MEDINA COUNTY
Mass Casualty/Mass Fatality Plan

Medina County Emergency Management Agency
2021

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Section 1.0: Introduction

This plan is an annex to the Medina County All-Hazards Emergency Operation Plan.

1.1 Promulgation Statement

The Medina County Mass Casualty/Mass Fatality Plan is maintained by the Medina County Office of Emergency Management and Homeland Security. It was developed in cooperation with representatives from the agencies, departments, and organizations that respond to disasters and emergencies that could result in mass casualties and/or mass fatalities.

This plan supports Medina County's All-Hazards Emergency Operations Plan (EOP) and provides additional guidance concerning the roles of government officials, agencies, and private organizations during mass casualty/mass fatality incidents. All agencies and organizations with responsibilities under this plan should develop and maintain their own plans, Standard Operating Procedures (SOP's), or other directives for fulfilling their requirements under this plan.

1.2 Approval

The signatures below attest approval of the plan and agreement to support the plan and to carry out responsibilities described therein. This plan may be modified under the authorization of the MCEMA. It supersedes all previous Mass Casualty and Mass Fatality Plans for Medina County, OH. The Director of Emergency Management is authorized to make modifications related to maintaining this plan.

Ralph Copley, Citizen-at-Large	Date
Michael Costello, Township Trustee	Date
Brian Guccion, Township Trustees	Date
Matt Hiscock, City of Wadsworth	Date
Bill Hutson, Medina County Commissioner	Date

City of Medina Date

Conrad Sarnowski, Date
Village Mayors

Colleen Swedyk, Date
Medina County Commissioner

1.3 Plan Development and Maintenance

Medina County EMA will maintain, update, and distribute changes to the plan, as required, based on the results of exercises, after-action reviews, actual incidents, and changes in local government structure. Officials of participating organizations may recommend revisions at any time based on changes of available resources.

This document will be reviewed in coordination with the training and exercise planning cycle of Medina County EMA, and as needed following large scale after-action review.

1.4 Record of Changes / Schedule

Change Number	Date of Change	Date Approved	Changes Made	Change Made By (Initials)

Section 2.0: Situation and Assumptions

2.1 Purpose

The purpose of this plan is to describe the organizational and operational concepts, responsibilities, and actions of Medina County agencies and partner organizations in response to mass casualty and mass fatality incidents.

Objectives of the plan are to:

- Minimize loss of life, injuries and human suffering by providing effective emergency medical assistance through the coordination of resources when incidents result in multiple casualties.
- Identify and describe the capabilities available to Medina County agencies in responding to mass casualty/mass fatality incident.
- Identify the functional responsibilities of community agencies and organizations in the event of a mass casualty/mass fatality incident.
- Facilitate Medina County's response to mass casualty and mass fatality incidents by ensuring unified command, multi-agency cooperation, effective collaboration, and community preparedness in accordance with the National Preparedness Framework and the National Incident Management System.
- Protect responder safety and well-being.

2.2 Scope

This plan is applicable to mass casualty and mass fatality operations within Medina County and applies to all participating departments and agencies of the jurisdictions within the county. This plan can be activated when an incident occurs in which the number of casualties and/or fatalities exceeds or is expected to exceed the capabilities of the responsible jurisdiction. The cause of the casualties/fatalities does not affect the use of this plan.

This plan describes recommended actions and identifies agency or organizational responsibilities throughout the entire mass casualty/mass fatality incident, from initial notification to demobilization. Primary responsibility for managing a mass casualty/mass fatality incident within Medina County resides with the jurisdiction in which the incident occurred, The Medina County Coroner has jurisdiction over mass fatalities within the county.

Fire/EMS has primary responsibility for managing a mass casualty incident within their jurisdiction. The Medina County Coroner has primary responsibility jurisdiction over mass fatalities countywide.

When the number of casualties or fatalities exceeds local resources and capabilities, the Incident Commander or the Coroner may request that the Medina County EMA request state-level assistance or request mutual aid from another jurisdiction.

2.3 Assumptions

The following planning assumptions were considered in the development of this plan:

- A disaster may occur at any time in or near Medina County with casualties, fatalities, property damage, disruption of normal services, and damage to economic, physical, and social infrastructure.
- An incident that begins as a mass casualty event can quickly evolve into a mass fatality event.
- The number of casualties or fatalities incurred may overwhelm the capabilities of the jurisdiction where the incident has occurred and will require county-wide, regional, or state assistance.
- Rapid triage, treatment, and transport will be necessary to minimize the loss of life.
- Some incidents will require special handling, such as extrication of victims or crime scene preservation.
- Injured but ambulatory persons will self-transport to nearby hospitals and clinics.
- The amount and type of support services and resources needed will vary with the type of incident.
- Hospital capacity to treat injured persons within Medina County is limited and may be insufficient.
- The Medina County Coroner has limited resources that will likely be surpassed in a mass fatality incident.
- During a Mass Fatality Incident, the Coroner's office will continue to experience their normal caseload and must continue to manage both the incident and standard services.
- Limits on the county's capacity to store human remains may require the use of temporary systems.
- The jurisdiction where the incident has occurred will request emergency medical and fatality management resources and other support through the Medina County EOC.
- Regional and state resources will be available to treat casualties and manage mass fatalities, including conducting decedent evaluation and handling the temporary storage of remains.
- Adjacent counties have significant resources which may be available.
- The incident scene will be complex with multiple organizations responding and multiple functions occurring simultaneously. Situational awareness will be difficult to achieve and maintain.
- Communications between the responding agencies will be conducted on established networks.
- Spontaneous groups of responders and volunteers may cause traffic congestion and place extra strain on command-and-control efforts.
- Human remains will be handled with dignity and respect at all times.
- Response to the incident may be hindered by secondary incidents or failure of critical infrastructure.
- Relatives/friends will seek information regarding the status of their relatives/friend including whether they were injured and what hospital they are at, often arriving at the scene seeking this information.
- Notification of family members of victims will be conducted in a timely and compassionate manner.
- The event may require a Joint Information System (JIS) to be established to ensure accuracy of information.
- The incident may require mass casualty and/or mass fatality operations for an extended period.
- All agencies and organizations that have responsibilities under this plan have identified personnel and resources to ensure their full compliance with the plan.
- The safety and well-being of responders will be protected at all times.

2.4 Definition of Terms

Mass Casualty Incident (MCI)

A Mass Casualty Incident is an incident with multiple casualties that overwhelms the resources of a local jurisdiction.

Mass Fatality Incident

A Mass Fatality Incident is any incident that results in more fatalities than a local jurisdiction can adequately manage, whether natural or man-made, accidental or intentional.

2.5 Situation Overview

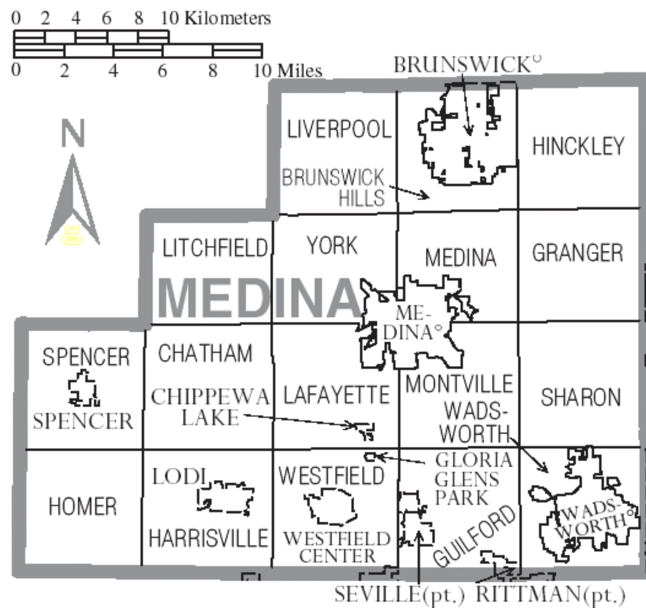
Medina County is the sixteenth most populous county in Ohio and is one of the fastest-growing counties in the state. The county's estimated population in 2020 was 179,746, an increase of 4.3 percent since 2010.

Medina County is part of the five-county Cleveland-Elyria Metropolitan Statistical Area (MSA) with more than 2 million residents. Medina County also borders the two-county Akron MSA with an additional 700,000 residents. This proximity to major urban areas provides Medina County with relatively rapid access to significant resources in the event of a large-scale disaster. Additional resources are available from more distant counties through Ohio's Intrastate Mutual Aid Contract (IMAC), from state and federal agencies, and through the nationwide Emergency Management Assistance Compact (EMAC).

Medina County covers 423 square miles and borders Cuyahoga County to the northeast, Lorain County to the northwest, Summit County to the east, Wayne County to the south, and Ashland County to the southwest.

Medina County is home to three cities: Brunswick, Medina, and Wadsworth. The City of Medina is the county seat. There are six villages: Chippewa Lake, Gloria Glens Park, Lodi, Seville, Spencer, and Westfield Center. There are also seventeen townships: Brunswick Hills, Chatham, Granger, Guilford, Harrisville, Hinckley, Homer, Lafayette, Litchfield, Liverpool, Medina Twp., Montville, Sharon, Spencer, Wadsworth Twp., Westfield, and York. Parts of the Village of Creston and the City of Rittman are in Medina County, but both municipalities are primarily in Wayne County.

The county is served by township, county, state, interstate, and federal highways exceeding 1,105.54 miles. There are three interstate highways, six FAA registered heliports, nine FAA registered airports, including two municipal airports (1G5-Medina Municipal Airport and 3G3-Wadsworth Municipal Airport) and two rail systems (Wheeling & Lake Erie Railway Co. and CSX Transportation, Inc.) operating in the county.



2.5.A. Hazards

Medina County is vulnerable to a variety of natural and man-made hazards, including floods, tornadoes, drought, winter storms, severe storms, dam failures. transportation accidents, industrial accidents, and criminal activity. Any of these hazards can result in a large number of injuries and/or deaths and can require the county to activate its Mass Casualty/Mass Fatality plan.

Mass casualty and mass fatality incidents may result in the following response impacts:

1. Disruptions to health and lifesaving systems.
2. Large numbers of human casualties and/or fatalities.
3. Severe damage or disruption to transportation infrastructure and/or routes
4. Severe damage or disruption to communication infrastructure and/or systems
5. Significant increases to the response time of public safety and other critical resources and/or services, and/or interruptions of the application and/or availability of resources.

A hazard analysis for Medina County is maintained in the Medina County All-Hazard & Flood Mitigation Plan. This plan is available at the Medina County Office of Emergency Management & Homeland Security and on the agency's website.

2.5.B. Capabilities

Medina County and each local jurisdiction have various emergency response capabilities. Local, Regional, and State mutual aid agreements exist to ensure sufficient capability is available to every jurisdiction for the hazards they face.

2.5.C. Resources

The National Response Framework has established a tiered structure for the nation's emergency management system. Primary responsibility for managing disasters is assigned to the local jurisdiction where the incident occurred or is centered. If the local jurisdiction requires additional resources, they can

be requested from other jurisdictions through mutual aid agreements or other arrangements. If resources available through mutual aid agreements are insufficient, the local jurisdiction may request additional resources through the Medina County Emergency Management Agency. If necessary, MCEMA may request additional resources from the state. Should state resources be insufficient, the state may request federal assistance.

2.5.C.1. Agencies

Numerous government agencies and other organizations are prepared to respond to mass casualty and mass fatality events.

Fire and EMS Departments

The Fire & EMS departments serving Medina County are Brunswick, Brunswick Hills, Chatham, Erhart / York Township, Granger, Hinckley, Lafayette, Litchfield, Liverpool/ Valley City, Lodi, Medina City, Rittman, Seville/ Guilford, Sharon, Spencer, Town & County (Homer), and Westfield Center.

Cleveland Clinic's Medina Life Support Team is the primary EMS provider for Medina City, Medina Township, and Montville Township.

If an incident requires fire service resources beyond those available in the county, additional resources may be obtained through activation of the Ohio Fire Service Emergency Response Plan, which is maintained by the Ohio Fire Chiefs' Association. The Emergency Response Plan provides for the rapid activation, mobilization, and dispatch of aid to a community in the event of a disaster or other incident that may overwhelm the local fire department and its normal mutual aid resources.

Law Enforcement

Medina County has the following law enforcement agencies: Brunswick, Brunswick Hills, Hinckley, Lodi, Medina City, Medina Township, Montville, Seville, Spencer, Wadsworth, Westfield Center, Westfield OFIC Police, Medina County Park District, Cleveland Metroparks, the Ohio State Highway Patrol, and the Medina County Sheriff's Office.

Medina County law enforcement agencies support each other through Mutual Aid Agreements. If a disaster or incident requires assistance from agencies outside the county, Ohio's Law Enforcement Response Plan can be activated to obtain additional law enforcement resources.

Dispatch Centers

There are four twenty-four-hour public safety dispatch centers in Medina County: Medina County Sheriff's Office, Medina Police Department, Wadsworth Police Department, and Brunswick Division of Police.

Medina County agencies use a P25 digital radio system, a legacy UHF analog system, or the state's Multi-Agency Radio Communications System (MARCS).

County P25 system:

- The Medina County Sheriff's Office (MCSO) Dispatch Center.
  - Hinckley Township Police, Lodi Village Police, Seville Village Police, Spencer Village Police, Westfield Center Village Police, Medina County Park District Rangers, and the Medina County Sheriff's Office.
- Medina Police Department Dispatch Center
  - Medina City Police and Fire, Medina Township Police, Montville Township Police, Life Support Team

UHF system:

- Wadsworth Police Dispatch Center
  - Wadsworth Police and Fire

MARCS system:

- Medina County Sheriff's Office (MCSO) Dispatch Center
  - Chatham, Erhart / York Township, Granger, Hinckley, Lafayette, Litchfield, Liverpool/ Valley City, Lodi, Seville/ Guilford, Sharon, Spencer, and Westfield Center
- Brunswick Police Dispatch Center
  - Brunswick City Police and Fire, Brunswick Hills Police and Fire

Volunteer Units

EMA Communications Unit:

The EMA Communications Unit consists of volunteers who provide communications capabilities, support, & coordination to EMA, public safety & other organizations. These volunteers work under the direct authority of EMA.

EMA Community Emergency Response Team:

The Community Emergency Response Team are volunteers under the authority of EMA. Members are trained in nationally standardized CERT Basic Training including basic disaster response skills. The team has several Medina County specific capabilities.

Medical Reserve Corp:

Medical Reserve Corps are authorized by the Health Department. Members include medical and public health professionals, as well as no medical personnel. They contribute for disaster, public health emergencies, and planned events.

Hospitals

Medina County has two registered hospitals: Cleveland Clinic Medina Hospital with one hundred and seventy-one beds, and Lodi Hospital with twenty beds. There are also three freestanding emergency departments: Summa Wadsworth-Rittman, Cleveland Clinic-Brunswick, and Southwest General Brunswick Medical Center.

Numerous well-equipped hospitals are located within adjacent counties. Trauma Level One hospitals include Akron City Hospital, Akron General Medical Center, and Metro Health Medical Center in Cleveland. Metro Health also operates a Burn Center. Other nearby hospitals include Akron Children's Hospital (Pediatric Trauma Level 2 and Burn Center), Fairview Hospital in Cleveland, Hillcrest Hospital in Mayfield Heights, Southwest General Health Center in Middleburg Heights, St. John Westshore Hospital in Westlake, and University Hospital Rainbow Babies and Children's Hospital in Cleveland (Pediatric Trauma level 1.)

Medina County Coroner

The County Coroner is charged by Ohio law with the responsibility of determining the cause and manner of death in all cases of death by violence, accident, suicide, or suspicious or unusual manner (ORC 313.12). The Medina County Coroner has jurisdiction for managing and handling remains during mass fatality incidents.

Medina County All-Hazards Team

The Media County All-Hazards Team is a multi-disciplinary response team with personnel provided by participating public safety departments. The team provides specialized response capabilities that departments do not typically possess individually. The team functions under the authority having jurisdiction for the incident.

All-Hazards team capabilities include hazardous materials, rope rescue, confined space rescue, trench rescue, structural collapse rescue, drone support, fire investigation, and water rescue.

Red Cross

Medina County is served by the Greater Akron and Mahoning Valley Chapter of the American Red Cross of Northern Ohio. The Red Cross assists communities in preventing, preparing for, and responding to emergencies 24 hours per day, seven days a week. Ninety percent of the Red Cross workforce are volunteers.

During disasters and emergencies – including mass casualty and mass fatality incidents – the Red Cross may operate Family Notification Centers, canteens to serve responders, and assist the Coroner and hospitals with patient tracking and family notifications.

Medina County Health Department

The mission of the Medina County Health Department is to prevent disease, assure a healthful environment, prolong life, and promote the well-being of county residents and visitors. During Mass Casualty and Mass Fatality incidents the Medina County Health Department can assist by coordinating mass burials, issuing temporary internment orders, and assisting with operation of the Emergency Death Registration System (EDRS).

Medina County Emergency Management Agency (MCEMA)

The primary responsibility of the Medina County Emergency Management Agency is to assist local communities in planning, training, and educating Medina County organizations and residents for natural or man-made disasters or emergencies through emergency planning, education, warning, response and recovery activities. MCEMA also supports first responders and government agencies during disasters or emergencies by providing resources, managing communications, and maintaining situational awareness.

During large-scale emergencies or disasters, MCEMA may activate the county's Emergency Operations Center (EOC) to better manage communications and information and assist in coordinating the efforts of government officials, response agencies, and community volunteers.

Regional Resources

Medina County's location on the periphery of two major urban areas provides the county with access to significant emergency medical, treatment, transport, and cold storage resources.

Medina County Emergency Management Agency can work directly with other county EMA's or through Ohio EMA to obtain additional resources.

Assistance from within Ohio may be facilitated through the use of the Ohio Intrastate Mutual Aid Compact, which enables communities to request and receive assistance from other political subdivisions in Ohio.

During governor-declared emergencies, resources from outside of Ohio may be obtained through use of the nationwide Emergency Management Assistance Compact (EMAC), a mutual aid framework that allows states to send personnel and equipment to help disaster relief efforts in other states. EMAC is accessed through the Ohio EMA.

2.5.C.2. Equipment

Ambulances

Normally, there are about 18 ambulances in the county that are staffed and are available to respond. Within the county there are about 36 ambulance vehicles.

Air Ambulances

Air Ambulance providers include Metro, MedEvac, MedFlight, and the Cleveland Clinic. Each department has their own preferred provider, but aircraft from multiple providers can be requested if the situation requires it. Air ambulances are requested through dispatch.

Communications

Medina County's dispatch centers, police, fire, and EMS responders communicate on three different communications systems: the county's P25 system, a UHF system, and the State of Ohio's Multi-Agency Radio Communications System (MARCS) system. The Medina County EOC and the county's Mobile Command can communicate on all local public safety radio systems in addition to MARCS. The

MCEMA radio room is equipped with additional systems including HF, SHARES, Winlink, and Digital-Fldigi

Mobile Command

Medina County EMA maintains a Mobile Command vehicle that has been outfitted with various public safety and amateur radio equipment and other communications capabilities.

Mobile Command vehicle provides advanced communications and information management capabilities that can support incident commanders at the scene of disasters and emergencies. Mobile Command has equipment to form temporary audio gateways between radio systems. It can serve as an Incident Command Post, an alternate EOC, or workspace.

MCI Trailers

There are three well-equipped Mass Casualty Trailers for use during mass casualty incidents. Each unit is equipped to manage up to approximately 100 victims depending on severity of injuries. MCI Trailers are located at the following locations:

- Trailer 327-1 housed in the City of Medina
- Trailer 327-2 housed in the City of Brunswick
- Trailer 327-3 housed in the City of Wadsworth

Each city has agreed to maintain security, maintain documentation and inventory records, provide drivers and tow vehicles, and keep the units clean and dry. Details on the operations and use of the MCI Trailers are provided in Appendix 5.

EMS MCI Kits

Each EMS squad in Medina County is equipped with an EMS MCI kit for use during mass casualty/mass fatality incidents.

Contents of the MCI Kits include:

- Four (4) aprons of Mass Casualty Triage Tags per EMS unit, plus one (1) additional apron without tags for use by the Transport Officer.
- Blue vests marked as follows on front and back:
  "EMS Control Officer"
  "EMS Triage Officer"
  "EMS Treatment Officer"
  "EMS Transport Officer"
  "EMS Staging Officer"
  "EMS Safety Officer"
  "EMS Scribe"
- Job Action Sheets
- Yellow fire line tape
- Paper, pens, clip boards
- MCI forms:
    - Coordinating Hospital Mass Casualty Guidelines

    - Coordinating Hospital's Victim Record
    - Receiving Hospital's Victim Record
    - Transport Officer's Victim Record
    - Transport Officer Resource Log
    - Staging Officer Personnel Roster
    - Staging Officer Vehicle Roster
    - Treatment Officer's Victim Record
- Map Book
- Colored Flags and salvage covers for the victim treatment area: (Red, Yellow, Green, Black) In addition, each EMS squad shall be equipped with
- 100 Tags provided by Medina County Emergency Management Agency (MCEMA)

In addition, each EMS squad shall be equipped with a flag or green flashing light to designate COMMAND POST and color-coded salvage covers for victim collection.

Morgues/Cold Storage

Medina County has a total morgue capacity of 4. However, this capacity may not be fully available if there are non-incident remains already being stored.

Additional remains storage capacity is available through county funeral homes, the Cleveland Clinic's Mortuary Enhanced Remains System, temporary cold storage trailers provided by the Ohio Department of Health, and can be leased through the State of Ohio. In addition, portable morgues may be available from the U.S. Department of Health and Human Service's Disaster Mortuary Operational Response Team.

Medina Hospital is the point of contact for the Cleveland Clinic's Mortuary Enhanced Remains System.

Resources for Cold Storage of Human Remains

Resource	Capacity	Owner	Jurisdiction Level
Medina Hospital/County Morgue"	4 adults	Medina Hospital (Cleveland Clinic)	Local
Waite Funeral Home (Brunswick)	12	Waite Funeral Home	Local
Mortuary Enhanced Remains System	40	Cleveland Clinic	Regional
Temporary cold storage trailers (4)	18 each, 72 total	Ohio Department of Health	State
Semi-trailers (lease or purchase)	22 each, 44 each with one shelving level	State of Ohio	State
Portable morgues (3)	Exact capacity unknown	US Department of Health and Human Services (DMORT)	Federal

Note: Semi-trailers obtained through the State of Ohio require diesel fuel or generator/power hook-ups.

In addition, OMORT is capable of setting up temporary morgue processing center.

2.6 Incident Levels

Mass casualty incidents can be categorized by the number of injured persons and the resources needed to manage the incident. Medina County uses a four-level structure, beginning with Level 1 incidents and rising to Level 4 incidents.

MCI Level 1: A mass casualty or mass fatality incident that can be managed by a single jurisdiction, with assistance through standard mutual aid processes.

Victims: 3-10 immediate/red victims
Responding units:

- 5 ambulances
- 2 engine companies
- 1 EMS Supervisor/Operational Chief

MCI Level 2: A larger medical incident with multiple agencies responding, which may require a fully developed medical group.

Victims: 11-20 immediate/red victims
Responding units:

- 10 ambulances
- 5 engine companies or 15 first responders
- 2 EMS Supervisors/Operational Chiefs
- 1 MCI Trailer

MCI Level 3: A major medical incident with an EMS/Medical Branch and multiple EMS/ Medical Divisions. These incidents may cover large areas or may last long periods of time and may require state assistance.

Victims: 21-100 immediate/red victims
Responding units:

- 15 ambulances
- 10 engine companies or 30 first responders
- 3 EMS Supervisors/Operational Chiefs
- 1-2 MCI Trailers

MCI Level 4: A major medical disaster and will require multiple jurisdictions, specialty teams, state and federal resources.

Victims: 101-1000 immediate/red victims
Responding units:

- 20 ambulances
- 10 engine companies or 30 first responders
- 2 buses
- 5 EMS Supervisors/Operational Chiefs
- 3 MCI Trailers
- Mobile Command

2.7 Command Structure (ICS)

To effectively organize the work of multiple agencies, reduce friction, and conduct Mass Casualty/Mass Fatality operations most efficiently, Medina County responders will comply fully with the practices of the National Incident Management System (NIMS) and the Incident Command System.

2.7.A. National Incident Management System

The National Incident Management System (NIMS) describes how local, state, and federal agencies work together to prevent, protect against, mitigate, respond to and recover from incidents regardless of cause, size, or complexity. The use of the Incident Command System and other elements of this plan are in full compliance with NIMS.

2.7.B. The Incident Command System (ICS)

The Incident Command System (ICS) is a standardized, modular, and scalable command and control structure that facilitates interagency cooperation and coordination by establishing a common framework which enables personnel from multiple organizations to work together seamlessly. ICS provides common terminology, common organization, incident action planning, integrated communications, unified command, and other incident management activities. ICS is an accepted 'best practice' and is widely used in emergency management. It can be used for both planned events and unplanned incidents.

ICS includes a standard set of command-and-control positions that can be utilized to manage incidents of any size or complexity. Each incident is managed by an **Incident Commander or Unified Commander**, who determines which command positions should be filled to most effectively manage the situation.

Training in ICS procedures is available to all organizations that support this plan and can be arranged through the Medina County Emergency Management Agency. All members of public safety first-responder organizations should be trained on and maintain competence with ICS and NIMS concepts.

2.7.C. Unified Command

Whenever multiple jurisdictions are involved in a Mass Casualty/Mass Fatality response effort, the Incident Command leadership expands into a Unified Command. The Unified Command is a structure that brings together the Incident Commanders of the major organizations involved in the incident in order to coordinate an effective response, while at the same time allowing each to carry out their own jurisdictional, legal, and functional responsibilities.

Members of the Unified Command work together to develop a common set of incident objectives and strategies, share information, maximize the use of available resources, and enhance the efficiency of the individual response organizations.

2.7.D. ICS Positions

Standard ICS positions include the Incident Commander, the Operations Chief, the Plans Chief, Logistics Chief, Finance and Administration Chief, Public Information Officer, and Safety Officer. Not all of these positions are necessary for every incident.

Functional positions that are essential to effective Mass Casualty/Mass Fatality operations include Triage Unit Leader, Treatment Unit Leader, Extrication Unit Leader, and Transportation Unit Leader. These are time-critical life-saving functions and these positions should be assigned as soon as possible in Mass Casualty/Mass Fatality incidents.

The following are brief descriptions of the general responsibilities of the most common ICS positions. More detailed discussions of the specific Mass Casualty/Mass Fatality responsibilities of critical positions are provided in Section 4 of this plan.

Incident Commander/Unified Command

The Incident Commander or Unified Command is responsible for the overall management of the incident. **The Incident Commander is the only position that is always staffed in ICS applications.** On small incidents and events, one person—the Incident Commander—may accomplish all management functions. For larger incidents, the Incident Commander or Unified Command will assign additional personnel to manage important functions.

Operations Chief

The Operations Chief is responsible for managing all tactical operations at the incident, identifying the need for additional resources, and developing the operations portion of the Incident Action Plan (IAP). If no Operations Section is established, the Incident Commander or Unified Command will perform all operations functions.

During Mass Casualty/Mass Fatality incidents the Operations Chief may be replaced by the **Medical Group Chief**. The Medical Group Chief coordinates, directs, and manages all EMS/medical functions including triage, treatment, and transportation.

Planning Chief

The Planning Chief is responsible for preparing Incident Action Plans, managing information, and maintaining situational awareness for the incident. If no Planning Section is established, the Incident Commander or Unified Command will perform all planning functions.

Logistics Chief

The Logistics Chief is responsible for ordering, obtaining, maintaining, and accounting for essential personnel, equipment, and supplies. If no Logistics Section is established, the Incident Commander or Unified Command will perform all logistics functions.

Public Information Officer

The Public Information Officer is responsible for formulating and disseminating factual and timely information about the incident to the news media and other appropriate agencies. If no Public Information Section is established, the Incident Commander or Unified Command will perform all public information functions.

Safety Officer

The Safety Officer is responsible for ensuring that all health and safety hazards are identified, that tactical operations are performed safely, and that all personnel are briefed on safety procedures and requirements. If no Safety Officer is assigned, the Incident Commander or Unified Command will perform all safety functions.

2.7.E. Mass Casualty/Mass Fatality Functional Positions

The following positions are critical to conducting Mass Casualty/Mass Fatality operations and should be filled as soon as possible during the response. The Unit Leaders will report to the Medical Group Chief, if one is assigned, or to the Incident Commander/Unified Command. If no Unit Leader is assigned, the Medical Group Chief or the Incident Commander/Unified Command will manage all functions.

Triage Unit Leader

The Triage Unit Leader is responsible for directing and coordinating triage activities including tagging and movement to treatment/transport areas.

Extrication Unit Leader

The Extrication Unit Leader is responsible for directing and coordinating extrication activities if victims are trapped in any way.

Treatment Unit Leader

The Treatment Unit Leader is responsible for establishing treatment areas and/or patient loading areas and for supervising treatment and prioritizing patients for transport.

Transportation Unit Leader

The Transportation Unit Leader is responsible for coordinating the loading and transport of all patients from the incident site and coordinating transport with the coordinating hospital.

Section 3.0 Concept of Operations

The Concept of Operations described in this plan is designed to ensure that the right capabilities are deployed to the right place at the right time. By adhering to the guidance contained in this plan, Medina County responders can coordinate their actions effectively, complete all necessary tasks, and make the most efficient use of available resources.

3.1 Incident Authority

Command and incident management authority legally lies with the jurisdiction where the incident has occurred. County, state, and federal organizations may provide additional resources and other forms of support. Typically, these supporting organizations respond to requests for assistance from the local jurisdiction and do not respond independently.

When a mass casualty or mass fatality incident requires a sustained multi-jurisdictional or multi-discipline response, a **Unified Command** structure should be established in accordance with ICS/NIMS principles.

3.2. Mass Casualty/Mass Fatality Response Overview

The following outline summarizes the primary actions that occur during a mass casualty or mass fatality incident.

Pre-Arrival:

- Mass casualty and/or mass fatality incident occurs
- Dispatch is notified
- Dispatch sends appropriate personnel/equipment, advising of potential mass casualties/mass fatalities.

Arrival:

- First arriving unit conducts initial assessment, confirms actual mass casualty/mass fatality incident, and establishes command per department SOP.
- Command notifies dispatch of situation, and requests additional resources as needed.
- Incident Command/ Unified Command activates Mass Casualty/Mass Fatality Plan.
- Dispatch notifies Coordinating Hospital, Emergency Management Agency, Coroner (if mass fatality is declared), Red Cross (if requested by IC).

Operations:

- First available personnel begin triage using Simple Treatment and Rapid Treatment (START) system.
- Incident Commander assigns responsibility for needed command positions, including Unified Command.
- Unified Command establishes staging area, treatment area, transport area, temporary morgue, media area, and family notification location.
- Unified Command determines need for additional resources.
- Unified Command reports un-met needs to Medina County Emergency Management Agency.
- Coroner assumes responsibility for fatalities

- Law enforcement establishes and maintains the inner and outer perimeter, establishes access control, maintains scene security, and provides additional support as needed.
- Medical group establishes patient flow:
  - Patients are tagged and directed to appropriate treatment areas.
  - Patients are treated and medical treatment is documented
  - Patients are moved to the appropriate loading area.
  - Patients are transported to medical facilities as directed by Coordinating Hospital.

3.3 Guiding Principles

This Concept of Operations is based on the following principles:

1. The local jurisdiction retains authority for the operation.
2. Critical information flows freely between Unified Command and field personnel.
3. Medical treatment is provided on a priority basis.
4. Concise and professional communications are critical to an effective response.
5. On-scene activities will be fully documented.
6. The health and safety of responders is protected at all times.
7. All operations involving victims, decedents, or their families will be conducted with respect and compassion.

3.4 Activation

Activation of this plan will occur when a mass casualty-producing incident exceeds local response capabilities. The incident may gradually increase in scale and complexity or it may be obvious from the first moments that additional resources available through mutual aid.

3.4.A. Activation Decision Points

Any incident consistent with one or more of the following criteria may precipitate the activation of Medina County's Mass Casualty/Mass Fatality Plan:

- An incident involving a number of injuries or deaths that exceeds the responding community's capacity for treatment and/or transport
- An incident involving a protracted or complex rescue or decedent recovery operation
- A situation in which the number of decedents exceeds the County Coroner's capacity
- An incident or other special circumstance requiring a multi-agency or multi-county response to support Mass Casualty and/or Mass Fatality operations

3.5 Dispatch

Upon receiving initial reports of a potential mass casualty/mass fatality incident, the dispatcher for the affected jurisdiction will immediately dispatch the appropriate responding unit using the Mutual Aid Box Alarm System (MABAS).

- Upon activation of the MCI/ Mass Fatality Plan, dispatch notifies Coordinating Hospital (Medina Hospital), the Medina County Emergency Management Agency, the Medina County Coroner (if mass fatality is declared), and the Red Cross (if requested by IC).
- Dispatch will activate the Chiefs Box to provide command assistance on scene and to provide a Hospital Transport Officer at Medina Hospital.

Dispatch will initiate the MABAS preplanned call-up of equipment, personnel, agencies, and additional resources.

Throughout the incident each dispatch center will maintain responsibility for dispatching their own agency's responders. Affected dispatch centers should consider bringing in extra personnel to assist in managing the workload.

3.6. Field Activities

3.6.A. Arrival and Assessment

The initial moments of a response to a mass casualty/mass fatality incident are critical. The first unit on the scene sets the tone for the response. A fast, accurate assessment; proper communications; and adherence to plans and protocols will help ensure an effective operation.

The priority for the first units on scene is to accurately assess the situation and inform dispatch of the parameters of the incident. An accurate assessment will facilitate an effective response by dispatch, follow-on units, and supporting organizations.

Upon arrival the first unit establishes scene safety before rescuers enter the area to estimate the number of casualties and the type of incident. The first squad begins primary survival scan from the back of the incident to the front. The initial assessment will be conducted per department EMS protocol.

If fatalities are present at the scene during the initial assessment, the Coroner will evaluate the incident site and determine if Mass Fatality operations are to be conducted, and if so, determine the requirements for temporary morgue, cold storage, transportation, and logistics.

3.6.B. Mass Casualty/Mass Fatality Incident Alert

The first arriving unit should immediately advise the dispatcher that mass casualties/fatalities are present. If this notification is not made by the first unit, it should be made by the first arriving officer or person designated to do so.

It is critical that the local dispatcher be clearly told "**This is a Mass Casualty/Mass Fatality Incident**" including the **number** and **condition** of patients so that the plan can be immediately activated. The alert should come from a trained responder who is at the scene.

3.6.C. Notifications

Once a Mass Casualty/Mass Fatality Incident has been declared, the dispatcher for the responding jurisdiction will make the following notifications:

1. Medina County Coroner / 330-723-3641

2. Medina County Emergency Management Agency / 330-722-9240
3. Medina Hospital / 330-723-3118
4. The Red Cross / 216-496-1618
5. The Medina County Sheriff's Dispatch Office (if the incident is being handled by a different dispatch center) / 330-725-6631

When making notifications, the dispatcher should provide the following information:

- Type of incident
- Location of incident
- Approximate number and condition of patients

3.6.D. Incident Command

The Incident Command System (ICS) shall be used as the basis for the command structure for any Mass Casualty/Mass Fatality incident. This complies with the federal requirements of the NIMS (National Incident Management System).

ICS is a standardized, on-scene, all-hazards incident management approach that provides a flexible structure for response to emergency situations. It allows local, state, federal, and private entities to be integrated under a single command structure.

When a Mass Casualty or Mass Fatality incident requires a sustained multi-jurisdictional or multi-discipline response, a **Unified Command** structure should be established in accordance with ICS/NIMS principles.

The first unit on the scene will establish Incident Command and will manage the incident until a senior officer or other qualified person arrives. As soon as possible, a qualified officer will relieve the first responding unit and assume Incident Command. The Incident Commander will advise Dispatch immediately.

Initially, all medical and security operations at the scene will be coordinated and managed by the Incident Commander. If fatalities are present, the Coroner will assume responsibility for all handling of deceased victims.

Initially the Incident Commander will be responsible for all operations, and for smaller incidents the IC may not require the assignment of additional officers at the Incident Command Post. But if the scale and complexity of the incident increases, the IC will request additional qualified officers to fill certain essential positions. The IC will notify Dispatch of the need for additional senior officers and Dispatch will notify the appropriate departments.

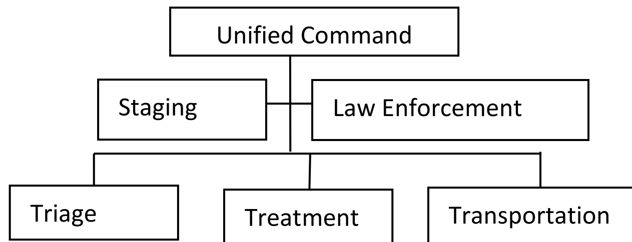
As multiple agencies arrive at the scene, Incident Command will transition to Unified Command.

The standard ICS structure includes four primary groups: Operations, Planning, Logistics, and Finance and Administration. However, in the early stages of a Mass Casualty/Mass Fatality Incident, the Incident Commander should focus on assigning staff to manage the critical life-saving functions of Triage, Treatment, and Transport first. Later, as more resources become available, the structure can be expanded. The positions should be filled in roughly this order:

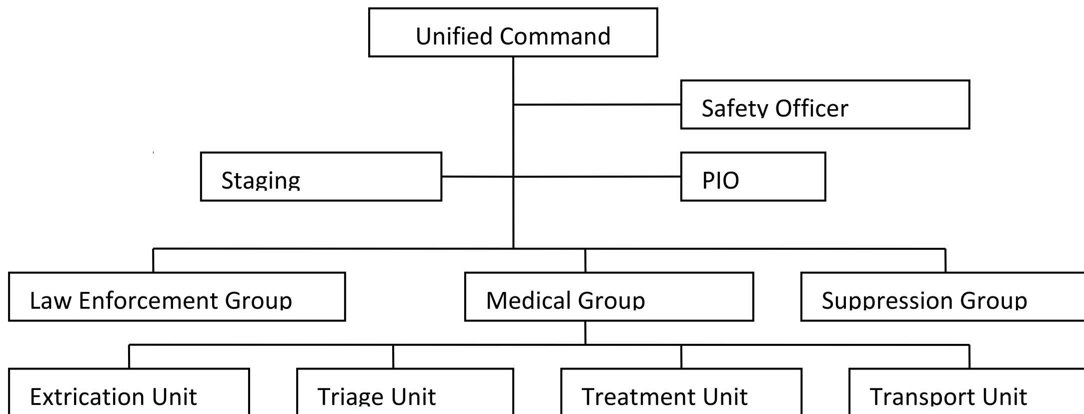
1. Incident Commander
2. Triage Unit Leader
3. Transport Unit Leader
4. Treatment Unit Leader
5. Staging Officer
6. Law Enforcement Unit Leader
7. Medical Supply Officer
8. EMS Group Supervisor

Until enough personnel and resources arrive, it may be necessary to combine some functions.

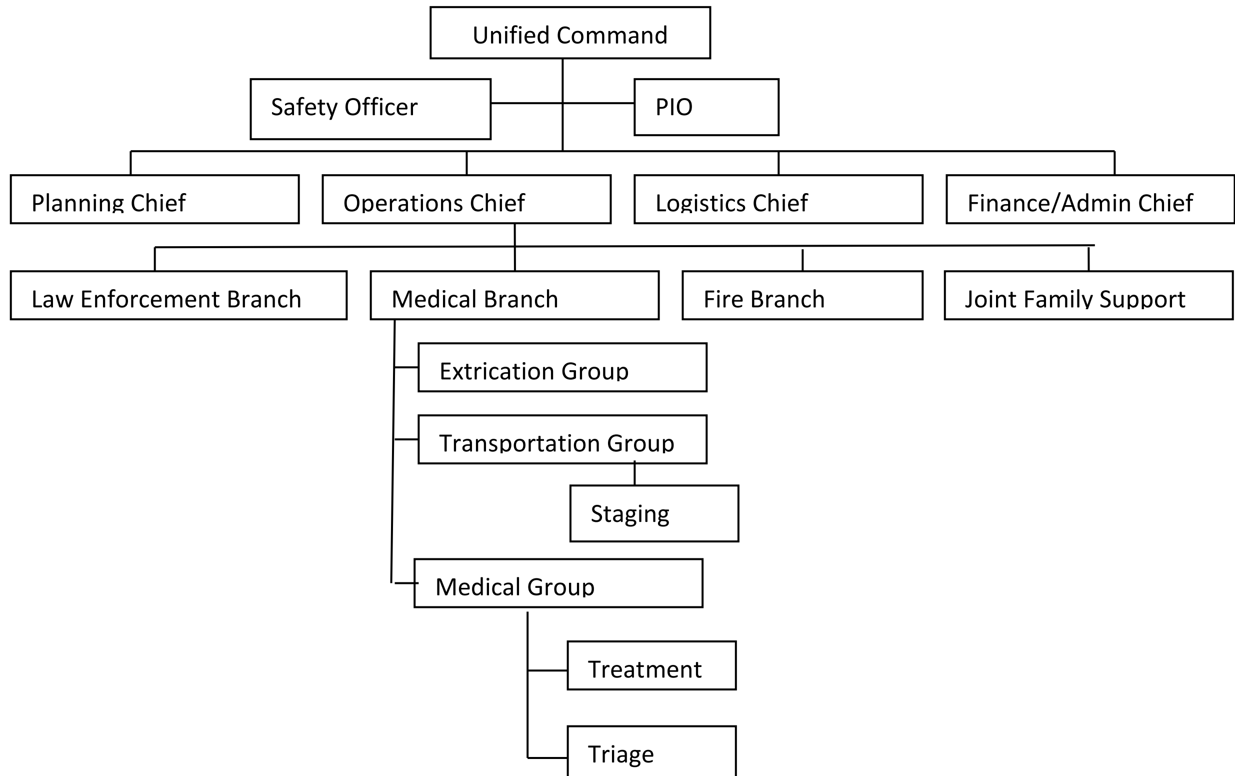
An initial ICS structure for a Mass Casualty / Mass Fatality incident might look like this:



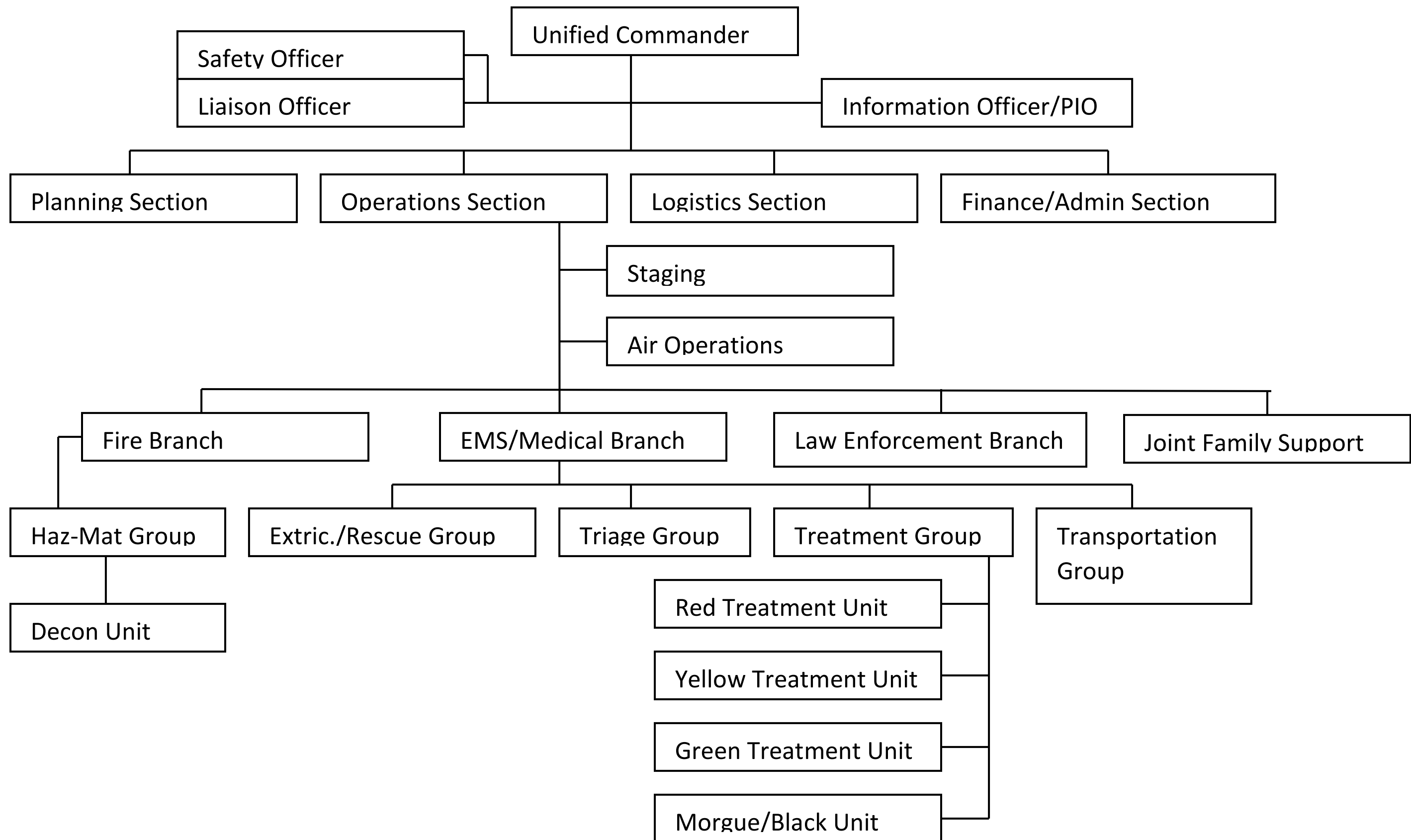
As the scale of the incident grows with multiple agencies responding, an expanded ICS structure might include a fully-developed medical group and may look like this:



If the incident becomes a major medical incident the structure will expand to include an EMS/Medical Branch and multiple EMS/ Medical Divisions. These incidents may cover large areas or may last long periods of time. The ICS organization may look like this:



If the incident is a major medical disaster requiring multiple jurisdictions, specialty teams, state resources, and federal resources, the ICS structure may look like this:



These examples are intended to illustrate the adaptability and scalability of ICS. It is up to the Incident Commander or unified Command to create the structure that is most appropriate for the incident at hand.

3.6.E. Establish Site

After the scene has been determined safe, specific areas (such as the Treatment, Staging, Morgue Area, etc.) shall be identified by the Incident Commander or Unified Command. The early designation of these areas will assist in organizing and facilitating patent flow and will materially improve the efficiency of the mass casualty/mass fatality operation. Whenever possible, sites should be marked with flags, lights, or signage.

<u>Incident Command Post</u>

A single field location at which on-scene incident command functions are performed, and where the Command and General Staff and Support Agency representatives coordinate operations. The Command Post should be at the edge of the inner perimeter, outside of any potential hazard area. It must be a well-marked location and should be identified with a flashing green light & green flag.

Medina County EMA has a Mobile Command vehicle that can serve as the ICP.

Rescue/Extraction Area

If patients need to be extracted from rubble or debris, or if they must be immediately moved to a safer location, an Extraction/Rescue Area should be established. This is an area where responders may immediately place patients to prevent further injuries and await initial triage and/or decontamination. This area should be located as close to the incident location as safety permits.

Decontamination Area

If patients need to be decontaminated prior to any treatment, a Decontamination Area should be designated. The Decontamination Area should be located as close to the incident site as possible, yet outside the contaminated zone. Decontaminated patients should be marked with orange ribbons or other markings to identify that they have been decontaminated and are ready to be moved to triage or treatment areas.

Initial Triage Area

The Triage Area is the place where victims are first brought to be examined and tagged. No significant treatment occurs here. The Triage Area should be near the incident site to reduce the distance patients have to be moved but should be in an area free of hazards or contamination. Patients that need to be extricated or decontaminated can be initially triaged during those operations. The Triage Area should be large enough and free of obstructions to provide a clear view of the overall triage operation.

Casualty Collection Point

Casualty Collection Points (CCPs) are short-term staging areas where patients can be brought by field units, families, law enforcement, or other public safety agencies to await transportation to medical facilities. They are typically established when delays in transportation to medical facilities are expected. They are especially useful when large numbers of ‘walking wounded’ are present at the scene. These ambulatory patients can be held at the CCP until transport is available to take them to medical facilities. Critically injured patients received at CCPs should be re-triaged before being moved to the treatment area. Whenever possible, CCPs should be protected from inclement weather. CCPs should be located between the incident scene and the Treatment Area.

Treatment Areas

Treatment Areas should be located a safe distance away from hazards, upwind from toxic fumes and should provide for easy access/egress. The site should be located as close as possible to the Casualty Collection Point. When locating the Treatment Area, consider weather, safety and the possibility of hazardous materials. Designate entrance and exit areas which are readily accessible.

If possible, a Treatment Area should be located indoors, especially under poor weather conditions. Look for a building with sufficient open floor space capable of accommodating the number of victims and

equipment. Use scene tape and traffic cones to define the Treatment Area and define corridors from Triage to the Transport Area.

Within the Treatment Area, sections should be identified for the various triage categories (Red, Green, Yellow) using tarps, flags and barricade tape. If deployed, mass casualty trailers should be stationed near the Treatment Area. Additional medical supplies brought to the incident should be delivered to the Treatment Area. The Treatment Area should be marked with colored tarps and flags.

Transportation Loading Area

This is the area designated for the loading of patients into transport units. It should be located near the Treatment Area and should provide easy ingress and egress for ambulances or other vehicles. Ambulances will move from the staging area to the Transportation Loading Area when patients are ready for transport.

The area must be located to allow a vehicle to proceed directly from staging to the Loading Area, be loaded, and then depart promptly for its destination. The Loading Area should have good road access and allow for safe loading. The area should be established within the outer perimeter and out of view of the media, family members, and the public.

Air Ambulance Landing Area (Helispot)

If air ambulances are to be used, a helicopter landing area (helispot) must be identified. Landing conditions (wind, weather, obstructions, etc.) will dictate the location of the helicopter Landing Area. The Landing Area should not interfere with ingress or egress of ground transportation.

LZ requirements will be set by local policy. At a minimum the LZ should be:

- Flat, firm, and free of debris that could blow up into the rotor system (minimum 100x100 ft.)
- Free of any obstructions such as cell towers, power lines, etc.
- At least 300’ from the Treatment Area.

For a large incident, multiple helispots may be required.

Staging Area

A Staging Area is temporary location where personnel and equipment are kept while waiting for tactical assignments. Staging Areas require appropriate ingress/egress and sufficient space to expand as necessary. Staging Areas should be close to major transportation routes and should have easy access to the Transportation Loading Area. All vehicles entering the incident perimeter will be initially directed to the staging area. A separate area should be established for Fire/EMS resources. These areas will be the gathering point for personnel and equipment and should provide some personnel comfort features, including cover for personnel working in the Staging Area and restrooms. Transport units will be staged as close to the loading area as possible and should be arranged in a one-way traffic pattern facing the loading area.

Large incidents may require more than one Staging Area.

<u>Temporary Morgue Area</u>

A temporary Morgue Area should be established for the temporary storage of deceased patients. The Temporary Morgue should be located in a sheltered area away from the Casualty Collection Point, Treatment, and Triage Areas. The location should be determined by the Coroner or Law Enforcement. The temporary Morgue Area should be accessible to vehicles and should be marked.

The Temporary Morgue should include:

- Building space
- Life support including electricity, running water, heating, ventilation, and air conditioning
- Cold storage

<u>Rehabilitation Area</u>

If Mass Casualty/Mass Fatality operations are to continue for a sustained time period, a Rehabilitation Area for responders should be established. The Rehabilitation Area will provide a secure place for responders and recovery personnel to rest and relax during breaks. Whenever possible, the area should be close enough to the incident scene that personnel can walk to it but remain out of view of incident operations. The area should be secured with entry controls to allow personnel to rest/relax without interruption by media or unauthorized personnel.

3.6.F. Ingress and Egress Control

The first law enforcement units on the scene should establish and secure ingress and egress routes for ambulances and other responding units.

3.6.G. Perimeter Security and Access Control

When sufficient law enforcement personnel arrive, appropriate perimeters and access control should be established.

An **<u>Inner Perimeter "Hot Zone"</u>** should be established that encompasses the immediate area around the scene of the disaster where extrication, triage, immediate support, and transport is occurring. Only first responders, coroners, and investigators should be in this area.

An **<u>Inner Perimeter "Cold Zone"</u>** should be established near the "hot zone" where activities are not impeding care for victims or putting workers in this zone within danger of hazardous materials or hazardous activities. In this zone is a treatment area of walking sounded, incident command post, reunification, canteening, patient tracking, and transport of non-critical people.

An **<u>Outer Perimeter</u>** should be established that separates bystanders and other traffic from the incident. The Outer Perimeter should be totally outside the of the zone of the disaster and is a place where media, community members, and others who are not involved can gather. The staging area and any friends and family reception sites should be in this area.

Inner and outer perimeters should be marked with barricades, ropes, tape, or other materials. Law enforcement officers should maintain the perimeters and control access. When necessary, traffic should be routed around Incident Perimeters.

Law enforcement should establish an **Entry Control Point** on the outer perimeter to limit access to the site to authorized personnel. Persons entering through an Entry Control Point (ECP) should be positively identified by law enforcement personnel stationed at the ECP.

3.6.H Patient Flow

The movement of patients through the Mass Casualty/Mass Fatality incident site follows an established process that minimizes delays and ensures that all patients receive the most appropriate treatment. Key steps in the Patient Flow process are:

1. Ambulatory patients are directed to a medically supervised area, and then moved from the scene to a Treatment Area as soon as that area is identified.
2. Non-ambulatory patients are properly tagged prior to movement.
3. If required, patients are decontaminated before leaving the incident scene.
4. Patients are triaged at the Triage Area.
5. Patients are treated at the appropriate Treatment Area (Red, Green, Yellow)
6. Deceased patients are left in place when possible, until removal is authorized by the Coroner.
7. Treated patients are moved to the Loading Area when transport is available.
8. Patients are transported to appropriate receiving medical facilities, as identified by the Transportation Unit Leader and Coordinating Hospital (Medina Hospital).

3.6.I. Triage

Triage is the heart of mass casualty and mass fatality response. It enables responders to make the most efficient and effective use of limited resources by identifying and separating patients rapidly according to the severity of their injuries and their need for treatment. This allows medical personnel to quickly identify those victims that are in most need of immediate medical care.

Before conducting triage, responders should direct all ambulatory patients (walking wounded) to a Casualty Collection Point or other designated safe area where they can be further assessed as more medical personnel become available.

When conducting triage, medical responders follow a pre-designed clinical algorithm as established by EMS protocols to evaluate each patient and assign a color-based triage category.

Patient data is recorded on a triage tag which is attached to the victim so that medical personnel following the triage provider will be able to quickly take appropriate action.

Triage is performed using *Simple Triage and Rapid Treatment* (START). Once a patient is evaluated, he or she is assigned an emergency triage level: **Minor, Delayed, Immediate,** and **Morgue**.

A modified procedure called *JumpSTART* is used to triage patients 8 years old or younger.

Patients exposed to hazardous materials (HAZMAT) should be triaged according to the agent they were exposed to. The Medina County All-Hazards Team can assist in identifying any type of HAZMAT contamination. Initial triage can take place at the decontamination station. Decontaminated victims who require urgent medical care should be triaged and tagged appropriately.

S.T.A.R.T. – Simple Triage and Rapid Treatment

START enables first responders to triage victims in less than one minute, based on three primary observations: ***Respiration, Perfusion, and Mental Status (RPM*).**

In using START, the steps are always the same no matter what injuries the victim may have.

Patients are tagged for easy recognition by other rescuers arriving on the scene. Tagging should be done using one of the triage tags provided in each MCI kit. However, other means of tagging are acceptable if approved triage tags are not accessible.

Red Tags indicate the most urgent and highest priority patients, including those with life-threatening injuries. These patients have a high probability of survival if provided immediate care and if they are rapidly transported.

Yellow Tags indicate patients with injuries that may have life-threatening implications if not treated; however, these victims are not yet in life-threatening shock or hypoxia. These patients are the second priority.

Green Tags indicate victims with localized injuries that need treatment but do not have an immediate systemic implication. They are the third priority.

Black Tags indicate victims who are obviously dead or in full cardio-pulmonary arrest. They are the fourth priority.

Completion of Triage Tags will depend on the number of victims and rescuers and the nature of the incident. Generally, the following steps will be taken:

1. Each victim will be assessed and tagged prior to movement into the Casualty Collection Point (CCP) or Treatment Area.
2. The primary nature of the injury will be noted in as few words as possible.
3. Later assessments and treatment will be noted on the tags.
4. The reverse side of the tag may be used to record more treatment data, make drawings, etc. as needed.
5. The tag will remain with the victim at the medical treatment facility.

Treatment or Transport will not be delayed in order to complete information on the triage tag.

Victims tagged 'Black – DOA' are Coroners cases, and they will be left in the location found unless movement is needed to reach potentially viable victims.

*Jump*START

*Jump*START was developed specifically for the triage of children. *Jump*START parallels the structure of the START system but is modified to reflect the key differences between adult and pediatric physiology.

Detailed instructions for performing START and *Jump*START are provided in Appendix 3 of this plan.

3.6.J. Treatment

Once triaged and tagged, patients are moved from the Triage Area to the Treatment Area.

Upon arrival at the Treatment Area, patients are provided definitive / stabilizing emergency medical care on the basis of triage priority by medical personnel.

3.6.K. Transport

Transport is the movement of patients to medical facilities with the capacity to treat them. Transport typically occurs after treatment. Patients should not be moved from the Treatment Area to the Transport Area until transport is available.

Transportation resources are assigned on the basis of triage priority. Air transportation should be utilized when needed.

The most important element of transport is ensuring that patients are transported to medical facilities that are capable of receiving them and are prepared to do so. The Transport Group Leader and the Coordinating Hospital (Medina Hospital) will assign patients to appropriate hospital or medical facilities prior to transport. The Transport Group Leader and the Coordinating Hospital will rotate patients among the Receiving Hospitals.

Transporting patients to more distant hospitals should be considered in Mass Casualty/Mass Fatality situations to reduce overcrowding of local medical facilities. Hospitals (especially those closest to the incident) are likely to receive patients not only via EMS, but also walk-ins and the "worried well," in addition to their normal patient load.

The Transportation Unit Leader will coordinate the transport of all injured patients with Receiving Hospitals. Communications from the Transportation Unit Leader to the Receiving Hospital should be limited to patient count and severity such as 1 Red or 2 Green.

Green patients may be transported by buses. These patients should be accompanied by a medically qualified individual capable of maintaining medical treatment and evaluation as needed.

Patient Tracking is a critical component of transport. The Transportation Unit Leader will be responsible for maintaining a hospital routing log.

3.6.L. Communications

Communications between all involved agencies should be established early in the incident. The primary means of interoperable communications between Medina County Fire Departments is the MARCS radio system. Due to other responding stakeholders being on different radio systems, an audio patch between systems may be requested through dispatch.

Radio communication during major incidents is almost always overburdened and confused. To help reduce confusion and to support interoperability, the following guidelines should be followed:

1. When possible, communication should take place face to face.

2. If radio transmissions are required, messages should be in plain language and should be brief and to the point.
3. If a long conversation or message is required, a runner should be sent or a meeting requested at the Incident Command Post.
4. For unity of command, no one but Unified Command should have radio contact with the dispatcher.
5. Radio assignments will be made by the Unified Command.
6. Unified Command will assign talk groups.
7. If agencies using multiple communications centers are dispatched, the dispatch center for the jurisdiction in which the incident occurred will assume the role as the primary communications center for the event. The other communication centers will continue their normal operations while monitoring the Mass Casualty operations frequency.
8. The Transport Unit Leader should be the only person communicating with hospitals.
9. Ambulances transporting patients from the scene should NOT make a report to the hospital. This should be done by the Transportation Unit Leader.
10. Receiving Hospitals may call the Coordinating Hospital, but should refrain from contacting the scene directly.
11. The Air Ambulance Team Leader must have radio contact with incoming helicopters.
12. Public safety units not involved in the Mass Casualty/Mass Fatality incident should minimize all radio communications.

3.6.M. Deceased persons

The Medina County Coroner will direct the processing of the deceased. The concept of preservation of evidence should be applied when caring for the deceased.

Local agency personnel, and the staff of other agencies and non-governmental agencies will work together at the scene, at the Family Assistance Center, at the incident morgue, and at the Medina County Emergency Operations Center (EOC) to manage the safe recovery of the deceased with dignity and respect.

Public safety personnel performing triage and treatment of injured persons shall not move deceased persons and shall avoid disturbing the area immediately surrounding the body. Deceased persons will be tagged, covered with a sheet or blanket, and not moved unless necessary Bodies must be safeguarded at all times until the arrival of the Coroner or the Coroner’s representative.

If it becomes necessary to move bodies or parts of bodies, photographs should be taken showing their relative position within the debris/wreckage, and a sketch of their respective positions should be made prior to removal.

Personal effects should never be removed from a body. If personal effects are found and thought to belong to a body, place them in a separate container and tag them. Responders should not assume any loose effects belong to the body that they were found next to.

Tags should be affixed to each body or part of the wreckage that was displaced, and corresponding flags, stakes or tags should be placed where they were found in the wreckage. A record should be kept of all tags issued.

Personnel should attach tag or label to each body with the following information:

- Date and time found.
- Name and address of decedent, if known.
- If identified, how and when.
- If body is contaminated.
- Exact location found.
- Name/phone of person making identity or filling out tag.

Responders should place each tagged body in a disaster pouch or in plastic sheeting tied securely to prevent unwrapping. Responders should attach a second tag to the sheeting or pouch. Using a red surveyor's flag, responders should mark the location where a body/part was removed, writing the Triage Tag Number on the flag. Responders should move the properly tagged body with their personal effects to an established Temporary Morgue, i.e., garage or other cool building, preferably one with refrigeration.

The Coroner may determine that remains should be cremated or buried expeditiously to protect public health. Disposition of remains will be coordinated with the Medina County Health Department (MCHD).

Waite Funeral Home in Brunswick is the only crematory facility in Medina County. There is also one facility in Cuyahoga County and one in Summit County that could potentially assist with cremations in a mass fatality incident.

The identified deceased may be buried in cemeteries of their choice, assuming conditions of the incident permit this. Unidentified remains may be interred in potter's fields. Most cemeteries in Medina County have potter's fields for indigent within their township. Most potter's field spaces require cremation.

3.6.N. Documentation

Proper documentation will support accurately monitoring of the incident, and will provide critical information for subsequent investigations.

Utilizing standard ICS forms is an effective method to ensure proper documentation. The ICS structure allows for modification of the standard forms to ensure they contain the information that is needed for specific situations/agencies.

ICS Form 214, Unit Log will be used by Command Staff and Unit Leaders to record unit activities. It can also serve as a basic reference from which to extract information for inclusion in any after action report.

Special forms are provided in each Mass Casualty Incident kit. These forms include:

- Coordinating Hospital Mass Casualty Guidelines
- Coordinating Hospital's Victim Record
- Receiving Hospital's Victim Record
- Transport Officer's Victim Record
- Transport Officer Resource Log
- Staging Officer Personnel Roster

- Staging Officer Vehicle Roster
- Treatment Officer's Victim Record

Triage tags will be used for patient triage and documenting assessment findings and patient care. The triage tag will become part of the patient's hospital medical record.

The Transportation Unit Leader will document the number and type of patients (i.e., morgue, immediate, delayed, and minor) sent to each area hospital on a Transportation Log for each receiving facility.

Unified Command will coordinate the gathering of all pertinent documentation following the end of the response.

3.6.O. EOC Operations

Upon notification of a Mass Casualty/Mass Fatality incident, Medina County EMA may respond to the Incident Command Post or may activate the county Emergency Operations Center (EOC).

Medina County EMA will support the Unified Command by locating additional resources at the local, state, or federal level and establishing and maintaining situational awareness.

3.6.P. Public Information / Joint Information System (JIS)

To prevent or minimize loss of life, damage to property, and harm to the environment as a result of a Mass Casualty/Mass Fatality incident, Medina County will provide consistent, coordinated, accurate, and timely information to the public. The information flow will begin as early as possible, be maintained throughout the event, and continue well after the event ends.

All statements from the field will be made through the Unified Command or the designated Public Information Officer. The Public Information Officer will normally be the PIO from one of the unified command agencies. The PIO will be the sole point of contact for all media and will provide accurate information to the media, governmental agencies, and others.

The PIO will issue news releases on a timely basis and shall maintain accurate records of information released to the media.

The PIO will establish a Media Area away from the Command Post. Members of the media should not be allowed inside the outer perimeter without permission of the Unified Command.

If the Medina County EOC is activated, a **Joint Information Center (JIC)** will be established to disseminate information to the media and the public. Representatives from the affected Local Government, the Coordinating Hospital, Receiving Hospitals, the Coroner's Office, and other participating agencies may be invited to participate in all formal briefings. The Unified Command and any of the above agencies may request that a Joint Information System be established.

Key information to be communicated should include:

- How to report missing persons

- The number of an information line for family members and friends outside the area who wish to obtain information on recovery and identification efforts
- Volunteer opportunities
- If donations are needed and how to donate

Critical information should be shared in a controlled manner. Below is a suggested order of notification:

- Incident responders with a need to know
- Designated public officials
- Victim family members and friends at FAC briefings
- General public and media

3.7 Hospital Operations

The local hospitals must be among the first institutions notified of a Mass Casualty/Mass Fatality Incident. Upon notification, they will prepare for the influx of patients, either by clearing the emergency department or by activating their Internal Disaster Plan. During a Mass Casualty/Mass Fatality incident, hospitals serve either as the Coordinating Hospital or as a Receiving Hospital.

3.7.A. Coordinating Hospital:

The Coordinating Hospital in a Mass Casualty/Mass Fatality incident will coordinate communication and victim movement between the scene and all potential Receiving Hospitals.

Cleveland Clinic Medina Hospital will always serve as the Coordinating Hospital.

Communications should take place over MARCS radio. Cellular and landline phone communications should not be relied upon as local towers may become overwhelmed and disrupt communications.

Upon notification of a Mass Casualty/Mass Fatality incident, Cleveland Clinic Medina Hospital shall notify the Northeast Central Ohio (NECO) Regional Healthcare Coordination Center (RHCC) and provide a briefing on the incident. The RHCC will notify hospitals in the NECO and Northeast Ohio Region (NEO) if necessary, via mass notification systems.

Cleveland Clinic Medina Hospital will assign an initial **Hospital Transport Officer** from its staff. Meanwhile, Dispatch will activate the Chiefs Box and a Chief Officer will respond to the hospital to serve as the **Incident Hospital Transport Officer.**

The Incident Hospital Transport Officer will report to the Cleveland Clinic Medina Hospital Emergency Department and conduct a face-to-face briefing with the Hospital Transport Officer. Both will proceed to the Hospital Command Center where they will conduct Transport Coordination. The Hospital Transport Officer can continue to work as the Deputy Hospital Transport Officer or be reassigned.

The Incident Hospital Transport Officer will coordinate operations with the Transport Unit Leader at the scene. The Incident Hospital Transport Officer and the Transport Unit leader at the scene will communicate via MARCS Radio Medina County TAC-9.

Cleveland Clinic Medina Hospital will enter the incident into OHTrac to begin the tracking of patient destinations. Receiving hospitals will enter arrived patients into OHTrac to assist with determining surge capacity and to assist in reuniting patients with family.

As transport becomes available, the Incident Hospital Transport Officer and the Transport Unit Leader (at the scene) will determine where patients should be transported to. The Incident Hospital Transport Officer and the Transport Unit Leader will rotate the patients among the Receiving Hospitals.
.
The Transport Unit Leader will provide the Coordinating Hospital with periodic briefings on the activities at the scene and the number of victims.

As patients are transported from the scene, the Transport Unit Leader will notify the Coordinating Hospital of the transporting department, number of victims, tag color, brief description of injuries, and the Receiving Hospital. (Example: Medina Medic 1 will be transporting one red with severe head injury, to Medina Hospital).

Cleveland Clinic Medina Hospital will then post patient information into OHTrac, the State of Ohio patient reunification system.

After all victims have been cleared from the scene, the Transport Unit Leader and Incident Hospital Transport Officer will conduct a patient accountability review.

3.7.B. Receiving Hospital:

Any facility that accepts victims during a Mass Casualty/Mass Fatality incident will serve as a Receiving Hospital.

Receiving Hospitals will be notified of the occurrence of a Mass Casualty/Mass Fatality incident by Cleveland Clinic Medina Hospital or by RHCC via mass notification systems.

All information from the scene will be received through Medina Hospital Cleveland Clinic. The Receiving Hospital **will not** attempt to contact a dispatch center or responders at the scene.

It is expected that all area hospitals will receive victims in rotation during an MCI. Receiving Hospitals may activate their Emergency Operations Plans and ICS.

Each Receiving Hospital is responsible for entering patient tracking information into OHTRAC; notifying the Red Cross of the names and status of victims received; completing all patient tracking documentation and activating a Family Assistance Center to reunite patients and families.

Receiving hospitals shall maintain all Triage Tags as a part of the victims' medical record and for later incident evaluation purposes.

3.7.C. Patient Tracking

Upon notification of a Mass Casualty/Mass Fatality incident, Cleveland Clinic Medina Hospital will generate a Mass Casualty incident on OHTrac, the state of Ohio's web-based patient tracking site.

Receiving hospitals should enter the following patient information into OHTrac upon arrival at the emergency department: triage tag number, injury severity color, gender, approximate age, and full name.

Participating hospitals should ensure that the patients' tracking status, or location, remains current on the website.

3.8 Coroner Operations

The Coroner will be notified by Dispatch in the event of a Mass Casualty/Mass Fatality incident.

The Coroner will decide if a representative from the Coroner's Office will respond to the incident scene. If a Coroner's representative responds to the scene, they will report to the Incident Command Post.

3.8.A. Assessment

If fatalities are present at the scene during the initial assessment, the Coroner will evaluate the incident site and determine the requirements for temporary morgue, cold storage, transportation, logistics, and the Family Assistance Center. During this assessment, the Coroner or Coroner's representative may be accompanied by representative(s) from local first responders and representative(s) from supporting outside agencies such as Ohio Mortuary Operations Response Team (OMORT).

The Coroner shall evaluate the site for the following:

- Potential or actual number of fatalities
- Condition of human remains
- Size and accessibility of the incident site
- Level of difficulty in recovery
- Possible CBRNE hazards

The Coroner or a Coroner's representative will call Cleveland Clinic Medina Hospital to determine their current storage capacity.

The Coroner will determine if the incident requires activation of the mass fatality portions of the Mass Casualty/Mass Fatality plan and will advise Unified Command. In making this assessment, items to consider may include the number of fatalities or potential fatalities, fragmentation of remains, the scale of recovery efforts, and the likelihood that outside assistance will be required for medical operations, family assistance, and public information operations.

Based on the on-scene assessment, the Coroner will determine the following:

- Type and number of personnel and equipment needed for human remains recovery, and transportation needs
- Location of temporary morgue operations (if needed) and type and number of personnel and equipment needed for the processing and identification of human remains
- Site for Family Assistance Center and an estimate of personnel needs (in concert with the Unified Command)

Upon initial assessment, the Coroner will also determine if outside assistance is required. Depending on the type of assistance required, the Coroner may request assistance from other county coroners, the Ohio Mortuary Operational Response Team (OMORT), funeral providers, or other sources. The Medina County EMA can assist in requesting additional resources.

3.8.B. Responsibility for Remains

The Coroner will take charge of all deceased victims.

Fatalities will not be moved until their location has been properly documented and removal has been approved by the Coroner.

3.8.C. Black Tag Area

The Coroner will establish a DOA 'Black Tag' area at the scene if local emergency response personnel have not done so. This will be out of view of the victim collection are. Victims that expire in the victim collection area will be placed in the 'Black Tag' area.

3.8.D Electronic Death Registration System (EDRS)

The web-based EDRS application can flag death records associated with a pandemic or mass fatality event. The Vital Statistics (VS) HelpDesk can provide real time instructions to Ohio coroners, deputy coroners and local vital statistics staff on the correct use of the system flags. Questions can be directed to the vs.helpdesk@odh.ohio.gov or 614-466-2531.

3.8.E. On-Scene Investigation

The location of the incident will dictate which Coroner has authority for death certification of victims. In a Mass Casualty/Mass Fatality incident, inquest resources are likely to be overwhelmed and local law enforcement will likely assume responsibility for conducting a preliminary investigation.

Law enforcement investigators will process death scenes to properly document the site and record, collect, and safeguard evidence. The Coroner will assume responsibility for the victims and associated personal effects (PE). Any PE having potential value as evidence will be collected by law enforcement as part of their investigation. Recovery teams must be mindful of crime scene preservation techniques and exercise caution to protect potential evidence as they conduct their operations.

Investigation efforts take precedence over human remains recovery when those tasks are assigned to separate teams. At all times investigation and recovery will be conducted in close cooperation to ensure timely and dignified recovery as soon as possible.

3.8.F. Remains Recovery

The Coroner must approve the removal of any remains from the incident site. The recovery of human remains must be managed in an efficient, yet meticulous and respectful manner.

The Coroner shall implement a human remains numbering system to track the locations where human remains were found. The numbering system should be as uncomplicated as possible in order to reduce errors or confusion.

In the event of a geographically dispersed incident scene with multiple locations of fatalities, it may be necessary to have multiple teams assigned to recovery and transport of remains and to establish multiple body collection points.

3.8.G. Personal Effects

Personal Effects not considered to be investigative evidence will remain at the site for collection by a team(s) designated by the Coroner for that purpose. Clothing found on victims and PE in the clothing

will be kept with the victim and transported to the morgue with the body. Disassociated PE from the site should be transported to a location designated by the Coroner after appropriate inventorying and numbering is completed

3.8.H. Human Remains Removal and Transportation

Fatalities will not be transported from the scene until cleared by the Coroner. All will be held at the scene until the Coroner or Designee institutes the following procedure:

- A temporary morgue is established at a location near the incident site. The Coroner will determine the temporary morgue's location.
- The Coroner shall hold all victims who expire enroute to or after arrival at any hospital for disposition. No autopsy is to be performed without specific permission of the Coroner.

The Coroner may request transportation assistance from local funeral directors to move remains from the scene to the appropriate morgue.

A transportation log should be maintained to document the removal time, vehicle identification, operator information, and identity of the funeral home/service accepting responsibility for body transport to the morgue. A manifest should be prepared to document the tracking numbers of those remains being transported.

3.8.I. Storage of Remains

A temporary morgue facility may be established to handle remains from a Mass Casualty/Mass Fatality incident.

A temporary facility can utilize an existing building or a temporary structure. Either option must have running water, electricity, and heating/air conditioning. The structure footprint should be a single floor configuration with a minimum of 6,000 square feet and arranged in such a manner to facilitate efficient processing. If the incident has resulted in more than 100 sets of remains a larger facility should be utilized. For 101-200 remains, the facility should exceed 8,000 square feet, and for incidents resulting in more than 200 sets of remains, the facility should reach or exceed 10,000 square feet.

The temporary morgue should be located relatively close to the incident site yet sufficiently distanced to be clear of danger from the site and associated incident aftermath. The facility must also be conducive to security and controlled access. Avoiding highly-trafficked areas is preferable when possible.

Possible locations for a temporary morgue include tented structures, empty warehouses, athletic fields, tents, and trailers.

The below table outlines characteristics associated with selecting a temporary morgue site.

Required characteristics	Additional desired characteristics	Disqualifying characteristics
A single floor of sufficient size (depending on number of remains)	On-site cold storage that can be used for human remains (must be a refrigerator, not a freezer).	Location is a school or other sensitive community location where the processing of human remains would have significant

		lasting impact on community association with that location
Refrigerated trucks can easily access the location to allow for the accommodation of cold storage of remains	Away from high-traffic areas	Private property location whose owner declines to provide access
Far enough away from the Family Assistance Center that family members won't have to pass the morgue on their way to the FAC	Operations easily out of sight of media or other onlookers	
Far enough away from the incident site to be clear of danger of any secondary emergencies		
Has running water, electricity, and heating or air conditioning as relevant to the current weather		

If necessary, OMORT has a mobile morgue equipment set that can be deployed to the incident site and installed in an appropriate structure to facilitate processing. Hospital morgues should not be relied upon for decedent storage due to a potential requirement surge from the incident.

3.8.J. Supporting Agencies

A significant number of state and federal agencies are available to assist the Coroner's Office in handling fatalities and conducting required investigations.

State Agencies:

Ohio Emergency Management Agency (OEMA)

The Ohio EMA, within the Ohio Department of Public Safety, is responsible for coordinating and facilitating state-level emergency management operations, including planning, training, mitigation, preparedness, response, and recovery. The State Emergency Operations Center (SEOC) manages state-level disaster response and aids in the appropriation of federal and state resources during disasters.

Ohio Department of Health (ODH)

ODH assures an effective statewide health response through planning and collaboration. ODH is the lead agency for planning for Mass Fatality Incidents in the State of Ohio. ODH also maintains four temporary storage trailers for cold storage of remains that can be deployed throughout the state.

Ohio Mortuary Operational Response Team (OMORT)

OMORT can provide assistance with body processing and victim identification, and can assist at the Family Assistance Center by facilitating family interviews and collecting identifying documentation such as dental records at the direction of the Coroner. OMORT members have experience with Federal DMORT deployments and have been trained in the handling of mass fatalities.

Federal Agencies:

Disaster Mortuary Operational Response Team (DMORT)

Assist with mortuary response if requested. During an emergency response, DMORTs work under the guidance of local authorities by providing technical assistance and personnel to identify and process deceased victims. Equipment resources include three portable morgues and are located throughout the US. Each team has subject matter experts for every discipline of morgue operation.

National Transportation Safety Board

The National Transportation Safety Board has authority for investigating all public transportation fatalities including civil aviation, railroad, highway, marine, and pipeline accidents in the United States. In the absence of suspected criminal activity, NTSB is the lead investigative agency for transportation incidents. The Aviation Disaster Family Assistance Act of 1996 mandates transportation carriers meet the needs of aviation disaster victims and their families. These needs include victim identification, providing a Family Assistance Center (FAC), and crisis counseling.

US Department of Health and Human Services

Federal resources for MFI response, including DMORTs, are within the control of the US Department of Health and Human Services (HHS).

National Guard Bureau

The National Guard Bureau maintains a 120-man Fatality Search and Recovery Team (FSRT) capable of limited decedent recovery from contaminated field settings under the authority, direction, and supervision of coroners. This capability is part of the National Guard Bureau Chemical, Biological, Radiological, Nuclear, and Explosives (CBRNE) Enhanced Response Force Package and can be activated either as a state (Title 32) or federal (Title 10) asset and can be used to support civilian MFI response.

Department of Defense

Title 10 Forces refers to active component soldiers, sailors, airmen, and Marines. Under routine circumstances, these resources *cannot* be used for civil support. However, Title 10 Forces may be called upon as part of a DoD activation of its Joint Task Force-Civil Support in response to a Chemical, Biological, Radiological, Nuclear, and Explosives (CBRNE) incident due to weapons of mass destruction. DoD Directive 1300.22, Mortuary Affairs Policy, requires a Title 10 mortuary affairs force structure capable of providing support for search, recovery identification, evacuation, and, when required, temporary internment, disinterment, decontamination, and re-internment of (among others) US noncombatants.

Federal Bureau of Investigation

The FBI is the lead federal investigative agency for any mass fatality incident resulting from or suspected of resulting from domestic terrorism or other criminal acts.

3.9 Red Cross Operations

The American Red Cross has the responsibility to manage mass care needs for sheltering and feeding, as well as Reunification for non-hospitalized victims using Red Cross processes and systems. The Red Cross will coordinate a Family Assistance Center as needed, lead the Joint Family Support Operations Center

(JFSOC) as needed, support patient tracking, and provide support for victims, families, and emergency workers.

The Medina County Chapter of the Red Cross will be notified of the occurrence of a Mass Casualty/Mass Fatality incident by Dispatch.

39.A. Joint Family Support Operations Center (JFSOC)

For larger-scale incidents, the Red Cross will coordinate the establishment and operation of a Joint Family Support Operations Center (JFSOC). The JFSOC is a central location where participating organizations are brought together to monitor, plan, coordinate, and execute family support operations. The JFSOC is intended for agency representatives and is not appropriate for family members.

Organizations typically involved in the JFSOC include the Red Cross, local government and law enforcement, and the local coroner. If the incident involves a major transportation disaster, the National Transportation Safety Board, the passenger carrier, and other federal agencies will also participate at the JFSOC.

The JFSOC serves as the central point for coordination and sharing of information among participating organizations, monitors ongoing family support activities, oversees reunification, tracks mission activities of each organization, manages and coordinates requests for services, coordinates activities of the family Assistance Center and the Victim Intake Center, and maintains a daily journal of organizational activities and responses.

The location of the JFSOC will be determined on the basis of available space, such as hotels, local government buildings, or mobile command posts. In the event of a transportation accident, the passenger carrier is responsible for securing space to accommodate family members, the FAC, and the JFSOC.

3.9.B. Hospitals

Red Cross personnel may be available to assist at hospitals during Mass Casualty/Mass Fatality incidents by:

- Supporting the regional hospital system in ensuring that patient information is entered into OHtrack to facilitate patient tracking. The Red Cross does not participate directly in the input or data collection of patient tracking.
- Supporting hospital internal plans for establishing a friends and family reception site
- Communicating hospital plans for a reception site with the Joint Family Support Operations Center team who can assist hospital personnel in implementing best practices for family support

3.9.C. Coroner Liaison

The Red Cross will receive information on identified victims from the Coroner’s appointed liaison until the Coroner is fully integrated into the Joint Family Support Operations Center.

3.9.D. Non-Injured Operations:

When there are numbers of non-injured persons at sites where mass casualties or mass fatalities have occurred, the Red Cross may register victims who are affected, un-injured but involved, and walking wounded into the Reunification System (Safe & Well) to facilitate reunification (if they desire) and create a list that can support Law Enforcement missing person efforts.

Safe & Well is the nationally-recognized system to support reunification for local, regional, and national families during disasters that result in displacement and/or concern.

3.9.E. Reunification

At MCI Level 2 and above, Unified Command should consider establishing a Reunification Unit to reconnect victims and family members as quickly as possible.

The American Red Cross Reunification Services deploys workers and technology to reconnect individuals following disasters or emergencies. Technology tools include the organization's Emergency!App and the Safe and Well website.

Emergency! App

The Red Cross Emergency! App features an "I'm Safe" button that allows users to post a message to their social accounts, letting friends and family know they are out of harm's way. The Emergency! App is free and can be found in the app store for mobile devices by searching for "American Red Cross" or by going to redcross.org/apps.

Safe and Well

The Red Cross also offers the Safe and Well website which is a secure and more private option than the "I'm Safe" feature on the Emergency App. It allows people to list their own status and allows friends and family to search for messages from their loved ones. The Safe and Well website is a free public reunification tool that allows individuals and organizations to register and post messages to indicate that they are safe, or to search for loved ones. The site is always available and open to the public and available

3.9.F. Shelters

If persons are left homeless by the Mass Casualty/Mass Fatality incident, the Red Cross may provide emergency housing or may open a shelter. Shelter operations will be coordinated with the Medina County EMA.

3.9.G. Disaster Assistance

During Mass Casualty/Mass Fatality incidents the Red Cross may deploy Disaster Assistance Teams to meet the immediate disaster-caused needs of individuals, families, and communities, including temporary shelter, food, water, and emergency supplies.

3.9.H. Support to Responders

Red Cross personnel may assist Coroner operations by operating a canteen and providing support for workers just outside the morgue area to allow respite.

If on-scene operations continue for a prolonged period of time, the Red Cross may provide food and other support to responders through operation of an Emergency Response Vehicle.

3.10 Family Assistance Center (FAC)

Word of a possible Mass Casualty/Mass Fatality incident will spread quickly and families and friends of possible victims are likely to gather at the scene. At MCI Level 2 and above, Unified Command should consider requesting assistance from the American Red cross to coordinate and operate a Family Assistance Center to provide information and services to family members of victims or other persons impacted by the incident.

The Family Assistance Center should provide a controlled location where family members can go and await information about their family members. The Family Assistance Center also provides a location where mental health services can be provided and where family members can be shielded from the media. In addition, the FAC provides the opportunity to collect personal information about the victim, allowing authorities to obtain vital information for victim identification.

The size of the FAC should mirror the scale and complexity of the incident. For smaller incidents, a less-capable, less elaborate FAC may suffice. However, any incident with multiple fatalities will draw family members to the scene, so Unified Command should always be prepared to provide support to some family members.

Law enforcement will establish security and access control at the Family Assistance Center. Entry should be limited to authorized personnel and family members only. There should be a constant security presence on-site at the FAC.

At the time of the incident, the Unified Command or other delegated individuals will select a site for the FAC. This site is based on the type, size, and location of the incident. Ease of access to the facility and availability of internet and other services are also determining factors. A FAC must comply with the Americans with Disabilities Act (ADA). Once the FAC site is selected and the Coroner approves the site, the FAC Supervisor should request the needed supplies, equipment, and technical support through the command staff.

There are no established guidelines for square footage of a potential FAC site. However, it is estimated that there will be an average of 10 family members and friends at the FAC per deceased individual. An estimated fatality rate for the incident should be used to estimate the number of individuals that the FAC site will need to accommodate. Ideally, there will be several small rooms to conduct interviews, counseling, office work, and other FAC activities.

Staffing may be provided by a variety of human services agencies and non-governmental organizations (NGOs).

Patrons entering the FAC should be managed in an orderly fashion. Coordination with the American Red Cross Safe and Well Website will assist in distributing information to family members. It is critical that patrons receive a continuous flow of information and understand the identification process. **Family Briefings** help to meet this need. It is imperative that information is provided to the families as soon as possible and before being released to the media.

The Public Information Officer (PIO) or designated representative should lead family briefings and bring patrons up to date on the latest developments. A conference call bridge may be set up in the briefing room to connect to family members who are not on site. Family briefings should be conducted at least once daily, ideally at the same time each day, and in between the noon and evening news broadcasts if possible. In order for families to feel that they are being kept fully informed, briefings should be held even if there is no significant news to report. The briefing location and times should be posted throughout the FAC.

Topics for Family Briefings should include: rescue and recovery efforts, victim identification efforts, investigation updates, site visits, memorial services, disposition and return of remains, return of personal effects, and a description of services available at the FAC.

Services available at the Family Assistance Center may include information updates on the status of the operation and information on the condition of their family members; grief counseling; and basic physical needs (water, food, communications, medical care, and child care).

Resources that should be available at the Family Assistance Center include:

- Communications systems (telephone, radio, public address system, and internet access)
- Computer and copy machines
- Furniture (desks, chairs, sofas, etc)
- Paper goods (cups, tissues, etc)
- Food (meals, snacks, and beverages)
- Children’s activities
- Signage and badging

3.10.A. Temporary Reception Center

A Temporary Reception Center should be established to provide victims and family members with information and immediate attention until the Family Assistance Center is established. A limited number of staff and services should be allocated to the Temporary Reception Center since the primary focus will be on establishing the Family Assistance Center.

The Reception Center staff must advise family members that a more permanent Family Assistance center is being developed. Staff should turn away any news media representatives or attorneys who try to enter the Center.

3.10.B. Survivor Area

A survivor area may be established near the scene so that survivors have a place where they can be isolated from response operations, the media, etc. The site can be something as simple as a bus parked near the incident scene that could be used until a FAC can be established.

Survivors of an incident that do not require transportation to the hospital may be reluctant to leave the incident scene, especially if they believe that a friend or family member is one of the fatalities. Counselors/clergy should be available to work with the survivors to help alleviate their fears and to assure them that the remains of their family member(s) or friend(s) will be handled with dignity.

3.10.C. Demobilization of the Family Assistance Center

Demobilization of the Family Assistance Center should begin when the following criteria have been met:

- Daily briefings are no longer needed.
- Rescue, recovery, investigations, and identification issues have decreased to the degree that ongoing operations can take place at the Coroner's office.
- Memorial services have been arranged for family and friends.
- Provision for the return of personal effects has been arranged.
- Ongoing case management and/or a hotline number has been established (if needed).

3.11 Resource Requests

The Unified Command will advise the Medina County Emergency Management Agency when additional resources are required. The Medina County Emergency Management Agency will coordinate resource requests and will notify the State EOC of the status of the operation and the need for assistance.

3.12 Demobilization

Planning for demobilization should begin early in the operation to ensure that resources are returned to the proper agencies and responders have an opportunity to decompress.

Once all survivors have been removed, the incident scene will be secured and access restricted to facilitate further investigation and removal of the remains.

Law enforcement should maintain site security until all of the appropriate authorities have released control of the scene. The Unified Command is responsible for ensuring that all records and other documentation are properly completed and collected.

All incident workers should attend a Critical Incident Stress Debriefing (CISD).

The Unified Command should schedule an After-Action Review (AAR) or critique of the Mass Casualty/Mass Fatality incident. The Medina County EMA may assist in the preparation and conduct of the AAR.

The Planning Section is responsible for developing the Demobilization Plan. Factors to consider during Demobilization include:

- Priority release of personnel and units
- Need for resources to be sent to other incidents
- Feasibility of demobilization schedule
- Inspection and replacement of equipment and medical supplies
- Completion of ALL documentation
- Disposing of medical waste
- Restoration of area to pre-incident conditions

A careful demobilization will facilitate an effective transition to normal operations.

3.13 Special Considerations

3.13.A. Burn Victims

The Cleveland Clinic Medina Hospital will notify Akron Children's and Metro Health's Burn Units of the incident and will ascertain bed availability.

3.13.B. Active Shooter

A Mass Casualty/Mass Fatality incident that is the result of an active shooter requires special response operations. These attacks may cause multiple casualties requiring extensive triage, treatment and transportation efforts.

Although Active Shooter attacks usually end within a few minutes from the time they begin, the incident and response actions may play out over an extended period of time. Also, they may include a 'direct threat' or 'hot zone' with an ongoing active shooter(s) and a 'warm zone' where victims are located.

Managing the results of an active shooter situation will require close collaboration between law enforcement and emergency medical responders. A Unified Command should be established with Law Enforcement (LE) as lead operational component. The UC/LE lead determines the objectives and operations.

Key considerations:

- A scene is not considered secure until a deliberate search of the entire area is concluded.
- The Staging Area should provide hard cover and concealment from perpetrators.
- Medical assets are typically staged a safe distance from the threat, out of sight of any potential shooter if possible. However, in some situations a more aggressive EMS operation may be considered if the risk to responders can be mitigated permitting rapid triage, treatment, and transport of victims.
- Patients should be removed from the danger zone in a manner consistent with predetermined agency training and standards of practice. Law Enforcement officers may bypass casualties in order to eliminate the threat.

- Point-of-wounding medical stabilization should occur prior to evacuation to the Casualty Collection Point, which should provide cover to the injured and responders and be secured by LE officers.

Several Medina County communities have trained first responders to create a Rescue Task Force of specially trained and equipped EMTs that will go into a "warm zone" to rescue casualties. Some departments have purchased body armor for their ambulances so the responding personnel can be part of an RTF.

3.13.C. Crime Scene Preservation

Regardless of cause, a Mass Casualty/Mass Fatality scene should always be treated as a crime scene. The site should be maintained intact and minimally disturbed during the removal of survivors. Exceptions may be made in the case of natural disasters

Every effort should be made by all personnel responding to a Mass Casualty/Mass Fatality incident to limit disruption of any potential evidence. It is recognized that life safety including rescue and extrication of the injured may result in some unintended disruption of the scene.

No property, body parts, or other items should be removed unless they are critical to the recovery of a survivor. In that case, they may be transported to the hospital with the victim. Such items should be documented and tracked so that arrangements can be made for their return to the incident scene or other designated location.

Incidents resulting from an act of terrorism will involve the Federal Bureau of Investigation (FBI) as the lead investigative agency.

3.13.D. Extrication

The first priority following scene safety is to locate patients and remove them from any immediate physical danger. Some victims may be trapped in a vehicle, a collapsed building, or a Hazardous Material situation.

If extrication is required, an Extrication Unit Leader should be assigned. Extrication efforts should be conducted by the Medina County All-Hazards Team. Trapped victims requiring prolonged extrication should receive advanced life support care as required and feasible.

The Extrication Unit Leader and the Safety Officer are responsible for the safety of all those within any hazard zone.

Extrication of the deceased prior to the arrival of the Coroner should be performed only when necessary.

3.13.E Search and Recovery

Some Mass Casualty/Mass Fatality incidents will cover a large area that will need to be searched for victims, human remains, evidence, and personal effects of victims.

The size and scope of the search and recovery operation will be determined by the incident size, the condition of remains and/or the search and recovery environment. If Unified Command determines that local resources are insufficient to conduct the required search and recovery operations, the UC may request that the Medina County Emergency Management Agency request state assistance. State resources include recovery teams from the Ohio Mortuary Operations Team or one of the nation's Urban Search and Rescue Task Forces.

The State of Ohio and the Federal Government operate 28 highly-capable deployable Urban Search and Rescue Task Forces. One of those task forces – OH Task Force – 1 - is stationed in Ohio and is prepared to deploy within six hours.

Urban Search and Rescue Task Force capabilities include:

- Physical search and rescue operations in damaged/collapsed structures
- Emergency medical care for entrapped survivors, task force personnel and search canines
- Reconnaissance to assess damage and needs, and provide feedback to local officials.
- Assessment/shut-off of utilities to houses and other buildings
- Hazardous materials surveys/evaluations
- Structural/hazard evaluations of buildings needed for immediate occupancy to support disaster relief operations
- Stabilization of damaged structures, including shoring and cribbing operations on damaged buildings
- Hazardous Materials Equipment Push Packages for operations in a contaminated environment
- Search and rescue operations in a water environment

3.13.F. Hazardous Materials (HAZMAT)

Mass Casualty/Mass Fatality incidents may involve sites that are contaminated by HAZMAT. HAZMAT may range from mild irritants to highly toxic and lethal substances. Prior to any incident site processing, the area must be examined by trained HAZMAT personnel to determine if hazardous materials are present.

When hazardous materials are present or suspected at a Mass Casualty/Mass Fatality incident, the Medina County All-Hazards Team should be deployed to determine if hazards exist, what those hazards may be, and what should be done to mitigate the effect of the hazards.

If there is any suspicion of a hazardous materials spill, responders should stay away. Unless responders have received training in handling hazardous materials and can take the necessary precautions to protect themselves, they should keep far away from the contaminated area or "hot zone".

During a hazardous materials incident, responders must wear personal protective equipment (PPE).

Trained units on scene prior to the arrival of the All-Hazards Team may be able to identify hazardous materials present by locating hazardous material signs required on all vehicles or containers that contain significant quantities of hazardous materials.

Once the appropriate protection of the responders has been accomplished, triage and treatment in the hot zone should be limited to rudimentary airway management (opening) and then evacuation to a safer area.

Secondary triage can occur after decontamination has been conducted.

3.13.G. Decontamination

Decontamination is the physical or chemical process of removing, reducing, or preventing the spread of contaminants from people, equipment, structures, the environment or anything else that may be contaminated.

All patients must be decontaminated prior to entry into the Triage or Treatment Areas. Initial triage may be conducted during decontamination.

The goals of decontamination are to:

- Remove the agent from the patient's skin and clothing, thereby reducing further possible agent exposure and further effects among victims.
- Protect emergency responders and medical personnel from secondary contamination.
- Provide patients with psychological comfort at, or near, the incident site, so as to prevent them from spreading contamination over greater areas.

If decontamination is necessary, NO ONE should by-pass the decontamination system.

3.13.H. Debris Removal

The Medina County Engineer may be requested to conduct debris removal during a Mass Casualty/Mass Fatality incident. The request to the Engineer should be made by Medina County EMA.

3.13.I. Mass Transportation

The Transportation Unit may transport patients who do not require immediate medical attention, such as GREEN or "walking wounded" via mass transportation resources. Consider utilizing the following resources for mass transportation:

1. Medina County Mass Transit System vehicles
2. School buses

Section 4.0: Responsibilities

A successful response to mass casualty/mass fatality incidents requires coordination of effort and a clear understanding on the part of all agencies and personnel of their responsibilities.

4.1 Organizational Responsibilities

In the event of a mass casualty/mass fatality incident, numerous county agencies and organizations will participate in the county's response.

4.1.A. American Red Cross

Red Cross volunteers and staff members support mass casualty/mass fatality incident response by assisting hospitals in tracking patients, reunifying families, and providing comprehensive support to victims and their families through operation of the Family Support Center.

The American Red Cross shall:

- Coordinate the joint Family Support Operations center (JFSOC) and participate in leadership on that team.
- Coordinate and operate the Family Assistance Center (FAC)
- Support Health, Mental Health, Disaster Assistance, Canteening (disaster Nutrition), and Spiritual Care for the victims, families, responders, and morgue staff.
- Lead and operate reunification efforts.
- Coordinate within the JFSOC model to support site operations for memorials, gatherings, and site visits.

4.1.B. Medina County Coroner

The Medina County Coroner is responsible for the collection, storage, and disposition of all human remains and victim's personal effects in coordination with local law enforcement agencies. The Coroner's Office will provide advice and assistance to Unified Command during Mass Casualty/Mass Fatality incidents.

The Coroner and Unified Command will determine whether local resources and capabilities will be sufficient. If additional resources are needed, representatives from the Coroner's office will request assistance as required.

The Coroner is responsible for making appropriate notifications and for determining the cause of death, completing required reports, ensuring issuance of death certificates, and arranging for release or disposition of personal effects.

The Coroner shall:

- Investigate deaths that are not due to natural causes or that do not occur in the presence of an attending physician.
- When authorized by officials and the family, assist with the preparation processing and release of human remains for final disposition.

- Release human remains and personal effects of victims to the next of kin or their representative.
- Determine the cause and manner of death, authorizing autopsies to determine the cause of death, authorizing forensic investigations to identify unidentified bodies, and authorizing removal of bodies from incident sites.
- Coordinate with mortuary service providers to collect bodies of victims from the scene and from hospitals (including stand-alone emergency departments), morgues, incident morgue facilities and other locations.
- Ensure that proper victim identification forms are used and that ante-mortem interviews are completed using the proper forms at the FAC.
- Coordinate with law enforcement to ensure security at the scene, the morgue site, and at family assistance centers.

4.1.C. Emergency Medical Services (EMS)

Emergency Medical Service agencies respond to the scene, conduct all EMS functions, and may assume Incident or Unified Command.

4.1.D. Fire Departments

Fire departments conduct all fire suppression, search and rescue, technical rescue, and hazardous materials response activities. They respond to the scene and may assume Incident Command or Unified Command. Fire departments stabilize the incident scene, assist with triage and treatment, assist with protection of the incident site, and assist with search and rescue when required.

A fire apparatus typically consists of a minimum of three (3) firefighters, one of whom is assumed to be qualified as a company level officer. Additional manpower is encouraged. In a Mass Casualty/Mass fatality incident the Engine Company can expect to be used both as manpower and to perform patient care to their level of training.

4.1.E. Law Enforcement

Law enforcement investigators will process death scenes to properly document the site and record, collect, and safeguard evidence. The Coroner will assume responsibility for the victims and associated personal effects (PE). Any PE having potential value as evidence will be collected by law enforcement as part of their investigation. Recovery assets must be mindful of crime scene preservation techniques and exercise caution to protect potential evidence as they conduct their operations.

Investigation efforts take precedence over human remains recovery when those tasks are assigned to separate teams.

Local law enforcement is also responsible for security at the incident scene, the morgue site and at Family Assistance Centers. These responsibilities include assuring ingress and egress for responders, establishing inner and outer perimeters, controlling scene access, preserving the scene, rerouting traffic around the incident perimeter, maintaining security at staging areas, and assisting with search and rescue.

A senior law enforcement officer will generally serve on the ICS command staff, and a law enforcement officer may serve as part of Unified Command. If the incident is a possible criminal/terrorist act, a law enforcement agency will serve as lead agency and as part of Unified Command.

4.1.F. Medina County Emergency Management Agency (MCEMA)

Medina County EMA will obtain resources at the local, state, or federal levels, including governmental, non-governmental, private sector, and volunteer resources. Medina County EMA is the link between Unified Command and the resources available under the National Response Framework. In support of the UC, MCEMA may recommend declarations of emergency, ensure information flow, maintain situational awareness, and document emergency information.

MCEMA may activate the county's Emergency Operations Center to provide a central point for emergency management operations, including managing resource requests and developing and disseminating daily situation reports. MCEMA may also activate the county's Joint Public Information System.

MCEMA also has two volunteer groups, Community Emergency Response Team (CERT) and the EMA Communication Unit, which function under the authority of MCEMA.

4.1.G. Medina County Health Department

During a Mass Casualty/Mass Fatality incident the Medina County Health Department will coordinate the delivery of mental health services to survivors, families of victims, and responders. The Health Department may also assist the County Coroner's office by coordinating and expediting temporary or emergency burial operations and tracking disposition of remains. Health Department personnel may also assist hospitals by coordinating medical surge efforts and assisting in patient tracking.

The MCHD Office of Vital Statistics will assist with administrative tracking of the disposition of remains as deemed necessary by the Health Commissioner utilizing the web-based **Electronic Death Registration System (EDRS)**. Reports generated by the EDRS system will be available to all necessary entities through the Regional Vital Statistics Centers.

The Medina County Health Department shall:

- Issue orders for temporary interment of the deceased when available burial resources and systems cannot keep up with demand
- Issue disposition certificates
- If ordered by the Coroner, coordinate mass burial operations.
- Work with other support agencies to ensure proper credentialing of persons who volunteer to assist at the scene or at a Family Assistance Center.
- Provide assistance to ensure that proper victim identification forms are used and that ante-mortem interviews are completed using the proper forms at FACs.
- Assist in identifying and facilitating the use of county assets during a mass fatality incident.
- Provide assistance to make estimates of the number of confirmed deaths using the EDRS system and information from the Incident Commander in consultation with the Coroner and provide the estimate to the Public Information Officer for proper dissemination.

4.1.H. Medina County Engineer

During a Mass Casualty/Mass Fatality incident the Medina County Engineer may assist response efforts by providing equipment, personnel, and other resources for heavy rescue operations, debris removal, repairs to bridges and roads, and traffic control.

4.1.I. Medina County All-Hazards Team

The Medina County All-Hazards Team provides technical rescue and hazardous material response services throughout Medina County during Mass Casualty/Mass Fatality incidents. The team provides technical assistance to the Unified Commander, conducts rescue and extrication operations, identifies potentially hazardous materials, conducts operations to prevent/mitigate exposure to hazardous materials, conducts decontamination, and assists with triage and treatment of survivors.

4.1.J. Coordinating Hospital (Cleveland Clinic Medina Hospital)

The coordinating hospital in a Mass Casualty/Mass Fatality incident will be Cleveland Clinic Medina Hospital. The Coordinating Hospital will coordinate communications and victim movement between the scene and all potential receiving facilities.

Hospital personnel work with the Transportation Unit Leader of the Incident Command Staff to coordinate communication and victim movement and distribute patients in rotation to medical treatment facilities.

Upon receipt of a notification of a Mass Casualty/Mass Fatality incident, the Coordinating Hospital shall notify all potential receiving hospitals of the situation, the nature of the incident, and the estimated number of victims. The Coordinating Hospital will ask all potential receiving hospitals for bed availability and will advise the Transportation Unit Leader at the incident scene of the status of all receiving hospitals.

4.1.K Receiving Hospital

Any hospital that receives patients from a Mass Casualty/Mass Fatality incident is considered a Receiving Hospital, including the Coordinating Hospital.

Receiving Hospitals treat patients sent to them by the Transport Unit and follow pre-determined communications, notification, and documentation procedures.

4.1.L. Dispatch

Dispatch centers dispatch appropriate units, providing pre-arrival information and instructions, maintain situational awareness, and make required notifications. During the incident Dispatch will advise public safety units of changing conditions, and respond to requests from Unified Command for additional resources by following mutual aid protocols or other resource request procedures.

Throughout the incident Dispatch will also perform regular non-incident duties.

4.1.M Critical Incident Stress Management Teams

Critical Incident Stress Management teams may be asked to respond to Medina County to provide stress management services for emergency service personnel. CISM teams are typically composed of first responders and mental health professionals. The following CISM teams will respond to requests for support from Medina County agencies:

- Westshore Critical Incident Response Services: **440-333-1237**
- Stark County Critical Incident Stress Management Team: **330-452-6000**

Medina County officials can also contact the Ohio CISM Network at **800-367-6524** and representatives there will contact an available team.

4.1.N. Funeral Providers

Private funeral providers may transport human remains from incident site to body collection point, temporary morgues, or county morgue as directed by the Coroner.

4.1.O. Host Jurisdiction

Under the National Response Framework, the primary responsibility for managing disasters – including mass casualty/mass fatality incidents – lies with the local community where the disaster has occurred. The host jurisdiction will provide the initial responding units and the initial Incident Commander.

While other communities and county, state, and federal agencies are available to assist, the overall management of the incident will remain the responsibility of the host jurisdiction.

In addition to managing the incident scene, the host jurisdiction will be responsible for assigning a Public Information Officer, establishing a Family Assistance Center, documenting the incident response, coordinating resource requests with the Medina County EMA, conducting a post-incident After-Action Review (AAR), and managing the community's recovery.

4.2 Position Responsibilities

The following sections describe the primary responsibilities of key positions.

4.2.A. First Units on Scene

Reports to Incident Commander (upon arrival), then as assigned

The primary responsibilities of the first units on scene at a Mass Casualty/Mass Fatality incident are to rapidly assess the situation and provide an accurate and succinct report to Dispatch.

Upon arrival on scene, the initial actions of the first responding units include:

- Conduct initial assessment
- Determine if the scene is safe to enter
- Confirm actual Mass Casualty / Mass Fatality incident

- Give an initial radio report of the overall situation
- Estimate the number and severity of patients
- Establish command (per department SOP) until properly relieved
- Establish an Incident Command Post (ICP)
- Activate the Mass Casualty/Mass Fatality Plan
- Keep Dispatch informed

The secondary actions of the first unit on scene include:

- Isolate 'walking wounded' (if possible)
    - *Ask anyone who can walk to go to a designated area*
- Begin triage of severely injured persons
- Assume role of Triage Unit Leader until relieved
- Direct Mass Casualty/Mass Fatality scene set-up
- Identify ingress and egress routes
- Establish staging area
- Identify areas for triage, treatment, and transport
- Request additional resources as necessary

4.2.B. Incident Commander/Unified Command

Manages all aspects of the operation.

The Incident Commander or Unified Command are responsible for all incident activities, including developing strategies and tactics and the ordering and the release of resources.

The Incident Commander or Unified Command will determine whether additional assistance is and if so, what resources are necessary.

- Upon arriving on scene, the Incident Commander should obtain a briefing from the prior IC, assess the situation, relieve the prior IC, and advise Dispatch that they have assumed Incident Command.
- Initially, the IC will direct all tactical operations until additional staff officers become available.
- The IC shall request additional officers to fill IC staff positions via Chiefs Box
- The IC shall assign officers to staff positions, starting with Triage, Treatment, Transport, and Staging.
- Later, when additional officers are available, the IC shall assign an EMS/Medical Group Leader (to oversee Triage, Treatment, and Transport) and a Medical Supply Officer
- The IC shall ensure that the ICP is visible and recognizable
- The IC shall advise Dispatch of the number of victims and their categories (Red, Yellow, Green, Black) and shall provide updates as information changes.
- When appropriate, the Incident Command will transition to Unified Command

The Incident Commander/Unified Command responsibilities include:

- Ensuring incident safety
- Establishing immediate priorities
- Determining objectives and strategy
- Approving the Incident Action Plan

- Approving requests for additional resources
- Authorizing release of information to news media
- Ordering demobilization of the incident when appropriate
- Ensuring incident after-action reports are complete

4.2.C Medina County Coroner

Has jurisdiction for mass fatalities in Medina County.

The Medina County Coroner works closely with Unified Command, Law Enforcement, and community partners to ensure proper handling of deceased persons and full compliance with regulations and other requirements.

The Coroner will assess the situation and will determine when remains may be moved and where they should be moved to.

If the Coroner determines that the number of fatalities exceeds local capabilities, the Coroner may ask the Medina County Emergency Management Agency to request state-level assistance.

4.2.D. Triage Unit Leader

Reports to the Incident Commander/Unified Command or to the EMS/Medical Group Supervisor (when assigned). Supervises EMS Triage personnel and Temporary Morgue Team Leader

The first available paramedic should be assigned to supervise the Triage Unit. Triage should begin immediately and the first arriving units should be organized as a Triage Team. As additional EMS personnel arrive, they should be assigned to assist.

The Triage Unit Leader is responsible for initiating and directing the rapid assessment and categorization of all patients and the tagging and movement of victims to the Treatment Area.

The Triage Unit Leader shall:

- Assemble the walking wounded and uninjured in a safe area.
- Organize the Triage Team and Litter Bearer Teams to begin the initial triaging of victims, utilizing the S.T.A.R.T. and JumpSTART triage systems.
- Assign early arriving EMTs to initiate field triage. If non-EMT personnel are available, they can assist by moving victims, maintaining documentation, or attaching tags to patients.
- If danger exists, ensure all patients are moved out of the incident area before establishing triage.
- Obtain medical supplies from the Treatment Team for Triage Areas.
- Coordinate with the Treatment Unit Leader to assure proper patient designation and ensure that priority victims are treated first.
- Direct movement of patients to proper Treatment Areas.
- Maintain communications with Extrication and Treatment units. Provide frequent progress reports to UC or EMS/Medical as appropriate.
- Leave all black-tagged victims in place unless they need to be moved to assist viable victims.
- Ensure that all patients are tagged.
- Establish Temporary Morgue.
- Advise UC or EMS if there is a need for additional resources.

- Account for all personnel assigned to Triage and monitor the welfare of assigned personnel. Request relief crews to maintain safety and mental health of personnel and maintain progress toward group objectives. The Litter Bearer function is especially exhausting - consider frequent relief.
- Document unit activity on ICS Form 214.
- Ensure that all areas around the Mass Casualty/Mass Fatality incident scene have been checked for potential victims, walking wounded, ejected victims, etc., and that all victims have been triaged.
- Report to UC or EMS upon completion of duties for further assignments

4.2.E. Treatment Unit Leader

Reports to the Incident Commander/Unified Command or to the EMS/Medical Group Supervisor (when assigned). Supervises EMS Treatment personnel and Medical Supply Unit

The Treatment Unit stabilizes patients before they can be transported to hospitals or other medical treatment facilities by conducting continuous assessment and by beginning stabilizing and/or definitive treatment based on established priorities and available resources. The Treatment Unit Leader also determines priority for transportation to medical facilities.

The Treatment Unit Leader shall:

- Establish and direct the Treatment Teams
- Establish a Treatment Area subdivided unto Red (Immediate), Yellow (Delayed), and Green (Minor) areas of sufficient size to enable medical personnel to move about. The Red Area should be located closest to transport. Mark areas for each triage category using colored tarps, flags, tape, etc.
- Account for all personnel assigned. Monitor the welfare of assigned personnel and request relief crews as necessary.
- Ensure patients are re-triaged as they enter the Treatment Area and the assessment is documented on the triage tag.
- Order and maintain appropriate amounts of medical supplies. When personnel are available, assign a Medical Supply Coordinator.
- Control patient flow by creating pathways with cones, hoses, or other markers and monitoring Treatment Area entrances and exits.
- Communicate with Transport to coordinate proper transport of victims.
- Ensure that all Red-tagged victims are transported as soon as as transport units become available.
- Coordinate patient loading with the Transport Unit leader and assist in moving patients to transport area.
- Continually reassess patients' conditions and priorities.
- Provide periodic updates to Unified Command or EMS/Medical as appropriate.
- Appoint immediate, delayed and minor care managers as needed.
- If the number of patients in the Treatment Area is large, consider assignment of a Treatment Dispatcher to coordinate with the Transport Group (or Transport Dispatcher) on the priority movement of patients.
- Document unit activity on ICS Form 214.

4.2.F. Transportation Unit Leader

Reports to the Incident Commander/Unified Command or to the EMS/Medical Group Supervisor (when assigned). Supervises Staging Team Leader, Air Ambulance Coordinator, Ground Ambulance Coordinator, Patient Tracking Team Leader, and Transport Dispatcher

The Transportation Unit Leader directs the movement of all victims from the victim collection area and/or Treatment Area to the receiving hospitals and handles staging of air and ambulances until an Air Ambulance Coordinator and a Ground Ambulance Coordinator are assigned.

The Transportation Unit Leader shall:

- Establish Ambulance Staging Area and appoint Staging Team Leader. Ensure that drivers remain with units. They have one job – transport.
- Establish transport vehicle flow from Ambulance Staging Area to Treatment Area and from the Treatment Area to Hospitals in cooperation with law enforcement.
- Assign personnel (as they become available) to Transport Teams; Staging, Patient Tracking, Transport Dispatch, Ground and Air Ambulances coordination.
- Contact the Cleveland Clinic Medina Hospital via MARCS Radio Medina County TAC-9 to coordinate patient transport.
- Arrange transportation of patients in priority order determined by Treatment Officer.
- Assign patients to transport units based on patient needs and capabilities of available vehicles.
- Assign transport units to hospitals in coordination with Incident Transport Officer at Cleveland Clinic Medina Hospital.
- As patients are transported from the scene, notify the Coordinating Hospital of the transporting department, number of victims, tag color, brief description of injuries, and the Receiving Hospital. (*Example: Medina Medic 1 will be transporting one red with severe head injury, to Medina Hospital*).
- Ensure patient information and destination are recorded.
- Inform transport crews of their destination and of refueling/restocking sites (if necessary)
- Remind ambulance crews that they do not need to contact receiving facility unless patient status changes.
- Maintain close communications with Treatment and Staging Units and with the EMS/Medical Group.
- Provide periodic updates to Unified Command or EMS/Medical as appropriate.
- Designate a Transport Dispatcher if needed.
- Request additional ambulances, as required
- Document patient and unit movements and destination in Transportation Log
- Document unit activity on ICS Form 214.

4.2.G. Staging Team Leader

Reports to Transportation Unit Leader

The Staging Team Leader is responsible for the check-in of all in-coming transport units, making requests for additional transport resources, and the dispatch of transport units at the request of the Transportation Unit Leader. The first task of the Staging Team Leader, in consultation with the Transportation Unit Leader, is to identify one or more Staging Areas and Loading Areas with adequate road access.

The Staging Team Leader shall:

- Identify and secure a Staging Area with clear avenues in and out of Loading Areas. Ensure that all personnel stay with their vehicles unless otherwise directed
- Coordinate with law enforcement for traffic control.
- Organize apparatus in Staging Area for ease of exit to prevent congestion.
- Track all resources in Staging and Area report inventory to Transport Group Supervisor.
- Ensure that each ambulance is properly staffed and equipped.
- Allocate staged resources in response to requests.
- Maintain personnel accountability.
- Advise Transportation Unit Leader when resources of a particular type are nearly exhausted.
- Maintain radio contact with incoming ground and air ambulances, and keep the Transport Unit Leader (or Transport Dispatcher) advised of status of ambulances' arrivals and departures.

4.2.H. Extrication Unit Leader

Reports to Unified Command and then to EMS/Medical Group Supervisor (when assigned)

The Extrication Unit Leader is responsible for the disentangling and extraction of patients that are trapped by debris or wreckage. Trapped victims requiring prolonged extrication should receive advanced life support care as required.

The Extrication Unit Leader and the Safety Officer are responsible for the safety of all those within any hazard zone.

The Extrication Unit Leader shall:

- Supervise and coordinate the extrication process.
- Assist Triage Unit Leader in determining if triage can be conducted at the incident site or if victims must be moved to a safe area prior triage.
- Locate and remove trapped victims/patients and deliver them to the treatment area.
- Assist in determining need for emergency medical care for patients undergoing extended/delayed extrication and request additional medical resources.
- Maintain patient and team safety during all phases of the extrication.
- Request relief crews to maintain progress towards extrication objectives.
- Request specialized equipment and/or supplies.
- Request additional manpower and/or fire suppression personnel to protect entrapped victims during the extrication process.
- Provide essential and frequent progress reports to Triage and EMS/Medical Group Supervisor as appropriate

4.2.I. Law Enforcement Unit Leader

Reports to Unified Command and then to Operations Section Chief (when assigned)

The Law Enforcement Unit Leader is responsible for maintaining security of the scene, controlling access, maintaining traffic flow, and preserving the scene for later investigations.

The Law Enforcement Unit Leader shall:

- Supervise and coordinate the establishment of inner and outer perimeters, access control points, and operations to secure and protect the incident scene.
- Assist Staging Team Leader in maintaining traffic control
- Assist Transportation Unit Leader in establishing transport vehicle flow from Ambulance Staging Area to Treatment Area and from the Treatment Area to Hospitals.
- establish an Entry Control Point on the outer perimeter to limit access to the site to authorized personnel.
- Provide security personnel for the Staging Area and the Family Assistance Center
- Limit destruction of any potential evidence throughout the incident site.
- Ensure that no items are removed from the scene unless they are critical to the recovery of a survivor. If any items are removed from the scene, ensure that they are documented and tracked.
- Assist with search and rescue operations.

4.2.J. EMS/Medical Group Supervisor

Reports to Unified Command or Operations Section Chief (if assigned). Supervises Triage Unit Leader, Treatment Unit Leader, Transport Unit Leader, and Extrication Unit Leader.

The EMS/Medical Group Supervisor is responsible for all EMS-related activities and for directing the activities of the Medical Group. On small incidents these responsibilities may be assumed by the Incident Commander.

The EMS/Medical Group Supervisor shall:

- Establish and supervise the medical response, including triage, treatment, transportation, extrication, and temporary morgue operations.
- Ensure resources are sufficient to handle the magnitude of the incident.
- Request additional assistance through Unified Command as required
- Appoint Triage, Treatment, and Transport Unit personnel as necessary.
- Ensure that Dispatch has been notified with exact number of victims and their categories.
- Designate appropriate on-scene locations for triage, treatment, and transport.
- Ensure hospital notification and communication.
- Determine amount and types of additional medical resources, supplies, and specialized resources from hospitals (medical caches, helicopters etc.).
- Establish liaisons with on-scene agencies, such as Coroner’s Office, Law Enforcement, EMA, County Health Dept., ambulance companies, etc.
- Ensure that proper security, traffic control, and access have been established.
- Report and provide frequent updates to the Unified Command or Operations Section Chief.
- Account for all personnel assigned to this group.
- Monitor safety and welfare of group personnel - consider relief crews.
- Document unit activity on ICS Form 214

4.2.K. Public Information Officer

Reports to the Incident Commander or Unified Command

The Public Information Officer (PIO) is responsible for developing and disseminating factual and timely information about the incident to the news media and other appropriate agencies. No other member of the

command staff or supporting units, except the Unified Command, should provide statements to the news media without authorization from the PIO.

The Public Information Officer shall:

- Establish a media area away from the Incident Command Post, treatment areas, the Family Assistance Center, or the rehabilitation area.
- Establish a single telephone number that can be released to the public for information.
- Develop and maintain a complete and accurate understanding of the operation.
- Serve as the single point of contact for media inquiries.
- Obtain Unified Command approval before releasing information.
- NEVER release the names of patients.
- Facilitate interviews, brief responders, and document actions.
- Maintain copies of all media releases for inclusion in the final incident package.
- Establish a schedule for periodic news briefings if the operation will be sustained.

Information that is typically released to the news media includes:

- Time of incident
- Type of incident
- Scope of incident
- Location of incident
- Number of public safety personnel on scene
- Rescue efforts underway
- Amount of equipment
- Number of people rescued/injured
- Nature of injuries
- Hospital(s) to which injured patients(s) are taken

4.2.L. Temporary Morgue Team Leader

Reports to the Triage Unit Leader

The Temporary Morgue Team Leader is responsible for establishing and maintaining a Temporary Morgue Area, coordinating the management of the deceased, and providing security for bodies and personal effects. The Temporary Morgue Team Leader will work closely with the Coroner and will conduct all operations in strict compliance with Coroner directives. The Temporary Morgue will remain in operation until the Coroner can arrange appropriate long-term storage.

The Morgue Team leader shall:

- Establish a Temporary Morgue Area remote from the treatment site and not readily accessible to other victims. A sheltered area within the outer perimeter is preferred. The Temporary Morgue site should be accessible to vehicles and must be large enough to accommodate the anticipated number of deceased persons.
- Coordinate with the Coroner
- Coordinate with law enforcement to ensure security of the Temporary Morgue.
- Coordinate disposition of patients who die in the Treatment Area.
- Maintain records, including victim’s identities (if available), location found, personal effects, etc.
- Maintain secrecy regarding identification and personal information of victims.

- Maintain dignity of the deceased. Place bodies in body bags or cover with disposable, non-absorbent sheets.
- Ensure that no bodies are moved from the incident site prior to approval from the Coroner.
- Maintain communications with EMS / Medical, Triage, and Treatment.
- Coordinate removal of deceased persons to long-term storage facilities when directed by Coroner.
- Document unit activity on ICS Form 214

4.2.M. Patient Tracking Team Leader

Reports to the Transportation Unit Leader

The Patient Tracking Team Leader is responsible for accurately recording the status of and tracking the location of patients from the beginning of the incident response to acceptance at a care facility.

The Patient Tracking Team Leader shall:

- Assist the Transportation Unit leader with patient tracking documentation and communications.
- Maintain and coordinate patient information and destinations.
- Document all victim / patient and unit movements.
- Provide Transport Reports to Dispatch to include:
    - Unit Transporting
    - Destination Hospital
    - Number of Patients
    - Patient Information (Age, Gender, Triage Category, Major Injury / Illness Triage tag number)
    - ETA
- Communicate patient medical information to care facilities and family reunification.

Communications support may be requested from the Medina County EMA Communications Unit.

For larger, more complex incidents, a separate Transport Dispatcher may be assigned. In that case, the Transport Dispatcher focuses on radio communications while the Patient Tracking Team Leader focuses on documentation.

4.2.N. Safety Officer

Reports to the Incident Commander

The Safety Officer is responsible for monitoring and assessing safety hazards or unsafe situations and for developing measures for ensuring responder safety. The Safety Officer must have incident-specific training and knowledge.

The Safety Officer shall:

- Identify and coordinate the correction of any health and safety hazards affecting responding personnel at the incident.
- Prepare and disseminate safety messages and/or briefings.
- Ensure appropriate levels of PPE are available and are being used properly.
- Observe operations on the scene and ensures a safe environment for all personnel.
- Take immediate corrective action or stop unsafe situations or practices.

- Monitor hazardous/toxic environments and exposure levels of emergency personnel
- Ensure that responders are promptly notified of any immediate safety hazard and given appropriate instruction and/or alternatives.
- Document any injury involving responders and ensure that Unified Command has been notified.
- Coordinate Critical Incident Stress Management (CISM)/Mental Health debriefings.
- Participate in post-incident debriefings to review safety issues and any incident in which responding personnel were injured.

The Safety Officer has the authority to stop an operation when the health or safety of responding personnel is threatened.

4.2.O Medical Supply Coordinator

Reports to the Treatment Unit Leader

The Medical Supply Coordinator will acquire and maintain control of appropriate medical equipment and supplies.

The Medical Supply Coordinator shall:

- Acquire, distribute and maintain medical equipment and supplies for the Medical Group.
- Request additional medical supplies as required.
- Distributes medical supplies to Treatment and Triage Units.
- Document unit activity on ICS Form 214

4.2.P. Air Ambulance Coordinator

Reports to the Transportation Unit Leader

The Air Ambulance Coordinator manages and coordinates air ambulance operations at the scene of the incident.

The Air Ambulance Coordinator shall:

- Coordinate with Transportation Unit Leader and law enforcement to select and establish a helispot landing area.
- Work with law enforcement to ensure safety and security at landing area.
- Assign personnel to assist in establishing a Landing Zone.
- Establish and maintain radio contact with incoming helicopters
- Coordinate loading and transport of patients with the Transportation Unit.

The first priority for air lifting casualties will be given to patients who have been triaged as RED, and who are physically and mentally fit for air transportation.

LZ requirements will be set by local policy. At a minimum the LZ should be:

- Flat, firm, and free of debris that could blow up into the rotor system (minimum 100x100 ft.)
- Free of any obstructions such as cell tower, power lines, etc.
- At least 300’ from the Treatment Area.

4.2.Q. Ground Ambulance Coordinator

Reports to the Transportation Unit Leader

The Ground Ambulance Coordinator manages the ambulance staging area, dispatches ambulances as requested, and manages all patient movement, including patient loading, from the treatment area to the receiving hospitals.

The Ground Ambulance Coordinator shall:

- Establish appropriate staging areas for ambulances.
- Establish routes of travel for ambulances for incident operations.
- Advise Law Enforcement of staging, routes, etc.
- Coordinate activities with Treatment and Transport Unit Leaders.
- Establish and maintain communications with the Air Ambulance Coordinator regarding Air Ambulance transportation assignments.
- Establish and maintain communications with the Medical Communications Coordinator and Treatment and Transportation Unit Leaders.
- Provide ambulances upon request from the Transportation Unit Leader.
- Keep a record of vehicles and personnel arriving at, dispatched from, and returning to the staging area, e.g.; times, unit number and dept. name, dispatch destination, and any problems.
- Direct personnel upon arrival to keep radio silence unless otherwise ordered.
- Assure that necessary equipment is available in the ambulance for patient needs during transportation.
- Establish contact with ambulance providers at the scene.
- Request additional transport resources as appropriate.
- Provide an inventory of medical supplies available at ambulance staging area for use at the scene
- Maintain records of assigned personnel and levels of training. (An ICS 214 or other form listing assigned personnel and current levels of training may serve as a resource list.)
- Ensure that drivers remain with their vehicles.

4.2.R. Operations Section Chief

Reports to the Unified Command. Supervises EMS/Medical Group Supervisor and Law Enforcement Supervisor

An Operations Section Chief should be assigned when the incident has expanded to the point where Unified Command can no longer directly oversee the Medical Group or when the incident is expected to continue for multiple operational periods.

The Operations Section Chief is responsible for managing all tactical operations at an incident. The Operations Section Chief must have incident-specific training and/or knowledge.

The Operations Section Chief shall:

- Perform duties as directed by the Unified Command
- Ensure safety of tactical operations
- Develop Operations portion of the Incident Action Plan
- Request additional resources to support tactical operations

4.2.S. Planning Section Chief

Reports to the Unified Command

A Planning Section Chief should be assigned when the incident has expanded to the point where the Unified Command needs assistance in developing the Incident Action Plan (IAP) or when the incident is expected to continue for multiple operational periods.

The Planning Section Chief is responsible for tracking resources, collecting/analyzing information, and maintaining documentation. The Planning Section Chief must have incident-specific training and/or knowledge.

The Planning Section Chief shall:

- Collect, evaluate and display incident intelligence and information.
- Prepare the Incident Action Plan (IAP).
- Track resources assigned to the incident.
- Maintain incident documentation.
- Develop plans for demobilization.

4.2.T. Logistics Section Chief

Reports to the Unified Command

A Logistics Section Chief should be assigned when the incident has expanded to the point where the Unified Command needs assistance in managing and tracking resources or when the incident is expected to continue for multiple operational periods.

The Logistics Section Chief is responsible for obtaining and providing resources and needed services to support the achievement of the incident objectives. The Logistics Section Chief must have incident-specific training and/or knowledge.

The Logistics Section Chief shall:

- Order, obtain, maintain and account for essential personnel, equipment and supplies.
- Provide incident communications.
- Arrange food services for responders.
- Arrange and maintaining incident facilities

4.2.U. Finance and Administration Section Chief

Reports to the Unified Command

A Finance and Administration Section Chief should be assigned when the incident has expanded to the point where the Unified Command needs assistance in managing incident finances or when the incident is expected to continue for multiple operational periods.

The Finance and Administration Section Chief is responsible for monitoring costs related to the incident and providing accounting, procurement, time recording, and cost analyses. The Finance and Administration Section Chief must have incident-specific training and/or knowledge.

The Finance and Administration Section Chief shall:

- Conduct contract negotiation and monitor performance.
- Monitor timekeeping.
- Conduct cost analysis.
- Pay compensation for injury or damage to property.
- Maintain documentation for reimbursement — i.e., under Memorandums of Understanding (MOUs).

Section 5.0: Responder Health and Safety

Mass Casualty/Mass Fatality incidents can be extraordinarily stressful for first responders. The combination of large numbers of horrific injuries, the likelihood of fatalities, the unrelenting pace, physical risk, long work hours, and a chaotic operating environment can strain even the most resilient responders. The physical and psychological well-being of responders experiencing this stress, as well as their future ability to function through a prolonged operation, will depend upon how they and their organizations manage this stress.

5.1 Pre-Incident Actions

Public safety organizations can assist responders in building resilience by taking steps to promote a positive workplace environment and reduce stress in the workplace. The United States Department of Health and Human Services recommends that organizations implement a stress management plan that prioritizes environmental and organization health. Key elements of a workplace plan include effective management structure and leadership; clear purposes, goals, and training; team support; and a plan for stress management.

Public safety leaders can help responders build resilience by promoting a positive attitude and creating an environment in which people feel connected to their work and colleagues. Public safety organizations and public health agencies can help prevent or alleviate behavioral health issues in first responders through preventive training on resiliency and behavioral health prior to disasters or other events, interventions to address burnout, and peer support programs.

Some leadership techniques for minimizing stress in the public safety workplace are listed here:

- Set the tone by treating coworkers with respect and valuing their contributions.
- Hold regular staff meetings to plan, problem solve, recognize accomplishments, and promote staff cohesiveness.
- Clearly communicate the rationale behind procedural or supervisory changes and performance expectations.
- Create a formal employee suggestion system and encourage staff to contribute.
- Resolve conflicts early and quickly.
- Prepare workers for concrete tasks that they may perform through technical training.
- Acknowledge that work is often stressful and connect staff to professional help if necessary.
- Promote an atmosphere where attention to one's emotional state is acceptable and encouraged rather than stigmatized or disregarded.

5.2 Health and Safety Actions During Mass Casualty/Mass Fatality Incidents

During the response to mass casualty/mass fatality incidents, public safety leaders can take specific steps to mitigate stress and help responders perform the critical tasks at hand:

- Clearly define individual roles and reevaluate them if the situation changes.
- Assign a Safety Officer with authority to stop operations when the health or safety of responding personnel is threatened.
- Ensure that all safety hazards are identified and corrective, preventative, or mitigating actions are completed.
- Institute briefings at each shift change that cover the current status of the work environment, safety procedures, and required safety equipment.
- Ensure that all responders have the required PPE.

- Take immediate corrective action or stop unsafe situations or practices.
- Partner inexperienced workers with experienced veterans. The buddy system is an effective method to provide support, monitor stress, and reinforce safety procedures.
- Rotate workers from high-stress to lower-stress functions.
- Monitor all personnel for rehabilitation and replacement.
- Initiate, encourage, and monitor work breaks,
- Establish rehabilitation areas that visually separate workers from the scene and the public. At longer operations, establish an area where responders can shower, eat, change clothes, and sleep.
- Reduce noise as much as possible by providing earplugs, noise mufflers, or telephone headsets.
- Mitigate the effects of extreme temperatures through the use of protective clothing, proper hydration, and frequent breaks.
- Ensure that lighting is sufficient, adjustable, and in good working order.
- Lessen the effect of odors and tastes, and protect workers' breathing by supplying facemasks and respirators.
- Provide Critical Incident Stress Debriefings to all personnel working the incident, including dispatchers and other off-site workers. A Critical Incident Stress Debriefing Team should be at or near the incident site to informally greet participants as they are relieved of duty. A more formal CISD should be scheduled for later.

An EMS unit should be on site to monitor the safety environment and working conditions and to provide medical attention to responders as needed.

5.3 Critical Incident Stress Management and Debriefing

Stress is a natural reaction to mass casualty/mass fatality operations. Critical Incident Stress Management is an organized, simple and accepted method of assisting emergency personnel to appropriately manage the psychological trauma of emergency. CISM is system of education, prevention and mitigation of the effects from exposure to highly stressful critical incidents. It is handled most effectively by specially trained individuals, such as crisis intervention specialists.

A Critical Incident Stress Debriefing is a group process with seven phases designed to mitigate the impact of a critical incident on personnel and to accelerate their normal recovery process. Debriefings should be made available to all personnel working the incident, including dispatchers and other off-site workers. The location of the debriefing should be adequate in size and free from distractions and interruptions. This debriefing will be neutral in nature, not an accusation critique. The intent of the debriefing is to provide stress education, reassurance, and a mechanism for ventilation of feelings.

Critical Incident Stress Management teams that can respond to Medina County are listed in section 4.1.M. of this plan.

5.4 Rehabilitation Area

To ensure that the physical and mental condition of personnel operating at an incident are maintained, the Incident Commander and/or EMS/Medical Group Supervisor may establish a Rehabilitation Area. When a Rehabilitation Area is established, it will be manned at the minimum by one EMT or Paramedic who will be identified as the Rehabilitation Officer within the Incident Command Structure.

The Unified Command will evaluate the incident, considering physical, mental and environmental circumstances, and make provision for rest and rehabilitation of ALL personnel operating at the incident.

These provisions will include:

- Medical monitoring, evaluation and necessary treatment and transport to an appropriate medical facility.
- Food fluid replenishment
- Mental rest and recovery
- Relief from environmental and abnormal weather

Rehabilitation Areas should be located up wind from the incident site in an area that is free from exhaust fumes from emergency or other vehicles. Depending upon environmental conditions, the Rehab Area should be located in an area that will provide shelter from inclement weather. This might entail the use of a nearby building. The area should be protected from noise disturbance from emergency operations, equipment or crowds and should be out of sight of the incident if possible.

The EMS/Medical Group Supervisor and medical group unit leaders will continuously evaluate the need for and effectiveness of the Rehab Area to ensure that its purpose is being maintained. During extended periods of operation or highly physical working conditions, all personnel involved in the incident should be encouraged to continuously maintain their hydration through drinking of water, activity beverages (such as Gatorade) or non-caffeinated hot drinks.

Throughout the incident, personnel will monitor their own level of fatigue and the levels of their co-workers and report to any Incident or EMS Officer when they feel that the level of physical or mental fatigue or exposure to the environment could affect the health and/or safety of themselves or others.

Twelve hours is the maximum amount of time that ANY emergency responder should be continuously involved at an emergency scene, no matter how many rest/rotations sequences are provided. Personnel should be rotated through heavy, moderate, and light work between each Rehab period.

5.5 Red Cross Services

During extended disaster operations, the Red Cross may provide food and beverage services to responders on-scene.

5.6 Hazardous Materials

A mass casualty/mass fatality event may include the release of hazardous materials, including chemical, radiological, and biological substances. The Medina County All-Hazards Team should can provide technical assistance to the Unified Command regarding the detection, identification, and handling of potentially hazardous materials. The All-Hazards Team can also conduct operations to prevent/mitigate exposure to hazardous materials, and decontamination victims and responders.

There is a high probability that responders at an incident involving mass casualties and/or fatalities will come in to contact with bodily fluids. The IC must take appropriate precautions for infectious disease control.

The Unified Command, in coordination with health and medical officials, should establish and enforce an appropriate level of protection for response and recovery personnel. All personnel involved in response

and recovery operations should wear approved safety equipment and protective clothing. All other personnel should remain outside the inner perimeter until the Unified Command declares it safe to enter. A means to dispose of the large quantities of biohazard materials generated must be identified and established.

Protective immunization and infectious disease screening should be considered for all personnel that may come in direct contact with remains.

5.7 Post-Incident Actions

The ending of an incident can be a period of mixed emotions for workers. Though there may be relief that the disaster operation is ending, there is often a sense of loss and "letdown", with some difficulty making the transition back into family life and the regular job. The following are action steps that can help ease the disengagement and transition process for workers.

- Allow time off for workers who have experienced personal trauma or loss. Transition these individuals back into the organization by initially assigning them to less-demanding jobs.
- Develop protocols to provide workers with stigma-free counseling so that workers can address the emotional aspects of their experience.
- Institute exit interviews and/or seminars to help workers put their experiences in perspective and to validate what they have seen, done, thought, and felt.
- Provide educational in-services or workshops around stress management and self-care.
- Offer group self-care activities and acknowledgments.

Section 6.0: Training

The following are recommended local training guidelines for Mass Casualty Incidents:

- Completion of NIMS training.
- Train all public safety personnel in the Medina County Mass Casualty/Mass Fatality Plan.
- Train all EMS personnel in S.T.A.R.T. Triage and JumpSTART.
- Train all EMS personnel in the standard operating procedures related to the county's Mass Casualty Trailers. (Appendix 5)
- Participate in exercises in conjunction with Medina County Emergency Management Agency and local hospitals.

Tabletop exercises allow providers to think theoretically through situations while getting feedback from instructors. Tabletop exercises can be done frequently as part of recurring training programs for providers.

Live exercises should be completed at least once a year. These should also present varied situations that fit local circumstances. Live exercise training, while time-consuming to plan and carry out, is invaluable in assuring that EMS providers are exposed to large-scale scenarios with instructor feedback before they're involved in a live situation where safety is at risk.

Appendix 1 Glossary of Terms

Advanced Life Support (ALS)
The advanced pre-hospital and inter-hospital emergency care of serious illness or injury by appropriately trained health professionals and Advance-EMT, Paramedics, PHRN.

Ambulance
A vehicle specifically designed, constructed or modified and equipped, used or intended to be used, and maintained or operated for the purpose of providing emergency medical care to patients and the transportation of patients if used for that purpose. The term includes ALS or BLS vehicles that may or may not transport patients.

Basic Life Support (BLS)
The basic pre-hospital and inter-hospital emergency medical care and management of illness or injury performed by specially trained, certified or licensed personnel.

Decontamination
The process of making any individual, object or area safe for unprotected personnel; the process of rendering any chemical or biological agents harmless; or the process of removing chemical or radiation agents.

Dispatch Center
A facility from which resources are ordered, mobilized, and assigned to an incident.

Emergency Operations Center (EOC)
A pre-designated facility established by an agency or jurisdiction to coordinate the overall agency or jurisdictional response and support to an emergency.

Emergency Operations Plan
The plan that each jurisdiction has and maintains for responding to appropriate hazards.

Finance/Administration Section
Responsible for all incident costs and financial considerations.

Funnel Point
A point between the incident site and treatment areas designated by the Triage Unit Leader and identified by a white flag, through which every casualty should pass to access the treatment areas. The purpose of the point is to number and tag patients.

General Staff
The group of incident management personnel reporting to the Incident Commander. They may each have a deputy as needed. The General Staff consists of:

- ✓ Operations Section Chief
- ✓ Planning Section Chief
- ✓ Logistics Section Chief
- ✓ Finance/Administration Section Chief

Hazardous Material
Any material which is explosive, flammable, poisonous, corrosive, reactive, or radioactive or any combination and requires special care in handling because of the hazards it poses to public health, safety, and/or the environment.

Hazardous Materials Incident (HazMat)
Uncontrolled, unlicensed release of hazardous materials during storage or use from a fixed facility or during transport outside a fixed facility that may impact the public health, safety and/or environment.

Incident Action Plan (IAP)
An oral or written plan containing general objectives reflecting the overall strategy for managing an incident. It may include the identification of operation resources and assignments. It may also include attachments that provide direction and important information for management of the incident during one or more operations periods. (Ex: ICS forms 202,203,204)

Incident Commander (IC)
The individual responsible for all incident activities, including the development of strategies and tactics and the ordering and the release of resources. The IC has overall authority and responsibility for conduction incident operations and is responsible for the management of all incident operations at the incident site.

Incident Command Post (ICP)
The standard position for the IC, usually stationary, inside a command vehicle or in a specified area as designated by the IC. It is identified by a green flashing light or an orange flag.

Incident Command System (ICS)
A standardized on-scene emergency management construct specifically designed to provide for the adoption of an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in the management of resources during incidents.

Incident Objectives
Statements of guidance and direction necessary for the selection of appropriate strategy (ies), and the tactical direction of resources. Incident objectives are based on realistic expectations of what can be accomplished when all allocated resources have been effectively deployed.

Joint Information Center (JIC)
A JIC is a central location that facilitates operation of the Joint Information System. The JIC is a location where personnel with public information responsibilities perform critical emergency information functions, crisis communications and public affairs functions. JICs may be established at various levels of government or at incident sites, or can be components of Multiagency Coordination Systems.

Logistics Section
The section responsible for providing facilities, services, and materials for then incidents.

Mass Casualty Incident (MCI)
An emergency incident involving the injury and/or death of a number of patients beyond what the jurisdiction is routinely capable of handling. Also called a Multi-Casualty Incident or Multiple Patient Incident.

Morgue
An area on or near the incident site that is designated for the temporary placement of deceased victims.

Mutual Aid Agreement
Written agreement between agencies and/or jurisdictions in which they agree to assist one another upon request by furnishing personnel and equipment.

National Incident Management System (NIMS)
A system described in HSPD-5 that provides a consistent nationwide approach for Federal, State, local, and tribal governments; the private sector; and nongovernmental organizations to work effectively and efficiently together to prepare for, respond to, and recover from domestic incidents regardless of cause, size, or complexity.

National Response Framework (NRF)
Guides how the nation conducts all-hazards response. The framework documents the key response principles, roles, and structures that organize national response. It describes how communities, States, the Federal government, and private sector and nongovernmental partners apply these principles for a coordinated and effective national response.

Operations Section
The section responsible for all tactical operations at the incident. Includes branches, divisions and/or groups, task forces, strike teams, single resources, and staging areas.

Planning Section
Responsible for the collection, evaluation, and dissemination of tactical information related to the incident and for the preparation and documentation of Incident Action Plans. The section also maintains information on the current and forecasted situation and on the status of resources assigned to the incident.

Public Information Officer (PIO)
A member of the Command Staff who is responsible for interfacing with the public and media or with other agencies with incident-related information requirements.

Rehabilitation Area
An area outside the fire ground perimeter where crews are assigned for rest, nourishment, comfort and medical evacuation.

Resources
All personnel, equipment, and supplies potentially available for assignment to an incident and that are tracked.

Safety Officer
A member of the Command Staff responsible for monitoring and assessing safety hazards or unsafe situations, and for developing measures for ensuring personnel safety. The Safety Officer may have assistants.

S.T.A.R.T. (Simple Triage and Rapid Treatment)
A system that allows rapid triage of a large number of patients using the assessment of respirations, pulse, and mental status (RPM) to determine the triage category. This triage method allows rapid, prioritized medical treatment and transportation of the most seriously injured patients.

Staging Area
Staging areas are locations set up at an incident where resources can be place while awaiting a tactical assignment.

Triage
Medical screening of patients to determine their relative priority for treatment.

Triage Area
An area of the Patient Collection Station specifically designated for **IMMEDIATE**, **DELAYED**, **MINOR** and [redacted] patients.

Triage Tag
A tag used by triage personnel to identify and document the patient's medical condition.

Treatment
Medical management of a patient.

Treatment Area
A designated area for the stabilization of patients.

Transport
Movement of patients; typically referring from the scene to a health care facility.

Transportation Area
A designated area where patients are moved following treatment as they await transport to a medical facility.

Unified Command
An application of ICS used when there is more than one agency with incident jurisdiction or when incidents cross political jurisdictions. Agencies work together through the designated members of the UC, often the senior person from agencies and/or disciplines participating in the UC, to establish a common set of objectives, strategies, and a single IAP.

Unit: (Unit Leader)
The organizational element having functional responsibility for a specific incident planning, logistics, or finance/administration activity.

Unity of Command
The concept by which each person within an organization reports to one and only one designated person. The purpose of Unity of Command is to ensure unity of effort under one.

Appendix 2: Checklists

First Unit On-Scene Checklist

	Determine if scene is safe to enter. Assess the scene for:
	✓ Electrical hazards
	✓ Flammable liquids
	✓ Hazardous Materials
	✓ Other life-threatening situations
	✓ Secondary explosive devices
	Size-up the scene: How big and how bad is it?
	✓ Type or cause of incident
	✓ Approximate number of patients
	✓ Severity level of injuries (either MAJOR or MINOR)
	✓ Area involved, including problems with scene access
	Send an initial radio report of the overall situation
	✓ Advise your dispatcher and Medical Control: “WE HAVE A MASS CASUALTY INCIDENT CAUSED BY________WITH APPROXIMATELY_______ VICTIMS.”
	✓ Request additional resources
	Assume the role of the Incident Commander (until properly relieved)
	Set up the scene:
	✓ Establish staging
	✓ Identify access and egress routes
	✓ Identify adequate work areas for Triage, Treatment, and Transportation
	Establish an Incident Command Post (ICP)
	Isolate ‘walking wounded’ (if possible)
	✓ Ask anyone who can walk to go to a designated area
	Begin triage of severely injured persons using START or JumpSTART as appropriate
	Assume role of Triage Unit Leader until relieved
	Keep Dispatch informed

Incident Commander Checklist

	Obtain a briefing from the prior IC, assess the situation, relieve the prior IC
	Mark location of Command Post with flag or light
	Advise Dispatch that you have assumed Incident Command and provide an initial report:
	✓ Description and exact location of the incident
	✓ Possibility of hazardous materials exposure
	✓ Possible need for public evacuation
	✓ Estimated number, severity, and nature of injuries and estimated number of fatalities
	✓ Location of Command Post
	Identify safety hazards
	Identify route of approach for responders
	Determine immediate priorities
	Request Dispatch make notifications as required
	Request dispatch of additional chiefs to fill ICS positions
	Request additional resources as required
	Designate radio frequencies for on-scene use
	Establish and mark Staging, Triage, Treatment, and Transport areas and Casualty Collection Point
	Appoint ICS positions based on initial size-up. (Triage, Treatment, Transportation, Staging)
	Transition to Unified Command
	Coordinate with Law Enforcement to establish perimeters
	Coordinate operations with Coroner
	Establish Family Assistance Center
	Assign EMS/Medical Group Supervisor, Safety Officer, and Public Information Officer
	Determine objectives and strategy
	Assess need for ICS Branches, Divisions, Groups, etc
	Maintain Unit Log (ICS-214)
	Approve Incident Action Plan
	Monitor operations to ensure safety of responders
	Authorize release of information to news media
	Order demobilization of the incident when appropriate
	Ensure incident after-action reports are complete

EMS/Medical Group Supervisor Checklist

	Obtain a briefing from the Unified Command
	Assess incident area, including safety
	Confirm that Coordinating Hospital has been notified
	Create Triage, Treatment, and Transport Units (if not already established)
	✓ Assign, brief, and direct Leaders of Units
	✓ Assign personnel
	Establish Extrication Unit, if required
	Ensure radio interoperability with all Units
	Ensure that Triage, Treatment & Transport Areas and Casualty Collection Point have been set up and marked
	Ensure all areas are free of hazards
	Establish and maintain communications with Unified Command
	Request patient count by color, including the number of pediatric patients, from Triage Unit Leader
	Confirm that Dispatch has been notified with exact number of victims and their categories
	Coordinate establishment of Temporary Morgue with Coroner
	Establish (or confirm) Medical Supply Area and Helispot Landing Area
	Coordinate with Law Enforcement to ensure security at all medical areas
	Anticipate and request additional medical supplies as needed
	✓ Consider Mass Casualty Trailer
	✓ Consider specialized medical resources
	Request additional ambulances if needed
	Estimate and request additional personnel from Unified Command
	Monitor safety and welfare of group personnel - consider relief crews
	Provide frequent updates to the Unified Command
	Notify Unified Command when Triage, Treatment and Transport duties are completed
	Document unit activity on ICS Form 214
	Demobilize as directed by Unified Command
	Forward all records/reports to Unified Command

Triage Unit Leader Checklist

	Obtain briefing from Medical/EMS Group Supervisor or Unified Command
	Size up incident area, including safety
	If danger exists, ensure all patients are moved out of incident area before establishing triage.
	Establish and maintain communications with Medical/EMS Group Supervisor or Unified Command
	Establish and mark a suitable and safe Triage Area
	Establish and mark a suitable and safe Casualty Collection Point (CCP)
	✓ In many cases, the Treatment Area is the CCP
	✓ Announce "Anyone who is able to walk is to get up and move to the Collection Point" (or GREEN Treatment Area)
	Assign early arriving EMTs to initiate field triage
	As resources become available, organize the Triage Teams to begin the triaging of victims, utilizing the S.T.A.R.T. and JumpSTART triage systems
	If non-EMTs are available, use them to move victims, maintain documentation, or attach tags to patients
	Estimate patient count, including the number of pediatric patients, by triage color
	Report count to the Medical/EMS Group Supervisor or Unified Command
	Inform Medical/EMS Group Supervisor or Unified Command of resource needs
	If patients are trapped, coordinate with the Extraction Unit Leader for triage of entrapped patients
	Coordinate with Coroner to establish Temporary Morgue.
	Coordinate with Treatment Unit Leader to assure proper patient designation and ensure that priority victims are treated first
	Establish system to move patients from Triage to CCP and/or Treatment Area
	Ensure that all patients are tagged
	Ensure that deceased persons are not moved unless needed to extract or treat viable patients
	Direct movement of patients to proper Treatment Areas.
	Monitor the availability of triage supplies, tags, and marking system
	Obtain medical supplies from the Treatment Team for Triage Areas.
	Provide progress reports to Unified Command or EMS/Medical
	Monitor safety and welfare of unit personnel - consider relief crews.
	Notify Unified Command when Triage duties are completed
	Ensure that all areas around the incident scene have been checked for potential victims, walking wounded, ejected victims, etc., and that all victims have been triaged.
	Maintain Unit Log (ICS 214)
	Demobilize as directed by Unified Command or EMS/Medical Group Supervisor
	Forward all records/reports to Unified Command or EMS/Medical Group Supervisor

Treatment Unit Leader Checklist

	Obtain briefing from Medical/EMS Group Supervisor or Unified Command
	Size up incident area, including safety
	Establish and maintain communications with Medical/EMS Group Supervisor or Unified Commander
	Establish and maintain contact with Triage and Transport Unit Leaders
	Establish and mark a suitable and safe Treatment Area
	Subdivide Treatment Area into Red (Immediate), Yellow (Delayed), and Green (Minor) areas
	Maintain 3 feet of working space between patients
	Designate Treatment Area entrances and exits
	Announce locations of Treatment Areas
	Assemble and direct the Treatment Teams
	Coordinate with Triage Unit Leader to establish system to move patients from Triage to CCP and/or Treatment Area
	Control patient flow by creating pathways with cones, hoses, or other markers and monitoring Treatment Area entrances and exits.
	Ensure patients are re-triaged as they enter the Treatment Area and the assessment is documented on the triage tag.
	Coordinate with Triage Unit Leader to assure proper patient designation and ensure that priority victims are treated first
	Coordinate with Transport Unit Leader to ensure proper loading and transport of patients
	Assist in moving patients to transport area.
	Continually reassess patients' conditions and priorities.
	Ensure proper documentation of each patient's treatment
	Provide periodic updates to Unified Commander or EMS/Medical as appropriate.
	Inform Medical/EMS Group Supervisor or Unified Commander of resource needs
	Order and maintain appropriate amounts of medical supplies. When personnel are available, assign a Medical Supply Coordinator.
	When resources are available, assign Red, Yellow, Green, and Black Team leaders
	Monitor safety and welfare of unit personnel - consider relief crews.
	Notify Unified Commander when Treatment duties are completed
	Maintain Unit Log (ICS 214)
	Demobilize as directed by the Unified Commander or EMS/Medical Group Supervisor
	Forward all records/reports to the Unified Commander or EMS/Medical Group Supervisor

Transport Unit Leader Checklist

	Obtain briefing from Medical/EMS Group Supervisor or Unified Commander
	Establish communications with Medical/EMS Group Supervisor or Unified Commander
	Establish and maintain contact with Treatment Unit Leader and Staging Unit Leader
	Establish and mark a suitable and safe Transport Area
	Coordinate with Law Enforcement to establish transport vehicle flow from Ambulance Staging Area to Treatment Area and from the Treatment Area to Hospitals
	Assemble and direct the Transport Teams
	Assign personnel (as they become available) to Transport Teams; Staging, Patient Tracking, Transport Dispatch, Ground and Air Ambulances.
	Contact the Cleveland Clinic Medina Hospital via MARCS Radio Medina County TAC-9. (Do not use landline or cellular telephones.)
	Monitor hospital capacity in coordination with the Coordinating Hospital and maintain patient flow
	Designate a helispot and appoint an Air Ambulance Coordinator
	Designate patient Loading Area and appoint a Ground Ambulance Coordinator
	Coordinate with Treatment Unit Leader to ensure proper loading and transport of patients
	Ensure that All Red-tagged victims are transported immediately as transport units become available. These victims should not be delayed in the Treatment Area.
	Assign patients to transport units based on patient needs and capabilities of available vehicles
	Ensure that stretchers/cots are matched with their home vehicles for transport safety
	Assign transport units to hospitals in coordination with Cleveland Clinic Medina Hospital Transport Office. Rotate patients equally among hospitals.
	Coordinate with Staging Area to bring ambulances to the Loading Area
	As patients are transported from the scene, notify the Coordinating Hospital of the transporting department, number of victims, tag color, brief description of injuries, and the destination
	Record of each person's name, triage tag number and color, transporting ambulance, and hospital destination
	Request additional ambulances, as required
	Request buses or other transport for removal of GREEN patients
	Document patient and unit movements and destination in Transportation Log
	Provide periodic updates to Unified Commander or EMS/Medical as appropriate.
	Inform Medical/EMS Group Supervisor or Unified Commander of resource needs
	Monitor safety and welfare of unit personnel - consider relief crews.
	Notify Unified Commander when Transport duties are completed
	Maintain Unit Log (ICS 214)
	Demobilize as directed by the Unified Commander or EMS/Medical Group Supervisor
	Forward all records/reports to the Unified Commander or EMS/Medical Group Supervisor

Staging Unit Leader Checklist

	Obtain briefing from Transportation Unit Leader, Medical/EMS Group Supervisor or Unified Commander
	Establish communications with Medical/EMS Group Supervisor or Unified Commander
	Establish and maintain contact with Transportation Unit Leader
	Coordinate with Law Enforcement to establish and mark a suitable and safe Staging Area with clear avenues in and out
	Coordinate with Law Enforcement and Treatment Unit Leader to establish transport vehicle flow from Ambulance Staging Area to Treatment Area
	Coordinate with Law Enforcement to establish and maintain security of Staging Area and vehicles
	Organize apparatus in Staging Area for ease of exit to prevent congestion.
	Control and document all resources entering and leaving the Staging Area
	Ensure that each ambulance is properly staffed and equipped
	Maintain communications with Ambulance Team Leader(s) in the Loading Area
	Direct ambulance crews to leave stretchers in ambulances unless needed for patient movement
	Order all personnel to remain with their units until assigned
	Maintain status of number and types of resources in the Staging Area and report inventory to Transportation Unit Leader
	Advise Transportation Unit Leader of ambulance capacities
	Advise Transportation Unit Leader when resources of a particular type are nearly exhausted.
	Maintain radio contact with incoming ground and air ambulances, and keep the Transport Unit Leader (or Transport Dispatcher) advised of status of ambulances' arrivals and departures.
	Recommend additional staffing, equipment, and resources when necessary
	Provide periodic updates to Unified Commander or EMS/Medical as appropriate.
	Inform Medical/EMS Group Supervisor or Unified Commander of resource needs
	Monitor safety and welfare of unit personnel - consider relief crews.
	Notify Unified Commander when Staging duties are completed
	Maintain Unit Log (ICS 214)
	Demobilize as directed by the Unified Commander or EMS/Medical Group Supervisor
	Forward all records/reports to the Unified Commander or EMS/Medical Group Supervisor

Ground Ambulance Coordinator Checklist

	Obtain briefing from Transportation Unit Leader
	Coordinate with Law Enforcement to establish and mark a suitable and safe Staging Area for ambulances with clear avenues in and out
	Coordinate with Law Enforcement, Transport Unit Leader and Treatment Unit Leader to establish transport vehicle flow from Ambulance Staging Area to Treatment Area
	Establish contact with ambulance providers at the scene.
	Designate a Loading Area close to the Treatment Area
	Ensure that each ambulance is properly staffed and equipped
	Provide an inventory of medical supplies available at ambulance staging area for use at the scene
	Ensure that drivers remain with their vehicles
	Maintain communications with Ambulance Team Leader(s) in the Loading Area
	Direct ambulance crews to leave stretchers in ambulances unless needed for patient movement
	Maintain status of number and types of resources in the Staging Area and their capabilities and report inventory to Transportation Unit Leader
	Remind ambulance crews to maintain radio silence unless otherwise ordered.
	Notify Staging Area when ready for rotating ambulances into the Loading Area
	Provide ambulances upon request from the Transportation Unit Leader.
	Ensure patients selected for transportation are ready for transport and safely loaded
	Ensure all patients being loaded have triage tags attached and the transport stub has been removed
	Maintain radio contact with incoming ground and air ambulances, and keep the Transport Unit Leader (or Transport Dispatcher) advised of status of ambulances' arrivals and departures.
	Advise Transportation Unit Leader when resources of a particular type are nearly exhausted.
	Recommend additional staffing, equipment, and resources when necessary
	Inform ambulance crews of the destination hospital/facility and provide directions
	Remind ambulance crews that they should not contact receiving facility unless there is significant deterioration in the patient's condition, or if they need physician's orders
	Keep record of vehicles and personnel arriving at, dispatched from, and returning to the staging area, including times, unit number, department, dispatch destination, and any problems.
	Remind crews to return to the Staging Area upon completion of their assignment
	Provide periodic updates to Transportation Unit Leader
	Monitor safety and welfare of unit personnel - consider relief crews.
	Notify Transportation Unit Leader when Ground Ambulance transport duties are completed
	Maintain Unit Log (ICS 214)
	Demobilize as directed by the Transportation Unit Leader
	Forward all records/reports to the Transportation Unit Leader

Air Ambulance Coordinator Checklist

	Obtain briefing from Transportation Unit Leader
	Coordinate with Transportation Unit Leader and Law Enforcement to establish and mark a suitable and safe Landing Zone for air ambulances
	Flat, firm, and free of debris (minimum 100x100 ft.)
	Free of any obstructions such as cell tower, power lines, etc.
	At least 300’ from the Treatment Area
	Work with law enforcement to ensure safety and security at landing area.
	Assign personnel to assist in establishing a Landing Zone.
	Establish and Maintain radio contact with incoming helicopters
	Coordinate loading and transport of patients with Transportation.
	Ensure all patients being loaded have triage tags attached and the transport stub has been removed
	Provide periodic updates to Transportation Unit Leader
	Monitor safety and welfare of unit personnel
	Notify Transportation Unit Leader when Air Ambulance transport duties are completed
	Maintain Unit Log (ICS 214)
	Demobilize as directed by the Transportation Unit Leader
	Forward all records/reports to the Transportation Unit Leader

Appendix 3: Triage

1. Overview

Triage is the process of medically screening and prioritizing patients by the severity of their condition or likelihood of recovery with and without treatment. It is an essential element of Medina County's response to mass casualty/mass fatality incidents.

The preferred method for initial field triage for adults is the **START (Simple Triage and Rapid Treatment)** method. For patients eight-years-of-age or younger, a modified process called **JumpSTART** is preferred.

Triage efforts at mass casualty/mass fatality incidents typically begin as soon as the initial assessment of the scene is complete. As triage begins, responders should direct all ambulatory patients (walking wounded) to a safe designated area where they can be further assessed as more personnel become available. Responders should then triage the remaining victims and 'tag' them with color-coded Medina County Mass Casualty Tags to identify and document the patient's medical condition.

Patients exposed to HAZMAT or WMD's (chemical, radiological, nuclear, or biological) should be triaged according to the agent they were exposed to. Patients who are contaminated with hazardous materials must be decontaminated before being treated. The Medina County HAZMAT Team can assist in this kind of situation.

2. Categories

During triage, patients are sorted into four categories:

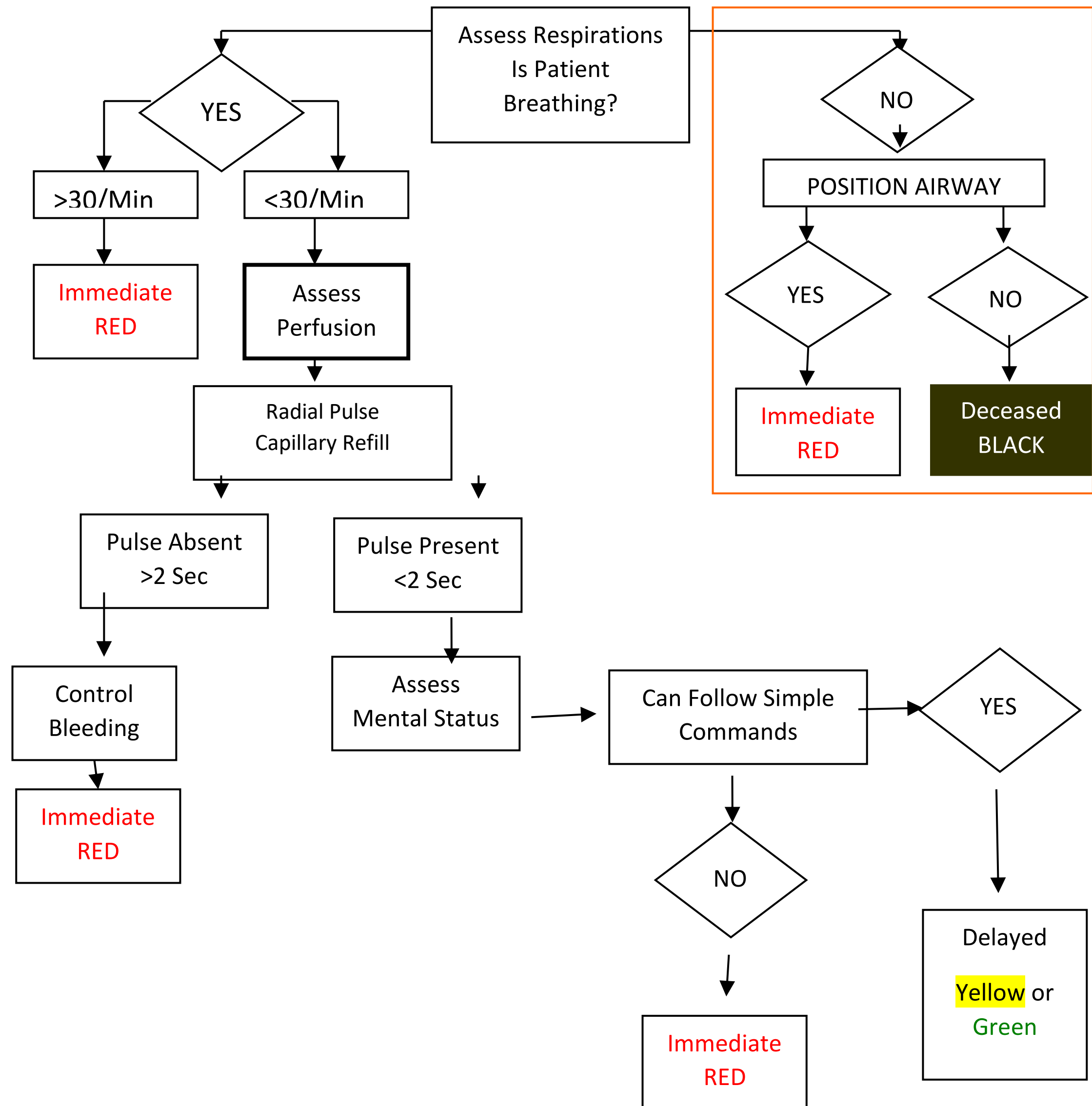
- **Immediate (Red)**
  Critical patient, life-threatening injuries. Patient is likely to survive if they receive definitive care within 30 minutes. These patients should be moved with minimal stabilization as quickly as possible to treatment area for reassessment and treatment.

- **Delayed (Yellow)**
  Serious injuries but stable, possibly life threatening. Likely to survive if care is received within several hours. These patients will be moved as quickly as possible to the ambulatory casualty collection area for reassessment and treatment.

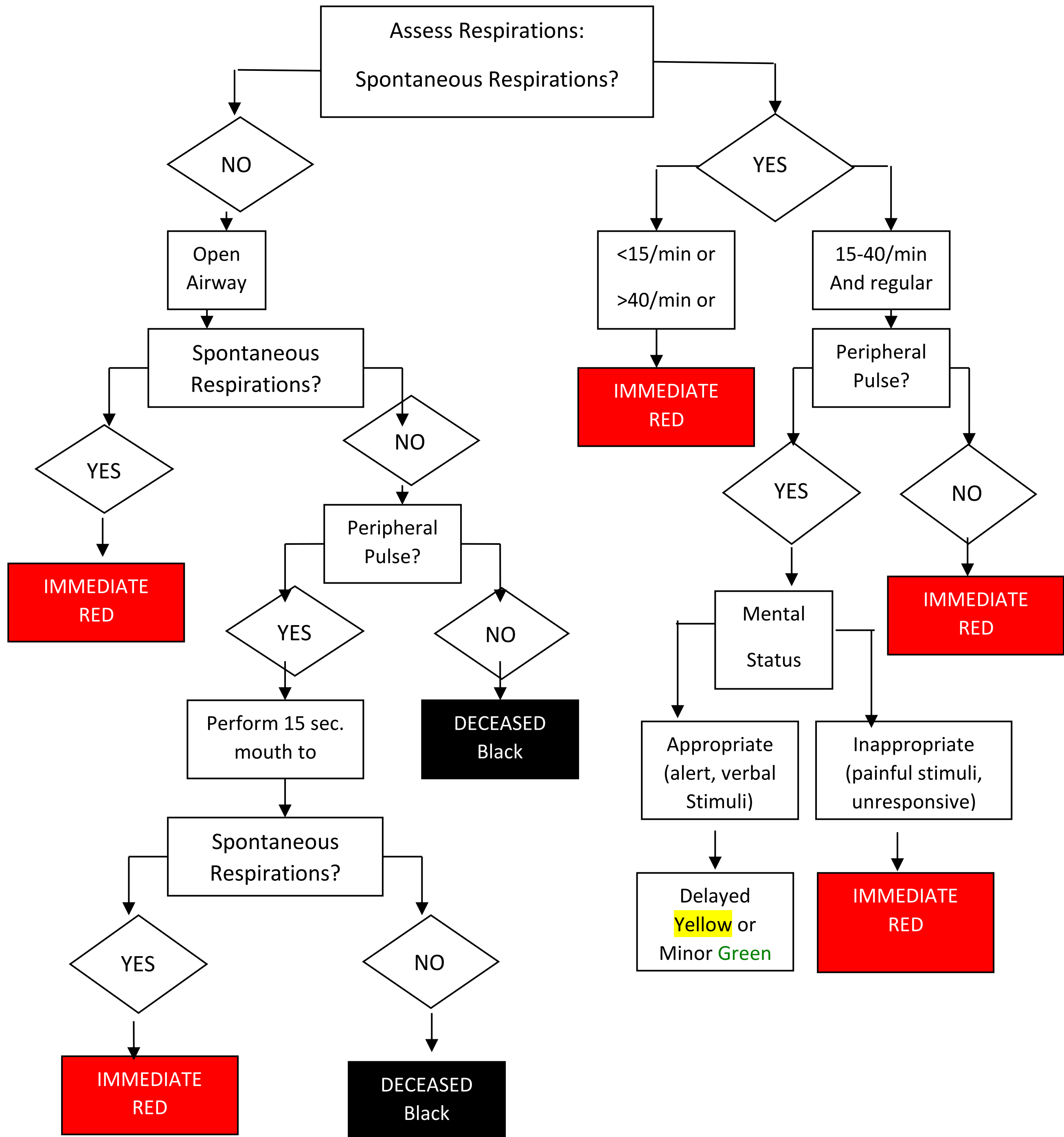
- **Minor (Green)**
  Victims who are able to walk and only have minor injuries

S.T.A.R.T. – Simple Triage and Rapid Treatment

Remember RPM (Respirations, Perfusion, Mental Status)



JumpSTART
Field Pediatric Multicasualty Triage System
Patients aged 1-8 years



CONTAMINATED

Personal Property Receipt/ Evidence Tag

453781

Destination ______
Via ______

453781

TRIAGE TAG

453781

S Salivation	L Lacrimation	U Urination	D Defecation	G G.I. Distress	E Emesis

AUTO INJECTOR ☐1 ☐2 ☐3 ☐4 ☐5

Yes	No	Gross Decon
Yes	No	Secondary Decon

Solution

- Blunt Trauma
- Burn
- C-Spine
- Cardiac
- Crushing
- Fracture
- Laceration
- Penetrating Injury

RADIOLOGICAL AGENT / BIOLOGICAL AGENT / CHEMICAL AGENT

Age____

☐ Male ☐ Female

Other: ______

VITAL SIGNS

Time	B/P	Pulse	Respiration

Time	Drug Solution	Dose

453781

EVIDENCE

MORGUE
Pulseless/Non-Breathing
453781

IMMEDIATE
Life Threatening Injury
453781

DELAYED
Serious, Non Life Threatening
453781

MINOR
Walking Wounded
453781

Comments/Information

Comments/Information

RESPIRATIONS
R ☐ Yes ☐ No

PERFUSION
P ☐ + 2 Sec. ☐ - 2 Sec

MENTAL STATUS
M ☐ Can Do ☐ Can't Do

TRIAGE FLOW CHART

ALL WALKING WOUNDED — Minor

RESPIRATIONS
- NO → POSITION AIRWAY → NO: Morgue; YES: Immediate
- YES → Over 30/Min.: Immediate; Under 30/Min.: PERFUSION

PERFUSION
- Radial Pulse Absent OR Capillary Refill Nail Bed Press Over 2 Seconds → Control Bleeding → Immediate
- Radial Pulse Present OR Capillary Refill Under 2 Seconds → MENTAL STATUS

MENTAL STATUS
- Can't Follow Simple Commands → Immediate
- Can Follow Simple Commands → Delayed

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Zip DMS rev 2/5/2002

PERSONAL INFORMATION

NAME		
ADDRESS		
CITY	ST	ZIP
PHONE		
COMMENTS	RELIGIOUS PREF.	

MORGUE

IMMEDIATE

DELAYED

MINOR

CONTAMINATED

EVIDENCE

Appendix 4: SOP for Medina County EMA Mass Casualty Incident Trailers

One (1) MCI Trailer has been assigned to each of the three Cities in Medina County.

1. Trailer 327-1 is housed in the City of Medina
2. Trailer 327-2 is housed in the City of Brunswick
3. Trailer 327-3 is housed in the City of Wadsworth

1. Responsibilities:

1.1. Host Department responsibilities:

- House each assigned trailer indoors in an accessible heated facility
- Maintain security of the trailer and inventory
- Keep units clean and dry
- Keep trailer compartments locked at all times.
- Maintain documentation of deployment or a sign out log for training purposes. (Provided)
- Maintain an inventory sheet for supplies. (Provided)
- Provide personnel and a tow vehicle for emergency deployment of the trailer

1.2. Medina County Fire Chiefs and Medina County EMS agencies responsibilities:

- Properly sign out the trailer when used for training or stand-by deployment
- Provide an appropriate tow vehicle and personnel when utilizing the trailer for non-emergency deployment or training
- Maintain security of the trailer and supplies
- Properly document the use or loss of supplies. (Inventory Sheet supplied)
- Promptly return the trailer to its original housing location after use
- Minimize the removal of equipment and supplies for training purposes to only those supplies marked as training supplies
- Maintain, clean, and restock the trailer and supplies after deployment

1.3. The trailers and supplies will be available to all Medina County Primary Emergency Medical Service providers for:

- Emergency deployment to an MCI
- Deployment to stand by at large community events that are deemed to have significant risk for Mass Casualty Incident (MCI)
- Training and orientation of personnel

Note: Supplies contained within the MCI trailers **ARE NOT** to be used to restock individual departments or EMS units.

2. Concept of Operations:

Upon arrival at the scene of a potential Mass casualty/Mass fatality Incident, the Incident Commander shall determine if one or more of the the Medina County EMA Mass Casualty Incident Trailers are required.

2.1. Incident Command shall:

- Request deployment of the nearest MCI trailer. (Brunswick, Medina, Wadsworth)
- 1, 2 or 3 units may be deployed depending on number of victims.
- Each Unit is equipped to manage up to approximately 100 victims depending on severity of injuries.
- Identify the Staging area(s) in which trailer(s) are to be set up.
- Identify a Staging Officer and Supply Logistics Officer.
- Supply Logistics Officer will report to the Staging Officer.

2.2. Deployment of Host Department

Host Department shall:

- Provide personnel (EMT, Firefighter, Officer, etc.) and an appropriate tow vehicle.
- Deliver the MCI Trailer to the designated Staging Area.
- Unlock all compartment doors.
- Assist with set up or distribution of supplies as requested, or report to Staging Officer for assignment appropriate to your level of training, or return to normal duty assignment if required to do so by your department duty officer.

2.3. Treatment Officer or Logistics Officer

The Treatment Officer or, when assigned, the Logistics Officer shall:

- Distribute MCI supplies to EMS personnel reporting to the various designated treatment areas.
- Appoint additional personnel to Logistics assignments as needed (Scribes, Restock personnel, Retrieval Staff, etc).
- assist in the after-action inventory process and restock of the trailer.
- Oversee the assignment of personnel to retrieve reusable supplies from receiving hospitals post incident.
- Report to Incident Command an itemized list of all inventory that needs replaced after incident.

Appendix 5: Medina County Morgue Operations

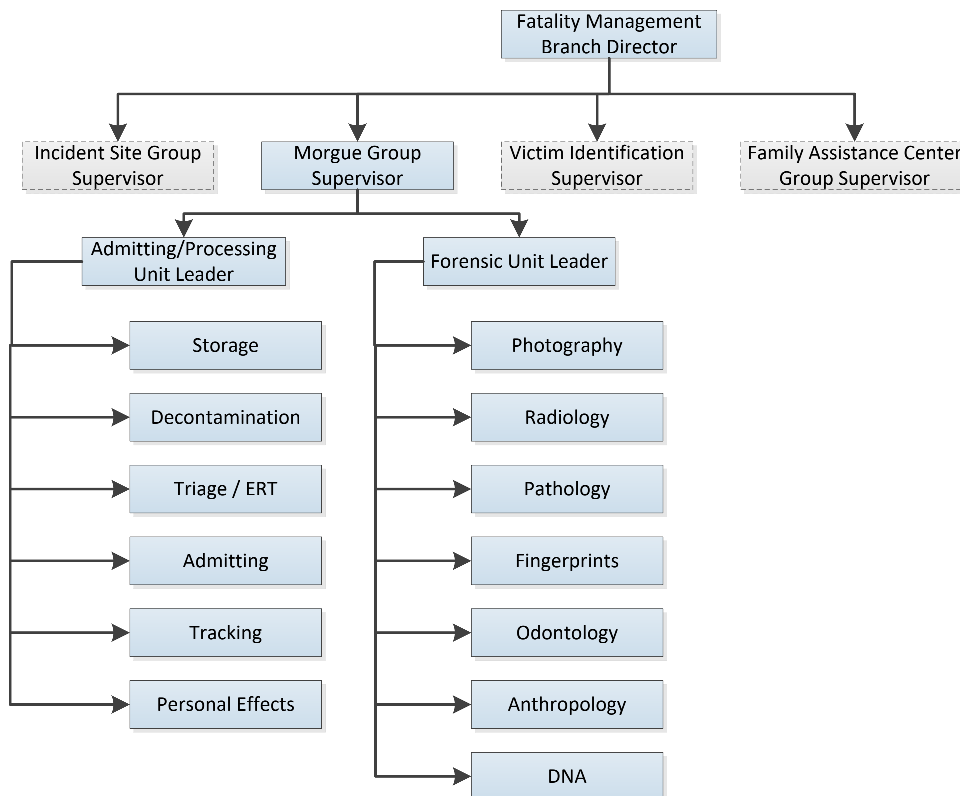
Proper treatment and care of both human remains and victim's families are vital to successful incident response. As victims are removed from the scene, they are transported to the county morgue or a temporary morgue.

Logistical requirements for the support of morgue operations for a Mass Casualty/Mass Fatality Incident may include but are not limited to:

- building space,
- life support including electricity, running water, heating, ventilation, and air conditioning,
- cold storage (should not rely upon hospital morgues),
- computers,
- medical equipment, expendable medical supplies, PPE, and biohazard waste containers.

If necessary, OMORT has a mobile morgue that can be deployed to the incident site to facilitate processing. Hospital morgues should not be relied upon for decedent storage due to a potential requirement surge from the incident.

1. Morgue Organization:



2. Personnel

Subject matter experts (SMEs) must be approved by the Coroner before being assigned to the morgue. More general positions—such as scribes and data entry clerks—can be filled by individuals who receive just-in-time training. Individuals experienced in the funeral business may assist in supporting morgue operations. Spontaneous, unaffiliated volunteers should not be permitted to work in the MFI morgue. OMORT (state) or DMORT (federal) personnel will likely need to be requested for assistance.

3. Documentation

A significant amount of documentation is produced in the effort of collecting, classifying, describing, and controlling human remains post incident. All documents produced in the effort of collecting, classifying, describing, and controlling human remains for a Mass Casualty/Mass Fatality Incident fall under the control of the Coroner. Authority over the release of information concerning human remains and morgue operations falls to the Coroner or their official designee. Care must be taken to safeguard sensitive personal identifiable information to prevent identity theft.

4. Logistics

The logistics section will likely need to store and manage morgue supplies at the morgue. Expendable medical supplies will be depleted at varying "burn" rates, and must be monitored closely. Depletion of any given supply item could abruptly halt morgue operations and cause significant delays in the identification process. Morgue operations should routinely communicate logistical requirements to the logistics section.

5. Safety

A Safety Office should be appointed to oversee all aspects of morgue operations. Personnel working in the morgue must comply with international safety precautions and wear appropriate PPE. Biohazard waste bags and sharps containers must be available for disposal of all waste generated from human remains processing and disposal of used scalpels, syringes, etc. Personnel assigned to work in morgue operations must have completed bloodborne pathogens training prior to assignment.

6. Security

Local law enforcement is responsible for morgue security. A form of badging should be used in permitting anyone to enter the morgue, as to prevent unauthorized individuals from entering the morgue.

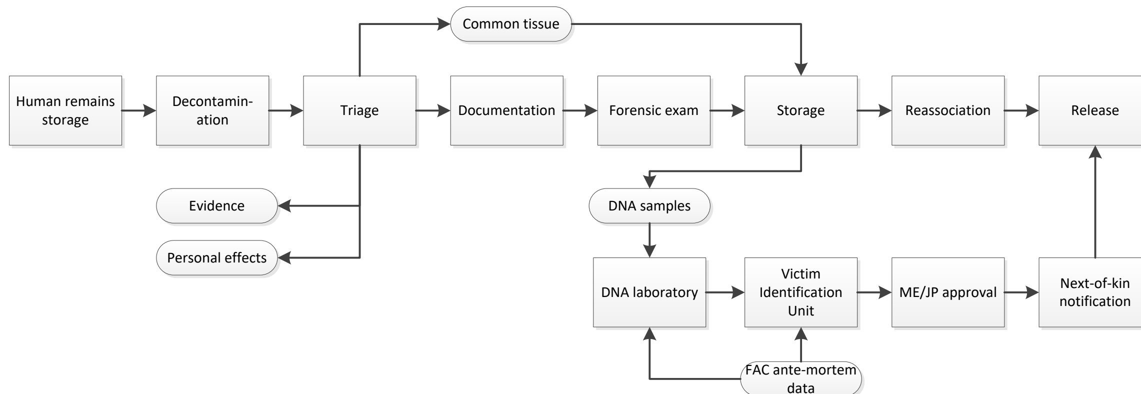
7. Known Decedents

It is not uncommon for Mass Casualty/Mass Fatality Incident victims to pass away hours, days, or even weeks after the incident. If their cause of death was a direct result of injury or medical conditions resulting from the incident, they should be processed as Mass Casualty/Mass Fatality Incident victims. The remains of these victims should be transported to the incident-designated morgue for processing.

8. Work Flow

All human remains entering the morgue for processing should be handled in uniform fashion. The remains pass through various operational phases, categorized into three general functions: Admitting/Processing, Forensic Examination, and Victim Identification.

Suggested Morgue Station Flow



8. Admitting/Processing

There must be a formal admitting procedure in place to properly account for each set of human remains submitted to the morgue, and to create a record of each step throughout the process by the various forensic disciplines to document procedures, classify, and identify the remains. The Admitting Team creates a folder of pre-printed forms for use by each morgue station along with a tracking log to verify each set of remains has been examined at each station. The Admitting Team also assigns a Tracker for each set of remains to direct the remains from station to station.

9. Tracking:

Individuals assigned as Trackers will escort a set of remains from station to station, ensuring each required discipline has the opportunity to examine the human remains. Trackers use a one-page form listing each morgue station where the human remains are presented for examination. A station representative must check and initial the tracking form to verify each set of human remains has been presented for examination. The Tracker also collects the station's documents generated from the exam or evaluation. In the event that the human remains are presented to a station, but are determined to be unsuitable for examination, the station representative must initial the tracking document as verification that no examination is required at that station. After the Tracker has completed the entire morgue circuit, the human remains are return to storage and documentation is returned to the Admitting Team for subsequent release to the Victim Identification Unit.

10. Demobilization

Demobilization for the morgue should begin when the following criteria have been met:

- All human remains have been recovered from the site and processed through the morgue.
- Identification processes have concluded.
- Temporary storage issues for human remains have been addressed.
- Release of identifiable human remains to NOK has been accomplished.
- Disposition of unidentified human remains has been addressed.
- Radiation surveys of triage areas to ensure no radiological contamination remains.

(**Note:** See the *Morgue Operations Standard Operating Guide* for detailed information on morgue stations, operations, and protocols)

Appendix 6: Contact Information

Medina County Emergency Management Agency	(330) 722-9240
Medina County Coroner	(330) 722-9330
Medina County Sheriff	(330) 725-6631
Medina County Sheriff's Dispatch	(330) 725-6631
Medina County Health Department	(330) 723-9688
Medina County Engineer	(330) 723-9561
Medina County All-Hazards Team	(330) 722-9240
Medina Hospital (Cleveland Clinic)	(330) 725-1000
Ohio Critical Incident Stress Management Network	(800) 367-6524
Westshore Critical Incident Response Services	(440) 333-1237
Stark County Critical Incident Stress Management Team	(330) 452-6000
American Red Cross Greater Akron and Mahoning Valley	(330) 535-6131