BTI Institute

Borders • Trade • Immigration

A Department of Homeland Security Center of Excellence

COMPLEX COORDINATED TERRORIST ATTACKS AND ACTIVE ATTACKS:

After Action Review Recommendations and Best Practices - By Incident

2nd Edition

As of July 8, 2022

The Borders, Trade, and Immigration Institute
A Department Of Homeland Security Center Of Excellence

www.uh.edu/bti

This research was funded by a Unified Response to a Complex Coordinated Terrorist Attack grant awarded by the U.S. Department of Homeland Security

Please provide comments and recommended changes to:

Kevin M. Clement
Executive Director, Strategic Partnerships
College of Technology
University of Houston
713.743.1676
KClement@uh.edu

EXECUTIVE SUMMARY

Funded by the Department of Homeland Security's 2016 Complex Coordinated Terrorist Attack Grant, the University of Houston's College of Technology conducted a comprehensive review to create the enclosed compilation of recommendations and best practices found in the After Action Reports (AAR) of Complex Coordinated Terrorist Attacks (CCTA) and significant Active Attack incidents, both in the United States and around the world.

Its purpose is to provide community leaders and first responders ready access to lessons learned from acts of terrorism and criminal attacks. It is hoped that the listed recommendations will assist the communities in efforts to prepare and enact a Unified Regional Response to Complex Coordinated Terrorist Attacks.

This document organizes the recommendations and best practices by incident, and will be sequenced by functional area (i.e., operational communications, intelligence, tactical response, medical response, public information, victim and family support and services) in a separate document to gain added clarity in discerning recurring recommendations and significant issues facing our community leaders, homeland security agencies, and first responders. In the development of a Unified Regional Response Plan to a Complex Coordinated Terrorist Attack, these recommendations may be used to enhance and provide detail to the region's Response Plan, associated Action Plan, Synchronization Matrix, and resulting drills, exercises, improvement plans and agency training programs.

Often, the merit and number of these recommendations are dependent upon the quality of the AARs and the availability of such reports to Homeland Security personnel and first responders outside the host organization.

The recommendations are collected and printed without editing. There are a select few with which the University of Houston's project team takes issue – those that contradict DHS and/or Department of Justice doctrine. While these are included as recommendations, they are printed in red, with an explanation in Appendix A.

This remains an active document, labeled with an "As of" date. Regrettably, it is anticipated that recommendations will be added over time as more attacks take place and as terrorists' tactics change and first responders continue to adapt. Electronic copies of this document may be obtained by contacting the University of Houston College of Technology at KClement@uh.edu.

THIS PAGE INTENTIONALLY LEFT BLANK

TABLE OF CONTENTS

THIS PAGE INTENTIONALLY LEFT BLANK

After Action Recommendations

Virginia Tech, Blacksburg, VA (April 16, 2007)

The following lessons learned are taken from the "Mass Shooting at Virginia Tech: Addendum to the Report of the Review Panel" dated, November 2009.

University Setting and Security

1. Universities should do a risk analysis (threat assessment) and then choose a level of security appropriate for their campus. How far to go in safeguarding campuses, and from which threats, need to be considered by each institution. Security requirements vary across universities, and each must do its own threat assessment to determine what security measures are appropriate. (p. 19)

2. Virginia Tech should update and enhance its Emergency Response Plan and bring it into compliance with federal and state guidelines. (p. 19)

3. Virginia Tech and other institutions of higher learning should have a threat assessment team that includes representatives from law enforcement, human resources, student and academic affairs, legal counsel, and mental health functions. The team should be empowered to take actions such as additional investigation, gathering background information, identification of additional dangerous warning signs, establishing a threat potential risk level (1 to 10) for a case, preparing a case for hearings (for instance, commitment hearings), and disseminating warning information. (p. 19)

4. Students, faculty, and staff should be trained annually about responding to various emergencies and about the notification systems that will be used. An annual reminder provided as part of registration should be considered. (p. 19)

5. Universities and colleges must comply with the Clery Act, which requires timely public warnings of imminent danger. "Timely" should be defined clearly in the federal law. (p. 19)

6. Campus emergency communications systems must have multiple means of sharing information. (p. 19)

7. In an emergency, immediate messages must be sent to the campus community that provide clear information on the nature of the emergency and actions to be taken The initial messages should be followed by update messages as more information becomes known. (p. 19)

8. Campus police as well as administration officials should have the authority and capability to send an emergency message. Schools without a police department or senior security official must designate someone able to make a quick decision without convening a committee. (p. 19)

9. The head of campus police should be a member of a threat assessment team as well as the emergency response team for the university. In some cases where there is a security department but not a police department, the security head may be appropriate. (p. 19)

10. Campus police must report directly to the senior operations officer responsible for emergency decision making. They should be part of the policy team deciding on emergency planning. (p. 19)

11. Campus police must train for active shooters (as did the Virginia Tech Police Department). Experience has shown that waiting for a SWAT team often takes too long. The best chance to save lives is often an immediate assault by first responders. (p. 19-20)

12. The mission statement of campus police should give primacy to their law enforcement and crime prevention role. They also must be designated as having a function in education so as to be able to review records of students brought to the attention of the university as potential threats. The lack of emphasis on safety as the first responsibility of the police department may create the wrong mindset, with the police yielding to academic considerations when it comes time to make decisions on, say, whether to send out an alert to the students that may disrupt classes. On the other hand, it is useful to identify the police as being involved in the education role in order for them to gain access to records under educational privacy act provisions. Specific findings and recommendations on police actions taken on April 16 are addressed in the later chapters. (p. 20)

Response

13. In the preliminary stages of an investigation, the police should resist focusing on a single theory and communicating that to decision makers. (p. 87)

14. All key facts should be included in an alerting message, and it should be disseminated as quickly as possible, with explicit information. (p. 87)

15. Recipients of emergency messages should be urged to inform others. (p. 87)

16. Universities should have multiple communication systems, including some not dependent on high technology. Do not assume that 21st century communications may survive an attack or natural disaster or power failure. (p. 87)

17. Plans for canceling classes or closing the campus should be included in the university's emergency operations plan. It is not certain that canceling classes and stopping work would have decreased the number of casualties at Virginia Tech on April 16, but those actions may have done so. Lockdowns or cancellation of classes should be considered on campuses where it is feasible to do so rapidly. (p. 87)

18. Campus police everywhere should train with local police departments on response to active shooters and other emergencies. (p. 99)

19. Dispatchers should be cautious when giving advice or instructions by phone to people in a shooting or facing other threats without knowing the situation. This is a broad recommendation that stems from reviewing other U.S. shooting incidents as well, such as the Columbine High School shootings. For instance, telling someone to stay still when they should flee or flee when they should stay still can result in unnecessary deaths. When in doubt, dispatchers should just be reassuring. They should be careful when asking people to talk into the phone when they may be overheard by a gunman. Also, local law enforcement dispatchers should become familiar with the major campus buildings of colleges and universities in their area. (p. 99)

20. Police should escort survivors out of buildings, where circumstances and manpower permit. (p. 99)

21. Schools should check the hardware on exterior doors to ensure that they are not subject to being chained shut. (p. 99)

22. Take bomb threats seriously. Students and staff should report them immediately, even if most do turn out to be false alarms. (p. 99)

Emergency Medical Services Response

23. Montgomery County, VA should develop a countywide emergency medical services, fire, and law enforcement communications center to address the issues of interoperability and economies of scale. (p. 122)

24. A unified command post should be established and operated based on the National Incident Management System Incident Command System model. For this incident, law enforcement would have been the lead agency. (p. 122)

25. Emergency personnel should use the National Incident Management System procedures for nomenclature, resource typing and utilization, communications, interoperability, and unified command. (p. 122)

26. An emergency operations center must be activated early during a mass casualty incident. (p. 122)

27. Regional disaster drills should be held on an annual basis. The drills should include hospitals, the Regional Hospital Coordinating Center, all appropriate public safety and state agencies, and the medical examiner's office. They should be followed by a formal post incident evaluation. (p. 122)

28. To improve multi-casualty incident management, the Western Virginia Emergency Medical Services Council should review/revise the Multi-Casualty Incident Medical Control and the Regional Hospital Coordinating Center functions. (p. 122)

29. Triage tags, patient care reports, or standardized Incident Command System forms must be completed accurately and retained after a multi-casualty incident. They are instrumental in evaluating each component of a multi-casualty incident. (p. 122)

30. Hospitalists, when available, should assist with emergency department patient dispositions in preparing for a multicasualty incident patient surge. (p. 122)

31. Under no circumstances should the deceased be transported under emergency conditions. It benefits no one and increases the likelihood of hurting others. (p. 122)

32. Critical incident stress management and psychological services should continue to be available to EMS providers as needed. (p. 122)

Mumbai Attacks, Mumbai, India (November 26, 2008)

The following lessons learned are taken from the Rand Corporation "The Lessons of Mumbai," dated January 9, 2009.

Key Judgments

1. Given that terrorist seek to maximize the psychological impact of the attacks, we can expect that future attacks will aim at both large-scale casualties and symbolic targets. The jihadists have stated, and Mumbai attacks demonstrates, the determination of the terrorists to seek high body counts, go after iconic targets, and cause economic damage. (p. 21)

2. The jihadists have stated…the determination of the terrorists to seek high body counts, go after iconic targets, and cause economic damage. (p. 21)

3. Since attacks against soft targets are relatively easy and cheap to mount, such institutions will remain targets of future attacks. (p.21)

Broome County, NY (April 3, 2009)

The following recommendation are taken from the "Broome Country American Civic Association Shooting April 3, 2009 After Action Report and Improvement Plan."

Area 1. Full implementation of an Incident Command System including Unified Command (p. 18)

1. Fortify ICS concepts in all incident trainings
2. Continue to train jurisdictions within the county regarding the use and implementation of ICS
3. NIMS training should also be incorporated into training programs and exercised appropriately

Area 2. Better integration of communications, particularly with regard to interoperable communications among law enforcement, fire and EMS (p. 18)

1. Establish a unified command center and staff it with all relevant players
2. Assign a communications liaison from the Command Post to the EOC. Designate a central location near site of the incident to filter information
3. Create a policy statement to pre-plan radio overhaul
4. Create a controlled access policy
5. First response agencies should develop policies for when an officer initiates self-dispatch. A staging area should be created for such officers given the inability to control self-dispatch.
6. Assign a BPD representative to the EOC or deploy the mobile command vehicle on scene.
7. ~~Remove ICS language form EOC Forms where it is not applicable to Broome EOC operations~~

Area 3. Utilization and integration of the Broome County mobile communications vehicle (p. 18-19)

1. Use of the Mobile Command vehicle will alleviate transfer communications and multiple radio frequencies issues.

Area 4. Timely information flow and enlistment of help from the State office of Emergency Management; NY ALERT should be utilized earlier in an event (p. 19)

1. Ensure all field commanders are educated and trained to use the NY ALERT system

2. PIOs should maximize the capability of NY ALERT system to provide information to the public.

Area 5. Familiarization of Victim Services personnel with the tenets of ICS (p. 19)

1. Provide training to Victims' Assistance staff in ICS 100/200

Area 6. Familiarization of first responders with GETS/WPS (p. 19)

1. Obtain WPS assets and training for personnel at city and county level- enabled phone

Area 7. Increased experience/training of American Red Cross personnel in post- disaster criminal situations (p. 19)

1. Expose ARC staff to instruction and protocols for working within a crime scene, perhaps through a program similar to the Citizens Police Academy already offered by BPD
2. American Red Cross will follow the lead of Crime Victims Assistance to ensure crime scene compliance maintained for crime-related incidents

Area 8. Enhancement of current plans to address the areas of worst-case scenario medical surges, the handling of large numbers of bodies, Family Assistance Center planning, etc. (p. 19-20)

1. Because the Red Cross has initiated development of a plan, it is recommended that the Red Cross FAC plan incorporate a county approach and integrate with the County EOP. This plan should set guidelines for selecting a site and/or multiple jurisdictions to host FAC services.
2. Hold a Public Officials Conference to establish an understanding of roles and responsibilities under article IIB, as well as guidelines for recognizing the size and scope of an incident
3. Develop a Comprehensive Appendix with a list of available state resources
4. Incorporate state, county and municipality into the state mobilization plan. The Emergency Manager and incident management should agree on use of IMAT based on the size and scope of the incident
5. Develop a crisis communications plan that integrates municipality and county levels
6. Add the mass fatality plan component to the crisis communications plan and ensure training
7. Develop plans with area-wide hospitals, including Binghamton General, to establish centralized management of hospital resources
8. Provide mental health resources through the American Red Cross

Area 9. Creation of plans for determining which agency is the lead agency for human services needs and providing guidance regarding who is responsible for that determination. (p. 20)

1. Broome County is currently updating language for NIMS compliance
2. Create a policy statement to establish the following: In the emergency action plan for criminal events, crime victims specialists lead the situation. In a natural disaster, biological/medical hazard, the health department leads the situation

Area 10. Integration of Coroner Liaison or other informed designee available to families at the FAC to conduct regular briefings on the death identification process sand treatment of the deceased. (p. 20)

1. Chiefs should be briefed on the county fatality management plan, which should be reviewed by OES and the County Coroner. The Erie County Plan should be reviewed as an example
2. Review death investigation and body identification plans to gather best practice
3. Because integration ion the planning process is critical, create a death notification plan and integrate with the mass casualty plan. Victim's
   Assistance should be included in this process to make personnel, referrals and other resources available to families
4. During a potential mass fatality incident, it will be beneficial to include the County Coroner or a Coroner representative in the EOC to assist with planning modifications

Area 11. Clear guidance for the dissemination of public information and the role of Public Information Officers (p. 20-21)

1. Establish clear use of public information tools, such as NY ALERT, jurisdiction sites, 311, and/or specific hotlines
2. Develop a Joint Information Center (JIC) plan (currently in process). The plan should include specific information regarding the role of a Public Information Officer (PIO) which should be discussed at the Public Officials Conference.
3. Provisions should be made for an at-incident PIO to handle media queries and to contain public confusion
4. Emergency public information is currently being developed for Broome County in 17 languages

Area 12. Incorporation of self-dispatched responder protocols to alleviate

response redundancies (p. 21)

1. First response agencies should develop policies for when an officer initiates self-dispatch. A staging area should be created for such officers given the inability to control self-dispatch activities.

Aurora Century 16 Theater Shooting, Aurora, CO (July 20, 2012)

The following recommendations were taken from the "Aurora Century 16 Theater Shooting After Action Report for the City of Aurora, Colorado," System Planning Corporation, dated April 2014.

Private Sector

1.1 **Alarms and Emergency Announcement Capability in Theaters.** To improve personal safety, theaters should consider putting alarms on emergency or secondary exits, and preferably monitor them by video surveillance. Having a voice communications system to inform people about emergencies also is important in an emergency. Additionally, theater complexes should be able to quickly switch off the movies and turn on the lights in each theater, to facilitate exiting and improving visibility in an emergency. Besides cost, the downside is that if leaving through an exit sets off an alarm, some may be tempted to do it for fun. (*Aurora AAR*, p. 11)

1.2 **Public Education.** Inform the public on appropriate measures if caught in a shooting situation. Nationally, thousands of people have been exposed each year to small and large-scale shooting incidents. There are likely to be more. The key guidance to offer is:

- Flee if you can
- If not possible, hide or shelter.
- If neither is possible, consider attacking, preferably in concert with others, throwing anything handy to distract or injure

The Houston Police Department has an excellent free instructional video for the public on what to do in a shooting situation. The West Virginia State Police have been training office workers in Charleston. Aurora Police Department and other departments in the Denver region should consider this education and enlist the media to help disseminate it. (*Aurora AAR*, p. 12)

Initial Response

3.1 **Pre-Incident Planning.** Revise pre-incident planning and training for an active shooter or bomber. Aurora police had paid great attention to this

planning prior to the incident and have been refining their approaches in light of the lessons learned. Police in departments small as well as large must plan in advance for a large-scale critical incident response, including pre-planned mutual aid and mutual assistance. Such planning should include establishing joint command with fire, building diagrams, internal contact telephone numbers, mutual aid staging locations, and communications procedures. (*Aurora AAR*, p. 28)

3.2 **Unified Command.** Plan and practice unified command for complex incidents. The Aurora police and fire departments have changed procedures and have trained on active shooter and other major emergencies, including how to ensure there will be face-to-face contact between police and fire commanders. Joint police-fire training has been approved for the rapid deployment of four-person (two police, two fire paramedic) "combat" medical treatment and extraction teams. Radio procedures also have been changed in an attempt to improve police-fire communications. (*Aurora AAR*, p. 28)

3.3 **Identifying Incident Commander.** Clearly identify who is the incident commander. At least one mutual aid command officer advised that due to the presence of many high-ranking Aurora police commanders, he had difficulty in determining who was in charge and to whom he should report. This problem was compounded by lack of a designated staging area and staging officer. The Incident Commander should announce his status and location on all pertinent radio talk groups (channels) or have the information rebroadcast by the Communications Center. As higher-ranking staff members arrive, they should assume command at their option. ICS command vests help in identification. (*Aurora AAR*, p. 28)

2.1 **SWAT Paramedics.** Train several more fire or police personnel as SWAT paramedics. Dispatch SWAT paramedics to live shooting incidents where victims may be in the hot zone. The location of SWAT paramedics on duty should be known to the extent possible. SWAT paramedics should report their arrival on scene. (*Aurora AAR,* p. 29)

2.2 **Ambulance Access.** Keep paths open for ambulances and discuss access issues with fire/EMS as they occur. Likewise, Fire/EMS should actively seek access routes. It cannot be assumed that if one police car finds a path to a victim, other fire and police units will be able to do so too. Ambulance access should be a high priority task of police and fire incident command, but may get lost as the first attention of police is stopping and apprehending… Factors to consider for facilitating access:

- Initial parking of police vehicles.

- Repositioning police vehicles, which would be easier if the department uses universal car keys. Universal car keys have their pros and cons, but many departments use them. Further research his needed on how to handle this with “chip” controlled vehicles.
- Towing or pushing civilian vehicles out of the way.
- Determining in pre-plans and purchase decisions whether ambulances and fire vehicles can be driven over curbs. Educate fire and ambulance drivers as to what heights of curbs and off-road terrain are likely to be traversable.
- Familiarization of fire, police, and ambulance crews with street and parking lot geography.
- Having a police vehicle lead ambulances up to triage areas.
- Sending pictures or maps of the parking lots or street configuration in real time, using photos from helicopters, remotely piloted vehicles, or fixed wing aircraft.
- Using pathfinder vehicles to show the path through congestions. Once one vehicle figures out how to get through a maze, the path can be sent to ambulances or other vehicles using apps on smart phones, or possibly via email from the pathfinder to the communications center for relaying to others. (*Aurora AAR*, p. 29-30).

2.3 **Wearing Armor.** In addition to wearing protective vests, uniformed officers should carry active shooter armor kits. The Department of Justice requires patrol use of protective vests if DOJ subsidized their purchase, but there is no requirement for additional ballistics protection… Rapid arrival and a police of confronting a shooter increase the need for protective equipment. (*Aurora AAR,* p. 30)

2.4 **Tactical Medical Kit.** Officers assigned to patrol should have a tactical medical kit (like IFAKs). While the main motivation is to be able to assist wounded officers, the skills and equipment can be used for civilians as well. At the Tucson, AZ shooting incident on January 8, 2011, in which Congresswoman Gabrielle Giffords and several other people were host, lives were probably saved because the Tucson police had combat medic kits and training which they used to attend to some of the gunshot wounds. Since the Aurora theater shooting, a medical kit has been developed for Aurora officers. The department established a training schedule, with priority given to patrol and school resource officers who are most likely to be involved in active shooter incidents. Details on the kit are discussed in Chapter V. (*Aurora AAR*, p. 30)

2.5 **Gas Masks.** Police should broaden their training on use of gas masks, if not

already done. Gas masks can protect officers from hostile gas munitions as well as gas munitions they deploy themselves. (*Aurora AAR,* p. 31)

2.6 **Reducing Stressors.** Reduce noise and light stressors at incident scenes as soon as possible. Sound and darkness add to confusion and make it difficult to identify hostiles. They also may hinder evacuations and search and rescue efforts. Movie and alarm shut-offs and switches for theater lights would be useful for public safety personnel. Theater personnel should not be expected to stay behind and operate shutoffs in a hostile environment. (*Aurora AAR*, p. 31)

2.7 **Staging Mutual Aid.** Stage mutual aid assistance forces when their help is not needed for the active shooting portion of the incident. Establish the staging area remote from the incident scene. Assign a staging officer from the primary jurisdiction. The staging officer under NIMS/ICS guidelines may direct specific assignments. Mutual aid forces would be dispatched from the staging area. If the shooting had taken place on the border of Aurora, mutual aid units might have been closest, and in that case should follow the same strategy the primary jurisdiction uses. Prior agreements should be reached regarding the authority of outside agency supervisors and their ability to direct officer from agencies other than their own. (*Aurora AAR,* p. 31)

2.8 **Air Support.** Develop agreements for air support for critical incidents; consider procurement of a low-cost Remotely Piloted Vehicle (drone). Many studies have shown that airborne monitoring can increase safety of pursuits, help set up perimeters to contain suspects, respond quickly to criminal activity, and assist in other activities. However, operating rotary or fixed wing aircraft for surveillance is expensive. The APD does not have independent air support, but is generally able to obtain airborne coverage from the Denver Police Department. Unfortunately, at the time of the Century 16 shooting, the Denver helicopter was not immediately available. A relatively new, cost-effective alternative is to use a small helicopter drone that provides aerial imaging of the incident commander. Some cost less than $5,000 and can be operated with no more skill than needed for a model airplane. The images might have been of use to both fire and police command in this incident and would have been helpful if the event had gone on longer. (*Aurora AAR*, p. 31)

2.9 **Incident Command System.** Activate the ICS and establish a unified command as soon as possible. The need for formal ICS varies from incident to incident. Activation of ICS does not mean waiting until every element of the ICS system is in place before acting. The main ICS

deficiency in this incident was the failure to quickly establish a Unified Command between Aurora police and fire, and a failure to establish a Transportation Group to coordinate transports. (*Aurora AAR,* p. 32)

2.10 **Second Duty Lieutenant.** Designate someone not involved in the incident to be responsible for the remainder of the city when the senior commander is focused on a major incident. While Aurora was fortunate to be able to devote virtually all of its police resources to the theater shooting for the first several hours, this will not always be the case. It may be necessary in some incidents to turn over regular patrol operations to mutual aid forces and their commanders or "double up" mutual aid officers with Aurora officers. (*Aurora AAR*, p. 32)

2.11 **Command Post Location.** Locate the command post at a safe distance and maintain a scene safety zone. Although there was some suspicion that a second shooter may have been involved and the area had not been cleared for explosive devices, the command post and most of the command staff were located directly in front of the theater building. Additionally, witnesses were initially allowed to remain in the general vicinity of the theater parking lot. Had there been a second shooter or explosive device, all of those people would have been in a danger zone. (*Aurora AAR,* p. 32)

2.12 **Designate a Safety Officer.** As the incident unfolds, a police command officer not directly involved in management of the incident should be designated as the Safety Officer responsible for monitoring activities and advising the Incident Commander if circumstances develop that adversely affect officer safety. This is a routine procedure of fire departments during major incidents. (*Aurora AAR*, p. 32)

2.13 **Command Vehicles.** Specialized command vehicles or trailers should be reserved for commanders to use, and not be taken over by public information officers. (*Aurora AAR,* p. 32)

2.14 **Automated Note-Taking.** Officers can make use of "smart phone" note taking and video capability. One officer reported that he used his cell phone to record witness identification and statements in the theater parking lot. Smart phones also may be used to record the location of evidence and victims or transmit pictures to the command post or police headquarters. In the absence of smart phone technology, officers can notify the Communications Center on an alternative radio channel or talk group (separate from primary dispatch of incident command channel) so

that CAD notes may be updated to create a permanent record. (*Aurora AAR*, p. 32)

2.15 **Building Side Nomenclature.** Harmonize designations for building sides. At this incident three different identification systems were in use – compass directions (i.e., Northwest Corner, East Side, etc.); building sides A, B, C and D (Fire Department system) and building sides 1, 2, 3, and 4 (Jefferson County K-9 system). An agreement would be desirable to establish one system for Denver area agencies. (*Aurora AAR,* p. 33)

2.16 **Lab Mutual Aid.** Consider use of mutual aid resources to reduce lab overloads. The crime lab became overloaded by the vast amount of evidence collected at the theater and the Paris Street apartment. The ATF laboratory was uniquely well equipped to process gun evidence and could have been tasked more to share the crime lab workload. (*Aurora AAR*, p. 33)

2.17 **Officer Rest and Recovery.** Several officers reported being required to return to work with little sleep and limited psychological assistance. When possible, fatigued officers exposed to high levels of trauma should be relieved by officers who were off-duty when the incident occurred. As soon as a critical incident is stabilized, assign someone to plan for continuity of operations.
(*Aurora AAR,* p. 33)

2.18 **Defer Reports.** Defer report writing until officers have had time to recover. Many officers advised that although exhausted (and in some cases traumatized), they followed normal procedures requiring submission of written reports before going off duty. Also, fatigue can impair report quality. (*Aurora AAR*, p. 33)

2.19 **Crime Scene Security.** Make sure the scene is secure. One entry control point should be established and records maintained of all persons entering and leaving the crime scene. (*Aurora AAR,* p. 33)

2.20 **Decontamination and Hydration.** Be prepared to set up officer, firefighter and EMS decontamination and hydration stations. Several officers were covered with blood and did not have access to clean water for washing and drinking. Consider procurement of a suitable “cleanup/hydration” station for use at major fires and police emergencies, if not available from fire rehab vehicles. (*Aurora AAR*, p. 33)

Response to Improvised Explosive Devices

4.1 **Size of Evacuation Area.** Make the size of the safe area match the threat. Ensure the area cleared around potential explosive or fire hazards is large enough to prevent injury to bystanders if a device explodes. A police supervisor at Paris Street said that before starting the rendering safe procedures of the explosive devices they should have created a larger safe area around the suspect's apartment then they did initially. Eventually, they did expand the safe area. The basic rule is 'do not remove the device, move the people.'
(*Aurora AAR,* p. 40)

4.2 **Bomb Squad Resources.** Know the available bomb disposal resources. Every law enforcement agency needs to make sure they know who to call for bomb technician and render-safe assistance should they encounter hazardous incendiary materials, explosives, or explosive devices beyond their in- house capability, or for second opinions and back-up. Aurora knew whom to call immediately, and that was crucial to the success. Training with the bomb squads to be used is also essential. In the past, many jurisdictions relied on military assistance for explosive ordnance disposal. Under current bomb disposal and render-safe procedures, military Explosive Ordnance Detachment (EOD) personnel are responsible only for the disposal of military ordnance. With the increase in the number of civilian criminal and terrorist uses of explosive devices, public safety bomb technicians now have that responsibility. For complex situations, the FBI and ATF are excellent resources. (*Aurora AAR*, p. 41)

4.3 **Language Interpretation.** Plan for interpretation services in real time. There now are apps for smart phones and iPads as well as telephone interpretation services to identify and translate a wide variety of foreign languages. Emergency responders should know how to access theses services to facilitate evacuation and give instructions to non-English speakers. One can speak in English and get voice out in another language with a smart phone, and vice versa. (*Aurora AAR,* p. 41)

Emergency Medical Services

5.1 **Scene Safety.** During a mass casualty incident, command should announce when the scene is reasonably safe for EMS to proceed, or what level of protection responding providers need to operate under (e.g., police guarding EMTs). There almost always will be the possibility of another shooter or another bomb, but the probability will vary. Different

Departments or incident commanders may have different value judgments as to what is acceptable risk to firefighters vs. victims who need their help, but there should be strong police-fire discussion as to the detailed circumstances of risk in a particular incident. Several recommendations have been offered by various national and regional agencies regarding how aggressive EMS providers should be in entering and providing triage in a warm zone. Choices include SWAT trained EMS providers, SWAT or law enforcement teams to escort and protect EMS providers in the warm zone, body armor for EMS providers, or having law enforcement quickly remove patients to a triage unit in the cold zone. There is not enough data or experience to determine one best solution. Therefore, we recommend that whichever solution is chosen, the following guidelines be followed:

- All personnel are trained and exercised in the performance of active shooter scenarios;
- Policies are developed with input of all agencies that can possibly be involved;
- Mass purchases of any protective or countermeasure equipment be performed only after determining which types of active shooter policies will be embraced by local agencies; and
- Whenever an incident occurs that requires the use of the active shooter policy, an AAR is conducted to evaluate all aspects of the response. Data should be collected to determine what procedures and equipment were used, and whether effective. (*Aurora AAR*, p. 73-74)

5.2 **Safety Officer.** As noted earlier, there needs to be an Incident Safety Officer quickly appointed who should pay particular attention to the access or egress of emergency vehicles. Based on other conditions, it may be appropriate to rapidly move all patients away from the incident. Choices include direct transportation to hospitals or awaiting ambulances in the staging area.
(*Aurora AAR*, p. 74)

5.3 **Staging Manager.** The Incident Commander should quickly appoint a Staging Area Manager who will find and report on a location for staging. Engine 7 was to be the staging manager but there was no one in staging until about 26 minutes and 37 seconds into the event when Rural Metro 402 arrived.
(*Aurora AAR*, p. 74)

5.4 **Strike Teams.** Dispatch and incident commanders should consider

calling for multiple fire or EMS units as strike teams or task forces when large numbers of responders or equipment are needed after the first several units arrive on the scene. Dispatch and the EOC must have the authority to plan responses based on using these teams. The strike teams do not necessarily stag together; the intent is to promote order and have a supervisor with the team to assure enough supervisory personnel, rather than a continual stream of units arriving, or attempting to call for exact numbers of units using surgical precision, which is harder to manage. While prompted here primarily by the EMS situation, it also applies to police mutual aid, especially after the initial response. (*Aurora AAR*, p. 74)

5.5 **Access of Ambulances.** When access is difficult, police, fire or other agencies may have to physically guide ambulance units into the scene. During this incident, police personnel were aware of an access and egress point via the south side of the incident. By guiding units into the scene, ambulances would have gotten closer to patients, and a transition from police to ambulance transportation could have quickly occurred. (*Aurora AAR*, p. 75)

5.6 **Police EMS Transports.** In situations where immediate transport of patients is warranted, of police or other emergency vehicles is appropriate when ambulances are not immediately available. This is especially true for patients suffering from penetrating wounds to the turaco-abdominal area. Specific guidelines should be developed to guide police, fire and EMS crews.
(*Aurora AAR*, p. 75)

5.7 **Active Shooter Protocol.** Ensure that the new active shooter protocol remains a "living document" with leaders from AFD, APD, and EMS provider monitoring and evaluating the SOGs success and continued relevance. (*Aurora AAR*, p. 76)

5.8 **Triage Ribbons and Tags.** Aurora public safety providers should adopt a triage identification systems that includes color-coded triage ribbons for patients. Traditional patient triage tags should be saved for use in treatment units. Initially, patient details are not necessary, just the patient's initial condition…Recent research has suggested that initial on-site (hot zone) triage be limited to just red or green identifiers (acute or not acute). (*Aurora AAR*, p. 76)

5.9 **Implementing NIMS and ICS.** Continue to implement NIMS and ICS throughout the Aurora public safety system. This should be a priority for all public safety organizations. (*Aurora AAR*, p. 77)

5.10 **Integrating Rural Metro into ICS.** The AFD should further integrate RMA into the ICS process, especially regarding responsibility for the Transportation Group. The current agreement between AFD and RMA fixes EMS ICS authority with the AFD. This should not change. But during mass casualty incidents, the AFD Medical Group Supervisor should delegate responsibility for the Transportation Group to RMA. An RMA supervisor is usually readily available. During the theater incident, RMA and mutual aid agencies had supervisory personnel on scene could have assisted with the EMS ICS process. (*Aurora AAR*, p. 77)

5.11 **EMS ICS Vests.** EMS ICS position vests should be used to identify those placed in key ICS positions. During larger mass casualty incidents, there is often mutual aid from places where providers are unfamiliar with each other. ICS vests help providers to understand the EMS command functions and to identify key leaders. (*Aurora AAR*, p. 78)

5.12 **Use of Treatment Dispatch Managers.** Appoint Treatment Dispatch Managers under ICS in order to have better organized transfer of patients from treatment units to awaiting ambulances. (*Aurora AAR*, p. 78)

5.13 **ICS Reporting.** Pay closer attention to completing ICS forms and transportation records in order to better document incidents. (*Aurora AAR*, p. 78)

5.14 **Expanded Police EMS Role.** Aurora Police Department should consider expanding the EMS scope of practice for police officers, especially for gunshot wounds. The International Association of Chiefs of Police now recommends (since October 2013) that every law enforcement officer receive tactical emergency medical training including critical core skills of early, life- threatening hemorrhage control and rapid evacuation of mass casualty victims to a casualty collection point. Tactical emergency medical skills are critical life- saving interventions whether as officer applied self-aid or aid given to a fellow officer, or aid to victims of a mass casualty situation such as an active shooter or bombing event. (*Aurora*

AAR, p. 78)

Public Safety Communications

6.1 **Public Safety Three-Party Team.** Foster more integration of planning and exercises among public safety communications, fire, and police. Communications personnel felt there was not enough understanding, respect, and training among the agencies, and that emergency preparedness should be considered a three-legged stool. (*Aurora AAR*, p. 88)

6.2 **Communications Interoperability Drills.** The Communications Department should hold regular inter-department interoperability communications drills with all three agencies – police, fire, and public safety communications. (*Aurora AAR*, p. 88)

6.3 **Call-taking in MCI.** Empower telecommunications to use their judgment in a large scale event, and to suspend the usual protocols when they are inefficient or troublesome. Do not waste time requesting the same information over and over again form the same event. Once the nature and size of the incident is realized, it should suffice to say something like "Are you at the theater? Are you safe? Area you hurt?" Even inexperienced call takers should be told they may suspend the usual full protocols for such situations.
(*Aurora AAR*, p. 88)

6.4 **Prepare for Second Surge.** In a mass casualty incident, there is likely to be a second surge of calls from family, friends and media following the initial emergency call surge. This extra workload will hit an already fatigued work staff. Procedures should be established early in the incident to temporarily divert non-emergency calls elsewhere, as was done in this incident. The calls could be sent to the city EOC, PIOs or a special office set up for that purpose.
(*Aurora AAR*, p. 88)

6.5 **Adequate Tele communicator Relief.** The Communications Department should prepare to provide relief to its tele communicators for a long duration incident. The Communications Department has an Everbridge Interactive Communications and Mass Notification System that can be programmed to do callbacks efficiently using group notifications. This can save Communications Department staff and field

commanders' time in the midst of an emergency. The lead or shift supervisor should have responsibility for deciding when to initiate callbacks of communications staff. A set of notifications should be pre-planned and stored in the system. (*Aurora AAR*, p. 88)

Clear definitions must be established for all public safety staff (including police, fire and communications) as to what situations required a request for immediate call backs to which personnel must respond, versus a non-urgent request for which personnel decide voluntarily. Guidelines on callbacks need to specify when to call, whom to call, what text to use to convey a sense of urgency, and how acknowledgement is to be obtained from the person notifies.
(*Aurora AAR*, p. 88)

6.6 **Face-to-Face Command Communication.** As recommended in other chapters, establish a unified police, fire and EMS command, or at least face-to-face communications at a command center, as early as possible in a mass casualty incident, to reduce reliance on radio communications. (*Aurora AAR*, p. 89)

6.7 **Simplify Operation of Radio System.** The radio system needs to be reconfigured to make it simpler to use its inter-operative capabilities. Attempting to use interoperability talk groups (channels) or scanning capability is too complicated during an emergency and may result in missing critical transmissions. Consider reprogramming police radios to simplify communications. Place specialized talk groups in separate and distinct fleets and do not comingle them with a standard (universal or department-wide programming. Consider reducing the number of "fleets" (radio talk groups) to avoid operational confusion. Use identical radio "profiles" (channel configurations). (*Aurora AAR*, p. 89)

6.8 **Do Not Rely on Scan Feature.** The scan feature on radios is not effective during a critical incident; the radio will prioritize to the selected talk group and transmissions on non-selected talk groups will be cut off. More training on the radio system would help, but probably not suffice. (*Aurora AAR*, p. 89)

6.9 **Separate Command Radios.** Consider installing both police and fire radios in police and fire command vehicles. This would allow for continuous monitoring of each other's activities without switching radio systems or talk groups. This capability is especially useful while en route

to an incident. Reprogramming existing radios probably would help, but not suffice, because the portable radios will not always be set to the correct talk group; they are difficult to adjust while driving; and they do not work well inside a vehicle. Further study probably will be required to determine how best to allow reliable inter-department communications using portable radios. (*Aurora AAR*, p. 89)

6.10 **Facilitate Cell Phone Use.** A back-up inter-department communications system such as cell phone direct connect should be considered. The Communications Dispatch should maintain listings of police and fire department cellular telephone numbers. However the radio system still should be the primary system, because cell phone structure may become overloaded and fail during emergency situations. Note: The Communications Manager is of the opinion that cellular telephone numbers released to the Communications Department become public records…We recommend consultation with legal counsel prior to proceeding. (*Aurora AAR*, p. 89)

6.11 **Satellite Phones.** If not already available, consider purchasing a small number of satellite phones that do not rely on cell phone sites and will work at almost any location. During destruction of the explosives removed from the Paris Street apartment, ATF reported that the destruction location was so remote that cell phones did not work. Also, the cell phone system can get overloaded in an emergency. (*Aurora AAR*, p. 90)

6.12 **Mutual Aid Communications.** Provide a way for mutual aid units to monitor Aurora police talk groups. It appears that adequate patching capabilities that can be used for this are now operational. (*Aurora AAR*, p. 90)

6.13 **Empower Dispatchers**. Dispatchers should be empowered and encouraged to, with tact, recommend or suggest and, if needed, direct Incident Commanders to undertake actions in support of the management of an operation. In the theater shooting, it would have been appropriate to suggest that the fire IC call for additional chief-level support, or even to initiate it themselves, but the dispatcher was uncertain about the appropriateness of this. Dispatchers should also have the ability to solicit critical information from the Incident Commander (i.e., incident status, personnel accountability reports, etc.) (*Aurora AAR*, p. 90)

6.14 **Mobile Terminals in Vehicles.** Do not rely on mobile terminals in vehicles for critical incident communications because incident commanders and supervisors often will be out of their vehicles and unable to monitor computer displays. (*Aurora AAR*, p. 90)

6.15 **Computer Aided Dispatch System Database.** If not already done, program into the Aurora Intergraph CAD system all Denver Fire/EMS units, private ambulances, and public medical care facilities. Consider use of the communications technology called CAD 2 CAD Data Exchange Hub (DEH) in the metro area to improve integration with surrounding jurisdiction's CAD systems and to improve unit situational awareness and real time unit availability in routine and major incidents. (*Aurora AAR*, p. 90)

6.16 **Major Incident Working Area in Communications Department.** The Communications Department now has a combined police-fire-major incident dispatching are where police and fire dispatchers can be seated next to each other and easily exchange information. (*Aurora AAR*, p. 91)

6.17 **National Incident Management System (NIMS)/Incident Command System.** Communications Department staff, as well as police, fire, and EMS personnel, must be versed in the use of NIMS and ICS, including the roles of various positions. Communications Department personnel need to understand the system when field command is setting up ICS positions, and might even prompt or query them about doing so if they forget, as was the case in this incident with the absence of a Transportation Group Coordinator.
(*Aurora AAR*, p. 91)

6.18 **Toll Free 1-800 Number.** After this incident, the city acquired a toll free number to facilitate public contact with the city after a major incident. Aurora set up some special telephone lines, but a ready-to-go 1-800 number would make it easier for callers and staff. (*Aurora AAR*, p. 91)

6.19 **Critical Incident Stress Management.** CISM needs to be available to telecommunicators and their managers as well as to first responders. When CISM counselors are used, they need to be informed on what telecommunicators do. (*Aurora AAR*, p. 91)

6.20 **After Action Debriefing.** A debriefing for Communications Department

personnel should be conducted soon after a major event. One purpose is to dispel any lingering rumors. (*Aurora AAR*, p. 91)

Public Information

7.1 **Institutionalize Practices.** The processes that the city used to manage and provide public information should be institutionalized in its major incident response plans. This should include the manner in which volunteers with requisite skill sets and experience were identified and used to support public information surge operations. (*Aurora AAR*, p. 98)

7.2 **Public Information Command Post.** Establish a Public Information Command Post remote from the crime scene in a major incident. Reporters want access to a "talking head" and the ability to video something for the electronic media. Establishing a press command post that provides regular briefings and the ability to photograph police activities from a distance usually satisfies that need. PIOs had set up inside the police primary command post, but this interfered with command and control operations. They should have been relocated, and left the vehicle for its primary purpose of police incident command. (*Aurora AAR*, p. 98)

7.3 **Joint Information Center.** A Joint Information Center should be established when there is a major incident or other disaster, to provide consistent, accurate, and unified messages from all disciplines, agencies and responders. (*Aurora AAR*, p. 99)

7.4 **Local Media Priority.** Local media should be allowed to do interviews first, before the national media is accommodated. The information is more important to get out locally, and the local media has more of a vested interest and will be covering the story for a long time after the national media leaves the area. (*Aurora AAR*, p. 99)

7.5 **Coordination of Plans.** Decisions or planed information actions should be well coordinated in advance with other affected city departments, as they were for almost all information actions. (*Aurora AAR*, p. 99)

Emergency Operations Center

8.1 **EOC Organizational Reporting.** The City of Aurora should consider changing its organizational structure for emergency management. Emergency management by its very nature involves support to and cooperation from all city departments in order to be effective. It is usually more difficult for this to be accomplished if the emergency management function is placed in one of the public safety departments – fire or police – because it is then perceived as "belonging" to one or the other department and often as a lower priority division at that.

Emergency Management should be in a direct line relationship with the City Manager's Office where a higher level of authority and oversight would underscore the importance of this function and provide greater visibility for planning and EOC operations, and more easily facility coordination with other key city departments and agencies. (*Aurora AAR*, p. 113)

8.2 **Notification and Opening EOC.** The OEM Coordinator should be informed as soon as a critical incident occurs, and the EOC should be opened earlier than it was. (*Aurora AAR*, p. 113)

8.3 **Equipment in the Police DOC and City EOC.** There were not enough phones and computers for all the representatives in the operations centers, and the communications were not recorded since many people were using their personal devices. (*Aurora AAR*, p. 113)

Victim Services and Family Support

9.1 **Family Assistance Volunteers.** Do not allow even good-hearted volunteers without family assistance training to have easy access to families and victims after a mass casualty incident. They can do harm. (*Aurora AAR*, p. 135)

9.2 **Consistent Advocates.** Once a family advocate is assigned to a victim or family, it is best not to eliminate that advocate, even if another advocate needs to be added per legal protocols. Of course, an exception would be removal if requested by the victim, or for some overt problem. A key aspect of the assistance is providing someone the family can regard as a trusted advocate. (*Aurora AAR,* p. 135)

9.3 **Explanation of Identification Delays.** Be prepared to explain to families of victims why identification of the deceased takes so long. While certain details may be best to avoid, families should be given general

information about how and why the crime scene has to be processed first before the deceased can be processed – and how long both processes generally take. They also should be informed about what is considered "positive identification" and what the law and good practice require. Explain the potential impact of an incorrect identification on other families. Families will still be unhappy, but at least they will have more information about why the process requires a certain amount of time to be completed correctly. (*Aurora AAR,* p. 136)

9.4 **Victim Donations.** Include in the mass casualty plan options for receiving and distributing large amounts of donations likely to flow in to help victims. One approach that worked well in Aurora and in Boston after their Marathon bombing is to quickly establish a "One Fund" into which all unrestricted financial donations are channeled. Other types of donations, for example airline tickets for victims, families can be accommodated separately.
(*Aurora AAR,* p. 136)

9.5 **Staggered Leave.** Victim Services should consider scheduling leave so that there are not too many advocates on leave at the same time. Advocates also recommended establishing a phone tree with assigned team leads to facilitate the process of callbacks. (*Aurora AAR,* p. 136)

9.6 **Hospital-Based Advocates.** There should be a lead advocate assigned to each hospital that receives victims to coordinate all victim advocates responding to that location. Hospitals should include a point of contact in their mass casualty plans who would work with that victim advocate coordinator. As a team, they would be in position to handle requests for information on the status of the injured, help family members to be with their loved ones and coordinate information with the family reunification center. (*Aurora AAR,* p. 136)

9.7 **Gathering Place.** In a major incident, designate an area near but not immediately adjacent to the family reunification center where people can gather without interfering. Establish access control as soon as a family reunification center is opened. (*Aurora AAR,* p. 136)

9.8 **Clergy.** Designate a special area where clergy can assemble within the family reunification center. Let them know that family members and friend will initiate contact if they want their assistance, and make sure the families are aware of which clergy are present. Do not allow clergy to

circulate and approach families on their own. (*Aurora AAR,* p. 136)

9.9 **Single Victim File.** Establish one central file on victim information to avoid multiple files with conflicting or incomplete information. Hospitals, police and victim advocates are the primary suppliers and users of this information and should work together to create a template for any future mass casualty incidents. Aurora may be able to accomplish this using Versadex (Police Records Management System) (*Aurora AAR,* p. 136)

9.10 **Family PIOs.** Promote the successful concept of assigning PIOs to families of the deceased victims at state and federal level, including DOJ's Office of Victim Assistance in Washington D.C. (*Aurora AAR*, p. 137)

9.11 **First Responder Relief.** If possible, do not require first responders who worked at a traumatic incident to work their immediate next shift, especially if those become 12-hour shifts. Give first responders and other city employees a change to rest and unwind. For vigils, visits by the President or other high-ranking officials, or memorial events held immediately following a mass casualty event, use mutual aid agencies to relieve officers who are likely to have been physically and emotionally fatigued. (*Aurora AAR,* p. 137)

Newtown Shooting Incident, Newtown, CT (December 14, 2012)

The following recommendation are taken from the "After Action Report of the Connecticut State Police – Newtown Shooting Incident 12-14-2012."

Pre-incident Planning

1. Pre-incident planning is critical for active shooter or other mass casualty incidents. Police departments of all sizes must plan in advance for a large-scale critical incident response, including pre-planned mutual aid agreements and mutual assistance. Such planning should include identifying high risk target areas, building diagrams, appropriate staging areas and command post locations, establishing joint command with local police agencies, fire, and EMS, as well as compiling internal contact telephone numbers and testing communications procedures. (p. 68)

Command and Control

2. Staging Area: It is important that the Incident Scene Commander establish a staging area for emergency personnel as soon as practically possible, and all responding units, including those that self-dispatch, should report to the Incident Command Staging area for appropriate task assignments. Failure to do so can limit management control, increase risk, and severely hinder accountability. (p. 68)

3. Second Duty Commander: Designate an individual not involved in the incident to be responsible for the remainder of the troop patrol functions. Typically this function would fall back to the second in command (Troop Master Sergeant) when the senior commander is focused on a major incident. During this incident, the initial first responder team was comprised of the Commanding Officer and Executive Officer, as well as the duty supervisor. While Troop A was able to devote virtually all of its resources to this incident for the first several hours, this will not always be the case. It may be necessary in some instances to assign regular patrol operations to other troops within the district or adjoining districts. (p. 68)

4. Mutual Aid: All responding personnel and mutual aid that are not immediately needed should be staged at a nearby location. This will ensure their rapid deployment when their services are necessary, without flooding the incident scene prematurely. In accordance with NIMS/ICS guideline, assign a staging officer from the primary jurisdiction who may direct assignments. It is preferably to reach agreement before an emergency

incident regarding span of control and the authority of outside agency supervisors to direct officers from other agencies. (p. 68)

5. Building Side Nomenclature: Standardize the designation of the front, rear, and sides of a building (e.g. “A” side, “B” side, etc.) and reinforce during training to ensure compliance and understanding among first responders. All involved agencies should operate under one system. Ensure all submitted reports reflect consistency in reporting. (p. 68)

Crime Scene Management

6. Reducing Stressors: Reduce noise and light stressors at incident scenes as soon as possible. Attempt to identify non-combatants and distinguish between potential threats and civilians. Sound and low light conditions add to confusion and make it difficult to make timely and appropriate identifications. Additional stressors may hinder evacuations and search and rescue efforts. (p. 68-69)

7. Scene Security: Access to and from the crime scene should be strictly controlled from clearly established entrance and egress points, and reserved only for authorized personnel that have a legitimate and clearly defined reason for being on scene. No personnel should be allowed within a crime scene unless there is a legitimate law enforcement purpose. Agencies should consider video streaming or other means for crime scene viewing to assist in minimizing unnecessary crime scene traffic. Clearly established crime scene zones should be created and closely monitored with established ingress and egress points. Current policy and protocols should be reviewed to ensure that clear roles, responsibilities, and scope of authority are established for crime scene management. (p. 69)

8. Command Post (CP): CP operations were set up during the early stages of this incident at various locations, including a Crime Scene Processing CP at Sandy Hook Elementary School, a Criminal Investigation CP at the Emergency Operation Center, and an overall Incident CP at the Sandy Hook Fire House. As more emergency response personnel, family members, and media continued to converge on the scene, access to the Incident CP at the Fire House became difficult and it became apparent that it was an error to establish a CP at the school. At no time should any type of CP be set up inside an active crime scene, and commanders should be prepared to set up CP locations in a location that is outside of the crime scene and not widely accessible to the public. (p. 69)

Equipment

9. Body Armor: The Department currently provides body armor for each trooper; however, personnel are not required to wear the armor at all times. The department, in consultation with relevant labor unions, should consider revisiting the policies on body armor. Additionally, the armor provided to all troopers would not have protected responding personnel from the type of ammunition used at this scene. The Department should consider providing additional ballistic protection beyond the standard issued body armor for an extra layer of protection, especially to those who may be called to respond to an active shooter situation. (p. 69)

10. Medical Kits: Troopers assigned to patrol should have ready access to a medical kit. In the months following the Sandy Hook shooting incident, all CSP personnel were issued Individual First Aid Kits (IFAKs) and trained in their use. While the main purpose of the IFAK is to assist wounded officers, the skills and equipment can be used for civilian injuries as well. Decontamination and Hydration: Many active crime scenes require decontamination and hydration stations and in this instance, several officers did not have access to clean water for washing and drinking. Consider procurement of a suitable “cleanup/hydration” station for use at major emergencies if not readily available from local emergency services. (p. 69)

11. Technology: Even with limited cell phone service, unit and district commanders should be able to communicate through the use of a smart phone or tablet. It should be noted that the agency has begun the process of updating phone technology and should consider issuing tablets with Wi-Fi hot spot capabilities. The Agency should also review the technology capabilities for detectives within the Major Crime Units and update equipment and software as needed. (p. 69-70)

12. Major Crime: Each district Major Crime Unit should establish and maintain the equipment and resources necessary to respond to a mass casualty event within their respective geographic area of responsibility. Additionally, in accordance with available resources, the units should also have a secondary crime scene processing van and plan for its utilization. (p. 70)

13. Mobile Command Vehicle: The CSP was fortunate to have the use of various locations to use as CP locations. However, the Agency does not currently have an adequate mobile command vehicle with multi-functionality designed to handle an incident of this magnitude. Consideration should be given to acquiring a mobile command vehicle. (p. 70)

Training

14. Active Shooter: In response to the Hartford Distributor's active shooter incident in Manchester, CT in 2010, the department implemented mandatory training specific to active shooter incidents for all personnel during in-service. Additionally, all CSP personnel are given active shooter training at the recruit level. Numerous CSP first responders to Newtown indicated that the previous training they received provided an increased level of confidence. Future training would be beneficial to personnel, and should encompass additional response dynamics to include evacuation protocols, treatment of the injured, establishing perimeter zones, incident command and scene management, and setting up initial scene security. Active shooter training should include incorporating "stressors" to inoculate troopers to sensory overload. Troopers should also be mindful of the potential for "blue on blue" encounters and ensure muzzle discipline at all times. All levels of command should participate in integrated training exercises in mass casualty events to include the effective management of personnel, resources, technology, and command post operations. (p. 70)

15. Medical: The department has established a continuous EMS training schedule, and has also offered advanced training workshops in Tactical Combat Casualty Care (TCCC). (p. 70)

16. Emergency Vehicle Operation: It is critical for responding personnel to arrive to any incident safely. Despite the large law enforcement response to Sandy Hook Elementary School, there were no department accidents. All police departments should ensure their personnel are trained in emergency vehicle operation at the recruit level and on a regular basis thereafter. (p. 70)

17. Integrated Tactical Response: The FBI and the CSP responded in an integrated, tactical manner, which was influenced by prior training and pre-established professional working relationships. Local, state, and federal tactical teams should train together on joint problem-solving scenarios to ensure success during future integrated operations. (p. 70)

18. Incident Command System and Unified Command: The CSP established its command presence within minutes of the incident. Other supporting agencies, with few exceptions, operated seamlessly and collaboratively within the existing operational framework. Organizations and individuals unfamiliar with the ICS and Unified Command concepts should train accordingly. (p. 70)

Communications

19. Radio Communications: Continuous radio updates were critical for personnel responding to Newtown. If an outside agency is provided a radio, ensure team leaders are advised accordingly. Use plain talk when communicating between agencies and attempt to increase effective communication between agencies. (p. 71)

20. Clearly Defined Roles and Responsibilities: Clearly defined roles and responsibilities should be established to limit miscommunication and potential for future errors. Protocols should be put in place in order to voice concerns upward through the chain of command without fear of reprisal. (p. 71)

21. Internal Agency Communication: The Agency kept the public informed through the Public Information Office and kept the families informed with informational meetings. The Agency should improve communications within the CSP, particularly with those who were involved directly as first responders. (p. 71)

Self-Dispatching

22. Organizations, response units, and individuals proceeding on their own initiative directly to an incident site, without the knowledge and permission of the host jurisdiction and the Incident Commander complicate the exercise of command, increase the risks faced by responders, and challenge accountability. Mass casualty and active shooter response plans should include preselected and well-marked staging areas and a plan for handling self-dispatched personnel. Dispatch instructions should be clear. Law enforcement agencies should be familiar with deployment plans and quickly establish incident site access controls. When identified, self-dispatched resources should be immediately released from the scene, unless incorporated into the Incident Commander's response plan. (p. 71)

Mental Health and Wellness

23. Ensuring access to care: The magnitude of this incident, especially given the age and number of victims, certainly had an impact on all responding personnel. The agency must ensure that responding personnel are receiving proper mental health services prior to an event and long after. Employee Assistance Programs are a critical component to a long term mental wellness process. Additionally, the CSP currently has a confidential employee assistance and peer support (STOPS) program. They also have established policy and procedures outlined in the A&O Manual which

addresses dealing with potentially distressed employees through the Personnel Early Awareness and Intervention System. Commanders should be prepared to deal with the short and long term effects on personnel who respond to mass casualty incidents. Investigators, responders, and the families of those who were involved in this investigation should be provided EAP and other resources in order to deal with any potential adverse effects. (p. 71)

24. Limiting impact of trauma: Commanders should strive to minimize the potential adverse effects of crime scene exposure and all law enforcement personnel should be mindful to avoid unnecessary exposure to trauma. Crime scene access should be given only to individuals with a legitimate law enforcement need, regardless of rank. (p. 71)

25. Long term care: Mental health experts maintain that effects of post-traumatic stress may not manifest until years after the event. CSP leaders should continuously support their personnel's health and well-being in the short and long term. (p. 72)

Law Enforcement Collaboration

26. Due to the magnitude of this incident, there was an overwhelming law enforcement response on the local, state, and federal level. All available resources were made available to investigative personnel. Commanders established effective communication between the State's Attorney as well as other law enforcement partners. It is important to have effective working relationships and personal points of contact in place before the need for the contact arises. Establishing and maintaining law enforcement partnerships is critical to overall mission success. (p. 72)

Reporting

27. The agency utilizes an in-house system to document investigations. There were some issues regarding late reports and the submission of reports that had errors despite having been approved by a supervisor. The agency should emphasize the importance of report writing competencies and strive to take immediate corrective steps to prevent inaccurate, untimely, and poorly written reports. The Agency currently has policies and procedures outlined in the A&O Manual that address reporting requirements and these policies and procedures should be followed and enforced. Additionally, at the time of the incident certain units did not fully utilize the electronic reporting system which made it difficult for the assigned investigators to access and review reports; however, since that time the system has been

implemented in all units agency-wide and now all reports are completed through the same system. (p. 72)

Support Services

28. Death Notifications: Accurate and timely death notification to victims' families should be one of the highest priorities. Delays in notification were a great source of frustration for agency personnel at the firehouse CP location and added confusion, frustration, and stress for the family members. Policy and procedures should be clearly established and enforced to ensure accurate and timely death notifications are made to family members. If feasible, consider honoring family requests to view the victim. (p. 72)

29. Family Liaison Program: The family liaison program was an important victim assistance program that provided support and communication to the victims' families. The agency should continue to develop this program and include it in operational response protocols for mass casualty incidents, along with other victim services as deemed appropriate. (p. 72)

30. Family and Individual Meetings: In addition to assigning liaison officers to each impacted family, CSP made every attempt to keep the families informed of the case investigation through individual and group meetings. The purpose of the meetings was to provide accurate and timely information and to dispel circulating rumors. The meetings were private and helped prepare the families for upcoming media releases. The practice of conducting individual and group family meetings should be sustained and included in operational protocols. Ensure that meeting guidelines are set and adhered to ahead of time. LE should be prepared to answer questions and provide assistance to individuals who are grieving. Victim assistance should be done in consultation with mental health and grief counseling experts. (p. 72)

31. Scene Walk-Throughs: Family members were allowed to visit the school once the crime scene was cleared. In the future, this could include victim advocates, mental health professionals, and LE personnel to answer questions and assist as appropriate. (p. 73)

Public Information

32. PIO released accurate and timely information to the numerous media outlets. PIO was able to convey information without compromising the investigation, and at the same time honoring the privacy of the impacted families. PIO should further consider preparing operational plans for similar

mass media events and anticipate the various equipment and personnel needs that may arise. (p. 73)

Boston Marathon Bombings, Boston, MA (April 15, 2013)

The following recommendations are taken from the "After Action Report for the Response to the 2013 Boston Marathon Bombings."

Recommendations

1. **Create an Integrated All-Hazards Public Safety Operational Plan for the Boston Marathon each year**. An integrated public safety operational plan that includes all disciplines and jurisdictions, addresses all hazards, and provides appropriate contingency planning should be developed for the Boston Marathon each year. (*Boston Marathon AAR*, p. 77)

2. **Implement Strategies and Enhance Security to Limit Risk for Large, Public, Mass Gatherings, While Maintaining a Family Friendly Atmosphere.** Because the Boston Marathon is a large, public, family event, there needs to be an appropriate balance between security protocols and the feel of the event. However, steps could be taken to enhance the overall security of the event, and thereby increase the sense of security felt by runners and spectators. Local and state law enforcement personnel should re-evaluate existing security protocols and make determinations as to what security enhancements should be implemented along the course. The format and content of plans was inconsistent and varied in substance and level of detail from community to community, and from agency to agency. In addition, although many plans identified potential locations that could serve as shelters for runners, none of the plans detailed how runners would be directed to shelters, or how they would be transported to a final destination. While there are some elements of capabilities to handle a course disruption, there were no specific details on how a response to a course disruption would be coordinated among disciplines and jurisdictions. (*Boston Marathon AAR*, p. 78).

3. **Activate EOC in Support of the Marathon.** The Boston EOC should be open and staffed with appropriate City agency liaisons as a precautionary measure. The liaisons to the EOC should be individuals who are authorized to communicate with other senior agency personnel and to make decisions. (*Boston Marathon AAR, p. 74*)

4. **Designate the Boston EOC as the City's Lead EOC and Clarify Roles**

of All City Departments in Boston EOC. To eliminate confusion over roles and responsibilities and effectively maintain a common operating picture on city-wide emergency response activities, ensure that each City department with a role in emergency response designates a representative at the Boston EOC to provide situational awareness and coordinate resources for that purpose. (*Boston Marathon AAR*, p. 87).

5. **Pre-identify and equip location(s) in Boston that can serve as a UCC should a large-scale incident disrupt the Marathon**. Although the UCC was stood up fairly quickly, the physical location of the UCC had not been pre- identified and therefore the location was not well equipped to support such an operation. …hotels do not necessarily have the capabilities and equipment on hand to support the activities of an emergency operations center, such as large quantities of phones, phone jacks, electrical outlets, computer equipment, and other resources necessary to support emergency operations.
(*Boston Marathon AAR*, p. 88).

6. **Develop and implement a Unified Coordination System for the Marathon**. All agencies and organizations with a responsibility for supporting the Marathon should plan and design a unified coordination system that identifies the roles, responsibilities, reporting relationships, and missions for all organizations and operations centers supporting Marathon public safety and medical operations. (*Boston Marathon AAR,* p. 89)

7. **Retain Public Safety Assets for a longer duration**. Public safety assets should be maintained at an appropriate level until crowds have largely disbursed and the contiguous town is cleared as runners. Maintain emergency buses on standby until the race has successfully concluded. (*Boston Marathon AAR*, p. 89).

8. **Provide additional training to hospitals on Investigative Protocols and Evidence Collection**. Law enforcement officials should provide additional training to hospitals on investigative protocols and evidence collection. (*Boston Marathon AAR*, p. 90).

9. **Establish protocols for Integrating Local Law Enforcement into Hospital Security during Emergencies**. Hospitals and local law enforcement should meet to discuss the circumstances under which law enforcement resources may be assigned to enhance hospital security, and

establish protocols for (*Boston Marathon AAR,* p. 90)

10. **Explore mechanisms for Bolstering Hospital Security**. Hospitals should consider options for contracting for additional security personnel when needed. (*Boston Marathon AAR*, p. 91).

11. **Identify or develop a process that could allow for safety inspections to be conducted while simultaneously ensuring the integrity of the crime scene**. Safety inspectors sought access to the restricted area to conduct safety assessments of infrastructure impacted by the blasts. The safety inspectors were not allowed access out of concern for maintaining the integrity of the crime scene, despite having experience with working in crime scenes alongside investigators. Investigators working the crime scene could have been at risk and the City exposed to liability claims. (*Boston Marathon AAR*, p. 91).

12. **Ensure adequate relief**. Law enforcement command should anticipate the potential relief needs of law enforcement officers supporting a long-term incident, and ensure officers are provided adequate relief, using mutual aid resources as necessary. (*Boston Marathon AAR,* p. 91)

13. **Provide additional Training On and Exercise the Use of Triage Ribbons and tags for Mass Casualty Incidents**. EMS personnel should train and exercise using triage tags and ribbons during mass casualty incidents to ensure they are well practiced in efficiently implementing this system.
(*Boston Marathon AAR,* p. 92)

14. **Identify an Alternative Mechanism to Secure Crowd Control Barriers that Allow for easy Disassembly by First Responders During Emergencies.** (*Boston Marathon AAR,* p. 93)

15. **Ensure Hospital Staff are familiar with their Facility's Bomb Threat, procedures, protocols, roles and responsibilities**. Hospitals should ensure that all staff members understand their hospital's protocols and procedures, as well as their individual roles and responsibilities during a bomb threat or discovery of a suspicious package. Hospitals should regularly exercise these procedures in coordination with local police and fire departments.
(*Boston Marathon AAR,* p. 94)

16. **Evaluate inventory for responding to Mass Casualty incidents.** Hospitals and EMS agencies should evaluate options and contingencies for obtaining additional supplies and equipment in a Mass Casualty incident. In addition, each region should work to develop a listing of regional resources that can be accessed during emergencies, and detail steps on how to obtain such resources. (*Boston Marathon AAR,* p. 94)

17. **Develop a formal course evacuation coordination plan**. MACC agencies with a role in coordinating response to course disruption nor evacuation of the course should develop a formal course disruption and evacuation coordination plan that identifies temporary shelter locations, stages appropriate transportation assets. (*Boston Marathon AAR,* p. 95)

18. **Ensure in-field personnel have food and relief**. Plan for supplying food and other necessities for in-field personnel who may be activated for long periods of time. (*Boston Marathon AAR,* p. 96)

19. **Obtain WPS access for key Public Safety personnel**. Evaluate the need to obtain WPS for key public safety personnel and obtain WPS access as appropriate. (*Boston Marathon AAR,* p. 96)

20. **Obtain redundant Communications Systems and Equipment for key leadership, and create protocols for implementing them.** Evaluate the need to obtain redundant communications systems for key leaders. If obtained, develop protocols for implanting these systems. (*Boston Marathon AAR,* p. 96)

21. **Conduct additional training on the Marathon Communications Plan and use of designated radio channels**. Ensure all disciplines are aware of the Marathon Communications Plan and how to access all designated channels. (*Boston Marathon AAR,* p. 97)

22. **Maintain an adequate supply of or develop a streamlined process for obtaining radio and cell phone chargers and batteries.** Because of the long duration of the event and incident, response partners worked far longer hours than anticipated and used their communications equipment more than anticipated. The ability to obtain fresh radio batteries and charge radio and cell phone batteries became a critical need. (*Boston Marathon AAR,* p. 97)

23. **Ensure that all CBRNE results information are widely communicated to the Public Safety, Public Health and Healthcare Communities**

during a Mass Casualty incident. All CBRNE monitoring results – negative and positive – must be rapidly reported to all public safety, public health, and healthcare partners as soon as possible. (*Boston Marathon AAR,* p. 98)

24. **Develop and distribute HIPAA Guidance for Emergency Situations.** Collaborate with appropriate federal authorities, legal counsel and hospitals to develop guidance on emergency allowances to HIPAA to release patient information. This guidance should be distributed to all hospitals. (*Boston Marathon AAR,* p. 99)

25. **Identify whether a central resource of patient information can be developed and shared after Mass Casualty Incidents.** Coordinate with legal counsel, hospitals and human services to determine whether a centralized resource of patient information should be developed following mass casualty and other emergency incidents, and whether information contained in that resources could be shared with family members of victims and survivors and/or human services agencies. (*Boston Marathon AAR,* p. 99)

26. **Review Protocols for Issuing Emergency Alert Messages**. Review protocols that would prompt and allow emergency personnel to issue emergency alerts during quickly unfolding incidents. (*Boston Marathon AAR,* p. 100)

27. **Develop Information Center Call Sheets for Call Center staff**. Develop ready-to-use templates including script outlines with basic responses and typical questions with answers that can be used by all call center staff during an emergency situation. Ensure call center staff are adequately trained in their use. (*Boston Marathon AAR,* p. 100)

28. **Develop a Disaster Mental Health Coordination Plan.** [Agencies] should lead the development of a Statewide Disaster Mental Health Coordination Plan with all appropriate public health and disaster mental health partners. The plan should delineate roles and responsibilities for coordinating the activation of a disaster mental health support system after a major incident or disaster. (*Boston Marathon AAR,* p. 101)
29. **Develop a centralized source that identifies Disaster Mental Health Specialists.** Agencies should partner to explore the potential for developing a centralized source of information on available disaster

mental health service providers, including contact information, credentials, specialized training, and other applicable details. (*Boston Marathon AAR,* p. 101)

30. **Clarify mass care and shelter roles in the City**. Though various agencies worked well together, there were several instances where primary responsibility for a particular aspect of the operation was unclear. (*Boston Marathon AAR,* p. 102)

31. **Develop alternate plan for reuniting runners with their personal belongings.** Develop a coordinated plan to reunite [runners] with their belongings should the race become disrupted. (*Boston Marathon AAR,* p. 103)

32. **Explore revising policy to allow arming of soldiers assigned to law enforcement missions.** Develop a coordinated plan for arming soldiers assigned to law enforcement missions, under appropriate circumstances. (*Boston Marathon AAR,* p. 93)

33. **Issue and train on tourniquet kits for all first responders.** First responders across the Commonwealth, in particular police, fire and EMS, should have a tourniquet kit issued to them as a standard practice. Conduct training to ensure first responders know how to apply issued tourniquets on the injured. (*Boston Marathon AAR,* p. 106)

34. **Assign a Logistics Coordinator to Disaster Mental Health Team.** (*Boston Marathon AAR,* p. 106)

35. **Establish a Joint Information Center for large-scale incidents to ensure coordinated public messaging.** Establish a JIC for large scale incidents or events to ensure that all public messages, including those disseminated through social media, are coordinated and validated. (*Boston Marathon AAR,* p. 107)

36. **Develop a Family Assistance Center Plan.** Both the City and the Commonwealth should develop a FAC plan for providing services to survivors, their families and families of the victims after a major incident. [Plan] would identify all considerations for establishing a FAC, including g services, staffing, security, supplies and potential locations. (*Boston Marathon AAR,* p. 107)

37. **Conduct enhanced ICS training for Law Enforcement**. Ensure appropriate law enforcement personnel receive enhanced ICS training to stress the importance of a command structure in a complex incident involving multiple aid resources, as well as the critical role of the Logistics Section Chief. (*Boston Marathon AAR,* p. 113)

38. **Establish a state-wide policy regarding on-scene command during complex critical incidents**. Law enforcement officials representing law enforcement agencies from across the Commonwealth should create plans and policies that can be implemented to maintain on-scene command at complex incidents. (*Boston Marathon AAR,* p. 113)

39. **Ensure Command Vehicles are located away from the staging area**. Vehicles used as command posts were located directly next to the designated mutual aid staging area. Because the staging area was overflowing with personnel and equipment, access to the command vehicles was, at times, problematic. (*Boston Marathon AAR,* p. 114)

40. **Conduct additional training on weapons discipline.** Conduct additional ICS and firearms training with a focused emphasis on weapons discipline, including ensuring careful target acquisition, trigger discipline, and authorization. (*Boston Marathon AAR,* p. 115)

41. **Review protocols and conduct training on management of responding vehicles**. Review protocols for responding officers and the management of their vehicles, as well as for dispatchers to remind responding officers to maintain open roadways when appropriate. Conduct training to ensure these protocols are universally understood. In an effort to respond quickly to the ongoing incident, arriving police officers topped their vehicles at the closest point of access to the ongoing scene and abandoned them, often with emergency lights on and doors left open. This bottle neck of vehicles hindered access to the area by senior police officials, as well as egress from the area. This also was an issue for the ambulance transporting a critically wounded officer and for police vehicles that may have otherwise been able to pursue the fleeing suspect (*Boston Marathon AAR,* p. 115)

42. **Regularly exercise removing and using rifles and other tactical equipment stored in vehicles.** It is common that law enforcement officers do not regularly practice removing and using tactical equipment mounted and/or stored in their vehicles. As such, all law enforcement

officers should exercise removing equipment from their mounts/storage areas at least weekly, and practice using equipment to ensure they are able to access and use it under high-stress conditions. (*Boston Marathon AAR,* p. 116)

43. **Conduct IED Awareness Training for Law Enforcement.** Ensure law enforcement officers can obtain IED awareness training. (*Boston Marathon AAR,* p. 116)

44. **Consult local knowledge as Standard Practice.** Mutual aid law enforcement officials should always relay on local expertise familiar with the community. (*Boston Marathon AAR,* p. 116)

45. **Revise the Mutual Aid Protocol**. Convene a meeting of state and local law enforcement officials …to establish a law enforcement mobilization plan for mutual aid at large incidents that addresses:
    - Requests for immediate assistance;
    - Identification of an Incident Commander (in cases where the community with the incident needs assistance in managing a large event;
    - Specific requests by the IC or UCC for longer term assistance (usually for specific capabilities such as SWAT, EOD, and crime scene investigations);
    - Guidelines for responding mutual aid personnel;
    - Use of ICS for law enforcement in a large incident. (*Boston Marathon AAR,* p. 117)

46. **Provide Mobilization Training.** Following development of the law enforcement mobilization plan proposed [in Recommendation 45], develop in- service training modules for all police officers in Massachusetts to understand the statewide mobilization system and policies for rendering mutual aid. (*Boston Marathon AAR,* p. 118)

47. **Designate a Dedicated Logistics Section Chief and/or Staging Area Manager.** Designating a Logistics Section Chief and/or Staging Area Manager will support the operation, create check-in procedures, and will track sources, personnel, assignments, and deployments from the staging area. (*Boston Marathon AAR,* p. 118)

48. **Limit Self-Deployment.** It must be part of police training throughout the state that in complex, large incidents, or multiple incidents, an officer does

not respond unless requested by an official with the authority to make such a request. Only police units assigned by incident command should respond. If an officer who does not have an assignment happens to be near the location where the suspect is reported to be, that officer should report availability to respond, rather than responding directly to the incident. (*Boston Marathon AAR,* p. 118)

49. **Plan and provide adequate relief for responders**. Designate a Logistics Section Chief, especially for larger incidents, to ensure officers in the field are provided an opportunity for relief, even if it is only for a short period of time. Additionally, when staffing a large operation, Command should plan for a second shift to limit officer fatigue and maintain officer/responder safety. (*Boston Marathon AAR,* p. 119)

50. **Reinforce the need to maintain radio discipline.** All first responders need to be reminded of the need for good radio discipline during a large scale event, and provided with protocols outlining appropriate and inappropriate use of messaging. (*Boston Marathon AAR,* p. 94)

51. **Provide training to field personnel on the capabilities of their radio systems for use in large operations.** Additional training and tactical exercises should be conducted to increase public safety personnel's experience and comfort with using interoperable systems and tactical channels. (*Boston Marathon AAR,* p. 116)

52. **Address radio equipment gaps in interoperability.** Review radio equipment gaps in interoperability and make recommendations to address them. (*Boston Marathon AAR,* p. 120)

53. **Ensure interoperable channels are programmed into public safety radios**. The Massachusetts Tactical Channel Plan outlines the need to program the state interoperability channels into every radio. The agencies and SWAT Teams with these channels programmed into their radios were able to access radio patches that allowed interoperable communications between teams. Those teams that did not have the channels programmed were either unable to communicate across teams or needed to utilize a cache radio. Additionally, consider holding joint training and exercises for area SWAT teams, to identify and resolve communications and coordination issues prior to the next major incident where multiple SWAT teams need to operate together. (*Boston Marathon AAR,* p. 120)

54. **Federal agencies should evaluate how their systems can be better integrated into local and state systems**.
(*Boston Marathon AAR,* p. 120)

55. **Work to create formal definitions and protocols for Shelter-in- Place requests**. There must be a concentrated effort on the part of political officials, in collaboration with public health entities and hospitals, to develop formal definitions and protocols for shelter-in-place requests. MEMA should work with MDPH and other stakeholders to clarify shelter-in-place requests and identify critical personnel and services that may be exempt.
(*Boston Marathon AAR,* p. 121)

56. **Activate a Joint Information Center.** Utilize a Joint Information Center (JIC) or Joint Information System (JIS) concept to manage large incidents. A JIC would have primary responsibilities of coordinating messages across and between agencies and jurisdictions and managing the media. This could include providing periodic briefings between press conferences to satisfy the media's need for the mots updated information. A JIC/JIS could also provide a mechanism to coordinate messages shared with traditional media and on social media platforms. (*Boston Marathon AAR,* p. 121)

57. **Ensure cross-training on use of notification tools and social media**. Agencies should ensure that more than one person within the agency can access notification tools and official social media accounts.
(*Boston Marathon AAR,* p. 122)

58. **Better define critical sectors, personnel and possible exemptions for Shelter-In-Place requests.** Area hospitals should work with DPS and MEMA to better define critical sectors, critical personnel, and outline possible exemptions from orders or requests that impose travel restrictions. (*Boston Marathon AAR,* p. 122)

59. **Ensure a regional stockpile of surgical supplies are ready for rapid access.** (*Boston Marathon AAR,* p. 116)

60. **Ensure access to Mental Health Services for all employees involved in disaster response and recovery activities.** Healthcare employers, human services employers, the Commonwealth and the City of Boston

should explore opportunities to provide post-disaster services for employees. Employee Assistance Programs should not serve as the sole resource for employees who have had direct contact with survivors, families, and impacted individuals, or who have worked directly in the area of impact. (*Boston Marathon AAR,* p. 127)

61. **Train managers on psychological first aid.** Healthcare employers, human services employers, the Commonwealth and the City of Boston should consider providing psychological first aid training to managers to provide them with skills to identify signs of psychological trauma in their employees.
(*Boston Marathon AAR,* p. 127)

62. **Develop strong PA guidance on eligibility of activities for Acts of Terrorism.** FEMA, in coordination with MEMA, should proactively develop strong guidance for sub- applicants on eligible activities, costs and documentation requirements associated with the PA Program for acts of terrorism. (*Boston Marathon AAR,* p. 128)

63. **Ensure timely communication of post-disaster grant opportunities.** Ensuring timely communication of grant opportunities will allow the State Administrative Agency (SAA) and program staff to better communicate with potential applicants, streamline the request for information, and ultimately, create more efficient and effective use of federal grant dollars. (*Boston Marathon AAR,* p. 128

Shooting at the Washington Navy Yard, Washington, D.C. (September 16, 2013)

The following "Lessons Learned" are taken from the "After Action Report - Washington Navy Yard, September 16, 2013: Internal Review of the Metropolitan Police Department, Washington, D.C." dated July, 2014.

Emergency Calls and Initial Notification

1.1 It may be prudent for military installations, especially those located in or near a largely populated area, to review their emergency call-taking procedures and policies to ensure they include guidelines for actions in the event of a large scale incident that will inevitably result in multiple agencies responding to the scene. (*Washington Navy Yard AAR*, p. 70).

1.2 The installation's emergency call takers and dispatchers should establish strong relationships with their local jurisdiction's 911 services agency. Both parties should be familiar with the other's emergency procedures. They may also consider developing a process and protocol for ensuring vital information from callers is quickly relayed between call centers during an incident. This relationship may be formalized in a memorandum of understanding (MOU) that is reviewed and updated on an annual basis. (*Washington Navy Yard AAR*, p. 70).

1.3 Emergency call-takers and dispatchers from the military installations communications center should train with the local jurisdiction's emergency communications personnel. Both parties should also be included in the scenario- based training exercises that are regularly conducted by emergency medical and law enforcement agencies. (*Washington Navy Yard AAR*, p. 70).

2.21 Conduct a review of the scripted call-taking procedures and policies. Determined if there should be a prudent best-practice or innovative approaches
("tactical dispatching") implemented for exigent circumstances, such as an ongoing active shooter. Even If the reported details may be difficult to believe, call takers should exhibit the proper demeanor at all times and should avoid conveying their doubt or skepticism over the line as it may undermine the caller's confidence in the operator. (*Washington Navy Yard AAR*, p. 70).

2.22 Ensure all street names and addresses of internal or gated complexes are included in the city's computer aided dispatch (CAD) system. Review and update on a regularly scheduled basis. (*Washington Navy Yard AAR*, p. 70).

2.23 Whether the emergency call center is part of a jurisdiction's law enforcement agency or it is part of a separate agency, it is the police department's responsibility to engage them in training and work with them to jointly develop applicable policies and procedures. (*Washington Navy Yard AAR*, p. 71)

3.1 Review and update policies and procedures to ensure 911 operators follow-up with all callers in order to obtain any potentially valuable information. Callers may be able to provide first responders with additional real-time intelligence or details of the incident. Information provided by callers may also be pertinent to the subsequent investigation of the incident. Call takers and dispatchers must be active participants in active shooter training. (*Washington Navy Yard AAR*, p. 71)

Police Response to the Scene

4.1 NDW is now reviewing their lockdown protocols. Consideration should be given to prudent modifications of protocol that will ensure local emergency responders are able to access the base in the event of a future incident. (*Washington Navy Yard AAR*, p. 71)

5.1 MPD commanders and officers should be familiar with the military installations and other gated complexes located within their police districts. District Commanders should obtain at least basic information regarding military installations, to include commanding officer of the installation, security structure, emergency contact information, emergency protocols, capabilities, installation maps/building locations, security camera locations, video control room location and building floor plans. Conversely, the commanders of military installations should be familiar with the local police response protocols and capabilities. Additionally, security and facility managers of large campuses, facilities, or office buildings may consider having a "go bag" at entry points that can be quickly provided to first responders in the event of a major incident like an active shooter. This bag would contain maps of the facility, floor plans, access keys/cards, contact phone numbers, radio communication information, and other pertinent items of information. (*Washington Navy Yard AAR*, p. 71)

5.2 Military installations (and other gated facilities or complexes) should

ensure that their street names and addresses are included in the computer aided dispatch (CAD) system of the jurisdiction in which they are located. This will assist officers in locating the proper location in an efficient and timely manner. The information should be reviewed and updated on a regular basis. Additionally, military installations and other large complexes/campuses) may want to explore the possibility of utilizing more conspicuous visual markers for building and streets within their installation. (*Washington Navy Yard AAR*, p. 71)

Tactical Operations: Search for the Gunman

6.1 Neighboring law enforcement agencies, both Federal and local, should conduct collaborative, inter-agency training exercises. By training together, officers from different agencies are able to develop trust and mutual understanding prior to responding together to an incident that may require a multi- agency response. The tactical teams for the various regional agencies train
together on a regular basis. MPD's Emergency Response Team (ERT) and the other area agencies' tactical operators are extremely familiar with one another's teams, tactics and response plans. This familiarity should exist on additional levels throughout the agency – including patrol officers, field agents and deputies
– since these will often be the first personnel to arrive on the scene of an active shooter. Active shooter training should include different types of locations, including military bases. It is also important to note that even if a closed campus or gated facility has its own plans and protocols to respond to and manage a crisis, it is vital that the facility's personnel plan for the unexpected and include larger-scale response. (*Washington Navy Yard AAR*, p. 72)

6.2 The personnel from different agencies should receive standardized training, which results in a consistent understanding of tactics, communications, and approach. Collaborative training is also an opportunity to highlight the importance of coordinated response by all involved. Ultimately, all personnel who arrive on scene should report to and be deployed by the incident commander. (*Washington Navy Yard AAR*, p. 72)

7.1 Equipping personnel with strong leadership skills and the ability to make difficult decisions in the midst of a crisis requires a long-term effort. The Command on scene was a veteran police official with over 35 years of

service. Strong leadership skills are honed through exposure to a myriad of experiences, comprehensive training, and police leadership opportunities. One consistent theme in the after action reports published by other agencies following similar mass shooting incidents is the recognized need for strong, composed and decisive leadership during the initial response. A well-coordinated and effective response often hinges on the leadership of the police official managing the on- scene efforts. The leadership of the initial tactical response at the Navy Yard serves as another example of that important element.
(*Washington Navy Yard AAR*, p. 72)

7.2 Provide position-specific training for Incident Command System (ICS) and Incident Management Team (IMT). While all police personnel should be familiar with ICS and IMT roles and principles, most mid-to-upper-level police officials will likely serve in a specific management role during an incident response; especially in larger agencies. For these large agencies, having all sworn officers, regardless of rank, train tactically may not provide the most benefit since most command officials and managers are not required to respond in a tactical mode. They will, however, be needed to manage personnel and the overall response to an incident. There are many good mid- to upper-level police officers who should be trained to take leadership of a portion of the operational responsibilities, rather than just waiting for an assignment.
(*Washington Navy Yard AAR*, p. 72)

8.1 Review active shooter formations and train officers to adapt their tactics to fit the environment. For instance, the current standard of training instructs active shooter teams to move in a diamond formation. While this formation may work well for scenarios involving large hallways, in schools for example, it may not be effective in narrow hallways and walkways of offices and cubicles. In narrower environments, the diamond formation may allow a hidden gunman to more easily target officers. (*Washington Navy Yard AAR*, p. 73)

8.2 Active shooter training should include difference types of locations, buildings and structures in the scenarios, including modern buildings with various levels of security, access card entry, motion sensors, cypher locks, alarms and narrow hallways and complex layouts. These security features are becoming more common in both private and public sector buildings…
(*Washington Navy Yard AAR*, p. 73)

8.3 Police departments should conduct pre-incident evaluations of buildings

and facilities located within their area of responsibility. The evaluations should be stored in an accessible, central location. (*Washington Navy Yard AAR*, p. 73)

8.4 MPD is in the process of obtaining and distributing earpieces to all of its members. The extensive noise and sensory overload may result in officers not being able to hear all radio communications. The fire alarm in Building 197 complicated communications, especially for officers searching for the shooter. Earpieces will allow officers to better hear communications in loud environments and also keep radio communications from potentially giving away the officers' position to a shooter. (*Washington Navy Yard AAR*, p. 73)

8.5 Review and update the policies regarding when officers should switch to an alternate radio channel during a large scale, critical incident. The current policy governing when officers should switch channels is based on the more common scenarios of pursuits or barricades, but it does not take into account the unique dangers of a critical incident like an active shooter. At the Navy Yard, the initial responding officers, the ones who entered the building to search for the shooter, were on the First District (or "1D") radio channel, but they were asked to switch to an alternate channel during the search. In critical incidents, like active shooter, the responding officers should remain on the original channel. Due to the nature of the ongoing threat and sensory overload, officers involved in the search for active shooter will often not hear requests to switch to an alternate channel. Additionally, all officers inside the "hot zone" should be communicating on the same designated channel. There are obvious safety risks if, for example, some of the officers are operating on one channel and other officers, such as ERT, are operating on their own ERT channel. (*Washington Navy Yard AAR*, p. 73)

8.6 MPD is procuring shorter barrel rifles and additional ballistic shields. Many years ago, police departments across the country, MPD include, began to acquire semi-automatic rifles, such as the AR-15s, in the event of an active shooter or other incident in which responding police officers may find themselves outgunned by suspects. (*Washington Navy Yard AAR*, p. 74)

8.7 MPD is exploring the procurement and deployment of an equipment truck that is manned and ready for rapid deployment to any location in the city in the event of a critical incident. This truck would hold various tools and equipment
– such as breeching equipment, rifles, shotguns, Level III vests and helmets, compact shields, lights, batteries, etc. MPD has long had the

equipment deployed to various officers throughout the department, however, the deployment of an equipment truck, standing by 24-7, is a practical approach that allows the equipment to be ready and available for responding officers….many patrol officers are not in vehicles, but rather patrol on foot, bike, motorcycle, or other mode that does not allow for carrying large pieces or large amounts of this type of equipment. (*Washington Navy Yard AAR*, p. 35)

9.1 There are two critical pieces to ensuring that good emergency plans are more than just another book on the shelf. Even the best crafted and most comprehensive plans rely on the awareness and understanding of the workers and the first responders. Facilities should conduct regular awareness training and drills for their employees and building occupants so everyone will know what to do in the event of an emergency. Additionally, the local first responders should be aware of the emergency plan. In this particular instance, MPD and FEMS should be intimately familiar with NDW's emergency plans. (*Washington Navy Yard AAR*, p. 74)

9.2 It may also be prudent for the local agencies to train with first responders on military installations, in this case NDW Police, Fire and Medical Services. D.C. Fire and Emergency Medical Services have trained with NDW personnel, but prior inter-agency training between MPD and NDW was minimal….Additionally, the agencies may consider entering into MOU to formalize the roles and relationships. (*Washington Navy Yard AAR*, p. 75)

10.1 Consider extending the training and exercises that are conducted by emergency responders beyond merely testing and assessing the tactical response. Training should also include portions on what must occur during or following a large-scale, multi-agency tactical response, such as witness management, investigations, crime scene management, medical response, coroner/medical examiner, victim services, family reunification and other major components. Managers should train to their most likely role in the response. Having a written plan for the aforementioned portions of a response is of course vital, but fully understanding and adequate preparation requires hands-on training and simulated exercises. (*Washington Navy Yard AAR*, p. 75)

Operational Coordination

11.1 Regularly voice the location of Unified Command over the radio and make the location as visible as possible. Utilize a beacon or other visible

marker to indicate the location and distribute vests to identify personnel and their roles. (*Washington Navy Yard AAR*, p. 75).

11.2 All responding agencies should have policies and training that direct the first responding member of an agency to check in with the IC to become the IC liaison so critical directions and information can be effectively shared with that agency. (*Washington Navy Yard AAR*, p. 75).

11.3 Provide position-specific training for Incident Command System (ICS) and Incident Management Team (IMT). While all personnel should be familiar with ICS and IMT roles and principles, most mid- to upper-level police officials will likely serve in a specific role during a large response and a full understanding of that particular role and its responsibilities is imperative. (*Washington Navy Yard AAR*, p. 76).

12.1 The IAP and planning process is important and should be completed properly, but the focus on completing all portions of the IAP during an initial tactical response may be unnecessarily burdensome or even counterproductive. A tactical checklist that includes all the immediate goals and objectives may be a more appropriate format for an immediate tactical response in active shooter scenarios. (*Washington Navy Yard*, p. 76).

13.1 To avoid confusion and congestion, it may be prudent to designate a primary command bus and operations center for Unified Command. This will ensure that there is adequate representation from all agencies for the duration of the incident. If other agencies wish to transport their command bus to the scene of an incident or activate their operations center, they should ensure that neither impacts the functions of the primary designated bus and center. (*Washington Navy Yard AAR*, p. 76).

Scene Management and Security

14.1 Ensure comprehensive actions are taken to establish site security. (*Washington Navy Yard AAR*, p. 76).

14.2 Have personnel prepared and standing by to respond rapidly to a secondary or additional incident. (*Washington Navy Yard AAR*, p. 76).

14.3 Ensure all personnel understand the importance of proper site security. All personnel should be wearing appropriate identification and it should be conspicuously displayed. (*Washington Navy Yard AAR*, p. 76).

15. If not already in existence, agencies should establish clear policies regarding self-dispatching. MPD has reiterated its policy regarding members not self-dispatching. Officers should instead follow established protocols (Example: report to the appropriate patrol district or nearest police facility) and if required to report to the scene of the incident, do so at a designated location or staging area. Training should test the officers understanding of self-dispatch procedures. (*Washington Navy Yard AAR*, p.76)

15.2 Training and exercises should also test the supervisors' and managers' ability to manage an incident in which there are many self-dispatching officers. (*Washington Navy Yard AAR*, p.76)

16.1 Explore technology to track officers when entering a hot zone in order to account for those who entered the area, especially in the event of a secondary incident. (*Washington Navy Yard AAR*, p.76)

16.2 As an alternative, have an official quickly record the ID number of officers as teams are formed and deployed into the hot zone. (*Washington Navy Yard AAR*, p.77)

16.3 For a possible use of force investigation, officials must track and debrief officers and inspect weapons prior to the officer departing the scene to determine which officers have used force or deadly force. (*Washington Navy Yard AAR*, p.77)

17.1 Police should be prepared to investigate multiple leads and should consider the possibility of multiple suspects. Focusing on one lead or suspect and ignoring the possibility of multiple shooters may distract police from pursuing a threat that continues to expose the community and first responders to further danger. (*Washington Navy Yard AAR*, p.77)

18.1 Ensure that an official is tasked with maintaining a route for emergency vehicles to quickly access and depart the scene. (*Washington Navy Yard AAR*, p.77)

18.2 Remain mindful of the impact the incident may have on citywide traffic. Street and road closures are inevitable; however, ensure an official is tasked with monitoring citywide traffic and mitigating the potential negative impacts. (*Washington Navy Yard AAR*, p.77)

18.3 Provide the public and media with regular updates as to the street and road closures resulting from the emergency response.(*Washington Navy*

Yard AAR, p.77)

Operational Communications

22.1 When responding to a major incident, officers may find that radio communications and cell phone service are not available. First responders should be prepared for the possibility of having to relay information through non- traditional modes of communication, such as utilizing runners or hand signals. (*Washington Navy Yard AAR*, p.78)

22.2 MPD is exploring the establishment of secure multi-jurisdictional tactical channel and separate support channel and developing the appropriate policies and ensure officers know how and when to use those channels. These policies must be consistent with Recommendation 8.5, which outlines the updates to the policies related to switching channels during large tactical response operations such as an active shooter. Again, the initial tactical operations should remain on the original radio channel. The communications for all other activities and functions should be moved to another channel. Due to the nature of the incident and sensory overload, officers involved in the search for an active shooter will often not hear requests to switch channels. The switch could potentially be life-threatening. Additionally, during recent training, MPD has emphasized officers' radio discipline in order to reduce unnecessary transmissions and ensure the channel is available for the most critical communications. (*Washington Navy Yard*, p.78)

22.3 Agencies should consider investing in encrypted radio channels. There are clear safety benefits of utilizing encrypted channels during a tactical response to an ongoing threat. MPD is spearheading an initiative that is evaluating shared encrypted tactical channels that would be available to many of the responding agencies. (*Washington Navy Yard*, p.79)

23.1 Incident Command should ensure that a representative with knowledge of the incident location – including buildings, security measures, and protocols – is identified early on and made available to provide background information. Police and other emergency response agencies should develop pre- incident relationships with the security directors and facility directors of large complexes, both public and private, that are located within their jurisdictions. (*Washington Navy Yard*, p.79)

23.2 The various units or entities responsible for CCTV cameras and security personnel at given locations (military installations, government facilities, transportation hubs, etc.) should regularly coordinate and train with one

another to ensure all personnel are aware of camera locations, access protocols, and information sharing procedures in the event of an incident. This is especially important for locations that may have multiple or different units responsible for various portions or sections of a large facility or installation. (*Washington Navy Yard*, p.79)

23.3 Training must include the most likely involved personnel. It is not enough to train solely with other law enforcement agencies. Training and exercises should also include both the armed and unarmed security guards, who should be familiar with the emergency plans of the facilities to which they are assigned. It is critical that they be included in training and exercises to ensure they fully understand their roles and responsibilities in the event of an emergency. (*Washington Navy Yard*, p.79)

24.1 The Unified Command must hold regular briefings with the appropriate branches of the Incident Command to ensure vital information is shared with all personnel. Additionally, a connection must be made with HSEMA to ensure that floor plans and other important information related to the location are relayed to Unified Command and all necessary tactical units. (*Washington Navy Yard AAR*, p.79)

25.1 Develop the appropriate policies and conduct comprehensive training related to communications protocols for investigative response to large incidents. Detectives/investigators should receive and be well-versed in ICS, especially their position-specific IMT role. When an incident occurs and the initial tactical objectives have been achieved (and the threat neutralized), an initial briefing should be conducted with all investigators to ensure awareness, accountability, and understanding of responsibilities. The investigative chief should be the only one providing directions and instructions from Unified Command. A dedicated radio channel should be available and known by all investigative personnel in order to coordinate and communicate actions. (*Washington Navy Yard AAR*, p.79)

25.2 Develop a mass witness management plan or operating procedure, outlining the process by which a large number of witnesses can be quickly evacuated, triaged, and interviewed. The plan would also include an appropriate checklist or form document that can be used by detectives to quickly process large numbers of potential witnesses. Ensure all members are trained in executing the plan. (*Washington Navy Yard AAR*, p.80)

25.3 At least some training exercises should go beyond merely testing the

tactical response and also include the investigative functions. All of the above investigative recommendations and actions should be exercised and tested. (*Washington Navy Yard AAR*, p.80)

26.1 By clarifying he specific roles of each agency early on, much of the subsequent confusion and uncertainty may have been avoided. While the FBI took the lead role of processing the crime scene, MPD remained responsible for the death investigations by virtue of applicable D.C. laws. MPD also remained responsible for the investigations of use-of-force by police officers. With the clear delineation of the roles and expectations, the necessary coordination and communication with the various involved agencies would have flowed much more naturally. (*Washington Navy Yard AAR*, p.80)

27.1 Conduct a conference call early on (after the initial crisis is over) with representatives from all local agencies in order to provide information/instructions and answer any questions. Hold additional briefings as necessary. Craft a pre-incident checklist, which lists all agencies, protocols and tasks and can be included in the city's overall response plan. (*Washington Navy Yard AAR*, p. 80)

27.2 Agencies should adhere to the notification and information sharing protocols that are outlined in the city's response plan. Review and update the plan to ensure that the notification protocols clearly outline the proper procedures for both requesting agency assistance and responding to the scene. May want to consider that in the event of a large-scale incident with multiple homicides, the request for the presence of the Medical Examiner should come from the local homicide unit (regardless of which agency is serving as the lead) since the local unit is familiar with and works with the Medical Examiner on a regular basis. (*Washington Navy Yard AAR*, p. 80)

Medical Services, Reunification, and Victim Services

19.1 As a result of this incident, MPD and D.C. Fire and Emergency Services (FEMS) are exploring collaborative training to ensure there is no delay in the provision of medical services, even in the instances of an active incident. Additionally, the U.S. Park Police utilizes a Federal combat or tactical medic program, through the Department of Health and Human Services, in which two of their members are both armed police officers and highly-trained medical personnel. These tactical medics are trained to provide immediate medical treatment on-site prior to the arrival of EMS personnel. Both of these tactical medics had responded to Building 197

and were assisting rescue efforts. There was also a Navy surgeon who happened to be at the Navy Yard that day. All three had set up to conduct triage on the first floor. (*Washington Navy Yard AAR,* p. 77)

19.2 MPD is procuring and will be distributing tactical emergency casualty care (TECC) kits to its officers that include such items as tourniquets, trauma gauze, and quick-clot, and training officers in TECC methods. This would allow officers to provide medical attention in those critical moments to those who may have suffered serious, life threatening injuries. While this approach may be interpreted as conflicting with the accepted active shooter training principles that instruct officers to bypass injured victims to find and neutralize the threat, a sensible balance can be struck. If life-saving measures can be provided to a seriously-injured victim or officer without delaying the search for the suspect or shooter, it would be reasonable to do so. The objectives -neutralizing the threat and saving injured victims – may not always be mutually exclusive and unnecessarily sacrificing one to achieve another is not necessary. (*Washington Navy Yard AAR,* p.77)

20.1 Begin preparing for and implementing the family reunification operations early on during the incident in order to provide family members with information and instructions. (*Washington Navy Yard AAR*, p.78)

20.2 The Family Assistance Center Plan should be reviewed, updated, and clarified. All pertinent agencies should be involved in the review. Modifications should be made that clearly denote the agency responsible for initiating and leading the family assistance and reunification efforts. (*Washington Navy Yard AAR*, p.78)

20.3 Conduct training and exercises to ensure all stakeholders fully understand their role and responsibilities with regard to the family reunification efforts. (*Washington Navy Yard AAR*, p.78)

21.1 In the District of Columbia, the MPD Homicide Unit conducts all family or next-of-kin notifications. It is an extremely difficult and emotional task that requires understanding, compassion, candor and strength. IN future incidents it is prudent that the death notifications be led and conducted by the local agency that is familiar with and experienced in carrying out such a difficult task. (*Washington Navy Yard AAR*, p.78)

21.2 The identification of victims is extremely challenging under these types of circumstances, however, law enforcement should attempt to identify victims as quickly as possible. (*Washington Navy Yard AAR*, p.78)

Public Information

28.1 Conduct training and exercises and include all Public Information and Affairs personnel from all relevant agencies to ensure they are aware of the roles and responsibilities of the JIC. (*Washington Navy Yard AAR*, p.80)

28.2 Ensure the appropriate public information officers and affairs personnel are ICT/IMT trained. The lead of the JIC should be identified early on during the establishment of the JIC. It is prudent that the individual serving as lead should possess prior ICS/IMT training in order to ensure all JIC responsibilities are properly managed. (*Washington Navy Yard AAR*, p.80)

29.1 Establish formal protocols for ensuring the appropriate representatives from the hospitals are integrated into the JIC. (*Washington Navy Yard AAR*, p.81)

29.2 Conduct training that involves the relevant personnel from the area hospitals and the D.C. agencies that coordinate with medical facilities including HSEMA and Department of Health. (*Washington Navy Yard*, p.81)

30.1 Craft an action plan for communications strategies, outlining roles and responsibilities that can be activated when an incident occurs. (*Washington Navy Yard AAR*, p.81)

30.2 Conduct comprehensive training for all members in the JIC and other public communications functions. (*Washington Navy Yard AAR*, p.81)

31.1 Law enforcement officials should put the press on notice – early on and in a public forum – clearly indicating that all official information regarding the incident will come from Incident Command or through the formal public information channels. (*Washington Navy Yard AAR*, p.81)

31.2 Monitor media outlets and social media in order to quickly correct mistaken or inaccurate information that is reported. There may also be investigative benefits, such as identifying potential witnesses (Navy Yard workers were posting information on their Twitter accounts.) (*Washington Navy Yard AAR*, p.81)

Resource Management

32.1 Incident Command should establish a resource staging location and

share this location with responding agencies so they can check in and be appropriately tracked. The location should be well-marked and clearly visible to all responding agencies. (*Washington Navy Yard AAR*, p.81)

32.2 All law enforcement and emergency response agencies should have clear policies and training that directs responding personnel to seek out and check in at the designated staging location. (*Washington Navy Yard AAR*, p.81)

33.1 Conduct training to exercise and test demobilization plans and preparations pursuant to ICS roles and responsibilities. (*Washington Navy Yard AAR*, p.81)

33.2 All law enforcement and emergency response agencies should have clear policies and training that directs responding personnel to follow the appropriate demobilization procedures prior to departing the incident location. (*Washington Navy Yard AAR*, p.81)

33.3 Debriefing of personnel, especially those in the “hot zone”, is a vital aspect of demobilization as it also allows officers to get critical witness information, assess the well-being of the officers, and offer EAP (Employee Assistance Program) support services once the crisis is over. We cannot ignore the fact that incidents with shocking mass casualties can be troubling to even a hardened, veteran police officer. (*Washington Navy Yard AAR*, p.82)

34.1 Officials must consider the long-term objectives and ensure there will be an adequate number of personnel to carry out prolonged response operations. This consideration is not only critical to ensuring there is no lapse in police operations, but is also vital for the health and well-being of personnel. A scheduling system, such as alpha/bravo, should be prepared well in advance of an incident requiring its activation. (*Washington Navy Yard AAR*, p.82)

Citywide Operations

34.1 Ensure there is an official tasked with monitoring and managing the citywide operations and functions. Calls for police service and other assignments will continues in spite of the larger incident. Regularly review personnel needs at both the incident location and throughout the city to ensure there is adequate staffing. Many of the officers working the incident were from the First Police District. Officials ensured that officers were brought in from other district in order to cover regular police

operations in the first district. (*Washington Navy Yard AAR*, p.82)

San Bernardino Terrorist Shootings, San Bernardino, CA (December 2, 2015)

The following "Lessons Learned" are taken from "Bringing Calm to Chaos: A Critical Incident Review of the San Bernardino Public Safety Response to the December 2, 2015, Terrorist Shooting Incident at the Inland Regional Center," dated 2016.

Lessons Learned

4.1 Organizational leadership should ensure that all involved in the respond feel valued and are provided access to the physical and mental health resources they may need after a critical incident. Agencies should identify best practices related to employee wellness. ("*Bringing Calm to Chaos*", p. 113)

4.2 Regularly review lessons learned from critical incidents with regional first responders and develop training that incorporate lessons and promising practices ("*Bringing Calm to Chaos*", p. 113)

4.3 Include representatives from all levels of the organization in critical decisions to enhance outcomes. ("*Bringing Calm to Chaos*", p. 113)

4.4 Predetermine elected officials roles and responsibilities in managing critical incidents and include them in critical incident training and exercises. ("*Bringing Calm to Chaos*", p. 113)

4.5 The intense media coverage associated with a high-profile event is overwhelming and will place additional demands on leaders that may take them away from daily operations. These demands will continue long after the conclusion of the incident, requiring leaders to constantly assess the effects the increased attention and notoriety bring on themselves and the organization. ("*Bringing Calm to Chaos*", p. 113)

4.6 Publicly demonstrate and recognize the collaboration and support from others. ("*Bringing Calm to Chaos*", p. 113)

5.1 Agencies should routinely examine critical incident reviews and plans at a regional level for the possibility of similar events. ("*Bringing Calm to Chaos*", p. 113)

5.2 Agencies should use ICS beyond large-scale tactical events and incorporate as many of the principles as possible in response to routine

emergencies so it becomes a regular component of a department's operating philosophy. ("*Bringing Calm to Chaos*", p. 113)

5.3 Regional public safety partners should plan and exercise unified command for complex incidents on a regular basis. This includes law enforcement, fire, EMS, and emergency management as well as other government or nongovernment agencies as appropriate. ("*Bringing Calm to Chaos*", p. 113)

5.4 As soon as possible and practical during an incident, establish a unified command of all primary first responders to facilitate communications, situational awareness, operational coordination, allocation of resources, and delivery of services. ("*Bringing Calm to Chaos*", p. 113)

5.5 After adequate personnel are on scene, additional personnel should be directed to a staging area for assignment of duties. As described in a variety of NIMS courses, designating a staging area manager is critical in the early moments of the response. ("*Bringing Calm to Chaos*", p. 113)

5.6 Agencies must plan for potential chaos created by public safety personnel responding to an active shooter. ("*Bringing Calm to Chaos*", p. 114)

5.7 Agencies should anticipate and plan a timely transition from the somewhat chaotic active shooter response to a more methodical search for possible suspects, triage of victims, and victim and witness extraction. ("*Bringing Calm to Chaos*", p. 114)

5.8 Responders should constantly evaluate security risks of command posts locations and make appropriate adjustments as required. ("*Bringing Calm to Chaos*", p. 114)

5.9 Send pictures or maps of the area – building layouts, parking lots, streets and the like – to dispatch and vehicle mobile data terminals (MDT). Employs technology, such as helicopters, unmanned aircraft systems (UAS), or pre-existing cameras (as available) to produce information in real time. ("*Bringing Calm to Chaos*", p. 114)

5.10 It is the responsibility of each first responder to assess a situation while en route to an active shooter incident as well as after arriving to determine if they are needed as part of the response. If an officer has initiated action at a scene or been assigned a specific task, the officer should not leave unless directed to do so. ("*Bringing Calm to Chaos*", p. 114)

5.11 Supervisors must anticipate the likelihood of unnecessary self-deployment and make efforts to discourage and restrict officer response. ("*Bringing Calm to Chaos*", p. 114)

5.12 Agencies must continually plan and evaluate ingress and egress routes during critical incidents. An incident safety officer should be designated as quickly as possible and pay particular attention to the access or egress of emergency vehicles. Ambulance and medical transport should be given a high priority task for police and fire incident command. ("*Bringing Calm to Chaos*", p. 114)

6.1 Because initial responders to a critical incident may be from a variety of agencies, regional training improves performance in a crisis response and should include all disciplines and levels of first responders. Fire, EMS, and other potential first responders should be included in in-service active shooter training as appropriate. ("*Bringing Calm to Chaos*", p. 114)

6.2 In-service training, regardless of the topic, should be updated on an annual basis and meet federal, state, and other appropriate certification standards. ("*Bringing Calm to Chaos*", p. 114)

6.3 The ability to understand and apply response strategies in a high- stress environment improves performance. Training should attempt to create as much sensory deprivation or stimulus as possible to simulate real-world scenarios. ("*Bringing Calm to Chaos*", p. 114)

6.4 First responders should be familiar with critical infrastructure as well as facilities that regularly bring large numbers of people together. Consideration should be given to reducing or eliminating environmental stressors if possible. Sound, darkness, and other environmental stressors can make it difficult to find and identify suspects and may hinder evacuations as well as search and rescue efforts. ("*Bringing Calm to Chaos*", p. 114)

6.5 Law enforcement agencies should train all officers in tactical emergency medical care. ("*Bringing Calm to Chaos*", p. 115)

6.6 Active shooter training should include transition from a dynamic active shooter situation (a situation that is evolving very rapidly consistent with the suspect's actions) to a static situation (a situation that is not evolving or in motion because the suspect is contained, has escaped, or is incapacitated). Training

should recognize that active shooter incidents may evolve from dynamic to static situations and possibly back to dynamic or mass casualty situations requiring transitions over the course of police response. ("*Bringing Calm to Chaos*", p. 115)

6.7 Training exercises should continue past the point where the threat no longer exists and extend to notification of victims' families by the medical examiner or coroner. ("*Bringing Calm to Chaos*", p. 115)

6.8 Training should include secondary device identification, notification, and isolation. ("*Bringing Calm to Chaos*", p. 115)

6.9 Civilian and private sector training for active shooter event can save lives. Inform the public of appropriate measures to take if they are involved in an active shooter or other hostile event, and provide a general overview of the police response. ("*Bringing Calm to Chaos*", p. 115)

6.10 Communications centers should hold regular inter-department interoperability communication drills with regional public safety agencies. Human and equipment communications issues should be identified and remedied during communications drills and joint exercises. ("*Bringing Calm to Chaos*", p. 115)

6.11 Dispatch centers should be included in incident command system (ICS) training, which should include testing public safety proficiency in using radio and other communications systems. ("*Bringing Calm to Chaos*", p. 114)

6.12 Because dispatch systems can quickly become overwhelmed in a mass casualty, active shooter, or other critical incident, agencies should develop a tactical dispatcher system that provides a dedicated dispatcher responsible for the operational needs of the incident and tactical commander.
("*Bringing Calm to Chaos*", p. 115)

6.13 Develop a system and protocols for diverting nonemergency calls elsewhere as well as establishing protocols to handle calls from family, friends, and media. ("*Bringing Calm to Chaos,*" p. 115)

6.14 During large-scale multiagency events, dispatch personnel should be collocated to facilitate information exchange and resource coordination and to complement ICS. ("*Bringing Calm to Chaos,*" p. 115)

6.15 CAD systems should be load tested to ensure the systems can handle a significant event lasting a long period of time. ("*Bringing Calm to Chaos,*" p. 115)

6.16 Training exercises should simulate a system slowdown or shutdown during a crisis and describe alternative communication strategies and protocols. ("*Bringing Calm to Chaos,*" p. 115)

6.17 Agencies should identify facilities within their communities that pose radio transmission and reception difficulties and use those facilities to train personnel and identify ways to mitigate poor communication so they are prepared should an incident occur. ("*Bringing Calm to Chaos,*" p. 115)

6.18 Agencies must reinforce radio discipline. Merely increasing radio capacity alone does not reduce the volume nor does it establish a priority of communication. It is an officer's responsibility, based on training and agency policy, to differentiate between critical radio communication and less critical communication that does not need to be broadcast. ("*Bringing Calm to Chaos,*" p. 116)

6.19 Additional consideration should be given to merging radio systems and protocols between law enforcement, fire, and EMS. ("*Bringing Calm to Chaos,*" p. 116)

6.20 The ability to communicate using encrypted channels improves communication without jeopardizing officer and community safety. ("*Bringing Calm to Chaos,*" p. 116)

6.21 Ensure that communications extend to the appropriate public safety organizations even if the technology in use does not automatically do so. ("*Bringing Calm to Chaos,*" p. 116)

6.22 Pre-incident planning should include timely access to building diagrams, particularly critical infrastructure and plans of buildings where large numbers of people gather on a regular basis. ("*Bringing Calm to Chaos,*" p. 116)

6.23 Regions should adopt a standardized marking system, similar to the International Search and Rescue Advisory Group marking system, for easy identification of areas searched, cleared, and secured by law enforcement personnel. ("*Bringing Calm to Chaos,*" p. 116)

6.24 Law enforcement agencies should establish training and protocols for the

use of rapid entry systems used by fire and EMS providers so that the need to breach locked or barricade doors is reduced. ("*Bringing Calm to Chaos,*" p. 116)

6.25 States should establish a resource typing systems, similar to the system used by the fire service, to categorize and track available resources that may be required to respond to a critical incident. ("*Bringing Calm to Chaos,*" p. 116)

6.26 Public safety agencies should consider how they will deploy emergency medical responders in an active shooter or other hostile events to ensure victim triage, extrication, and treatment. ("*Bringing Calm to Chaos,*" p. 116)

6.27 To reduce the amount of time it takes for victims to receive medical care, regions should establish medical tactical teams designed to work in a "warm zone," allowing victims to be moved more quickly to a mass casualty triage area. ("*Bringing Calm to Chaos,*" p. 116)

6.28 Agencies should ensure adequate protective gear is issued to personnel that may respond to an active shooter incident. Equipment should include active shooter armor kits (ballistic helmets and ballistic vests with ceramic plates) that afford greater protection from high-powered, semi- and fully automatic weapons and ammunition. ("*Bringing Calm to Chaos,*" p. 116)

6.29 Law enforcement agencies should equip officers with personal tactical emergency medical kits. ("*Bringing Calm to Chaos,*" p. 116)

6.30 If equipment is incorporated as an integral part of training, officers should have the equipment issued and available to them. ("*Bringing Calm to Chaos,*" p. 117)

6.31 Response protocols should include positioning heavy fire response vehicles as shields from secondary devices and active shooters. ("*Bringing Calm to Chaos,*" p. 117)

7.1 All first responder agencies must recognize that not all mass casualty incidents are crime scenes (for example, natural disasters are not crime scenes) but all terrorist events are. All responders to a potential terrorist incident should understand the importance of evidence preservation, documentation, and collection. ("*Bringing Calm to Chaos,*" p. 117)

7.2 Critical incident management is greatly enhanced when there are pre-existing relationships between leaders and field supervisors from all

potential first responder agencies. (“*Bringing Calm to Chaos*,” p. 117)

7.3 A determination should be made in identifying agencies with the best skills and tools to perform investigative tasks. Jurisdictional investigative authority does not necessarily correlate with investigative skills, abilities, training, and equipment. (“*Bringing Calm to Chaos*,” p. 117)

7.4 Critical incident training and exercises should include an investigative component that includes identifying all aspects of victim and witness identification, interviewing, and reunification. (“*Bringing Calm to Chaos*,” p. 117)

8.1 Using social media such as Twitter, Facebook, YouTube, Instagram, Periscope, Flickr, NextDorr.com, and others has become critical for releasing timely and accurate information both to the public and to the traditional media. By being active on social media leading up to critical incidents, law enforcement agencies can better inform the public. (“*Bringing Calm to Chaos*,” p. 117)

8.2 The involvement of staff responsible for the release of information to the public in executive level strategy meetings provide critical in deciding which information should be released while allowing for a unified message to be relayed from multiple agencies and platforms. (“*Bringing Calm to Chaos*,” p. 117)

8.3 Public affairs units should be included in all training, whether it is conducted as a tabletop or a live exercise. Also, creating a system to classify multiple levels of response to different sorts of events for public affairs units will only improve the ability to respond quickly and effectively. (“*Bringing Calm to Chaos*,” p. 117)

8.4 When possible, identify a liaison to work directly with and coordinate elected officials involvement in the incident response. Liaisons should be at the scene, not in the office, as this is where many politicians will likely be located. The liaison can help officials stay focused on predesignated duties and responsibilities rather than being involved in scene or on camera when such involvement is outside the scope of the officials’ jurisdictions or duties. (“*Bringing Calm to Chaos*,” p. 117)

8.5 Law enforcement should establish and build upon relationships with communities of faith and faith leaders. These relationships need to be established over time and with proactive efforts prior to any sort of major incident. (“*Bringing Calm to Chaos,*” p. 117)

8.6 After an incident occurs that could negatively impact a specific community, law enforcement should take added steps to protect them from

potential retribution and advise them how to handle possible threats. ("*Bringing Calm to Chaos*," p. 118)

8.7 When establishing any type of public hotline, the infrastructure and staffing must be in place before a public announcement is made. ("*Bringing Calm to Chaos*," p. 118)

8.8 Law enforcement agencies must keep in mind the need to work with and prepare community members who own property that is involved in high profile crimes for the national and possibly international attention it will draw from the media. ("*Bringing Calm to Chaos*," p. 118)

9.1 Designate a family reunification center. ("*Bringing Calm to Chaos*," p. 118)

9.2 Establish and maintain access control and security as soon as the family reunification center is established. ("*Bringing Calm to Chaos*," p. 118)

9.3 Designate one or more areas near but not immediately adjacent to the family reunification center where the public and the media can gather without interfering. ("*Bringing Calm to Chaos*," p. 118)

9.4 Jurisdictions and communities facing similar challenges should consider venue security and controlled media staging areas and identify opportunities that facilitate reunification. ("*Bringing Calm to Chaos,*" p. 118)

9.5 Designate a special area where clergy and counselors can assemble within the family reunification center. ("*Bringing Calm to Chaos,*" p. 118)

9.6 Provide training regarding psychological first aid to clergy members and chaplains who are designated to respond to mass casualty and critical incidents. ("*Bringing Calm to Chaos,*" p. 118)

9.7 Credential clergy and counselors so that they are vetted, properly trained, and readily identifiable as to prevent untrained persons from entering secured areas. ("*Bringing Calm to Chaos,*" p. 118)

9.8 Be prepared to explain to families of victims why identification of the deceased takes so long. ("*Bringing Calm to Chaos,*" p. 118)

9.9 In mass casualty events, notifications should be made in a timely manner

to lessen the stress on family members or significant others as they are waiting notification about loved ones involved in the incident. Whenever possible, notifications should be made in person. ("*Bringing Calm to Chaos,*" p. 118)

9.10 If possible, establish one file on victim information to avoid conflicting or incomplete information being given to significant others. ("*Bringing Calm to Chaos,*" p. 118)

9.11 Jurisdictions and communities faced with similar challenges of managing large numbers of victims and witnesses (in this case more than 400 people) should identify safe, stable and comfortable facilities in advance of an incident. Natural disaster preparedness serves as a model for predesignated areas. ("*Bringing Calm to Chaos,*" p. 118)

9.12 Consider provisions for victim and witness care while they are awaiting interviews and family members being notified. These may include making cell phone charging stations and other forms of communication available and making food and water available. Counselors should be clearly identified with arm bands, vests, or similar so that they are readily identified by victims and witnesses. ("*Bringing Calm to Chaos,*" p. 118)

9.14 Jurisdictions and communities challenged by the need to interview large numbers of victims should consider staffing implications and request assistance from other agencies if appropriate. ("*Bringing Calm to Chaos,*" p. 118)

9.14 Jurisdictions and communities challenged by victim and witness accountability should consider methods for expediting the process to reduce stress on victims and witnesses. ("*Bringing Calm to Chaos,*" p. 118)

9.15 Post event victim and responder welfare should be an integral part of interagency planning, training, and exercises. ("*Bringing Calm to Chaos,*" p. 118)

9.16 Ensure your department has a policy regarding mental health support after critical incidents and clearly communicate it to the entire department. ("*Bringing Calm to Chaos,*" p. 118)

9.17 Assign a mental health or officer wellness incident commander to oversee officer mental health and coordinate services among participating agencies. ("*Bringing Calm to Chaos,*" p. 118)

9.18 Compel participation in critical incident debriefings or post-incident counseling both for victims and civilians and commissioned staff. ("*Bringing Calm to Chaos,*" p. 118)

9.19 Consider follow-up counseling as it is not unusual for post-traumatic stress to manifest itself several weeks or months after an event . ("*Bringing Calm to Chaos,*" p. 118)

9.20 In addition to mental health assistance, consider unit, team, or department-level briefings to bring closure to the event. ("*Bringing Calm to Chaos,*" p. 118)

Pulse Nightclub Shooting, Orlando FL (June 12, 2016)

The following analysis of issues are taken from the "Florida Department of Law Enforcement (FDLE) After Action Report", dated December 13, 2016.

Primary Areas for Improvement

Int.1 FDLE required the assistance of a management support team to handle logistical, planning, and financial/administrative needs of the event. Recommend creating and maintaining redundant FDLE Management Support Teams (FMST) in each region and Headquarters. (*FDLE AAR,* p. 6)

Int.2 FDLE did not have protocols in place for this process as they do not typically assume this responsibility. Recommend developing an operational procedure for victim identification and next of kin notification. (*FDLE AAR*, p. 6)

Int.3 There was a lack of immediate notification to Florida Fusion Center (FFC) partners. FFC will clarify dissemination practices during an incident and explore the use of secured communications and mass notification portals. (*FDLE AAR*, p. 6)

Preparedness

1.1 Establish a workgroup to identify office supplies and equipment necessary for immediate deployment. "Go-bags" should be assigned to a position and inventoried during quarterly line inspections to ensure laptops, portable printers, cellphone chargers, and other equipment and supplies are ready to deploy at all times. (*FDLE AAR,* p. 14)

1.2 Amend the approved response attire list to include lightweight, quick- dry clothing. (*FDLE AAR*, p. 14)

1.3 Ensure all training is complete and require annual exercise of the concepts. (*FDLE AAR*, p. 14)

Communication & Coordination

2.1 Consider deploying Information Technology Services members from outside the region to assist with connectivity issues. (*FDLE AAR,* p. 15)

2.2 Use the mass notification system approved for use by command staff, which is currently [REDACTED] training to appropriate personnel and use the system for inmate death notifications and Child Abduction Response Team (CART) call-outs and other regular operations to maintain a familiarity with the system. (*FDLE AAR*, p. 15)

2.3 Schedule refresher radio training or exercises at least once a year and conduct radio checks during line inspections. (*FDLE AAR*, p. 15)

2.4 The incoming shift supervisor should personally inform an assessment of the status of investigative and intelligence activities with the outgoing shift supervisor. The incoming shift supervisor should brief all incoming shift members regarding assignments. Implement ICS Form 201, which is designed for operational period briefings. Consider overlapping shifts. (*FDLE AAR*, p. 15)

2.5 Assign an FDLE Joint Terrorism Task Force (JTTF) special agent to the FBI EOC to liaise with FDLE members. (*FDLE AAR*, p. 16)

2.6 Establish a process for de-conflicting leads when multiple systems are used. (*FDLE AAR*, p. 16)

Incident Command System

3.1 Create redundant FDLE Management Support Teams (FMST) in each region and Headquarters. Develop operating guidelines to include qualifications, training, and equipment. FMSTs will be modeled after the National Incident Management System (NIMS) Incident Management Team (IMT).
(*FDLE AAR*, p. 17)

3.2 Assign a scribe to follow command staff to ensure all information is recorded and activities and decisions do not go undocumented.
(*FDLE AAR*, p. 17)

Incident Command Post

4.1 Create a sign-in form that is available to all ROCs for future events and stored on a shared drive. (*FDLE AAR*, p. 18)

Office of Statewide Intelligence

5.1 Develop and maintain a list of all databases intelligence analysts may have access to. Require intelligence analysts to complete as part of semi-annual line inspections. Maintain a consolidated list of intelligence analysts and accesses at the regional level. (*FDLE AAR,* p. 20)

5.2 No member will use their personal social media account to conduct open source research for investigative purposes. (*FDLE AAR*, p. 20)

5.3 Identify an alternate meeting room separate from designated secure briefing areas. (*FDLE AAR*, p. 21)

Business Support

6.1 Establish an on-site point of contact to liaison with Business Support Personnel (BSP) for member assignments and deployment periods. This member should be assigned to the regional FMST. (*FDLE AAR*, p. 21)

6.2 The Office of Financial Management (OFM) should directly email the Commissioner's emergency declaration and pertinent financial information to all command staff and IFS members. (*FDLE AAR*, p. 22)

6.3 The work-cycle determination should be made within 24 to 48 hours of an emergency event so that work-cycles can be adjusted in People First prior to the end of the cycle. This will allow members to record overtime hours in People First and have the system correctly calculate overtime payment.
(*FDLE AAR*, p. 22)

Protective Operations Section

7.1 [ALL RECOMMENDATIONS REDACTED]

Victim Identification, Medical Examiner, & Next of Kin Notification

8.1 Utilize the Regional Domestic Security Task Force (RDSTF) to pre-identify and establish a contact list for victim advocates and police chaplains in each region. (FDLE *AAR*, p. 24)

8.2 Pre-identify and select an area that can accommodate large numbers of family members and overestimate the turnout of individuals. Being in close proximity is important; however, intelligence analysts must be

isolated from the public. (*FDLE AAR*, p. 24)

8.3 Have sufficient Emergency Medical Technicians on standby when notifications are made. (*FDLE AAR*, p. 24)

8.4 Be prepared to answer questions arising from unofficial death notifications. (*FDLE AAR*, p. 25)

Public Information & Media Relations

9.1 Prepare for and anticipate an increase in the number of media and public records requests following an incident. (*FDLE AAR*, p. 25)

9.2 If FDLE is not in possession of an originating agency's documents, the public record request will be directed to the originating agency. During the investigative process, be strategic in the request for information from other agencies; only request information that is needed for investigative purposes. (*FDLE AAR*, p. 25-26)

9.3 Deploy a PIO to the Joint Information Center (JIC) for improved coordination between FDLE and PIOs from agencies working the incident. (FDLE has since hired a PIO for the OROC and TBROC areas). (*FDLE AAR*, p. 26)

9.4 FDLE should only withhold investigative information from public records requests. (*FDLE AAR*, p. 26)

9.5 Only send a PIO to manage public information responsibilities. FDLE RLAs should only be used for FDLE legal advice in consult with OGC. (*FDLE AAR*, p. 26)

Security Clearances

10.1 Increase the number of special agents and intelligence analysts with a Secret-level security clearance. Clearances are needed for members that meet the FBI/DHS guidelines. (*FDLE AAR*, p. 27)

10.2 Maintain a list of members who have a clearance and the issuing agency. (*FDLE AAR*, p. 27)

Critical Incident Stress Management

11.1 Ensure all traumatic event responders attend a stress management session debriefing. (*FDLE AAR*, p. 27)

11.2 Have supervisors monitor and check in with members to determine if they have a need for mental health provider services. Ensure all responders are aware and use the services as needed. (*FDLE AAR*, p. 28)

11.1 Require all responding members to attend a stress management session debriefing following a traumatic event. (*FDLE AAR*, p. 28)

Pulse Nightclub Shooting, Orlando, FL (June 12, 2016)

The following "Lessons Learned" are taken from "Rescue, Response, and Resilience: A Critical Incident Review of the Orlando Public Safety Response to the attack on the Pulse Nightclub," dated 2017.

Observations and Lessons Learned

1. 2.1.1 Responders and their leaders will be required to quickly make creative decisions with little to no reliable information under constantly changing and sometimes horrifying circumstances. These decisions could mean life or death for victims, department personnel, and bystanders. (p.122)

2. 2.1.2 Leaders should prepare and empower their command staff and responders – at every level of the organization – to make decisions under difficult circumstances through training and practices that focus on critical thinking, situational awareness, and collaboration. (p.122)

3. 2.2.1 Response to and management of critical incidents are greatly enhanced when pre-existing relationships exist between leaders and supervisors from all potential first responder agencies. Each leader involved in the response indicated that pre-existing relationships and trust amongst leaders enhanced decision-making, identifying steps that needed to be taken, allocation of resources, and delineation of roles and responsibilities for each agency. (p. 122)

4. 2.2.2 Mutual trust and respect between agency leaders and command personnel within and across agencies, along with trust among line-level personnel working toward a unified goal, are overarching components for reducing competing interests and ensuring a collaborative response. (p. 122)

5. 2.3.1 Ensuring that public safety leaders possess the necessary security clearances prior to a critical incident facilitates information sharing before, during, and after a terrorist incident. Incidents involving terrorism and federal law enforcement will require leaders to possess security clearances to participate in classified briefings. (p. 122)

6. 2.4.1 Leadership and unity of message before, during, and immediately following a critical incident set the tone for the days, weeks, and months to follow. (p. 123)

7. 2.4.2 Demonstrating unity and cooperation between public safety leadership and political officials is essential to gaining the confidence of the community. (p. 123)

8. 2.5.1 Leaders must recognize the need to balance the attention they give to external responsibilities with the time they spend within their agency, communicating with and caring for their personnel, their community, and themselves. (p. 123)

9. 2.5.2 Some OPD personnel expressed concern for the limited attention and recognition command staff gave to those who responded to the Pulse attack. (p. 123)

10. 2.6.1 Assessing and testing the strengths and needs of your own agency and surrounding first responder agencies in preparation for a critical incident can expedite mutual aid, facilitate interagency coordination, streamline operations, and identify deficits in regional resources. (p. 124)

11. 2.6.2 Conducting executive level, multiagency tabletop exercises – including elected and appointed officials as well as department heads from other government agencies – in preparation for a critical incident can help define roles and responsibilities, identify available resources, and have an agreed-upon incident command system in place. (p. 124)

12. 2.6.3 Interagency planning and training should consider access to resources beyond those found in the law enforcement community. (p. 124)

13. 2.7.1 Identify and implement promising practices and lessons learned from other relevant incident reviews and AARs, both internal and external to your jurisdiction. (p. 124)

14. 2.7.2 Conduct AARs and incident reviews, particularly those that include all stakeholder groups, on large-scale incidents to provide lesson internally and among regional partners to build organizations that are constantly learning and improving operations and tactics. (p. 125)

15. 3.1.1 The law enforcement community should consider the need to modify the application of current active shooter and barricaded hostage response protocols to terrorist incidents, and a review should be held by the law enforcement community. (p. 125)

16. 3.2.1 The first officers on scene of an active shooting incident should organize contact teams to engage, contain, apprehend, or neutralize the gunman and rescue victims. (p. 125)

17. 3.3.1 Incorporate special units – such as SWAT or HDT – in planning and training exercises so they are familiar with one another's command and control and tactical protocols. (p. 126)

18. 3.3.2 Command-level personnel should ensure appropriate interagency communications, planning, and execution to ensure the safety of law enforcement personnel during tactical operations. (p. 126)

19. 3.4.1 Law enforcement supervisors must anticipate and train to prevent uncoordinated and inefficient self-deployment. (p. 126)

20. 3.4.2 After adequate personnel are on scene, additional personnel should be directed to staging areas for assignment of duties and should be directed to return to the staging are prior to their dismissal, or return to their regular assignment after being relieved. (p. 126)

21. 3.4.3 As soon as practical, a supervisor should be designated as the scene safety officer to direct personnel and resources to staging areas, coordinate assignments, and ensure that adequate ingress and egress are maintained. (p. 126)

22. 3.5.1 As soon as possible and practical during an incident, establish a unified command of all primary first responders – including fire and EMS – to facilitate communications, situational awareness, operational coordination, allocation of resources, and delivery of services. (p. 126)

23. 3.5.2 Engender buy-in of traditional incident command system (ICS) training for law enforcement, which continues to present challenges. (p. 127)

24. 3.5.3 ICS planning, training, and implementation must involve all public safety, first responders, and medical facilities to ensure situational awareness across specialties and the effective coordination and use of resources. (p. 127)

25. 3.6.1 Be mindful of secondary explosive devices and potential secondary attacks. Have arriving explosive ordinance disposal units sweep staging, assembly, and command post areas to guard against secondary devices. (p. 127)

26. 3.6.2 Responders and supervisors should constantly evaluate security risks of command post, victim and witness triage, and personnel locations and make appropriate adjustments as required. (p. 127)

27. 3.6.3 Responders and responding agencies should continually plan and evaluate ingress and egress routes during critical incidents to ensure that routes are clear for ambulances and other emergency vehicles. (p. 127)

28. 4.1.1 Departments should consider the purchase of tactical robots on an individual basis or as regional asset to increase their ability to gain

intelligence to inform tactical decisions in highly volatile operating environments. (p. 127)

29. 4.2.1 Agencies should ensure that adequate personal protective equipment (PPE) is issued to and used by first responders. (p. 128)

30. 4.2.2 The balance between "militarizing" the police and ensuring they have the necessary equipment such as armored personnel carriers to protect themselves and community during incidents of mass public violence and terrorism needs continued discussion and analysis. (p. 128)

31. 4.3.1 Interoperability and the ability to patch together responding agency radios facilitated the sharing of information which greatly enhances response coordination when necessary. (p. 128)

32. 4.4.1 Agencies should identify facilities within their communities that pose radio and cell phone transmission and reception difficulties. These facilities can be used to train personnel and identify ways to mitigate poor communication. (p. 128)

33. 4.5.1 Agencies should build redundancy into command notification protocols to ensure all appropriate notifications of a critical incident occur in an organized and timely manner. (p. 128)

34. 4.5.2 Public safety communication centers should be designed to create situational awareness among dispatchers so that even if police, fire, and emergency medical services (EMS) operate on different systems – radio or paging – all public safety agencies are aware of activities in other disciplines and can act to support those activities if needed. (p. 129)

35. 4.6.1 The OPD and other law enforcement agencies should continue to develop and implement reality-based training that develops situational awareness, critical thinking, and the ability to execute tactics under high levels of stress. (p. 129)

36. 4.6.2 Agencies should continue to regularly plan, train, and exercise using tabletop and practical exercises that incorporate recognized practices and lessons learned from critical incident reviews and after action reports. (p. 129)

37. 4.7.1 Improved counterterrorism training is necessary to strengthen both community and officer safety. (p. 129)

38. 4.7.2 Increased attention should be paid to policies, procedures, and training regarding the law enforcement response to suicide bombers, secondary devices, and multi-site attacks. (p. 129)

39. 4.8.1 Training should consider transitions, phases, and additional risks posed by terrorists including those that extend beyond the arrest or neutralization of the suspect(s). (p. 130)

40. 4.8.2 Training should attempt to create as much sensory deprivation or stimuli as possible to simulate real-world scenarios. The ability to understand and apply response strategies in a high stress environment improves performance. (p. 130)

41. 4.9.1 Provide mass casualty and emergency response training to those in nontraditional roles who may be needed in an emergency situation to ensure they are prepared to deal with difficult and emotional calls and information. (0. 130)

42. 4.9.2 Post-event responder welfare should be included in agency planning, training and exercises so responders are better prepared to operate in high stress environments. (p. 130)

43. 4.10.1 Specialized law enforcement units should regularly train together to ensure familiarity with each unit's policies, procedures, and tactics. (p. 131)

44. 4.10.2 Law enforcement agencies should engage regional first responder agencies – including other law enforcement, fire, EMS, emergency management, and government and nongovernment, stakeholders – in crisis response training. (p. 131)

45. 4.10.3 Training exercises should continue past the point where the threat no longer exists and extend to the coordination of the medical response, the notification of victims' families, establishing reunification and assistance center(s), and providing resources to vigils and funerals and prolonged impact on the immediate community. (p. 131)

46. 5.1.1 Law enforcement agencies should equip and train officers in the use of personal tactical emergency medical kits that include tourniquets, "quick clot" occlusive dressings, and Israeli bandages. (p. 132)

47. 5.1.2 Law enforcement personnel should be prepared to improvise to save critically injured persons. (p. 132)

48. 5.2.1 Create relationships with and include hospital and medical personnel in regional mass casualty or terrorist training. (p. 132)

49. 5.2.2 Identify medical protocols and practices that can be adapted and administered in life-threatening situations. (p.132)

50. 5.2.3 Law enforcement personnel should be assigned to medical facilities receiving patients from critical incidents to provide security and assist medical staff with situational awareness and communication. (p. 132)

51. 5.3.1 Public safety agencies should consider, train and exercise how they will deploy emergency medical responders in active shooter or other hostile events to ensure victim extraction, triage, and treatment. (p. 133)

52. 5.4.1 To reduce the amount of time necessary for victims to receive emergency trauma care, law enforcement officers should be trained in IFAK or similar emergency medical care methods. (p. 133)

53. 6.1.1 An incident safety officer should be designated as quickly as possible during response to a mass casualty or emergency incident, especially a terrorist incident. (p. 133)

54. 6.1.2 The incident safety officer should oversee decontamination protocols for decontamination of all responding personnel and their vehicles. (p. 133)

55. 6.2.1 Decontamination protocols should be established before a critical incident occurs. (p, 134)

56. 6.3.1 Organizational leadership should ensure that all involved in the response feel valued and are provided access to the physical and mental health resources they may need after a critical incident. (p. 134)

57. 6.3.2 Agencies should create a post-event wellness strategy that accommodates everyone, including on-scene responders, support personnel, and other agency employees. (p. 134)

58. 6.4.1 Jurisdictions and individual agencies should consider whether their traditional EAP and mental health structure will suffice in the aftermath of a critical incident or if adjustments should be made for employees in need of other outside services. (p. 135)

59. 6.5.1 To further focus and prioritize the mental health in the aftermath of the Pulse incident, OPD, and other law enforcement agencies should assign a mental health incident Commander. (p. 135)

60. 7.1.1 Activating the EOC and declaring a state of emergency early in the process can help secure additional resources, relieving pressure and responsibility on the police department so that they can focus on other important law enforcement aspects of the response. (p. 135)

61. 7.2.1 Identify the location for an FRC near primary hospitals prior to a critical incident. The FRC should be a scalable, safe, stable, and comfortable facility that provides access to amenities such as restrooms and outlets to charge cell phones. (p. 136)

62. 7.2.2 In mass casualty events, the next-of-kin notification process should account for logistical issues, and notifications should be made in a timely manner to lessen the stress on family members and significant others as they wait to hear about loved ones involved in the incident. (p. 136)

63. 7.2.1 Police departments challenged by the need to identify and interview large numbers of victims and witnesses should consider staffing to expedite the interview process and request assistance from other agencies, if appropriate. (p. 136)

64. 7.3.1 Consider provisions for victims and witness care while they are awaiting interviews and being notified. (p 136)

65. 7.3.2 Designate a special area where clergy and counselors can assemble within the FRC and be made available to those who request them. (p. 137)

66. 7.4.1 Ensure security and privacy for families of victims going to and from the FRC as members of the media or other unscrupulous individuals may go to great lengths to access or harass them. (p. 137)

67. 7.4.2 Designate one or more areas near but not immediately surrounding or adjacent to the FRC where the public and the media can gather without interfering. (p. 137)

68. 7.5.1 When establishing any type of public hotline to provide information on a critical incident, the infrastructure, staffing, and ability of the staff to handle the calls, including call takers trained in crisis response, should be in place prior to public announcement being made. (p. 137)

69. 7.6.1 Establish an FAC that provides a one-stop location for victims and their families to access any products and services necessary in the aftermath of the incident. Publicize the availability of victim services or all press conferences, through fliers, and on social media. (p. 138)

70. 7.6.2 Partner with nontraditional jurisdiction agencies and stakeholders – including IT, public transportation, financial services, airlines and hotels, etc. – when creating an FAC to expedite the setup process and ensure the availability of various resources. (p. 138)

71. 8.1.1 The ability to immediately determine specific agency investigative roles and responsibilities is crucial to effective incident and investigation management. (p. 138)

72. 8.1.2 Critical incident training and exercises should continue through all aspects of survivor and witness identification, interviewing, and reunification.

73. 9.1.1 A media and public relations strategy that ensures the coordination of all jurisdiction – department public information officers (PIPs) and all information being released through various platforms and accounts is integral to effectively handling the media during a critical incident. (p. 139)

74. 9.1.2 The depth of the department's media and public relations team and strategy is extremely important to consider before a critical incident. (p. 139)

75. 9.2.1 Unity of message and communication that focus on resilience are imperative to the overall success of the response. (p. 140)

76. 9.3.1 Police departments should leverage pre-existing social media followings to act as a single primary source of information and communications with the public during a critical incident. (p. 140)

77. 9.4.1 PIOs should be involved and included in the UCC to directly participate in and observe decisions made related to press conferences and social media posts. Receiving information secondhand can eliminate important context behind statements. (p. 140)

78. 9.4.2 PIOs should be provided with mobile resources necessary to undertake their duties over a long period of time and in any location (laptops with necessary software and smart phones) (p. 141)

79. 9.5.1 Ensure that public statements – including during press conferences and interviews and on social media – properly balance law enforcement terminology with the perceptions and impacts on victims, their families, survivors, and the larger community. (p. 141)

80. 9.6.1 Having a recognizable local leader speak first at first press conferences portrayed a sense that the response was and would continue to be a local community-driven response led by trust and unity, not a federal response driven by terrorism. (p. 141)

81. 9.7.1 Prioritize the needs and requests of the local media before that of national and international media outlets. (p. 141)

82. 9.7.2 Establish a JIC or other location where PIOs or other personnel from stakeholder agencies can coordinate the incident media response and can monitor media and social media to keep abreast of erroneous information being reported and quell rumors. (p. 141)

83. 9.7.3 Prepare for negative questions and shifts in the news cycle from being on your side to looking for an exclusive story and trying to generate contention. (p. 141)

84. 9.8.1 Include elected officials' roles and responsibilities in planning and managing critical incidents, and include them in training and exercises. After a critical incident, be prepared to handle elected officials of all levels and political affiliations, providing them with constructive roles when possible. (p. 142)

85. 10.1.1 Building strong community-police relationships can assist in the response and resilience of a community following a terrorist or mass casualty incident. (p. 143)

86. 10.2.1 In the aftermath of a terrorist attack or other mass casualty incident, it is important for law enforcement to be sensitive to the needs of the particular group(s) most affected by the attack, including those victimized and those likely to face retribution. (p. 143)

87. 10.3.1 Prepare for the long haul (p. 143)

88. 10.4.1 Consider the needs of local businesses and have a city or law enforcement liaison who can provide information to and advocate for impacted local businesses during a critical incident that requires them to be closed. (p. 144)

The Paris Attacks, Paris, France (November 13, 2015)

The following recommendations are taken from "The Attacks on Paris: Lessons Learned, A Presentation of Findings by the Homeland Security Advisory Council," June 2016.

Intelligence

1. Increase efforts to cultivate and leverage human intelligence sources. (p. 28)
2. Improve tracking of fighters who travel abroad for training and return to the US. (p. 28)

Community Engagement

3. Adopt and/or create training programs to counter violent extremism. (p. 28)
4. Develop training programs and/or protocols to neutralize the radicalization of incarcerated individuals. (p. 28)

Investigation

5. Study past terrorist attacks to identify lessons learned. (p. 28)
6. Create an investigative tracking systems similar to SINUS to maintain real-time information. (p. 28)
7. Continue efforts to improve major case management software with a look at off-the-shelf product(s) that could be used today. (p. 28)
8. Continue use of real-time data tracking systems to enhance situational awareness for incidents involving multiple attacks in the Southern California region. (p. 28)

Incident Command

9. Encourage a working knowledge and application of National Incident Management System (NIMS) and Incident Command System training to all first responders and first supporters. (p. 28)
10. Ensure protocols are in place and practiced so that department emergency operations centers and city/county emergency

operations centers are ready to quickly stand up in a response to terrorist attacks. For large departments, consideration should be given to creating an operational command post out of existing centers. (p. 28)

11. Ensure multiple communications processes are in place to avoid communications challenges that can impact first responders. (p. 28)

Crisis Information

12. Continue current media protocols, including media credentialing systems. (p. 29)

13. Improve tracking of fighters who travel abroad for training and return to the US. (p. 29)

14. Educate the public on how to react and respond during an active shooter incident. (p. 29)

Training/Equipment

15. Continue and enhance counter-terrorist training provided to patrol officers. Training such as the Multiple Assault Counter Terrorism Action Capabilities (MACTAC) or an equivalent course should be offered to all first responders. (p. 29)

16. Continue and enhance efforts regarding Tactical Emergency Medical Service (TEMS) to include Special Weapons and Tactics (SWAT) Teams cross- training on TEMS with Fire Department personnel. (p. 29)

Las Vegas Harvest Music Festival, Las Vegas, NV (October 1, 2017)

The following "Lessons Learned" are taken from the "1 October After Action Report, August 24, 2018," compiled by the Clark County Fire Department and the Las Vegas Metropolitan Police Department in collaboration with the Federal Emergency Management Agency National Exercise Division.

Pre-Incident Special Events Planning

1. Develop a threshold for assigning a dispatcher to a special events channel based on anticipated crowd size and/or number of officers assigned to the event. The dispatchers should be included in staffing (reimbursable overtime) for these types of events as a required resource. (p. 11)

2. Continue to circulate a monthly special events calendar across all local emergency response agencies for events occurring within each jurisdiction. (p. 11)

3. Fire Department. Encourage partnerships with special event promoters to better coordinate pre-event planning. (p. 11)

4. Fire Department and Law Enforcement. Encourage venue promoters and operators to hire not only law enforcement but fire departments as well, so that they can be on hand and included in a unified command post. (p. 11)

5. Develop plans, policies and procedures for integrating Clark County Fire Department (CCFD), Las Vegas Metropolitan Police Department (LVMPD), and private ambulance command structure during special events with a single Incident Action Plan. (p. 12)

6. Disseminate a thorough and integrated special event IAP and map to participating and responding agencies prior to the event, even if they are not contracted by the event promoters themselves. (p. 12)

7. Continue to enhance communication of planned special events throughout the fire department to include both suppression and fire prevention. (p. 12)

8. Continue to circulate a monthly special events calendar across all local emergency response agencies for events occurring within each jurisdiction. (p. 12)

9. Conduct training that tests flexibility and adaptability upon arrival on scene and encourages players to train in their most likely role. (p. 14)

10. Law Enforcement. Continue to provide supervisors and officer assigned to special events with robust MCI/medical kits, including sufficient numbers of tourniquets and pressure bandages to have on hand. (p. 13)

11. Law Enforcement. Require special events promoters to provide a pre-determined amount of MCI equipment for all future special events. (p. 13)

12. Fire Department and Law Enforcement. Require throw/first-aid kits to be pre-staged at all special events of a pre-determined size. Kits can be given to people on scene for treatment, creating a force multiplier of first responders. (p. 13)

13. Fire Department and Law Enforcement. Consider providing Tactical Emergency Casualty Care (TECC) Training for officers. (p. 13)

Emergency 9-1-1 Services and Notifications

14. Law Enforcement. Continue to track and log all calls to the best of the dispatching center's ability. (p. 14)

15. Law Enforcement. Develop an internal policy to address radio communications procedures during a significant event, while acting in support of ICS. (p. 14)

16. Law Enforcement. Reach out to agencies with similar experienced in responding to MCIs and request information regarding training that was developed because of the incident. (p. 14)

17. Law Enforcement. Coordinate and conduct interagency, scenario-based training that tests or incorporates non-tactical elements, such as dispatch, and encourages players to train in their most likely role. (p. 14)

18. Law Enforcement. Provide an internal mass casualty preparedness training to dispatchers. (p. 14)

19. Fire Department and Law Enforcement. Create a one-page handout summarizing the fundamentals of ICS and NIMS, including roles and responsibilities during an incident, which dispatchers can keep at their consoles for reference. (p. 15)

20. Fire Department and Law Enforcement. Develop policies within the Las Vegas Metropolitan Police Department Communications Bureau and the FAO that incorporate best practices from ICS and NIMS into internal communications operations during both major and regularly occurring incidents. (p. 15)

21. Regional. Continue to use the Nevada Core Systems Network (NCORE) during MCIs and, more generally, special events. (p. 15)

22. Fire Department and Law Enforcement. Install a dedicated ring-down line between the FAO and the Las Vegas Metropolitan Police Department Communications Bureau. (p. 16)

23. Consider merging the FAO and LVMPD Communications dispatch centers into one main Emergency Communications Center to prevent the potential loss of critical information and provide face-to-face communications during critical incidents. (p. 16)

Initial Response to the Scene

24. Continue to train and exercise to further enhance ICS and MCI response. (p. 16)

25. Conduct ICS training and TTXs to reinforce the standard practice that the firs unit to an incident scene requiring multiple unites establishes command and a staging area. (p. 17)

26. Fire Department and Law Enforcement. Recognize that off-duty personnel may respond and encourage them to respond to staging. (p. 17)

27. Fire Department and Law Enforcement. Continue to teach and encourage crews and teams to remain disciplined when responding to emergency scenes. (p. 17)

28. Establish a documentation process to pass current information and status of teams in the field more efficiently and effectively. (p. 17)

Fire Mutual Aid and Scene Management

29. Incorporate medical tent security protocols in special event IAPs. (p.18)

30. Conduct training with officers on the proper chain of communication to request resources. (p. 18)

31. Conduct training to ensure that officers are prepared to fill nontraditional roles should the need arise prior to the arrival of EMS. (p. 18)

32. Consider providing MCI response training for officers. (p. 18)

33. Develop plans to coordinate law enforcement efforts to provide medical response with other EMS response entities, including private ambulance companies. (p. 18)

34. Ensure that response agencies have mechanism in place to coordinate with civilian volunteers and organize donations, efficiently incorporating these resources into operations. (p. 19)

35. Support community “Stop the Bleed” first-aid and education programs. (p. 19)

36. Develop policies and procedures for communications among dispatch, local hospitals, and private medical companies responding to an MCI to ensure interoperability of communications. (p. 19)

37. Conduct joint training and exercises with all medical providers, including fire departments, private ambulance companies, hospitals, FAO dispatchers, and FAO call takers, to ensure awareness of when and how to use these communications mechanisms. (p. 19)

38. Conduct integrated ICS training with all responding agencies. (p. 19)

39. Conduct further departmental training to encourage INCIDENT Commander use of terminology that clearly defines areas of operation (i.e., landmarks) as situationally dictated. This protocol is especially critical when managing incidents of this geographic size, magnitude, and complexity. (p. 20)

40. Develop protocols for pre-designated C-Staff assignments to be used on all MCI responses. (p. 20)

41. Review plans and procedures related to the location of and need for various assignments based on the incident. (p. 20)

42. Continue to conduct training on large incidents with the Operations Section in place to ensure that branch directors know how and when to advise command that they are ineffective. (p. 20)

43. Encourage staging managers to bolster staff with an aide and/or crew to assist with liaison, scribe, radio traffic, and tracking duties. (p. 21)

44. Conduct multidisciplinary staging and MCI training for large-scale incidents. (p. 21)

45. Provide refresher training for fire department personnel on the role and responsibilities of thee staging manager (e.g., unit tracking, tactical worksheet usage). (p. 21)

46. Provide clarification on the communications plan and policy for units leaving the scene to transport patients to the hospital subsequently returning to the scene. (p. 21)

47. Develop joint policies and procedures and conduct TXXs that reinforce the need for integrated coordination of both public and private ambulance assets during an MCI. (p. 22)

48. Require that all private ambulance companies responding to critical incidents are part of the Incident Command structure. (p. 22)

49. Incorporate private ambulance companies in all future MCI and ICS training and exercises. (p. 22)

50. Include supervisors or a liaison from private ambulance companies at the command post. (p. 22)

51. Ensure that all private assets report to a staging area that is coordinated with Unified Command. (p. 22)

52. Coordinate and jointly conduct training and TTXs with hospitals, private ambulance companies, and a law enforcement to improve patient tracking during a large-scale incident. (p. 22)

53. Create a tracking system that is routinely sent back to Incident Command and the LVMPD Department Operations Center (DOC) for timely consumption of actionable information. (p. 22)

54. Establish a consistent policy with all partner agencies, both public and private, for sharing Health Insurance Portability and Accountability Act (HIPPA) information. (p. 22)

Tactical Operational Response

55. Review potential policy changes to ensure both law enforcement and fire department personnel participate in mandatory joint Active Assailant MACTAC, and ICS training on an annual basis. (p. 23)

56. Ensure that, when possible, OT officers' vehicles are in close proximity to their assignments during special events. (p. 24)

57. Consider allowing officers to carry rifles and other needed gear depending on the event, as well as wear tactical vests, to ensure equipment and situational readiness. (p. 24)

58. Provide for the full capability to use tactical vehicles on a day-to-day basis. (p. 24)

59. Consider revising LVMPD policy on OT officers wearing reflective vests when not conducting traffic control during special events. (p. 24)

60. Consider offering training on crowd mitigation for all public safety officials, as well as private security officers, to provide additional capacity in the event of an MCI. (p. 25)

61. Continue to deploy teams to harden critical infrastructure in preparation for a multi-assault attack or distraction calls. (p. 26)

62. Conduct further training and exercises to reinforce the potential and probability of distraction calls during critical incidents. (p. 26)

63. Consider using alternate routes when responding to an incident of this magnitude. (p. 26)

64. Continue to make medical transports a priority during MCIs. (p. 26)

65. Continue maintaining relationships with area hospitals to ensure a seamless response with law enforcement. (p. 26)

66. Assist with triage and temporary intake sites at local hospitals. (p. 26)

67. Continue to plan, train, and exercise on target hardening of critical infrastructure to counter a complex coordinated terrorist attack. (p. 26)

68. Develop policies and procedures for on-duty and recall fire personnel to support hospitals with patient triage and moving during times of extraordinarily high patient volume. (p. 27)

69. Modify Hostile MCI polity to allow more flexibility for Incident Commanders to use the best assets available to them during a critical incident. (p. 27)

70. Provide additional staff for branch directors to help coordinate where RTF teams are required to go during a large-scale incident. (p. 27)

71. Build a demobilization plan with a consideration of current and forecasted operational needs. This plan must be approved by the Incident Commander prior to units being released. (p. 28)

72. Consider a physical location within the inner perimeter for assets to check in during a large-scale incident. (p. 28)

73. Emphasize the importance of, and conduct training on, secondary searches following incidents of mass violence. (p. 28)

74. Use a bullhorn or other sound amplification device to make announcements that it is safe for civilians to come out of hiding and approach law enforcement officers. (p. 28)

75. Ensure that officers are clearly identifiable to civilians during the venue clearing process. (p. 28)

76. Create on computer-aided dispatch (CAD) event number for LVMPD Communications during MCIs to list all the callers who may be injured or sheltered in place, including their location and contact information. (p. 28)

77. At the onset of an incident, ensure that federal, state, and local partners are incorporated in a process for vetting and deconflicting incoming tips, leads, and suspicious activity reports (SAR). (p. 29)

78. Continue to ensure that the fusion center is incorporated within the LVMPD DOC and providing the critical intelligence function to Incident Command. (p. 29)

79. Continue to maintain LVMPD representation on the FBI Joint Terrorism Task Force. (p. 29)

80. Ensure leadership has active LEEP accounts. (p. 29)

81. Ensure that multidisciplinary response practices are shared among response organizations. (p. 30)

82. Provide training on this practice in future Hostile MCI/MACTAC training with law enforcement, private ambulance companies, and special events personnel. (p. 30)

83. Consider using reflective tape to mark victims. (p. 30)

Operational Coordination

84. Conduct training and exercises that incorporate and reinforce ICS and MCI response. (p. 30)

85. Battalion chiefs should use available personnel such as staged engine or truck companies to assist the fire department Incident Commander, Operations Section Chief, or branch directors as needed. If addition resources are required strike additional alarms. (p. 31)

86. Provide additional ICS training to minimize surrounding roles and responsibilities. (p. 32)

87. Consider relocating additional staff to minimize overcrowding. (p. 32)

88. Provide ear buds in the ICP to lower background noise if multiple radios are in use. (p. 32)

89. Conduct additional TTXs and upper-level ICS training on the command structure and communications plan for large incidents with all ranks, including line personnel and administrative and C-staff personnel. (p. 32)

90. Incorporate the request for liaisons from relevant agencies based on the needs of the incident into protocols for establishing branches and responsibilities on emergency scenes. (p. 32)

91. Reach out to progressive law enforcement partners to model off of systems that are utilized to make ICS more efficient for law enforcement. (p. 33)

92. Contribute to the national conversation and propose policy changes needed at the NIMS level, with an emphasis on law enforcement emergencies situations. (p. 33)

93. Consider creating a committee of LVMPD and CCFD personnel who have commanded critical incidents within the organization. (p. 33)

94. Continue to pursue and promote joint planning, training, and exercise initiatives that foster relationships and mutual understanding of roles and responsibilities across public safety agencies. (p. 33)

95. Expand on this relationship and training philosophy to incorporate private ambulance companies, dispatch personnel, hotel security, and outside agencies. (p. 33)

Public Information Notifications

96. Consider pre-scripting messages that expedite communication with the public during instances in which no new information is available. (p 34)

97. Determine the optimal time intervals for releasing information on social media during a large-scale incident. (p. 34)

98. Identify additional support personnel to assist with answering phones and monitoring social media at the onset of a large-scale incident. (p. 34)

99. Consider appointing a CCFD PIO. (p. 35)

100. Establish a PIO setup in the command post to aid in pushing out timely press releases. (p. 35)

101. Ensure that the individual writing talking points for press briefings can shadow the PIO director in meetings and provide that information directly to those responsible for press releases. (p. 35)

102. Consider implementing training for PIOs related to handling questions that are likely t be asked by international media outlets. (p. 36)

103. Pre-designate a space for media presence at LVMPD headquarters away from active incident management operations. (p. 36)

104. Verify credentials of all individuals in the DOC (p. 36)

105. Use the Joint Information Center (JIC) to coordinate messaging across the LVMPD Office of Public Information, Nevada 2-1-1, and phone banks. (p. 36)

106. Ensure 2-1-1 receives the necessary training on how to surge operations when needed and to have out-of-state networks assist with overflow calls. (p. 37)

107. Consider using the JIC to ensure consistent messaging from these call centers. (p. 37)

108. Continue to train on MCIs and ensure all personnel are familiar with plans and policies. (p. 37)

109. Have established webpage available for emergency information and necessary call-in-numbers to be deployed at the onset of an incident. (p. 37)

Resource Management

110. The staging area manager should communicate with Incident Command as early as possible to gain a full understanding of the scope of the Incident and resources required. (p. 38)

111. Consider using a computer program to assist in tracking resources. (p. 38)

112. Ensure that all requests for personnel and resources go through the Incident Command structure, regardless of the rank of the individual issuing the request. (p. 38)

113. The staging area manager must take into consideration the access and egress abilities of staged units. (p. 38)

114. The staging area manager should consider requesting assistance (i.e., engine or truck companies) in large-scale incidents. (p. 38)

115. Continue to maintain relationships with local public safety agencies and conduct joint training. (p. 38)

116. Continue to conduct ICS training and ensure that command and control is maintained in the field. (p. 38)

117. Conduct training at the supervisory level between CCFD and partner agencies to include TXXs and multi-agency drills. (p. 39)

118. Fully integrate private ambulances and outside agencies into coordinated training and exercises. (p. 39)

119. Establish policies and procedures that clearly define dispatch's role and the appropriate response to resource requests from parties other than command. (p. 39)

120. Update policy to reflect expectations during a law enforcement incident, including where the JIC should reside and the proper staffing levels. (p. 39)

121. Train and exercise on the expectations and operations of the JIC with all agencies. (p. 39)

122. Consider creating infrastructure to house the JIC at LVMPD headquarters when necessary. (p. 39)

123. Provide clarification and possible policy changes related to declared emergency in Clark County that has law enforcement as the lead agency. Specifically, policies should address MACC and JIC functions as well as the policy group. (p. 40)

124. Provide additional training for local departments in Clark County to fulfill ESF and ICS positions in the MACC to cover prolonged, multi-operational periods. (p. 40)

125. Conduct additional training and clarify policies for patient tracking and information sharing for MSAC representatives, ESF & EMS providers, hospitals the coroner, and law enforcement. (p. 41)

126. Conduct additional training for fire and law enforcement on available MACC support (p. 41)

127. Update the checklist for the DOC to consult during critical incident. (p. 41)

128. Consider projecting CAD screens of partner agencies in the DOC. (p. 41)

129. Continue to provide training for officers to more quickly put together and release the A/B roster. (p. 41)

130. Continue to conduct training and exercises with local area hospitals. (p. 41)

Operational Communications

131. Develop clear communications plans to assign common radio channels. (p. 42)

132. Consider establishing an SOP that the special events channel becomes the police operations channel if a large-scale event or MCI occurs, until Incident Command formally assigns the operations channels. (p. 42)

133. Continue to reinforce the importance of timely notifications during MCI. (p. 43)

134. Incorporate communications plan and ICS framework expansion into training and TXXs, which include fire department line personnel and members of the FOA. (p. 43)

135. A communications plan should be clearly communicated across all channels to personnel on scene, as well as FAO dispatch, during a large-scale incident. (p. 43)

136. As FirstNet becomes available in the Las Vegas Valley for first responders, funding should be secured to facilitate fire department involvement. (p. 43)

137. Ensure that first responders are aware of the technical challenge posed by cell tower-based communications during incidents or events involving a high concentration of people. (p. 43)

138. Casino and hotels in the area should consider installing repeaters to enhance radio traffic for first responders within their buildings. (p. 44)

139. Casino properties should install the appropriate systems to bring in and distribute 700 and 800 MHz frequencies throughout their properties. (p. 44)

140. Continue to conduct joint training between CCFD and LVMPD in communications plan expansion and the importance of using multiple radio channels to assist in limiting radio traffic. (p. 44)

141. Ensure personnel in command supervisory roles consider requesting additional personnel to assist in unit tracking, radio channel monitoring, and charting of the communications plan. (p. 44)

142. Stress importance of only communicating necessary information and maintaining radio discipline. (p. 44)

143. The tactical response vehicle (TRV) should be outfitted to function as a communication and surveillance vehicle, as well as a backup TOC, should the SWAT TOC be out of commission. (p. 45)

144. Conduct additional training with radio shop staff on deploying radio equipment during tactical operations. (p. 45)

145. Conduct joint training and TXXs with CCFD, LVMPD, and LVMPD/FAO dispatchers and call takers to familiarize agencies with large-scale incident communications challenges and solutions. (p. 45)

Family Assistance and Victim Services

146. Reinforce the use of the UVIS system to facilitate collection of victim information and the circulation of that list with LVMPD, CCOCME, and local hospitals. (p. 46)

147. Ensure that website and phone bank are ready to be stood up at any given time to assist in pushing information out to the community during an incident. (p. 46)

148. Consider including the FAC in the hourly briefings with the MACC and the LVMPD DOC during a large-scale incident. (p. 46)

149. Establish Memoranda of Understanding (MOUs) with local agencies and community organizations to support FAC operations when an incident occurs. (p. 46)

150. Consider including the FAC in the hourly briefings with the MACC and the LVMPD DOC during a large-scale incident. (p. 46)

151. Document FBI property recovery processes for future responses. (p. 47)

152. Assign additional LVMPD personnel to conduct FAC operations for large-scale incidents. (p. 47)

153. Develop and appointment-based system to enable case workers to effectively assist clients. (p. 47)

154. Develop a state-wide, vetted network of licensed mental health professionals by local area. (p. 47)

155. Improve communication and collaboration with inter-state operations. (p. 47)

156. Improve law enforcement transparency with victim information. (p. 47)

Responder Wellness

157. Provide PEAP services beyond immediate emotional support to include long-term counseling and care. (p. 48)

158. Consider offering alternative forms of counseling, such as therapy dogs and art therapy. (p. 48)

159. Require mandatory debriefs when officers return from command areas. (p. 48)

160. Emphasize the importance of continued attention to wellness for first responders in the months and years following and incident. (p. 48)

161. Establish policies for adjusting the number of free counseling sessions and waiving co-pays based the severity of an incident. (p. 48)

162. Continue to provide counseling services to CCFD personnel affected by the 1 October incident. (p. 48)

Las Vegas Harvest Music Festival, Las Vegas, NV (October 1, 2017)

The following "Lessons Learned" are taken from the "1 October After Action Review" compiled by the Las Vegas Metropolitan Police Department, dated July 6, 2019.

Preparedness

1. Maintain open communication with key stakeholders in the tourism industry by holding monthly meetings and sending notifications when necessary to the Las Vegas Convention and Visitors Authority, Las Vegas Security Chiefs Association, and community stakeholders. (p. 13)

2. Support the education of and partnership with the Las Vegas Convention and Visitors Authority and the Las Vegas Security Chiefs Association with awareness training on "See Something, Say Something" as well as "Run, Hide, Fight." (p. 14)

3. Incorporate training, specifically for all commissioned officers within each area command, on the importance and requirements of the Command Post Liaison Identification Card. (p. 14)

4. Provide MACTAC response training to hotel and casino industry stakeholders as well as community partners, schools, churches, and those supporting critical infrastructure. (p. 15)

5. During large-scale events, designate and assign an LVMPD dispatcher to work the radio channel and dispatch officers working the event. (p. 17)

Scene Response

6. Develop curriculum and train all commissioned officers on clearing techniques for larger-than-normal establishments/venues, such as open-air events, in the case of a significant incident and/or MCI after an active shooter. (p. 26)

7. Supply officers with training and necessary equipment to mark areas that have been cleared to prevent duplication of efforts during a significant incident and/or MCI. (p. 26)

8. Ensure ICS protocols are followed and employee "shooting survivors" directly involved in a significant incident and/or MCI are sent to staging as they are relieved from their post. All department member "shooting survivors" should be identified and documented for later debriefing/wellness plans. (p. 28)

9. Evaluate the need for policy, procedures, and training regarding SWAT Aerial Platform Snipers in the event of an active-shooter incident where the shooter is at an elevated position of advantage. (p. 28)

10. Expand active-shooter training to include a barricaded active shooter when the shooter is in a position of advantage. (p. 30)

Incident Command

11. During large-scale events, identify a secondary location for a command post in the event the primary command post is inoperable, and include this in the Incident Action Plan. Incorporate this concept into training. (p. 34)

12. During a large-scale event and/or MCI, schedule and modify briefing times to communicate effectively. (p. 37)

13. Provide clear policy direction with ICS roles and responsibilities defined for the staging manager during a significant incident and/or MCI. (p. 38)

14. Create and strengthen policy to control and manage the inevitable self-deployment of off-duty first responders during these types of incidents. (p. 39)

15. Develop and implement electronic staging solutions software to account for and manage resources deployed during an incident as part of a larger incident management system. (p. 40)

16. Establish and implement geographical identifiers for responding teams during a significant incident and/or MCI. (p. 40)

17. The incident commander should assign an assistant to the staging manager during a significant incident and/or MCI. (p. 41)

18. Utilize Detention Services Division personnel as resources to be deployed during significant incidents and/or MCI. Include DSD in all training related to these types of incidents. (p. 44)

19. Provide additional training, including live exercises on MCI, for leadership at the rank of lieutenant and above, regardless of assignment. (p. 46)

Department Operations Center

20. Create a Department Operations Center quick reference guide for area commanders to be utilized for all levels of crisis including MCI. (p. 49)

21. Ensure LVMPD captains are trained on DOC activation. Conduct live training exercises with all captains. (p. 50)

22. Create policy, procedures, and protocols for securing the DOC and IC during a significant incident and/or MCI. As part of this process, ensure there is an established entry access list of authorized personnel. (p. 50)

23. Assign Information Technology and Fusion Watch personnel to the DOC with knowledge in programs, infrastructure, cameras, and audio/visual to assist in the DOC set up during full activations. (p. 51)

24. Establish the JIC at LVMPD Headquarters in a physically separate location from LVMPD's DOC during significant incidents where LVMPD is the lead police agency. (p. 52)

25. Evaluate the need for a staffing study to potentially increase the Emergency Management Section. (p. 53)

26. Establish annual or semi-annual reviews of all Emergency Management and DOC documents including section manuals. Ensure they are available in the DOC. (p. 53)

27. LVMPD, in conjunction with the Clark County Coroner's Office, Clark County Fire Department and hospital administrators, should develop a plan regarding victim identification and tracking during significant incidents and/or MCI. Establish protocol regarding who will respond to the DOC and facilitate the sharing of this information. (p. 54)

28. Re-evaluate the Emergency Mobilization Plan to include who specifically is responsible for implementing and documenting the ABX roster during significant incidents and/or MCI. (p. 55)

29. Expand the Emergency Mobilization Plan to include critical civilian positions during significant incidents and/or MCI. (p. 55)

Communications Bureau

30. Purchase a notification concept and/or program that allows employees to log in remotely with call signs, assignments, and locations. Create policy, procedures, and protocols regarding the use of this technology. (p. 58)

31. Establish a mechanism to restrict or limit CAD queries during significant incidents and/or MCI. (p. 59)

32. Require Communications Bureau personnel to participate in MACTAC training from their respective role and responsibility. (p. 59)

33. Enhance training (tabletops and large-scale exercises) for NCORE users on MACTAC and Rescue Task Force concepts. Reinforce plain language, not police/fire codes, as a form of communication during these training opportunities. (p. 60)

34. Create policy, procedures, and protocols for immediate internal review and cross-referencing of all data coming into or created by the Communications Bureau related to a significant incident and/or MCI to capture lessons learned for use in after-action review processes. (p. 60)

35. Reinforce radio discipline in the use of the red emergency button through training and practical live exercises such as reality-based training, advanced officer skills training, and biweekly area command training. (p. 61)

External Communication

36. Assign the PIO director an assistant to document information collected during intelligence and Executive Staff briefings. (p. 63)

37. Create policy, procedures, and protocols specifically outlining how information will be released internally and to the public via social media during significant incidents and/or MCI. (p. 63)

38. Establish an automatic email response during significant events when resources are overwhelmed that replies immediately to the public and/or requests from the media. A telephone message reflecting the same message should also be created and activated during significant incidents and/or MCI. (p. 64)

39. Develop a cadre of internal personnel (prior public information officers) who can assist the PIO with administrative functions during significant incidents including documenting requests for information. Activate the cadre when needed during significant incidents and/or MCI. (p. 64)

40. Include local law enforcement partners such as North Las Vegas and Henderson Police Departments and City of Las Vegas and Clark County PIOs in tabletop exercises related to significant events and/or MCI. (p. 65)

41. Create a designated workstation in the DOC for Public Information Office personnel to promote efficient and timely updates, release information, and monitor online media. (p. 65)

42. Research the costs and benefits of purchasing a media monitoring service to assist the PIOs in determining the needs of the community during and after significant events and/or MCI. (p. 65)

43. Compile and release accurate, timely facts and maintain a running chronology of information released (e.g., a fact sheet) with the newest information at the beginning. LVMPD's PIOs should only rely on vetted and confirmed information. (p. 65)

44. Assign a PIO to monitor and collate information of concern that various news outlets and social media platforms report on a significant incident and/or MCI. (p. 65)

45. Create policy, procedures and protocols that mandate information briefed to the public is well vetted and speaking points include specific verbiage such as "sequence of events" and "preliminary details" to ensure accuracy while maintaining a commitment to transparency. (p. 67)

46. Ensure that all heads of partnering agencies are available and visible at press conferences and other press engagements. (p. 67)

47. Evaluate the need for a staffing study to potentially increase staffing within the Public Information Office, specifically civilian personnel assigned to manage LVMPD's website and social media platforms. (p. 68)

48. Designate an alternate media staging area that is large enough and equipped to accommodate media press conferences and media personnel during large events. (p. 69)

Investigation

49. Research and identify a critical incident management software program with sufficient capacity to accommodate an investigation the size of 1 October. The system must easily enable access for all investigative personnel involved (internal and external to LVMPD) and permit extensive data entry, record the assignment of investigative tasks, and track leads and follow up steps. (p. 74)

50. Develop and train investigative crime scene protocols with federal partners for significant incidents and/or MCI. (p. 77)

51. Ensure the investigative team is established and gathered before conducting an initial intelligence briefing following a significant incident and/or MCI. Investigative team briefings should be directed by the lead investigator(s) and leadership. (p. 78)

52. Reinforce training and curriculum related to documentation (i.e., major incident log) on major incident crime scenes at each crime scene location. (p. 79)

53. Develop policy, procedures, and protocols for a major case squad to be activated at the discretion of the head of the Agency. This policy should be specific in detailing all components necessary including specific roles and responsibilities required to conduct large-scale, in-depth, lengthy investigations. (p. 80)

54. The Coroner's Office should develop MCI protocols that include the coordination of next-of-kin death notifications with area hospitals. (p. 83)

Leadership

55. Conduct regular tabletop and full-scale exercises with top agency leaders of nearby and partner jurisdictions in Incident Command System and joint command of significant incidents and/or mass-casualty incidents. (p. 85)

56. Create policy, procedures, and protocols that describe the roles, responsibilities, and expectations of the sheriff and the Executive Staff during a significant incident and/or MCI and incorporate training as needed. (p. 86)

57. All heads of law enforcement agencies within Clark County should create policy, procedures, and protocols for a comprehensive mass-casualty incident plan. (p. 86)

Partnering Agencies

58. Establish policy that requires Agency leaders to debrief operations, response, resources, and communications following a significant incident. (p. 89)

59. Strengthen working relationships with partnering agencies through regular communication and frequent joint training across ranks of personnel. Federal agencies should be included in tabletop and full-scale exercises practicing ICS. (p. 94)

Equipment and Technology

60. Create policy, procedures, and protocols for the tracking and disbursement of internal donations following a significant incident and/or MCI. Responsibility for such tracking should fall within the Logistics Bureau. (p. 95)

61. Establish response protocols to the DOC for the Logistics Bureau during a significant incident and/or MCI. (p. 95)

62. Develop protocol and training that allows officers to use discretion during critical incidents to remove reflective vests based on the circumstances of the incident. (p. 96)

63. Update LVMPD's uniform policy establishing criteria for lettering, sizing, coloring, and placement of law enforcement identification on department issued equipment. This update should include the labeling of personal protective equipment and department-issued property with last name and personnel number. (p. 97)

64. Explore the feasibility of establishing pre-identified locations, in proximity to officers working special events overtime, to store weapons and personal protective equipment for a quicker response in the event of an emergency. (p. 97)

65. Provide a surge supply of trauma kits within proximity to major events. (p. 98)

66. Purchase a mobile and/or stand-alone radio repeater to augment existing radio coverage in remote sites or during large-scale, planned, or unplanned incidents. (p. 100)

67. Continue existing efforts to assess the quality of first-responder communication capacity inside Las Vegas buildings. Ensure full communications capacity by end of 2020. (p. 100)

68. Evaluate associated costs for IT hardware, software, cloud, file, and drive storage as well as expanded Wi-Fi access needed during significant incidents and/or MCI. Create a plan for procurement in emergencies. (p. 101)

69. Establish the quantity of laptops/computers necessary in key locations (DOC, area commands) for external users to access reliable Wi-Fi and network access. Purchase, stage, and have ready dedicated equipment (pre-determined number of devices) for utilization during significant incidents and/or MCI. These devices should have network access and supporting programs for investigative units. (p. 101)

70. Establish an information technologies team that can respond and provide IT support during significant incidents and/or MCI. (p. 101)

71. Identify classification and appropriate handling of electronic evidence. Consider how the management of such evidence will interoperate with investigative case management and sharing contingencies. (p. 102)

Policy and Training

72. Create policy, procedures and protocols for a comprehensive mass-casualty incident plan, including the identification of likely partnering agencies and their anticipated roles and responsibilities during MCIs. (p. 104)

73. Further develop the current after-action review process to reference significant incidents and/or MCI. This process should also include all the necessary staffing and logistical needs based on the size and scope of the review. (p. 104)

74. Develop a plan for annual review (audit) of all policies and procedures related to full-scale exercises requiring multi-agency response and Unified Command. Ensure policies have clear and concise definitions, assignments, and role descriptions for responding personnel. (p. 106)

75. Routinely establish the DOC for pre-planned events with large numbers of attendees. (p. 106)

76. Create policy, procedures, and protocols that establish Incident Command System training requirements for all LVMPD sergeants and above. (p. 106)

77. Develop ICS policies with procedures and protocols specifically for LVMPD Communications Bureau and leadership. Include Communications Bureau personnel in ICS training, tabletop, and large-scale exercises to familiarize them with key concepts and common language used during significant incidents and/or MCI. (p. 107)

78. Incorporate additional active-shooter/MACTAC training between SWAT and patrol officers for a more coordinated response during significant incidents and/or MCI. (p. 107)

Victims, Survivors, and Family Response

79. Update policy, procedures, and protocols that include LVMPD victim advocates in significant incidents and/or MCI response. Incorporate victim advocates in all significant incident and/or MCI training. (p. 111)

80. Continue to include administrators of private-sector partners, such as public transportation and ride-share companies, in tabletop exercises related to significant incidents and/or MCI. (p. 111)

81. Increase the Agency's knowledge and expertise in establishing a Family Assistance Center. (p. 112)

Employee Wellness and Healing

82. Expand MCI tabletop exercises and training beyond initial response to include post-incident needs such as establishing a Family Assistance Center and employee wellness and healing. Relevant partnering agencies should be included in this training. (p. 112)

83. Develop a cadre of individuals and agencies from the region who are trained and willing to serve as force multipliers when additional peer support to LVMPD employees is necessary. (p. 117)

84. Provide crisis and trauma training to collective bargaining associations to assist membership in the aftermath of a critical incident. (p. 118)

85. Expand the Significant Event Reporting (SER) program to all Agency employees following a significant incident and/or MCI. (p. 119)

86. Re-evaluate EAP benefits to ensure all LVMPD employees and their family members have similar access to the same programs and providers. (p. 120)

The Months after 1 October

87. Create and implement policy, procedures, and protocols for an agency-wide, critical-incident, stress-management debriefing process. (p. 123)

88. Create policy, procedures, and protocols outlining authorization for speaking and training engagements pertaining to lessons learned following significant incidents and/or MCI. (p. 123)

89. Establish and reinforce policy, procedures, and protocols for LVMPD employees who are asked to attend community events, speaking engagements and interviews related to significant incidents and/or MCI. (p. 124)

90. Review and update policy for commendations to include honorary ceremonies and community events resulting from significant events and/or MCI, in which large numbers of employees are involved. (p. 125)

91. Create policy, procedures, and protocols to meet the mandates for releasing public records in large-scale incidents and/or MCI. (p. 126)

92. Establish a cadre system under the current Digital Investigations Bureau to meet the mandates of releasing public records. (p. 126)

93. Enhance the current digital forensic examination platform for maintaining digital records. (p. 126)

Tree of Life Synagogue, Pittsburgh, PA (October 27, 2018)

The following "Lessons Learned" are taken from "After Action Report and Lessons Learned – Tree of Life Synagogue – Pittsburg, PA", dated May 22, 2019.

Lessons Learned

1. Multiple SWAT operators were found to not have their IFAKs and tourniquets when inspected by TEMS personnel at the request of SWAT team physician after the CPMS event. The police component of the SWAT team is roughly 45 members in total with only 5 being full- time. Consequently 40 members of the team split their time between standard daily operations where they are normally assigned in addition to SWAT team activations. Thus they have multiple armor sets/configurations (tac heavy, tac light, clandestine, patrol) that they don and doff often. Due to budgetary constraints the officers are not issued IFAKs and TQs for each armor set. Officers will frequently move their IFAKs and TQ between armor sets. Many times this leaves the operators without IFAKs and TQs because of the need for rapid response and forgetting to transfer their medical gear. Operators will also sometimes keep IFAKs and TQs in the cargo pants pocket opposite their thigh rigs, again exposing them to forgetting to transfer gear when changing uniforms. (p. 7)
2. Recent trauma literature suggests differences in wounding patterns that are considered survivable when comparing modern combat theatre and civilian public mass shooting (CPMS) incidents.* Interestingly the two injured SWAT operators both suffered from extremity hemorrhage amenable to C-TECC/TCCC training, with the extremity hemorrhage similar to combat theatre preventable death injuries. We only had an n=2 but further analysis would be interesting. While the vast majority of extremity injury in combat is from IEDs, the type of armor used during SWAT operations protects most of the thoracoabdominal area and head thus it exposes the extremities and face/neck areas to injury. This makes extremity hemorrhage control extremely important. No official autopsy reports were available at the time of this writing but on-scene observation of civilian wounds closely matched injury patterns in other CPMS events recently published. This validates

TEMS medical training in C-TECC algorithms and specialized medical equipment carried. (p. 7)

3. Despite properly medically trained operators and TEMS medics, both SWAT operators wounded in the shooting required multiple tourniquets on their wounded limbs. In both instances the TQs were properly placed, tightened, inspected, re-tightened and then a secondary TQ was deployed. The issue and lesson learned is multifactorial. As previously discussed, the operators sometimes will not have their IFAKs or TQs on the armor they are wearing. In addition, all operators are only assigned one TQ each. Thus the potential for lack of adequate medical equipment exists. One operator suffered an arterial injury, did not have a tourniquet with him and was isolated from TEMS personnel for ~18 minutes due to active gunfire and juxtaposition to the rest of the team. Had a fellow operator not been with him and used his TQ the results could have been catastrophic. The city is currently working on funding to outfit each operator with multiple TQs and IFAKs. (p. 7-8)
4. TEMS elements deployed as far forward as safely possible saved lives. Patient 3 initially thought deceased until TEMS was cleared to perform hands-on assessment. He arrived at the closest level 1 trauma center with a heart rate of 125 and blood pressure of 50/palpation. He spent 4 minutes in the trauma bay and was taken to the operating room where trauma surgeons were greeted with greater than 2 liters of hemoperitoneum. He would have died on scene with standard EMS model. In the instance of the most critically injured SWAT operator, only 45 seconds went by between him being shot multiple times and being delivered to the TEMS cadre whom were staged 30 feet away. He already had his armor removed and helmet taken off prior to the hand-off to TEMS. Immediate point of injury care was started by the embedded SWAT physician and a full compliment of TEMS medics. This allowed for a full MARCH algorithm assessment and treatment in less than 3 minutes with exfiltration and transport immediately afterward. Despite the rapid treatment, transport and delivery to a level one trauma center he arrived hypotensive and minimally responsive. Had there been a delay at any point in the chain of treatment it is the author's belief he would have died. In addition, the TEMS cadre addressed two other patients with

potentially life-threatening extremity hemorrhages. Both could have easily resulted in death had the injuries not been addressed in a timely fashion. (p. 8)

5. On scene medical equipment was not accessed. The Tree of Life congregation had recently undergone ‘Stop The Bleed’ (STB) training and had a fully stocked STB kit directly underneath an AED near a main entrance of the facility. Likely wounded civilians on scene were unable to access the kit due to the ongoing danger of the shooter moving through the structure repeatedly. The kit was placed in a very advantageous and visible location, but this unfortunately meant it likely presented a danger for those wanting to approach and access it. (p. 8)

6. Training pays off when it sucks. The military and law enforcement arena abound with clichés but one that proves true more often than not is ‘The more you sweat in peace time, the less you bleed in war.’ We have a multidisciplinary TEMS cadre with experts in high angle rope rescue, river rescue, moulage, etc. One example, when we train with new ‘movement’ equipment and we are ready for final evolutions we will use the heaviest operators available. They get carried for hundreds of meters, up and down stairs and through tundra. It sucks. On the day of the synagogue shooting it was one of our heaviest operators (that we commonly use in training because of his size) that was critically injured. There was absolutely no delay and no difficulty moving him down 3 flights of stairs and to a waiting stretcher. (p. 8-9)

Henry Pratt Active Shooter Incident, Aurora, IL (February 15, 2019)

Incident Command

1. There is a need to isolate the Incident Command Post, especially early in response. Some reported that the influx of personnel made it difficult to coordinate and distracted Unified Command from the mission (p. 14)

2. Develop an SOP for coordinating with external jurisdiction and regional liaisons, with the goal of ensuring effective communications and minimizing the number of people at the Incident Command Post. (p. 14)

3. Having a liaison for Command Staff to work with the Incident Command Post through. Some agencies reported not receiving updates, and without having Aurora communications, they couldn't stay informed. (p. 14)

4. There were a few recommendations to stand up a Tactical Operations Center (TOC) in a centralized location. This would allow Command Staff to remain in one location, while others who needed to meet with them could easily identify the location. It was noted that even without a TOC, the Incident Commander did an excellent job coordinating responses and teams. (p. 14)

5. Have a map of the building and marking off cleared areas. Even without the floor plan, a crude diagram with some basic layout information on a dry erase board would have been helpful. (p. 14)

6. Since the incident, several issues centered on the mobile command vehicle have been addressed. APD has increased the number of trained drivers and given them keys to the vehicle. Extra keys are now also kept in a communal location. There are plans to cross-train SRT personnel to drive it as well. (p. 14)

7. Develop and socialize a SOP on distinguishing between the "mobile command vehicle" and Incident Command Post/Mobile Command Post to reduce miscommunications. (p. 14)

8. Encourage common use of terminology per the Incident Command System (ICS) wherever possible. In areas where this is untenable, ensure police and fire understand specialized terminology (e.g., North side of the building vs. "A" side). (p. 14)

9. Going forward, an Incident Management Assistance Team may be needed. This team could be deployed to set up staging, begin scribing, etc. Team

members could be preassigned to come in as other officers are reassigned. In addition, the Incident Commander may be offered a trained assistant to take some of the administrative burden off the position. (p. 15)

10. Include plans an emphasis that support personnel should be assigned to assist Incident Command, rather than pulling personnel from Incident Command to attend to duties elsewhere. (p. 15)

11. The EOC was activated quickly and effectively coordinated with Command. Some suggested further clarifying the City EOC's responsibilities. (p. 15)

12. Some officers mentioned they would have preferred to have more information about the offender (picture, further description, etc.). While some officers were provided information and photographs of the offender, others noted that they were not. Review and update SOPs as appropriate, to determine who is responsible for sharing this information, when the information should be provided, and a method to ensure the information is shared. (p. 15)

13. If feasible, responders recommended having the perimeter pushed out farther than it was to prevent non-response personnel from crowding and hindering response efforts. (p. 15)

14. Plan to establish a forward command closer to the scene; separate from the Incident Command for larger incidents to prevent overcrowding end enable perimeter control. (p. 16)

15. Review and update SOPs on police action during officer-involved shootings to include contacting the hospital's Public Information Officer (PIO), discussing hospital security, and intercepting media, as appropriate. (p. 16)

16. Determine if triage tags could be used to track patients and identities – add to SOPs as appropriate. (p. 16)

Emergency Operations Center

17. Determine ways to provide a common operating picture on incident operations – this could include projecting incident information of the EOC wall or tapping into television screens to regularly update EOC personnel on incident information. (p. 18)

18. Conduct regular technology testing to ensure televisions and other systems are working. (p. 18)

19. Provide training on how to get all of the technology within the EOC up and running. Step-by-step checklist may also be helpful for specific systems. (p. 18)
20. Personnel noted the need for more information on roles and responsibilities and recommended pre-populated checklists with specific guidance. Recommend developing checklists or reviewing/updating if they currently exist. (P. 18)

21. Review and update SOPs as appropriate to establish a line of direct and consistent communication between the PIO on scene (in this case, APD PIO) and the City's Communications Director to encourage effective communications coordination. (p. 18)

22. The Communications Director could have used more assistance to coordinate with the media and update social media. Consider developing a protocol between the Police PIO and City Communications Director for exchange of information and updates. (p. 18)

23. A JIS Plan be developed. A system of how people will operate. The thought that people will come together in today's world is very challenging. It is easier to operate remotely with the use of technology. For example, if a conference call had been established (JIS) to get all the key players on the same page, this would have saved time and redundancy. Getting those people in one room would have been a challenge. (p. 19)

24. PIO representation would be useful in the EOC to assist the Communications Director. (p. 19)

25. There may be other opportunities for those in the EOC to support communications; there must be protocols developed to outline how best to move forward. (p. 19)

26. Continue expanding usage of the mass notification system and building out accompanying SOPs. (p. 20)

27. Determine if a dedicated phone number for incident questions can be added to notifications. (p. 20)

28. Continue developing and EOC SOP for large-scale incidents such as this one. (p. 20)

29. The City of Aurora and surrounding area should address coordinated emergency communications, including lockdown notifications. (p. 20)

30. Continue to investigate additional avenues to contact affected organizations and community groups other than through the originating 9-1-1 center. This can include both PIO staff and the city EOC. (p. 20)

31. Continue reaching out to local stakeholders and adding user groups to the Everbridge notifications, including private and parochial schools, businesses, hospitals, and other critical infrastructure stakeholders. (p. 20)

32. Develop an updated listing of all schools, including day-care facilities, for future planning purposes. (p. 20)

Operational & Radio Communications

33. Review radio communications protocols and determine where there could be improvements for an incident of this size and scope. (p. 21)

34. Determine if a repeater is needed to improve communications in the area. Review and update SOPs, as needed, to ensure repeaters are available and accounted for within response protocols. (p. 21)

35. Continue to train responders in radio communications best practices, including when it is appropriate to contact Incident Command and when it would be more appropriate to use tactical channels. Ensure hands-on training using the technology is implemented at all levels. (p. 21)

36. Continue implementing hardware updates/improvements to simplify radio communications. (p. 21)

37. Ensure tactical channels are available and communicated to the appropriate parties. (p. 21)

38. This is available within the IEMA Region. Coordinating with their EOC/EMA for unmet needs would have aided them in acquiring this resource immediately. (p. 21)

9-1-1 Calls & Dispatch

39. Determine if there is a way for other agencies to patch into the Aurora dispatch system so they could surge support. (p. 22)

40. Identify how channels are allocated for active incidents and if there is a need to reserve specific channels. (p. 22)

41. Continue to provide training opportunities where possible. Include dispatchers in training (i.e., ALICE©) to ensure they have a better understanding of the information law enforcement would need when

responding to an incident or, to provide callers instructions on behalf of law enforcement during an incident. Additionally, conduct rotations with the SRT teams so dispatchers can gain experience with tactical dispatching. (p. 23)

42. Conduct frequent testing and use of the new Everbridge notification system that includes whole community partners. (p. 23)

43. Continue training on the CAD System. (p. 23)

44. Determine if there are any gaps in system functionality and address as appropriate. (p. 23)

45. Update MABAS box alarm cards. (p. 23)

46. Ensure dispatch is vetting information before redistributing. (p. 23)

47. Enact the patch for Aurora and Naperville radios to encourage interoperable communications. If there is a delay, swap radios with neighboring jurisdictions to improve delegation/passthrough communications as necessary. This would reduce the need for follow-on-phone calls and reduce delays in information sharing. (p. 24)

48. Recommend assigning personnel to monitor IFERN in the event a patch is not possible. (p. 24)

49. Recommend agencies evaluate best practices as highlighted above and review and revise SOPs as appropriate to harness these practices. (p. 24)

50. Employ a cache of radios to responding agencies. (p. 24)

51. Continue training on the CAD System. (p. 24)

52. Determine if there are any gaps in system functionality and address as appropriate. (p. 24)

53. Update MABAS box alarm cards. (p. 24)

Resource Staging & Management

54. Develop regional guidelines for responding agencies during a situation similar to an “Active Shooter”. This remains an issue with large-scale incidents across the country involving the need for law enforcement. (p. 25)

55. Reinforce ICS guidance on staging locations and the need for all responders to report to it. Some responders recommended a stronger perimeter and a check-in-location to provide access control. Upon arrival on scene, it is critical that responders receive assignments from Incident Command. (p. 25)

56. There are mixed reviews on whether a separate location for self-reporting off-duty personnel would be effective. (p. 25)

57. Review and reinforce communications to the responder community regarding self-deployment as appropriate. (p. 25)

58. There was a recommendation for Incident Command to advise dispatch centers that no more officers were needed earlier in incident response. (p. 25)

59. Continue offering integrated training opportunities across the region. (p. 25)

60. Encourage collaboration across the region in developing SOFs, including determining interoperable technologies and systems. (p. 25)

61. Recommend developing and implementing a system to track and assign resources, as well as check resources back in, in line with ICS and Illinois MABAS guidance. (p. 26)

62. Coordinate messaging on resource requests to ensure there is not an overwhelming amount of resources in the staging area. Avoid “all call” requesting. (p. 26)

63. Review and follow MABAS request best practices, going through levels appropriately based on need. (p. 26)

64. From a secondary PSAP view, establish a clearer point of contact for unit accountability from one PSAP to another to avoid duplicate requests and inquires for a single large incident (i.e., unit run downs, Illinois Law Enforcement Alarm System (ILEAS) call out fulfillments) (p. 26)

65. Develop up-to-date mutual aid organizational charts and distribute to the appropriate parties. (p. 26)

66. Review and revise SOPs as appropriate to determine who is responsible for personnel accountability and how it should be tracked. Ensure there are designated personnel to complete this assignment during an incident. Consider a pass card system for police for easier check-in and accountability. (p. 27)

67. While Illinois MABAS functioned successfully, consider developing an active shooter and/or MCI-specific disaster box card for regional coordination. (p. 27)

68. Continue integrated training opportunities to foster effective communications and build trust across teams. (p. 28)

69. Clearly mark TEMS and Medics to eliminate confusion as SRT responders (i.e., red name tape or insignia). (p. 28)

70. Wherever possible, keep a lane open to allow EMS to transport patients to definitive care. (p. 28)

71. It may be beneficial to address the option of take-home squad cars for SRT and/or magnetic blue lights that off-duty personnel can use when responding to this type of major incident. This may reduce the response time of critical personnel and provide safety for off-duty responders and the general public. (p. 28)

72. The flight restriction was cited as incredibly effective and should be formalized in SOPs where appropriate. (p. 29)

Rescue Task Force

73. Evaluate the number of responders assigned to each RTF – consider reducing from approximately 10 to 5-6 depending on operational awareness during the need to utilize RTF. (p. 29)

74. The City of Aurora should lead the development of an RTF SOP and validate during concurrent training and exercises. (p. 29)

75. The City of Aurora should continue to lead the development of regional RTF policy documents to make RTF operations and associated expectations clear to all responders. This will include follow-on to ensure responders know the protocol and are comfortable integrating across disciplines in a dynamic incident. (p. 30)

76. The City of Aurora should continue to plan and incorporate the RTF concept into training and exercises to enhance regional understanding of function and capability across disciplines. Recommend conducting joint RTF training on a minimum bi-annual schedule until all parties are comfortable with the RTF model. (p. 30)

77. The City of Aurora and the surrounding region should address the belief that fire/EMS should not deploy to worm zone operations and provide

guidance and integrated training to attempt to inform and address concerns. (p. 30)

78. The City of Aurora is in the process of training, manning and equipping RTFs. This includes the equipping and outfitting of medical kits, blow-out kits, and other resources such as tourniquets to assist with life-saving medical interventions. In addition to tourniquets, responders should consider carrying hemostatic dressings and occlusive dressings to reduce preventable deaths. (p. 31)

79. RTFs should have the proper equipment, both tactical and medical, ahead of making entry. Aurora and Naperville are reportedly in the procurement process working towards fully equipping RTF teams. The City of Aurora is in the process of developing procedures for the operational coordination of police, fire, and EMS organizations to maximize interagency coordination and update as needed. (p. 31)

80. Reviewing how staging and coordinating resources that are heading into the warm zone (RTF) and hot zone (contact teams) would be helpful. SOPs may need to be reviewed or revised as appropriate. (p. 31)

81. The Active Shooter SOP should incorporate real-world findings from this incident prior to finalization. (p. 31)

Tactical Response

82. Continue to develop and revise SOPs on RTF operations, namely warm zone operations. (p. 32)

83. Offer training opportunities for active shooter incident operations and management. (p. 32)

84. Several officers noted that they did not bring breaching equipment and it would have been helpful for building search and clearing. Others noted they could have used NFDDs. One SRT operator noted that in the future, they should ensure the bomb-disposal robot is loaded on the bearcat. Finally, officers mentioned needing their tourniquets but not having them handy.

- Often during response operations, responders are working quickly to get to the scene and equipment is left behind. Consider reviewing/developing pre-deployment checklists with materials that are likely to be forgotten during a high-stress incident. Share with the department and use during training when possible.
- Consider having a standard location for medical kits/tourniquets on the officer's uniform during steady-state operations (p. 32-33)

85. A drone or robot could have been utilized ahead of the contact teams. This would have been useful to get a forward look due to the unfamiliar layout, as well as the enormity, of the building. (p. 33)
86. Lead the development of regional standards for marking rooms akin to technical rescue standards. These may include indications if there are victims, what their status is, presence of absence of explosive devices, etc. Determine if there is a need to restrict access, such as the room the victims were in, and how best to standardize. Adopt best practices regionally among agencies and disciplines. (p. 33)

87. Provide standby teams with intelligence on how many contact teams and what areas had a primary clear where possible. (p. 33)

88. It was not noted how the victims were tagged, only that they could have used a marking to delineate that they had been assessed by medical personnel. Review and revise SOPs, as appropriate, for tagging victims after they've been medically assessed (e.g., a black tag for the deceased). (p. 33)

Medical Care

89. One officer mentioned that a tourniquet that was applied to another wounded officer was not tight enough to stop the bleeding. Tourniquets may fail for a variety of reasons – it is critical to have backups, including multiple tourniquets, hemostatic dressings, and other dressings as appropriate to treat the victim. It is also important to practice tourniquet application in training to ensure it is applied higher than (proximal to) the wound, tightened to effect much tighter than one might expect, will likely cause pain to the injured individual), and that direct pressure is applied to stem the bleeding during application. (p. 34)

90. Incorporate life-saving skills during training and exercises. (p. 34)

91. Determine if expanded medical/MCI kits should be issued to officers. Evaluate against TECC guidelines as appropriate. (p. 34)

92. Enforce officers keeping personal self-aid items on their person and ensure these items are not left in their vehicles so they have the equipment if needed. (p. 34)

93. Ensure hospital communications are prioritized during incident response to improve patient outcomes. Review and revise SOPs as appropriate to encourage proactive communications with hospitals. (p. 35)

94. Review all responding agency policies and procedures related to critical incident stress management. Response agencies should ensure that their staff are provided with opportunities for formal critical incident stress management – to "debrief" and "destress", as well as connect with others who have endured similar experiences. While these efforts are most effective in the time period immediately following an incident of this nature (in the first two days), they can also be valuable outside of this time frame. (p. 35)

95. Continue to provide access to long-term stress support in the form of peer support groups, critical incident stress management programs, psychological first aid, and formal therapy. (p. 35)

96. Develop long-term mental health and critical incident stress management programs for responders to ensure that they receive the support and resources they need. (p. 35)

97. Consider addressing cumulative stress, repeated exposure to traumatic events building over time, in addition to critical incident stress management. (p. 35)

Training, Exercises, Resources & Capabilities

98. It was noted that more drone personnel would have been helpful, but all were tasked with other assignments. (p. 36)

99. Another suggestion was to send a page out to the Drone Team to request more pilots on scene. (p. 36)

100. The Temporary Flight Restriction was effective, ensuring the news helicopters did not unduly impact air operations. In this incident, the Federal Aviation Administration (FAA) requested to talk to Incident Command to close the air space – they were not able to, but ultimately closed the air space as requested. For the future, recommend developing SOPs for closing airspace. (p. 36)

101. While the news helicopters were prevented from getting too close, they were still close enough to get high quality footage that could have hampered police tactical operations if there were more offenders launching a coordinated attack. Police should determine how to coordinate with the FAA and news agencies to balance the need to share information with the public with tactical operations. (p. 36-37)

Community Preparedness

102. Joint fire and police department pre-plan inspections could also assist response teams with familiarization of local building layouts. (p. 37)

103. Work with local government and Local Emergency Planning Committees (LEPCs) and community government to pass ordinances requiring businesses to register critical information for first responders (i.e., blueprints, floorplans, door numbering policies, additional information on layouts, workflow and traffic patterns, etc.) with responding agencies. Ordinances requiring that building plans be included with fire extinguisher boxes as a community-wide best practice were recently passed by the City of Aurora council. (p. 37)

104. Incorporate joint inspections as a way to increase agency familiarity with local building layouts. (p. 37)

105. Upload on-file plans and building details to the CAD and to responder vehicles to ensure they are accessible during the time-sensitive incidents. (p. 37)

106. Ensure that Victim Services and Notification Centers are written into SOPs; this may require wider discussion about responsible parties, resource commitments, where and how to establish, etc. Determine where a Notification Center may be established if there were a larger incident and ensure it is written into SOPs. (p. 38)

107. Continue strengthening relationships with non-traditional response partners, such as Aurora University. (p. 38)

Crime Scene Operations

108. There should be better witness accountability, including: when a witness was removed, where they went, who took them there, who they were taken to, and who interviewed them. (p. 38)

El Paso Walmart Active Shooter, El Paso, TX (August 3, 2019)

The following recommendation are the results of extensive interviews by the Federal Emergency Management Agency (FEMA) National Preparedness Directorate in collaboration with the El Paso City-County Office of Emergency Management, El Paso Police Department (EPPD), El Paso Fire Department (EPFD), El Paso Department of Public Health (DPH), El Paso 911 Communications, Office of the Medical Examiner (OME), Federal Bureau of Investigation (FBI), and Border Regional Advisory Council (BorderRAC).

Emergency 911 Services and Notification

1. Explore methods and technological solutions to centralize and prioritize CAD system usage during major events.

2. Establish policies, procedures, training, and exercises to refine the approach and support implementation.

3. Continue to establish, maintain, and expand upon interpersonal and interagency relationships through joint planning, training, and exercise to improve trust, communications, and coordination.

4. CAD (Computer Aided Dispatch) System: The CAD is used by most local law enforcement, fire, and medical response agencies in El Paso County. A CAD is the bridge between the call to 911 and the responder arriving to assist with a law enforcement, fire, or medical issue. El Paso County is unique in that the District provides a common CAD system for virtually all local agencies, making the County one of the most interoperable in the State.9

5. Continue cross-training for existing dispatchers between EPFD and EPPD.

6. Continue to cross-train volunteers across functions for communications personnel to stay updated on workflows/process in different functions.

7. Establish policy for non-involved units to switch to alternate channel and tactical teams continue using their own channels.

8. Consider SOPs that outline when and how EPPD and 911 Communications patch channels and establish additional channel(s) during a large-scale incident.

9. Consider SOPs on how staff will be distributed to absorb and redistribute volume of calls coming in on non-primary channels.

10. Develop active shooter/mass incident template or run card for dispatchers.

11. Continue to implement new policy that grants Communications the authority to automatically upgrade an incident once reports of an ongoing mass casual incident (MCI) are received.

12. Integrate dispatchers in MCI communications planning, training, incident procedure development and exercises.

13. Create a unified response plan for an active shooting incident that involves Communications, Emergency Management, EPFD, and EPPD.

14. Develop policy and trainings for dispatch and call takers specifically for active shooters.

15. Responding agency chiefs should consider sharing their respective active shooter policies with each other to inform trainings and day-of decision-making.

16. Reinforce alert and notification policy, procedures, training, and job aids to improve and standardize lines of authority/responsibility, message content, and establish trigger points for notifications.

17. Everbridge messages should not be issued unless vetted by the Communications Supervisor, Incident Commander (IC) or EOC.

18. Develop and/or improve policies and procedures regarding both alerts and notifications are issued and who is responsible for this notification process.

19. Continue protocol of quarterly audit to ensure personnel's contact information is accurate and running messaging tests using that information.

20. Consider having key first responders from various agencies establish an account with EMSystem: The EMSystem is an internet-based system for reporting and monitoring hospital status in the region. It allows emergency responders the ability to note the emergency department status of all hospitals and to better route patients.10

21. EMResource, to ensure each agency receives notifications from the EMResource system.

22. Continue assessments with area hospitals on their communication capabilities and solicit feedback on how to improve system-wide communications system for alerts

23. Assess current trainings for fusion center analysts to determine areas for improvement to strengthen analysts' capabilities.

24. Train additional fusion center analysts in proper information verification processes and tools in the event of a large-scale incident.

25. Develop protocol that the communications mobile unit be dispatched for active shooting mass casualty incident.

26. Ensure radio protocols account for external agency personnel interoperability channels to reduce radio traffic and dispatch burden.

27. Ensure extra radios are co-located at the staging area or another central location for responders to be assigned a radio that can access the appropriate channels.

28. First responders be trained or familiarized with ICS terminology and plain language.

29. Ensure Communications training and communication focuses on providing ICS specific addresses and location markers for external responders.

30. Incorporate ICS standardized interagency language and terminology for exchanging information regarding location and addresses.

Victims, Survivors, and Family Response

31. IC or the first responding officers should follow SOPs and responder checklist to obtain video footage for verification.

32. Consider setting arrangements with alarm companies in the city to share video security footage during mass casualty incidents to quickly identify shooters and potential, additional threats during the response

33. LE agencies designate SOP or standards for off-duty officer responses. These guidelines should include what LE identifications should be available and visible during the response and where/how to report.
34. Establish staging area away from the scene for off-duty personnel to check-in for tracking and assignment. This staging area should have ID markers available for plain clothed and off-duty officers to be distinctly identifiable as LE personnel.
35. LE agencies should consider having a reserve of identifiable clothing (vests, shirts, jackets, etc.) that have 4-sided markers that can be distributed at the scene.

Scene Management and Fire Mutual Aid

36. Ensure designated responders direct fleeing people to designated safe zone(s).

37. Conduct training and exercises to ensure responders understand their roles and roles of others in evacuating premises during active incident response.

38. To the extent practical, treat each individual as a suspect when clearing the scene to avoid potentially also clearing the shooter. Group bystanders orderly to a safe area to check IDs and do witness statement intake.

39. IC should distribute LE officers well to ensure there are enough officers to clear bystanders from the scene and respond to other needs in the location. Responders should continue with their assignment until/unless reassigned.

40. IC should discuss, clearly communicate, and identify agencies and individuals involved in and leading the first walkthrough.

41. Local responder agencies should communicate and routinely update inventories and plans with investigation tools, such as diagram scanners, and develop SOPs should tools need to be used by other agencies.

42. Response organizations should consider providing additional, joint planning, training and exercises to document and create understanding of each other's roles, priorities, expectations and operational tempos for scene processing and walkthroughs.

43. Ensure walkthrough communication updates among EPPD, supporting LE agencies, and the OME are established and maintained as part of IC duties and responsibilities.

44. Designate resources to block off/open traffic at various locations and throughout different stages of operations.

45. Have a designated person in charge of traffic flow and parking/sectioning off areas to keep transport corridor open.

46. MCI policies and personnel responsibilities need to ensure there is a proactive approach to maintain a corridor and parking security for an unobstructed transport corridor and to ensure there is no active shooter activity within it.

47. Law enforcement vehicles should not be parked in roadways to ensure roads are kept clear for a transport corridor and that entry and exit points are accessible.

48. Update ICS procedures to include LE staging assignments and check-in procedures.

49. Fire department to review MCI policies and procedures regarding access to warm zones for casualty collection points in these types of incidents.

50. Designate resources to block off/open traffic at various locations and throughout different stages of operations.

51. Have a designated person in charge of traffic flow and parking/sectioning off areas to keep transport corridor open.

52. Ensure IC identifies traffic patterns early in incident response to shut down appropriate roads and re-set traffic patterns.

Tactical Operational Response

53. Continue EPFD and EPPD developing a victim rescue unified response policy and related trainings.

54. Continue to conduct joint trainings, involving LE partners, on victim rescue and treatment.

55. Consider allocating funding for LE and fire personnel to attend external RTF related trainings.

56. In the event an RTF structure is established, build EPFD/EPPD RTF teams that are trained on the newly incorporated policies and procedures.

57. Designate at least one responder to set up a casualty control point and direct victims to appropriate area.

58. Consider Simple Triage and Rapid Treatment (START) and general triage trainings and incorporate in exercises.

59. Ensure that multidisciplinary response practices are shared among response organizations.

60. Collaboratively plan, train, and exercise on victim rescue and how to utilize their surrounding environment to safely transport victims.

61. Victim rescue trainings should include extraction practices for critically injured victims.

62. Establish primary points of contact for El Paso led clearing teams.

63. Develop plans and processes for establishing a unified command structure during a joint effort incident response for LE external agencies.

64. Develop plans and processes for outside agencies to integrate into the command structure and appropriate staging of resources.

Operational Coordination

65. Ensure that communications are made at critical points in time relevant to a shooting incident to key personnel and partner agencies.

66. Continue to use, refine, and document these processes and relationships. Consider documenting in plans and procedures and formalizing agreements as needed.

67. Notification and Information Center (NIC) family notification process and procedures should be reviewed and revised as needed to ensure a coordinated effort with supporting agencies, including EPPD Crimes Against Persons Unit.

68. Develop plans to prioritize personnel required to be at the OME.

69. Consider developing plans, policies, budget requests, and contracts to support the ability to expand operations by bringing in modular space (trailers, tents), command vehicles or by moving some operations to a larger, borrowed, or leased space.

70. Continue routine assessments on capacity and needs of the OME according to everyday needs and for large-scale incidents.

Operational Coordination: Incident Command

71. Continue following recently revised policies and SOPs to follow best practice that the first officer of scene assumes command until relieved by a supervisor.

72. Continue training on recently revised SOP that the supervisor should have an IC checklist on hand in case they get placed in that role.

73. Conduct ICS training on how to establish and announce the assumption of command and location of the command post.

74. Establish more training and familiarity among LE and Fire Department for critical incident response as well as ICS training on the Unified Command structure.

75. EPFD and EPFD should continue to participate in MCI trainings to establish relationships across agencies and have a clear understanding of interagency roles and responsibilities.

76. IC should establish an LE staging area away from command post for officers awaiting assignments.

77. Establish a staging area separate from the command post.

78. Preplan and Institute Staging Areas - create check-in station(s) for off-duty personnel to receive assignments and more detailed information on their arrival for major venues and locations in the jurisdiction.

79. Train and Establish Staging Officers: Communicate directly with the command post and dispatch to issue assignments as responders are en-route or at the scene.

80. Issue an additional Everbridge to notify responding officers of the staging area to report to upon arrival.

81. Create a pre-script for communications of key information that needs to be issued during a response. Leadership can use this as both a checklist and template of what needs to be communicated out to their agencies and external responders.

82. Establish a staging area separate from the command post.

83. Preplan and Institute Staging Areas - create check-in station(s) for off-duty personnel to receive assignments and more detailed information on their arrival for major venues and locations in the jurisdiction.

84. Train and Establish Staging Officers: Communicate directly with the command post and dispatch to issue assignments as responders are en-route or at the scene.

85. Issue an additional Everbridge to notify responding officers of the staging area to report to upon arrival.

86. Create a pre-script for communications of key information that needs to be issued during a response. Leadership can use this as both a checklist and template of what needs to be communicated out to their agencies and external responders.

87. Consider utilizing personnel tracking resources, such as Android Team Awareness Kit (ATAK) or blue force tracking.

88. Develop SOP that off-duty personnel have a form of LE identification as part of go bag and to report to a staging area or take up an open perimeter assignment.

89. LE agencies should consider having a reserve of identifiable clothing (vests, shirts, jackets, etc.) that have 4-sided markers that can be

distributed at the scene, to prevent from being misidentified as the shooter.

90. Ensure there are routine trainings on the establishment of a Command Post and divisions to cover a large geographic area.

91. Establish understanding of area command and the different branches for Crime Scene Management.

Operational Coordination: Emergency Operations Center

92. EOC leadership establish a working IAP among partners and share with IC at the scene.

93. El Paso emergency response partners should consider developing pre-loaded IAPs for different incident types (i.e. floods or shootings). Draft can be developed along the NIMS Intelligence/Investigations Guide and edited to address incident specific details during response.

94. Consider testing EOC personnel activation twice a year.

95. Incorporate Everbridge and WebEOC use in the EOC exercises and trainings.

96. Update Department Operations Center (DOC) Protocol to include assignment of WebEOC updates and EOC communication.

97. Create a stream dedicated to DOC operations within WebEOC.

98. Conduct further trainings and exercises for EOC members on how to use WebEOC and input injects in real-time.

99. Consider testing EOC personnel activation twice a year.

100. Incorporate Everbridge and WebEOC use in the EOC exercises and trainings.

101. Update Department Operations Center (DOC) Protocol to include assignment of WebEOC updates and EOC communication.

102. Create a stream dedicated to DOC operations within WebEOC.

103. Conduct further trainings and exercises for EOC members on how to use WebEOC and input injects in real-time.

104. Consider testing EOC personnel activation twice a year.

105. Incorporate Everbridge and WebEOC use in the EOC exercises and trainings.

106. Update DOC Protocol to include assignment of WebEOC updates and EOC communication.

107. Create a stream dedicated to DOC operations within WebEOC.

108. Conduct further trainings and exercises for EOC members on how to use WebEOC and input injects in real-time.

109. Consider testing EOC personnel activation twice a year.

110. Incorporate Everbridge and WebEOC use in the EOC exercises and trainings.

111. Update DOC Protocol to include assignment of WebEOC updates and EOC communication.

112. Create a stream dedicated to DOC operations within WebEOC.

113. Conduct further trainings and exercises for EOC members on how to use WebEOC and input injects in real-time.

Public Information Notification

114. Consider testing EOC personnel activation twice a year.

115. Incorporate Everbridge and WebEOC use in the EOC exercises and trainings.

116. Update DOC Protocol to include assignment of WebEOC updates and EOC communication.

117. Create a stream dedicated to DOC operations within WebEOC.

118. Conduct further trainings and exercises for EOC members on how to use WebEOC and input injects in real-time.

119. Consider conducting additional training and exercises for training members and PIOs to enhance communication exchange collaboration between PIOs from multiple agencies.

120. Revise public information and crisis communications plans to ensure pre-developed messages for active shooter incidents are available.

121. Revise plans to establish current available channels of communication with vulnerable populations.

122. Prioritize prompt public notification messages at the start of the incident and once it has been contained.

123. Develop IPAWS message templates for different scenarios and a standardized template for basic messages.

124. OEM should consider reviewing the policy on disseminating information to the public to for issuing and lifting the shelter in place restrictions. Currently Communications and OEM can issue IPAWS notifications for public safety.

125. Develop a process to identify and operationalize a JIC point of contact for news media and sources.

126. Familiarize and train JIC responders with existing EOC, public information and crisis communications plans.

Resource Management

127. Update Mass Fatality Management Plan to request for TMORT/DMORT support for medical examiners as soon as the need is identified.

128. Continue to proceed with similar protocol of redistributing resources to ensure EPFD coverage throughout the city.

129. Adjust policies to request Ambus at the start of a large-scale response.

130. Consider the use of incident support teams to provide personnel backup when responding to large-scale incidents and conducting large investigations.

131. Consider having an SOP to backfill personnel and resource needs in mass casual incidents, as well as to share resource allocation plans between agencies (e.g., number of days to provide support for).

132. El Paso LE Agencies should consider developing a formal Memorandum of Understanding (MOU) to provide personnel support during a large-scale response/investigation.

133. At the very onset of the memorial, consider guiding the memorial into a more manageable area where it is easier to secure vs. a public roadway.

134. The JIC and EOC should consider clear communication with media about official locations from vigils/memorials and that the public should stay away from the crime scene.

135. Ensure unified public messaging is incorporated in active shooter incident training and tabletop exercises.

136. Consider establishing a clear protocol when developing messages to the public about vigils and memorials.

137. Consider issuing additional mass casualty kits and training each responder.

138. Consider issuing Stop the Bleed kits for four personnel for each structural unit.

139. Continue current measures to place MCI kits in patrol cars.

140. Consider having a vehicle dedicated for the transport of the MCI trailer. If a vehicle cannot be dedicated for transport of the MCI trailer, consider developing a roster of city-owned vehicles with capabilities of transporting the MCI trailer.

141. Provide ballistics vests for all first responders and MCI bags for structural units.

142. Consider a tear away Individual First Aid Kit (IFAK) upgrade.

143. Consider centralizing/relocating trailer in a more accessible location.

144. Ensure every battalion and Rescue Operations Captains (ROC) have mass casualty kits separated and stop the bleed kits with every battalion.

145. Consider providing individual EPFD responders with MCI materials, in case of separation.

Operational Communications

146. Consider designating a specific individual responsible for conducting a continuous situational assessment to confirm/deny misinformation.

147. Train additional fusion center analysts in proper information verification processes and tools in the event of a large-scale incident.

148. Continue best practice for IC and Communications to be responsible for fielding calls and serving as ultimate decision makers on how to filter information and distribute resources.

149. Include relevant IT personnel and contractors/vendors in planning and mass notification systems for major events. Develop checklists, access accommodations, trigger points and assignments to boost network capacity/capability for major events.

150. Consider developing a roster of telecommunications contacts so that the appropriate personnel can be notified to ramp up power levels at radio tower networks for when the radio system is being overloaded.

151. Develop LE SOPs for radio traffic during large-scale incidents that informs multi-channel use.

152. Incorporate emergency communications in overall ICS communications training and planning.

153. Consider assigning an LE individual to cue responding officers for needed information on suspect ID, etc. Develop a checklist to guide questions and responses.

154. Establish and test interoperability and major event talk groups/channels.

155. Provide regional personnel with training and quick reference cards to use these backgrounds/channels.

156. Establish a command channel for LE officers directly involved in a large-scale incident.

157. Continue implementing new, routine training for LE on proper use of radios and frequencies, in terms of information prioritization, channels to use, and ensuring information is distributed effectively.

158. Upon request by the IC allow cross-channel access for responders during a large-scale incident, however, using designated channel when practical is the preferred solution.

Operational Communication: Emergency Operations Center

159. Conduct timely briefings and create other communication methods to cover information if briefings are not possible.

160. Continue to implement protocol developed after the incident to adhere to briefing schedules.

161. Consider designating the Planning Section Chief as the one to lead briefings.

162. Consider developing a formal IAP to ensure timeliness of briefings.

163. Consider conducting training and exercises for key personnel and decision makers that will be present within the EOC.

Family Assistance and Victim Services

164. Update Notification and Activation Protocol to include all four layers.

165. NIC operations can benefit from a community plan, in addition to just-in-time trainings, agency communications and briefings. Implement just-in-time training checklists and Job Action Sheets (to be included in the NIC plan).

166. Conduct briefings for each operating briefing, during which roles, responsibilities, duties, and tasks are assigned and handed over, as needed.

167. Develop a checklist for NIC and FAC facility requirements, such as air conditioning, appropriate bathrooms, and breakout and rest areas, to then pre-identify NIC and FAC locations.

168. Consider having El Paso emergency management partners work with Red Cross to collaborate additional facility options.

169. Consider automatic activation of IMT by the EOC as part of plans and processes for the set-up and operations of NIC during large-scale event response.

170. Train additional, multi-disciplinary IMT personnel for both a more diversified roster and to have alternatives, should the primary personnel not be available during a response.

171. Incorporate IMT activation in process and protocols to activate setup and operations of the NIC during a large-scale event response.

172. Activate FAC IMT concurrent to activating NIC operations and setup. This allows for more effective communication among the Department of Public Health, emergency responders, and victim services and support agencies within the NIC and FAC.

173. Continue conducting regular meetings and exercises of NIC and FAC partners.

174. Continue training and exercises for FAC personnel to develop flexible operating guidelines that can be used in better effectively managing the FAC.

175. Train NIC and FAC partners on roles and functions of individual agencies and the IMT.

176. Strengthen the IMT to be a multi-disciplined management team by including further representation from partners, including Department of Public Health, victim services and support groups and agency departments.

177. Train IC and emergency management on IMT's role and their roles and responsibilities in supporting IMT functions.

178. Consider providing trainings on the process of transitioning between the NIC and FAC.

179. Establish and distribute written plans to refer to during the incident to aide in decision making.

180. Develop plan for NIC operations based on assigned responsibilities and outlining agencies' responsibilities and ICS structure.

181. Adapt FAC protocols for check-in and wristband identification to NIC operations and security management.

182. The Department of Public Health should develop and dispatch prepackaged go-kits for NIC activation that include documents, forms, and access identification.

183. Department of Public Health should hold check-in and identification responsibilities for the NIC.

184. Train and familiarize law enforcement and NIC/FAC security with roles and responsibilities of those involved in operations and who should have access to the facilities.

185. Supervisors assigned to NIC and FAC security should be trained and/or briefed on which partners and individuals are allowed access and their respective roles. Establish formalized protocol for LE on NIC and FAC sites to supervisors.

186. El Paso emergency responder agencies, including the OME, and partners should participate in regular meetings or opportunities to establish working relationships and to understand each other's operations and responsibilities during a response.

187. Follow best practices to increase planning, training, coordination, and exercises related to NIC and FAC.

188. Implement standard operating guideline or orders from the executive team for dealing with elected officials, to be integrated into the NIC and FAC plan.

189. Local FAC/NIC leads should consider developing a yes/no list for local level access management.

190. Follow best practice of designating separate time for media and VIPs to tour NIC and FAC facilities before families arrive. This would lessen impact to victims and their families' wellbeing, as well as FAC operations.

191. Ensure NIC operations are ready to provide services as soon as possible after a location is identified.

192. Once a NIC location is identified, develop a formal PSA to provide information to the public with operational information (e.g., times of operations, location, general information, etc.).

193. Conduct regular and frequent briefings first to the family members at the NIC, followed by briefings and information releases to the media and general public.

194. Include planning consideration around increasing the number in security.

195. Incorporate onsite security in NIC planning and establishment.

196. Consider having stakeholders establish a clear checklist/policy/SOPs on operational requirements prior to when NIC opens, with security measures as a priority.

197. Ensure all victim service providers are included in tabletop exercises and ongoing meetings and trainings for large-scale incidents, particularly active shooting MCIs.

198. Consider establishing multi-agency task forces to conduct family notifications to streamline operations and reduce the likelihood of duplication of effort.

199. Responding agencies and city departments should identify points of contact who will coordinate information exchange and partnership throughout a response.

200. Capture and document these successful practices for future use. Consider including the need to manage/coordinate international notifications in plans and procedures.

201. Local agencies work in conjunction with appropriate consulates to ensure foreign nationals are connected with their representatives for family and victim support.

202. Local leadership and emergency management partners should include in their planning and operations consideration of working with international consulates representative of nationalities residing within the community.

203. Capture and document these successful practices for future use. Consider including the need to manage/coordinate international notifications in plans and procedures.

204. Local agencies work in conjunction with appropriate consulates to ensure foreign nationals are connected with their representatives for family and victim support.

205. Local leadership and emergency management partners should include in their planning and operations consideration of working with international consulates representative of nationalities residing within the community.

206. Pre-determine a list of possible FAC locations throughout the city to ensure facilities are adequate to meet the needs of the response. Such considerations can include Wi-Fi readiness, kitchen access, parking, centralized air, etc. Consider on an annual basis reassessing each pre-determined location's capabilities and identifying additional sites, if needed.

207. Develop a list of pre-identified NIC and FAC locations in the Emergency Management Shelter Annex. In developing this list, emergency response leadership should consider identifying options in different areas throughout the city. Additionally, leadership should consider city and county facilities that can host the NIC

208. Consider culture sensitivity when pre-identifying NIC service providers.

209. Local emergency response partners should account for having a roster of appropriate translators for their community.

210. Review JIC plan to include communication channels/avenues with vulnerable populations.

211. Build a roster of experienced translators who are practiced and credentialed in translating languages representative of the local languages spoken.

212. Establish understandings with news media to show translators when providing coverage of press conferences and briefings.

213. Incorporate activation of mass care branch in EOC's planning and operations for the set-up of NIC and FAC to provide transportation access for those in need.

214. Consider developing public-private partnership agreements with local transportation providers as stand-by resources for large-scale events.

215. Consider providing information on transportation services available to the IC at the scene and NIC leadership.

216. Provide detailed information to the public on needed materials to retrieve their vehicles.

217. LE agency leading vehicle return should coordinate a plan for messaging, document review and processing, and supporting investigations throughout the process.

218. Consider logistics of vehicle return when establishing perimeter at a scene with significant roadway and parking.

Family Assistance and Victim Services: Emergency Operations Center

219. Develop a plan for NIC operations based on assigned responsibilities for responding agencies and ICS structure.

220. Conduct training and exercise for partners on EOC role in supporting NIC/FAC establishment and subsequent communication throughout the response.

221. Update Notification and Activation Protocol to include all four layers.

222. Establish a formal NIC activation policy that also identifies key individuals, partners, and stakeholders.

223. Formalize continual update of points of contact for partners involved in establishment and operations of NIC and FAC.

224. Consider having DPH present at the onset of EOC activation to set internal and interagency communication channels and resource support.

225. Department of Public Health leadership should be present at the EOC throughout the response to represent their agency and coordinate with staff in the field.

226. El Paso Department of Public Health should consider conducting regular trainings on the delegation of authority structure and responsibilities at the EOC during large-scale incidents.

Responder Wellness

227. Consider establishing senior leader listening sessions for responders as soon after the shooting as possible.

228. Senior leaders should consider openly addressing the work force to express gratitude, acknowledge challenges, encourage employees to take advantage of available resources and answer questions.

229. Hold critical incident stress debrief for all directly involved in the response for a mass casualty incident, particularly an active shooting incident.

230. Identify additional trauma informed mental health support providers and programs for personnel and develop a plan for how those resources will be provided in the aftermath of large-scale incidents.

Medical

231. The rapid pace of these types of shootings does not allow for extended call back/notification times.

232. Consider developing protocols to direct, manage and maximize self-directed medical professionals.

233. Hospitals in El Paso and around the country should continue to utilize EMResource as a status board for rapid updates.

234. Area hospitals should continue updating and training personnel on how to use EMResource tool.

235. Continue incorporating hospitals and medical personnel in large-scale emergency response drills.

Medical: Incident Command

236. Designate specific individual(s) such as hospital social workers who can serve as the point of contact and liaison for patients, families of victims, and inquiring agencies. The liaisons' purpose is to limit demands on families and hospitals.

237. Ensure El Paso emergency management's MCI planning and coordination SOPs incorporate advanced coordination and agency relationships among response partners.

238. Capture and document successful use of forensic evidence collection training and implementation for future use.

239. Include forensic evidence collection in hospitals' plans and procedures for mass casualty incident response.

240. Consider hospital area command as part of revised SOPs.

241. In cases of active shooting MCI, area hospitals should follow their practice of immediately activating their lockdown protocols.

242. Continue to implement security SOPs and measures.

243. Area hospitals should continue coordination with local law enforcement to provide security during critical incidents.

244. Consider implementing hospital task forces to address needs of mass casualty incidents.

245. El Paso emergency management community, including EPPD, EPFD, area hospitals, Department of Public Health, and EOC members, should conduct routine assessments of the patient distribution plan to support medical providers’ capabilities in providing services to patients in need,

accounting for hospitals' intake capacity and accurate patient information.

246. Continue to evaluate patient care capabilities with hospitals within the local area on a regular basis.

Appendix A: Recommendations for De-Confliction

The recommendations listed below, and that are noted in red inside the text of the document, have been identified by the BTI team for review. These recommendations either conflict with DHS and/or Department of Justice guidance.

Self-Deployment/Self-Dispatch

Aspects of the following recommendations conflict with tenets of the National Incident Management System (NIMS) and Incident Command System (ICS) which prohibit self-dispatch.

Broome County, New York (AAR Compendium, p. 22)

Area 12. Incorporation of self-dispatched responder protocols to alleviate response redundancies

First response agencies should develop policies for when an officer initiates self-dispatch. A staging area should be created for such officers given the inability to control self-dispatch activities

Washington Navy Yard (AAR Compendium, p. 47)

If not already in existence, agencies should establish clear policies regarding self-dispatching. MPD has reiterated its policy regarding members not self-dispatching. Officers should instead follow established protocols (Example: report to the appropriate patrol district or nearest police facility) and if required to report to the scene of the incident, do so at a designated location or staging area. Training should test the officers understanding of self-dispatch procedures. (*Washington Navy Yard AAR*, p.76)

Training and exercises should also test the supervisors' and managers' ability to manage an incident in which there are many self-dispatching officers. (*Washington Navy Yard AAR*, p.76)

Annex of References

The after-action reviews listed below were the primary sources for this Compendium. While not classified, several reports were labeled For Official Use Only (FOUO) and contain law enforcement sensitive information.

1. **Virginia Tech Shooting, Blacksburg, VA (April 16, 2007),** *Mass Shooting at Virginia Tech: Addendum to the Report of the Review Panel,* TriData Division, System Planning Corporation, November 2009.
2. **Mumbai, India Attack (November 26-29, 2008),** *The Lessons of Mumbai,* RAND Corporation, January 9, 2009.
3. **Broome County, New York (April 3, 2009),** *American Civic Association Shooting, April 3, 2009 After Action Report and Improvement Plan,* Beck Disaster Recovery, September 2009.
4. **Aurora, Colorado Century 16 Theater Shootings (July 20, 2012),** *Aurora Century 16 Theater Shooting After Action Report for the City of Aurora, Colorado*, System Planning Corporation, April 2014
5. **Newtown Shooting Incident, Newtown, CT (December 14, 2012),** *After Action Report of the Connecticut State Police – Newtown Shooting Incident 12-14-2012.*
6. **Boston Marathon Bombings (April 15, 2013),** *After Action Report for the Response to the 2013 Boston Marathon Bombings*, Massachusetts Emergency Management Agency, December 2014.
7. **Washington Navy Shipyard Shootings (September 16, 2013),** *After Action Report - Washington Navy Yard, September 16, 2013: Internal Review of the Metropolitan Police Department*, Washington, D.C., July 2014 (FOUO).
8. **Paris, France Attacks (November 13, 2015***), The Attacks on Paris: Lessons Learned, A Presentation of Findings* by the Homeland Security Advisory Council, June 2016.
9. **San Bernardino Shootings (December 2, 2015),** Braziel, Rick, Frank Straub, George Watson, and Rod Hoops. 2016. *Bringing Calm to Chaos: A Critical Incident Review of the San Bernardino Public Safety Response to the December 2, 2015, Terrorist Shooting Incident at the Inland Regional Center.* Critical Response Initiative. Washington, DC: Office of Community Oriented Policing Services.
10. **Pulse Nightclub Shooting, Orlando, FL (June 12, 2016),** *Florida Department of Law Enforcement After Action Report*, December 13, 2016 (FOUO).
11. **Pulse Nightclub Shooting, Orlando, FL (June 12, 2016),** Straub, Frank, Jack Cambria, Jane Castor, Ben Gorban, Brett Meade, David Waltemeyer, and Jennifer

Zeunik. 2017. *Rescue, Response, and Resilience: A Critical Incident Review of the Orlando Public Safety Response to the Attack on the Pulse Nightclub*. Critical Response Initiative. Washington, DC: Office of Community Oriented Policing Services.

12. **Las Vegas Harvest Music Festival (October 1, 2017),** *1 October After Action Report, August 24, 2018,* Clark County Fire Department and the Las Vegas Metropolitan Police Department in collaboration with the Federal Emergency Management Agency National Exercise Division, August 24, 2018.
13. **Las Vegas Harvest Music Festival (October 1, 2017),** *1 October After Action Review*, Las Vegas Metropolitan Police Department, July 6, 2019.
14. **Tree of Life Synagogue, Pittsburgh, PA (October 27, 2018),** *After Action Report and Lessons Learned – Tree of Life Synagogue – Pittsburg, PA,* May 22, 2019.
15. **Henry Pratt Active Shooter Incident, Aurora, IL (February 15, 2019)**
16. **El Paso Walmart Active Shooter, El Paso, TX (August 3, 2019)**