# MASS CASUALTY INCIDENT RESPONSE PLAN

## METRO-BOSTON
## Urban Area Security Initiative


## JANUARY 2011

***MCI Response Plan***
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Metro-Boston Urban Area Security Initiative (UASI) Mass Casualty Incident Response Plan

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**NIMS STATEMENT**

In March 2004, the Secretary of Homeland Security, at the request of the President, released the National Incident Management System (NIMS). The NIMS is a comprehensive system to improve response operations, using the Incident Command System (ICS) and other standard procedures and preparedness measures. It will also promote development of cross-jurisdictional, statewide, and interstate regional mechanisms for coordinating incident management and obtaining assistance during large-scale or complex incidents.

The NIMS Integration Center (NIC) recognizes that the overwhelming majority of emergency incidents are handled on a daily basis by a single jurisdiction at the local level. However, it is critically important that all jurisdictions comply with the NIMS because the nation may face challenges far greater than the capabilities of any one jurisdiction. However, these challenges are not greater than the combined efforts of all. Homeland Security Presidential Directive 5 (HSPD- 5), Management of Domestic Incidents, requires all federal departments and agencies to adopt and implement the NIMS, and requires states, territories, tribes, and local governments to implement the NIMS to receive federal preparedness funding.

When NIMS is fully implemented, states and local jurisdictions will be able to:

- Ensure common and proven incident management doctrine, practices and principles are used to plan for, protect against, respond to and recover from emergency incidents and preplanned events;
- Maintain a response operation capable of expanding to meet an escalating situation and the ability to integrate resources and equipment from intrastate and interstate mutual aid agreements, state-provided assistance and federal government response;
- Order and track response assets using common resource typing and definitions, and draw on mutual aid agreements for additional assistance;
- Establish staging and allocation plans for the re-distribution of equipment, supplies and aid coming into the area from other localities, states or the federal government through mutual aid agreements;

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• Conduct situational assessments and establish the appropriate ICS organizational structure to effectively manage the incident; and

• Establish communication processes, procedures and protocols that will ensure effective interoperable communications among emergency responders, 9-1-1 centers, and multi-agency coordination systems such as Emergency Operations Centers (EOC).

## GENERAL OVERVIEW

The Metro-Boston Homeland Security region includes the City of Boston and eight of the surrounding cities and towns including Brookline, Cambridge, Chelsea, Everett, Quincy, Revere, Somerville, and Winthrop. The Emergency Medical Service (EMS) provider(s) in each jurisdiction assist in pre-hospital medical emergencies that may overwhelm any of the regional Urban Area Security Initiative (U.A.S.I.) partners. The regional partners are committed to a system of ongoing and open communications, planning, and prevention strategy development. The U.A.S.I. EMS partners are especially committed to the coordination of assets for the consistent training of all members in the regional EMS community. This process will ensure confidence, proficiency, and safety for the jurisdictional EMS providers.

The Metro-Boston U.A.S.I. Region is densely populated and steeped in history and culture, making it a target rich environment for acts of terrorism. The region is also vulnerable to natural disasters such as winter storms, summer heat waves, hurricanes, and flooding. Hazardous land, air, and sea cargo shipments regularly pass through the region. Hundreds of bio level one, two, and three research labs currently operate in the region, and plans exist for a bio level four research facility in the near future. The region is less than fifty miles from two large, commercial nuclear power plants as well as smaller reactors at local universities.

The Metro-Boston U.A.S.I. EMS providers are committed to a mutual aid system of providing response to any member community that requests EMS assistance.

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**MASS CASUALTY INCIDENT**

Any incident, whether intentional or accidental, which could potentially generate a number of victims that requires resources beyond those normally available from local, regional or statewide sources. In any incident with more than five victims at a scene, the first arriving crew should begin using MCI protocols.

**PHASED INCIDENTS**

A "Phased Incident Response" is a system of responding resources to an incident based on the number of potential victims that could be generated from that incident. The phases indicate the number of potential causalities at a declared mass casualty incident (MCI) should any of the regional EMS providers ask for a mutual aid response.

**PHASE DESIGNATIONS**

| | |
|---|---|
| Phase 1 | 1 to 10 potential victims |
| Phase 2 | 11 to 30 potential victims |
| Phase 3 | 31 to 50 potential victims |
| Phase 4 | 51 to 200 potential victims |
| Phase 5 | Greater than 200 potential victims |
| Phase 6 | Incident or Event Requiring Sustained EMS Operations (longer than twenty-four hours) |

**MUTUAL AID STATEMENT**

A Metro-Boston U.A.S.I. city or town requesting mutual aid will advise the Metro-Boston regional C-MED center located at Boston EMS Dispatch Operations, of the nature, location and

declared phase of an incident. Metro-Boston C-MED will call member agencies and determine available resources and an estimated time for a potential response. Metro-Boston C-MED will ascertain the number of response units, support personnel or specialty equipment requested to respond, and the established staging location. The nearest adjoining member agency will provide the initial mutual aid response if resources are available. Response will default to the next neighboring system until the needs are met.

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The primary affected jurisdiction shall establish incident command, and all mutual aid response will report to that command. If requested, responding mutual aid partners may undertake positions in the established ICS structure. When feasible, U.A.S.I. partners will assign supervisory staff to respond with any resources dispatched to an incident.

If the affected jurisdiction establishes a Unified Command Center (UCC), the affected jurisdiction's principal EMS provider shall provide EMS representation in the UCC. The UCC may be at a predetermined location in the jurisdiction, or it may be at an ad hoc location near the MCI site. The UCC should include at least one representative from each discipline involved in the MCI response.

### *SECTION 1: PHASE DESIGNATIONS*

**PHASE ONE**

In any MCI, the first arriving crew is responsible for performing triage and a situation size-up. Any incident where the potential for up to ten patients exists may be designated a phase one incident and trigger the institution of the ICS System. The transport unit commitment will be based on specific need and may include U.A.S.I. member agency units. Special units may also be called on an individual basis, as required.

The following actions are suggested for a phase one response, depending on the primary jurisdiction's capabilities. A phase one incident should be a mandated response for a Supervisor

/ Command level officer. Declared phase incidents should be announced on all Dispatch and Tactical channels to alert field units to expedite patient transfers at hospitals and to exercise radio traffic brevity. A Tactical frequency with a dedicated Telecommunicator should be established for incident coordination. An internal Command level notification to the primary jurisdiction's command staff should be instituted for any declared phase incident. The Incident Commander may notify C-MED of a phase one incident if he or she expects the situation to escalate. Consider mutual aid and other outside requests early in the incident.

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**PHASE TWO**

An incident where the potential for eleven to thirty patients exists will be designated a phase two incident and cause the institution of the ICS System. The following actions are suggested for a phase two response, depending on the primary jurisdiction's capabilities. A Supervisor / Command level officer from the affected jurisdiction should respond, if available. Any Special / MCI support assets should be automatically notified, readied and available to respond. An internal Command level notification should be instituted for any updated information on the phase incident. Metro-Boston C-MED should be notified of any incident above phase one and updated as escalation occurs, whether mutual aid is required or not. Consider mutual aid and other outside requests early in the incident.

Due to patient number, difficulty in extraction, or hazards present, such incidents may require that distinct Incident Operations, Patient Triage & Treatment, Patient Transportation, and Resource Staging Areas be established and staffed.

**PHASE THREE**

An incident where the potential for thirty-one to fifty patients exists shall be designated a phase three incident. Command level officers shall report to their respective areas of responsibility to

manage operations. Any Special / MCI assets including Equipment Trailers, Technical Support Unit(s), a Mobile Command Unit (if available), Regional EMS representative (if applicable), and MMRS Coordinator shall be notified. Additional Support personnel may be activated at the discretion of the Incident Commander. An internal Command level notification shall be instituted for any updated information on the phase incident. Metro-Boston C-MED shall be notified of any declared phase incident, and updated as escalation occurs, whether mutual aid is required or not. Consider mutual aid and other outside requests early in the incident. The Incident Commander may determine that a selective or general recall of off-duty personnel is warranted within his or her agency.

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**PHASE FOUR**

An incident where the potential for fifty-one to two hundred patients exists shall be designated a phase four incident. All provisions for lower phases apply. The primary jurisdiction's EMS provider should notify mutual aid partners who will immediately dispatch at least one transport asset and one supervisor to a designated staging area. A phase four incident may require redistribution of patients to hospitals beyond initial receiving or out of the area facilities, necessitating State EMS Ambulance Task Force assets, aero-medical operations, and/or other EMS resources. All efforts will be made to distribute patients among nearby receiving facilities to avoid overwhelming any one facility.

**PHASE FIVE**

An incident where the potential for greater than two hundred patients exists shall be designated a phase five incident. Such an incident may exceed the ability of the city, town or regional mutual-aid resources to manage and may result in a local / state declaration of a disaster

area. Regional disasters such as earthquakes, tornadoes, conflagrations, or major terrorist attacks, which may require state assistance, fall into this category. The primary jurisdiction should establish an Emergency Operations Center (EOC). The jurisdictional Incident Command System (ICS) will shift to accommodate this operation. The primary jurisdiction's EOC shall notify the Massachusetts Emergency Management Agency (MEMA) of the situation. NIMS format operations shall be instituted and a general recall of all public safety personnel should be considered. Special work assignments and shifts could be necessitated. Provisions for food and shelter for off-shift personnel should be considered early in the response. The agencies involved should arrange for specifically designated Critical Incident Stress Management (CISM), Pastoral Services, and Employee Family Support if their personnel might need these services. Federal agencies such as the Department of Homeland Security *(DHS),* Federal Emergency Management Agency *(FEMA)*, National Disaster Medical System *(NDMS)*, etc. may be requested to respond and assist if the incident overwhelms local, regional, and state capabilities.

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**PHASE SIX**

Any incident that will require continual EMS response for an extended period shall be designated a phase six incident, regardless of the number of casualties expected. A pandemic flu outbreak or a biological terror attack would be an example of a phase six incident. Affected jurisdictions may need to change shift schedules to respond to higher demand. The Incident Commander should establish the planning and administration sections of the MCI Organization Chart (Appendix A) if these sections are not yet established. The public may make large donations during a phase six incident, and the materials management and fiscal affairs sections should handle these donations.

EMS providers may need to provide food and shelter for their personnel during a phase six incident. Providers should work to develop agreements with other organizations or businesses

that could supply food, fuel, or lodging during a prolonged incident. Providers may need to apply contingency plans for alternative forms of transportation for lower priority cases. Non-uniformed personnel may need to be recalled. EMS providers should develop plans for treating their own personnel who may become sick or injured during a phase six incident.

### *SECTION 2: INCIDENT NOTIFICATION / ACTIVATION*

**DISPATCH CENTER / FIRE ALARM**

The Dispatch Center / Fire Alarm (for municipalities without a separate EMS dispatch center), under the initial direction of the onsite supervisor, and later, the command level staff, is responsible for the notification, activation, and initial assignment of response personnel and equipment to a potential Multiple Casualty Incident.

*See Appendix E.1, Dispatch Center / Fire Alarm Checklist*

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### *SECTION 3: UNITS ASSIGNED TO THE INCIDENT OPERATIONS AREA*

The area affected by and directly adjacent to the incident, including the building involved, area of debris, total area containing patients down, as well as any area where potential hazards exist, shall be known as the Incident Operations Area**.** This area is under the direction of one of the first arriving EMTs who will assume the designation of Incident Commander.

Any EMS personnel working in the incident operations area while hazards are present will don personal protective equipment (PPE) prior to entry into the incident operations area or will be excluded until the area is deemed safe.

The objective of the first arriving EMS unit, regardless of clinical level or rank, will be to perform a situation size-up, organize operations, and begin triage. One EMT assumes the size-up and ICS organizational responsibilities as the Incident Commander while another assumes the Triage Officer role. Some limitation of duties will occur when the first arriving unit is a Supervisor or Commander who is alone.

Upon arrival of the first supervisory personnel, who will assume Incident Command, the most previous EMS personnel acting as I/C will transition to the “EXTRACTION OFFICER” position to ensure rapid clearing of the affected victims from the Incident Operations Area to the Treatment Area in a quick and efficient manner.

In order that incident operations are quickly organized, the first unit on scene will have the authority to activate the system and escalate as high as a phase two incident without the authorization of the responding Supervisor, Commander, or other command level staff.

**INCIDENT SIZE-UP METHOD FOR FIRST RESPONDING UNIT:**

When first arriving at the scene of a potential MCI, certain steps are necessary to evaluate the situation. Be aware of everything around you: the bystanders on the scene, the objects or people that caused the injury, the injured parties, the mechanisms of the injury, any hostile parties involved and their location, weapons, hazardous materials, etc. Remember, "everyone sees, but few observe." A proven method of incident observation is listed here for your use.

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**M E T H A N E** *(acronym adopted from the London Ambulance Service)*

***M*** = major incident declared
***E*** = exact location
***T*** = type of incident
***H*** = hazards present
***A*** = access
***N*** = number of causalities & severity
***E*** = emergency services required

INCIDENT SIZE: Estimate by the use of geographic boundaries, building size, number of affected locations, and approximate number of patients.

HAZARDS: Visible hazards such as fire/smoke/plume, partially collapsed structures or unstable working surfaces should be noted. Invisible hazards such as known or suspected toxic fumes or liquids, suspected structural damage, suspected secondary devices, or other hazards should also be considered and noted in the report.

EMS NEEDS: An assessment of the expected resources needed. The declaration of the appropriate Phase level is based on the number of **potential** patients expected for the duration of the immediate incident. Additional resources including special equipment needed above the phase level should be noted as soon as possible.

*See Appendix E.2, Operations Area Checklists*

***SECTION 4: TREATMENT AREA***

The Treatment Area is under the direction of the second arriving unit, one member who shall assume the designation of "Treatment Officer" until relieved by the first arriving Paramedic. When available, a Department Physician may respond to the incident and assume this role. All personnel, including physicians, nurses and other health professionals working in this area will be under the operational control of the Treatment Officer. This does not include the direction of specific medical care for patients by a physician on scene. Such decisions will be the responsibility of the treating physician.

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The Treatment Area shall be established in a safe location adjacent to the Incident Operations Area. All patients removed from the Incident Operations Area will be taken to the Treatment Area for triage conformation; tagging and medical care with the exception of "walking wounded" that may be assembled in another controlled area. All contaminated personnel, patients, and equipment must be decontaminated before entering the treatment area.

Within the Treatment Area, teams may be established to treat patients based on their priority classification or grouping, [i.e. RED (Immediate), YELLOW (Delayed), GREEN (Minor)]. A team leader will be assigned by the Treatment Officer and answer to the call sign "Red Team", "Yellow Team", etc. Personnel assigned as team leaders will monitor the condition of patients and supervise the treatment based on the level established by the Treatment Officer.

Each agency should use its Basic Life Support *(BLS)* Protocols as the standard of care to achieve a patent airway, control hemorrhage, and relieve or prevent shock. The jurisdiction Incident Commander or designee shall set all other levels or extent of care. Any patients without spontaneous respirations or pulse that are classified BLACK *(Expectant),* will only be removed to the designated morgue site at the direction of the jurisdiction Incident Commander. Exceptions to the non-resuscitation rule can be made at the discretion of the Treatment Officer in smaller incidents where sufficient resources are available.

Precautionary spinal immobilization and fracture splinting will be a low priority and may be delayed until the patient is in the transport mode. Advanced Life Support *(ALS)* measures shall be avoided and such treatment will be conducted only when resources permit and at the discretion of the jurisdiction Incident Commander.

***STAFF***: EMT FROM THE SECOND ARRIVING VEHICLE

*See Appendix E.3, Treatment Area Checklists*

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### *SECTION 5: TRANSPORTATION AREA*

The patient Transportation Area will be located adjacent to the patient Treatment Area so that patients can be quickly moved into position for loading into vehicles and matched for transport. Patients shall be grouped, wherever possible, so those patients with compatible needs for care are loaded together. For example, one would avoid loading two patients with airway compromise into the same ambulance.

The second arriving Supervisor shall assume the designation of "Transportation Officer". An EMT from an additional arriving vehicle may assume the designation of "Loading Officer". If the Treatment Officer or Triage Officer is overburdened, an EMT from an additional arriving vehicle may assist with treatment or triage and wait for additional personnel to arrive before designating a Loading Officer. The Transportation Officer and Loading Officer will both staff the Transportation Area. It shall be the duty of the Loading Officer to monitor his/her radio on the event tactical radio channel, assign transport priority, and determine the compatibility of care for patients to be loaded into vehicles and to serve as the recorder of patients being transported. The Transportation Officer shall have the duty to change his/her radio to an assigned Metro Boston C-MED radio channel, designate prioritized patients to ambulances and assigning hospital destination through consultation with C-MED. Hospital destination shall be determined when the Transportation Officer notifies C-MED that a number of prioritized patients are ready for transport via radio. C-MED will then assign a hospital destination. The Transportation Officer will advise the transporting unit of their destination and mark the destination on the transportation log or board. The Transportation Officer will then enter the patient into the patient tracking system, (if applicable).

The Transportation Officer, upon receiving a hospital destination from Metro Boston C-MED, will transmit the ambulance identification *(number, and organization)*, the number and color priority of patients on board, and the name of the receiving hospital.

Backboards or other devices from equipment trailers may convey patients directly to the ambulances and directly from the ambulances to a hospital stretcher.

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Ambulances transporting patients should not transmit voice messages by radio of their "en-route" or "arriving at hospital" status, nor will they make hospital notifications. Upon clearing a hospital, the ambulance should again return to the Staging Area without voice radio

transmission, unless otherwise directed by the Dispatch Center / Fire Alarm. If available, CAD unit updates will be used to monitor vehicle status.

***STAFF**:* Assigned as applicable.

*See Appendix E.4, Transportation Area Checklists*

### *SECTION 6: STAGING AREA*

In order to maintain control of EMS resources, vehicles and equipment will be pooled in a location approximately 1-2 minutes driving time from the Transportation Area. The Staging Area shall be established by a Supervisor or designated Department member who shall assume the designation of "Staging Officer".

All ambulances and other equipment not immediately needed at the incident site shall report to the Staging Area, check in with the Staging Officer, and stand by until directed elsewhere. Ambulances that clear a hospital transport will return to the Staging Area and will report directly to the Staging Officer unless directed otherwise by the Dispatch Center / Fire Alarm.

***STAFF**:* Designated EMT or Supervisor.

*See Appendix E.5, Staging Officer Checklist*

### *SECTION 7: INCIDENT COMMAND SYSTEM*

An EMT from the first arriving vehicle will assume EMS command of an incident by using the "Incident Command" call sign. "I/C" shall be prefaced with the location of the incident (i.e., "Logan I/C" for an incident at Logan Airport). The first Supervisor assumes command upon his/her arrival and assumes the "IC" call sign. The first arriving Command level officer will relieve the Supervisor. The Supervisor will then assume the duties of another ICS staff position at the discretion of the Incident Commander.

Upon the arrival of a Senior Command Staff officer, the Commander may pass off Incident Command. The Senior Command Staff officer may defer Incident Command to a member of the Command Staff of lower rank at his/her discretion.

MAJOR EMERGENCY OPERATIONS AND THE INCIDENT COMMAND SYSTEM

For any incident at or above a Phase Three, or whenever a Command level officer directs, an expanded NIMS format Incident Command System will be activated to manage additional responsibilities. Designated or Supervisory level staff will respond and assume command of the Administration Section, Planning Section, Logistics Section, Operations Section and Incident Commander's Staff (Safety, Liaison, Public Information and Intelligence) as needed.

*See Appendix A, MCI Organizational Chart*.

OPERATIONS SECTION

The Operations Section is responsible for directing and coordinating all of the tactical operations involved in the consequence management of an event. The Operations Section is broken down into three functional branches. These branches are Dispatch Center / Fire Alarm Operations, Field Operations and Special Operations.

*Dispatch Center / Fire Alarm Operations Branch*, under the direction of the Incident Commander or designee, shall establish and maintain systems needed to enable clear communications and control. They shall provide frequency designation, coordination and establish information links with Metro-Boston C-MED and other public safety or support agencies for the timely exchange of information and resources relative to the incident.

*Field Operations Branch*, under the direction of the Incident Commander or designee, shall establish and maintain systems including actual emergency triage, extraction, treatment, and transportation of patients from the MCI and progress reporting to the jurisdictional I/C. The on scene MCI management plan is subdivided into four functional areas, which are manned by personnel from this division. These areas are the Incident Operations Area, the Treatment Area, the Transportation Area, and the Staging Area.

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*Special Operations Branch*, under the direction of the Incident Commander or designee, shall establish and maintain systems in support of the consequence management effort. Personnel from this division may respond with specialty vehicles and equipment, provide and maintain portable radios, batteries, lighting, shelter, and auxiliary power, as required. Personnel from this division may also be assigned, as needed, to coordinate EMS perimeter and operating area safety and security. Technical specialists such as toxicologists, mass care and shelter personnel, CISM, etc., may be assigned under this section. Such personnel are intended to provide information and technical assistance allowing the primary jurisdiction to adapt to meet special needs. All other sections work to provide support to the Operations Section.

INCIDENT COMMANDER'S STAFF

Dependent on incident scope, the Incident Commander may establish the positions of *Safety Officer*, *Liaison Officer*, *Public Information Officer,* and *Intelligence Officer*. A Safety Officer's primary responsibility is to monitor and oversee the safety of the incident operations, with the authority to immediately suspend unsafe procedures. The Safety Officer should be the first appointed member of the Incident Commander's staff. The Liaison Officer coordinates with other public and private agencies that may respond to the incident. A Public Information Officer can assist the Incident Commander in dealing with media relations. An Intelligence Officer's primary responsibility is to monitor and interpret information on special circumstances and hazards present on scene and patient information from hospitals post arrival of victims.

*See Appendix E.7, Incident Commander Checklist*

LOGISTICS SECTION

The Incident Commander may designate a Logistics Officer to oversee all logistics functions. This section will be divided into functional branches from within different EMS Bureaus.

*Communications Engineering Branch*, under the direction of the Incident Commander or Logistics Officer (if one is designated), shall establish and maintain systems, that may necessitate the establishment of a Mobile Communications Unit, establishing a remote repeater

system, supporting telephone communication capability, and maintaining the technical integrity of the overall communications system.

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*Materials Management / Support Services Branch*, under the direction of the Incident Commander or Logistics Officer (if designated), shall establish and maintain systems, for the assembly of reserve ambulances, equipment and supplies that will be readied for deployment to an incident under the control of the Staging Area Officer. Demobilization will also occur through this section. In conjunction with the Incident Commander, a process for the release or relief of units will be determined. The demobilization function will also necessitate the restocking and cleaning of units in preparation to return to normal service. The Support Services Branch may also be responsible for the acquisition and preparation of satellite treatment areas, morgues, etc.

*Fleet Services Branch*, under the direction of the Incident Commander or Logistics Officer (if designated), shall establish and maintain systems, for the operational readiness, maintenance, fueling and repair of vehicles and equipment involved in the incident.

*Management Information Systems Branch*, under the direction of the Incident Commander or Logistics Officer (if designated), shall establish and maintain systems, for the operational readiness, maintenance, modification and functionality of the management information system and equipment.

PLANNING SECTION

Personnel from this Section shall work as the Resource Officer and staff, who will maintain a running record of resources and the incident situation status to enable planning for the continuation of the operation. Documentation of all aspects of the incident beyond the transport of patients is assigned under this Section. Personnel to staff the Jurisdiction EOC, once activated, will report under this Section.

*See Appendix E.6, Resource Officer Checklist*

ADMINISTRATION SECTION

The Administration Section, under the direction of appropriate personnel, will be activated for large scale or long-term operations.

*The Fiscal Branch*, under the direction of appropriate personnel, will be responsible for time keeping and payroll for long-term operations. It is also responsible for the purchase, rental, or loan of supplies, equipment, or services, as they may be needed. This section will work to control and record all expenditures outside of normal EMS costs. This section will work in close physical proximity to and in cooperation with, the Planning and Logistics Sections.



*The Human Resource Branch*, under the direction of a designee, will be responsible for all personnel and workers' compensation / injury issues.

*The Legal Affairs Branch*, under the direction of a designee, will address post incident issues that will include determining what costs can be recovered for the operation under existing state and federal laws or regulations. Claims by civilians, personnel, or services will also be directed to the Legal Affairs Office.

### *SECTION 8: EMS PERSONNEL RECALL*

Whenever possible, off-duty personnel will be recalled to duty in a prescribed manner. If an MCI occurs close to a shift change, the IC will consider holding off-going members as part of a recall. All off-duty personnel will report to a designated muster location*(s).* Personnel will be directed to staff stocked spare ambulances, special equipment, or serve in other functions at the incident.

### *SECTION 9: MUTUAL AID POLICY*

Metro-Boston U.A.S.I. member agencies will maintain a current back-up agreement with each other and shall be called to provide additional MCI support capability or to provide jurisdictional coverage. Requests will be made on a location-dependent basis just as in routine operations.

Any outside EMS agency units responding to a declared Multiple Casualty Incident will be directed to the Staging Area for briefing and deployment, if needed. The Dispatch Center / Fire Alarm Operations Branch will announce the location of the EMS Staging Area to state and local

police who will be instructed to direct any independent units found arriving on scene to report to the established Staging Area.

It is the U.A.S.I. member agency's responsibility to make effective use of all available resources by including them in a coordinated effort. This will insure absolute personnel accountability, quality patient care, and proper documentation of designated hospital destinations.

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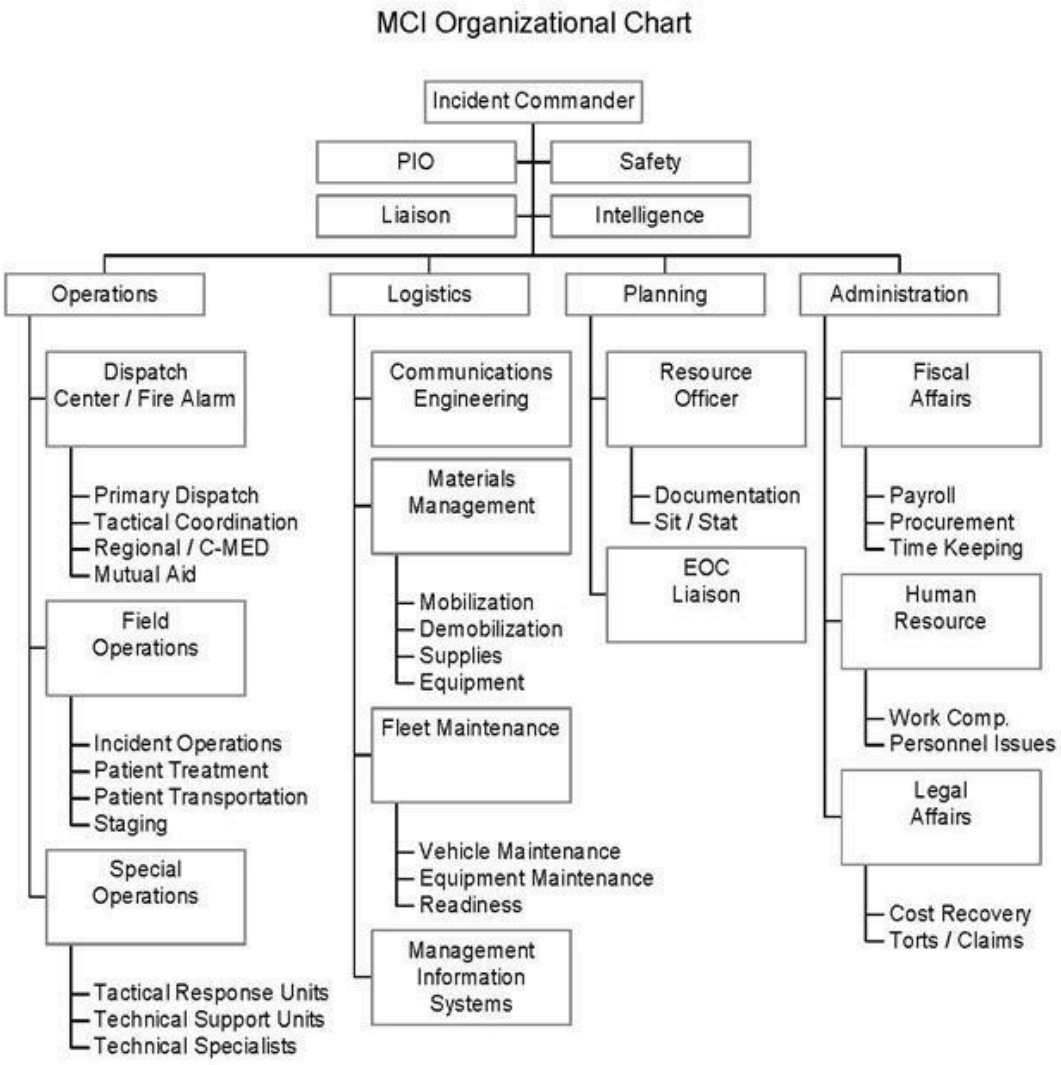
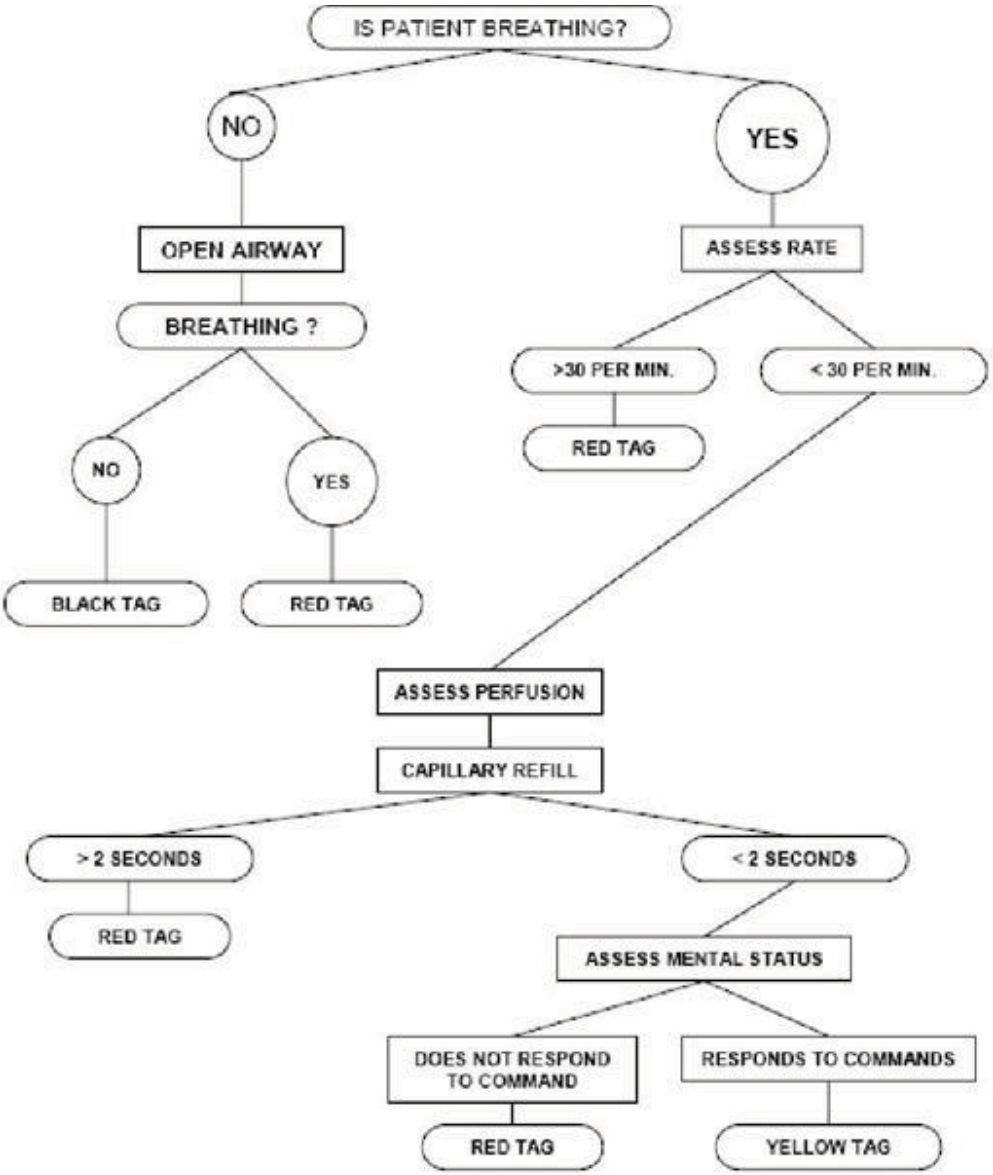
***Appendix A***




***Appendix B***

## START Triage Protocol


IS PATIENT BREATHING?
NO
YES
OPEN AIRWAY
ASSESS RATE
BREATHING ?
>30 PER MIN.
< 30 PER MIN.
NO
YES
RED TAG
BLACK TAG
RED TAG
ASSESS PERFUSION
CAPILLARY REFILL
> 2 SECONDS
< 2 SECONDS
RED TAG
ASSESS MENTAL STATUS
DOES NOT RESPOND TO COMMAND
RESPONDS TO COMMANDS
RED TAG
YELLOW TAG

***Appendix C***

***MCI SWEEP TRIAGE & TAG INSTRUCTIONS***

- Triage patient using **S.T.A.R.T.** protocol and affix appropriate tape or tag to extremity.
- Remove patient to treatment area and re-assess condition, as required.
- Adjust tag to appropriate color classification.
- Mark the anatomical chart to identify injury sites.

  **L = *laceration***
  **B = *burn***
  **F = *fracture***
- Acquire patient information as conditions permit and document on tag.
- Affix the tag around patient's extremity.
- Tear off the patient information / transport tab *(with transport marking)* at the loading area, and give it to the Transportation Officer.

***MCI TAG INJURY / SEVERITY CLASSIFICATION***

**MCI TAGS shall be used whenever up to Ten *(10)* or more patients are expected.**

*RED:* IMMEDIATE - Patients that you think will only survive for about one hour until they reach a definitive care facility, patients in an uncontrollable emotional state, or a co-worker regardless of severity.

*YELLOW:* DELAYED - Patients that you think could survive for up to two hours until they reach a definitive care facility. Some of these patients may need surgery. However, they do not appear to have any "life- threatening" injuries.

*GREEN:* MINOR - Injuries or conditions which, even if untreated for an extensive period, will not likely lead to shock, respiratory compromise or altered mental status. This category includes all "walking wounded".

*BLACK:* NON-TRANSPORT - Deceased

| | Patients | Field Supervisor | Command Staff Response | Special Units | Notification |
|---|---|---|---|---|---|
| Phase 1 | 1-10 | 1 | Shift Commander | TRU on request | Agency Head, Agency Medical Director |
| Phase 2 | 11-30 | 2 | On-duty Command Staff | Special OPS; TRU | Command Staff |
| Phase 3 | 31-50 | Recall | On-Call Command Staff | TRU, TSU, MCU, Communication Support | Command Staff |
| Phase 4 | 51-200 | Recall | Recall | Mutual Aid, State Ambulance Task Force | Command Staff |
| Phase 5 | >200 | Recall | Recall | State and Federal Assistance | Command Staff |
| Phase 6 | Long Term OPS | As Needed | As Needed | As Needed | Command Staff, update regularly |

Definitions: TRU= Tactical Response Unit
TSU= Tactical Support Unit
MCU= Mass Casualty Unit

*Appendix E.1*

***DISPATCH CENTER / FIRE ALARM CHECKLIST***

PHASE ONE INCIDENT - TEN or LESS PATIENTS EXPECTED

- Bring initial minimum dispatch package to three ambulances, (2 BLS & 1 ALS), to reflect minimum staffing needs to manage ICS positions.
- Respond Field Supervisor.
- Respond on-duty Commander.
- Announce Phase One Incident in progress on dispatch and TAC channels.
- Dedicate and staff a TACTICAL channel.
- Initiate PHASE alert to METRO-BOSTON C-MED.
- Transmit the appropriate system notifications.
- If phased incident declaration is expected, announce, "MCI Protocols are in effect for this response."

PHASE TWO INCIDENT – ELEVEN TO THIRTY PATIENTS EXPECTED

- Bring minimum dispatch package to total of six *(6)* ambulances, *(4 BLS & 2 ALS)*.
- Confirm appropriate Phase One actions are completed.
- Announce Phase Two Incident in progress on dispatch and TAC channels.
- Respond On-Call Commander to the scene.
- Respond second Field Supervisor.
- Respond additional Special / Mutual Aid Units as needed.
- Identify/Announce ICS positions and their transitions.
- Announce the location of the Incident Operations Area

  _____
- Announce the location of the Treatment Area

  _____
- Announce the location of the Transportation Area

  _____
- Announce the location of the Staging Area

  _____

- Declare location of Staging Area to police departments.

*Appendix E.1*

- Transmit the appropriate paging system incident updates.
- Recall off-duty commanders to fill the Incident Command System as needed or requested by the Incident Commander.
- Recall any off-site Dispatch Center / Fire Alarm personnel, if necessary.
- Notify the mayor's office of the primary jurisdiction.
- Poll mutual aid providers for resource availability.
- Consider contacting the MBTA for additional transportation capabilities, if needed.
- Access mapping or GIS resources of affected area.
- If a television is available, turn on a local news channel to see any media coverage of the event.

PHASE THREE INCIDENT – THIRTY-ONE TO FIFTY PATIENTS EXPECTED

- Bring minimum dispatch package to eight (8) ambulances, (5 BLS & 3 ALS).
- Confirm appropriate actions from lower Phases are completed.
- Transmit the appropriate paging system incident updates.
- Prepare to make selective or general recall of personnel.

PHASE FOUR INCIDENT – FIFTY-ONE TO TWO HUNDRED PATIENTS EXPECTED

- Confirm actions from lower phases are completed.
- Notify all mutual aid partners of a phase four incident, and direct them to dispatch one transport asset and one supervisor to the designated staging area.

- Confirm that the Incident Commander has notified C-MED of a phase four incident.

*Appendix E.1*

PHASE FIVE INCIDENT – MORE THAN TWO HUNDRED PATIENTS EXPECTED

- Confirm all actions from lower phases are completed.
- Ensure all additional requests or notifications go through the Incident Commander.

PHASE SIX INCIDENT – SUSTAINED OPERATIONS

- No additional checklist items.

*Appendix E.2*

## ***INCIDENT OPERATIONS AREA CHECKLISTS***

INCIDENT COMMANDER (FROM FIRST ARRIVING EMS CREW):

- Assume call sign "_____ I/C" until the first supervisor arrives, then assume call sign "_____ EXTRACTION".
- Don appropriate PPE and identification vest.
- Conduct initial situation size-up, *"M-E-T-H-A-N-E"*.
- Assign a Phase level.
- Direct in-coming units.
- Designate operational areas.
    - Incident Operations Area _____
    - Treatment Area _____
    - Transportation Area _____
    - Staging Area _____

- Direct the removal of patients by other public safety / rescue personnel in order of triage priority.
- Advise I/C of additional resource needs if any.
- After incident, complete after action report and submit to the incident commander.

**TRANSITION:** FROM INITIAL INCIDENT I/C, TO INCIDENT OPERATIONS AREA - EXTRACTION OFFICER. MAY BE RELIEVED ONCE INCIDENT OPERATIONS AREA IS CLEARED OF AFFECTED VICTIMS OR AT THE DIRECTION OF THE I/C.

*Appendix E.2*

TRIAGE OFFICER (SECOND MEMBER OF FIRST ARRIVING EMS CREW)

- Assume call sign "_____TRIAGE".
- Don appropriate PPE and identification vest.
- Assess potential hazards and safety of operations. If another agency is in control of the area (i.e. the Police or Fire Department), wait for an assurance of safety by the agency in control.
- If hazards prevent triage within the Incident Operations Area, patients will be extricated to a triage point in a safe location adjacent to the Treatment Areas. Affected personnel, patients, and equipment must be decontaminated before they are allowed to transfer to the treatment areas.
- Begin triage process using the START Protocol and SWEEP TRIAGE method (See Appendices B and C).

- Direct supplemental EMS personnel in triage of patients.

***Initial interventions instituted for patients within the following limitations:***

- Airway controls by use of oral / nasal airway or head positioning.
- Control of severe bleeding by use of standard measures.
- Treatment of shock by Trendelenburg *(or similar)* positioning.
- Prolonged or in-depth treatment shall be limited to entrapped patients. Such medical care will start only after triage is complete or if there is sufficient staff on hand to ensure that triage will be completed immediately.
- Whenever possible, "walking wounded" or bystanders can be used to assist in patient interventions.

***TRANSITION:*** WHEN TRIAGE IS COMPLETE, TRANSITION TO OPS STAFF.

*Appendix E.2*

OTHER UNIFORMED PERSONNEL WORKING IN THE INCIDENT OPERATIONS AREA

- Don appropriate PPE.
- Complete triage and taping/tagging of all patients.
- Assist in the removal of patients with other public safety/rescue personnel in order of triage priority.

Treat patients within the following limitations:

- Airway controls by use of oral airway or head position.
- Control of severe bleeding by use of standard measures.
- Treatment of shock by Trendelenburg (or similar) position.

*Prolonged or in-depth treatment shall be limited to patients entrapped. Such medical care will start only after triage is complete or there is sufficient staff on hand to ensure that triage will be complete immediately. Whenever possible, "walking wounded" or bystanders can be used to care for patients.*

*Appendix E.2*

FIRST ARRIVING SUPERVISOR:

- Assume "_____IC" call sign.
- Don appropriate PPE and identification vest.
- Obtain situation report from previous I/C.
- Provide radio updates every 10 minutes, and escalate Phase level as necessary.
- Replenish Triage Officer's supply of MCI equipment, if necessary.

- Ensure victim extraction operations are moving efficiently.
- Request additional resources from Dispatch Center / Fire Alarm as necessary.
- Distribute ICS position identification vests.
- Designate location of Command Post.
- Establish Unified Command with other Public Safety Agencies.
- After incident, complete after action report and submit to the incident commander.

***TRANSITION:*** RELIEVED BY COMMANDER, TRANSITION TO INCIDENT OPERATIONS OFFICER.

*Appendix E.3*

## ***TREATMENT AREA CHECKLISTS***

TREATMENT OFFICER

- Assume "_____ TREATMENT" call sign.
- Don appropriate PPE and identification vest.

- Establish treatment area in safe and accessible location adjacent to the incident operations area.
- Identify and delineate area with tape, cones, signage, or other resources.
- Screen patients for proper decontamination.
- Re-triage incoming patients or delegate task.
- Assign treatment teams and leaders if necessary.
- Supervise patient care.
- Coordinate with the Transportation Officer to maximize transport resources.
- Update I/C at regular intervals.
- After incident, complete after action report and submit to the incident commander.

***TRANSITION:*** *RELIEVED BY FIRST ARRIVING PARAMEDIC, TRANSITION TO TREATMENT AREA STAFF.*

*Appendix E.3*

OTHER TREATMENT STAFF:

- Don appropriate PPE.

- Direct / divide patients into treatment groups.
- All contaminated personnel, patients, and equipment must be decontaminated before entering the treatment area.
- Treat patients to level established by TREATMENT OFFICER and EMS Treatment Protocols.
- Prepare patients for transport.

***TRANSITION:*** *NO TRANSITION EXPECTED.*

*Appendix E.4*

***TRANSPORTATION AREA CHECKLISTS***

TRANSPORATION OFFICER

- Assume "_____ TRANSPORTATION" call sign.
- Don identification vest.
- Identify a resource officer as soon as possible to assist in documenting patients or communicating over the radio.
- Establish Transportation Area next to Treatment Area with good access and egress. Coordinate with the Police Department when possible.
- Announce location of Transportation Area on event tactical channel.
- Secure assignment of a coordination radio channel from C-MED.

- Identify priority patients for transport from Treatment Area.
- Relay patient information to C-MED as patients are loaded.
- Secure hospital designations from C-MED & direct ambulances to designated hospitals.
- Transmit patient information for receiving hospitals to monitor.
- Maintain proper documentation of patients transported on MCI Tag Transportation Tab.
- Scan barcode into Patient Tracking System, *(if applicable).*
- Request additional resources through IC as needed.
- After incident, complete after action report and submit to incident commander

***TRANSITION:*** RELIEVED BY SECOND ARRIVING SUPERVISOR, TRANSITION TO "LOADING OFFICER".

*Appendix E.4*

LOADING OFFICER

- Assume "_____LOADING" call sign.
- Don identification vest.
- Monitor event tactical radio channel for operational updates & report to TRANSPORTATION OFFICER.
- Assign transport priorities for vehicle loading.
- Group patients for transport compatibility.
- Maintain records of patients transported.
- Request additional resources through TRANSPORTATION OFFICER as needed.
- After incident, complete after action report and submit to the incident commander.

***TRANSITION:*** RELIEVED BY ADDITIONAL ARRIVING SUPERVISOR (if applicable), TRANSITION TO"TRANSPORTATION AREA STAFF".

*Appendix E.5*

STAGING OFFICER

- Assume "_____STAGING" call sign.
- Don identification vest.
- Coordinate with police for traffic control of area.
- Establish Staging Area.
- Announce staging area location to IC and C-MED.
- Monitor frequency and dispatch resources as needed.
- Assemble resources in orderly fashion.
- Ensure that vehicles conserve electric power and fuel.
- Instruct drivers to stay with their vehicles.
- Advise IC when special units arrive.
- Segregate resources as required (BLS; ALS; SPECIALITY; etc.).
- After incident, complete after action report and submit to the incident commander.

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*Appendix F*

## ***RESOURCE OFFICER CHECKLIST***

- Assume "_____Resource" call sign.
- Don identification vest.
- Develop a brief description of the incident.
- Develop a map of the affected area.
- Assess and record current resources deployed.
- Record level of activity of other Public Safety Agencies.
- Make recommendations to IC and Planning/Logistics Section of additional resources needed or changes needed in location of operational areas, etc.
- Record and maintain status reports of the activity in the four main operational areas to include:

    Number of patients remaining.

    Number of personnel engaged.

    Progress of operations.

    Supply status.

    Remaining uncommitted resources
- Make progress reports to EMS Incident Commander at established intervals. Remain near EOC except while gathering information from other areas.

- Interface with Elected Officials and State and Federal Agency Representatives as needed.

*Appendix F*

## ***INCIDENT COMMANDER CHECKLIST***

STAFF: HIGHEST-RANKING COMMAND STAFF MEMBER

- Report to command post.
- Receive briefing from preceding EMS IC.
- Assume IC call sign.
- Don identification vest.
- Meet with IC support staff to assess situation.
- Develop plan to re-deploy resources if needed.
- Interface with ICs from other public safety agencies.
- Prepare to assign an On-Scene Incident Commander and move to EOC if necessary.
- Interface with elected officials and state and federal agency representatives as needed.
- Determine appropriate time to de-escalate.
- Re-align staffs to fortify post incident recovery assignments.
- Oversee final report of EMS operation.
- Request additional assets as needed.
- Consider palliative care if overwhelming number of expectant patients are possible.

- Collect after action reports, write Incident Commander after action report, and give to the Superintendent of Communications & Professional Standards.

*Appendix F*

| *AFTER ACTION REPORT* | |
|---|---|
| **Name** | **ICS Position** |
| **Time of Incident** | **Location of Incident** |
| **Type of Incident** | |

**Chronological Summary of Events**

*Appendix F*

**Interacting Systems, Agencies, and Programs: Include mutual aid systems (law enforcement, fire/rescue, medical, etc.); cooperating entities (utilities, American Red Cross, university departments, etc.); telecommunications and media interactions.**

| |
|---|
| **Improvements, Conclusions, Recommendations: As applicable, include a description of actions taken, assignments, associated costs or budget, timetable for completion or correction, and follow-up responsibility.** |
| **Training Needs** |
| **Recovery Activities** |
| **References: Maps, charts, training materials, etc.** |