THURSTON COUNTY MEDIC ONE
OPERATIONS COMMITTEE ~ REGULAR MEETING
HYBRID MEETING

AGENDA

November 3, 2022, 2:00 PM

I. CALL TO ORDER/ROLL CALL

II. APPROVAL OF AGENDA

III. PUBLIC PARTICIPATION

IV. REVIEW AND APPROVAL OF MINUTES
- A. Operations Committee – October 6, 2022
- B. EMS Council - October 19, 2022 (informational only)

V. COMMITTEE REPORTS
- A. West Region EMS Council
- B. Subcommittees
  1. Equipment Committee (EqC) – Chair or Representative
  2. Mass Casualty Incident (MCI) Committee – Chair or Representative
  3. Training Advisory Committee (TAC) – Chair or Representative
  4. Transportation Resource Utilization Committee (TRU) – Chair or Representative
  5. ePCR Committee – Chair or Representative
- C. Staff Report - https://www.thurstoncountywa.gov/m1/Pages/meetings.aspx

VI. OLD BUSINESS

	ITEM	PRESENTER	EXPECTED OUTCOME
A.	EMSC Report	VanCamp	Information

VII. NEW BUSINESS

	ITEM	PRESENTER	EXPECTED OUTCOME
A.	MCI Plan Revisions	Crimmins	Approval
B.	EMS/FIRE components of the C3 Pathways Hostile Event Plan	Crimmins	Approval
C.	2023 Ambulance License Applications	VanCamp	Discussion/Possible Action
D.	ALS Unit Utilization Workgroup Briefing	VanCamp	Information

VIII. GOOD OF THE ORDER

IX. ADJOURNMENT

This meeting is hybrid. If you would like to attend in person, the meeting will be at 2703 Pacific Ave SE, Olympia. If you would like to attend this meeting virtually, please follow the instructions below:

November 3, 2022, 2:00 (PDT)

Join Zoom Meeting
https://us02web.zoom.us/j/86297865054?pwd=RDZGUVJYclRZbFpEamd2OEFHeUFtUT09

Meeting ID: 862 9786 5054
Passcode: 634954

You can also dial in using your phone.

Dial by your location
+1 312 626 6799 US
+1 646 558 8656 US
Meeting ID: 862 9786 5054
Passcode: 634954

Persons with hearing or speaking impairments can call Washington Relay Service at 711 or 1-800-833-6388

THURSTON COUNTY MEDIC ONE
OPERATIONS COMMITTEE ~ MEETING MINUTES
HYBRID
October 6, 2022

PRESENT: Steve Brooks, Tony Kuzma, Mark Gregory, Larry Fontanilla, Corey Rux, Brian VanCamp, Jeff DeHan, Wendy Rife, Ciaran Keogh, Todd Carson, Brian Hurley

ABSENT: Garth Wade, Mindy Churchwell

EXCUSED: Wendy Hill

GUESTS: Mike Buchanan, Chris Clem, Shawn Crimmins, Jennifer Schmidt, Michael Hughes, James Osberg, Lisa Skinner

STAFF: Sandra Bush, Ben Miller-Todd, Scott Brownell, Jerett Latimer

I. CALL TO ORDER/ROLL CALL – Chair VanCamp called the meeting to order at 2:00.

II. APPROVAL OF AGENDA –MSC – (Brooks/Hurley) move to approve the agenda as presented, and this carried.

III. PUBLIC PARTICIPATION – None

IV. REVIEW AND APPROVAL OF MINUTES

1. Operations Committee – September 1, 2022 – (Hurley/Brooks) move to approve and this carried.
2. EMS Council – September 21, 2022 (Informational only)

V. COMMITTEE REPORTS

A. **West Region EMS Council** – Clem reported for the September 7th meeting: 1) The financial year has been closed out and they came out ahead by $2,897.95 which will roll over to this years budget and will be used for training expenses and anything else that may be needed. 2) There was discussion on hospital divert. 3) A request came in from Lewis County Fire District #1 asking to upgrade their license to ALS verified because the Medic One system in Lewis County is in jeopardy. WREMS recommended approval of their upgrade request.

B. **Subcommittees**

1. Equipment Committee (EqC) – Nothing new to report.
2. Mass Casualty Incident (MCI) Committee – Crimmins reported: The committee met on September 29th and approved the C3pathways/Hostile event plan which will come to the Ops committee in November for their approval.
3. Training Advisory Committee (TAC) – Clem reported: 1) At the last meeting there was continued discussion of procedures for folks looking to get certified in the county, everything from BLS initial to BLS reciprocity. These have developed over the years so we are looking at updating each procedure and where they could be combined or better organized. 2) Reminder about the BLS MPD in-services.
4. Transportation Resource Utilization Committee (TRU) / Hospital Diversion – Brooks reported: The primary discussion at the last meeting was about the pilot ambulance dispatch project. Miller-Todd briefed the committee on the potential effects that some of the COVID19 rules variances that were allowed for the hospitals are set to expire with the repeal of the Governor's COVID19 mandate on the 31st of this month. Hospitals are working on how to deal with these impacts, but it is likely to present a delay in admitting patients in the emergency department and subsequent transport impacts. Miller-Todd also informed the committee that Falck Ambulance will be leaving Western Washington at the end of this year.
5. ePCR Committee – No meeting to report on.

C. **Staff Report** – Staff report is located on the website at – https://www.thurstoncountywa.gov/m1/Pages/meetings.aspx Miller-Todd added: 1) Paramedic hiring process is October 12 – 13th. 2) EMT training is going smoothly. Chief Rux is heading this up. 3) BLS Program Manager interviews are scheduled for October 18th.

VI. OLD BUSINESS

A. EMSC Report – VanCamp reported on the September 21st meeting: 1) Discussions of the 2023-2025 ALS contracts, which the BoCC has approved. VanCamp shared a few highlights of the new contracts. 2) The council voted to approve a recommendation to the BoCC of an equipment surplus resolution, for equipment that Medic One no longer has a use for. 3) Medic One staffing issues were discussed – see New Business, Item B. VanCamp jumped to this agenda item and informed the committee that he and Stan Moon met with Kurt and Ben regarding their concerns with

the shortage of staff at Medic One. They also met with Commissioner Edwards and the County Manager Chavez. 4) The MPD contract has been modified to include an MPD Delegate.

B. 30-Day status on the pilot ambulance dispatch project – Chief Schmidt reported: She just received reports back from Olympic Ambulance and AMR but she hasn't had a chance to put the numbers to data. However, the first 30 days there was a decline in both numbers being looked at, which is the 'no-loads' and 'drop-calls'. There is disparity in what different agencies have seen, depending on how often they use private ambulances, locations, etc., but generally, the Operations Chiefs have had positive reviews on how things are going so far. There is also the need to look at staffing models that have probably improved with both agencies and what role that plays as far as what the data comes back with. Operations Chiefs have committed to looking at the data at the end of October, which will be the full 90 days, and then make a recommendation to the Chiefs.

VII. NEW BUSINESS

A. Min/Max Review – Miller-Todd reminded the committee that min-max is directed not at a licensure, but as a verified licensure. (Brooks/Fontanilla) move to approve changing BLS AIDV state approved minimum from 5 to 0, and this carried. Brooks also expressed concern about the licensure status of Southeast Thurston as AIDV rather than AMBV (an adjustment made through a legal action by the Washington Attorney General's Office) and that it should be consistent with the other AMBV licenses in the county; Miller-Todd was to look further into this matter.

B. Meeting with Commissioner Edwards & County Manager Chavez – See Old Business, Item A. EMSC Report.

C. MPD Contract – An amendment has been agreed upon with OES for an expansion of hours by adding an MPD Delegate, and this was approved by the BoCC. Dr. Lisa Skinner has accepted this position and was introduced to the committee.

D. MPD Directive – Patient Care Records Update – Miller-Todd reported that we are better defining dispositions that are available to all the providers in the field. The reason for this is to provide patient care records for all calls, which the current pcr/no pcr does not allow for. The disposition packet will be vetted before we move forward with changing the charting recommendations and the directive from the MPD. Training will be provided before the end of the year, and the goal is to start with a new expectation beginning the first of 2023. Once feedback is received from the Chiefs, information will be sent out to the providers.

E. ESO CAD Unit Identifiers Reminder – Brownell reported: We currently have an interface with CAD and ESO that allows us to pass information on for auto population of the chart. Part of this requires that ESO knows about every unit in CAD. One breakdown we have had is when a call sign is changed or a unit is added, we are not notified about it. When providers notify TCOMM about a change, please notify Medic One as well.

F. Health Data Exchange (HDE) Upcoming Training – Miller-Todd reported: Confirmation was received today that we will be able to accept within the next two weeks outcome information from MultiCare facilities within the County (i.e., CMC). CMC has gone to the HDE platform which allows bi-directional information from the field, into the hospital, and back out, and will allow us to see patient outcomes.

VIII. GOOD OF THE ORDER –

Chief Rux said FD13 received their ambulance service verification for transport, from the State of Washington. They should be live in 8 – 12 weeks.

IX. ADJOURNMENT –

Meeting adjourned at 2:58 pm.

Thurston County Medic One
Emergency Medical Services Council – Regular Meeting
Hybrid
October 19, 2022

PRESENT: Cindy Hambly, Stan Moon, John Ricks, Brian VanCamp, Angela Jefferson, Harry Miller, Frank Kirkbride, Larry Fontanilla, Sheila Fay, Lenny Greenstein

ABSENT: Dontae Payne, Wayne Fournier

EXCUSED: Margaret McPhee, Gary Edwards

GUESTS: Dan Bivens, Shawn Crimmins, Chris Clem, Michael Hughes, Jennifer Schmidt, Steve Brooks

STAFF: Ben Miller-Todd, Sandra Bush

CALL TO ORDER/ROLL CALL – Stan Moon called the meeting of the Emergency Medical Services Council (EMSC) to order at 3:30 PM.

I. APPROVAL OF AGENDA – **MSC –** Added Old Business Item A. Ambulance Updates, Item B. MPD Contract Update, and New Business Item C. Kirkbride WREMS Application. (Kirkbride/Ricks) move to approve the agenda as amended, and this carried.

II. PUBLIC PARTICIPATION – None.

III. REVIEW AND APPROVAL OF MINUTES

A. EMS COUNCIL – September 21, 2022 – (Greenstein/Hambly) approve of the minutes, and this carried.
B. OPERATIONS COMMITTEE – October 6, 2022 (informational only)

IV. COMMITTEE REPORTS

A. **OPERATIONS COMMITTEE:** VanCamp reported: 1) A report was provided by the Transport Resource Utilization (TRU) committee, who are working with the Fire Chiefs Association committee on a pilot for private carrier transports where they will only be dispatched if needed. The first month of this report was provided by Chief Schmidt with LFD3, and we will continue to get updated reports as data rolls in. This is a 90-day pilot program. 2) Ops performed a review of the min/max, which is required by DOH. The Ops committee suggested changing AIDV for BLS state approved minimum from 5 to 0. There was a question regarding S.E. Thurston's license classification, and Ben Miller-Todd is looking into this. 3) The MPD talked about patient care records and dispositions. Training will be provided for providers on how to appropriately code dispatch information on patient records. The MPD is asking for a patient care record on all dispatch calls, even if a patient isn't seen by a provider. 4) Expiration of the Governor's COVID mandates may change staffing at the hospitals.

B. **WEST REGION**: No meeting – next meeting is December 7th. Hambly asked Kirkbride about his comment at the last EMSC meeting regarding parliamentary procedures at WREMS meetings, and Kirkbride said he sent a letter to the WREMS Director regarding his concerns.

C. **STAFF REPORT**: Staff report is available on the website. Thurston County | Medic One | Committee Meeting Information (thurstoncountywa.gov). Miller-Todd highlighted on the following: 1) The paramedic hiring process shows a 66% pass rate. 2) BLS Program Manager interviews were yesterday, and staff hopes to make a job offer soon. 3) CPR classes are down year-to-date, compared to pre-COVID. As of September 6th we are at 1900 individuals trained in CPR, and normally at this time of year we are around 4,000 – 5,000.

V. OLD BUSINESS

A. Ambulance Updates – Chief Schmidt with LFD3 provided an update on the 90-day ambulance dispatch pilot program. The intent of this project is to increase the availability of private BLS resources. The dispatch practices for Fire Department-based BLS transport resources will not be affected by this project. Performance metrics to be monitored will be private ambulance "no load" and "dropped call" data. "no load" is when a private ambulance goes enroute after being toned for response but is cancelled and they

do not transport; "dropped call" is when a private ambulance is required for response and transport, but the agency does not have a unit available for service. Noted trends from involved groups: **TCOMM** – Overall good feedback from dispatchers. Decreased workload/communication in "searching" for private carriers compared to process before pilot. **Olympic Ambulance** – Overall lost and no-load calls have decreased; however, agency staffing has improved steadily over the past several months. Lost call data is highly variable depending on other private agencies and hospital staffing/capacity. Private ambulance crews have not been receiving call information when requested (TCOMM is working on with dispatch processes). **AMR** – Significant improvement in lost and no-load calls. Data from Thurston County rigs is now closer to AMR rigs in Pierce. Overall, very pleased with process and changes.

B. MPD Contract Update – Miller-Todd advised the council that the contract amendment was approved by the BoCC, which doubles the hours for the MPD, so we went from 42 hours per month to 84 hours per month which added an MPD delegate to the system. Dr. Skinner, MPD delegate, started on October 6th. Dr. Fontanilla thanked the council, as well as the Commissioners, for support. Having the MDP delegate will allow for new technologies and protocols and will help reinforce quality measures.

VI. NEW BUSINESS

A. Surplus Medic Units Distribution – A surplus vehicle disposal assignment matrix was included in the meeting packet and displayed on the screen. We received 5 applications for 5 of the old units we plan to surplus, and staff is asking the council for approval of this distribution. (Ricks/Greenstein) move to approve surplus of the units to the agencies listed, and this carried.

B. Hardin WREMS Application – (Hambly/Jefferson) move to approve Kurt Hardin's application to WREMS, and this carried.

C. Kirkbride WREMS Application – (Greenstein/Jefferson) move to approve Frank Kirkbride's application to WREMS, and this carried.

VII. PUBLIC PARTICIPATION – None

VIII. GOOD OF THE ORDER – Miller-Todd will be on vacation from October 28th thru November 21st. In his absence, Kurt Hardin will be stepping in for meetings, and Pete Suver and Anna Lee Drewry will be stepping in as well.

IX. ADJOURNMENT – Meeting adjourned at 4:08.

Thurston County Multiple Casualty Incident Plan

Thurston County

Medic One

45

Years of

Public Service

Excellence

Revision Adopted ~~September 3, 2020~~New Date
Thurston County Medic One Operations Committee

Thurston County Multiple Casualty Incident (MCI) Plan 2020

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 2022~~0~~ revision of this MCI Plan were directed by the Thurston County Operations Committee, to be completed this 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. A revision was completed on October 5, 2017 and again on October 31, 2018. This completed edition with revisions is being published and distributed in ~~September of 2020.~~New Date A number of 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.

This list needs adjustments?

~~Anne Benoist~~Greg Perry, Director
West Region EMS & Trauma Care Council

~~Cathy Blakeway, Administrative Assistant~~
~~City of Tumwater Fire Department~~

~~Bruce Brenna~~Jay Mason, Commander~~Lieutenant~~
City of Tumwater Police Department

Steve Brooks, Fire Chief
Lacey Fire District Number 3

~~Jim Brown~~Michael Hughes, Captain – MSO
City of Olympia Fire Department

~~Alex Christensen~~Karen Weiss, Assistant Chief ~~Lieutenant/Paramedic~~
Lacey Fire District Number 3

Kenneth Clark, Lieutenant
Thurston County Sheriff's Office

Chris Clem, Director of Operations
Olympic Ambulance

Paul Counts, Lieutenant
Thurston County Sheriff's Office

Shawn Crimmins, ~~Captain – MSO~~Assistant Chief
City of Tumwater Fire Department

Anna Lee Drewry, BLS Program Manager
Thurston County Emergency Services

Dr. Larry Fontanilla, Medical Program Director
Thurston County EMS

Mark Gregory, Fire Chief
Thurston County Fire District Number 17

Jody Halsey, RN
Providence St. Peters Hospital

Kurt Hardin, Director
Thurston County Emergency Services

Tony Kuzma, Operations Manager
American Medical Response

Dr. Amy Larson, Emergency Department Medical Director
Capital Medical Center

Brian Hurley~~Scott LaVielle~~, Fire Chief/Emergency Services Director
City of Tumwater Fire Department

Formatted: Highlight

Formatted: Highlight

Formatted: Highlight

Formatted: Highlight

Formatted: Highlight

Formatted: Highlight

Cherie Leyva, Lieutenant/Paramedic
Lacey Fire District Number 3

~~Jim McGarva, Assistant Fire Chief~~
~~City of Tumwater Fire Department~~

Alan Provencher, Purchasing Manager
Thurston County Emergency Services

~~James Spicklemire~~Jonnica Elkins, Operations Supervisor
TCOMM

Ben Miller – Todd, ALS Program Manager
Thurston County Emergency Services

~~Greg Wright~~Todd Carson, Interim Fire Chief
City of Olympia Fire Department

Stewart Mason, Director of Emergency Services
Capital Medical Center

Corey Nygaard, Emergency Preparedness Manager
Providence Centralia Hospital

Wendy Rife, Trauma Program Manager
Providence St. Peters Hospital

~~Mark Stewart~~, Lieutenant/Paramedic
City of Olympia Fire Department

Jason Winner, Detective/Fire Arms Instructor
City of Olympia Police Department

Formatted: Highlight
Formatted: Highlight
Formatted: Highlight
Formatted: Highlight
Formatted: Highlight

Thurston County Multiple Casualty Incident Plan

Table of Contents Page

I. 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~~, START~~ 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 a Multiple Casualty Incident.

II. 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.

III. 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): ~~An overall area found at the scene of an MCI where patients are gathered then moved to triage/treatment areas in preparation for transport.~~ **Casualty Collection Point (CCP):** A specific Warm Zone location with security measures to assemble nearby casualties and provide Indirect Threat Care.

Formatted: Font: Bold

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)

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 Decon Trailer. Regionally Decon resources are available on site at Capital Medical Center, Providence St. Peters and Centralia Hospitals.

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 hospitals capabilities. For the purpose of the plan, Providence St. Peter Hospital will be the primary DMCC for Thurston County~~, with Good Samaritan Hospital as backup.~~

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**~~, and other triage systems such as START an acronym for **S**imple **T**riage and **R**apid **T**ransport~~ used to determine the patient's severity and transport priority.

- **S.A.L.T. / R.P.M. Triage:** An acronym for **S**ort, **A**ssess, **L**ifesaving Interventions **T**reatment and **T**ransport, and is defined as being a method that first responders evaluate a patient's status based on **R**espirations, **P**ulse , and **M**entation 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.

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.

Formatted: Font: Bold

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.

Formatted: Not Highlight

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 ~~Career~~ 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 ~~start~~ triage system. It utilizes four colors of survey tape to categorize patients during the sifting and sorting process.

Formatted: Not Highlight

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

~~**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.~~

Formatted: Numbered + Level: 1 + Numbering Style: I, II, III, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.75"

~~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.~~

IV. MCI CONCEPT OF OPERATIONS

Formatted: Left

A. 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

B. 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

1. 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

2. Tactical Benchmarks

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

C. 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

D. Recon

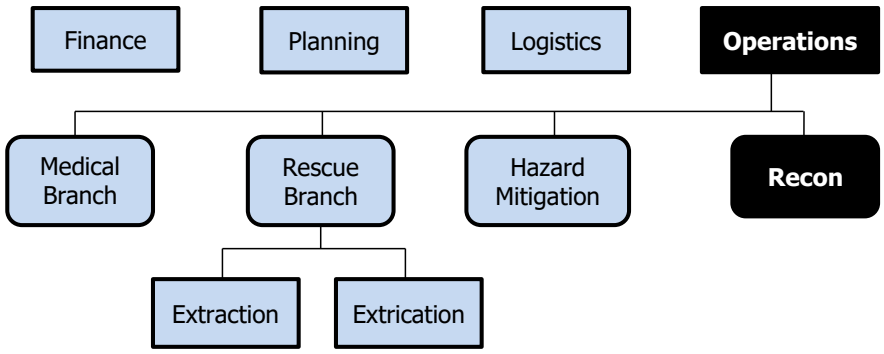
A rapid reconnaissance of the entire MCI site is essential to establish the scope and scale of the incident. Depending on the size and complexity of the incident, this may require a Recon Group consisting of multiple teams. The overriding factor should be speed as opposed to specificity to ensure that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



E. 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.

1. Operational Zones

Commented [JK1]: In definitions we say Zones?

Formatted: Highlight

Formatted: Highlight

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.

2. 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.

3. 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.

F. Staging

Three separate staging areas should be considered based on the size and complexity of the MCI. The first two staging areas 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.

G. 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.

H. 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~~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.

1. 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

I. 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.

J. Green Patient Area

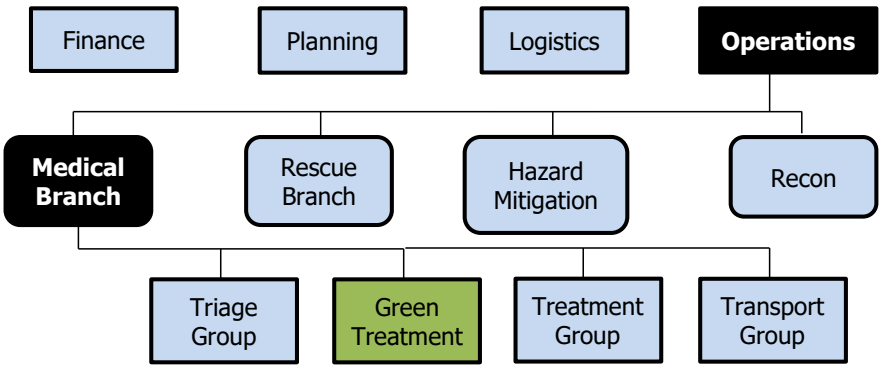
The Triage Team(s) at an MCI will direct those that can walk to a designated area of refuge, or Green Patient Area. These patients will be initially classified as green patients. As soon as possible, a Green Patient Area Manager should be designated.

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.



K. 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

V. PATIENT DISPOSITION

A. 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.

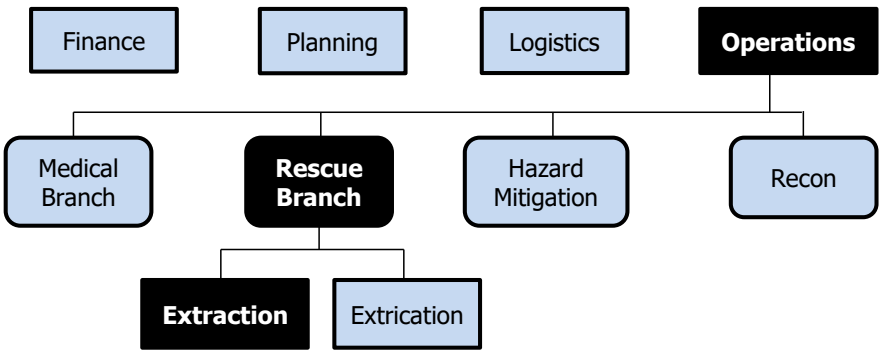
Large or complex incidents may require the hazard zone to be divided into geographical divisions. Supervisors should be alert to recon their assigned area.

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

1. Extraction

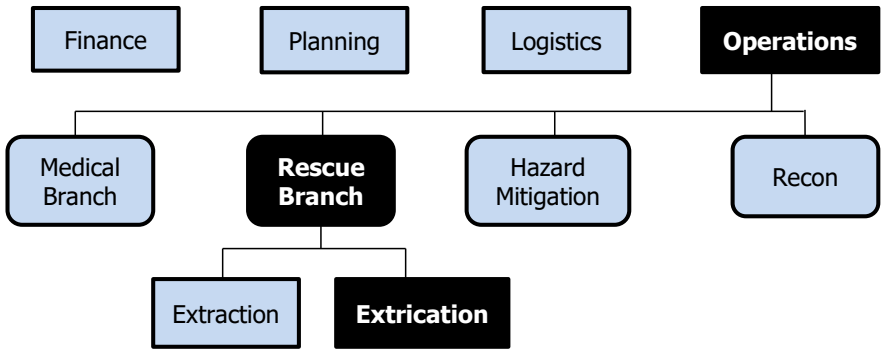
Extraction teams (litter carriers) will be composed of one or more pairs of personnel and will report to Medical or Rescue, depending on incident size, for the purpose of patient removal (harvesting) and delivery to the patient treatment area.



2. 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.



B. Decontamination

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: wear the appropriate level of PPE, consider a larger evacuation zone, and start emergency decontamination procedures.

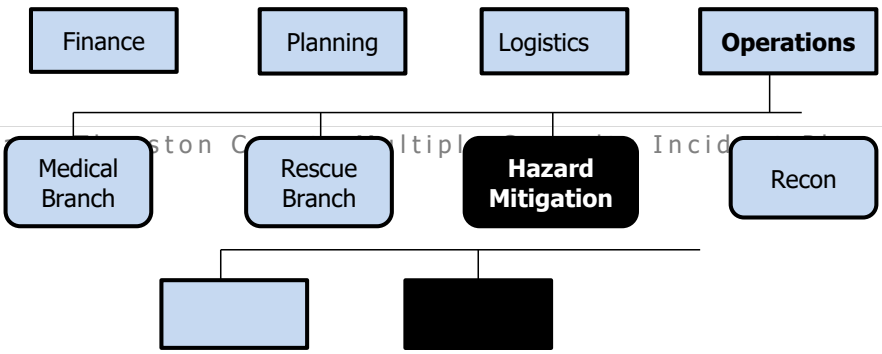
Treatment and/or transport of any patient cannot occur until the patient has gone through emergency decontamination.

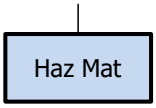
It may be difficult to determine in the field if a patient is completely decontaminated, therefore patient contact should be limited to essential procedures in the field and during transport.

Tyvek suits should be used for patients after gross decon 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 decon.





C. 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 Decon 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.

D. 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).~~-~~ ~~Good Samaritan Hospital shall serve as back up DMCC.?~~ ~~-~~Once contact has been made with Hospital Control the connection shall not be disconnected.

~~If neither primary nor back up DMCC is able to coordinate patient destination, Harborview Medical Center shall serve as the third option. ? 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.

E. 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.

F. Documentation

1. ~~Medical Incident Report Forms (MIRFS)/~~Electronic Patient Care Reporting (ePCR)

Patient documentation is important; however documentation should never delay patient care or transport. Individual ~~MIRFs/~~ePCRs should be attempted at every incident, however, as an incident grows in size and complexity ePCRs ~~MIRFs/ePCRs~~ may not be reasonable to complete. Incidents may have segments when ePCRs ~~MIRFs/ePCRs~~ may be completed and other segments that circumstances prevent usage of ePCRs ~~MIRFs/ePcRs~~. At a minimum, a photograph of all patient tracking, command and

Formatted: Highlight

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.~~

2. 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 ePCRs~~MIRF/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.

G. 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.

VI. JOB ASSIGNMENTS

A. Medical

One of the first arriving ALS members should assume the role of ~~Medical~~MEDICAL. The role of MEDICAL~~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.

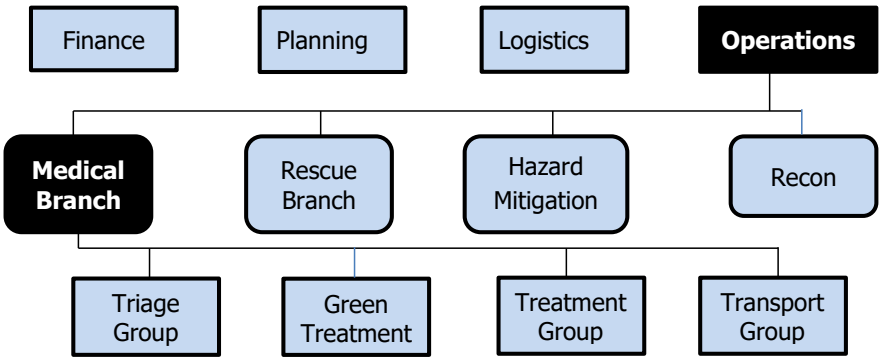
MEDICAL is responsible for the following tasks:

- 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~~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.



1. Treatment

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

- Receiving patients from Extraction
- Placing bar code sticker on patient tracking board

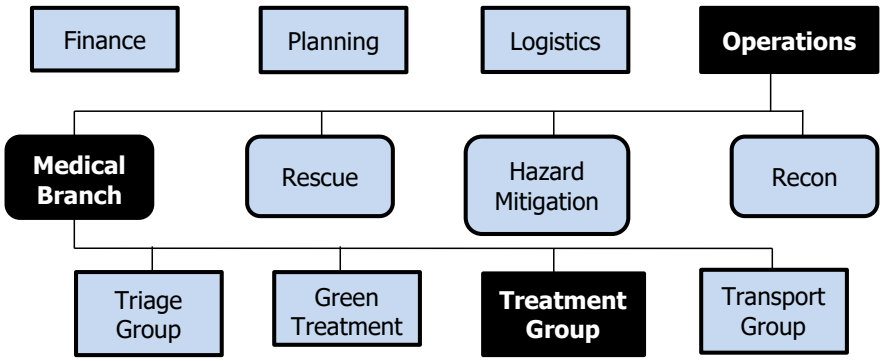
- Supervising treatment of patients
- Managing Treatment Personnel
- Coordinating with TRANSPORTATION~~ransportation~~
- Prioritizing patients for transport

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.



2. Transportation

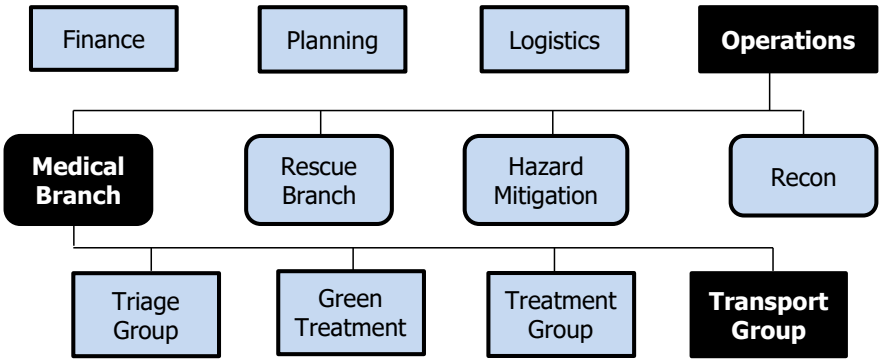
TRANSPORTATION should be designated early by MEDICAL. Smaller incidents may allow MEDICAL to retain this role. TRANSPORTATION should be a senior ALS member capable of performing a wide range of duties including:

- 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~~reatment~~
- 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~~ransportation~~ 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.



B. Rescue

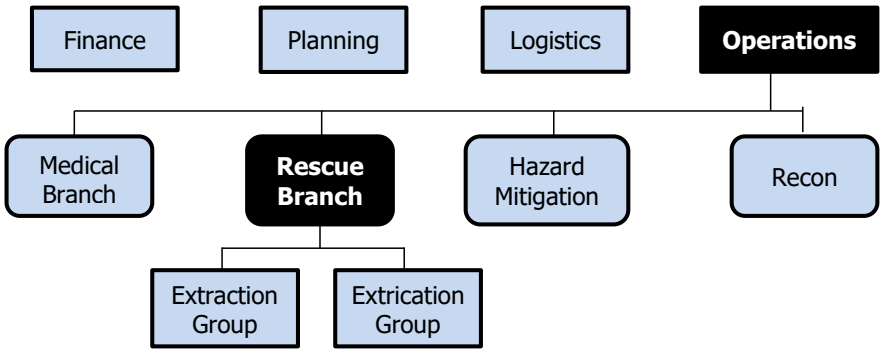
Rescue should be considered when:

- 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 & Decon 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. ~~Good Samaritan is the backup (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 through TCOMM. (Level I MCI: 1 Chaplain, Level II MCI: 2 Chaplains, Level III MCI: 3 Chaplains)

Appendix C: MCI SITE PLAN AND JOB AIDES

Formatted: Not Highlight

Formatted: Font: (Default) Tahoma, 14 pt

Formatted: Indent: Left: 0.5", No bullets or numbering

Formatted: Not Highlight

Formatted: Indent: Left: 0.25", No bullets or numbering

1

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

2

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

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. ~~Back up DMCC Good Samaritan Hosp. 253.697.4000~~
- ☐ 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 Casualty Collection Point 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

Formatted: Not Highlight

4

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 ~~S.T.A.R.T.~~ S.A.L.T. 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

Formatted: Not Highlight

Formatted: Not Highlight

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

Formatted: Not Highlight

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
- ☐ ~~Back-up DMCC Good Samaritan Hosp. 253.697.4000~~

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
- ☐ ~~Back-up DMCC Good Samaritan Hosp. 253.697.4000~~
- ☐ Communicate destination information to transport vehicles
- ☐ Collect and deliver transport unit/patient logs to supervisor

Formatted: Highlight

Formatted: Not Highlight

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
- ☐ ~~Back-up DMCC Good Samaritan Hosp. 253.697.4000~~?
- ☐ 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

Formatted: Not Highlight

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 Treatment Area ~~Casualty Collection Point~~
- Other ALS resources should respond directly to Staging Area
- Check in with Staging Area Manager immediately

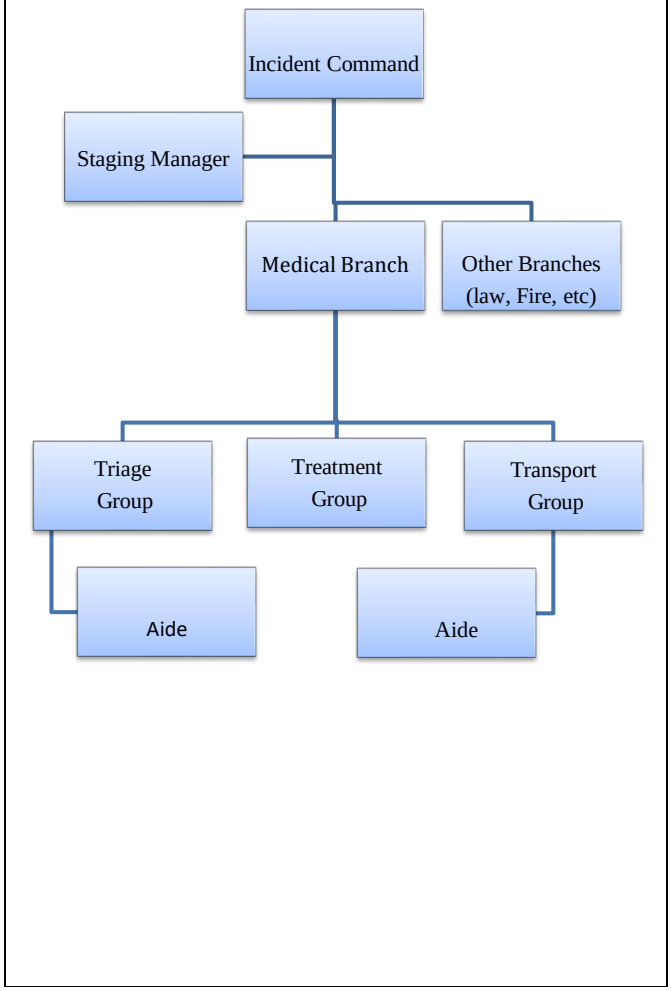
10

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

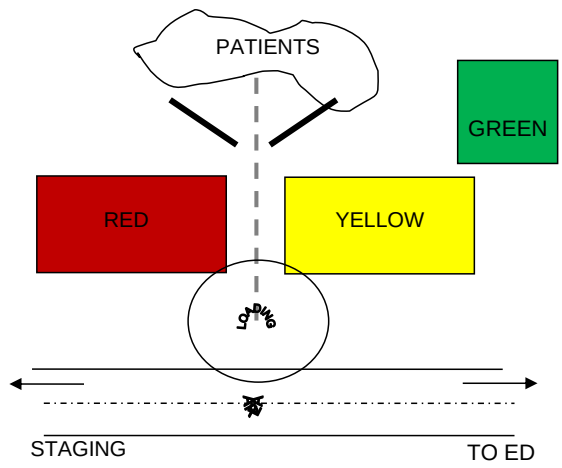
11

Command Structure



12

~~Casualty Collection~~ Treatement Area ~~Point~~ 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.

14

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

NOTES

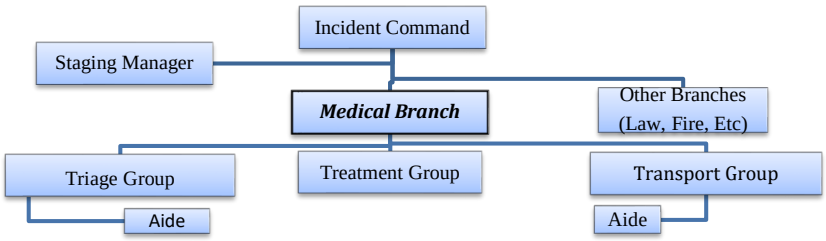
MEDICAL BRANCH DIRECTOR

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

MEDICAL BRANCH DIRECTOR TACTICS

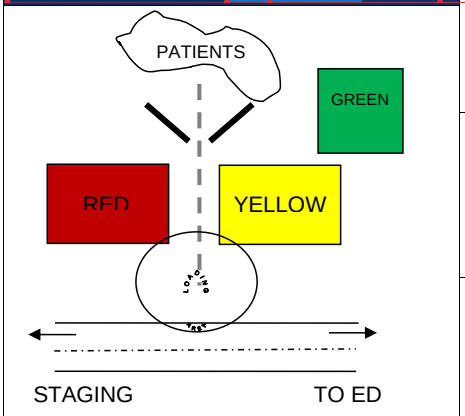
- ☐ Don GREEN ICS vest & obtain Job Aide Board
- ☐ Receive briefing
- ☐ ~~Contact DMCC (PSPH) 360.491.8888 or 360.438.6666~~
- ☐ ~~Back-up Good Samaritan Hosp. Puyallup 253.697.4000~~?
- ☐ Type of incident
- ☐ Estimated patient census

Formatted: Not Highlight

- ☐ Special situations (WMD, decontamination, etc.)
- ☐ Consider span-of-control
- ☐ Triage Group Supervisor *Name*:
- ☐ Treatment Group Supervisor *Name*:
- ☐ Transportation Group Supervisor *Name*:
- ☐ Direct ~~Casualty Collection Point~~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

Commented [JK2]: IS CCP correct here?

~~Casualty Collection Point~~ 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

Formatted: Character scale: 63%, Not Expanded by / Condensed by

Formatted: Character scale: 63%

Formatted: Character scale: 63%, Not Expanded by / Condensed by

Formatted: Character scale: 63%, Expanded by 2.75 pt

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

Formatted: Expanded by 2.8 pt

Formatted: Condensed by 2.05 pt

- ☐ Triage Group Supervisor
- ☐ Treatment Group Supervisor
- ☐ Transportation Group Supervisor

☐ Maintain awareness of subordinate progress toward objectives

- ☐ Triage
  - ☐ ~~START~~ 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)*	

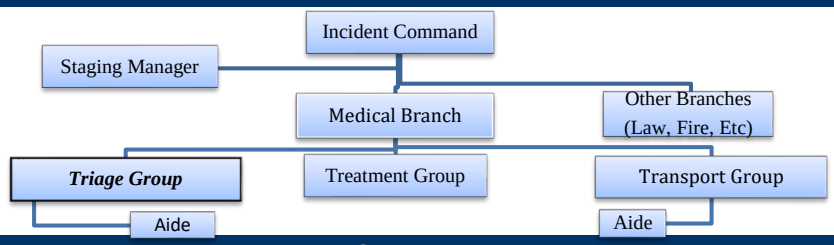
TRIAGE GROUP SUPERVISOR

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)~~1) Life Safety – Responders and Civilians
~~7)~~2) Incident Stabilization
~~8)~~3) Property Conservation

~~9)~~

Formatted: Font: (Default) Times New Roman

Formatted: List Paragraph, Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0" + Indent at: 0.25"

Formatted: Indent: Left: 0.25", No bullets or numbering

TRIAGE GROUP ASSIGNED RESOURCES

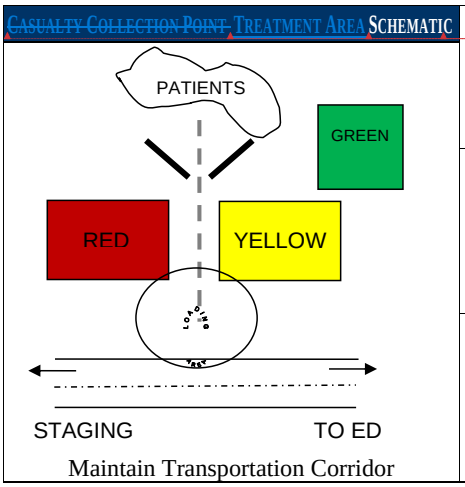
Resource Name	Resource Type	ETA	Assignment
	E A M		
	E A M		
	E A M		
	E A M		
	E A M		
	E A M		

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

Formatted: Not Highlight

- ☐ Ensure SALT~~START~~ 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



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

Formatted: Character scale: 63%, Not Expanded by / Condensed by

Formatted: Character scale: 63%

Formatted: Character scale: 63%, Not Expanded by / Condensed by

Formatted: Character scale: 63%, Expanded by 1.1 pt

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)
  - ☐ ~~START~~ 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)	

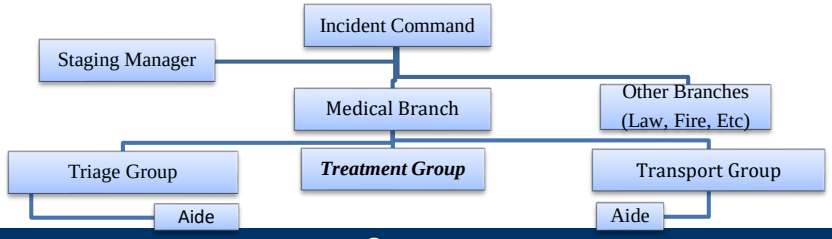
TREATMENT GROUP SUPERVISOR

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

~~10)~~1) Life Safety – Responders and Civilians
~~11)~~2) Incident Stabilization
~~12)~~3) Property Conservation

~~13)~~

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:*

Formatted: Font: (Default) Times New Roman

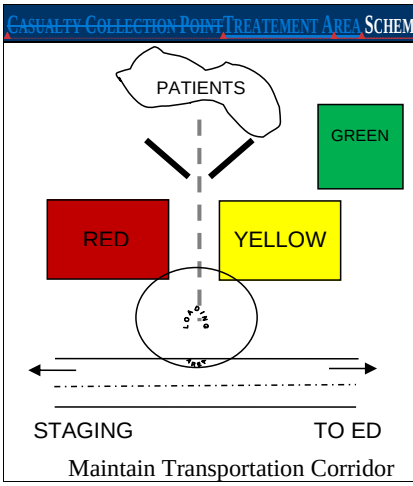
Formatted: List Paragraph, Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0" + Indent at: 0.25"

Formatted: No bullets or numbering

Formatted: Not Highlight

- ☐ 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



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

Formatted: Character scale: 62%, Not Expanded by / Condensed by

Formatted: Character scale: 62%

Formatted: Not Expanded by / Condensed by

Formatted: Character scale: 62%, Not Expanded by / Condensed by

Formatted: Character scale: 62%, Expanded by 3.65 pt

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)*	

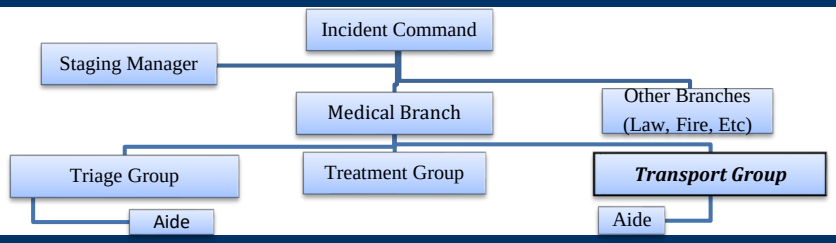
TRANSPORT GROUP SUPERVISOR

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)~~

Formatted: Indent: Left: 0.25", No bullets or numbering

TRANSPORT GROUP ASSIGNED RESOURCES

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

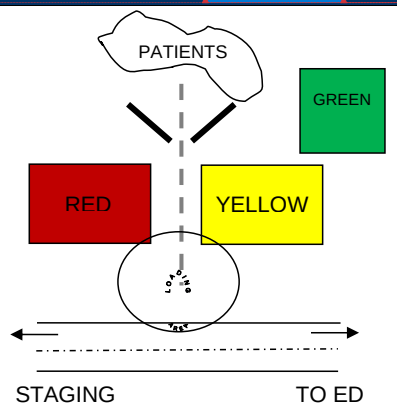
TRANSPORT GROUP SUPERVISOR TACTICS

- ☐ Don YELLOW ICS vest & obtain Job Aide Board
- ☐ Receive briefing

Formatted: Not Highlight

- ☐ 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. ~~Back up Good Samaritan 253 697 4000?~~
- ☐ 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

~~Casualty Collection Point~~ ~~Treatement 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

Formatted: Character scale: 62%, Not Expanded by / Condensed by

Formatted: Character scale: 62%

Formatted: Character scale: 62%, Not Expanded by / Condensed by

Formatted: Character scale: 62%, Expanded by 3.65 pt

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)*	

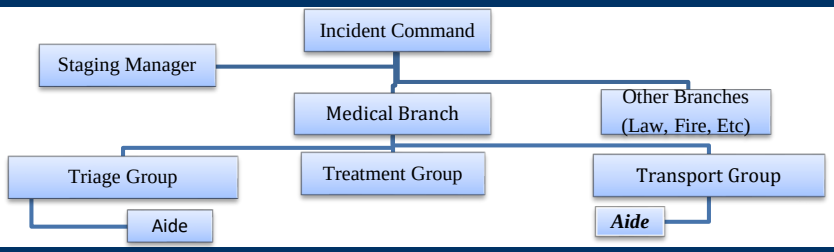
TRANSPORT GROUP SUPERVISOR AIDE

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)~~

Formatted: Indent: Left: 0.25", No bullets or numbering

TRANSPORT GROUP ASSIGNED RESOURCES

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

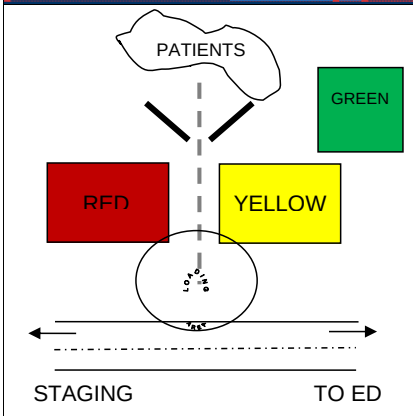
TRANSPORT GROUP SUPERVISOR AIDE TACTICS

- ☐ 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
- ☐ ~~Back up Good Samaritan Puyallup 253.697.4000~~
- ☐ 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:
  - ☐
  - ☐
  - ☐

Formatted: Not Highlight

Formatted: Highlight

~~CASUALTY COLLECTION POINT~~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

Formatted: Character scale: 64%, Not Expanded by / Condensed by

Formatted: Character scale: 64%

Formatted: Character scale: 64%, Not Expanded by / Condensed by

Formatted: Character scale: 64%, Expanded by 0.85 pt

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	

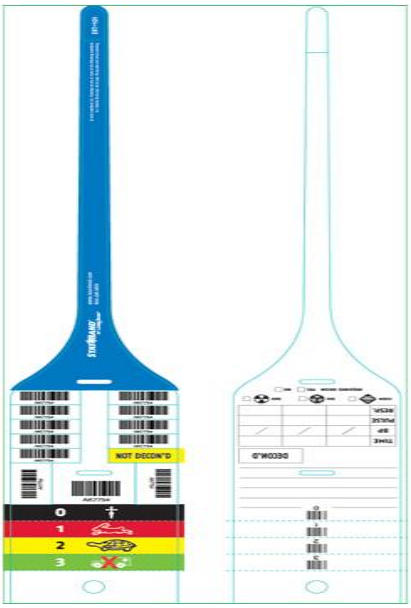
RETURN THIS DUPLICATE FORM TO TRANSPORT GROUP SUPERVISOR

Appendix E: Triage Tags

Unique Identifiers

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:

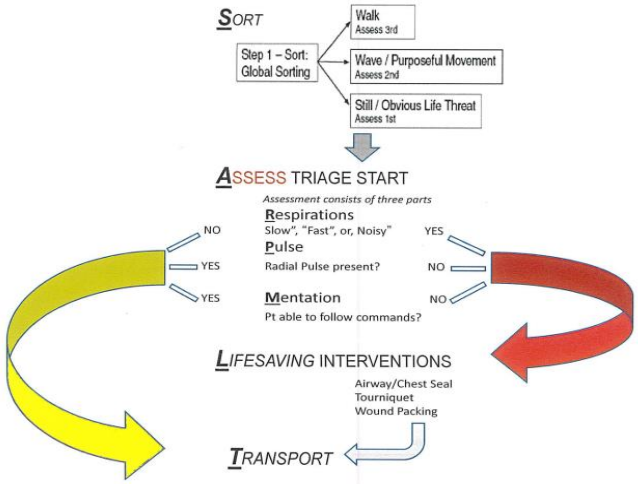
- 17.5" x 3" wristband tag/writable area on back for recording vital signs, haz-mat exp. & Pt. notes
- 11 glove/glass-ready and uniquely numbered/barcoded labels
- 3 Tear-off labels with specific triage status color and barcode

Appendix F: S.A.L.T. & R.P.M. Triage Algorithm Charts

S.A.L.T. Triage

SALT Triage

S Sort patients
A Assess- Use START
L Lifesaving interventions
Massive Hemorrhage
Airway
T Transport
Patients should leave warm zone with triage tape to denote their initial evaluation.



R.P.M. TRIAGE

Respirations
BREATHING ABSENT – OPEN AIRWAY
BREATHING – RED
NOT BREATHING – BLACK
BREATHING PRESENT
FAST, SLOW OR NOISY – RED
OTHERWISE CONTINUE….
Pulse
RADIAL PULSE ABSENT – RED
OTHERWISE CONTINUE….
Mentation
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:

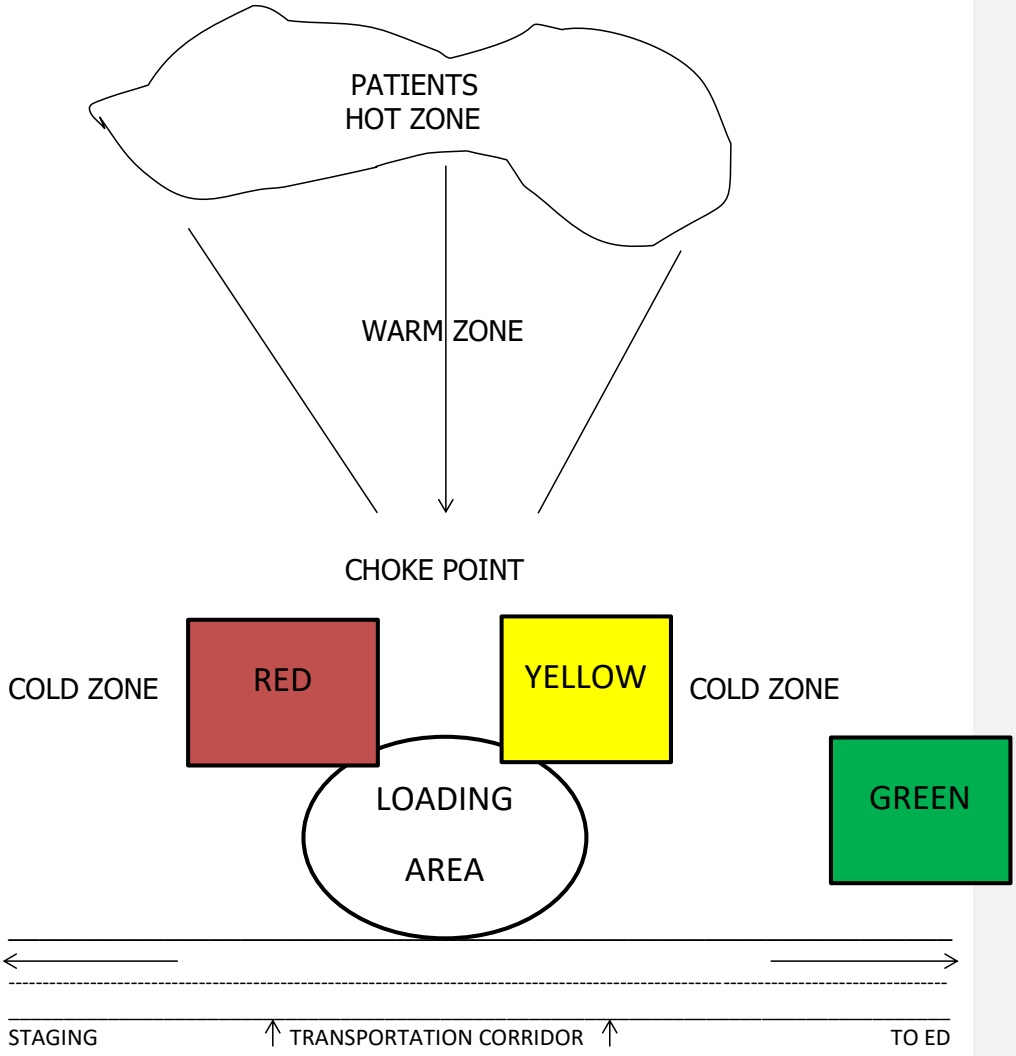
Appendix H: Treatment Group Supervisor Patient Tracking Board

TREATMENT GROUP SUPERVISOR
PATIENT TRACKING BOARD

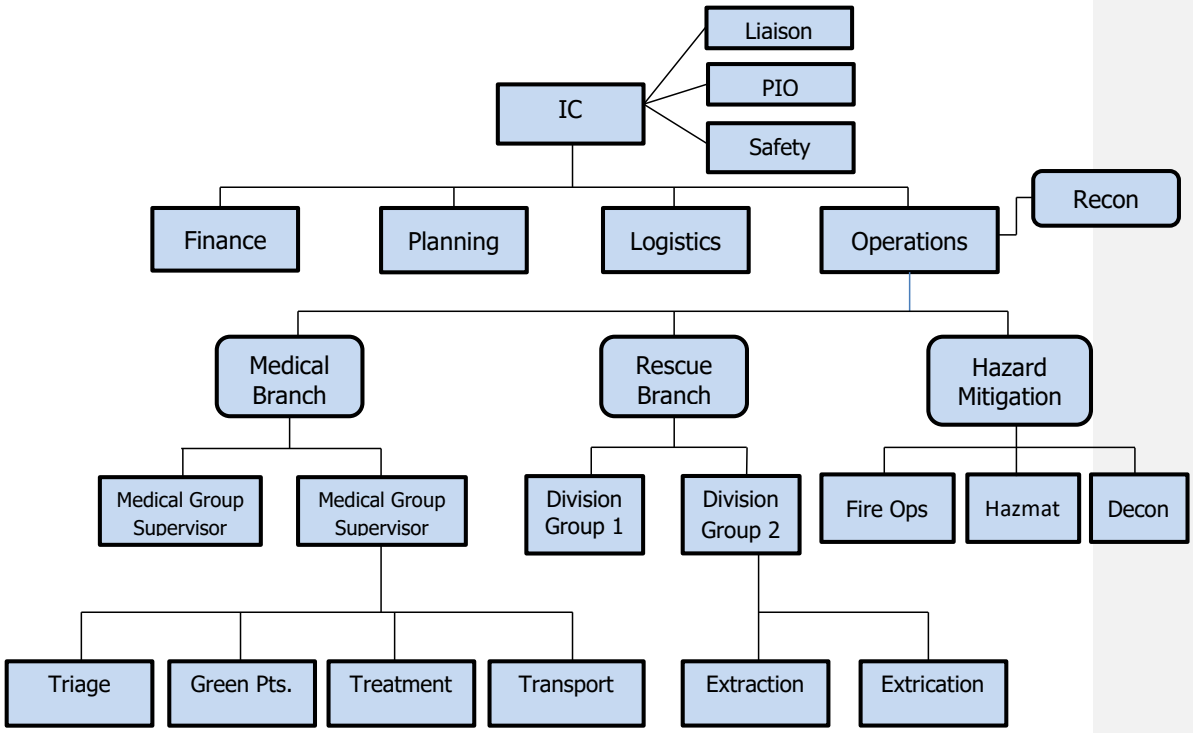
#	Circle M/F	IMMEDIATE	DELAYED	MINOR
1	M/F			
2	M/F			
3	M/F			
4	M/F			
5	M/F			
6	M/F			
7	M/F			
8	M/F			
9	M/F			
10	M/F			
11	M/F			
12	M/F			
13	M/F			
14	M/F			
15	M/F			

NOTES:

Appendix I: ~~Casualty Collection Point~~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.

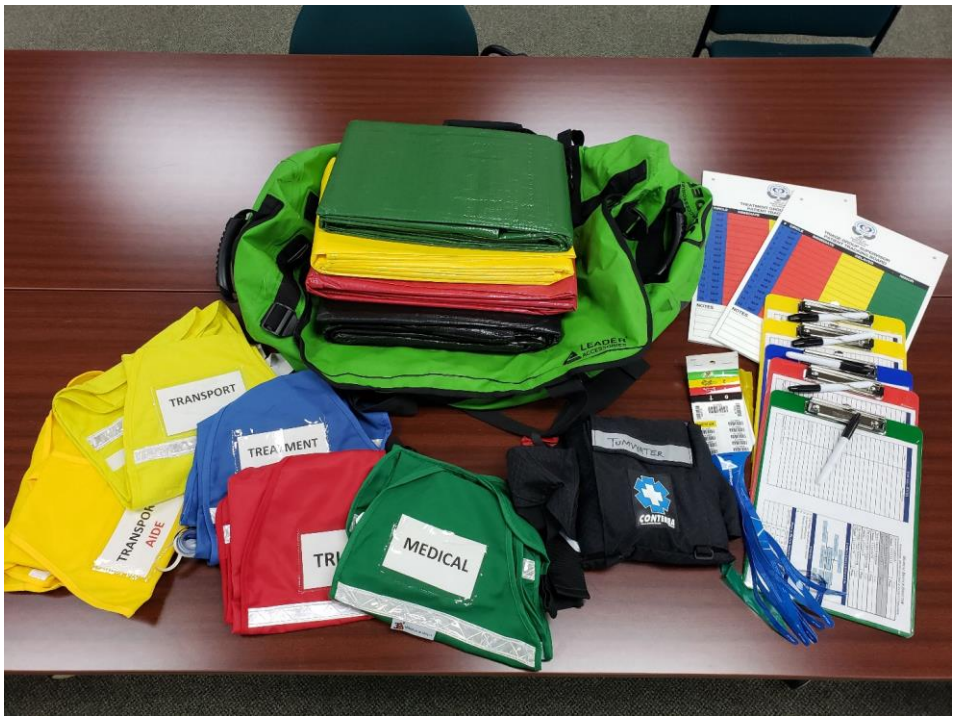
Appendix K: Ballistic Vest Example that may be used for Response to Large-Scale Violent Incidents within the "warm zone."

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

Formatted: Not Highlight



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
- Transport Unit Logs (double layer write in the rain) 50+ logs

Appendix M: E-Z Up Color Coded Canopy System

Appendix N: Thurston County Fire/EMS Response to Large-Scale Violent Incidents

THURSTON COUNTY FIRE/EMS RESPONSE TO LARGE- SCALE VIOLENT INCIDENTS

Commented [BM3]: Do we want to completely replace this section with C3 Pathways?

Purpose: To guide 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 prior to 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 may include but not limited to:

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.

5. Rescue Teams will self-initiate or be ordered by their supervisor to withdraw or abandon any area(s) where the level of threat is recognized to be above acceptable levels for any reason.

i. Multiple Casualty Response: All casualties outside or removed from "warm zones" will be managed in accordance with the Thurston County Multiple Casualty casualty Incident Response Plan.

ii. Rescue operations: To stabilize or alter entrapping hazards in order to remove victims or prevent future entrapments. These activities should be conducted under the direct supervision of a Rescue Group Supervisor with the requisite knowledge of hazard type(s) and in accordance with established departmental and/or SORT Team Guidelines.

iii. Fire Suppression: To stabilize existing or potential fire hazards. These efforts must be in coordination with other law enforcement priorities and rescue activities. Suppression activities should be conducted with a focus crime scene preservation whenever possible.

iv. Specialized Responses: Incidents known or believed to involve Chemical, Biological, Radiological, Nuclear and Explosive (CBRNE) elements require response, stabilization, and mitigation by qualified Technicians. Fire/EMS personnel activities should focus on the isolation and denial of entry to affected areas and operate only to their level of training and certification. Washington State Patrol is the established Authority Having Jurisdiction over CBRNE incidents and should be consulted on all tactical decisions.

1. GCross decontamination should be established for potentially exposed victims and responders whenever possible.

2. Isolation and intervention strategies should be based ~~on Department Of Transportation (DOT) Emergency Response Guidebook.~~ on best practices

3. Post Response/Recovery

a. The Unified Command will identify prioritized objectives and strategies for the demobilization of initial response units and the subsequent activities associated with investigation and recovery.

b. No information regarding the incident will be shared with the public or media without the expressed approval of the Unified Command. A Public Information Officer and a Joint Information System should be strongly considered for the coordinated and consistent sharing of information.

Formatted: Not Highlight

Commented [JK4]: Best practice vs DOT NAERG

Definitions

Commented [BM5]: Combine definitions sections into one in the beginning of MCI plan.

ACTIVE SHOOTER: One or more subjects who have used, is using or threatening to use a weapon to inflict deadly force on other, and/or continues to do so while having unrestricted access to additional victims. Prior actions demonstrate intent to continuously harm; objective appears to be mass injury or murder.

BARRICADED: A static situation involving an armed suspect, with or without hostages, who has demonstrated, or verbalized the intent to commit, violence. The suspect has fortified a position of advantage in a room or building.

CONCEALED / CONCEALMENT: Protected from observation, not from weapons fire.

CONTACT TEAM: One or more law enforcement officers whose intent is to take action to stop the suspect's deadly actions.

COVER: Protected from observation and weapons fire.

DIVERSIONARY THREAT: A threat that is intended to draw emergency response resources away from the primary target.

DYNAMIC SITUATION: An incident that is evolving with constantly changing tactical challenges.

MASS CASUALTY INCIDENT: An incident in which the emergency medical needs of the patients overwhelm the available resources to the extent that altered standards of care may become necessary.

RESCUE TEAM: A multidisciplinary team of Law Enforcement and Fire/EMS personnel who enter the Warm Zone for the purpose of triage and initial stabilization followed by extrication of viable patients. The configuration of the Rescue Team is intended to mitigate provider risk while forward deploying stabilizing medical care in conditions that might otherwise delay treatment.

SALT TRIAGE (Sort, Assess, Life Threatening Intervention, Treatment and Transport): A consensus triage system endorsed by multiple medical and scientific bodies. It allows for stabilizing interventions for life-threatening conditions as well as an additional step that allows providers to consider the entire context of the incident when performing triage. In this context, SALT is used in the warm zone.

Commented [JK6]: Do we want to define SALT? Sort Assess Life threating Intervention, Treatment and Transport

~~START TRIAGE: A method of triage that relies on the assessment of three physiologic Parameters: Respirations, Pulse, and Mentation.~~

SECONDARY DEVICE: Usually an Improvised Explosive Device (IED) that is designed to detonate after the arrival of first responders, in the hope of disrupting the response.

STAGING AREA: An incident area where resources are gathered prior to engagement.

STATIC SITUATION: The suspect(s) does not appear to be moving. Note that a static situation may become dynamic at any time the suspect escapes containment.

UNIFIED COMMAND: Incident Command entity comprised of Fire/EMS, Law Enforcement, and any other critical stakeholder based on involvement and incident type and/or complexity.

ZONES:

HOT ZONE: An incident area that has the following characteristics:

1) There is a known or suspected active threat in this area.

2) Law enforcement tactical actions are ongoing in this area.

WARM ZONE: An incident area that has the following characteristics:

1) The threat is neutralized, or contained in another area. There is no known, active threat in the defined area.

2) Law Enforcement has established, and maintains, control of the ingress and egress to the area.

3) The area has been searched by Law Enforcement.

4) There are potentially viable patients in the area.

5) There are possible undetected hazards (e.g. IEDs) in the area.

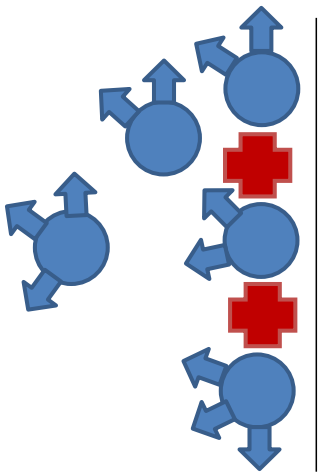
6) Unarmed responders working in this area have continuous, dedicated force protection from Law Enforcement.

COLD ZONE: An incident area that has the following characteristics:

1) There is no known active or suspected threat in this area.

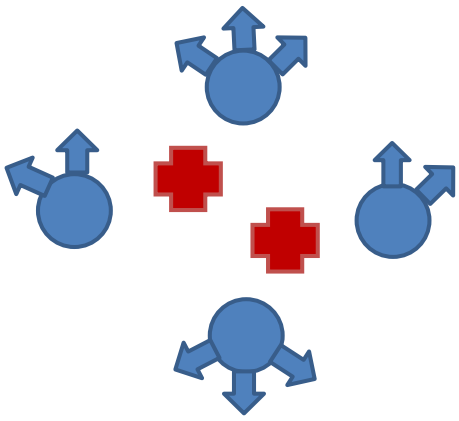
2) Responders working in this area do not require unusual protective measures

RESCUE TEAM



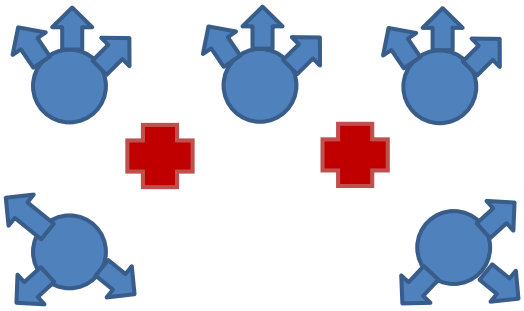
MOVEMENT IN HEAVY HEAD, NEXT TO WALL

RESCUE TEAM



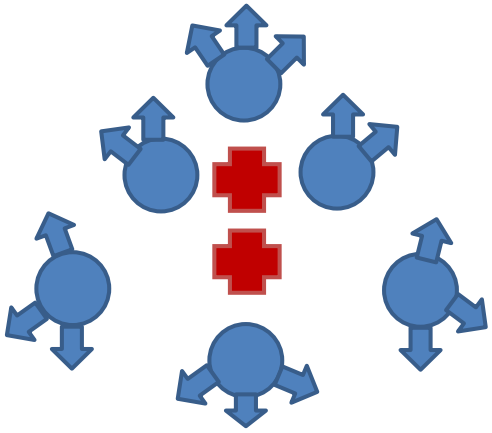
MOVEMENT IN DIAMOND FORMATION

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

DO NOT USE UNLESS AUTHORIZED. USER ASSUMES ALL RISK. FOR USAGE REQUIREMENTS AND WRITTEN PERMISSION, VISIT **https://c3.cm/asc**

www.C3Pathways.com

C3 PATHWAYS™


WHELEN

TABLE OF CONTENTS

Published by

C3 Pathways, Inc.
531 S Econ Cir Suite 1001
Oviedo, FL 32765
USA

info@c3pathways.com
Office: +1 (407) 490-1300
Fax: +1 (877) 347-4137

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

273 Aulin Ave. Suite 1015• Oviedo, FL 32765 • USA
(407) 490-1300 • info@c3pathways.com • www.c3pathways.com

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

273 Aulin Ave. Suite 1015• Oviedo, FL 32765 • USA
(407) 490-1300 • info@c3pathways.com • www.c3pathways.com

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!

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.

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.

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.

ACTIVE SHOOTER INCIDENT MANAGEMENT CHECKLIST

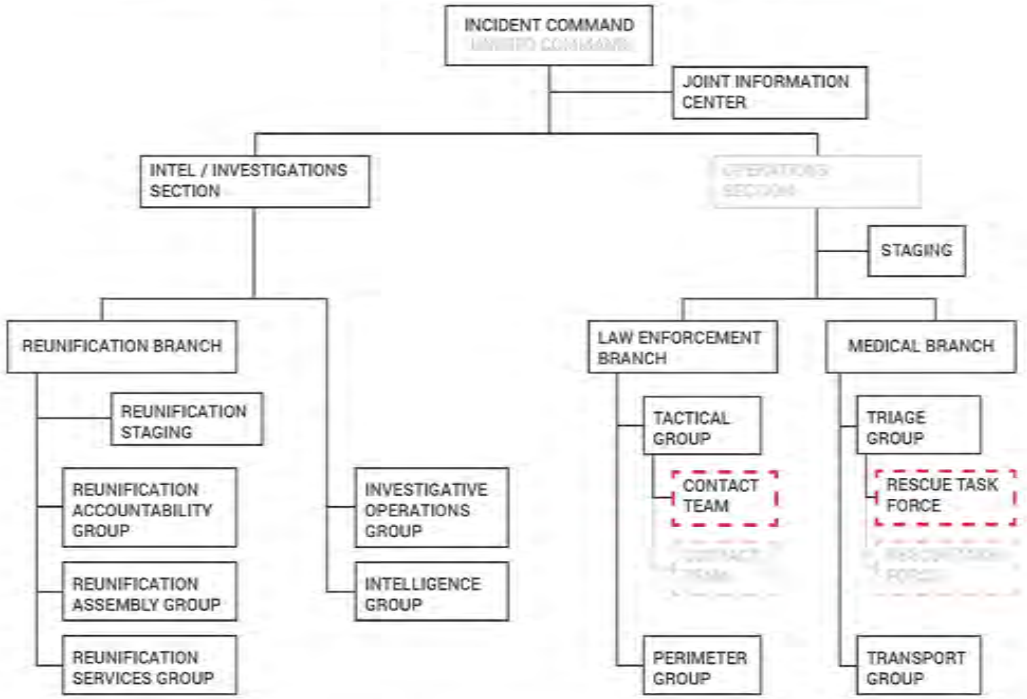


Fig 1. Active Shooter Incident Command Organizational Chart

WARNING! Rev 3.0 7/2019

DO NOT USE UNLESS AUTHORIZED. USER ASSUMES ALL RISK. FOR USAGE REQUIREMENTS AND WRITTEN PERMISSION, VISIT http://c3.cm/asc

C3 PATHWAYS
TRAINING. EXERCISES. CONSULTING.
Office : +1 (407) 490-1300
Toll Free : +1 (877) 340-4032
Email : info@c3pathways.com
531 S Econ Cir Suite 1001
Oviedo, FL 32765 • USA
C3Pathways.com

START ON OTHER SIDE

273 Aulin Ave. Suite 1015 • Oviedo, FL 32765 • USA
(407) 490-1300 • info@c3pathways.com • www.c3pathways.com

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

*Leave primary law enforcement tactical channel and the assigned BRANCH / COMMAND channel.

†Typically encouraged for LE 2 Medics for each RTF.

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.

273 Aulin Ave. Suite 1015• Oviedo, FL 32765 • USA
(407) 490-1300 • info@c3pathways.com • www.c3pathways.com

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.

273 Aulin Ave. Suite 1015• Oviedo, FL 32765 • USA
(407) 490-1300 • info@c3pathways.com • www.c3pathways.com

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.

273 Aulin Ave. Suite 1015• Oviedo, FL 32765 • USA
(407) 490-1300 • info@c3pathways.com • www.c3pathways.com

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).

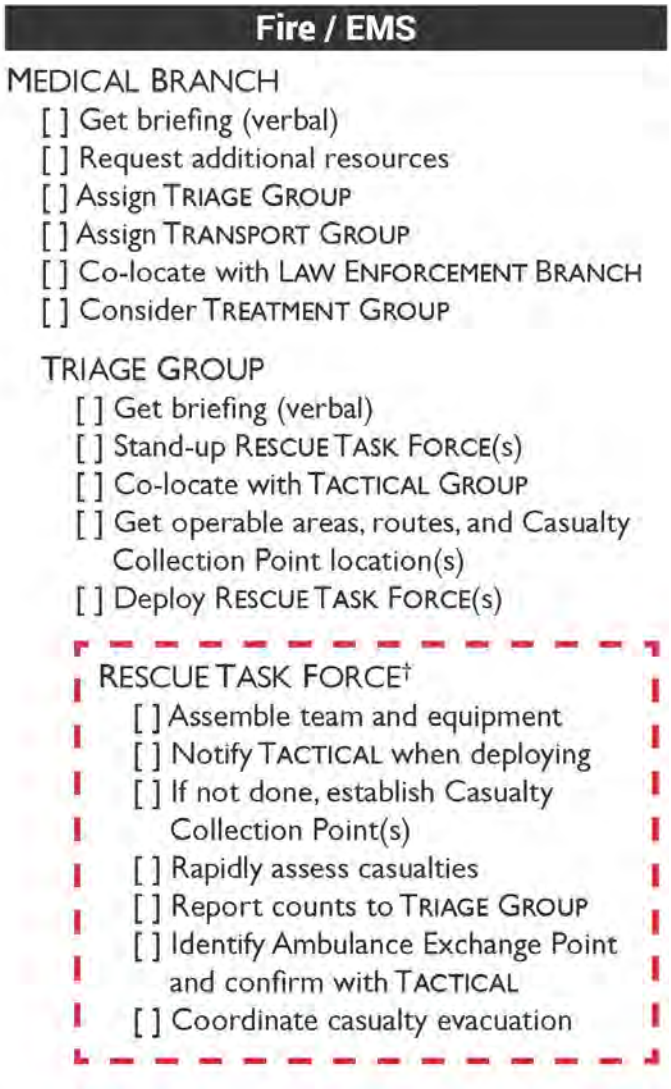
[ ] Notify TACTICAL when deploying - RTF law enforcement element notifies Tactical Group when the team is deploying from Staging to insure (1) Tactical is aware of the RTF movement, and (2) appropriate Contact Team(s) are aware of the RTF movement.

[ ] 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.

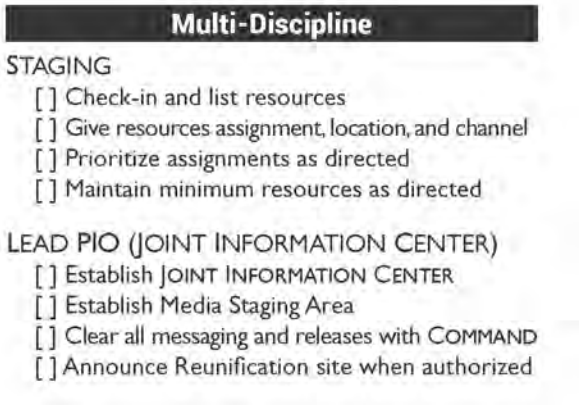
[ ] Prioritize assignments as directed - In the absence of direction, professional judgment should be used.

[ ] 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.

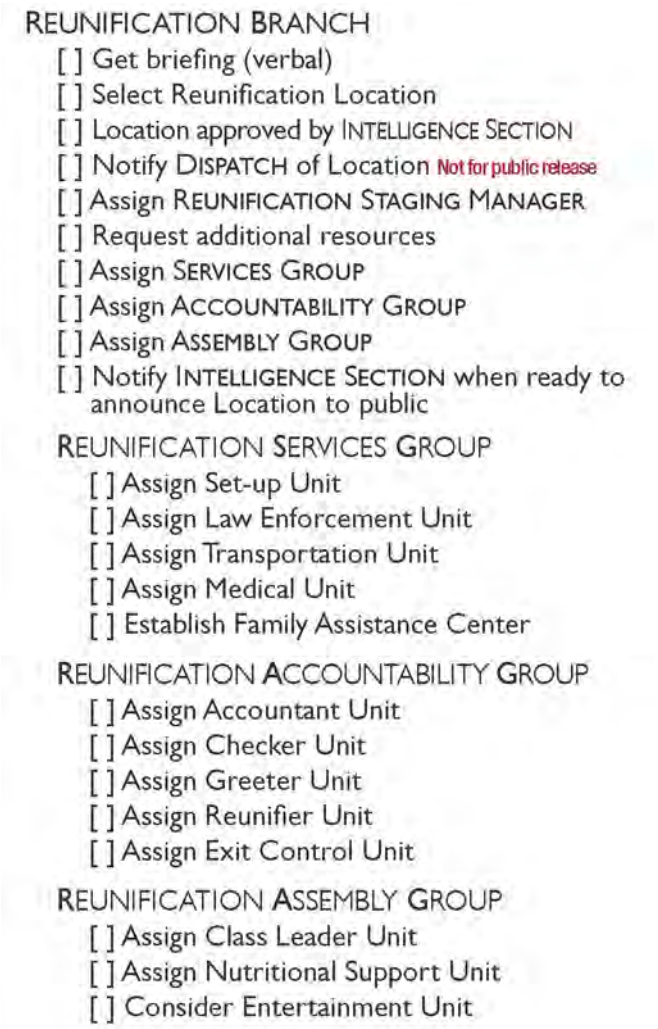
[ ] Assign ASSEMBLY GROUP - The ASSEMBLY GROUP will be dealing with the survivors, assign a supervisor and provide briefing/training and needed resources.

[ ] 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

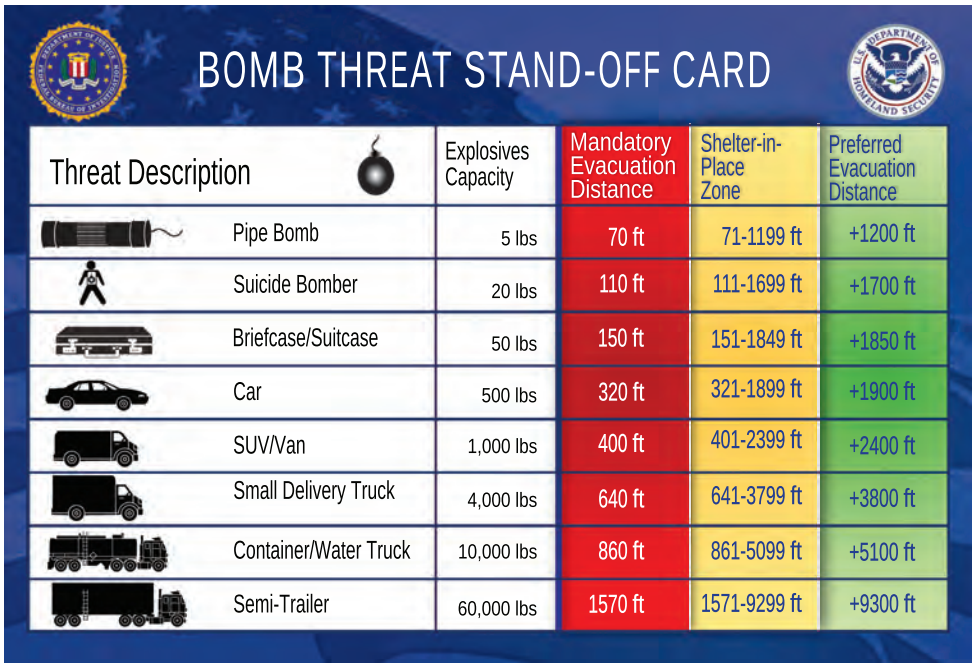
(300ft or standoff) - Everybody talks about the radio safe distances, 300 feet or safe standoff distance. That is not as big a problem as people make it out to be. The only recorded incident of a radio possibly initiating an explosive device was in the early 70's at an industrial site. Today, radios 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.

273 Aulin Ave. Suite 1015• Oviedo, FL 32765 • USA
(407) 490-1300 • info@c3pathways.com • www.c3pathways.com

[ ] 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.

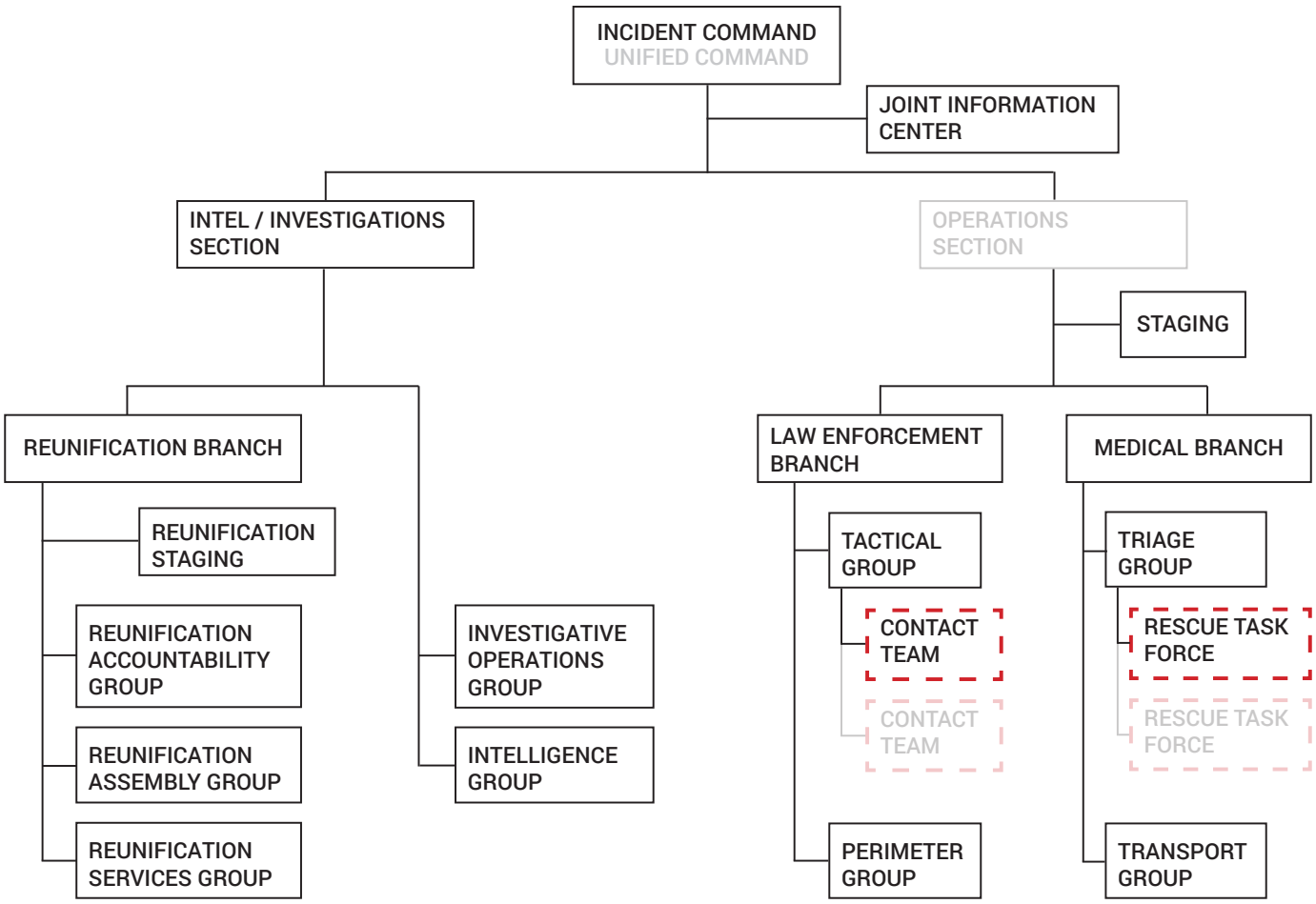
We're not trying to instill paranoia, just a caution, awareness, and what to do. If the bomb hasn't gone off, there's a good chance it probably will not. This drives home the fact that we need to have chem lights and we need to have training with this. You need to work with your local bomb squad. That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



273 Aulin Ave. Suite 1015• Oviedo, FL 32765 • USA
(407) 490-1300 • info@c3pathways.com • www.c3pathways.com

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.

References

Bichelmeyer, Barbara (October 4, 2003). Checklist for Formatting Checklists. Retrieved from https://wmich.edu/sites/default/files/attachments/u350/2014/formattingchecklist.pdf

Blair, Nichols, Burns, and Curnutt (2013). Active shooter events and response. Boca Raton, FL: CRC Press.

Burian, B. K. (October 2006). Design guidance for emergency and abnormal checklists in aviation. In the Proceedings of the Human Factors and Ergonomics Society 50th Annual Meeting, San Francisco. Retrieved from http://human-systems.arc.nasa.gov/flightcognition/Publications/EA_Checklist_Design.pdf

C3 Pathways: William Godfrey, Ron Otterbacher, David Agan, and Doug Fender (June 2013). 4 Best Practices for Active Shooter Incident Management: Lessons Learned from 10 Active Shooter Exercises with the University of North Florida. Retrieved from https://www.c3pathways.com/whitepaper/White_Paper_4_Best_Practices_Active_Shooter.pdf

Civil Aviation Authority (August 2006). CAP 676 Guidance on the Design, Presentation and Use of Emergency and Abnormal Checklists (Issue 3). Retrieved from https://publicapps.caa.co.uk/docs/33/CAP676.PDF

Department of Homeland Security and Federal Bureau of Investigation (January 1, 2014). Bomb Threat Stand Off Card. Retrieved from https://tripwire.dhs.gov/reports/220482

Department of the Army, United States Marine Corps (September 2005). Field Manual Interim: Improvised Explosive Device Defeat. Retrieved from https://fas.org/irp/doddir/army/fmi3-34-119-excerpt.pdf

FEMA (October 18, 2013). NIMS Intelligence/Investigations Function Guidance and Field Operations Guide. Retrieved from http://www.fema.gov/media-library/assets/documents/84807

Gawande, Atul (2012). The Checklist Manifesto: How to Get Things Right. New York, NY: Metropolitan Books Henry Holt and Company, LLC.

Keyes, John Michael. (April 2016). Standard Reunification Method. Retrieved from I love u guys Foundation: http://iloveuguys.org

NASA Ames Research Center: Asaf Degani, San Jose State (December 1992). On the Typography of Flight-Deck Documentation. Retrieved from http://ti.arc.nasa.gov/m/profile/adegani/Flight-Deck_Documentation.pd

Perry, W (2019). Active Shooter Incident Management Module 5 Lecture. [Power Point Slides].

Stufflebeam , Daniel L. (July 2000). Guidelines for Developing Evaluation Checklists: The Checklists Development Checklist (CDC). Retrieved from https://wmich.edu/sites/default/files/attachments/u350/2014/guidelines_cdc.pdf

US Fire Administration (September 2013). Fire/Emergency Medical Services Department Operational Considerations and Guide for Active Shooter and Mass Casualty Incidents. Retrieved from http://www.usfa.fema.gov/downloads/pdf/publications/active_shooter_guide.pdf

*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:

support@c3pathways.com
+1 (407) 490-1300
C3 Pathways, Inc.
531 S Econ Cir Suite 1001
Oviedo, FL 32765
USA

IMPROVING THROUGH PREPAREDNESS

EMERGENCY RESPONSE

ARE YOU READY?

Call Us Today (877) 340-4032
(407) 490-1300 • info@c3pathways.com • www.c3pathways.com
531 S Econ Cir Suite 1001 • Oviedo, FL 32765 • USA

C3 PATHWAYS™