Pre-Hospital Mass Casualty Incident (MCI)
Active Shooter/Hostile Event Response (ASHER) Procedure

PURPOSE

The purpose of this procedure is to identify the elements necessary to prepare and respond in a coordinated fashion to an all-hazard mass/multiple-casualty incident (MCI) to efficiently triage, treat, and transport victims of an MCI. The procedure is applicable to all multiple-victim situations whether it is a natural (e.g. weather related) or man-made (e.g. active shooter) incident. This procedure is intended for the everyday MCI when the number of injured exceeds the capabilities of the first-arriving unit(s) or a large-scale MCI when the incident exceeds immediate resources.

PROCEDURE

A. The officer of the first-arriving unit will establish Command and:
   1. Perform a size-up, estimating the number of victims.
   2. Request a Level 1, 2, 3, 4, or 5 response, and request additional units and/or specialized equipment as needed. Refer to the MCI Predetermined Response Plan Appendix #2.
      a) If the incident is suspected to be caused by an active shooter/hostile event (ASHE) with an unknown number of victims, request an MCI Level 2 response until a count can be determined and then upgrade or downgrade as needed. Utilize Appendix #3 and FOG #9
      b) If the incident is suspected to be caused by weapons of mass destruction (WMD) utilize FOG #8
   3. Identify a Staging Area.
   4. Initiate initial triage performed in accordance with START or JumpSTART Appendix #4. Prioritize victims utilizing the following color code and tie a corresponding-colored ribbon to the victim's wrist:

      Red Immediate care
      Yellow Delayed care
      Green Ambulatory (minor)
      Black Deceased (non-salvageable)

   5. Direct the "walking wounded" to one location away from the immediate incident area, if possible. These victims need to be assessed as soon as possible. Assign someone to keep the walking wounded together.

B. As additional units arrive, Command will designate the following positions:
   1. Triage (Initially the responsibility of the first-arriving officer)
   2. Treatment
   3. Transport
   4. Staging

C. Additional Branches/Sections may be required depending on the complexity of the incident. These may include, but are not limited to:
   1. Medical
   2. Landing Zone/Heli-spot
   3. Extrication
   4. Hazardous Materials (hazmat)
   5. Rehabilitation
   6. Safety
   7. Public Information Officer (PIO)
   8. Medical Intelligence—to assist with suspected or known WMD (weapons of mass destruction) events for decontamination, antidotes, and treatment.
   9. Recovery which includes the Incident Assistance Center (Victim Services Group) and Notification Center (Reunification and Death notification).

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RESPONSIBILITIES

A. COMMAND/OPERATIONS

1. Established by the first arriving officer. Radio designation "Command." In a large scale or complex incident Command should designate an Operations Section.
2. Follow Field Operation Guide FOG #1.
   - Obtain a briefing from law enforcement (LE).
   - Establish a Unified Command (UC) and co-locate with LE. The UC may be located at the initial Command location or another mutually agreed upon location.
3. Remain in a safe, fixed, and visible location, uphill and upwind of the incident.
4. Determine the MCI Level (1, 2, 3, 4, or 5). If unknown victims initiate an MCI level 2 until a count can be determined. MCI Pre-determined Response Plan Appendix #2

   FL MCI Levels
   MCI Level 1: 5-10 victims
   MCI Level 2: 11-20 victims
   MCI Level 3: 21-100 victims
   MCI Level 4: 100 -1000 victims
   MCI Level 5: Over 1000 victims

5. Designate a Staging Area.
6. Assign personnel to perform the functions of Triage, Rescue Task Force (RTF) if required, Treatment, Transport, Staging, Recovery (Reunification) and Public Information Officer
7. Advise the Communications Center of the number of victims and their categories once triage is complete.
8. During large-scale or complex MCIs (e.g., a fire with multiple victims, an ASHE, etc.), designate a Medical Branch to reduce the span of control.
9. Ensure proper security of the incident site, Treatment Area, and loading area; also provide for traffic control and access for emergency vehicles, including LE.
10. Direct and/or request a Liaison Officer to supervise on-scene personnel from agencies such as the Medical Examiner's Office, Red Cross, private ambulance companies, and hospital volunteers.
11. If the incident is due to a known or suspected weapon of mass destruction (WMD event), refer to WMD FOG #8 and designate a Medical Intelligence Officer to assist with determining decontamination methods, any specialized antidotes, and specific treatment of victims.
12. If the incident is due to a suspected ASHE refer to Appendix #3 & FOG #9
13. Identify if the situation will require a Recovery Branch with a notification center for reunification and death notification. Enact the agencies Reunification Plan
14. Identify if the situation will require Behavioral Health Access Program (BHAP) and/or a Critical Incident Stress Management (CISM) Team

B. MEDICAL BRANCH

1. Radio designation "Medical." Follow FOG #2.
2. Ensure Triage, RTF (if needed), Treatment, and Transport Officers have been established and if previously established, now report to Medical.
3. Assist Command/Operations with directing and/or supervising on-scene personnel from agencies such as the Medical Examiner's Office, Red Cross, private ambulance companies, and hospital staff/volunteers.
4. Ensure the notification of Medical Control has occurred.
5. If an ASHE incident, follow FOG #9

C. **TRIAGE OFFICER**

Reports to Command or Medical if established. Supervises the Triage Personnel, RTF (if needed), litter bearers, and directs the Medical Examiner personnel to deceased victims.

1. Radio designation "Triage", follow FOG #3.
2. Organize the Triage Team to begin initial triaging of victims and applying colored ribbons. Assemble the walking wounded and uninjured in a safe area. Use bullhorns or a public address (PA) system if necessary.
3. Advise Command/Medical as soon as possible if there is a need for additional resources.
4. Coordinate with Treatment to ensure that priority (Red/Trauma Alert) victims are treated first. If transport units are available coordinate with Transport to have priority victims moved to transport units.
5. Ensure that all areas around the MCI scene have been checked for potential victims, wounded walking, or ejected victims.
6. Maintain the security and control of the Triage Area and request assistance from LE.
7. Report to Command/Medical upon completion of duties for further assignments.

D. **TREATMENT OFFICER**

Reports to Command/Medical. Supervises the Treatment Managers of the Red, Yellow, and Green Areas. Coordinates the re-triage and secondary tagging of all victims and the on-site medical care. Directs the movement of victims to the Ambulance Loading Area(s).

1. Radio designation "Treatment", follow FOG #4.
2. Consider assigning a Documentation Aide to assist with paperwork.
3. Direct personnel to either begin treatment of the victims where they lay or establish a centralized Treatment Area. If an ASHE incident a Casualty Collection Point (CCP) may be needed.
4. Considerations for a Treatment Area:
   a) Capable of accommodating the number of victims and equipment.
   b) Consider weather, safety, and the possibility of hazardous materials.
   c) Designate entrance and exit areas, which are readily accessible (funnel points).
   d) Use appropriate-color tarps if available.
5. On large-scale incidents, divide the Treatment Area into three distinct areas based on priority. Designate a Treatment Manager for each area (Red, Yellow, Green).
   a) The Red, Yellow, and Green Treatment Area Managers report to the Treatment Officer and are responsible for the treatment and continual re-triaging of victims in their area.
   b) The Treatment Area Managers need to notify the Treatment Officer of victim priority for transportation. Assure that appropriate victim information is recorded
6. Complete a Treatment Log (Treatment FOG #4A) as victims enter the area.
7. Ensure that all victims are re-triaged through a secondary exam and the assessment is documented on a triage tag (Disaster Management System [DMS] - All Risk Triage tag).
8. All red-tagged victims will be transported immediately as transport units become available. These victims should not be delayed in the Treatment Area. If Trauma Centers are not overwhelmed victims that meet Trauma Alert criteria should be transported to a Trauma Center. For Trauma Alerts a "TA" can be written on the top of the triage tag and designated on the Log #4A.
9. Ensure that enough equipment is available to effectively treat all victims.
10. Establish communications with Transport to coordinate transport of victims, with priority victims first. Direct movement of victims to the Ambulance Loading Area(s).
11. Provide periodic status reports to Command/Medical.

E. **TRANSPORT OFFICER**

Reports to Command/Medical. Supervises the Medical Communication Coordinator, Documentation Aide(s) and Hospital Liaison(s). The Transport Officer is responsible for the coordination of victims and maintenance of records relating to victim identification, injuries, mode of transportation, and destination.

1. Radio designation "Transport", follow FOG #5.
2. Assign a Documentation Aide to assist with paperwork and communications.
3. Assign a Medical Communication Coordinator to establish continuous contact with Medical Control.
4. Establish an Ambulance Loading Area(s). Advise Staging of the location and direction of travel. Consider requesting LE assistance to ensure the security of the Loading Area(s).
5. Arrange for the transport of victims from the incident site or Treatment Area with the red/trauma alerts transported first. If Trauma Centers are not overwhelmed victims that meet Trauma Alert criteria should be transported to a Trauma Center.
6. Maintain a Hospital Transportation Log #5B. If available utilize a web-based victim tracking system.
7. Keep the appropriate section of the triage tag for future documentation.
8. Communicate with the Landing Zone (LZ)/Heli-spot Officer and relay the number of victims to be transported by air. Air-transported victims should be assigned to distant hospitals, unless the victims' needs dictate otherwise (e.g., trauma center, burn unit).
9. Provide victim information to the Recovery Branch for reunification and death notification (LE/ME to coordinate death notifications)

F. **MEDICAL COMMUNICATION COORDINATOR**

Reports to the Transport Officer and is responsible for maintaining communication with Medical Control and the Hospital Liaison(s) to assure victim information and transport destination.

1. Radio designation "Communication" Follow FOG #5A.
2. Establish communication with Medical Control.
   a) Advise Medical Control of the overall situation (e.g., smoke inhalation, trauma, burns, hazardous materials exposure) and the number and categories of victims.
   b) Medical Control will survey area hospitals to determine their capabilities and capacities and then relay this information. Web-based tracking system may also be used.
   c) Document this information on the Hospital Capability Worksheet #5C and maintain this document for the duration of the incident. Web-based tracking system may also be used.
3. When units are prepared for victim transport, advise Medical Control and supply the following information: Web-based tracking system may also be used.
   a) The unit transporting.
   b) The number of victims to be transported.
   c) Their priority: Red, Yellow, or Green.
   d) Any victims with special needs (e.g., cardiac, burn, trauma alerts).
4. The Communication Officer, in conjunction with Medical Control, will determine the most appropriate facility. Ground-transported victims should be assigned to hospitals on a rotating basis.
5. Once Medical Control receives the information from the Communication Officer, Medical Control will notify the appropriate hospital. Transporting units will not contact the individual hospital on their own, unless there is a need for medical direction/care outside of protocols.

G. **MEDICAL SUPPLY COORDINATOR**

Reports to Medical, responsible for acquiring and maintaining control of medical equipment and supplies.

1. Radio designation "Medical Supply", follow FOG #6.
2. Assure necessary equipment is available on the transporting vehicle.
3. Provide an inventory of medical supplies at the Staging Area for use on scene.
4. Assure support vehicles are requested. Consider local, regional, state, and federal resources.

H. **STAGING OFFICER**

Reports to Command and is responsible for managing all activities within the Staging Area.

1. Radio designation "Staging", follow FOG #7.
2. Establish the location of a Staging Area and notify the Communications Center to direct any incoming units.
3. Maintain a Unit Staging Log #7A.
4. Request LE to secure the Staging Area
5. Ensure that all personnel stay with their vehicles unless otherwise directed by Command. If personnel are directed to assist in another function, ensure that the keys stay with each vehicle.
6. Coordinate with the Transport Officer the designation of a location for victim loading area and the best route to the area.
7. Maintain a reserve of at least two transport vehicles. When the reserve is depleted, request additional units through Command.

I. RECOVERY BRANCH

Reports to Command and is responsible for the Incident Assistance Center (Victim Services Group) and Notification Center (NC), responsible for reunification and death notification. This Branch should be established as early as possible in the MCI incident

1. Radio designation "Recovery", follow FOG #10.
2. Identify a location that provides the appropriate level of safety and support for families & loved ones in the immediate aftermath of the event. Examples of locations, hotels, churches, schools, contact private facilities directly to request assistance, including (etc.)
3. The NC may be at the incident location or away from the incident location depending on the nature of the incident and other operational needs. In a large-scale MCI, it is preferable to locate the NC a sufficient distance from the incident, so not to interfere with the ongoing incident and/or the post-incident investigation and crime scene processing. Depending on the scope of the incident, you may need multiple centers.
4. The NC must be secured by LE and at no time will the media be allowed in the NC, to potentially include the parking lot, without express approval from Command.
5. If the incident occurred at a school, request trained school personnel to provide staff and assist with check-in and releasing uninjured people from the center.
6. All personnel entering the NC shall have their identification recorded.
7. Goals of the NC
    a) Meet short-term reunification needs of those directly impacted by the incident.
    b) Ensure that no minors are permitted to leave unless accompanied by a parent/guardian. Keep unaccompanied minors and separated children safe
    c) Provide swift transfer or reunification of survivors to family members, loved ones, guardian, or appropriate agency
    d) Provide water and food for people in the NC
    e) Next of kin notifications may take place at the NC. This will be the responsibility of LE/Medical Examiner and shall be in a separate location from the reunification center.

This information is for immediate needs and not meant to be all encompassing. Follow facility/agencies recovery and reunification plan.

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Appendix #1

Definitions

Active Assailant(s) (AA). An individual or individuals actively engaged in killing or attempting to kill people in a confined and populated area with means other than the use of firearms.

Active Shooter – An individual or individuals actively engaged in harming, or attempting to kill people in a populated area with the use of firearm(s)

Active Shooter Hostile Event (**ASHE) -** An incident where one or more individuals are or have been actively engaged in harming, killing, or attempting to kill people in a populated area by means such as firearms, explosives, toxic substances, vehicles, edged weapons, fire or a combination thereof.

Ballistic Protection Equipment (BPE) – An item(s) of personal protective equipment (PPE) intended to protect the wearer from threats that could include ballistic threats, stabbing, fragmentation, or blunt force trauma. Minimally consists of ballistic vest, helmet and/or shield.

Casualty Collection Point (CCP) – A temporary location used for gathering, triage, medical stabilization, and subsequent evacuation of nearby casualties. Where vehicular access might be limited and is usually occurring in the warm zone. Casualties can be transferred to an ambulance exchange point/loading zone from these locations.

Complex Coordinated Attack – Frequently this is done using multiple asymmetric attack modes, such as firearms, explosives, fire and smoke as weapon and/or vehicle assaults. It will also often involve coordinated and concurrent attacks on multiple locations which will usually require multiple attackers.

Concealment – The protection from observation. Anything that prevents direct observation from the threat that might or might not provide protection from the threat.

Contact Team/Law Enforcement Entry Team – A team of law enforcement officers (LEO) tasked with locating the suspect(s) and neutralizing the threat.

Cover – The protection from firearms or other hostile weapons.

Force Protection (FP): Preventive measures taken to mitigate hostile actions in specific areas or against a specific population, those protected by FP can include civilians and unarmed responders.

Improvised Explosive Device (IED) – Per the Department of Defense (DOD), it is a device placed or fabricated in an improvised manner incorporating destructive, lethal, noxious, pyrotechnic, or incendiary chemicals and designed to destroy, incapacitate, harass, or distract. An IED may be made with military or nonmilitary components.

Litter Bearers/Extraction Team – Personnel used to move the injured/uninjured to an area of safety.

Medical Control: A centralized communication center that assists in the management of communication between units in the field, the hospital, and fire rescue dispatch centers. This also may be facilitated through a web-based system interface such as Pulsara, ReadyOp, etc.

Operational Zones as they relate to Active Shooter/ Hostile Events: The areas at ASHE incidents within an established perimeter that are designated based upon safety and the degree of hazard.

Hot Zone – Area that has not been cleared by law enforcement personnel, an area where there is known hazard or direct and immediate threat. Rescue Task Force's (RTF's) should NOT be deployed in this area.

Warm Zone – An area where there is the potential for a hazard or an indirect threat to life. Where the perpetrator is not believed to be and is available for entry by a trained RTF to treat victims and extract them to the CCP.

Cold Zone - Areas where there is little or no threat due to geographic distance from the threat or the area has been secured by law enforcement (e.g., the area where fire/EMS may stage to triage, treat, and transport victims once removed from the warm zone).

Public Information Officer (PIO) – Reporting directly to the IC, an agency member responsible for the dissemination of information to the news media and the public.

Rescue Task Force (RTF) – A combination of fire and/or EMS personnel and law enforcement who provide force protection. The RTF could provide threat-based/lifesaving care, triage, and extracting victims to a casualty collection point or other designated location.

Reunification Area – Under the Recovery Branch, an area established where victims are transported to be reunited with family and friends and for victims' family and friends to await the rescue and debriefing of victims involved in the incident.

THREAT – Acronym from the Hartford Consensus highlighting the importance of initial actions to control hemorrhaging.
T – **T**hreat suppression
H – **H**emorrhage Control
RE – **R**apid **E**xtrication to safety
A – **A**ssessment by medical providers
T – **T**ransport to definitive care

Unified Command (UC) – An authority structure in which the role of the incident commander is shared by individuals from all responding organizations responsible for the incident, operating together to develop a single incident action plan. During an ASHE incident, the UC generally consists of law enforcement, fire and EMS representatives at a minimum.

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Appendix #2

Suggested MCI Pre-Determined Response Plan

CONSIDERATIONS

A. An MCI shall be classified by different levels depending on the number of victims. The number of victims will be based on the initial size-up, prior to triage.
B. Levels of response will augment the units already on the scene, and units enroute will be included in the assignment. The exception would be in conjunction with a Fire Alarm assignment e.g., a fire with multiple victims may be a Second Alarm with an MCI Level 3 response; this will be two separate assignments.
C. Command can downgrade or upgrade the assignments at any time.
D. All units are to respond to the Staging Area "emergency response" unless directed by Command.
E. When announcing an MCI, specify the general category (e.g., trauma, hazardous materials, smoke inhalation, etc.).
F. Any victim meeting Trauma Transport Criteria must be reported to a state-approved trauma center for determination as to transport destination. Trauma Transport Criteria will be determined during the secondary triage in the Treatment Phase. Trauma Centers should notify Medical Control if they are overwhelmed and unable to accept additional trauma alerts.
G. Consider the use of air transport for victims with special needs, private BLS transport units to augment existing resources, and mass-transit resources for multiple "walking wounded" victims.
H. Consider the use of command vehicles, medical supply trailers, and communication trailers as needed from regional or State resources.
I. Upon notification of an MCI, Medical Control will gather information about each hospital's capability and relay this information to the Transport Officer or Communication Officer or utilize a web-based victim tracking system.
J. On a level 3 or greater, assign a Hospital Liaison to each hospital to assist with communications.
K. Request LE to set up a safety parameter for the incident.

MCI Level 1 (5-10 victims)

- 4 ALS Transport Units
- 2 Suppression Units
- 1 Shift Supervisor
- 1 EMS Supervisor

Note - The 2 hospitals and trauma center closest to the incident will be notified by Medical Control.

MCI Level 2 (11-20 victims) (initially unknown number of victims)

- 6 ALS Transport Units
- 3 Suppression Units
- 2 Shift Supervisors
- 2 EMS Shift Supervisors

Note - The 3 hospitals and 2 trauma centers closest to the incident will be notified by Medical Control.

MCI Level 3 (21-100 victims)

- 8 ALS Transport Units
- 4 Suppression Units
- 3 Shift Supervisors
- 3 EMS Shift Supervisors
- Command Vehicle
- MCI Trailer (regional or State resources)
- Operations Chief

Note – The 4 hospitals and 3 trauma centers closest to the incident will be notified by Medical Control. The State Warning Point and local Emergency Management should be notified.

MCI Level 4 (101-1000 victims)

- 5 MCI Task Forces (25 units)
- 2 ALS Transport Strike Teams (10 units)
- 1 Suppression Unit Strike Team (5 units)
- 2 BLS Transport Strike Teams (10 units)
- 2 Mass Transit Buses
- 2 MCI Trailers (regional or State resources)
- Command Vehicle
- Communications Trailer
- 5 Shift Supervisors
- 3 EMS Shift Supervisors,1 EMS Chief
- Operations Chief

Note - The 10 hospitals and 5 trauma centers closest to the incident will be notified by Medical Control. The State Warning Point and local Emergency Management should be notified. In an on-going long-term MCI utilize local, regional, State, and Federal resources e.g. DMAT.

MCI Level 5 (more than 1000 victims)

- 10 MCI Task Forces (50 units)
- 4 ALS Transport Strike Teams (20 units)
- 2 Suppression Unit Strike Teams (10 units)
- 4 BLS Transport Strike Teams (20 units)
- 4 Mass Transit Buses
- 2 Command Vehicles
- 4 MCI Trailers (regional or State resources)
- Communications Trailer
- 10 Shift Supervisors
- 6 EMS Shift Supervisors
- 2 EMS Chiefs
- 2 Operations Chiefs

Note -The 20 hospitals and 10 trauma centers closest to the incident will be notified by Medical Control. The State Warning Point and local Emergency Management should be notified. In an on-going long-term MCI utilize local, regional, State, and Federal resources e.g. DMAT may be notified.

Strike Team: Five of the same type of units, with common communications and a leader.
Task Force: Five different types of units, with common communications and a leader.
MCI Task Force: May be two ALS Transport Units, two BLS Transport Units, and one Suppression Unit, including common communications and a leader.

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Appendix #3

For a Known or Suspected Active Shooter/Hostile Event (ASHE)

A. For an ASHE or any tactical environment MCI, establish a Unified Command (UC) comprised of Law Enforcement (LE), Fire, and EMS representation as a minimum.
B. Be on high alert for suspicious individuals, packages, vehicles or potential improvised explosive device (IED).
C. Integrated active shooter/assailant response should include the critical actions contained in the acronym THREAT, **T**hreat suppression (LE), **H**emorrhage Control, **R**apid **E**xtrication to safety, **A**ssessment by medical providers, **T**ransport to definitive care
D. A decision may be made to establish a Rescue Task Force (RTF) comprised of properly trained and equipped with ballistic protective equipment (BPE) fire and/or EMS personnel grouped with law enforcement officers (LEO) who provide force protection, allowing operation in the Warm Zone.

1. The RTF will initiate triage, provide immediate threat-based/life-saving treatment (e.g. hemorrhage control), and remove victims to a Casualty Collection Point (CCP) or other designated location.
2. The RTF is not intended to suppress the threat and will not operate in the Hot Zone.
3. The LEO's assigned to the RTF are for force protection and will not separate from the fire and/or EMS personnel.
4. Based on the scene, the number of victims, and available emergency personnel, there could be more than one RTF assigned. If more than one RTF team, designate the teams as RTF 1, RTF 2 etc.
5. The Triage Officer with Aide will maintain control of and accountability for deployed RTFs. These teams may be comprised of personnel from different agencies, and different disciplines.
6. When an RTF is formed, designate a Triage Aide to communicate with the RTF.
7. The deployment location and direction of movement for an RTF should be determined based on information provided by LEO's, the Contact Team or at the direction of the UC.
8. Tactics involving the actual ingress and egress of the RTF from the deployment location to its stopping point will be directed by the LEO's.
9. If a safe corridor has not/cannot be established, establish a CCP to treat victims.
10. Once in the area of the largest number of victims, the RTF should begin immediate life-threatening care and organize the movement of victims with litter bearers.
11. Fire rescue/EMS personnel will be responsible for the triage, treatment, and transport of all the victims. Priority is given to those categorized as RED with the most severe injuries and risk of death.
12. Tag victims utilizing triage ribbons especially the RED (priority) and BLACK (deceased) categories.
13. Treatment coordination and transport of the victims will be directed by fire rescue/EMS personnel. If Trauma Centers are not overwhelmed victims that meet Trauma Alert criteria should be transported to a Trauma Center.
14. Once the area is deemed safe to enter by the UC, remaining crew members and any additional arriving personnel should assist with triage, treatment and the movement of victims.

Reference source - National Fire Protection Association (NFPA) 3000 Active Shooter/Hostile Event Response document.

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Appendix #4

START/JumpSTART System of Triage

This procedure is based on the Simple Triage and Rapid Treatment (START) process for adult victims and the JumpSTART adaptation for pediatric victims.

PROCEDURE

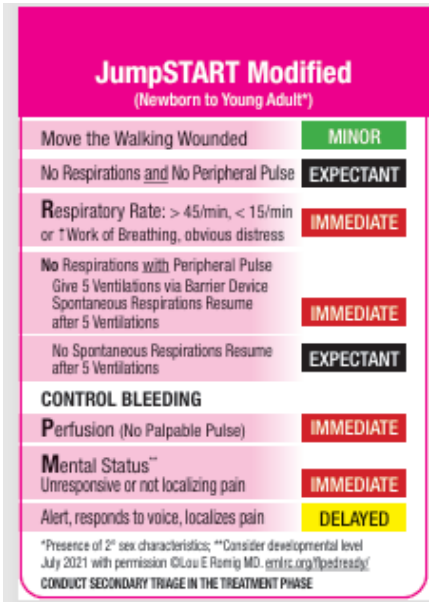
A. Initial triage: Using the START or JumpSTART method:
   1. Locate and direct all walking wounded to one location away from the incident if possible. Assign someone to keep them together (fire rescue personnel, law enforcement officer, or capable bystander).
   2. Begin assessing all non-ambulatory victims where they are found.
   3. Utilize the triage ribbons tied to an upper extremity in a visible location. Priority is to tag the Priority victims RED and the deceased victims BLACK.
   4. Independent decisions should be made for each victim. Do not base triage decisions on the perception of too many REDs, not enough GREENs, and so forth.
   5. If borderline decisions are encountered, always triage to the most urgent priority (e.g., for a GREEN/YELLOW patient, tag as YELLOW).

B. Secondary triage.
   1. Performed on all victims during the Treatment phase. If a victim is identified in the initial Triage phase as a RED and transport is available, do not delay transport to perform a secondary assessment.
   2. Utilize a triage tag (Disaster Management System, All Risk Triage tag) and attempt to assess for and complete all information required on the tag (time permitting). Affix the tag to the victim and remove the ribbon.
   3. The triage priority determined in the Treatment phase should be the priority used for transport. If trauma-related, the Trauma Transport Criteria will be applied to trauma victims during the secondary triage. If Trauma Centers are not overwhelmed victims that meet Trauma Alert criteria should be transported to a Trauma Center.

Remember the mnemonic RPM (Respiration, Perfusion, Mental status). The first assessment that produces a RED stops further assessment. Only correction of life-threatening problems, such as airway obstruction or severe hemorrhage, should be managed during the triage phase. Any major external bleeding should also be controlled at this time. Depending on the victim's injuries (burns, fractures, bleeding), it may be necessary to prioritize as YELLOW.

START
Simple Triage & Rapid Treatment

JumpSTART
Pediatric Simple Triage & Rapid Treatment



JumpSTART TRIAGE

Physiological differences in children necessitate adaptation of the standard START triage method in children 8 years of age or younger, or in those victims with the anatomical or physiological features of a child in the age group. Consider developmental level and 2° sex characteristics.

Note -Infants who are developmentally unable to walk should be triaged using the JumpSTART algorithm either during initial triage or in the GREEN area if carried out by a non-rescuer. During triage, if the infant does not fulfill the criteria of a RED victim and has no other outward signs of significant injury; he/she may be triaged as a GREEN victim.

Note -The START Triage system was developed by Newport Beach Fire Rescue and Hoag Hospital. The JumpSTART Triage system was developed by Dr. Lou Romig and was revised 05/13/2021 with permission ©Lou E Romig MD https://emlrc.org/flpedready/

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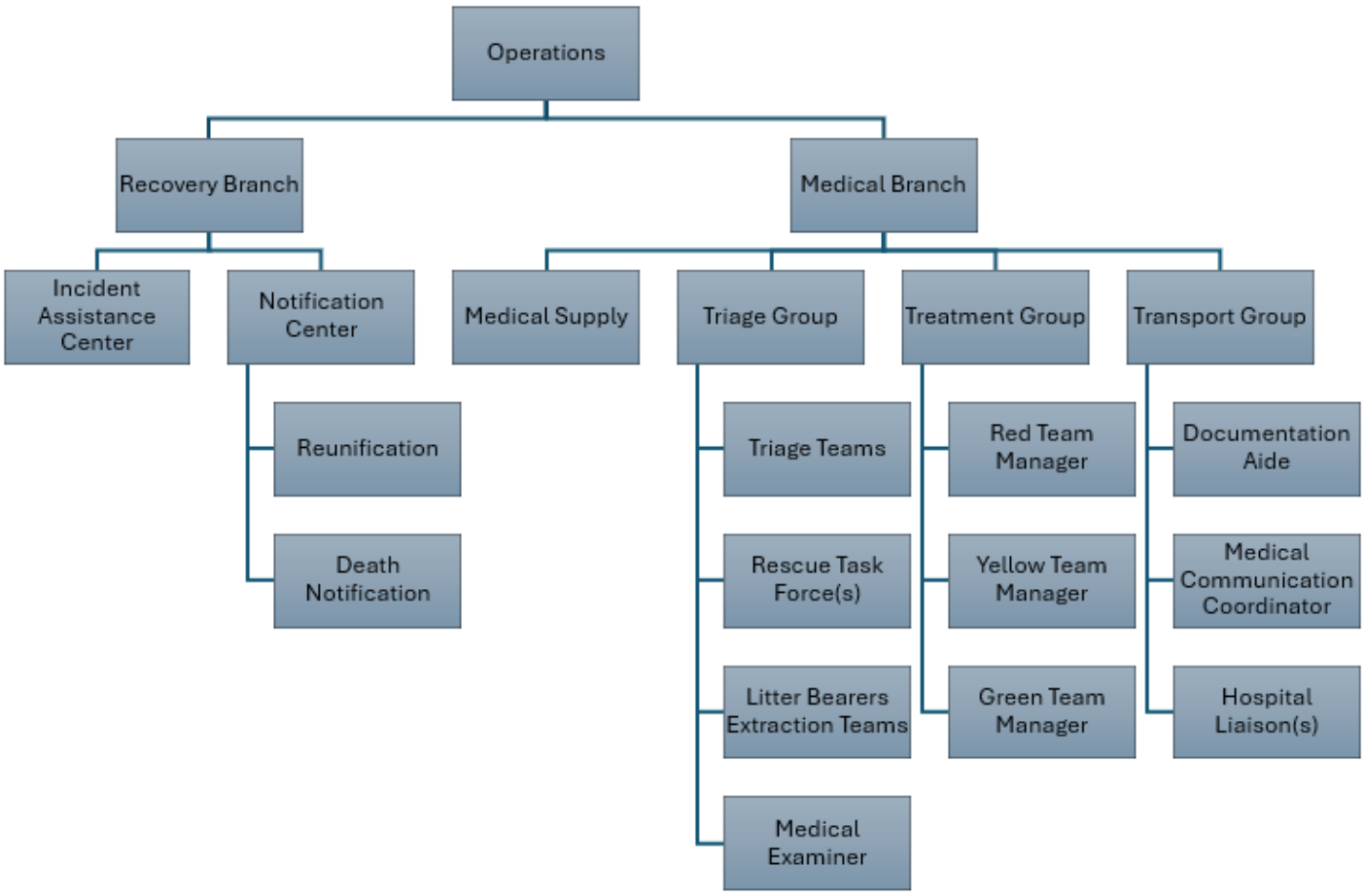
Appendix #5

MCI/ASHE Command Structure



MCI/ASHER

Field Operation Guides (FOG)

FOG #1	Command/Operations
FOG #2	Medical Branch
FOG #3	Triage
FOG #4	Treatment
	FOG #4A Treatment Log
FOG #5	Transport
	FOG #5A Medical Communication
	FOG #5B Hospital Transport Log
	FOG #5C Hospital Capability Worksheet
FOG #6	Medical Supply
FOG #7	Staging
	FOG #7A Unit Staging Log
FOG #8	Contaminated Victims/Weapons of Mass Destruction (WMD)
FOG #9	MCI/Active Shooter/Hostile Event
FOG #10	Recovery Branch- Immediate Notification Center (Reunification and Death Notification)

COMMAND/OPERATIONS

- ☐ Don the appropriate vest and use the radio designation "COMMAND" In a large-scale and/or complex event COMMAND should designate an OPERATIONS Section. Establish the Command Post in a safe, visible and fixed location uphill and upwind. Consider assigning an aide. If a WMD is suspected, refer to FOG #8. If an ASHE is suspected, refer to Appendix #3 and FOG #9 for additional guidance.
- ☐ Perform the initial size-up including wind direction. Determine any special needs, such as fire suppression, hazmat, extrication, air transport, and request as needed.
- ☐ Approximate the number of victims and category of injury (trauma, burns, smoke inhalation, etc.). Conduct a 360 of the area and try to account for all victims.

MCI	Level 1	Level 2	Level 3	Level 4	Level 5
Victims	5-10	11-20	21-100	101-1000	>1000

- ☐ Establish a Staging Area as soon as possible.
- ☐ Designate the following positions:
  - ☐ STAGING
  - ☐ MEDICAL BRANCH (for complex incidents, e.g., structural fire with an MCI)
  - ☐ TRIAGE
    - ☐ Triage Teams
    - ☐ Rescue Task Force (if needed)
    - ☐ Litter Bearers
    - ☐ Medical Examiner personnel
  - ☐ TREATMENT
    - ☐ RED, YELLOW, GREEN Treatment Teams & Managers
  - ☐ TRANSPORT
    - ☐ Documentation Aide
    - ☐ Medical Communication Coordinator
    - ☐ Hospital Liaison(s)
  - ☐ MEDICAL SUPPLY, REHAB, SAFETY, DECON, EXTRICATION, PIO, etc.
  - ☐ RECOVERY BRANCH (includes the Incident Assistance Center and Reunification Center)
- ☐ Advise the Communication Center of the number of victims and their categories once reported from TRIAGE.
- ☐ Request LE for scene security, traffic control, and access for emergency vehicles.
- ☐ When applicable, have a liaison for each involved agency at the Command Post. Some examples would include Law Enforcement, Medical Examiner, Emergency Management Agency, occupancy owner/representative, etc.

Two-sided (Predetermined Response Plan on back)

Pre-Hospital Mass Casualty Incident (MCI)
Active Shooter/Hostile Event Response (ASHER) Procedure

Predetermined Response Plan (For the back of COMMAND and MEDICAL FOG)

MCI LEVEL 1 (5-10 victims)

4 ALS Transport Units	1 Shift Supervisor
2 Suppression units	1 EMS Supervisor

Note: The 2 closest hospitals & Trauma Center to the incident will be notified by Medical Control.

MCI LEVEL 2 (11-20 victims)

6 ALS Transport Units	2 Shift Supervisors
3 Suppression units	2 EMS Shift Supervisors

Note: The 3 closest hospitals & 2 Trauma Centers to the incident will be notified by Medical Control.

MCI LEVEL 3 (21 - 100 victims)

8 ALS Transport Units	3 Shift Supervisors	Supply Trailer
4 Suppression Units	3 EMS Shift Supervisors	
Command Vehicle	Operations Chief	

Note: The 4 closest hospitals, 3 Trauma Centers to the incident, AND the County Emergency Management Agency will be notified by Medical Control.

MCI LEVEL 4 (101 – 1000 victims)

5 MCI Task Forces (25 units)	2 ALS Transport Strike Teams (10 units)
1 Suppression Unit Strike Team (5 units)	5 Shift Supervisors
2 BLS Transport Strike Teams (10 units)	3 EMS Shift Supervisors
2 Mass Transit Buses	1 EMS Chief
Command Vehicle	Operations Chief
2 Supply Trailers	Communications Trailer

Note: The 10 closest hospitals, 5 Trauma Centers to the incident AND the County Emergency Management Agency will be notified by Medical Control. For projected long-term incidents, Command should consider resources through the Statewide Emergency Response Plan (SERP) and/or the State Ambulance Deployment Plan (ADP).

MCI LEVEL 5 (over 1000 victims)

10 MCI Task Forces (50 units)	4 ALS Transport Strike Teams (20 units)
2 Suppression Unit Strike Team (10 units)	10 Shift Supervisors
4 BLS Transport Strike Teams (20 units)	6 EMS Shift Supervisors
4 Mass Transit Buses	2 EMS Chiefs
2 Command Vehicles	2 Operations Chiefs
4 Supply Trailers	Communications Trailer

Note: The 20 closest hospitals, 10 Trauma Centers to the incident AND the County Emergency Management Agency will be notified by Medical Control. The. For projected long-term incidents, Command should consider resources through the Statewide Emergency Response Plan (SERP) and/or the State Ambulance Deployment Plan (ADP).

Strike Team = 5 of the same type of units including common communications and leader
Task Force = 5 different types of units including common communications and leader
MCI Task Force = May be 2 ALS Transport units, 2 BLS Transport Units, 1 Suppression Unit including common communications and leader

MEDICAL BRANCH

- ☐ Don the appropriate vest and use the radio designation "MEDICAL".
- ☐ Establish in a safe, fixed and visible location or co-join command post.
- ☐ Verify that COMMAND/OPERATIONS has requested an appropriate number of units.
- ☐ Assign the following functions, if not done by COMMAND/OPERATIONS.
    - ☐ TRIAGE
        - ☐ Triage Team(s)
        - ☐ Rescue Task Force(s) (if needed)
        - ☐ Litter Bearers/Extraction Teams
        - ☐ Medical Examiner Personnel
    - ☐ TREATMENT
        - ☐ RED, YELLOW, GREEN Treatment Teams & Managers
        - ☐ Treatment Personnel
    - ☐ TRANSPORT
        - ☐ Documentation Aide(s)
        - ☐ Medical Communication Coordinator
        - ☐ Hospital Liaison(s)
    - ☐ STAGING for medical units
    - ☐ Medical Supply Officer

- ☐ Advise the Communication Center of the number of victims and their categories, once reported from TRIAGE. Determine the amount and type of additional medical supplies needed. Consider assigning a Medical Supply Officer.

- ☐ If the incident is due to a known or suspected WMD with contaminated victims, refer to WMD FOG #8.
- ☐ If known or suspected ASHE type incident utilize FOG #9.

Two-sided (Predetermined Response Plan on back)

MEDICAL

Pre-Hospital Mass Casualty Incident (MCI)
Active Shooter/Hostile Event Response (ASHER) Procedure

Predetermined Response Plan (For the back of COMMAND and MEDICAL FOG)

MCI LEVEL 1 (5-10 victims)

4 ALS Transport Units	1 Shift Supervisor
2 Suppression units	1 EMS Supervisor

Note: The 2 closest hospitals & Trauma Center to the incident will be notified by Medical Control.

MCI LEVEL 2 (11-20 victims)

6 ALS Transport Units	2 Shift Supervisors
3 Suppression units	2 EMS Shift Supervisors

Note: The 3 closest hospitals & 2 Trauma Centers to the incident will be notified by Medical Control.

MCI LEVEL 3 (21 - 100 victims)

8 ALS Transport Units	3 Shift Supervisors	Supply Trailer
4 Suppression Units	3 EMS Shift Supervisors	
Command Vehicle	Operations Chief	

Note: The 4 closest hospitals, 3 Trauma Centers to the incident, AND the County Emergency Management Agency will be notified by Medical Control.

MCI LEVEL 4 (101 – 1000 victims)

5 MCI Task Forces (25 units)	2 ALS Transport Strike Teams (10 units)
1 Suppression Unit Strike Team (5 units)	5 Shift Supervisors
2 BLS Transport Strike Teams (10 units)	3 EMS Shift Supervisors
2 Mass Transit Buses	1 EMS Chief
Command Vehicle	Operations Chief
2 Supply Trailers	Communications Trailer

Note: The 10 closest hospitals, 5 Trauma Centers to the incident AND the County Emergency Management Agency will be notified by Medical Control. For projected long-term incidents, Command should consider resources through the Statewide Emergency Response Plan (SERP) and/or the State Ambulance Deployment Plan (ADP).

MCI LEVEL 5 (over 1000 victims)

10 MCI Task Forces (50 units)	4 ALS Transport Strike Teams (20 units)
2 Suppression Unit Strike Team (10 units)	10 Shift Supervisors
4 BLS Transport Strike Teams (20 units)	6 EMS Shift Supervisors
4 Mass Transit Buses	2 EMS Chiefs
2 Command Vehicles	2 Operations Chiefs
4 Supply Trailers	Communications Trailer

Note: The 20 closest hospitals, 10 Trauma Centers to the incident AND the County Emergency Management Agency will be notified by Medical Control. The. For projected long-term incidents, Command should consider resources through the Statewide Emergency Response Plan (SERP) and/or the State Ambulance Deployment Plan (ADP).

Strike Team = 5 of the same type of units including common communications and leader
Task Force = 5 different types of units including common communications and leader
MCI Task Force = May be 2 ALS Transport units, 2 BLS Transport Units, 1 Suppression Unit including common communications and leader

MCI PROCEDURE **FOG #3**

TRIAGE

- ☐ Don the appropriate vest and use radio designation “TRIAGE”.
- ☐ Assign personnel to triage the "walking wounded". Use bullhorn/PA system to direct victims to a specific location or to decon area if needed.
- ☐ If the scene is safe, direct personnel to triage and tag victims where they lay.
- ☐ If the scene is unsafe, wait for COMMAND/OPERATIONS to determine if a Rescue Task Force (RTF) will be formed to make entry into the Warm Zone. Triage personnel can triage and treat victims in the cold zone.
- ☐ Prioritize victims using colored triage ribbons.
- ☐ If an RTF is formed designate a Triage Aide to communicate with the RTF
- ☐ If more than one RTF is assembled, designate them as RTF 1, RTF 2, etc.
- ☐ If in a building, mark the doors with the victim count using a grease pencil R# , Y#, G#, B# (Greens should have left the area but may stay to assist with care or supervision (e.g. teacher).
- ☐ Request Litter Bearer Teams from COMMAND/MEDICAL to assist with movement of victims from the incident site to the Treatment Area. Coordinate movement with the TREATMENT Officer.
- ☐ Victims that are tagged Black/Deceased should be left where they are found, and the medical examiner/law enforcement be notified.
- ☐ Report to COMMAND/MEDICAL the number and category of victims.
- ☐ Ensure that all areas of the incident have been checked for victims and that all victims have been triaged.
- ☐ Once triage is completed contact COMMAND/MEDICAL for further assignment.
- ☐ If the incident is due to a known or suspected WMD with contaminated victims, refer to WMD FOG #8. If known or suspected ASHE incident utilize FOG #9.

TRIAGE

TREATMENT

- ☐ Don the appropriate vest and use the radio designation "TREATMENT".
- ☐ Direct personnel to either begin treatment of victims where they lay OR establish a centralized Treatment Area. Ensure security with Law Enforcement.
- ☐ Coordinate the movement of victims into the Treatment Area with the Litter Bearers, if transport units are available priority victims should be moved directly into units for transport.
- ☐ Consider obtaining a Documentation Aide to assist with paperwork.
- ☐ Request additional medical supplies as necessary from the MEDICAL SUPPLY Coordinator.
- ☐ Ensure personnel perform a Secondary Triage and tag victims with a triage tag. Personnel will then remove the colored ribbon.
- ☐ If the incident size warrants it, designate a "Treatment Team Manager" for each color category. (RED, YELLOW, GREEN). Request Medical Examiner if deceased victims are in the Treatment Area.
- ☐ Advise TRANSPORT of victim(s) requiring immediate transportation.
- ☐ Account for all victims triaged and treated on the Treatment Log.
- ☐ Advise COMMAND/MEDICAL as to any changes in the victim count.
- ☐ If the incident is due to a known or suspected WMD with contaminated victims, refer to WMD FOG #8.
- ☐ If known or suspected ASHE utilize FOG #9.

TREATMENT

MCI PROCEDURE **LOG #4A**

TREATMENT LOG

DATE:_____ PAGE_____OF_____

INCIDENT / LOCATION: _____

Ribbon Color	Triage Tag Number	Triage Tag Color	Age/Sex	Victim Name or description if unable to get name

Two-sided

TREATMENT LOG

TRANSPORT

- ☐ Don the appropriate vest and use the radio designation "TRANSPORT".
- ☐ Obtain a Medical Communication Coordinator to maintain continuous communication with Medical Control and document the hospital information on the Hospital Capability Worksheet.
- ☐ Obtain a Documentation Aide(s) to record the triage tag numbers, victim name, age/sex, transporting unit and hospital destination for each victim on the Hospital Transport Log. Keep a portion of the triage tag.
- ☐ Assign personnel to go to the hospital(s) to become Hospital Liaison(s) to assist with communication.
- ☐ Establish an Ambulance Loading Area accessible to the Treatment Area/Casualty Collection Point (CCP) and having clear entry and exit points.
- ☐ Consult with TREATMENT on the number and priority of victims.
- ☐ Coordinate the loading of victims by priority to transport units and helicopters. If Trauma Centers are not overwhelmed victims that meet Trauma Alert criteria should be transported to a Trauma Center.
- ☐ Assign 2-3 victims to each unit, ensuring adequate transport crew. The severity of victims should be mixed if multiple victims are assigned to a unit.
- ☐ Advise the transport unit of the hospital destination; provide verbal and/or written travel instructions.
- ☐ Request additional transport units from STAGING.
- ☐ If the incident is due to a known or suspected WMD with contaminated victims, refer to WMD FOG #8. Work with the Medical Intelligence Officer to assist with decontamination, antidotes and treatments of victims.
- ☐ If known or suspected ASHE utilize FOG #9.

TRANSPORT

MEDICAL COMMUNICATION

- ☐ Don the appropriate vest and use the radio designation "COMMUNICATION".
- ☐ Establish early contact with Medical Control or utilize electronic patient tracking software.
- ☐ Advise Medical Control of overall situation (e.g. smoke inhalation, trauma, burns, HAZMAT exposure, etc.) number and priority of victims.
- ☐ Medical Control will gather hospital capabilities and capacities. Document this information on the Hospital Capability Worksheet.
- ☐ Communicate with the Hospital Liaison(s) to assist with communication.
- ☐ When units are prepared for transport, advise Medical Control and supply them with the following information:
  a) The unit transporting.
  b) The number of victims to be transported.
  c) Their priority; RED = Immediate
     YELLOW = Delayed
     GREEN = Ambulatory (minor)
  d) Any special need victims, cardiac, burn, trauma, etc.
- ☐ Ground transported victims should be assigned to hospitals on a rotating basis.
- ☐ Notify the hospital(s) of HAZMAT/WMD exposure and any antidotes given.

MEDICAL COMMUNICATION

MCI PROCEDURE **LOG #5B**

HOSPITAL TRANSPORT LOG

DATE:_____ PAGE_____OF_____

INCIDENT / LOCATION: _____

Triage Tag Number	Triage Tag Color	Transport Unit	Receiving Facility	Age/ Sex	Victim Name or description if unable to get name

Two-sided

HOSPITAL TRANSPORT LOG

MCI PROCEDURE **LOG #5C**

HOSPITAL CAPABILITY WORKSHEET

Initial Victims: Trauma Alerts: _____ REDS:_____YELLOWS: _____ GREENS: _____

MCI CATEGORY:_____ MCI LEVEL:_____ INCDENT # _____

Hospital	Accepting Trauma Alerts	Trauma Alerts Transported	Accepting REDS	REDS Transported	Accepting YELLOWS	YELLOWS Transported	Accepting Greens	GREENS Transported

USE HASH MARKS TO TRACK VICTIMS TRANSPORTED
Level 1 (5-10 victims) Level 2 (11-20 victims) Level 3 (21-100 victims) Level 4 (over 100 victims) Level 5 (over 1000 victims)

MEDICAL SUPPLY

- ☐ Don the appropriate vest and use the radio designation "SUPPLY".
- ☐ Assure necessary equipment is available on the transporting vehicle.
- ☐ Consult with TREATMENT on the need for medical supplies in the Treatment Area.
- ☐ Provide an inventory of medical supplies at the Staging Area.
- ☐ Request State and/or regional MCI supply trailer(s)

MEDICAL SUPPLY

STAGING

- ☐ Don the appropriate vest and use radio designation "STAGING".
- ☐ Maintain Staging Area established by COMMAND or establish a location and notify the communication center to direct all incoming units.
- ☐ Establish a visible location in the Staging Area.
- ☐ Maintain a Unit Staging Log
- ☐ Ensure that personnel stay with their vehicle unless otherwise directed.
- ☐ Organize arriving units, keeping like units together. If personnel leave their vehicle, keep the keys with each vehicle.
- ☐ Have arriving units put 'BLS' or 'ALS' on their front windshield using a marker, sign or tape.
- ☐ Coordinate with TRANSPORT the need for units and direct units to the victim loading area.
- ☐ Maintain a reserve of at least 2 transport units. Should this go down, advise COMMAND.

STAGING

MCI PROCEDURE **LOG #7A**

UNIT STAGING LOG

DATE:_____ PAGE_____OF_____

INCIDENT / LOCATION: _____

Unit Number	Officer in Charge	Type Unit ALS/BLS/Other	Time Arrived	Time Assigned

Two-sided

UNIT STAGING LOG

MCI – Contaminated Victims/WMD Event

Enroute

- ☐ Request additional resources. Examples are - HAZMAT, TRT, decon trailer, State or regional MCI/WMD trailers
- ☐ Use the DOT Emergency Response Guidebook (ERG) recommendations; Use the Florida Incident Field Operations Guide (FOG) book, and/or Emergency Response to Terrorism Job Aid.
- ☐ Respond in a combined approach of EMS/Fire-Rescue, LE, and a HAZMAT Task Force.
- ☐ Approach cautiously; from uphill/upwind if possible. Establish a safe staging area early. Do not use radios/cell phones in close proximity to suspicious devices (within 500ft).
- ☐ Stop/Park a safe distance from an identified hazard or area that could endanger personnel or equipment. Use binoculars, look for unusual sights, sounds and be prepared to relocate if odor/cloud/casualties are noted. Consider the victim's reported signs, symptoms, and mechanism.
- ☐ Consider secondary devices and request LE to sweep the area for a secondary device.

On-Scene

- ☐ Establish Command. Be prepared to establish a Unified Command with all agencies having jurisdiction and assess the security of the command post.
- ☐ Initiate an on-scene size up and hazard risk assessment, continually size up the incident, evaluate hazards and risks, verify a 360 has been completed of the scene.
- ☐ Establish an incident perimeter - Secure the scene, deny entry. Establish control zones (Hot, Warm, Cold) with the assistance of HAZMAT. Request LE to assist with the safety perimeter.
- ☐ Direct victims using bullhorns/PA systems to gross decon area. Use large volumes of water at low pressure (elevated master streams, hose lines, showers, sprinkler system, etc.). Be aware of the run-off.
- ☐ Ensure personnel wear proper PPE (consult with HAZMAT/Poison Control Center as needed)
- ☐ If needed use a HAZMAT/WMD antidote kit if available, write this information on the Disaster Management System (DMS) All Risk Triage tag.
- ☐ For contaminated victims -use the DMS All Risk Triage tag to identify contaminated victims, direct the victims to remove all clothing and place them in bags, use ID strip from DMS All Risk Triage tags to label, and request law enforcement to secure. Notify LE if any potential evidence is found.
- ☐ Notify hospitals/Medical Control of HAZMAT hazard, antidotes given, and degree of decontamination completed; Transport decontaminated victims only, Ensure the pink contamination strip from the DMS tag has been removed after the victim has been decontaminated (gross decon as a minimum).

Emergency Evacuation Procedure – The term "Emergency Traffic" shall be used to clear radio traffic. The communication center will sound a radio alert tone followed by clear text identifying the type of emergency. If an evacuation is warranted the IC shall designate a specific vehicle(s) to sound the evacuation signal. The signal will consist of repeated short blasts of the air horn for approximately 1 second, followed by 1 second of silence this will be done for 30 seconds. Following this the IC should conduct a Personal Accountability Report (PAR)

MCI – Contaminated Victims/WMD Event

MCI – Active Shooter/Hostile Event Incident

Enroute

- ☐ Have the Communication Center gather as much information as possible, victim location, number of victims.
- ☐ If an unknown number of victims, initiate a Level 2 MCI response and provide staging location (upgrade or downgrade as more information is obtained).
- ☐ Request additional resources. Examples, MCI trailers, command bus, TRT, HazMat, rehab trailer
- ☐ Use the FOG book, Emergency Response Guidebook and/or Emergency Response to Terrorism Job Aid.
- ☐ Approach the area cautiously. Establish a safe staging area early.
- ☐ Stop/Park a safe distance from an identified hazard or area that could endanger personnel or equipment. Consider the victim's reported signs, symptoms, and mechanism.

On-Scene

- ☐ Establish Command, establish/join a Unified Command with all AHJs and assess the security of the command post.
- ☐ Initiate an on-scene size up and hazard risk assessment, continually size up the incident, evaluate hazards and risks. Once the scene is safe to enter verify a 360 has been completed of the scene.
- ☐ ASHE considerations- Integrated LE/FD response should include the critical actions contained in the acronym THREAT - **T**hreat suppression, **H**emorrhage control, **R**apid **E**xtrication to safety, **A**ssessment by medical providers, **T**ransport to definitive care.
- ☐ Direct victims using bullhorns/PA systems to a safe area.
- ☐ Working with LE establish a Rescue Task Force (RTF) (Rescue and LE personnel together to make entry into the Warm Zone to triage victims and provide lifesaving immediate treatment as needed e.g., stopping hemorrhage). If an RTF is formed designate a Triage Aide to communicate with the RTF
- ☐ If more than one RTF is formed, designate them as RTF 1, RTF 2 etc.
- ☐ If in a building the RTF should mark the doors with the victim count using a grease pencil R#, Y#, G#, B# (Greens should have left the area but may stay to assist with care or supervision (e.g., teacher).
- ☐ Establish an incident perimeter - Request LE to establish safety parameter and establish control zones (Hot, Warm, Cold). Zones in relation to ASHE/MCIs:
  - Hot Zone – Direct Threat Care/Care Under Fire - This zone shall be designated at the area of the structure that has not been cleared by LE or the area that the perpetrator is currently in.
  - Warm Zone – Indirect Threat Care/Tactical Field Care - This zone shall be designated at any area of the ASHE that has been declared available for entry by Fire Rescue/EMS personnel with armed LE coverage to perform immediate lifesaving treatment and triage to victims prior to their removal from the initial hazard.
  - Cold Zone – Evacuation Care/Tactical Evacuation Care - This zone extends beyond the Warm Zone and is not in range by the perpetrator. This zone shall encompass positions such as the Command Post, Staging and other functional groups.

In an on-going incident, consider notifying the County Warning Point. They will notify the Emergency Management Agency who can request regional, state, and Federal resources.

Recovery Branch – Immediate Reunification/Notification Center

- ☐ Don the appropriate vest and use radio designation RECOVERY
- ☐ Report to the area established by COMMAND
- ☐ Responsible for the Incident Assistance Center (Victim Services Group) and Notification Center (NC)/Reunification, assisting family members/loved ones in reunification and death notification in separate areas with different access points.
- ☐ Identify a location that provides the appropriate level of safety and support for families & loved ones in the immediate aftermath of the event. Examples of locations hotels, churches, schools, contact private facilities directly to request assistance including (etc.) The NC may be at the incident location or away from the incident location depending on the nature of the incident and other operational needs. It is preferable to locate the NC a sufficient distance from the incident, so not to interfere with the ongoing incident and/or the post-incident investigation and crime scene processing. Depending on the scope of the incident, you may need multiple centers.
- ☐ The NC must be secured by LE and at no time will the media be allowed in the NC, to potentially include the parking lot, without express approval from Command.
- ☐ Immediate NC goals shall include, but not limited to,
  - Meet short-term reunification needs of those directly impacted by the incident. Provide swift transfer or reunification of survivors to family members, loved ones, guardian, or appropriate agency.
  - If the incident occurred at a school, request trained school personnel to provide staff and assist with check-in and releasing uninjured people from the center.
  - Ensure that no minors are permitted to leave unless accompanied by a parent/guardian. Keep unaccompanied minors and separated children safe.
  - Provide water, emergency medication, and food for people in the NC.
  - All personnel entering the NC shall have their identification recorded.
  - Victim Identification - Identify and verify victims and their family members, in coordination with the Medical Examiner or Coroner. Next of kin notifications may take place at the NC in a separate area. This will be the responsibility of LE/Medical Examiner.
  - Identify victims with injuries not requiring immediate medical attention and victims who were exposed to but not injured during the traumatic incident.
  - Manage information about missing persons.
  - Notification - Assemble and deploy the team (law enforcement officials, victim advocates, mental health professionals, crisis counselors, and faith or spiritual leaders), whose members are trained in notification, to provide information to family members/loved ones on fatalities, injuries, missing persons, and release and disposition of personal effects.

This FOG is for immediate needs and not meant to be all encompassing. Follow the facility/agencies recovery and reunification plan

Recovery Branch – Immediate Reunification/Notification Center