Guidance to First Responders for the
Active Assailant Incident

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A MESSAGE FROM GOVERNOR MARTIN O'MALLEY

Dear Friends:

We know that it is essential to ensure the safety of the public as well as to protect the first responders who serve them. Tragically, our nation has learned that mass violence can strike suddenly and unexpectedly, including close to home here in Maryland. An attempted act of mass violence requires that law enforcement officers, emergency medical services providers, fire fighters, and rescue personnel respond together rapidly and as a well-orchestrated team, not only to subdue the assailant, but also to provide immediate life sustaining treatment to the injured and to ensure that first responders themselves are protected while rendering aid to the public.

In October of 2013, I directed the Maryland State Police and Maryland Institute for Emergency Medical Services Systems to convene the Maryland Active Assailant Incident Response Workgroup. The Workgroup was comprised of federal, state and local partners from across the State and charged with developing practical, experience-based advice and guidance for Maryland's counties and cities as they work to better prepare for the potential of an active assailant event. The Maryland Active Assailant Incident Guidance is the product of the hard work of the many individuals and entities that worked together over many months to address this need. The guidelines are voluntary and are living document, but I am confident will help our State, local and county governments put in place plans to ensure our responders have the training, equipment and protocols to quickly and more effectively subdue the threat, treat the injured, and protect themselves.

On behalf of all Marylanders, I am grateful for the work of all who contributed to the Maryland Active Assailant Incident Guidance. Their efforts are another example of how we are One Maryland – prepared and secure.

Sincerely,

Governor

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Maryland Guidance to Local Responders for the Resolution of the Active Assailant Incident

Purpose and Scope

Active assailant incidents present unusual circumstances that require law enforcement officers (LEOs) and emergency medical services (EMS)/fire/rescue personnel to respond simultaneously to subdue the assailant and provide immediate treatment to those injured. All personnel will be thrust into situations in which they do not normally operate. Law enforcement patrol officers will be placed into tactical situations and may need to provide initial lifesaving care for victims while EMS/fire/rescue personnel may need to enter areas that have not been completely cleared of the assailant.

The goal of this document is to provide guidance and share best practices to local officials on planning, training, equipping (including personal protective equipment (PPE)), as well as the stages of response and recovery. It includes recommendations on all the phases of response. We have attempted to make the guidance herein scalable to allow some variation in local plans and standard operating procedures (SOPs), but still provide some consistency across jurisdictional lines. If local officials already have operational plans, this is not intended to override or limit those plans. It is recommended that those local plans be reviewed to ensure that they incorporate at a minimum the tenets discussed here. The protocols and operations of tactical entry teams or Tactical EMS are not addressed in this document as their availability may be limited and response to such an unplanned operation may be delayed.

This document and associated appendices serve to guide in planning and making preparations and help identify gaps and direct future funding to bridge those gaps. *The Maryland Medical Protocols for EMS Providers* was reviewed to ensure adequate guidance and establish variation when dealing with active assailant incidents. Appendix I contains the new Multiple Casualty Incident/Unusual Event protocol and a proposed Potentially Volatile Environments with Life Sustaining Interventions (PVE/LSI) protocol that will be submitted to the Maryland Protocol Review Committee for approval during the FY 2015 review process.

Community involvement is integral in planning, mitigation, response, and recovery, but this document is specifically directed to the first responders. Community participation will be addressed in a later document.

General Premise of Response

Immediate intervention is imperative. LEOs must make an immediate entry to subdue or isolate the assailant(s) rather than waiting for specialty tactical teams. Should EMS/fire/rescue arrive first, they should stage at a safe location at an appropriate distance and out of line of sight from the affected facility until law enforcement (LE) arrives. They should establish an external treatment area, care for injured that do make it to the secure area, congregate the uninjured, inform LE of the status, and anticipate making entry behind LE to begin care as soon as LE can provide adequate security.

When an initial entry is made, first responders should establish incident command between command personnel from LE and EMS/fire/rescue. Early, ***face-to-face*** interaction between initial commanders is paramount. As upper level command personnel arrive, a more formal Unified Command (UC) structure can be established.

Care for the injured must begin as "security and care teams" enter the area. This means that LE personnel may need to initiate basic critical lifesaving interventions (e.g., hemorrhage control). Both injured and ambulatory victims must be removed rapidly through a Warm Zone evacuation route.

All of these actions must be completed, but do not take priority over the safety and security of the personnel responding. The assurance of safety and security is based on assessment of locally-available resources and establishment of specific operational plans, adequate equipment and PPE, proper training, and frequent exercises.

Planning

To implement the strategies outlined in this document, jurisdictions must initiate a multi-agency planning process in which local policies, protocols, and response procedures are established. The process used to develop these local procedures is by far more important than the plan itself. It is during this process that local response agencies develop relationships with the agencies that will be involved in the response.

Stakeholders

The multi-agency planning committee must be comprised of all relevant response partners. While the specific agencies involved in the planning effort will vary by jurisdiction, at a minimum the following agencies should be included in a core planning team:

- Local, State, and Federal LE agencies
- Jurisdictional and County EMS agencies
- Local fire/rescue agencies
- Local and State emergency management agencies
- Local 9-1-1/PSAP/Dispatch/Communication agencies

In addition an expanded planning team consisting of other agencies and key local decision makers should be established. The role of an expanded planning team is to provide additional input and perspective into the policy. These members should have a role in an active assailant incident and may also include jurisdictional elected officials with legal power to make decisions during an incident. Suggested participants include:

- Neighboring jurisdictions providing mutual aid services
- Local or County elected officials
- Local school officials
- Private industry representatives from major public venues to include locations such as, but not limited to, shopping malls, stadiums, entertainment venues, private infrastructure

Plan Development

The outcome of the planning process, the plan or policy, should be delivered in a format that can be easily referenced during an incident. Rather than creating a document with long, grandiose statements, the plan should be brief yet effective. The plan should consist of a series of bulleted points within the concept of operations and should assign each response action to a particular agency or entity. Sample plan checklists, resources, and formats are included in Appendices II and III to this guidance document.

The plan should address all anticipated operations from dispatch through recovery. Issues such as responsibilities of first arriving units, tactical entry and response, threat identification and neutralization, rescue operations, family reunification, and recovery operations should be addressed. The plan should not only address what actions need to be taken, but also assign discipline-specific responsibility for each task. Additionally the plan should develop a system for incorporating agency liaisons into the command structure during response operations.

While plan development is occurring, the need for specialized annexes that provide more detail on specific topics may emerge. For instance, communications procedures should be mentioned in the core document, but there may need to be an annex that includes specific devices, talk groups, or even a NIMS form 205. Other specialized topics that may need to be addressed include family reunification and public information. Planners may also consider producing position-specific job aids for responders and incident command personnel. An example job action sheet is included in Appendix IV.

It is also important to note that the plan should be realistic and developed based on the resources available within the jurisdiction. The plan should reflect current conditions in the jurisdiction and should take critical assumptions into account. As jurisdictional conditions change, such as an increase or decrease of available resources, the plan should be revisited and updated if necessary. At a minimum the plan should be reviewed annually and updated as appropriate. Planners should also track the progress made toward the jurisdiction's capability to fulfill the tasks outlined in the plan.

It is imperative that the plan integrate with the existing policies and protocols of the jurisdiction, i.e., it should not conflict with established protocols or norms in the jurisdiction. All policy conflicts must be resolved before the active assailant operational plans are implemented in the jurisdiction.

In addition to producing a plan, the planning process is the time in which agencies should consider developing mutual aid agreements, memorandums of understanding, and other agreements for resource collaboration during an active assailant incident. Issues such as liability, equipment replacement, and agency responsibility should be clearly defined in the agreements. These agreements should be vetted through appropriate channels and should be signed by all agencies part of the agreement.

Plan Maintenance

The plan is not complete once written. Rather, it is the starting point for a robust training and exercise program in which local partner agencies regularly train on the plan, exercise the plan, and refine the

plan based on outcomes of these activities. The plan should be second nature to stakeholders when an incident occurs, since the time that an incident occurs is far too late to review the contents of the document. For specific recommendations regarding local-based training and exercise, see the *Training* section of this document.

Local agencies should incorporate Active Assailant Response Plans into their local Emergency Operations plans that are submitted to the Maryland Emergency Management Agency (MEMA). This step is important since incidents may draw resources from multiple jurisdictions, thus first responders need to be aware of local response protocols. This coordination will take place among response partners and with the state.

Training

There are multiple packaged training programs available for presentation. They include

- LASER – Law Enforcement Active Shooter Emergency Response (PER-275) is the Louisiana State University model (www.ncbrt.lsu.edu/catalog/performance/laser.aspx)
- ALERRT II – Advanced Law Enforcement Rapid Response Training (ALERRT) is the Texas State University model (www.alerrt.org)
- Tactical Emergency Casualty Care (TECC) (www.c-tecc.org)
- GTI SWAT and Active Shooter Training (www.gtitraining.org) (includes STORM)

It may be impractical to require that all responders attend one or more of these programs due to scheduling and expense. If they are made available locally, they should be adapted to be consistent with local SOPs or incorporate a module in local SOPs. Although there are many commercially available programs and independent instructors available on the market, the aforementioned programs are those that are consistent with the guidance in this document and supported by the workgroup. Many independent programs may not have been thoroughly reviewed or vetted through subject matter experts.

In addition to the focused training listed above, there are several training programs that each responder should complete based on his or her role in order to be prepared for the response. Some of the roles include:

- Law enforcement patrol level officer
- EMS care provider
- Fire/rescue responders
- EMS/fire/rescue command staff
- Law enforcement command staff
- Rescue Task Force EMS member
- Rescue Task Force LE member
- PSAP 9-1-1 call takers and dispatchers
- Emergency Manager and other emergency response personnel that may respond to an active assailant incident

In order to assist in assignment of the appropriate training requirements for individual personnel, the following four levels of training are recommended.

- Awareness – ***ALL*** personnel who have response capabilities to active assailant incidents (EMS, fire, LE, PSAP 9-1-1 call takers and dispatchers, etc.) should have base-line knowledge. This will

include an understanding of what an active assailant incident is, terminology associated with this type of incident (e.g., casualty collection points, evacuation corridors, incident management system, secondary devices), types of potential injuries and treatments, and the importance of expeditious patient removal. An online awareness level training program is being developed for statewide use.

- Base Level Operations – Participation in this level of training is dependent on established local jurisdictional response plans. This training is directed to personnel identified within the local plans and should include the following topics:
    - Phases of response as identified in local SOPs
    - Predetermined duties and responsibilities—including Job Action Sheets
    - A method for determining incident priorities
    - Incident management system and the importance of face-to-face communications, when possible, and the necessity of interagency communications at the operational level
    - Inter- and intra-agency communications
    - The importance of regular local exercises to reinforce all of the above
    - The program may include ALERRT II or equivalent for Law Enforcement and TECC or equivalent for the EMS Providers
- Rescue Teams or Rescue Task Forces – Jurisdictions providing this level of response should only do so if the jurisdiction can ensure all LEOs and primary EMS providers are properly trained and regularly participate in exercises in this type of operation. The critical nature of this type of activity requires a great deal of forethought, planning, and exercise before it becomes operational. Minimum training for this level should include the ALERRT II or equivalent for both LEOs and EMS Providers. TECC or equivalent is suggested for the EMS providers.
  Specialized – Special Weapons and Tactics (SWAT) teams and Integrated Tactical Medics. This is a highly specialized operation and it is absolutely critical to thoroughly and regularly plan, train, and exercise all personnel involved.

There should be adequate exercises that ensure all personnel participate in some manner. They do not need to be extravagant, but instead can be smaller, combined battalion/precinct drills that can easily be repeated for multiple shifts. All exercises should be planned, conducted, and evaluated according to Department of Homeland Security Exercise Evaluation Program (HSEEP) guidance. Any exercises involving weapons must meet standards to ensure all weapons are deemed safe and a security perimeter is established.

It is imperative that both training and exercises be conducted jointly with LE and EMS regularly. Every effort should be made to conduct realistic scenario-based training that mimics and induces stressors unique to actual active assailant situations in order to adequately prepare responders to function in this dynamic environment.

Response Stages

The following are guidelines assembled from several reference documents and after action reports from recent incidents. As described in the Planning section, each jurisdiction should establish its local SOPs to address their combined response to an active assailant.

Call Intake

It is strongly recommended that each Public Safety Answering Point (PSAP) in Maryland refer to its specific agency-approved dispatch protocol to include the most current version and associated training programs about active assailants. This information is critical to a successful

response by all agencies. The initial call to 9-1-1 provides an opportunity to assess the area of greatest threat and can help the initial responders ensure situational awareness and make critical decisions based on intelligence gathered. The information gathered by the call taker should refer to the agency-approved dispatch protocol and his or her specific training. Once the caller has provided enough information about the situation and assailants, the dispatcher should have the latitude to change cards from a LE card set to a medical card set to assist the caller or any injured person(s) near the caller.

Dispatch and Communication
Dispatch of EMS/fire/rescue and LE should be simultaneous and tactical frequencies/talk groups should be established immediately. Communications should not be delayed while information gathering is taking place. There should be one talk-group assigned to EMS/fire/rescue and one assigned to LE operations for primary response; additional channels may be needed later. While initial units are responding, it is imperative to have dispatchers push the latest intelligence to all responding agencies so that all units, EMS/fire/rescue and LE, will have good situational awareness of the event.

Once command declares an active assailant incident, the dispatcher should announce to all responding units that this is now a declared "Active Assailant." This announcement will trigger Life Sustaining Interventions (LSI) and Multiple Casualty/Unusual Event (MCI) protocols for EMS providers (see Appendix I). The LSI Protocol allows EMS providers to prioritize their care of patients while in an area of hazard. The MCI protocol ensures that hospitals and other support services are notified.

Until commanders can arrive on the scene and establish face-to-face contact, dispatchers must be vigilant in exchanging the information among all allied agencies to ensure a coordinated response. Incident pre-plans (if available) could assist responders in identifying staging areas, zone perimeters, and potential points of entry. Once command personnel arrive on the scene and establish face-to-face contact, they should announce that UC is established on both talk groups and reconfirm designated areas of operation. The primary responsibility for interdisciplinary coordination would then shift from the dispatchers to the on-scene command.

All communication in Hot and Warm Zones should be done using tactical communications devices to limit the possibility of exposing protective positions. As per the MCI/Unusual Event protocol, the Emergency Medical Resource Center (EMRC) should be advised of the incident so they may begin notification of hospitals, MEMA, and other response resources.

It is also recommended that each PSAP have or develop an "Active Assailant Checklist" for the dispatcher to ensure he or she has the necessary resources for a rapidly evolving incident. This checklist is completely jurisdictional-dependent, based on available assets (see Appendix IV for an example).

Establish Command Structure
Early initiation of UC is paramount. Face-to-face communication between the initial operations-level commanders will ensure both are aware of the other's operations. As upper level commanders arrive on the scene, a more formal UC can be established. This does not negate the need for the respective Operations Chiefs to remain together for coordination and unified supervision at the Operations Section Chief and tactical levels, especially if mixed asset teams

are being deployed. Once the formal UC Post (UCP) has been established, they can then begin to solidify staging areas, establish areas to debrief and shelter unharmed occupants, liaison with other responding agencies, perform crisis communication, and begin other planning, logistic, and administrative tasks required to manage what could easily become a protracted incident. Staging Area Managers and Liaison Officers should be appointed early and incoming units/agencies should be directed to report to those locations.

Each incident is a primary LE event but requires coordination between the LEO on-scene-lead and the EMS/fire/rescue on-scene-lead. UC provides the proper vehicle for command and control of active assailant incidents/MCIs; therefore, responders should establish UC and a UCP as soon as possible. Fire and EMS command elements should recognize that the LE on-scene-lead will be actively sending LE officers into the impacted area to directly engage the threat, secure the perimeter to ensure the perpetrator doesn't evade, and to exclude entry by any unauthorized person(s). Additionally, from almost the moment of arrival on-scene, the LE lead will be determining LE resource requirements, developing intelligence on the incident(s), identifying the location and viability of the victim(s), and many other tasks. Thus, the fire and EMS commands should move to the LE Command Post (CP) and establish UC as planned.[1] By maintaining awareness of LE activities, EMS/fire/rescue commanders can begin to prepare for entry to rescue the injured.

Scene Security and Awareness

All responding personnel must be vigilant to protect the security of the scene. Assailants may target first responders with secondary devices in staging areas and entrance areas. As other tasks are being performed, responders must continually scan the environment to be alert for suspicious unattended packages, improvised explosive devices (IEDs), hazardous material threats, individuals acting extremely nervous or having an unusual response to the incident, and individuals with unusually bulky clothing or bulging pockets. A Safety Officer must be assigned for both LE and EMS/fire/rescue operations. Periodic safety messages should be broadcasted over all talk groups to remind responders of potential threats.

While on scene, non-uniformed LE and EMS personnel MUST wear locally-approved high visibility arm bands or traffic safety vests that clearly identify them as LE or EMS personnel to facilitate easy recognition and reduce the risk of "blue on blue" or "friendly fire" encounters.

Zones of Operations

The scene of an active assailant incident should be divided into several operational "zones." These zones and the actions that should occur in each are described below.

> A) Perimeter Operations**:** Fire/rescue and LE will coordinate to establish an inner and outer perimeter as soon as practical. Consideration should be given to search/check for secondary threats and/or devices within the perimeter. Identified concerns should be reported to incident command for investigation and remediation.

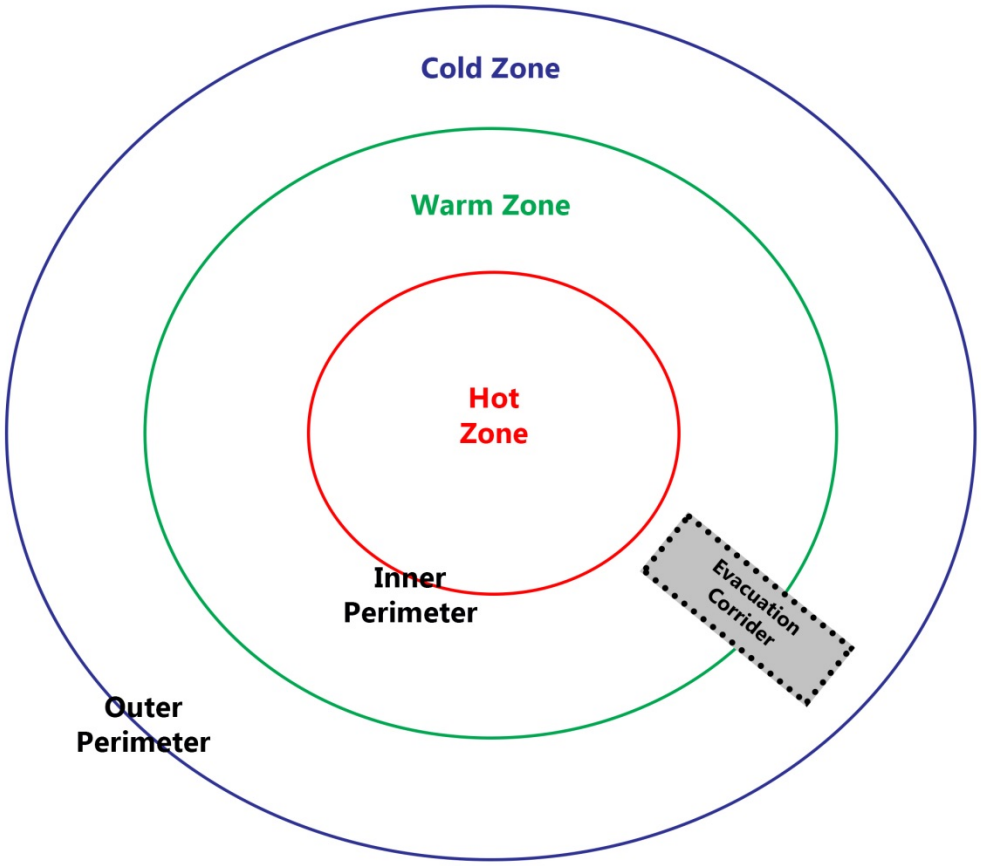
[1] US Fire Administration 2013

B) Zone Operations**:** Fire/rescue and LE will coordinate to establish **Cold**, **Warm**, and **Hot Zones**.

Cold Zone (Safe Zone): Any area surrounding the Warm Zone where first responders can operate without concern of danger or threat to personal safety or health.

Warm Zone (Indirect Threat): Any operational area with a potential threat to personal safety or health. The Warm Zone typically exists between the Hot and Cold Zones.

Hot Zone (Direct Threat): Any operational area with a direct and immediate threat to personal safety or health.[2]



[2] Metropolitan Washington Council of Governments 2011

HOT Zone Operations

Initial LE Entry

As per local SOPs, initial LEOs should enter the Hot Zone and begin to pursue and neutralize the assailant. That team should not stop to care for the injured and should instruct non-threatening occupants to shelter in place or evacuate, if safe to do so.

WARM Zone Operations

In this Zone the primary objectives are to further stabilize and secure each area initially cleared by law enforcement and to begin to care for the victims. As local officials draft their operational plan they should decide upon a method to accomplish these objectives. Following are two models that help to ensure providers remain safe and the injured receive the immediate lifesaving interventions they require to survive. One of these or another method should be outlined in the local operational plan.

Security and Care Team Entry

A security and care team of primarily LEOs should make entry to the Hot Zone with the intention of creating and extending the cleared Warm Zone. As they make entry, they may perform immediate care of the injured and direct any uninjured to a safe evacuation corridor once it is established. They should then begin to identify a safe location that can be secured for collection of casualties. Warm Zone victims should be evacuated through a safe corridor to the Cold Zone as soon as possible. Only if evacuation cannot occur due to safety issues should a Warm Zone casualty collection point be established using the best concealment and protection available.

Rescue Task Force

Some jurisdictions may elect to establish an interdisciplinary Rescue Task Force (RTF), which is comprised of at least two armed LEOs and two EMS providers. The LEOs assigned to the RTF remain vigilant of the potential threats and supply cover/protection as EMS providers deliver immediate care. It is not recommended that RTFs be incorporated into operations unless the given jurisdiction can ensure that all LEOs and primary EMS providers can be properly trained and the operations can be regularly exercised. All personnel should also have direct access to ballistic protection if they operate in this configuration.

Casualty Collection Point

A casualty collection point (CCP) is an area outside the Hot Zone that can be protected by LE and where immediate life-sustaining care can be delivered by EMS providers. Multiple CCPs may be required in both Warm and Cold Zones.

i) Considerations for the selection of the CCP should include, to the extent possible:
   a. A position of cover
   b. Concealed vehicular ingress and egress
   c. Adjacent to an exterior wall to aid in victim removal
   d. Proximity to the majority of injured
   e. Other factors as defined by the medical threat assessment

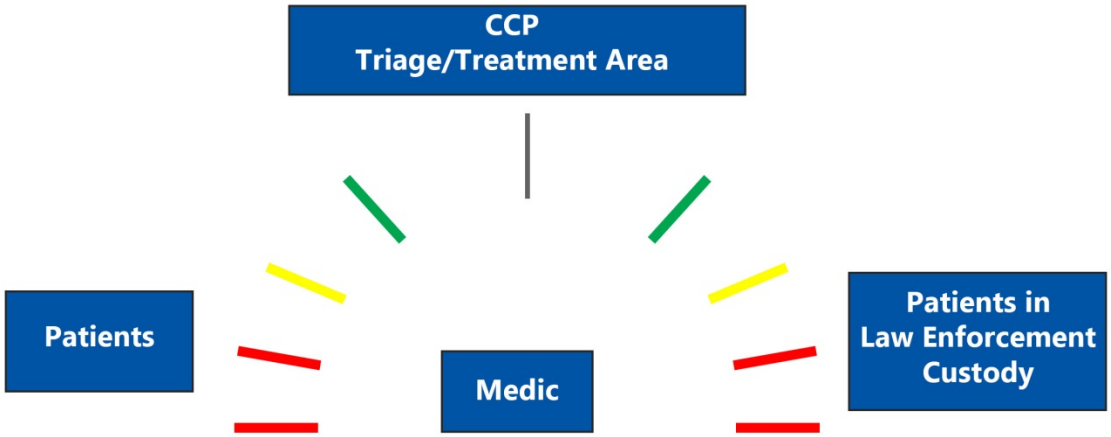
ii) Operations of CCP(s)
   a. Area is to be protected by LE and swept for threats before accepting injured.
   b. There should be a continuous and dedicated LE presence.
   c. Appropriately trained local EMS providers will staff the area.

d. An experienced EMS provider is required in this area to supervise personnel and ensure care is expedient and patients are extricated at the earliest possible opportunity.[3]

Actual care will be dictated by the LSI protocols in the CCP. The intent is to maintain patients until a safe corridor for evacuation can be identified and adequate personnel can be assigned to move the victims. Triaging and tagging of patients per protocol should be done as patients arrive in this area.

All patients brought to the CCP must be checked for weapons or IEDs prior to entry. Efforts should be made to not bring uninjured or deceased persons to the CCP. CCP personnel will provide incident command with regular updates and resource management requirements. Patient tracking will be initiated at the earliest opportunity using paper logs or the state's electronic patient tracking system. The method employed will be communicated to UC.

Patients who are in LE custody and/or who have movements restricted by LE by the use of handcuffs or flexcuffs, for example, should be segregated in the CCP and triage/treatment area (see example below). This practice will require a continuous LE presence whose role is solely the custody of these patients. Consideration should be given to the ratio of patients in custody and LE personnel. Patients in LE custody should receive treatment and transfer prioritized to their condition, in conjunction with all other patients.[4]



[3] Metropolitan Washington Council Of Governments 2011
[4] Ibid.

Evacuation Corridor

Operational elements will direct the selection of the Evacuation Corridor and communicate the selection to UC.

i. Considerations for the selection of the Evacuation Corridor may include:
    a. A route that offers a position of cover or concealment
    b. Able to be traversed with limited hindrance
ii. Operation of Evacuation Corridor
    a. Travel route(s) should be established as soon as possible.
    b. Corridor route should be cleared before use and kept clear for emergency access or egress.
    c. A LE element may accompany/facilitate patient movement.
    d. If required, vehicles to shuttle patients through the evacuation corridor should be positioned as close to CCP as possible.
    e. Corridor operations should be coordinated by UC.[5]

COLD ZONE Operations

Traditional Triage and Treatment Areas

In the Cold Zone EMS/fire/rescue personnel should establish treatment areas as per protocol. Multiple CCPs or triage/treatment areas may be required depending on the size and configuration of the facility involved. Treatment can continue there to complete life/limb sustaining procedures and prepare the patient for transportation to definitive care. As soon as transportation is available, patients should be moved to the Transportation Unit for disposition and transfer.

Transfer to Definitive Care

The Transportation Unit will be responsible for gathering information from EMRC on hospital capacity, determining the destination of patients, and tracking their disposition as per the MCI/Unusual Event protocol (see Appendix I). Regardless of the number of CCPs or triage/treatment areas established, all patients being transported MUST be processed through ONE transport unit to ensure the accountability of patients and the appropriate utilization of the medical facilities available.

Local Emergency Operation Center

In accordance with your local Emergency Operations Plan, Emergency Managers should consider activation of their emergency operations center (EOC) while the initial response is progressing. The EOC will be used to coordinate the support services that may be required in the Cold Zone, assist in the coordination of public messaging, and begin to plan the operational periods beyond that initial response. They must plan to support the community and begin to guide them toward recovery.

Evacuee Holding Areas

A systematic process for evacuating and interviewing uninjured survivors is imperative. The primary goal of incident commanders should be separating uninjured survivors from the threat. Although an expedited evacuation is desirable, it should be done in a methodical manner.

[5] Metropolitan Washington Council of Governments 2011

Survivors who witnessed or have knowledge of the active assailant need to be interviewed by LEOs. Unfortunately, evacuees may include the assailant or an accomplice so the approach to assisting evacuation must be organized. If possible all evacuees should be directed into one of three areas. These areas must be physically separated from one another, be sufficiently far away from the crisis scene, and be out of the view of the incident.

Known Suspect(s) Holding Area: This area is marked/designated as "KNOWN SUSPECTS." In this area suspects should be isolated from one another and be secured (handcuff or restraint), searched, silenced, segregated, and safeguarded. Once safeguarded, the known suspect must be transported away from the scene and debriefed rapidly.

Survivor/Witness Holding Area: In this area marked as "SURVIVORS/WITNESSES," all individuals should be searched and vetted, and then debriefed. Once it is determined they can be released, they may need to be sheltered or require assistance in arranging for transportation home. Emergency Management should arrange to provide victim assistance adjacent to this area.

Unknown Evacuee Holding Area: In this area marked as "UNKNOWN EVACUEES," evacuees should be secured (armed supervision), searched, silenced, segregated, and safeguarded. Initial vetting and determination of the evacuee's status must be conducted and confirmed. Once the evacuee's status has been determined, they will be either transported to the Known Suspects area or the Survivor/Witness area.

Family Reunification

Early into the incident, incident command must establish the location of a reunification facility where family of those evacuated can be directed to gain information about the incident and to learn the status of their loved ones. Emergency Managers should plan to have Mental Health Social Services providers in this area to assist. Once the area is established, the Joint Information Center (JIC) (see the *Public Information* section below) will relay the location of the reunification center to the media.

In addition to a physical location where survivors can be temporarily sheltered, a toll-free number must be activated to assist families with locating loved ones. The number should be pre-established before an incident occurs and should be activated or relayed to the media through the JIC during the incident. Assistance may be available through the Maryland Department of Human Resources (MDHR), which manages the state's family reunification system and has a pre-established number that may be available for use. Local jurisdictions should not rely on this resource, as it may be not available during an incident. EMS must maintain records of the patients transported to the hospital to assist with reunification. The use of the Electronic Patient Tracking System will assist in reunifying loved ones.

Public Information

Active assailant incidents attract intense media interest, which must be actively managed. As early as possible, a JIC should be established. Coordinating public messaging among local, state, and federal response partners is critical in creating a unified message about the incident. The JIC serves as the link between the incident command and the public. Rather than viewing the media as a nuisance, incident commanders, through the JIC, should leverage the media to

communicate to families about locating survivors at the family reunification site, ensure that the public avoids the area, and gather information to aid in the investigation.

Social media has revolutionized the rate and method by which information is shared. Local, state, and federal entities all utilize social media to connect with stakeholders on a regular basis. Thus, the JIC must incorporate both traditional mediums as well as new mediums such as Twitter, Facebook, etc. Social media is a powerful tool that should be leveraged by the JIC to aid in information flow and rumor control. Like establishing an active assailant protocol, a social media program must be developed before an incident occurs.

The JIC should be located adjacent to a media staging area. The media staging area should be in a location that will not impede ingress or egress routes for emergency response personnel, in the Cold Zone, and in a location in which survivors' privacy is protected. Incident commanders should expect and plan for a large convergence of local and national network media at the incident site.

Role of Tactical and Specialty Teams
Specialty or tactical teams (e.g., SWAT, HazMat, or bomb squads) should be specifically requested by UC and should not self-dispatch. Their operations will be directed through the appropriate command structure upon arrival at the scene.

Securing the Scene
After all occupants are safely removed from the facility, LE should complete a final sweep of the area to ensure all threats are removed. Deceased victims should remain in place until investigation is complete unless they would restrict safe evacuation of the other victims. Their initial locations must be marked if they are moved. Once investigation is complete and deceased victims are removed, command must then work with the facility owners and elected officials to safely turn control back to them.

Recovery
Short term recovery should include typical rehab operations, debriefing, and demobilization. Critical Incident Stress Management services should be made available to the responders requesting assistance. Consideration should be given to requesting mutual aid resources to fill in for the primary responders until recovery can be complete. An After Action Conference should be scheduled within a week or two of the event and include all response and support agencies or departments.

Long term recovery will involve more than just the immediate first responders. Local Emergency Managers should cooperate with local elected officials to determine the plan for long term recovery.

Crime-related disasters pose a uniquely high level of stress and psychological hazards to emergency responders. Some factors that make crime-related disasters more traumatic than natural disasters are the unexpected nature of the incident, the malicious intent behind it, and the extreme threat to life often associated with these incidents. As the personnel on the front lines of confronting such threats and disasters, emergency response personnel are especially susceptible to the psychological hazards associated with them. Furthermore, the relative infrequency with which emergency responders encounter these scenarios only further

heightens the stress associated with them. These added stresses and psychological hazards directly influence emergency responders' levels of performance and their long term resilience. By preparing emergency responders psychologically for crime-related disasters, responders' performance and resilience can be significantly enhanced.

Education prior to the incident about what they may experience under severe stress allows them to anticipate normal psychological and physical reactions, prepare them to remain focused on life-saving and/or other damage-mitigating activities, and enable them to better cope with the incident afterward.

Equipment and Personal Protective Equipment

Tactical Emergency Casualty Care/Individual First Aid Kits

All LEOs should be issued and required to wear the kits for all active assailant incidents and planned mass gatherings. All EMS/fire/rescue apparatus should have adequate tactical emergency casualty care (TECC) kits for personnel assigned to that apparatus. Commercial TECC kits are available for purchase. Before purchase, buyers should ensure they contain at least the following:

1. Two (2) commercially available tourniquets
2. Hemostatic dressings
3. Kling or bandaging to retain dressings
4. Nasal/oral airway assortment with lubricant (Optional based on training)
5. Occlusive dressings or chest seals
6. Non-sterile procedure gloves sized to the individual

Casualty Collection Point Equipment

Supplies for CCPs should be packaged separately in a "grab and go" kit. They should not be assembled by gathering multiple bags or packages. The care of patients will be limited to LSIs, so equipment will also be limited. A list of suggested items that may be included in a CCP supply kit appears below. It is recommended these kits be checked monthly and the stock rotated with the daily use stock on EMS units. It is difficult to determine the number of casualties one might be required to treat in a CCP. This list contains enough equipment to treat approximately ten patients. For Warm Zone care, we recommend that the kit contain what appears on the list below in order to provide LSI while reducing unnecessary gear.

This is a *recommended* list. The actual supplies carried by local EMS programs should be consistent with the operational procedures and response model selected by those programs and the certification/licensure levels of the providers available.

- 4 - Commercially available tourniquets
- 4 - Occlusive dressings or chest seals
- 2 - 4 in. pressure dressings
- 2 - 6 in. pressure dressings
- 1 - Oral airway kit
- 1 - Nasal airway kit
- 2 - Supraglottic airways of varying sizes (as per Maryland Medical Protocols)
- 1 - Bag-valve-mask
- 1 - Tactical suction device
- 2 - Surgical Cricothyroidotomy Kits

- 25 - 4X4 gauze pads
- 2 - Large trauma pad dressings
- 4 - Assorted hemostatic impregnated dressings
- 4 - Z-Fold Gauze
- 2 - Rolled formable splints
- 2 - Trauma shears
- 4 - 14g catheters or needle decompression thoracostomy kits
- 4 - 18g IV catheters w/saline locks
- 1 - EZ-IO Needle Kit
- 2 - Macro-drip IV administration kits
- 2 - 500mL bag Lactated Ringer's
- Pain Medication consistent with Maryland Medical Protocols and provider's level of certification/licensure
- 4 - Rolls adhesive tape
- 4 - Sets of triage marking tape containing four colors of tape each (black, red, green, and yellow)
- 2 - Indelible markers
- 4 - Stethoscopes
- 2 - 4 or 6 in. Ace bandages
- 1 - Pack (25) Triage Tags
- 1 - Set (4 colors) Triage Tape

Personal Protective Equipment
Level IIIA ballistic protection should be provided for all LEOs and for those EMS/fire/rescue personnel who are members of RTFs. Although there is not complete agreement in available national guidance, the trend appears to recommend that all personnel operating in areas of direct or indirect threat (Hot and Warm Zones) should be wearing the appropriate ballistic protection. The National Institute of Justice is continuing research on ballistic protection and is considering the added threat of the IED for civilian responders. Until further research is complete, we strongly recommend that the minimum level of protection should be at least level IIIA.

Local multi-agency planning committees should consider the need for adequate protection as they consider how they plan to deploy their personnel and protective equipment in their local SOPs. Caches of ballistic protective gear may be made available for those personnel who are asked to serve in vulnerable situations. Officials should take into consideration sizing and fit, safe storage, and the need for replacement of expired or damaged gear when making determinations on who should be issued gear and how it will be supplied.

Communications
All personnel operating in Hot or Warm Zones should be provided portable radios with the ability to complete discrete communication so they will be aware of the evolving response without broadcasting their location through the radios.

Community Preparedness and Involvement

Although not the focus of this document, it should be mentioned that all members of the community should take responsibility for prevention, preparedness, and mitigation of these incidents. Until additional specific guidance can be provided from the state, local Emergency Managers and elected officials may direct members of their community to the FEMA "Active Shooter – How to Respond" booklet for general guidance (www.dhs.gov/xlibrary/assets/active_shooter_booklet.pdf).

Appendix I
Maryland Medical Protocols for EMS Providers

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27. MULTIPLE CASUALTY INCIDENT/UNUSUAL EVENT (NEW '14)

A Multi-Casualty Incident (MCI) or Unusual Event is any event where the number of injured persons exceeds the normal capabilities of the EMS Operational Program in whose jurisdiction the event takes place. Due to the size of the incident, the responding EMS Operational Program may require additional resources and/or must distribute patients to multiple hospitals.

Local EMS Operational programs should have a plan or operational procedures that address response to multiple patient incidents or unusual events. This protocol does not supersede those plans. There are some general practices and procedures that must be followed to ensure the EMS system can be prepared to respond appropriately to support a local response.

ALERT: THIS PROTOCOL IS SIMPLY A LIST OF REQUIRED TASKS IN THE EVENT OF AN UNUSUAL EVENT. IT IS NOT ALL-INCLUSIVE. ALL PROVIDERS ARE ENCOURAGED TO REVIEW LOCAL EMERGENCY RESPONSE PLANS, THE MARYLAND TRIAGE SYSTEM TRAINING PROGRAM, START/JUMPSTART AND NIMS PRACTICES AND PROCEDURES ON AT LEAST AN ANNUAL BASIS.

Procedure

1. Assess scene and recognize that the incident is an MCI or Unusual Event. The definition of MCI or Unusual Event for the purposes of this protocol is an incident that causes more than 5 patient encounters or which involves unusual circumstances that suggest it could place an extraordinary strain on EMS or healthcare resources. The following events are **examples** of an MCI or Unusual Event.
   a. More than five patients from one or related incidents
   b. Multi-patient events that require specialized rescue
   c. Three or more immediate (Priority 1) patients
   d. Multiple pediatric patients requiring specialty resources
   e. More than one burn patient meeting burn center referral criteria
   f. Use of more than two medevac helicopters
   g. Use of Medical Ambulance Bus (MAB)
   h. Multiple patients with unusual signs and symptoms
   i. Unresolved WMD related activity which could result in multiple patients (Active Shooter, Bomb Threat, Intentional WMD Agent Release, etc.)
   j. Decontamination of more than 5 patients resulting in at least one transport
   k. Unresolved hazardous material incident that has the potential to affect multiple patients
   l. Evacuation of a licensed healthcare facility or housing complex for individuals requiring special assistance

2. Notify EMRC or the Regional EMRC as soon as the incident is recognized to be an MCI or Unusual event. Use the specific terms “MCI” or ”Unusual Event” when communicating with EMRC to be clear this protocol is being enacted. This should be done as early in the incident as possible when there is a strong suspicion that such an event has occurred so that EMRC may begin to notify hospitals and response partners of the incident. Responding units can request their dispatchers notify EMRC before the scene is fully assessed if there is reasonable information to suggest that the incident meets the criteria above. As soon as available, the following information should be relayed to EMRC.
   a. Type and general description of the incident
   b. General location or address of the incident
   c. Age range of patients
   d. Estimated number of patients by priority
   e. Approximate number of patients involved
   f. Any hazardous agents involved

3. Initiate the incident command structure according to local SOPs and/or the National Incident Management System. Update EMRC with more details about the incident as they become available.

4. Consider utilization of the MCI Communications protocol (Section II.G.6)

5. Triage patients using the START/JumpSTART methods (Section II.D.7.e).
   a. Identify the patient’s triage category by utilizing the appropriately colored triage ribbon and securely attach a MIEMSS-approved Triage Tag.

6. Do not delay transport of patients for extensive patient care procedures. Provide only the care required to sustain life and limb during transport to the hospital.

7. Track the care, movement, and disposition of EVERY patient utilizing the locally approved triage/treatment/transport logs and or the State electronic patient tracking system (PTS). Patient information should be written on the triage tag and be entered directly into PTS as it becomes available.

8. Consider the need for and request specialty resources through the local dispatch center and/or emergency management as per local procedures. These may include,
   a. Mass Casualty Support Units (MCSUs) – (Medical Supply Caches)
   b. Medical Ambulance Buses
   c. CHEMPACK (Organophosphate antidotes - contact EMRC)
   d. Ambulance Strike Teams or EMS Taskforces
   e. Shock Trauma Go-Team

9. The Transportation Group Supervisor and Medical Communications Coordinator responsibilities should be assigned as early as possible. They are the critical link to EMRC, hospitals, and the healthcare system. Their duties include
   a. Establish a final checkpoint through which all transport units MUST pass to ensure accountability of all patients.
   b. EMRC will have notified hospitals and acquired their bed availability based on the information originally received and will transmit that information to the scene when requested.
   c. Coordinate through EMRC the patient destination, and communicate the number of patients, general illnesses, ages, and triage category on each transport unit as they leave the scene to the receiving facilities.
   d. If a central point of contact cannot be established, individual transport units MUST communicate the above information individually through EMRC to the receiving hospitals during transport. Those units must announce that they are associated with the MCI or Unusual Event

10. Coordinate with law enforcement and, if requested, assist the Coroner or Medical Examiner with identification and disposition of deceased casualties.

11. After the last patient has been transported, notify 911 dispatch center and EMRC that last patient has been transported. Demobilize scene, stand down or release resources dedicated to incident, and complete appropriate documentation. Cooperate with local officials, EMRC, Hospitals, and Emergency Management to complete a final accounting of the disposition of all the patients.

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Proposed Potentially Volatile Environments with Life-Sustaining Interventions

Background

- A review of past active assailant incidents has shown that the conventional prehospital practice of not entering the scene until it is deemed safe by law enforcement (LE) has been associated with additional loss of life.
- This protocol is designed to be all-hazards in nature. It is meant to provide a clinical concept of operations that empowers trained and equipped, but not necessarily tactical, EMS prehospital providers, to access casualties and expedite life-sustaining interventions closer to the point and time of injury. For active assailant and other LE-related incidents, EMS providers shall be under LE escort. EMS providers shall use appropriate personal protective equipment as defined by local jurisdiction.
    - Examples of such potentially volatile environments include, but are not limited to:
        - Active assailant (active shooter/IED) situations
        - Post-blast detonations
        - Intentional release of a chemical agent
        - Industrial accident/explosion
        - Hazardous materials incident
        - Structural collapse/urban search and rescue situations
        - Transportation mishaps with limited scene access
        - In the immediate aftermath of a natural disaster such as a tornado

Introduction

- This protocol provides guidelines for the type of intervention and care that should be rendered at various proximities to a threat in a potentially volatile environment.
- By definition, potentially volatile environments are dynamic in nature. Scene conditions may change and emergent evacuation of responders and patients may interfere with the delivery of interventions described in this protocol.

Indications

- This protocol does not replace or supersede the general patient care practices in *The Maryland Medical Protocols for EMS Providers*, which are still to be followed once the concern of active threat has been mitigated.
- Use of this protocol is an acknowledgement by the EMS provider that the situation is:
    - Unique, austere, and different than the conventional environment of care in which EMS medicine is usually rendered AND
    - The application of standard prehospital emergency practices could unnecessarily jeopardize the safety of the patient and/or medical provider.
- An active assailant incident or Potentially Volatile Environments with Life-Sustaining Interventions (PVE/LSI) protocol is declared.

Contraindications

- Absent the presence of perceived or actual threat, standard general patient care practices should be followed.

Zones of Care/Operations

- The zones described below are intended to standardize the terminology used by responding emergency medical providers in Maryland and to establish a common understanding of the interventions to be performed within each zone.

- **Hot Zone (Direct Threat):** (Integrated Tactical EMS) Operational area with a direct and immediate threat to personal safety or health
    - The overarching priority in the Hot Zone is mitigation of active threat. Medical care is a secondary function to threat mitigation.
    - Medical providers must be an integrated tactical medic (i.e., TEMS) to operate in this environment. Medical priorities are to prevent casualties and responders from sustaining additional injuries and include prompt evacuation to a more secure zone.
        - If at all possible, casualties should self-evacuate.
        - Goals of care include keeping the response team engaged in neutralizing the threat, minimizing public harm, and controlling life-threatening extremity hemorrhage.
            - Control of severe hemorrhage in the direct threat environment is best accomplished with commercially available tourniquets.
            - Tourniquet should be placed as high up on the limb as possible without taking the time to expose the area.
            - For full or partial amputation, immediately place a tourniquet if possible.
            - Cardiopulmonary resuscitation (CPR) is not indicated in this environment.
        - In circumstances of chemical agent exposure, administration of Nerve Agent Antidote Kits (NAAK/MARK-1) might be warranted if available.

- **Warm Zone (Indirect Threat)**: (Limited LSI) Area with a potential threat to personal safety or health
    - **Evacuation of patients to a completely safe area is the primary objective of care in this area**. **The following care guidance is dependent on the availability of equipment, supplies, and the appropriate level providers. Extrication should NOT be delayed to provide advanced or involved treatment measures.**
        - The Warm Zone typically exists between the Hot Zones and Cold Zones, but is not geographic and depends on the evolving situation.
        - Responders must remain cognizant that scene security can change instantly.
        - A focused and deliberate approach to providing patient care should occur.
        - The potential benefits of providing medical care in these zones must outweigh the risks of the ongoing tactical operation and/or delaying opportunity to evacuate the patient.
        - Care in the Warm Zone typically occurs at or near the point of injury once scene stabilizing measures have occurred. Care may also take place at a casualty collection point (CCP).
        - A CCP is a location concealed and covered from immediate threat where victims can be assembled for movement from areas of risk to the triage/treatment area. Multiple CCPs may be required, which may be located in the Warm or Cold Zone. CCPs should be established and locations communicated as early as possible through operations to ALL responders.
        - If possible, an abbreviated triage system should be set up to identify the priority for the extrication of patients. The use of ribbons or markers to clearly identify

immediate and delayed (red and yellow, respectively) patients is highly recommended. Deceased individuals should also be labeled/tagged appropriately to prevent repeat assessments by multiple providers.

- Medical care in the Warm Zone should be limited to essential interventions only and is guided by the mnemonic "**MARCHED**"
    - M – Massive Hemorrhage Control
        - Massive hemorrhage remains the greatest threat to life in most trauma patients. Attaining hemorrhage control is the top priority.
        - Tourniquets remain the preferred means of hemorrhage control for life-threatening bleeding in this environment.
            - If a tourniquet was applied in the Hot Zone, it should be reassessed.
            - Tourniquets applied over clothing are not as effective and may need to be adjusted.
            - Tourniquets should only be discontinued by an appropriately trained ALS provider in consultation with medical control.
            - Other methods of hemorrhage control include deep wound packing with either sterile gauze or hemostatic impregnated gauze.
            - Vascular injuries in the neck, groin, and axilla (i.e., junctional zones) are not amenable to traditional extremity tourniquets. In addition, effective pressure dressings are often extremely difficult to apply. Hemostatic impregnated dressings with direct pressure (minimum 5 minutes with continuous pressure is preferred) have shown useful in such situations.
    - A – Airway management
        - Patients in the Warm Zones with airway issues are high priority for evacuation due to their often intense resource requirements.
        - Consider applying oxygen if available and indicated.
        - Unconscious casualty without airway obstruction:
            - Chin lift or jaw thrust maneuver
            - Nasopharyngeal airway
            - Place casualty in the recovery position
        - Casualty with airway obstruction or impending airway obstruction:
            - Chin lift or jaw thrust maneuver
            - Nasopharyngeal airway
            - Allow casualty to assume position that best protects the airway, including sitting up or leaning forward
            - Place unconscious casualty in the recovery position
        - If previous measures unsuccessful, if time and resources permit, consider per protocol:

        - Supraglottic Devices (e.g., King LT™, EASYTube® or CombiTube™).
        - Oro/nasotracheal intubation
        - Surgical cricothyroidotomy
- R- Respirations
    - The chest/upper abdomen should be assessed for any evidence of an open chest wound and an occlusive dressing should be applied accordingly.
    - Tension pneumothorax remains a significant cause of preventable death in trauma patients.
        - In suboptimal environments that interfere with complete physical assessment, any patient with significant blunt or penetrating chest trauma who displays dyspnea should be treated as a developing tension pneumothorax and receive needle decompression, if appropriate.
        - To be effective, needle decompression needs to be performed using at least a 3.25 inch, 14g needle/catheter or needle decompression thoracostomy kit.
- C- Circulation
    - In general, healthy adult trauma patients with a radial pulse and normal mentation do not need IV therapy in the Warm Zone.
    - Patients with evidence of hypotension:
        - If the patient displays signs of a closed head injury, IV fluid therapy is indicated to maintain at least a radial pulse or SBP of at least 90 mmHg.
        - Patients in hypovolemic shock should receive a one-time 500 mL bolus of IV fluid.
    - Patients in traumatic cardiac arrest should be considered deceased and no CPR should be performed in this zone.
- H- Hypothermia
    - Hypothermia in trauma patients has been associated with increased mortality. Hypothermia is easier to prevent than treat.
        - Patients should be moved to a warmed location if possible.
        - Efforts should be made to minimize heat loss.
- E – Everything else
    - Consider Mark I/DuoDote for suspected organophosphate/ nerve agent exposure.
    - Dependent upon resource availability, burns, eye injuries, and acute pain should be managed per *The Maryland Medical Protocols for EMS Providers*.

- D- Documentation
    - Key findings and interventions should be conveyed to the next phase of care.

- **Cold Zone:** (Traditional Patient Care Protocols) Area surrounding the Warm Zone. Responders can operate without concern of danger or threat to personal safety or health.
    - Casualties are moved from the Warm Zone to the Cold Zone by way of an evacuation corridor(s).
        - Evacuation Corridor: An area transitioning between the Warm and Cold Zone that is secured from immediate threat and allows for a mitigated risk in transporting victims from the CCP to the triage/treatment area beyond the outer perimeter.
    - Once in the Cold Zone, casualties will require re-triage, particularly assessing for the development of a life-threatening condition and effects of Warm Zone therapy.
        - If massive hemorrhage has not been addressed or has been ineffectively managed, it should be immediately readdressed with strategies mentioned above.
    - Patients should be triaged and transported per standard practices.
    - Medical care in the Cold Zone should be dictated by resource availability and, when possible, equate to the general patient care standards in *The Maryland Medical Protocols for EMS Providers*.
    - CPR may have a larger role during the evacuation phase especially for patients with electrocution, hypothermia, non-traumatic arrest, or near drowning; however, it is still casualty count/resource dependent.

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Appendix II

Planning Checklist and Resources

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Planning Steps Checklist and Resources

Planning Checklist

Step	Completed?
Form a Collaborative Planning Team (Core and Expanded)	
Identify and invite LE agencies.	
Identify and invite EMS agencies.	
Identify and invite fire/rescue agencies.	
Identify and invite local and state emergency management agencies.	
Identify and invite 9-1-1 PSAP/Dispatcher representatives.	
Identify and invite agencies providing mutual aid.	
Identify and invite local elected officials.	
Identify and invite private sector partners.	
Identify and invite other stakeholders as appropriate.	
Conduct project kickoff meeting with planning team.	
Understand the Situation	
Identify active assailant vulnerabilities within the jurisdiction.	
Make a prioritized list of hazards to which the policy will apply.	
Review past incidents that provide insight into the hazard.	
Review relevant state and/or federal guidance.	
Conduct planning meeting to review the situation.	
Determine Goals and Objectives	
Draft goals and objectives for the project.	
Determine operational and tactical goals and objectives.	
Conduct planning meeting to review goals and objectives.	
Plan Development	
Establish a timeline for incident operations, from dispatch to demobilization.	
Identify the required tasks for disciplines operating at an active assailant incident.	
Determine various options for ways in which on-scene operations can be conducted.	
Conduct planning meeting to review tasks and operational options.	
Based upon tasks identified, determine what resources are required for operations.	
Identify resource shortfalls and fill with mutual aid resources.	
Conduct planning meeting to review resources.	
Plan Preparation and Review	
Write the plan.	
Facilitate review and comment adjudication.	
Conduct planning meeting to present final draft.	
Implement the Plan	
Conduct training on the plan.	
Conduct local-level exercise.	
Review and update plan based on outcomes of exercise.	
Train regularly, incorporating relevant stakeholders.	

Planning Resources

1. Comprehensive Preparedness Guide 101 - www.fema.gov/pdf/about/divisions/npd/CPG_101_V2.pdf
2. Department of Homeland Security National Planners Course - www.alisinc.com/?q=content/national-planners-course
3. FEMA Independent Study - IS 253 - Emergency Planning - www.training.fema.gov/EMIWeb/IS/courseOverview.aspx?code=IS-235.b
4. FEMA Independent Study - IS 453 - Introduction to Homeland Security Planning - www.training.fema.gov/EMIWeb/IS/courseOverview.aspx?code=is-453
5. FEMA Fire/EMS Department Operational Considerations and Guide for Active Shooter and Mass Casualty Incidents - www.usfa.fema.gov/downloads/pdf/publications/active_shooter_guide.pdf

Appendix III
Response Plan Template

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Response Plan Format

Introductory Statement: Response Plans contain detailed information regarding how an agency or unit will use their assigned resources, personnel, and asset allocations in order to execute the objectives of higher level plans and operational priorities, including a full description of the concept of operations, specific roles and responsibilities, tasks, integration, and actions required, with support function annexes, as appropriate. A Response Plan details how the agency will execute the responsibilities described in higher order plans, such as an Operations Plan. It identifies individual tactics, actions, and objectives tailored to specific situations and fact patterns at an operational level. Response Plans seldom are written at the federal, interagency level.

[Address of Organization Preparing the Plan]
[Date-time group of signature]
[Organization's Plan Reference Number]

{PLAN TITLE} *[A plan's title should be a concise description of the plan's purpose.]*

1. SITUATION. *[Describe the plan's purpose from an agency or unit perspective, provide background information, identify any impact to existing authorities, fully describe the threat and the potential effects, and identify critical considerations and critical assumptions. The situation should provide agency or unit leaders and planners with an understanding of what will happen within the context of a given incident or capability and allow them to orient to the expected conditions. This "situation" must be understood by the agency or unit leaders and planners to properly develop detailed courses of action (COAs) and procedures that will address all aspects of the potential incident or capability. Information analysis is the primary source of information for this paragraph.]*

a. Purpose. *[Briefly describe the plan's purpose, scope, and any special information required.]*

b. Background. *[Provide any background information that supports understanding how the Response Plan will implement the higher order plans (such as an Operations Plan). This may include who is issuing this plan, the instruments of national, state, and local power available to the agency or unit and how they are being used, the role of non-governmental organizations (NGOs), the private sector and others involved at the tactical level, any policies altered or modified by the plan, and any other pertinent information. In general, information should not be repetitive.]*

c. Authorities. *[Identify any impacts on existing authorities exercised under applicable laws, policies, plans, or strategies by the leader.]*

d. Threat. *[Describe all aspects of the threat posed by the type of incident or capability the plan is intended to address. For example, in prevention plans, information should focus on the tactics a terrorist group would use to carry out an attack. For protection, response, and recovery plans, information should focus on the myriad of possible consequences of the actual occurrence of an incident, especially regarding potential impacts on critical infrastructure and key resources. Provide enough information for a full understanding of the consequences.]*

e. Critical Considerations. *[Identify critical considerations. These include but are not limited to, classification, spectrum and scope of operations, and legal considerations.]*

f. Critical Assumptions. *[List critical assumptions used to develop the concept of operations. Assumptions are suppositions about the current or future situation accepted as true in the absence of facts to facilitate planning.]*

g. Mission-Essential Tasks. *[Provide the list of mission-essential tasks determined during information analysis. Higher order plans will include many of these tasks.]*

2. MISSION. *[State the mission statement. This should be a detailed sentence or paragraph that describes the essential tasks and purpose—a clear statement of the action to be taken and the purpose for doing so. The mission statement contains all the elements of who, what, when, where, and why, but seldom specifies how. It forms the basis for planning and is included in the planning guidance, staff estimates, the concept of operations, and the completed plan. The mission statement is a key product from information analysis.]*

3. EXECUTION. *[Fully describe the concept of operations sufficiently to execute the mission; define key agency and unit roles and responsibilities; and include participating departments' and agencies' roles and responsibilities and coordination requirements for state and local governments, NGOs, the private sector, and others. Identify key agency and unit decisions, actions required and prohibited, and Critical Information Requirements (CIR).]*

a. Agency or Unit Leader's Intent. *[The intent is a clear and concise expression of the purpose of the operation, method, and the end-state. It provides focus for the planning staff and helps agency/unit leaders take actions to achieve the end-state without further direction, even when operations do not unfold as planned. The intent should also include where the leader will accept risk during the operation. A good intent allows subordinates to decide how to act when facing unforeseen opportunities and threats and in situations where the concept of operations no longer applies. This statement deals primarily with the conditions that lead to mission accomplishment, so the leader may highlight selected objectives and desired/undesired effects.]*

b. Concept of Operations. *[The concept of operations at the tactical level clearly and concisely expresses what the agency/unit leader intends to accomplish and how it will be done using available resources. It describes how the actions of agency/unit sub-components and supporting organizations will be integrated, synchronized, and phased to accomplish the mission, including potential branches and sequels to this plan. The concept of operations may be broken into phases of an incident as outlined below—or organized according to a timeline, capabilities, or other method that specifically explains how the mission will be accomplished.]*

(1) **General**

(2) **Alert/Activation**

(3) **Deployment**

(4) **Employment**

(5) **Demobilization**

c. Key Agency/Unit Roles and Responsibilities

(1) **Common Roles and Responsibilities.** *[Identify roles and responsibilities that are assigned to all participating agencies.]*

(2) **Specific Roles and Responsibilities.** *[Identify roles and responsibilities that are assigned to key agency/unit sub-components.]*

d. Other Government Coordination Requirements. *[Identify expected state, local, and tribal government actions that will necessitate the coordinated support of the agency/unit.]*

e. NGO Coordination Requirements. *[Identify expected NGO actions that will require coordination with the agency/unit.]*

f. Private Sector Coordination Requirements. *[Identify expected private sector actions that will require coordination the agency/unit.]*

g. Key Agency/Unit Decisions. *[Identify any key decisions required for the expected operation, who will make the decision, and when the decision must be made.]*

h. Actions Required and Prohibited. *[Describe any actions the agency/unit must take and those it cannot take. In addition, identify those actions that the agency/unit may take under special authorities.]*

i. Critical Information Requirements (CIR). *[List the CIRs needed by the leader to support making critical decisions within the context of expected operations. The list should be limited to ten or fewer to enhance comprehension. Key sources for CIRs include information analysis and COA analysis.]*

4. ADMINISTRATION, RESOURCES, AND FUNDING

a. Administration.

(1) *Responsibility for management oversight of all administrative and logistical requirements supporting operations*

(2) *Senior Financial Advisor responsibilities*

(3) *Coordination of mutual aid agreement(s)*

(4) *Financial oversight*

(5) *Personnel administrative management responsibilities*

(a) *Authorities for and policy on personnel augmentation*

(b) *Personnel training*

(c) *Travel and Travel Reimbursement*

b. Resources. *[Identify sustainment priorities and resources, site development, and interagency responsibilities; the priority and movement of major resources for each phase of the operation; resupply nodes; transportation policies, guidance, and procedures; resource and transportation assumptions; and planning requirements and subordinate tasks. Identify detailed planning requirements and subordinate taskings. Assign tasks for establishing and operating personnel facilities, managing accurate and timely personnel accountability and strength reporting, and making provisions for staffing. Discuss the administrative management of participating personnel, reconstituting personnel, leadership replacement and rotation policies, and required individual augmentation to headquarters and other tactical requirements.]*

(1) **Concept of Logistics Support**. *[State the policies, guidance, and procedures to support all options for anticipated operations.]*

(a) **Logistics Management**. *[Summarize the system being used for logistics management. Usually refers to the Logistics Annex for more detailed system descriptions.]*

(b) **Pre-Positioned Resources**.

c. Funding. *[Describe/identify how funding for operations will occur.]*

5. OVERSIGHT, COORDINATING INSTRUCTIONS, AND COMMUNICATIONS

a. Oversight. *[Identify the organization(s) or individual(s) that will exercise oversight of the various aspects of the operation.]*

b. Coordinating Instructions. *[List the common instructions applicable to the entire agency/unit or two or more components within the agency/unit that are necessary for proper coordination of the operation. Coordinating instructions establish, in particular, the conditions for execution. Examples include the time or condition when a plan or portion of the plan becomes effective, priority intelligence requirements, essential elements of friendly information, risk reduction control measures, use of force and force protection guidelines, environmental considerations, resource sharing and accountability, task coordination, and personnel assignments. Terms pertaining to the timing of execution and deployments should be explained as should other tactical terms that appear in the plan but are not defined in agency/unit publications. Identify agency/unit sub-components, including multi-agency or unit centers that have coordination responsibilities during the operation.]*

c. Communications. *[Identify what sub-unit will establish and maintain communications with applicable communities of interest. Identify specific communications systems (e.g., Homeland Security Information Network) that will be used during the operation. Usually refers to the Communications Plan or Annex for more detailed system descriptions.]*

Attachments

1 - Synchronization Matrix. *[A synchronization matrix displays the selected COA developed during COA Analysis. Specifically, the synchronization matrix identifies critical information such as the threat, decision points, and other key categories (e.g., medical and public health, public safety and security, mass care, logistics). The matrix shows how these elements change over the course of the operation (i.e., by the phase of the operation).]*

2 - Tactical Decision Checklist. *[Decision Checklists are support aids. They summarize key actions, decisions, milestones, and key reference information identified in a specific plan. Decision Checklists are simply the key highlights from a plan to facilitate informed decision making throughout the agency or unit. Checklist formats are determined by the authors of the plan.]*

Annexes (Sample Listing)
A. Task Organization
B. Intelligence
C. Operations
D. Logistics
F. Public Affairs
G. Coordination, Communications, and Computer Systems
H. Decision Checklist
I. Distribution

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Appendix IV
Sample Job Sheet

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INCIDENT COMMANDER

Mission: Organize and direct the Emergency Command Center. Give overall strategic direction for incident management and support activities, including emergency response and recovery.

Date: _____ Start: _____ End: _____
Position Assigned to: _____
Location:
Phone:
Fax:
Radio Title: Command

Immediate (Operational Period 0–2 Hours)	**Time**	**Initial**
Assume role of Incident Commander and activate the Emergency Operations Plan (EOP). • Establish face-to-face interface between LE and EMS/Fire/Rescue. • Declare Active Assailant Incident and initiate MCI and LSI protocols. • Ensure Emergency Command Center personnel are notified of the activation. • Follow EOP protocols for notifying the switchboard and initiate the EOP. o Use designated emergency code announcement for specific emergencies/disasters. • Refer to specific disaster procedures for additional considerations.		
Determine need for and appropriately appoint Command Staff: • PIO • Safety/Security Officer • Liaison Officer Determine need for and appropriately appoint Section Chiefs (Logistics, Finance, Planning, Operations) based on the disaster. • Distribute corresponding Job Action Sheets and position identification. Outline current incident command structure of activated positions on Incident Briefing Form (**201A**)		
Determine critical issues with the appropriate Section Chiefs and Command Staff positions in the following areas: 1. **Communications** 2. **Resources and Assets** 3. **Security and Safety** 4. **Staffing** 5. **Utilities Systems**		
Establish and ensure ongoing communication with: • Command Staff and Section Chiefs • Board of Directors or Corporate Offices, as applicable		
Determine scene safety and any threat to life via the Safety and Security Officer.		

Ensure outside agency notifications have been made, as necessary, via the Safety and Security Officer and Liaison Officer. This may include Fire/Police, DPH, EOEA, and Mutual Aid Plan activation.		
Ensure a team is deployed to the incident site to provide feedback to the Command Center.		

Suggested Dispatcher and Communications Checklist

- ❑ Command Staff Notification (Law Enforcement/EMS/Fire/Rescue/EM)
- ❑ Declaration of "Active Assailant" incident
- ❑ Specialty Law Enforcement Teams (SWAT)
- ❑ EMS/Fire/Rescue Mutual Aid (Additional Ambulances/Mobile Ambulance Buses)
- ❑ Public Information Officer
- ❑ Nearby "High Risk" facilities (adjacent schools or mass gathering facilities)
- ❑ Recall additional staffing as necessary
- ❑ Monitor commercial news agencies as well as social media outlets
- ❑ Maintain situational awareness and update responders

Appendix V
Glossary

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Active Assailant – One or more suspects who participate in an ongoing, random, or systematic shooting spree, the use of improvised explosive devices, or any weapon demonstrating the intent to inflict mass casualties.

Casualty Collection Point (CCP) – An area selected outside the Hot Zone where EMS providers are prepared to provide Life Sustaining Interventions (LSI) to the injured until they may be evacuated to the Treatment Area in the Cold Zone.

Clear – A term or declaration use by law enforcement that no assailant is in a room or specified area. This does not mean the area will remain secure unless it is protected or until all assailants are subdued. This is also used as a command by an EMS provider while treating a cardiac arrest patient to cause all providers to suspend care and remove contact from the patient to allow a defibrillator shock to the patient. It is also used to communicate to dispatchers that units have left the scene of an incident or hospital.

Life Sustaining Interventions (LSI) – Expedited care of individuals in potentially volatile environments, such as an active assailant, to simply sustain victims until the threat of further injury has been removed or they can be evacuated to an area of safety for more traditional EMS care. For this document LSI refers specifically to the proposed Potentially Volatile Environments with Life Sustaining Interventions protocol (see Appendix I).

Locked Down – The state of not allowing entry or exit to/from a building. This does not necessarily infer that there is a need for law enforcement or public safety personnel in the building, but there should be communications between law enforcement and the facility leadership to inform them to shelter-in-place until the potential treat has been mitigated. A partial lockdown means that the doors leading outside of the building are locked and people may not exit or enter the building. A full lockdown means that people must stay where they are and may not exit or enter a classroom, apartment unit, store unit, an office space, condo unit, or the building. If people are in a hallway they must go into the nearest classroom, apartment unit, condo unit, office space, or store unit.

Protected – A relative term referring to an area when law enforcement has checked/neutralized any threat in a specified area and can provide reasonable assurance of safety for EMS. This infers that there is armed law enforcement presence to monitor the area. In the spectrum of safety, this area is one of the least safe areas for EMS and is considered part of the Hot or Warm Zone. Local jurisdictions may further define this and other levels of safety in their SOPs.

Public Safety Answering Point (PSAP) – The center in each local jurisdiction at which the calls to 9-1-1 are answered and routed to the appropriate agency for dispatch. PSAPs are typically in the same location or closely associated with the EMS/fire/rescue and law enforcement agencies' dispatch centers.

Rescue Task Force (RTF) – A secondary entry team, which includes both LEOs and EMS personnel, that follows the initial law enforcement assault. The team enters Warm Zones to provide care for the injured under the cover of law enforcement, and then arranges extrication to a Casualty Collection Point. In this model both law enforcement and EMS must be provided the appropriate Ballistic PPE and be trained in and exercise operation in such a configuration.

Safe – A relative term referring to an area surrounding a building or area under threat by an assailant that provides the *most* assurance that the assailant will not enter. Until all the assailants are completely subdued and there are no other threats, no area is completely safe. Local jurisdictions may further define this and other levels of safety in their SOPs.

Secure – A relative term referring to an area within a Warm Zone that has been checked by law enforcement and is protected either by cover or physical barriers that will prevent an assailant from entering or threatening those within. In the gradient of safety, this is slightly safer than "protected," but not completely safe. Local jurisdictions may further define this and other levels of safety in their SOPs.

Security and Care Teams – A team of primarily law enforcement officers that make entry to the Hot Zone with the intention of extending the cleared Warm Zone. As they make entry they can then begin to perform immediate care of the injured and direct uninjured to a safe evacuation corridor, once established.

Standard Operating Procedures (SOPs) – A local response document that defines how each component of public safety agencies will operate under specific scenarios.

Tactical Combat Casualty Care (TCCC) – A course offered by the National Association of EMTs (NAEMT) geared toward military medical personnel and focused on expedited care for injuries sustained under combat.

Tactical Emergency Casualty Care (TECC) – The concept of care for civilians injured by active assailants to include immediate hemorrhage control, management of airways, chest decompression, and rapid evacuation. The care is based on the military TCCC program and adapted for civilian EMS providers.

Tactical Emergency Medical Services (TEMS) – Emergency medical services providers embedded with law enforcement special weapons and tactics (SWAT) teams for the support of the SWAT team members. They are also trained in the use of firearms and tactics. They assess the health of the team members and care for them should they become injured. The care of injured bystanders or perpetrators is not their primary mission, but they may render such care if circumstances allow.

Appendix VI

Maryland Interdisciplinary Work Group on the Response to the Active Assailant Membership and Committees

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Co-Chairpersons

Travis Nelson, Trooper First Class Maryland Department of the State Police,
Regional Liaison Officer, Maryland Emergency Management Agency
John Donohue, BS, Paramedic, Chief, Field Operations
Maryland Institute for Emergency Medical Services Systems

Member Organizations

Governor's Office of Homeland Security
Andrew Lauland, Governor's Homeland Security Advisor
Alternate - Amanda Faul

Maryland Institute for Emergency Medical Services Systems
Richard L. Alcorta, MD, FACEP; Acting Co-Executive Director and
State EMS Medical Director
Randy Linthicum, MS, Paramedic, Director of Emergency Operations
Les Hawthorne, BA, NRP, Project Specialist, Emergency Operations

Maryland Department of the State Police
Keith Runk, First Sergeant, Education and Training Division
Kevin Straight, Sergeant, Special Operations Division

Maryland Police Training Commission
Claude Nelson
Alternate - Larry Suther
Albert Liebno

Maryland Metropolitan Fire Chiefs
Gordon Wallace, Howard County Department of Fire and Rescue Services

Maryland State Firemen's Association
William Dousa, Chairperson EMS Committee
Alternate – Linda Dousa

Maryland Coordination and Analysis Center
David Lewis, Fire/EMS/EM Intelligence Analyst

Maryland Fire-Rescue Education and Training Commission
John Jerome
Alternate - Vacant

Maryland Fire and Rescue Institute
Larry Preston, Assistant Director, Field Operations
Alternate - Steven Edwards, Director

Maryland Fire Chiefs Association
Terry Thompson, Vice President
Alternate – Vacant

Johns Hopkins University
Matthew Levy, DO, MSc, FACEP - Johns Hopkins Department of Emergency Medicine

Maryland Emergency Management Agency
Kyle Overly, MS, CEM, Preparedness Planner
Alternate – John Reginaldi, Regional Liaison Officer

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Scott Hinckley, Assistant Special Agent In Charge (ASAC), Baltimore Office
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US Department of Homeland Security
Ray Hanna
Alternate - Vacant

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Alternate – William Graham, NRP

Prince Georges County Fire/EMS Department
Mike Marino, Battalion Chief
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Baltimore City Fire Department
Wade Gaasch, MD, FACEP, Medical Director
Alternate – Vacant

Talbot County Department of Emergency Services
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Alternate - Brian Micheliche, NRP

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Baltimore County Police and Fire Departments
Michael Balog, Captain, White Marsh Precinct
Alternates – Carl Lindhorst; Kenneth Hughes, Battalion Chief, NRP

Montgomery County Police Department
Robert Bolesta, Captain
Alternate – Paul Liquorie, Lieutenant

University of Maryland Police
Robert Mueck – Captain
Alternate – Mike Weller, MPO

Worcester County Sheriff
Andy McGee, Lieutenant
Alternate – Mike Hickman, Corporal

Local Emergency Management Agencies

Garrett County Emergency Management
John Frank
Alternate – Vacant

Anne Arundel County Emergency Management
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Charles Dorsey, Maryland Institute for Emergency Medical Services Systems
Leesa Radja, Maryland Department of the State Police

Editorial Support

Aleithea Warmack, Maryland Institute for Emergency Medical Services Systems

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Planning

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- John Reginaldi, MEMA
- John Frank, Garrett County EMA
- Robert Mueck, University of Maryland Police
- Charles Summers, Washington County EMA

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Chair – Larry Preston (MFRI)
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- Scott Hinckley, FBI
- John Jerome, Fire Training Commission
- Lou Luciano, FBI
- Dr. Wade Gaasch, Baltimore City Fire Department
- David Stamey, MIEMSS

9-1-1/Dispatch/Communication

Chair – Brian LeCates (Talbot County DES)
Members:
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- Mike Balog, Baltimore County Police
- Tony Rose, Charles County DES
- Chip Jewell, Frederick County Emergency Communications
- Les Hawthorne, MIEMSS

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Chair – Dr. Matthew Levy (Johns Hopkins University)
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- Dr. Richard Alcorta, MIEMSS
- Michael Marino, Prince Georges FRS
- Kevin Straight, MSP
- Michael Deckard, Cecil County DPS

Appendix VII
Additional Resources

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Additional Resources

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Appendix VIII
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