and inadvertent exposure to harm.

[ ] Establish COMMAND (mobile) - COMMAND is the single term that identifies clearly to everyone that there is a SINGLE POINT OF CONTACT for information, direction, decision and resources. Even if multiple units arrive simultaneously, one and ONLY ONE unit MUST take the role as COMMAND, even if it is only for a short while. Without this, situational awareness and control will rapidly decay while risks exponentially increase.

[ ] Radio ID: CONTACT 1 - Identify from the beginning as a Contact Team. That is the primary function of these first arriving units and consistency in radio identification will help avoid confusion moving forward.

[ ] Engage - The ultimate goal in an ASE is to stop the killing. Departmental policies and training will guide the officers' actions and will be based on his or her size up assessment. Entrance into the Hot Zone should be determined by the situation, operational necessity and officer safety.

LE 2ND-4TH ARRIVING

[ ] Communicate with CONTACT 1 - Calling the unit that has established COMMAND develops the resources at hand, insures that everyone knows who is making decisions, where that person is and what the next immediate steps will be.

[ ] Link-Up - Example only and should be directed by local policy: "CONTACT 1 from Patrol 103, on scene-your location?" Contact 1 would reply with where he/she is and give directions. The following units would report "On Scene, linking-up with Contact 1" unless otherwise directed.

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LE "5TH" MAN"

This concept formalizes the root incident command structure.

[ ] Radio ID: Tactical - The ID matches the role. TACTICAL is controlling the downrange activities of resources. Using the RadiomID from the onset will help ensure continuity throughout the event.

[ ] Get briefing (verbal) - This can be done either face to face or by radio. This should be concise and communicate conditions (situation-one suspect shots being fired), actions (move to contact team#1 formed and moving towards last gunfire) and needs (more Move to Contact (MTC) teams to side 3).

[ ] Assume COMMAND - Announces this clearly over the radio with his/her physical location. TACTICAL is the Radio ID and the role is COMMAND.

[ ] Set STAGING location - This is a new concept with many law enforcement agencies this early in any event. However, it can be critical to the effective deployment of resources. In setting the location, responding units should alter their trajectory to the designated STAGING location. COMMAND should direct all units to report to that location and specifically request resources to fulfill the next Checklist Items.

[ ] Request additional resources - Depending on initial dispatch and local response procedures, it may be necessary to call for additional law enforcement, fire, and EMS resources. Notify dispatch of additional needed resources with instruction to respond to Staging.

[ ] Assign more CONTACT TEAMs - Form and deploy teams as "Contact 2, Contact 3," etc.).

FIRST LE SUPERVISOR

Corporal, Sergeant or higher (local policy). This step builds on the root command structure and divides the intense workload in efforts to reduce divided attention and improve situational awareness.

[ ] Get briefing (verbal) - Optimally this should be a face-to-face briefing, but that may not be reasonable. The content should be marginally more detailed that the previous briefing, but should still be quick and concise. The Conditions, Actions, Needs format can assist with obtaining that information that is quick while providing necessary actionable decision points.

[ ] Assume COMMAND - ONLY AFTER OBTAINING A BRIEFING SHOULD COMMAND BE ASSUMED. Announce this clearly over the radio. This is the first instance when the radio ID of COMMAND should be used. "All Units, Supervisor 1 has COMMAND."

START HERE

LE First arriving
- [ ] Size up report
- [ ] Identify Hot Zone
- [ ] Establish COMMAND (mobile)
- [ ] Radio ID: CONTACT 1
- [ ] Engage

LE 2nd-4th arriving
- [ ] Communicate with CONTACT 1
- [ ] Link-up

LE 5th arriving (5th Man)
- [ ] Radio ID:TACTICAL
- [ ] Get briefing (verbal)
- [ ] Assume COMMAND
- [ ] Set STAGING location
- [ ] Request additional resources
- [ ] Assign more CONTACT TEAMs

First LE Supervisor
- [ ] Get briefing (verbal)
- [ ] Assume COMMAND
- [ ] Set COMMAND POST location
- [ ] Assign STAGING manager
- [ ] Assign PERIMETER GROUP
- [ ] Assign MEDICAL BRANCH to FD/EMS

Second LE Supervisor
- [ ] Get briefing (verbal)
- [ ] Assume COMMAND
- [ ] Request additional resources
- [ ] Designate First LE Supervisor as LAW ENFORCEMENT BRANCH
- [ ] Assign INTELLIGENCE SECTION
- [ ] Assign LEAD PIO to establish JOINT INFORMATION CENTER

First FD/EMS Supervisor
- [ ] Go to COMMAND POST
- [ ] Request MEDICAL BRANCH assignment

[ ] Set COMMAND POST location - Clearly announce the physical location over the radio. "All Units from COMMAND. The COMMAND Post is at the intersection of Huey St. and Hazel St."

[ ] Assign STAGING manager - Identify a unit that has arrived at the staging location and assign that unit as "Staging". This person will manage, organize, document what units and types are in staging and keep the Incident Commander aware of his resource pool.

[ ] Assign PERIMETER GROUP- Once staging has been assigned, the order can be given to the Staging Manager to assign a unit as the Perimeter Group Supervisor as well as assigning resources to him/her. The Perimeter Group Supervisor should request any additional resources needed.

[ ] Assign MEDICAL BRANCH to FD/EMS - If FD/EMS is not on scene, request the first arriving FD/EMS officer to the command post for assignment as the MEDICAL BRANCH. Should FD/EMS check in at the command post, they should request this assignment following a briefing. SEE FIRST FD/EMS SUPERVISOR Checklist.

SECOND LE SUPERVISOR

[ ] Get briefing (verbal) - Optimally this should be a face-to-face briefing. The content should be more detailed that the previous briefing, but should be conducted within a few minutes.

[ ] Assume COMMAND - ONLY AFTER OBTAINING A BRIEFING SHOULD COMMAND BE ASSUMED. Clearly stating over the radio "Supervisor 2 has COMMAND". The Incident Commander at this point should limit contact over the radio and focus on the bigger picture.

[ ] Request additional resources - Depending on resources already deployed and local response procedures, it may be necessary to call for additional resources. Discuss with the LE Branch and the Medical Branch needed resources with instruction to respond to Staging.

[ ] Designate First LE Supervisor as the LAW ENFORCEMENT BRANCH and clearly communicate this assignment. This officer remains at the command post. He not only possesses the most recent/best situational awareness, he also is the point of contact for all of the units currently deployed, has set in motion tactical and strategic plans and must remain focused on objectives. This position becomes the eyes and ears of the Incident Commander, communicating direction from COMMAND and handling radio traffic for COMMAND.

[ ] Assign INTELLIGENCE SECTION - Identify a resource qualified to begin the functions of this section chief, collocate this position close to the command post and provide the Checklist for this activity as part of the COMMAND GENERAL STAFF.

[ ] Assign LEAD PIO to establish JOINT INFORMATION CENTER - Identify a resource qualified to begin the functions of Lead Public Information Officer (PIO) to establish a Joint Information Center (JIC) (NIMS designates the Lead PIO as the leader of a JIC). Other PIOs should report to the JIC. A more qualified PIO may replace the Lead PIO later.

FIRST FD/EMS SUPERVISOR

[ ] Go to COMMAND POST - Important that contact is made with the INCIDENT COMMANDER. Call dispatch to determine location of law enforcement COMMAND POST and move to that location in a safe manner.

[ ] Request MEDICAL BRANCH assignment - If not verbalized, confirm the assignment with a specific request. Remember, the situation is fluid and stressful. This singularly can assist the INCIDENT COMMANDER by off-loading critical tasks from him/her while supporting the operation.

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SECTION 2

LAW ENFORCEMENT

Law Enforcement Branch Sub Checklist

Once the Law Enforcement Branch is designated, all tactical operations become the primary focus of this position. Further decisions are made based on the cumulatively acquired situational awareness that is communicated from the Tactical Group and Perimeter Group Supervisors. Communications made by the individual contact and perimeter teams must be directed to their respective Group Supervisors, which in turn communicates directly to the Law Enforcement Branch Director.

LAW ENFORCEMENT BRANCH

[ ] Get briefing (verbal) - This will be accomplished during the change when the Second LE Supervisor arrives.

[ ] Co-locate with MEDICAL BRANCH - Critical communications as to the fluidity of the Hot Zone boundaries, ingress/egress paths for Rescue Task Forces, location and number of casualties and grant access permission into Hot Zone.

[ ] Coordinate with INTELLIGENCE SECTION - Establish contact with the Intelligence Section, provide information, and stay updated on findings.

TACTICAL GROUP

[ ] Coordinate CONTACT TEAM(s) - Responsible for management, monitoring location and status from each Contact Team. Communications should be from one "team leader" in each team.

[ ] Prioritize 1Threat, 2Rescue, 3Clear - Prioritize actions and resources: Priority 1 is to neutralize or contain any active threat, Priority 2 is Rescue of injured, and Priority 3 is Clearing the affected area for any remaining threat.

[ ] Update Hot and Warm Zones - Keep Triage Group and Transport Group updated on the boundaries of the Hot Zone and Warm Zones. Update LE Branch as able.

[ ] Update casualty information to Triage Group - Keep Triage Group updated on injured in Hot and Warm Zones.

Law Enforcement

LAW ENFORCEMENT BRANCH
- [ ] Get briefing (verbal)
- [ ] Co-locate with MEDICAL BRANCH
- [ ] Coordinate with INTELLIGENCE SECTION

TACTICAL GROUP
- [ ] Coordinate CONTACT TEAM(s)
- [ ] Prioritize 1Threat, 2Rescue, 3Clear
- [ ] Update Hot and Warm Zones
- [ ] Update casualty information to Triage Group

CONTACT TEAM
- [ ] Contain or neutralize threat
- [ ] Update location as moving
- [ ] Report casualty locations, numbers
- [ ] Establish Casualty Collection Point(s)

PERIMETER GROUP
- [ ] Separate radio channel*
- [ ] Establish INNER PERIMETER
- [ ] Establish OUTER PERIMETER

INTELLIGENCE / INVESTIGATIONS SECTION
- [ ] Get briefing (verbal)
- [ ] Separate radio channel*
- [ ] Coordinate with Communications Center
- [ ] Collect incoming information, tips, leads
- [ ] Brief COMMAND
- [ ] Consider REUNIFICATION BRANCH
- [ ] Assign INVESTIGATIVE OPERATIONS GROUP
- [ ] Assign INTELLIGENCE GROUP

CONTACT TEAM(s)

[ ] Contain or neutralize threat - Locate and contain or neutralize any active threat.

[ ] Update location as moving - IMPORTANT! As you are moving to meet the threat, update Tactical Group with your location and team status.

[ ] Report casualty locations, numbers - Location and number of casualties is important for Rescue Task Force deployment. Contact Teams should report casualties as they encounter them. Instead of trying to remember a running count of casualties, personnel are STRONGLY encouraged to use a "plus x casualties" radio call. For example, "Contact 1 to Tactical, plus 5 casualties room 110." TACTICAL GROUP should keep a tally count, and dispatch in many jurisdictions will also record the information. **It is critically important to specify a NUMBER -- even if it's an ESTIMATE!** Reporting "multiple down" is meaningless. Estimating "plus 20 casualties" is actionable, enabling the rest of the Command team to request and organize the needed resources.

[ ] Establish Casualty Collection Point(s) - After threat suppression is addressed, the CONTACT TEAM assesses the need for and establishes one or more Casualty Collection Points as indicated. Report the location of each Casualty Collection Point.

PERIMETER GROUP

[ ] Separate radio channel* - The Perimeter Group Supervisor will communicate with Command elements on main radio channel but communicates with perimeter resources on separate radio channel. This frees the main radio channel from perimeter deployment radio traffic.

[ ] Establish INNER PERIMETER – The inner perimeter is designed to control the incident, provide strict control of access to authorized personnel only, and contain the suspect. Plain clothed LEO's should be replaced by uniformed LEO's as soon as practical. Remind personnel to utilize proper cover and concealment while on perimeter post. Limit the movement of LEO's assigned to control the inner perimeter.

[ ] Establish OUTER PERIMETER – Utilized to control access to an emergency event. Identify and secure safe routes of travel for emergency vehicles to and from the emergency event. Protect the inner perimeter from unauthorized access. Establish a media assembly area. All outer perimeter personnel should be advised of the Hot Zone, Inner Perimeter, Command Post, Staging Area, Reunification Location, and Media Assembly Area.

INTELLIGENCE / INVESTIGATIONS SECTION

The **NIMS Intelligence/Investigations Function Guidance and Field Operations Guide** is hereby incorporated by reference and should be used for guidance on Intelligence/Investigative functions. **http://www.fema.gov/media-library/assets/documents/84807**.

[ ] Get briefing (verbal) - Obtain a briefing from the Incident Commander.

[ ] Separate radio channel - Receiving, clarifying, and communicating information and updates to the command element should be separated from the tactical channel.

[ ] Coordinate with Communications Center - Intel should have a presence in the communications center to collect critical information and keep the center updated on critical items such as reunification location and public release.

[ ] Collect incoming information, tips, leads - Provide a single entry point for all incoming information, tips, leads, etc. Categorize, assess, and analyze information to form a common operating picture and support situational awareness. For example, dispatch notification of a 911 call reporting a man with a gun, or reports of survivors hiding in a specific location.

[ ] Brief Command - Provide meaningful information to Incident Command and other ICS elements to help form a common operating picture and support situational awareness.

[ ] Consider REUNIFICATION BRANCH - If the incident involves a large gathering, a school, a group of kids, etc., assign a REUNIFICATION BRANCH Director immediately. Determine if a reunification plan exists (most schools have one) and if it's suitable for the incident. Coordinate location, notifications, and management with Command and other involved entities.

Parents and family members of survivors/victims will present at the scene very early in the incident. All survivors must be searched and interviewed by law enforcement prior to release. Timely and sensitive notification to parents and family is important.

The **STANDARD REUNIFICATION METHOD** developed by the **i love u guys® Foundation** is recommended and may be found at: **http://iloveuguys.org/srm.html**

[ ] Assign INVESTIGATIVE OPERATIONS GROUP - Contact Staging Manager and request resource assignment to perform INVESTIGATIVE OPERATIONS GROUP functions. See NIMS Intelligence/Investigations Function Guidance document for additional information.

[ ] Assign INTELLIGENCE GROUP - Contact Staging Manager and request resource assignment to perform INTELLIGENCE GROUP functions. See NIMS Intelligence/Investigations Function Guidance document for additional information.

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SECTION 3

FIRE / EMS

Fire / EMS Sub Checklist

Gaining access to the injured, providing lifesaving treatment, evacuating the injured out of the Hot Zone and providing transportation to medical facilities as quickly and safely as possible is the responsibility of the MEDICAL BRANCH Director. It is **critical** that the MEDICAL BRANCH Director work closely and in coordination with the LAW ENFORCEMENT BRANCH (LEB). Task assignments must be proactively performed to shorten deployment reflex time to the minimum possible. Updating the LEB on team status and receiving low risk/safe avenues of ingress/egress is paramount.

Once the first arriving fire/EMS officer assumes the Medical Branch, focusing on the formation of Rescue Task Force(s) to meet the estimated need is paramount. Assigning the task to the Triage Group and committing the need resources as quickly as possible cannot be understated. Creating a Transport Group and delegating tasks to manage the movement of casualties is another priority.

MEDICAL BRANCH

[ ] Get briefing (verbal) - Obtain this briefing from the Incident Commander and assume the MEDICAL BRANCH Director assignment.

[ ] Request additional resources - Obtain estimated number of injured from LE Branch. Call for additional transport and manpower resources as needed and if necessary, declare the MCI (Mass Casualty Incident) level per local policy.

[ ] Assign TRIAGE GROUP - Contact Staging Manager and request resource assignment to perform TRIAGE GROUP functions. Give directions to assemble resources to create appropriate number of RESCUE TASK FORCE(S) as a high priority.

[ ] Assign TRANSPORT GROUP - Contact Staging Manager and request resource assignment to perform TRANSPORT GROUP functions. Give directions to determine group location and assemble transport resources for number of expected injuries.

[ ] Collocate with LAW ENFORCEMENT BRANCH - This is critical to insure situational awareness of the status of downrange teams within the Hot Zone, to receive updates to casualty locations and status, and gain access permission control for go/no-go deployment of Rescue Task Force(s).

[ ] Consider TREATMENT GROUP - Create TREATMENT GROUP if situation presents movement challenges based on number of patients, resource limitations, geography constraints or other circumstances that inhibit rapid distribution of patients from the incident.

TRIAGE GROUP

[ ] Get briefing (verbal) - Obtain situational awareness from the Medical Branch Director.

[ ] Stand-up RESCUE TASK FORCE(s) - **CRITICAL FUNCTION** - Assemble teams with law enforcement and medical personnel. Target staffing is 2 LE and 2 medical (or as required by local policy). The RTF works for the Triage Group. The medical element communicates with Triage Group. The law enforcement element (1) communicates with Tactical Group, (2) controls and dictates team movement for security, and (3) **never leaves** the medical element — **team protection is the priority**.

NOTE: Staffing should be adjusted based on incident circumstances, which should be supported by local policy. Available resources, current security situation, and elapsed incident time are considerations. Example: The first RTF into the Warm Zone should be small and travel light, but the second or third RTF may be staffed heavier with more equipment when the situation is more known (i.e. elapsed time with no active threat).

[ ] Collocate with TACTICAL GROUP - This is **critical** to insure situational awareness of the status of downrange teams within the Hot and Warm Zones, to receive updates on casualty locations and status, and gain access permission control for go/no-go deployment of Rescue Task Force(s).

[ ] Get operable areas, routes, and Casualty Collection Point location(s) - Obtain the Hot Zone and Warm Zone areas, ingress/egress routes, and location of Casualty Collection Point(s).

[ ] Deploy RESCUE TASK FORCE(s) - Deploy RTFs from Staging as soon as requested by Contact Team(s) and approved by Tactical Group. As possible, specify routes of travel (ingress/egress), location of Casualty Collection Point or destination, and Contact Team identifier for link-up.

RESCUE TASK FORCE

[ ] Assemble team and equipment - Obtain assignment from the Triage Group Supervisor. Coordinate communications with LE team members. Assemble needed materials to provide and indirect-threat care (including direct-threat care). Conduct team pre-deployment security briefing, to include introduction of team members, movement assignments, and security rules (i.e. tactical do's/don'ts for medical personnel).

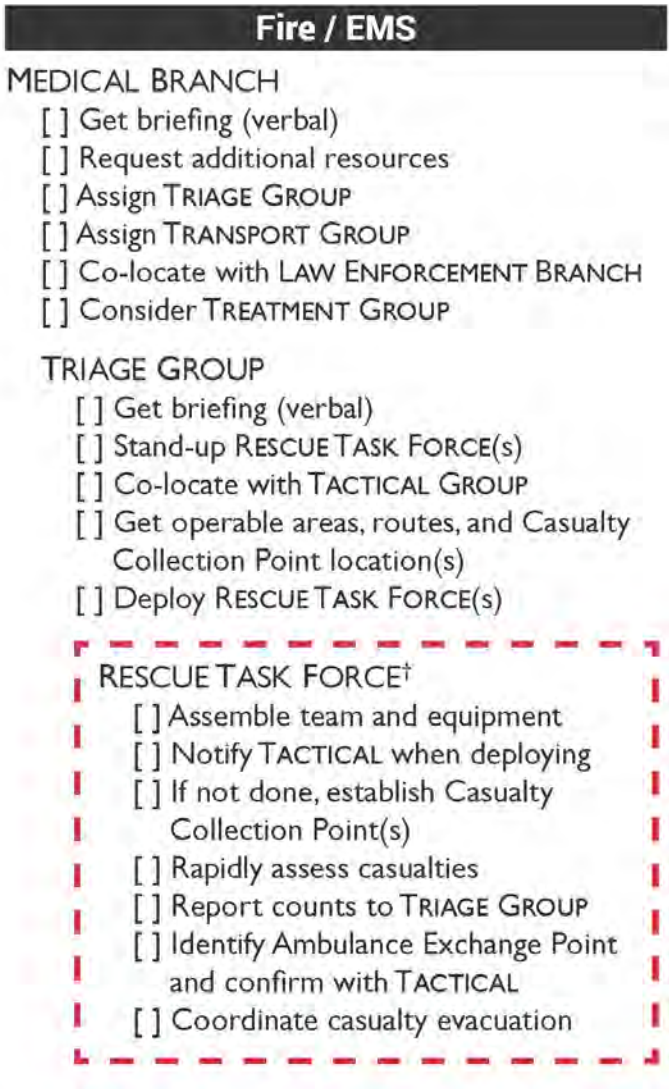
[ ] Notify TACTICAL when deploying - RTF law enforcement element notifies Tactical Group when the team is deploying from Staging to insure (1) Tactical is aware of the RTF movement, and (2) appropriate Contact Team(s) are aware of the RTF movement.

[ ] If not done, establish Casualty Collection Point(s) - An RTF is typically deployed to a Casualty Collection Point (CCP) established by a Contact Team, however a Contact Team may not have time or resources to establish a CCP prior to RTF entry. If not established, the RTF team should establish a CCP in consultation with law enforcement.

[ ] Rapidly assess casualties - Triage with emphasis on hemorrhage control and rapid evacuation from Warm Zone/Inner Perimeter.

[ ] Report counts to TRIAGE GROUP - Keep Group Supervisor updated on casualty counts, colors, and locations.

[ ] Identify Ambulance Exchange Point and confirm with Tactical - The RTF medical element, in consultation with their law enforcement element, should select the desired Ambulance Exchange Point (AEP) and confirm with



Tactical Group via radio. If needed, Tactical Group should direct and additional Contact Team to the AEP for security..

[ ] Coordinate casualty evacuation - Rescue Task Force medical and law enforcement members must work together face-to-face to coordinate the best Ambulance Exchange Point location(s), the priority order of casualties to be evacuated, and coordinate the timing of ambulances moving up to the Exchange Point. Tactical Group must insure the AEP location and route are secure. When ready, RTF's request from Triage Group an ambulance at the AEP, and Triage coordinates that request with Transport Group.

There may be multiple RTF's and AEP's in use. Triage Group sets evacuation priority. Transport Group moves ambulances.

TRANSPORT GROUP

[ ] Get Briefing (verbal) - Obtain situational awareness from the Medical Branch Director.

[ ] Co-locate with TACTICAL GROUP - This is **critical** to receive timely updates on casualty locations and priorities, location of Ambulance Exchange Point(s), and safe routes of travel.

[ ] Determine routes - safe operable ingress/egress for casualty evacuation and movement of ambulances.

[ ] Separate radio channel - hospital capacity counts, explicit movement of ambulances, and hospital destination instructions should be separated from the main channel.

[ ] Get Hospital capacity count - Coordinate with the MEDICAL BRANCH Director. This information is usually obtained through the communications center and/or medical control.

[ ] Transport casualties from Ambulance Exchange Point(s) - If possible, have ambulances to transport directly to hospital after loading casualties at the Ambulance Exchange Point. If necessary, establish a traditional Mass Casualty Incident ambulance Loading Zone to manage transport of large numbers of casualties.

[ ] Target 3 per ambulance (1ea Red/Yel/Grn) – Target loading for each ambulance is 1 Red, 1 Yellow, and 1 Green patient. The ambulance should report to Transport Group the number and severity (color) of casualties being transported.

This approach makes the best use of each ambulance resource, without overloading the transport crew or receiving facility. Importantly, this method also insures that Yellow and Green patients (some of which may be seriously injured) are not left waiting until every Red is first transported -- a mistake that can cost lives.

Triage systems are prone to under-triage and over-triage error, and some are worse than others. Because of this built-in error, one cannot assume Green patients "can wait" or "every red is critical." The Transport Group Supervisor is responsible for distributing both the severity and the number of casualties to the appropriate facilities. By loading patients in this manner and then distributing to the most appropriate hospitals, the Transport Group Supervisor ensures the fastest overall transport of all casualties and avoids overloading any one facility with patients.

[ ] Distribute to Hospitals - determine appropriate destination based on patient severity, hospital capacities, hospital travel times and number of casualties to be evacuated. Transport Group should specify the hospital destination to each transporting ambulance.

[ ] Keep Transport Log - Consider assigning this important task to one person to manage/maintain for accuracy.

TRANSPORT GROUP
- [ ] Get briefing (verbal)
- [ ] Co-locate with TACTICAL GROUP
- [ ] Determine routes
- [ ] Separate radio channel*
- [ ] Get Hospital capacity count
- [ ] Transport casualties from Ambulance Exchange Point(s)
- [ ] Target 3 per ambulance (1ea Red/Yel/Grn)
- [ ] Distribute to Hospitals
- [ ] Keep Transport Log

SECTION 4

MULTI-DISCIPLINE

Multi-Discipline Elements Sub Checklist

Resources must be channeled to the most need with task and purpose and at the direction of the Incident Commander or designee. Optimally, determine one Staging location for all resources in a safe but accessible location. The PIOs must be organized into a Joint Information Center to ensure one unified message approved by the Incident Commander. Reunification is organized under the Intelligence Section to not only ensure people are reunited with their families/loved ones, but to make sure all pertinent witness information is gathered prior to releasing people from the incident.

STAGING

Resources must be assigned with task and purpose to the highest need — Staging makes this possible. One Staging location should be used for all resources in a safe and accessible location. An LE and FD/EMS person should be teamed as Staging Manager.

[ ] Check-in and list resources - Check-in arriving resources and maintain list of type and number of units with capabilities and personnel. Update list when resources are assigned. Do not erase resources from your log. Rather, showed their deployment downrange.

[ ] Give resources assignments, location and channel - On the direction/request of command element, assemble the appropriate assets, give the assignment, boss (to whom to report), channel, destination and equipment needed.

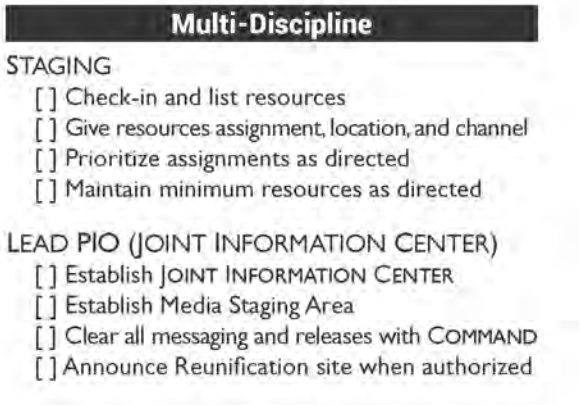
[ ] Prioritize assignments as directed - In the absence of direction, professional judgment should be used.

[ ] Maintain minimum resources as directed - Request from the command element minimum resources levels of each capability to meet anticipated needs.

LEAD PIO (JOINT INFORMATION CENTER)

The **NIMS Basic Guidance for Public Information Officers (PIOs)** is hereby incorporated by reference and should be used for guidance on PIO and JIC functions. **https://www.fema.gov/media-library-data/20130726-1623-20490-0276/basic_guidance_for_pios_final_draft_12_06_07.pdf**.

[ ] Establish JOINT INFORMATION CENTER - Determine an optimal location near **but distinctly separate** from the Command Post. Consider security of the location and ability to limit unauthorized personnel from the Command Post. Notify Command and dispatch of the JIC location.



[ ] Establish Media Staging Area - Determine an optimal location near **but distinctly separate** from the JIC. Consider security of the location and ability to limit unauthorized personnel from the JIC and the Command Post. Notify Command and dispatch of the Media Staging location.

[ ] Clear all messaging and releases with COMMAND - Insure all public messaging and information releases are explicitly cleared by COMMAND. Law enforcement commonly restricts the release of some information and sensitive details; this can be a surprise to some PIOs and elected officials.

[ ] Announce Reunification site when authorized- It is essential to coordinate the public release of the location with the **Reunification Branch Director**. The release should only be made when the site is set up with security in place and ready to receive people.

REUNIFICATION BRANCH

Reunification is organized under the Incident Command structure as a branch of the Intelligence Section. It includes the Reunification Accountability Group, the Reunification Assembly Group, and the Reunification Services Group.

[ ] Get Briefing (verbal) - Obtain situational awareness from the Intel / Investigations Section Chief.

[ ] Select Reunification Location- Consider security and proximity to affected site. Consult any plans that may have pre-selected sites.

[ ] Location approved by INTELLIGENCE SECTION- Discuss with the INTELLIGENCE SECTION and obtain site approval.

[ ] Notify Dispatch of Location- Advise Dispatch of location, preferably via phone to avoid any leak of the location information prior to set up, ensure Dispatch knows that this is for responders only and not for general public release at this time.

[ ] Assign REUNIFICATION STAGING MANAGER- The site will require staging at the site to check in resources. Assign a staging manager to coordinate activities.

[ ] Request additional resources- Consider the current resources assigned and decide if they are adequate and/or in need of replacement

[ ] Assign SERVICES GROUP- The SERVICES GROUP will do the set up and provide security and other services. Assign this early.

[ ] Assign ACCOUNTABILITY GROUP - The ACCOUNTABILITY GROUP will be the face of the reunification effort, assign a supervisor and provide briefing/training.

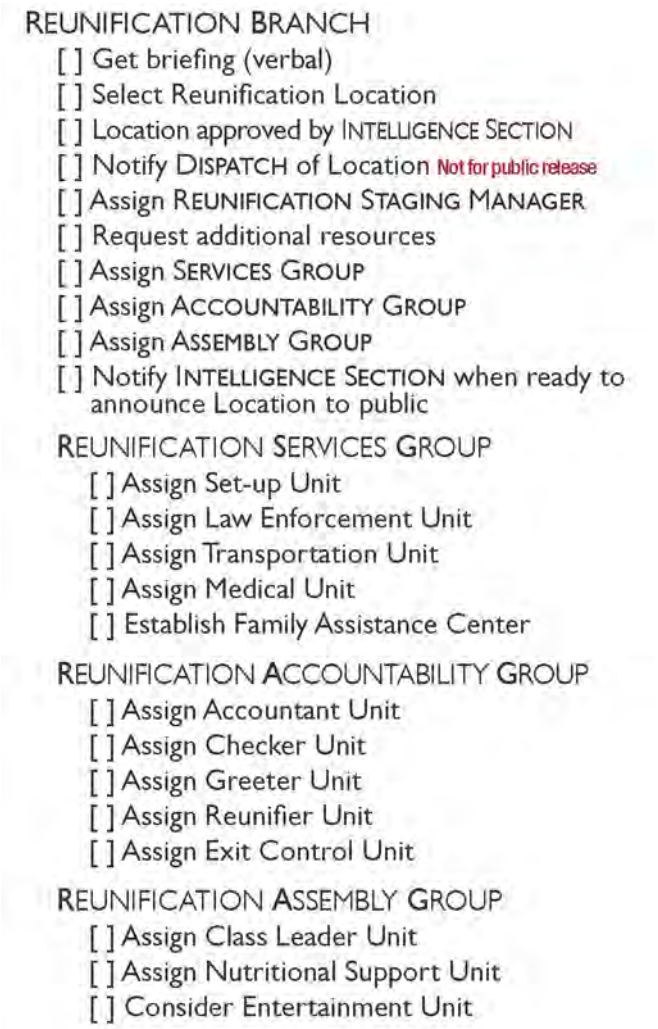
[ ] Assign ASSEMBLY GROUP - The ASSEMBLY GROUP will be dealing with the survivors, assign a supervisor and provide briefing/training and needed resources.

[ ] Notify INTELLIGENCE SECTION when ready to announce location to public- When the site is ready to receive survivors, notify the INTELLIGENCE SECTION, Dispatch and the PIO and prepare all groups for the process.

REUNIFICATION SERVICES GROUP

[ ] Assign Set-up Unit - Organize and assign personnel to set up the reunification area

[ ] Assign Law Enforcement Unit- Law Enforcement will be responsible for perimeter security, interior and exterior security.


REUNIFICATION BRANCH
[ ] Get briefing (verbal)
[ ] Select Reunification Location
[ ] Location approved by INTELLIGENCE SECTION
[ ] Notify DISPATCH of Location Not for public release
[ ] Assign REUNIFICATION STAGING MANAGER
[ ] Request additional resources
[ ] Assign SERVICES GROUP
[ ] Assign ACCOUNTABILITY GROUP
[ ] Assign ASSEMBLY GROUP
[ ] Notify INTELLIGENCE SECTION when ready to announce Location to public
REUNIFICATION SERVICES GROUP
[ ] Assign Set-up Unit
[ ] Assign Law Enforcement Unit
[ ] Assign Transportation Unit
[ ] Assign Medical Unit
[ ] Establish Family Assistance Center
REUNIFICATION ACCOUNTABILITY GROUP
[ ] Assign Accountant Unit
[ ] Assign Checker Unit
[ ] Assign Greeter Unit
[ ] Assign Reunifier Unit
[ ] Assign Exit Control Unit
REUNIFICATION ASSEMBLY GROUP
[ ] Assign Class Leader Unit
[ ] Assign Nutritional Support Unit
[ ] Consider Entertainment Unit

[ ] Assign Transportation Unit- Bus transportation will likely be needed from the affected site.

[ ] Assign Medical Unit- The reunification site will need medical standby.

[ ] Establish Family Assistance Center- This will be essential for families of victims and casualties. This unit will provide counseling, support, information and coordination with other agencies to assit family members.

REUNIFICATION ACCOUNTABILITY GROUP

[ ] Assign Accountant Unit- Assign an Accountant unit leader to organize and supervise the accountants. Accountants are responsible for both student and staff roster verifications. Recover Attendance from Class Leaders, assemble student rosters and Assemble staff rosters. They alert the unit leader when students or staff are known missing.

[ ] Assign Checker Unit- Assign a unit leader to organize and supervise the checkers. A checkers job is to verify ID of the parent or guardian. Checkers confirm all information is provided on the Reunification Card. Indicate on card if ID is confirmed and parent or guardian is authorized for student release Separate the card on the perforation returning bottom of card to parent and deliver top of card to the Accountant Unit.

[ ] Assign Greeter Unit- Assign a unit leader to organize and supervise the greeters. This units is the initial contact at the center and provides the families with reunification cards to fill out. Distribute cards and pens to parents as they arrive and instruct on use of the reunification card and then direct parents to the check-in table with Identification in hand

[ ] Assign Reunifier Unit- Assign a unit leader to organize and supervise reunifiers. The primary job is the reunite family with loved ones. They take the reunification slip from the Parent and then bring the student named on the slip to the parent. They ask student if they are comfortable going home with this adult, Initial the slip and give to the Accountant. If student is unavailable they give the slip to The Family Assistance Center, for further handling

[ ] Assign Exit Control Unit- This is the last person(s) the families/loved ones will see before they leave the reunification site. This should be an administrative person that can answer any questions or concerns the families have. In the case of a school reunification this is most likely the school principal.

REUNIFICATION ASSEMBLY GROUP

[ ] Assign Class Leader Unit- During a school reunification these are typically teachers and are charged with organizing their students and taking attendance. Position may not be needed in the case of a business reunification. However during large non-school reunification events there will be a need for organizing people into smaller groups and therefore the concept here of a groups unit leader may still apply.

[ ] Assign Nutritional Support Unit- During reunification especially with children there will be a need for water and snacks.

[ ] Assign Entertainment Unit- Most likely to be assigned for school reunification to keep small children entertained with short videos etc.. Do not use full length feature films since children may be upset if they "miss' the ending

THE STANDARD REUNIFICATION METHOD

We gratefully acknowledge and thank the I Love U Guys Foundation for granting permission to include the full text of the document within this manual.
You may also download the Standard Reunification Method at:
http://iloveuguys.org/srm.html
This is a proven method used by many schools. It's a well-structured, well-thought out, and well-documented approach to reunification. The process was developed by the I Love U Guys Foundation out of tragedy.

i love u guys Foundation®

On September 27th, 2006, a gunman entered Platte Canyon High School, held seven girls hostage and ultimately shot and killed Emily Keyes. During the time she was held hostage, Emily sent her parents these text messages: "**I love you guys" and "I love u guys. k?**" Emily's kindness, spirit, fierce joy, and the dignity and grace shown by the Keyes family following this tragic event define the core of The "I Love U Guys" Foundation.
http://iloveuguys.org

SECTION 5

IED

Improvised Explosive Device (IED) Sub Checklist

Improvised Explosive Devices (IED) are extremely dangerous. The following is general guidance for non-EOD first responders encountering a suspected IED during an Active Shooter Event. The guidance is based largely on military procedures for encountering an IED on the battlefield and civilian procedures adjusted for the context of an Active Shooter Event, most notably that the IED is likely to be smaller (50 lbs or less) and inside a building or other confined area.

BOMBERS ARE BOMBS

NEVER TOUCH BOMBS

The Checklist introduces a process that is a way of mitigating the risk and saving lives. Let's talk about the Checklist. What changes? What doesn't change? What stays the same? What's our primary mission? The primary mission never changes. We are here to save lives, and what are the two things that are going to kill people? It's the shooter -- whether he is shooting them or whether he detonates a device, or whether a device that he has planted is detonated -- and the clock. Nothing changes, so let's keep that in mind.

Checklist users are cautioned to have their leadership and local EOD/Bomb Team review these procedures and adopt or modify as a local policy decision. See **DHS Bomb Threat Stand Off Card** for more information **https://www.llis.dhs.gov/content/dhs-bomb-threat-stand-card**

DISCOVERY or DETONATION

[ ] Announce "Bomb Cover" or "Bomb Go" - If you see a suspected device, there are two different commands that you can give: "Bomb cover" and "Bomb go." If the bomb is in front of you, it's "Bomb cover." If the bomb(er) is moving towards you or in a place where you don't have cover, it's going to be "Bomb go." You're going to move past it and create angles and air gaps.

[ ] Secondary threat scan (device, 5ft, 25ft) - The military uses a 5 meter and a 25 meter scan around all devices. We have slightly modified that to 5 feet and 25 feet. Number one, if you can see a bomb, a bomb can see you, and what are we looking for in that 5 foot and that 25 foot scan? Several things. Do we have victims/survivors there? What kind of initiating devices or mechanisms are in place? Are there other devices? Because bombers are like knife fighters. They are from the department of redundancy department. If they have one, they're going to have multiples. It's just the way that they are. Maintain that secondary threat scan.

[ ] Maintain 540^0 scan- We should always be scanning 540°. That's 180° up and down and 360° around, always having a 540° scan.

[ ] NEVER TOUCH Bombs- When should we touch bombs? NEVER. That is correct. Never ever, never ever, never ever… We never ever touch a bomb. If we must move past an IED, and there is actionable intelligence such as: gunfire, screaming, things that we have to act on. Then we are moving past it. We're not going to touch it. We are not even going to look at it, just move past it smartly and continue with the mission.

[ ] Bombers are Bombs- Bombers themselves are bombs. Never touch them. Don't handcuff them. Don't do anything with them. You need to talk to your prosecutor's office about how you're going to mitigate that.

CONTACT and RESCUE

[ ] Consider threat to life and alternate route - You must consider threat to life and alternate route. If you can find an alternate route, take it.

[ ] Mark (Chem Lights) and bypass - The need for chem lights is paramount. We highly recommend carrying two sets of chem lights. You have a green chem light and a red chem light. Green means you can go past it. Red means do not go past it. A green and a red together, means go past it, but don't delay. Move past as quickly as possible.

[ ] Provide security element if possible - If the situation and Team size permit, assign resources to secure the area and prevent accidental contact with the IED.

EXPOSED SURVIVOR RESCUE

[ ] Direct survivor movement explicitly - If you have an exposed survivor, then they're probably not in front of a PIR device, so we need to go ahead and get them out of harm's way.

[ ] View area for secondary threats - Scan from floor to waist along perimeters (e.g. walls) first, then interior. Repeat scan from waist to ceiling paying attention to tops of furniture/cabinets. **Look for unordinary things (**wire, antenna, watch or timer, cell phone, remote control device, handheld radio, passive infrared (PIR) or motion sensor, chemicals, powder, liquid, batteries, etc.), **unusual chemical smells, and proximity of any hazards** (e.g. flammable liquid/gas, chemicals, etc). If post detonation, look for structural damage or collapse threat.

[ ] Establish narrow cordon in/out of area - Establish a narrow path in and out of the area to access survivors as directly as possible while avoiding proximity to the IED. Attempt to retrace steps and path as much as possible (think of it like operating in a minefield).

[ ] Provide Direct Threat Care only - Casualties exposed to an IED are considered to be in a Direct Threat environment. Limit medical care to Direct Threat Care only to minimize exposure time.

[ ] Evacuate to standoff / Isolate / Barricade - Evacuate survivors to standoff distance (see chart) as soon as possible. If evacuation is not practical, isolate survivors from the IED kill zone by use of angles and air gaps. If isolation to the minimum with cover standoff distance, barricade survivors using terrain features or large/heavy objects (e.g. file cabinet, desk, etc.). See STANDOFF DISTANCE for additional information.

Improvised Explosive Device (IED)

DISCOVERY or DETONATION
- [ ] Announce "Bomb Cover" or "Bomb Go"
- [ ] Secondary threat scan (device, 5ft, 25ft)
- [ ] Maintain 540° scan
- [ ] NEVER TOUCH Bombs
- [ ] Bombers are Bombs

CONTACT and RESCUE
- [ ] Consider threat to life and alternate route
- [ ] Mark (Chem Lights) and bypass
- [ ] Provide security element if possible

EXPOSED SURVIVOR RESCUE
- [ ] Direct survivor movement explicitly
- [ ] View area for secondary threats
- [ ] Establish narrow cordon in/out of area
- [ ] Provide Direct Threat Care only
- [ ] Evacuate to standoff / Isolate / Barricade

FROM RADIO SAFE DISTANCE (300ft or standoff)
- [ ] Report IED location, description, size
- [ ] Report action taken
- [ ] Request Bomb Squad

NO SURVIVORS THREATENED
- [ ] View area for secondary threats
- [ ] Reposition personnel to safe standoff
- [ ] Report impact to assignment and priority
- [ ] Cordon off 360° device kill zone
- [ ] Control cordon security awaiting Bomb Squad

Standoff Distance[1]

IED	Size	Minimum with Cover	Preferred
Pipe Bomb	5 lb	**70 ft**	**1200 ft**
Suicide Bomber	20	**110**	**1700**
Briefcase/Suitcase	50	**150**	**1850**
SUV / Van	1000	**400**	**2400**

[1]See Help Guide and DHS reference for IMPORTANT information.

FROM RADIO SAFE DISTANCE

(300ft or standoff) - Everybody talks about the radio safe distances, 300 feet or safe standoff distance. That is not as big a problem as people make it out to be. The only recorded incident of a radio possibly initiating an explosive device was in the early 70's at an industrial site. Today, radios are regularly used on bomb suits, while leaning over devices. We are not telling you to rewrite your own policy. We are not telling you what to do. We are just telling you that in the bomb community, they do use radios around explosive devices.

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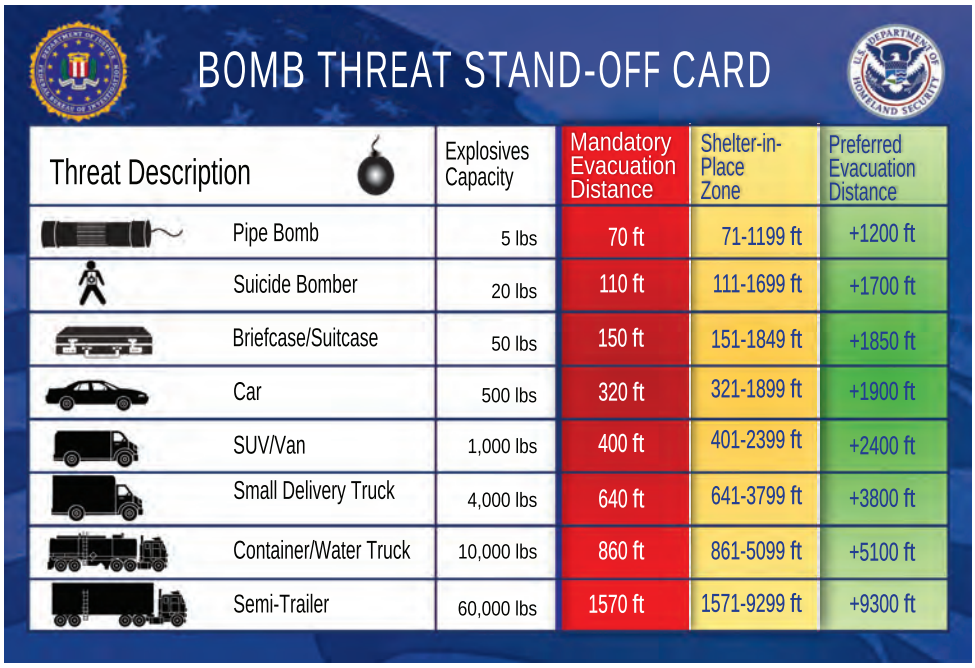
[ ] Report IED location, description, size - Report the location, brief description, and estimated size in pounds of suspected IED. Report any indication of CBRN (Chemical, Biological, Radiological, Nuclear) in detail. Note CBRN threats are outside the scope of this document.

[ ] Report action taken - Report actions taken related to the suspected IED.

[ ] Request Bomb Squad - Request local EOD/Bomb Squad response.



Threat Description	Explosives Capacity	Mandatory Evacuation Distance	Shelter-in-Place Zone	Preferred Evacuation Distance
Pipe Bomb	5 lbs	70 ft	71-1199 ft	+1200 ft
Suicide Bomber	20 lbs	110 ft	111-1699 ft	+1700 ft
Briefcase/Suitcase	50 lbs	150 ft	151-1849 ft	+1850 ft
Car	500 lbs	320 ft	321-1899 ft	+1900 ft
SUV/Van	1,000 lbs	400 ft	401-2399 ft	+2400 ft
Small Delivery Truck	4,000 lbs	640 ft	641-3799 ft	+3800 ft
Container/Water Truck	10,000 lbs	860 ft	861-5099 ft	+5100 ft
Semi-Trailer	60,000 lbs	1570 ft	1571-9299 ft	+9300 ft

NO SURVIVORS

THREATENED

[ ] View area for secondary threats - Scan from floor to waist along perimeters (e.g. walls) first, then interior. Repeat scan from waist to ceiling paying attention to tops of furniture/cabinets. **Look for unordinary things (**wire, antenna, watch or timer, cell phone, remote control device, handheld radio, passive infrared (PIR) or motion sensor, chemicals, powder, liquid, batteries, etc.), **unusual chemical smells, and proximity of any hazards** (e.g. flammable liquid/gas, chemicals, etc). If post detonation, look for structural damage or collapse threat.

[ ] Reposition personnel to safe standoff - Evacuate personnel to standoff distance (see chart) as soon as possible.

[ ] Report impact to assignment and priority - Report impact to previous assignment caused by suspected IED and communicate the priority of mitigating the suspected IED.

[ ] Cordon off 360° device kill zone - Cordon off a 360 degree radius around the suspected IED utilizing the standoff chart as a guide.

[ ] Control cordon security awaiting Bomb Squad - Secure the 360 degree cordon perimeter while awaiting EOD/Bomb Squad response. Monitor the entire area and maintain eyes on the suspected IED if possible.

STANDOFF DISTANCE

Refer to the figure above on standoff distances. A pipe bomb which is five pounds is minimum with cover 70 feet, preferred 1,200 feet. A suicide bomber with 20 pounds of explosive is 110 feet with cover to 1,700 feet. A briefcase/suitcase could be 50 pounds of explosive, and minimum distance is 150 feet or 1,850 without cover, and an SUV/van is 1,000 pounds, and a minimum with cover is 400 feet or 2,400 feet, almost half a mile. So be cognizant of that, and how realistic is that going to be? Are we going to be able to get that? But it's something to keep in mind, and a five-pound explosive is really significant.

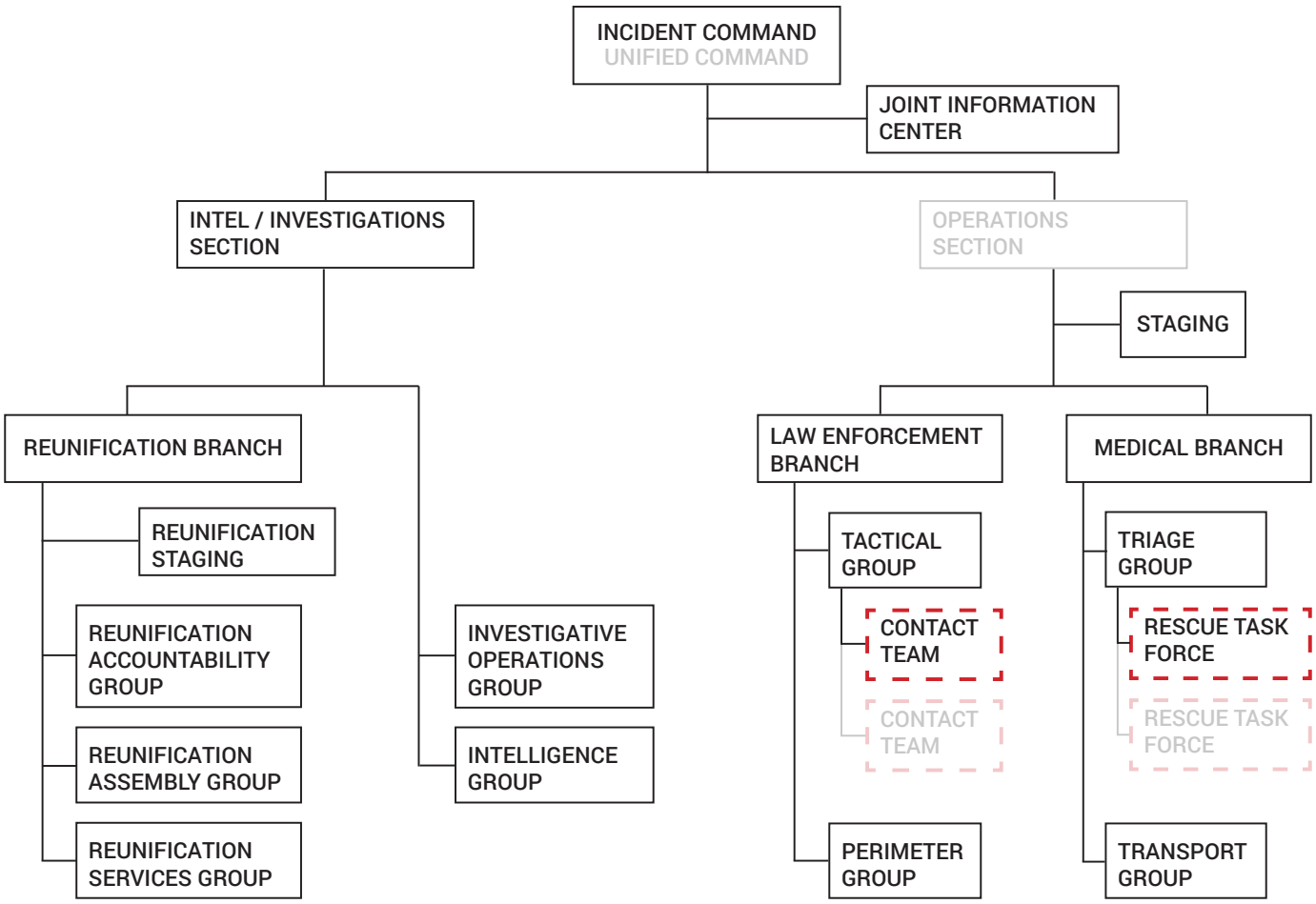
We're not trying to instill paranoia, just a caution, awareness, and what to do. If the bomb hasn't gone off, there's a good chance it probably will not. This drives home the fact that we need to have chem lights and we need to have training with this. You need to work with your local bomb squad. That cannot be stressed enough, that is paramount.

SECTION 6

ORG CHART

Active Shooter Event Incident Command System Organizational Chart

This chart complements the checklist by providing a quick, graphical view of the management structure. It demonstrates the chain of command, communication pathways and organizes the roles and responsibilities. Each role in the chart can be coupled directly to the Active Shooter Incident Management Checklist.



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APPENDIX

Abbreviations

AEP	Ambulance Exchange Point	LE	Law Enforcement	MTC	Move-to-Contact (Team)
ASE	Active Shooter Event	LEB	Law Enforcement Branch	PIR	Passive Infrared
CCP	Casualty Collection Point	LEO	Law Enforcement Officer	RTF	Rescue Task Force
IED	Improvised Explosive Device	MCI	Mass Casualty Incident		

Glossary of Terms

5th Man A generic term for the 5th arriving law enforcement officer without regard to rank. Assumes the leadership duties and responsibilities of the 5th man whether a patrol officer or chief of department.

Ambulance Exchange Point (AEP) A specific location where an ambulance is sent to pick up evacuated casualties from a team operating in the Warm Zone. The ambulance may or may not transport directly to a hospital after picking up casualties.

Casualty Collection Point (CCP) A specific Warm Zone location with security measures to assemble nearby casualties and provide Indirect Threat Care.

Cold Zone An area outside of the Inner Perimeter and inside the Outer Perimeter where no threat is reasonably expected.

Complex Coordinated Attack (CCA) Killing or threatening to kill multiple unrelated individuals where there are [a] three or more attackers, or [b] simultaneous attack of two or more sites, or [c] an act of terrorism* which overwhelms the local jurisdiction and initiates a regional/statewide response.

Complex Coordinated Terrorist Attack (CCTA) Department of Homeland Security Definition: Acts of terrorism that involve synchronized and independent team(s) at multiple locations, sequentially or in close succession, initiated with little or no warning, and employing one or more weapon systems: firearms, explosives, fire as a weapon, and other nontraditional attack methodologies that are intended to result in large numbers of casualties

Contact Team A team of law enforcement officers formed-up tactically to rapidly move toward the shooting and neutralize the threat.

Danger Zone See Hot Zone

Direct Threat Care A defined set of limited medical procedures provided in the Hot Zone, e.g. care provided under direct threat.

Hot Zone An area inside of the Inner Perimeter under direct threat.

Indirect Threat Care A defined set of limited medical procedures provided in the Warm Zone, e.g. care provided while an indirect threat may exist.

Inner Perimeter A perimeter containing the Warm and Hot Zones.

Loading Zone A large open area where all casualties from an incident are assembled, organized, and loaded into awaiting ambulances that then transport to directed hospitals. Typically used when casualties outnumber available transport ambulances.

Mobile Command The Incident Commander is performing command functions in addition to other critical duties, such as a first arriving officer moving to contact a shooter. Another responder should assume Command (and establish a stable Command) as soon as practical. Mobile Command is sometimes referred to as a "working command."

Move-to-Contact Team (MTC) See Contact Team

Outer Perimeter A perimeter containing the Cold Zone and stopping at the Inner Perimeter.

Rescue Task Force (RTF) A mixed discipline ad-hoc unit with a security element, a medical element, and a team leader who operate in the Warm Zone to triage patients, provide Indirect Threat Care, and coordinate casualty evacuation to an Ambulance Exchange Point. The unit is typically comprised of two (2) law enforcement officers and two (2) EMS personnel, however staffing may vary based on incident need and local policy. Typically one law enforcement officer serves on point and the other rear guard, escorting the EMS personnel and providing security.

Warm Zone An area inside of the Inner Perimeter where security measures are in place.

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*Title VIII, Section 802 of the USA PATRIOT Act: [An] act of terrorism means any activity that (A) involves a violent act or an act dangerous to human life that is a violation of the criminal laws of the United States or any State, or that would be a criminal violation if committed within the jurisdiction of the United States or of any State; and (B) appears to be intended (i) to intimidate or coerce a civilian population; (ii) to influence the policy of a government by intimidation or coercion; or (iii) to affect the conduct of a government by assassination or kidnapping.

Support

For questions concerning the ACTIVE SHOOTER INCIDENT MANAGEMENT CHECKLIST please contact:

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C3 PATHWAYS™

START HERE

LE First arriving
- [ ] Size up report
- [ ] Identify Hot Zone
- [ ] Establish COMMAND (mobile)
- [ ] Radio ID: CONTACT **1**
- [ ] Engage

LE 2nd-4th arriving
- [ ] Communicate with CONTACT **1**
- [ ] Link-up

LE 5th arriving (5th Man)
- [ ] Radio ID:TACTICAL
- [ ] Get briefing (verbal)
- [ ] Assume COMMAND
- [ ] Set STAGING location
- [ ] Request additional resources
- [ ] Assign more CONTACT TEAMs

First LE Supervisor
- [ ] Get briefing (verbal)
- [ ] Assume COMMAND
- [ ] Set COMMAND POST location
- [ ] Assign STAGING manager
- [ ] Assign PERIMETER GROUP
- [ ] Assign MEDICAL BRANCH to FD/EMS

Second LE Supervisor
- [ ] Get briefing (verbal)
- [ ] Assume COMMAND
- [ ] Request additional resources
- [ ] Designate First LE Supervisor as LAW ENFORCEMENT BRANCH
- [ ] Assign INTELLIGENCE SECTION
- [ ] Assign LEAD PIO to establish JOINT INFORMATION CENTER

First FD/EMS Supervisor
- [ ] Go to COMMAND POST
- [ ] Request MEDICAL BRANCH assignment

fold here

Law Enforcement

LAW ENFORCEMENT BRANCH
- [ ] Get briefing (verbal)
- [ ] Co-locate with MEDICAL BRANCH
- [ ] Coordinate with INTELLIGENCE SECTION

TACTICAL GROUP
- [ ] Coordinate CONTACT TEAM(s)
- [ ] Prioritize 1Threat, 2Rescue, 3Clear
- [ ] Update Hot and Warm Zones
- [ ] Update casualty information to Triage Group

CONTACT TEAM
- [ ] Contain or neutralize threat
- [ ] Update location as moving
- [ ] Report casualty locations, numbers
- [ ] Establish Casualty Collection Point(s)

PERIMETER GROUP
- [ ] Separate radio channel*
- [ ] Establish INNER PERIMETER
- [ ] Establish OUTER PERIMETER

INTELLIGENCE / INVESTIGATIONS SECTION
- [ ] Get briefing (verbal)
- [ ] Separate radio channel*
- [ ] Coordinate with Communications Center
- [ ] Collect incoming information, tips, leads
- [ ] Brief COMMAND
- [ ] Consider REUNIFICATION BRANCH
- [ ] Assign INVESTIGATIVE OPERATIONS GROUP
- [ ] Assign INTELLIGENCE GROUP

*Leader monitors two channels, their channel and the assigned BRANCH / COMMAND channel.

†Target minimum staffing 2 LE, 2 Medical for each RTF.

fold here

Fire / EMS

MEDICAL BRANCH
- [ ] Get briefing (verbal)
- [ ] Request additional resources
- [ ] Assign TRIAGE GROUP
- [ ] Assign TRANSPORT GROUP
- [ ] Co-locate with LAW ENFORCEMENT BRANCH
- [ ] Consider TREATMENT GROUP

TRIAGE GROUP
- [ ] Get briefing (verbal)
- [ ] Stand-up RESCUE TASK FORCE(s)
- [ ] Co-locate with TACTICAL GROUP
- [ ] Get operable areas, routes, and Casualty Collection Point location(s)
- [ ] Deploy RESCUE TASK FORCE(s)

RESCUE TASK FORCE†
- [ ] Assemble team and equipment
- [ ] Notify TACTICAL when deploying
- [ ] If not done, establish Casualty Collection Point(s)
- [ ] Rapidly assess casualties
- [ ] Report counts to TRIAGE GROUP
- [ ] Identify Ambulance Exchange Point and confirm with TACTICAL
- [ ] Coordinate casualty evacuation

TRANSPORT GROUP
- [ ] Get briefing (verbal)
- [ ] Co-locate with TACTICAL GROUP
- [ ] Determine routes
- [ ] Separate radio channel*
- [ ] Get Hospital capacity count
- [ ] Transport casualties from Ambulance Exchange Point(s)
- [ ] Target 3 per ambulance (1ea Red/Yel/Grn)
- [ ] Distribute to Hospitals
- [ ] Keep Transport Log

fold here

Multi-Discipline

STAGING
- [ ] Check-in and list resources
- [ ] Give resources assignment, location, and channel
- [ ] Prioritize assignments as directed
- [ ] Maintain minimum resources as directed

LEAD PIO (JOINT INFORMATION CENTER)
- [ ] Establish JOINT INFORMATION CENTER
- [ ] Establish Media Staging Area
- [ ] Clear all messaging and releases with COMMAND
- [ ] Announce Reunification site when authorized

REUNIFICATION BRANCH
- [ ] Get briefing (verbal)
- [ ] Select Reunification Location
- [ ] Location approved by INTELLIGENCE SECTION
- [ ] Notify DISPATCH of Location **Not for public release**
- [ ] Assign REUNIFICATION STAGING MANAGER
- [ ] Request additional resources
- [ ] Assign SERVICES GROUP
- [ ] Assign ACCOUNTABILITY GROUP
- [ ] Assign ASSEMBLY GROUP
- [ ] Notify INTELLIGENCE SECTION when ready to announce Location to public

REUNIFICATION SERVICES GROUP
- [ ] Assign Set-up Unit
- [ ] Assign Law Enforcement Unit
- [ ] Assign Transportation Unit
- [ ] Assign Medical Unit
- [ ] Establish Family Assistance Center

REUNIFICATION ACCOUNTABILITY GROUP
- [ ] Assign Accountant Unit
- [ ] Assign Checker Unit
- [ ] Assign Greeter Unit
- [ ] Assign Reunifier Unit
- [ ] Assign Exit Control Unit

REUNIFICATION ASSEMBLY GROUP
- [ ] Assign Class Leader Unit
- [ ] Assign Nutritional Support Unit
- [ ] Consider Entertainment Unit

Improvised Explosive Device (IED)

DISCOVERY or DETONATION
- [ ] Announce "Bomb Cover" or "Bomb Go"
- [ ] Secondary threat scan (device, 5ft, 25ft)
- [ ] Maintain 540° scan
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- [ ] Bombers are Bombs

CONTACT and RESCUE
- [ ] Consider threat to life and alternate route
- [ ] Mark (Chem Lights) and bypass
- [ ] Provide security element if possible

EXPOSED SURVIVOR RESCUE
- [ ] Direct survivor movement explicitly
- [ ] View area for secondary threats
- [ ] Establish narrow cordon in/out of area
- [ ] Provide Direct Threat Care only
- [ ] Evacuate to standoff / Isolate / Barricade

FROM RADIO SAFE DISTANCE (300ft or standoff)
- [ ] Report IED location, description, size
- [ ] Report action taken
- [ ] Request Bomb Squad

NO SURVIVORS THREATENED
- [ ] View area for secondary threats
- [ ] Reposition personnel to safe standoff
- [ ] Report impact to assignment and priority
- [ ] Cordon off 360° device kill zone
- [ ] Control cordon security awaiting Bomb Squad

Standoff Distance‡

IED	Size	Minimum with Cover	Preferred
Pipe Bomb	5 lb	**70 ft**	**1200 ft**
Suicide Bomber	20	**110**	**1700**
Briefcase/Suitcase	50	**150**	**1850**
SUV / Van	1000	**400**	**2400**

‡See Help Guide and DHS reference for IMPORTANT information.

ACTIVE SHOOTER INCIDENT MANAGEMENT CHECKLIST

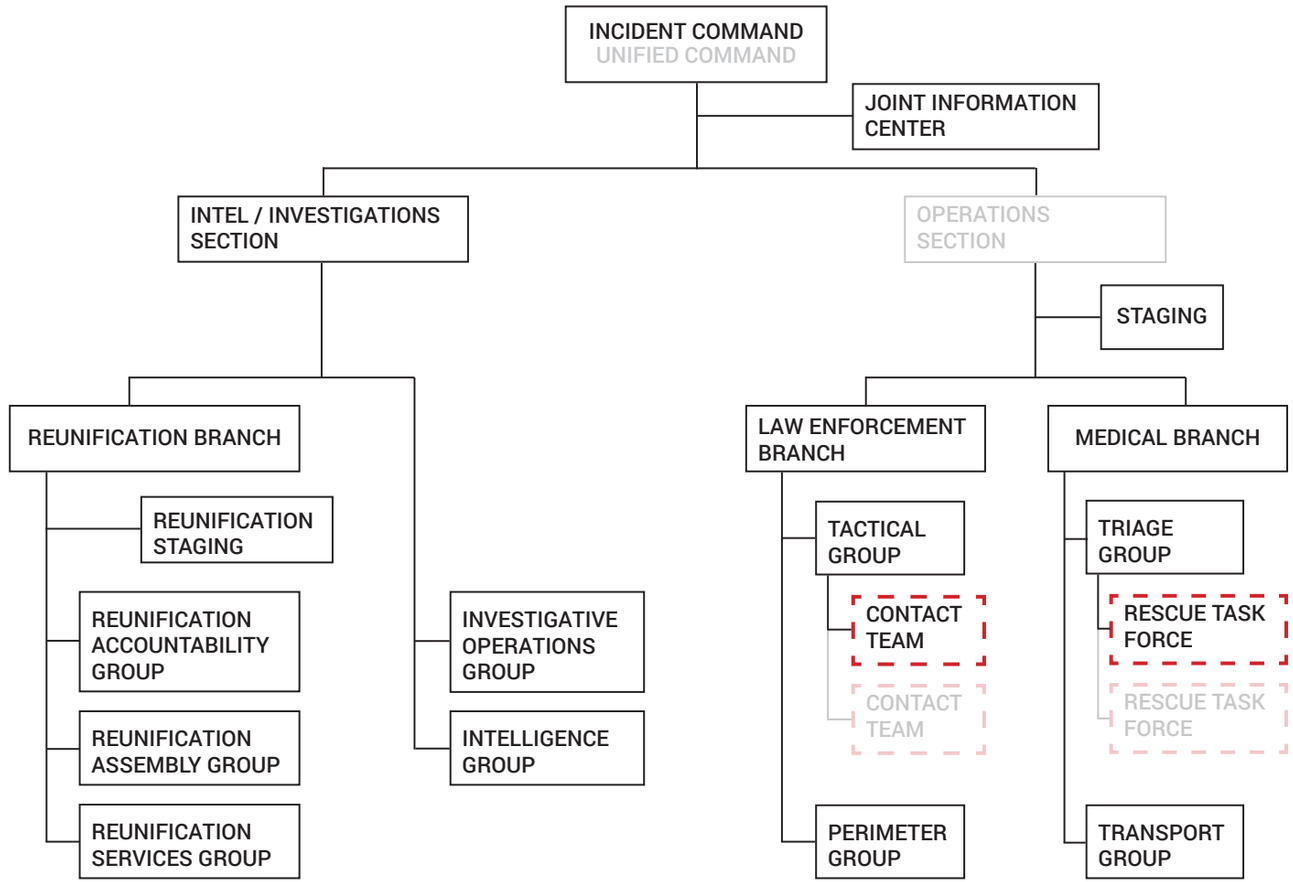

Fig 1. Active Shooter Incident Command Organizational Chart

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START ON OTHER SIDE