NFPA 3000™

Standard for an Active Shooter/Hostile Event Response (ASHER) Program

2021

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NFPA 3000™

Standard for an

Active Shooter/Hostile Event Response (ASHER) Program

2021 Edition

This edition of NFPA 3000™, *Standard for an Active Shooter/Hostile Event Response (ASHER) Program*, was prepared by the Technical Committee on Cross Functional Emergency Preparedness and Response. It was issued by the Standards Council on March 15, 2020, with an effective date of April 4, 2020, and supersedes all previous editions.

This edition of NFPA 3000 was approved as an American National Standard on April 4, 2020.

Origin and Development of NFPA 3000

The first edition of NFPA 3000 was published in 2018 as only the second provisional standard in the NFPA's history. At the time there was no consensus standard for the components of a multidisciplinary program for preparedness, response, and recovery to active shooter and/or hostile events. In October of 2016 the NFPA received a new project request for the development of the standard, which was submitted by Chief Otto Drozd of Orange County Fire and Rescue in Florida on behalf of the International Association of Fire Chiefs. Orange County was one of the departments that responded to the Pulse nightclub shooting in 2016 in which 49 people were killed and an additional 58 physically injured.

Over the next 3 months, 103 committee applications and over 100 comments (97 percent supportive) were submitted supporting the development of the standard. In April 2017, the NFPA Standards Council formed the Technical Committee on Cross Functional Emergency Preparedness and Response. This group was made up of a wide swath of representatives from the fire service, law enforcement, EMS, emergency, management, higher education, and facility management. In addition to the committee representatives and organizations, there were also several guests and organizations who, while not committee members, were contributors and participants in the development of the document. Jeffrey Sarnacki, M. Scott Taylor, Brian Murphy, John Curnutt, Peter Blair, Dr. Kathryn Floyd, and J. Scott Quirarte contributed significantly to the development of the document and participated in every meeting. Also the National Lodge of the Fraternal Order of Police, the National Institute for Standards and Technology, the National Highway Traffic Safety Administration Office of Emergency Medical Services, the National Sheriff's Association, the Advanced Law Enforcement Rapid Response Training Center, the International Association of College Law Enforcement Administrators, and the International Public Safety Association sent representatives to each meeting and assisted in the development.

In November 2017, the committee petitioned the Standards Council to expedite the development and release of NFPA 3000. They cited the increased frequency and severity of active shooter/hostile events since 1999 and the lack of a standard program. At the time there was an abundance of guidance material but no accredited consensus standard. In April 2018, the Standards Council released the first edition of NFPA 3000™ (PS), *Standard for an Active Shooter/Hostile Event Response (ASHER) Program.*

The 2021 edition of NFPA 3000 marks the first time that the standard has gone through a full NFPA document revision cycle. The development of this edition included a complete review and revisions of the entire content of the document by a technical committee that swelled to over 70 members. NFPA 3000 remains the first and only consensus standard that provides information for a community's efforts to prepare for, respond to, and recover from a potential active shooter/hostile event. In just 2 years, the standard's revisions reflect a rapidly growing and changing methodology around these types of events.

As an example, the term for *reunification and family assistance centers* has changed to *notification and incident assistance centers.* This reflects directly on lessons learned from ASHER incidents that occurred during the development and after the release of the 2018 edition of NFPA 3000. The new

terminology is designed to be more inclusive so that loved ones and those who are vicarious victims — not only blood relatives — can feel empowered to seek services and information after an event. Also, the terminology is designed to create a more accurate sense of services provided rather than give a false sense of hope to someone who is seeking reunification where that may not be an option.

In an effort to continue to promote collaboration and whole-community participation, additional annual exercise requirements have been added to the chapter for responder training to match the chapters for at-risk facilities and health care. Other sections of the standard have been revised for grammar and to better inform the user of the intent of the technical committee.

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NOTE: Membership on a committee shall not in and of itself constitute an endorsement of the Association or any document developed by the committee on which the member serves.

Committee Scope: This Committee shall have primary responsibility for documents relating to the preparedness, planning, and response to cross-functional, multidiscipline, and cross-coordinated emergency events that are not already established by the NFPA. This includes all documents that establish criteria for the professional qualifications of those who are responsible for preparation, planning, exercising, and responding to cross-functional, cross-jurisdictional events.

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NOTICE: An asterisk (*) following the number or letter designating a paragraph indicates that explanatory material on the paragraph can be found in Annex A.

A reference in brackets [ ] following a section or paragraph indicates material that has been extracted from another NFPA document. Extracted text may be edited for consistency and style and may include the revision of internal paragraph references and other references as appropriate. Requests for interpretations or revisions of extracted text shall be sent to the technical committee responsible for the source document.

Information on referenced and extracted publications can be found in Chapter 2 and Annex D.

Chapter 1 Administration

1.1 Scope. The scope of this standard is limited to the necessary functions and actions related to preparedness, response, and recovery from an active shooter/hostile event response (ASHER).

1.2 Purpose. The purpose of this standard is to identify the program elements necessary to develop, plan, coordinate, evaluate, revise, and sustain an ASHER program.

1.2.1 Determining specific policies, tactics, and protocols shall be the responsibility of the authority having jurisdiction (AHJ).

1.3 Equivalency. Nothing in this standard is intended to prevent the use of systems, methods, or devices of equivalent or superior quality, strength, resistance, effectiveness, durability, and safety over those prescribed by this standard.

1.3.1 Technical documentation shall be submitted to the AHJ to demonstrate equivalency.

1.4* Application. This standard applies to any community, AHJ, facility, or member of any organization that prepares for, responds to, or assists in recovery from active shooter/hostile events (ASHE).

1.4.1* Portions of this standard might not be applicable to every jurisdiction or entity applying the standard, depending on their scope of responsibilities.

1.4.2* This standard does not apply to the prevention of an ASHE incident.

Chapter 2 Referenced Publications

2.1 General. The documents or portions thereof listed in this chapter are referenced within this standard and shall be considered part of the requirements of this document.

2.2 NFPA Publications. National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169-7471.

NFPA 72®, *National Fire Alarm and Signaling Code®*, 2019 edition.

NFPA *101®*, *Life Safety Code®*, 2021 edition.

NFPA 472, *Standard for Competence of Responders to Hazardous Materials/Weapons of Mass Destruction Incidents*, 2018 edition.

NFPA 473, *Standard for Competencies for EMS Personnel Responding to Hazardous Materials/Weapons of Mass Destruction Incidents*, 2018 edition.

NFPA 1061, *Standard for Public Safety Telecommunications Personnel Professional Qualifications*, 2018 edition.

NFPA 1221, *Standard for the Installation, Maintenance, and Use of Emergency Services Communications Systems*, 2019 edition.

NFPA 1500™, *Standard on Fire Department Occupational Safety, Health, and Wellness Program*, 2020 edition.

NFPA 1561, *Standard on Emergency Services Incident Management System and Command Safety*, 2020 edition.

NFPA 1710, *Standard for the Organization and Deployment of Fire Suppression Operations, Emergency Medical Operations, and Special Operations to the Public by Career Fire Departments*, 2020 edition.

NFPA 1720, *Standard for the Organization and Deployment of Fire Suppression Operations, Emergency Medical Operations, and Special Operations to the Public by Volunteer Fire Departments*, 2020 edition.

2.3 Other Publications.

APCO/NENA 2.105.1-2017, *NG9-1-1 Emergency Incident Data Document (EIDD)*, National Emergency Number Association, 2017.

C-TECC Tactical Emergency Casualty Care (TECC) *Tactical Emergency Casualty Care (TECC) Guidelines for First Responders with a Duty to Act*, 2017.

C-TECC Tactical Emergency Casualty Care (TECC) *Tactical Emergency Casualty Care (TECC) Guidelines for BLS/ALS Medical Providers*, 2017.

DOT *Emergency Response Guidebook*, 2016.

Merriam-Webster's Collegiate Dictionary, 11th edition, Merriam-Webster, Inc., Springfield, MA, 2003.

National Institute of Justice (NIJ) Guide-0101.06, *Selection and Application Guide to Ballistic-Resistant Body Armor for Law Enforcement, Corrections and Public Safety.*

National Institute of Justice (NIJ) Standard-0101.06, *Ballistic Resistance of Body Armor.*

NENA-STA-004.1-2014, *Next Generation United States Civic Location Data Exchange Format (CLDXF),* National Emergency Number Association, 2014.

NENA-STA-012.2-2017, *NG9-1-1 Additional Data Standard,* National Emergency Number Association, 2017.

2.4 References for Extracts in Mandatory Sections.

NFPA *101®, Life Safety Code®,* 2018 edition.

NFPA 731, *Standard for the Installation of Electronic Premises Security Systems,* 2017 edition.

NFPA 1221, *Standard for the Installation, Maintenance, and Use of Emergency Services Communications Systems,* 2019 edition.

NFPA 1600®, Standard on Continuity, Emergency, and Crisis Management, 2019 edition.

Chapter 3 Definitions

3.1 General. The definitions contained in this chapter apply to the terms used in this standard. Where terms are not defined in this chapter or within another chapter, they should be defined using their ordinarily accepted meanings within the context in which they are used. *Merriam-Webster's Collegiate Dictionary,* 11th edition, should be used as the source for the ordinarily accepted meaning.

3.2 NFPA Official Definitions.

3.2.1* Approved. Acceptable to the authority having jurisdiction.

3.2.2* Authority Having Jurisdiction (AHJ). An organization, office, or individual responsible for enforcing the requirements of a code or standard, or for approving equipment, materials, an installation, or a procedure.

3.2.3* Listed. Equipment, materials, or services included in a list published by an organization that is acceptable to the authority having jurisdiction and concerned with evaluation of products or services, that maintains periodic inspection of production of listed equipment or materials or periodic evaluation of services, and whose listing states that either the equipment, material, or service meets appropriate designated standards or has been tested and found suitable for a specified purpose.

3.2.4 Shall. Indicates a mandatory requirement.

3.2.5 Should. Indicates a recommendation or that which is advised but not required.

3.2.6 Standard. An NFPA Standard, the main text of which contains only mandatory provisions using the word "shall" to indicate requirements and that is in a form generally suitable for mandatory reference by another standard or code or for adoption into law. Non-mandatory provisions are not to be considered a part of the requirements of a standard and shall be located in an appendix, annex, footnote, informational note, or other means as permitted in the NFPA Manuals of Style. When used in a generic sense, such as in the phrase "standards development process" or "standards development activities," the term "standards" includes all NFPA Standards, including Codes, Standards, Recommended Practices, and Guides.

3.3 General Definitions.

3.3.1 Access and Functional Needs (AFN). Persons requiring special accommodations because of health, social, economic, or language challenges. [**1600,** 2019]

3.3.2* Active Assailant(s) (AA). One or more individuals actively engaged in harming, killing, or attempting to kill people in a populated area by means other than the use of firearms.

3.3.3 Active Shooter(s) (AS). One or more individuals actively engaged in harming, killing, or attempting to kill people in a populated area by the use of firearm(s).

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

3.3.5 Active Shooter/Hostile Event Response (ASHER). A response to an ASHE incident.

3.3.6 Active Shooter/Hostile Event Response (ASHER) Program. A community-based approach to preparedness, mitigation, response, and recovery from an ASHER incident, including public and private partnerships, emergency management, the medical community, emergency responders, and the public.

3.3.7* After Action Report (AAR). A comprehensive document to be completed following a review of a planned or spontaneous operation to include the actions taken (or failures to act and omissions) by personnel and involved individuals, mission results, and any pertinent and relevant information related to same operation, including lessons learned and any identified training recommendations.

3.3.8* Associated Off-Site Operations. Areas of operations that are directly related to the management of the incident but are outside the secured incident perimeter.

3.3.9* Ballistic Protective Equipment (BPE). An item of personal protective equipment (PPE) intended to protect the wearer from threats that could include ballistic threats, stabbing, fragmentation, or blunt force trauma.

3.3.10* Building Sides. A method of identifying locations in and around a building or structure consistent with the National Incident Management System (NIMS).

3.3.10.1 ***Side A (Alpha).*** Side A, also known as Side Alpha, is normally the front or main entrance/access to the building and usually the side bearing the building address. For buildings with an unusual side A, side A will be identified by the incident commander.

3.3.10.2 ***Side B (Bravo).*** Side B, also known as Side Bravo, is the adjacent side of the building or structure clockwise from Side A.

3.3.10.3 ***Side C (Charlie).*** Side C, also known as Side Charlie, is the adjacent side of the building or structure clockwise from Side B. Generally, this is the back of the building or structure.

3.3.10.4 ***Side D (Delta).*** Side D, also known as Side Delta, is the adjacent side of the building or structure clockwise from Side C.

3.3.11 Casualty. A victim who is physically injured or killed as a result of the incident. *(See also 3.3.65, Victim.)*

3.3.12* Casualty Collection Point (CCP). A temporary location used for the gathering, threat-based care, subsequent medical care, and evacuation of nearby casualties.

3.3.13 Clear. A term used to describe the status of an environment determined by law enforcement to have no active threat based on an initial assessment and might or might not be controlled by law enforcement.

3.3.14 Communications Center. A building or portion of a building that is specifically configured for the primary purpose of providing emergency communications services or public safety answering point (PSAP) services to one or more public safety agencies under the authority or authorities having jurisdiction. [**1221,** 2019]

3.3.15 Community Resiliency Center (CRC). A physical or virtual place of healing and support dedicated to serving as a resource and referral center for residents, visitors, and responders affected by an ASHE incident. A CRC will also continue to provide ongoing services and assistance to directly or proximately harmed victims, family members, first responders, and community members.

3.3.16 Competence. Possessing knowledge, skills, and judgment needed to perform indicated objectives.

3.3.17* Complex Coordinated Attack. Synchronized attacks conducted by one or more independent teams occurring at multiple locations sequentially or in close succession using multiple attackers and employing one or more weapon systems.

3.3.18 Concealment. Hidden from observation. Anything that prevents direct observation from the threat.

3.3.19 Consensus Standard. A standard that has been adopted and promulgated by a nationally recognized and accredited standards-producing organization under procedures whereby it can be determined that persons interested and affected by the scope or provisions of the standard have reached substantial agreement on its adoption, it was formulated in a manner that afforded an opportunity for diverse views to be considered, and it has been designated as such.

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

3.3.21 Containment. A law enforcement term that connotes the establishment of a perimeter to control and isolate movement.

3.3.22* Control Zones. The areas at ASHE incidents within an established perimeter that are designated based upon safety and the degree of hazard.

3.3.23 Coordination. The process of bringing individuals, stakeholders, and resources from different organizations together to work integrally and harmoniously in a common action or effort.

3.3.24 Cover. Anything capable of physically protecting an individual from the threat(s), such as ballistic rounds and shrapnel.

3.3.25 Emergency Operations Center (EOC). The physical or virtual location where the coordination of information and resources to support incident management (on-scene operations) activities.

3.3.26 Evaluate. The process of assessing or judging the effectiveness or need of an action or course of action within the training and capabilities of the emergency responder.

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

3.3.28 Family Assistance Center. See 3.3.35, Incident Assistance Center (IAC).

3.3.29 Force Protection. Law enforcement or armed security, as authorized by the AHJ, providing armed protection of other responders to achieve tactical objectives.

3.3.30* Functional Task Force (FTF). Separate from a rescue task force, this is any combination of resources, requiring force protection, assembled to meet a specific tactical need. An FTF can have objectives such as information gathering, breaching, utility control, managing building systems, fire control, and additional tasks as needed.

3.3.31 Fusion Center. A focal point within the state, region, and/or major urban area for the receipt, analysis, gathering, and sharing of threat-related information between the federal government and state, local, tribal, territorial, and private sector partners.

3.3.32* Hazardous Device. An object or tool incorporating destructive, lethal, noxious, energetic, or incendiary materials and designed to destroy, incapacitate, harass, or distract.

3.3.33 Health Care Receiving Facilities. Locations that are in their normal course of business expected to receive ambulance and emergency patients.

3.3.34 Hospital. A building or portion thereof used on a 24-hour basis for the medical, psychiatric, obstetrical, or surgical care of four or more inpatients. [***101,*** 2018]

3.3.35* Incident Assistance Center (IAC). A physical or virtual center where victims, family members, and loved ones can seek referrals and services for mental health counseling, health care, and child care; legal, travel, creditor, employee, and financial planning assistance; information on insurance benefits, IRS and tax policies, social security and disability; and other victim services established after the immediate recovery operations have taken place. The IAC is typically established following the closure of the notification center.

3.3.36 Incident Command Post. A stationary work location used by the incident commander or a unified command for the purpose of command and control.

3.3.37 Incident Command System (ICS). A specific component of an incident management system (IMS) designed to enable effective and efficient on-scene incident management by integrating organizational functions, tactical operations,

incident planning, incident logistics, and administrative tasks within a common organizational structure.

3.3.38 Incident Commander (IC). The individual, regardless of rank, responsible for all incident activities, including the development of strategies and tactics and the ordering and the release of resources.

3.3.39 Incident Management System (IMS). A process that defines the roles and responsibilities to be assumed by personnel and the operating procedures to be used in the management and direction of emergency operations to include the incident command system (ICS), unified command, multiagency coordination system, training, and management of resources.

3.3.40* Individual First Aid Kit (IFAK). A component of the responder's personal protective equipment (PPE).

3.3.41 Joint Information Center (JIC). A location used to coordinate critical emergency information, crisis communications, and public affairs functions. This is also the central location that facilitates operation of the joint information system (JIS).

3.3.42 Joint Information System (JIS). The mechanism to organize, integrate, and coordinate information to ensure timely, accurate, accessible, and consistent messaging across multiple jurisdictions or disciplines, including private sector and nongovernment organizations.

3.3.43* Loading Zone. One or more geographic locations where transport vehicles are available to load victims.

3.3.44 Logistics. Coordination of a complex operation involving many people, facilities, or supplies.

3.3.45* Mutual Aid. When agencies and/or jurisdictions assist one another on request by furnishing personnel, equipment, and/or expertise in a specified manner. This is frequently based on previously agreed upon plans, memorandums of understanding, contracts, or agreements.

3.3.46 National Incident Management System (NIMS). A comprehensive, national approach to incident management that is applicable at all jurisdictional levels and across functional disciplines. It is intended to be applicable across a full spectrum of potential incidents, hazards, and impacts, regardless of size, location, or complexity; improve coordination and cooperation between public and private entities in a variety of incident management activities; and provide a common standard for overall incident management.

3.3.47* Notification Center. A secure facility in a centralized location that provides information about injured, missing, unaccounted for, or deceased persons and initial services for victims, family members, and designated points of contact. The notification center also helps displaced survivors, including children, to re-establish contact or be reunited with their family and friends after a period of separation. The notification center is not intended for the general public, media, or unaffiliated individuals.

3.3.48 Patient. A victim receiving medical evaluation and treatment, which can include physical and mental health services.

3.3.49 Personal Protective Equipment (PPE). Equipment designed and approved to be worn for identified risk(s) to minimize exposure to hazards that cause injuries and illnesses. PPE includes BPE.

3.3.50 Plan. Typically any diagram or list of steps with details of timing and resources, used to achieve an objective to do something. It is commonly understood as a temporal set of intended actions through to achieve a goal.

3.3.50.1 ***Emergency Action Plan (EAP).*** A document to facilitate and organize employer and employee actions during workplace emergencies.

3.3.50.2 ***Emergency Operations Plan (EOP).*** A document that assigns responsibility to organizations and individuals, sets forth lines of authority and organizational relationships, describes how people and property are protected, identifies personnel, equipment, facilities, supplies, and other resources, and reconciles requirements with other jurisdictions. An EOP includes prevention, preparedness, response, mitigation, and recovery functions.

3.3.50.3 ***Incident Action Plan (IAP).*** A verbal plan, written plan, or combination of both that is updated throughout the incident and reflects the overall incident strategy, tactics, risk management, and member safety requirements approved by the incident commander. [**1600,** 2019]

3.3.51 Premises Security System. A system or portion of a combination system that consists of components and circuits arranged to monitor or control activity at or access to a protected premises. [**731,** 2017]

3.3.52* Public Access Trauma Kits. These kits are readily available to the public. They are designed to give the public access to medical supplies that can be used to address preventable causes of death due to trauma.

3.3.53 Public Information Officer (PIO). An individual(s) who gathers, verifies, coordinates, and disseminates public information and enables effective communications with various target audiences. The PIO coordinates closely with unified command and the JIC throughout the incident.

3.3.54 Recovery. Continuity of services and support to restore the equilibrium and meet the needs of the whole community, affected businesses, and direct or proximate victims who have been physically, psychologically, or otherwise affected in the short- or long-term following the incident.

3.3.55 Recovery Coordinator. A person designated for incorporating recovery and mitigation considerations into the early decision-making processes. The recovery coordinator monitors the impacts and results of such decisions and evaluates the need for additional assistance and resources to enhance resiliency.

3.3.56 Risk Assessment. The process of identifying threats and hazards to life, property, operations, the environment, and entities, and the analysis of probabilities, vulnerabilities, and impacts. [**1600,** 2019]

3.3.57 Scenario. A sequence or synopsis of actual or imagined events used in the field or classroom to provide information necessary to meet student competencies; can be based upon threat assessment.

3.3.58* Secured. A location that is determined to have no continuing threat and is controlled by law enforcement.

3.3.59 Specialized Teams. A law enforcement unit or team responsible for specialized tactics at high-risk incidents; also known as law enforcement special response team (SRT) or special weapons and tactics (SWAT).

3.3.60* Threat-Based Care. Medical care provided as determined by the hazard or risk present.

3.3.61 Treatment Area. Location for the treatment of victims after extraction and sorting, prior to loading for transport to definitive care.

3.3.62 Triage. A continuous process of determining the priority of casualty based upon the severity of their condition and resources available.

3.3.63 Unified Command. An application of the ICS that allows all stakeholders with responsibility for an incident or planned event, either geographical or functional, to manage an incident or planned event by establishing a common set of incident objectives and strategies. Depending on the needs of an ASHE incident, this consists of law enforcement, fire, EMS, a location representative, or others as dictated by the AHJ and needs of the incident.

3.3.64* Unified Command Post. The physical location where the primary tactical level, on-scene unified incident command functions are performed.

3.3.65* Victim. Person(s), including responders, who are directly or proximately harmed by the incident as the result of a criminal offense.

3.3.66* Victim Advocate. Professionals trained to directly assist victims and families with resources, information, emotional support, and other services.

3.3.67* Victim Navigator. Serves as the point of contact for victims and families impacted by ASHE incidents.

3.3.68 Warm Zone Response Models. The models in 3.3.68.1 through 3.3.68.4 represent four warm zone operational tactics that can be employed by an AHJ for the purposes of integrated medical response to ASHE incidents.

3.3.68.1* ***Rescue Task Force (RTF).*** A team of law enforcement or armed security, as authorized by the AHJ, and any combination of fire and EMS personnel that provides threat-based care and victim extraction. This group moves within the warm zone.

3.3.68.2 ***Protected Island Operations.*** A warm zone response concept in which law enforcement or armed security, as authorized by the AHJ, forms a secure perimeter around fire and EMS responders in order for them to provide threat-based care until extraction and egress is available.

3.3.68.3 ***Protected Corridor Operations.*** A warm zone response concept in which law enforcement or armed security, as authorized by the AHJ, forms a secure path through which fire and EMS responders provide threat-based care and extract victims.

3.3.68.4 ***Law Enforcement/Armed Security Rescue.*** A warm zone response modality in which law enforcement officers or private security, if authorized by the AHJ, form teams for the purpose of threat-based care and extraction of victims.

3.3.69 Witness. A person who has information or evidence regarding an event or incident.

3.3.70 Witness Interview/Debrief Area. A location where individuals with knowledge of or involvement in the incident assemble for interviews.

3.3.71* Zones. Dynamic locations during an incident.

3.3.71.1* ***Hot Zone.*** An area where there is a known hazard or direct and immediate life threat.

3.3.71.2* ***Warm Zone.*** An area where there is the potential for a hazard or an indirect threat to life.

3.3.71.3* ***Cold Zone.*** Areas where there is little or no threat due to geographic distance from the threat or the area has been secured by law enforcement.

Chapter 4 ASHER Program Development Process

4.1 Administration.

4.1.1 Scope. This chapter outlines the necessary components of an ASHER program.

4.1.2 Purpose. This chapter provides organizations including AHJs and stakeholders with a framework for developing an ASHER program.

4.2 ASHER Program Organizational Statement. The organization and/or jurisdiction shall maintain a documented policy that establishes the following:

(1)* Existence of the ASHER program
(2) Services that the ASHER program will provide
(3) List of ASHER program stakeholders
(4) Functions that ASHER program stakeholders are expected to perform
(5) Risk assessment in accordance with Chapter 5
(6) Planning and coordination in accordance with Chapter 6
(7) Resource management in accordance with Chapter 7
(8) Unified command policies in accordance with Chapter 8
(9) Facility preparedness in accordance with Chapter 9
(10) Financial management in accordance with Chapter 10
(11) Pre-, during, and post-event communications procedures in accordance with Chapter 11 and 17
(12) First responder and public training programs in accordance with Chapters 12, 13, and 15
(13) Use of personal protective equipment (PPE) in accordance with Chapter 14
(14) Public education in accordance with Chapter 16
(15) Public Information, communications, and media relations in accordance with Chapters 17 and 20
(16) Continuity of operation in accordance with Chapter 18
(17) Hospital preparedness and response in accordance with Chapter 19
(18)* Recovery operations, including whole community, business continuity, victim services, and after action reporting in accordance with Chapter 20

Chapter 5 Risk Assessment

5.1 Administration.

5.1.1* Scope.

5.1.1.1 This chapter applies to those responsible for organizing, managing, and sustaining an ASHE preparedness, mitigation, response, and recovery program.

5.1.1.2 The chapter provides requirements for assessing community and facility risks associated with an ASHE incident.

5.1.2 Purpose. This chapter provides the requirements for conducting a community's and a facility's risk assessment, including hazard identification, vulnerability assessment, consequence identification, and risk analysis.

5.1.2.1 Risk assessment characterizes the likelihood of and the impact associated with an ASHE incident.

5.1.2.2 Risk assessment influences all phases of an ASHER program: preparedness, mitigation, response, and recovery.

5.2 At-Risk Locations.

5.2.1* At-risk locations shall include places where ASHE incidents are capable of causing death, physical injury, psychological harm, property damage, environmental impact, or system disruptions.

5.2.2* Any location shall be considered to be at risk for an ASHE incident. However, conducting a risk assessment shall help determine the level of risk for each specific location.

5.2.2.1 Consideration of at-risk locations or events shall include but shall not be limited to the following:

(1) Public gatherings
(2) Places and events of national or local significance
(3) The target of credible threats

5.2.2.2 Consideration of the conditions and circumstances in proximity of the potential incident site shall include the following:

(1) Population demographics, including vulnerable groups and communities or neighborhoods
(2)* Private and public property, including critical facilities, critical infrastructures, and transportation facilities and corridors
(3)* Any positions that would provide a tactical advantage
(4) Environmental features or conditions

5.3* Analyzing the Consequences of an Attack. The consequences of an attack shall be analyzed at each identified location within the organization/jurisdiction to include potential impact to human life, property loss, economic impact, and system disruptions.

5.3.1 Reviews of estimated outcomes shall include the following:

(1) Dimensions of the affected area, based on the type and scope of attack
(2) Likely number and types of impacts within the affected area, including fatalities and injured individuals, environment, property, and systems, based on the type and scope of attack
(3) Likely physical, health, and safety hazards within the impacted and surrounding areas
(4) Likely outcomes within the area based on exposures within the areas of impact

5.3.2 Cascading and Complex Coordinated Incidents.

5.3.2.1 Cascading incidents and complex coordinated attacks shall compound the stresses placed on the response system as a whole and shall be considered when assessing risk.

5.3.2.2 When evaluating cascading incident potential, each location shall be viewed as an individual incident within the context of a larger event.

5.4* Hazard/Risk Assessment (Probability/Consequence).

5.4.1* Community Risk Assessment. Community risk assessment shall be conducted to determine the probability of an incident and the consequences of such an attack.

5.4.1.1 Consequences shall be determined by the evaluation of the assessed risks duration and nature of the event, property loss, personal injury or loss of life, psychological trauma, economic loss, interruption of commerce, and environmental impact.

5.4.1.2 These consequences shall be grouped into the following four categories:

(1) Human impacts (civilian and responder injuries, deaths, or psychological trauma)
(2) Economic impacts (property loss, both direct and indirect effects)
(3) Community impact (public confidence)
(4) Functional impact (continuity of operations)

5.4.2* Facility/Venue Risk Assessment. For each identified at-risk location, the following information shall be considered in the risk assessment and made available to the AHJ to be considered in the community risk assessment:

(1) Special consideration for occupants/attendees shall include the following:
    (a) Age groups
    (b) Access and functional needs
    (c) Language barriers
(2) Building/venue property owner or owner representative
(3) Name or other identification of area/facility
(4) Number of occupants/attendees and maximum capacity
(5)* Security capabilities of venue (cameras, security, detection)
(6) Ingress
(7) Egress
(8) Area accessibility
(9) Public access control
(10) Facility/area use
(11) Fire alarm systems and mass notification systems consistent with *NFPA 72*
(12) Existence of fire protection systems
(13)* Building construction type and protective features
(14) Availability of building/venue map and/or site plan
(15) Threat-related intelligence
(16) Distance to and capabilities of medical facilities
(17) Nearby structures
(18) Seasonal weather conditions
(19)* Emergency responder accessibility
(20)* Onsite medical or trauma equipment
(21)* Integrated response plan
(22) Other relevant information

5.4.3 Prioritizing Community Vulnerability.

5.4.3.1 Factors used to prioritize the need for individual facility risk assessment shall include, but are not limited to, the following:

(1) High occupancy
(2) Easy access
(3) Public profile

(4) Known target or previous threats (known political and religious affiliation)
(5) Potential for significant public impact

5.4.3.2 Once risk assessment is complete, target hazards shall be ranked based on probability and consequence.

5.4.4* Geographic-Based Analysis. A geographic information system (GIS) provides layers of information that shall be used to map locations and assess potential impact, which allows planners to identify the relationships between the hazards, predict outcomes, visualize scenarios, and plan strategies.

Chapter 6 Planning/Coordination

6.1 Administration.

6.1.1 Scope. This chapter establishes the planning process for those jurisdictions or organizations responsible for developing, managing, and sustaining an ASHER program.

6.1.1.1 Plans shall be flexible and adjusted to address emerging and evolving risks, threats, and changes in operational or organizational conditions.

6.1.2* Purpose. This chapter addresses emergency operations plans (EOPs), standard operating procedures (SOPs), standard operating guidelines (SOGs), and pre-incident plans for the safe, effective response to ASHE incidents.

6.2* Plan Development. The AHJ shall establish an ASHER plan organized in a logical framework based on its resource capabilities and current risk assessment as referenced in Chapter 5.

6.2.1* Multi-agency and multidiscipline relationships shall be established for the development of plans, risk assessments, mutual aid agreements, and memorandums of understanding (MOU).

6.2.2 As part of an ASHER program, jurisdictions or organizations shall conduct a resource analysis.

6.2.2.1 This analysis shall include at a minimum the following:

(1) Review of minimum standards for responder competencies
(2) Current resource capabilities
(3) Mutual-aid and other agreements that are already in place
(4) Gaps between minimum standards and current capabilities
(5) Capabilities required to address needs identified in gap assessment

6.2.3 The AHJ shall utilize a formal process to ensure that plans are developed, maintained, updated, tested, and activated, including at a minimum the following:

(1) A needs or gap assessment
(2) Plan development
(3) Implementation
(4) Evaluation

6.2.4* The AHJ's planning team shall perform a needs or gap assessment of resources necessary to meet the mission identified in the plan.

6.2.5 Plans shall address coordination among agencies, including the at a minimum the following:

(1) Resource management
(2) Staffing requirements
(3) Integrated training with other disciplines
(4) Health and medical issues, including responder behavioral health
(5) Financial responsibilities and management
(6) Recovery and restoration

6.2.6* Plans shall provide a starting point for multi-agency multidisciplinary operations.

6.3* EOPs. Local jurisdictions shall have an emergency operations plan with guidance for preparedness, mitigation, response, and recovery for ASHE incidents.

6.4* SOP Planning Components. SOPs shall be built around relevant core capabilities as identified by the EOP.

6.4.1 Local jurisdictions shall develop SOPs.

6.4.2* SOPs shall be developed as part of the ASHER program for the following:

(1) Personal safety
(2) Response consistency
(3) Guide response actions
(4) Decision making
(5) Coordination and interoperability with other agencies and organizations
(6) Unified incident management

6.5 Post-Incident Procedures. An ASHER program shall have procedures for specific processes that shall be followed after an ASHE incident.

6.5.1 Each participating entity shall conduct an operations debrief.

6.5.2 Post-incident procedures shall include a plan for demobilization.

6.5.3* Post-incident procedural steps shall include a plan for restoring units and personnel to operational readiness.

6.5.4* A formalized debriefing and the generation of an AAR shall be completed and include input from all participating entities.

6.5.5 Jurisdictions and organizations shall implement and integrate AAR recommendations in plan(s) as practical.

6.6 Incident Management. An ASHER program shall have an incident structure that is consistent with the National Incident Management System (NIMS).

6.7 Active Shooter/Hostile Event Response Guideline.

6.7.1 Guidelines for response to an incident involving ASHE incidents shall be based on available resources, trained personnel, and capabilities necessary to perform assigned tasks.

6.7.2* As part of the ASHER program, the AHJ shall develop guidelines, procedures, or both that outline but are not limited to the following:

(1) Unified strategic objectives
(2) Unified tactical considerations
(3) Interoperability among resources
(4) Resource needs
(5) Dispatching and notification procedures
(6) Public safety telecommunicator pre-arrival instructions
(7) Staging management to avoid over-convergence

(8) Predetermined mutual aid requests
(9) Emergency operation center activation guideline
(10)* Civilian action response and reaction plan
(11) Personnel recall
(12) Incident stabilization
(13) Information sharing
(14) Considerations for those with access and functional needs
(15) Family or loved ones notification
(16) Victim and survivor assistance
(17) Public information and media management
(18) The transition to recovery
(19) Incident assistance center

6.8* Operational Security. Operational security (OPSEC) shall be an integral element of the organization/jurisdiction preparedness program.

6.9 Information and Intelligence Sharing.

6.9.1* The AHJs shall develop and maintain relationships that help facilitate intelligence and information sharing, including formal relationships with government fusion centers, local/regional/tribal/state offices of emergency management, and law enforcement/fire/EMS partners to coordinate response plans consistent with current threats.

6.9.2 AHJs shall develop programs and plans that utilize social media for the purpose of intelligence gathering, evidence collection, or information distribution.

Chapter 7 Resource Management

7.1* Administration.

7.1.1 Scope. This chapter provides requirements for developing a resource management plan to ensure that required resources are available to meet program objectives.

7.1.2 Purpose. This chapter addresses needed resources to enhance efficient and effective response to active shooter/hostile events while reducing risk.

7.2 Personnel. The AHJ shall have tools, systems, policy, and procedures in place for the tracking of personnel.

7.2.1 The AHJs and responsible parties shall create necessary personnel policies and procedures.

7.2.2 The AHJs shall determine the appropriate personnel required to meet the needs of the ASHER program.

7.3* Mutual Aid. In order to supplement operations at an existing emergency incident, the AHJ shall coordinate with local response and emergency management agencies and have knowledge of the following, at a minimum:

(1) Relevant mutual aid assistance agreements
(2) Existing mutual aid systems
(3) Available mutual aid resources
(4) Automatic aid

7.4* Logistics and Records Management. The AHJ shall have knowledge of logistical resources and maintain a system to acquire resources as needed and available.

7.4.1 AHJs shall ensure they have a logistics plan in place to support the resource requirements of their ASHER program.

7.4.2 The AHJ shall establish a thorough and complete resource record-keeping system to ensure that supply management is documented and recorded.

Chapter 8 Incident Management

8.1 Administration.

8.1.1 Scope. This chapter provides requirements for incident management on a command level to ensure that incidents are managed in a unified and organized manner in accordance with all local, state, tribal, and federal requirements.

8.1.2 Purpose. This chapter addresses incident management requirements for the safe, effective response to ASHE incidents.

8.2 Application of Unified Command.

8.2.1* The incident command system and unified command shall be utilized at all emergency incidents.

8.2.2 Unified command shall be applied to drills, exercises, pre-planned events, and other situations that involve hazards similar to those encountered at actual emergency incidents.

8.2.3 Unified command shall be responsible for the overall management of the incident and the safety of all members involved.

8.2.3.1* The command structure shall be set up so that all agency representatives share responsibilities to command resources in a coordinated effort through a common strategy and shared objectives.

8.2.3.2 The goals of unified command shall be the following:

(1) Life safety
(2) Incident stabilization
(3) Resource and property conservation

8.2.3.3 To accomplish the goals listed in 8.2.3.2, unified command shall do the following:

(1) Recognize the presence of the incident, conduct an evaluation, and respond to the threat(s)
(2) Provide for the safety of victims, bystanders, the community, and response personnel
(3) Maintain situational awareness, which includes an ongoing risk assessment
(4) Initiate, maintain, and control incident communications and joint information sharing
(5)* Develop an overall strategy and incident action plan, which includes managing resources, maintaining an effective span of control, and maintaining direct supervision over the entire incident, and functional groups or geographical divisions
(6) Ensure personnel resource assignments, logistics, and accountability
(7) Review, evaluate, and revise the incident action plan as required
(8) Initiate an incident communications plan
(9) Coordinate public information
(10) Maintain, transfer, and terminate command

8.3 Incident Size-Up. A size-up shall be conducted initially and followed by an ongoing dynamic risk assessment throughout the incident.

8.3.1 The elements of size-up shall include but not be limited to the following:

(1) Major incident notification as classified by the AHJ in the ASHER program
(2)* Specific location and characteristics
(3) Type of incident
(4) Known hazards and the number of potential assailants and their location
(5) Access and staging for incoming units
(6) Approximate number of victims
(7) Additional resources needed

8.4 Establishing Unified Command. The AHJ for the ASHER program's agencies shall establish practices to ensure prompt implementation of unified command.

8.4.1* Unified command shall meet the requirements of NFPA 1561 and shall have written SOPs applying to all members involved in emergency operations within the AHJ.

8.4.2 Unified command shall be comprised of the following essential disciplines, if applicable:

(1) Fire
(2) EMS
(3) Law enforcement
(4) Emergency management
(5)* Additional participating or coordinating agencies as dictated by the needs of the incident

8.4.3* Each discipline shall evaluate the incident from their perspective, and these independent evaluations shall be combined to form an incident action plan (IAP).

8.4.3.1 This coordinated response shall include each discipline required to achieve the desired outcome of managing the incident.

8.4.3.2 This coordinated response shall be an ongoing process until such time as the incident is concluded.

8.4.4 As incidents evolve in size and complexity, the unified command shall divide the incident into functional or geographical level components, or both, as necessary.

8.5 Transfer of Command. The transfer of command shall not eliminate the need for unified command to remain co-located for the duration of the incident.

8.6* Incident Stabilization. The need for unified command shall be dictated by the incident objectives and personnel responsibilities, and it is likely to extend beyond the emergency response phase of the incident.

8.6.1 After incident stabilization, incident management shall transition to recovery phases as detailed in Chapter 20.

8.6.2 All ASHE incidents shall be considered crime scenes.

8.6.2.1 All personnel shall refrain from unnecessarily disrupting any part of the incident scene.

8.6.2.2 Evidence preservation, victim and witness identification, and overall scene preservation shall be primary considerations after life safety objectives have been met.

8.7* After Action Reports. AHJs that have experienced an ASHE incident shall complete an AAR of the event.

8.7.1 The completed AAR shall be shared with all parties involved with the response to the ASHE incident.

8.7.2 Special consideration shall be given to updating ASHER program training, policies, and documents to reflect an improvement plan as part of the AAR.

Chapter 9 Facility Preparedness

9.1 Administration.

9.1.1* Scope. The scope of this chapter provides requirements for facility preparedness and planning for onsite ASHE incidents.

9.1.2* Application. This chapter shall apply to facilities at risk for an ASHE incident as determined by the AHJ.

9.2 Facility and Occupancy Characteristics.

9.2.1 Facility preparedness shall consider the following attributes:

(1) The number of occupants
(2)* The ability of the occupants to evacuate, relocate, or secure in place
(3)* Internal staff response and assistance to include threat recognition and threat reaction procedures and training
(4) External notification systems
(5) The number, location, and contents of public access trauma kits
(6)* Building construction type and protective features
(7)* Physical security
(8)* Facility internal notification and signaling systems
(9) Signage
(10)* Emergency communications equipment
(11) Surrounding areas and possible relocation resources
(12) A system to support the AHJ's efforts to conduct notification of family and loved ones

9.2.2* The mobility characteristics of the occupants shall be evaluated as part of the facility response plan.

9.3* Emergency Action Plans (EAP).

9.3.1* EAPs for ASHE incidents shall include guidelines and procedures to maximize life safety and include the following criteria, at a minimum:

(1)* Facility assessment to support preparedness, protective actions, and communications
(2) Communications plan
(3) Alert and warning plans
(4) Personal emergency preparedness training for protective and medical actions for individuals to take before, during, and after an ASHE incident
(5) Appropriate evacuation, relocation, and secure-in-place procedures

9.3.2 The plan for ASHE incidents shall include the location and identification of lockable or securable spaces and rooms as well as the locations of exits that lead directly to the outside or to a stairwell.

9.3.3 The plan for ASHE incidents shall include procedures for locking or securing of doors from inside of the designated areas.

9.3.3.1 The plan for ASHE incidents shall include the use of physical security capabilities identified in the risk assessment in Chapter 5.

9.3.3.2 Plans and procedures for doors for areas designated in 9.3.3 shall comply with locking or securing and unlocking or unsecuring and unlatching requirements of NFPA *101*.

9.3.3.3 The procedures for unlocking or unsecuring doors from outside the designated areas shall be included in the plan.

9.3.4 Means of egress and escape shall comply with the requirements of NFPA *101*.

9.3.5 Facilities shall make emergency action plans available to the AHJ.

9.4 Notification.

9.4.1 Occupant notification shall be made in a timely manner.

9.4.2* The signaling and messaging process or procedure shall be designed to be readily distinguishable from the fire alarm signals.

9.5* Exercise. Owners and operators of an individual building shall exercise their ASHER program not less than once annually.

9.5.1* The AHJ shall be notified of an exercise.

9.5.2* Organizations with multiple buildings on a single campus shall exercise their ASHER program not less than once annually.

Chapter 10 Financial Management

10.1 Administration.

10.1.1 Scope. This chapter applies to those organizations or jurisdictions responsible for organizing, managing, and sustaining an ASHER program and provides guidance for managing financial elements of the program.

10.1.2* Purpose. This chapter addresses revenue sources, program costs, inventory control, and cost recovery issues to underscore the importance of funding an ASHER program

10.2 Documentation and Management Policy.

10.2.1 The ASHER program shall have a comprehensive, documented, and consistently maintained financial management policy maintained by the AHJ.

10.2.1.1 The AHJ shall ensure memorandums of understanding (MOU)s are in place and address the ASHER program's needs.

10.3* Revenue Sources. AHJs shall utilize multiple revenue sources for ASHER programs, if needed.

10.3.1 Operating Budgets. The AHJs with management responsibility for an ASHER program shall ensure they are aware of the applicable financial management policy in accordance with Section 10.2.

10.4* Program Costs. An ASHER program budget shall be categorized by applicable cost centers.

10.5* Cost Recovery. The AHJ shall identify opportunities for cost recovery for ASHER programs, response, and recovery.

Chapter 11 Communications Center Support

11.1 Administration.

11.1.1 Scope. Communications centers support, manage, and receive emergency requests for services and gather and relay information as appropriate during an ASHE incident.

11.1.2 Purpose. This chapter provides requirements in order for communications centers to be able to meet the mission of supporting, managing, gathering, and relaying information during ASHE incidents.

11.2* Communication Center Coordination.

11.2.1 Communication centers shall incorporate first responder ASHE incident goals and objectives into center operations.

11.2.2 AHJs shall ensure that emergency communications centers have plans and procedures in place, including but not limited to the following:

(1) Effectively being able to communicate with all of their dispatched responding units/personnel
(2) Rollover plans for 911 and emergency calls to other emergency communication centers
(3) The ability for backup/rollover agencies to share information with partner agencies
(4) Interoperable radio communications between emergency communications centers
(5) Ensuring effective staffing, including emergency call in for staffing
(6) Ensuring effective processing of peak emergency call volume

11.2.3* Communications personnel shall participate in ASHER program training and exercises on an annual basis at a minimum.

11.3* Communication Relationships. The comprehensive communication plan shall describe and define the communication relationships between all AHJs.

11.4* Communication and Dispatch Systems. Communications and dispatch systems shall follow NFPA 1221.

11.4.1* In planning and preparing for ASHE incidents, AHJs shall ensure they plan for sufficient emergency communications and dispatch capabilities to manage the ASHE incident.

11.4.2* Communications center personnel handling an ASHE incident shall follow NFPA 1061 regardless of their physical location.

11.5* Data and Information Management Data and information management shall follow NENA-STA-012.2-2017, NENA-STA-004.1-2014, and APCO/NENA 2.105.1-2017.

11.6 Essential Data Elements for ASHE Incidents. AHJs shall create or maintain mechanisms to capture specific data elements to be included in AARs and used to improve program plans.

11.6.1 AHJs shall identify and measure predetermined response and victim care benchmarks to evaluate performance and track improvement for future incidents.

11.6.1.1 These benchmarks shall include the following at a minimum:

(1) Elapsed time until the first law enforcement unit is on scene
(2) Elapsed time until unified command is established
(3) Elapsed time until the first contact team is deployed
(4) Elapsed time until the threat(s) is stopped
(5) Elapsed time until the first integrated response team is assembled, if applicable
(6) Elapsed time until the first and subsequent integrated response teams are deployed
(7) Elapsed time until the establishment of warm zone care of victims
(8) Receipt of appropriate deployment guidance for integrated response teams from unified command
(9) Elapsed time until contact with the first victim
(10) Elapsed time until the last victim is contacted
(11) Performance of essential victim care procedures, such as tourniquet application
(12) Elapsed time until the first victim is evacuated
(13) Elapsed time until the last victim is evacuated
(14) Elapsed time until the first victim arrives at the hospital
(15) Elapsed time until the last victim arrives at the hospital

11.6.1.2 Additional measures to evaluate the intended goals and functions of each element of response shall include the following at a minimum:

(1) Command and control
(2) Contact team
(3) Integrated response teams

11.7 Operability.

11.7.1* The communications system shall allow for radio communications between all public safety personnel within the confines of standard operating procedures (SOP) and standard operating guidelines (SOG).

11.7.2 If communication system interoperability is not immediately available, the communication center shall ensure that the locations for incident command and other functional elements—staging, tactical, or triage—are relayed to all responding resources.

11.8* Preplanned Response Packages. Preplanned response packages consisting of the appropriate effective response force shall be dispatched to suspected ASHE incidents.

11.8.1 Communications centers shall be guided by incident command and SOPs or SOGs regarding the assignment of additional resources to ASHE incidents.

11.8.2 Communication centers shall ensure appropriate levels of coverage and response for other calls for service occurring outside of the active ASHE incident.

Chapter 12 Competencies for Law Enforcement Personnel

12.1 Administration.

12.1.1 Scope. This chapter applies to all law enforcement personnel who in the course of their duties could find themselves responding to an ASHE incident.

12.1.2 Purpose. The purpose of the competencies in this chapter is to provide law enforcement officers who in the course of their duties could encounter ASHE incidents with the knowledge and skills to respond effectively and efficiently in an integrated manner.

12.1.3 Competencies and Tasks.

12.1.3.1* Law enforcement officers shall be trained in ASHER in accordance with an established agency policy, including, but is not limited to, the following:

(1) Unified command structure
(2) Tasks
(3) Competencies

12.1.3.2 Law enforcement officers shall receive training to meet applicable governmental regulations according to federal, state, and local standards.

12.1.3.3* Law enforcement officers shall have knowledge of a threat-based system of medical care that is consistent with the AHJ's policies and procedures.

Chapter 13 Competencies for Fire and EMS Personnel

13.1 Administration.

13.1.1* Scope. This chapter shall apply to all fire and EMS personnel who in course of their duties could find themselves responding to an ASHE incident.

13.1.2 Purpose. The purpose of this chapter is to provide fire and EMS personnel with the knowledge and skills to respond effectively and efficiently in an integrated manner to ASHE incidents.

13.1.3 Introduction.

13.1.3.1 Fire and EMS responders shall be defined as personnel who in the course of their duties encounter an emergency involving an ASHE incident. Fire and EMS responders are expected to protect themselves, call for other trained personnel, and provide triage, rapid medical intervention, and transport of the sick and injured.

13.1.3.2 Fire and EMS personnel shall be trained to meet all competencies defined in Section 13.3.

13.1.3.3 Fire and EMS responders shall receive additional training to meet applicable federal, state, local, tribal, and provincial occupational health and safety regulations, scope of practice, and protocol.

13.1.4 Goal.

13.1.4.1 The goal of the competencies in Section 13.3 shall be to provide fire and EMS personnel who encounter ASHE incidents with the knowledge and skills to respond in an integrated manner with law enforcement.

13.1.4.2 All personnel, as part of their minimum competencies, shall understand the concepts and requirements of the ASHER hot, warm, and cold zones.

13.2 Threat-Based Care.

13.2.1 Fire and EMS personnel shall have knowledge of a system where the medical care provided is determined by the hazard or risk that is present.

13.2.2* The system of care that is used to provide medical aid to self and others, including emergency patient care, at a minimum shall be in accordance with the guidelines of Tactical Emergency Casualty Care (TECC) *Guidelines for First Responders with a Duty to Act* and *Guidelines for BLS/ALS Medical Providers*.

13.3 Tasks.

13.3.1 Hot Zone Tasks.

13.3.1.1* Personnel shall not operate in the hot zone without the proper training and equipment to address the hazards that they could encounter.

13.3.1.2 Fire and EMS personnel who are not part of a specialized team, who find themselves unexpectedly in a hot zone, shall be able to perform the following tasks:

(1) Recognize the zone(s) delineation has changed and communicate same as appropriate
(2) Take measures to evacuate, defend, or engage in order to minimize injury and harm
(3) Provide threat-based care

13.3.2 Warm Zone Tasks. Fire and EMS personnel who are not part of a specialized team and who are assigned to operate in a warm zone shall be able to perform the following tasks:

(1) Communicate the following:
   (a) Determine the potential number and location of casualties.
   (b) Locate a casualty collection point(s).
   (c) Identify additional resources required.
(2) Constantly evaluate the scene for emerging or re-emerging threats and recognize conditions that could cause the zone to change from warm to hot.
(3) Conduct an evaluation and take measures to ensure personal safety as listed in 13.3.1.2.
(4) Provide threat-based triage and care.

13.3.3 Cold Zone Tasks. Fire and EMS personnel who are assigned to operate in a cold zone shall be able to perform the following tasks:

(1) Operate within the unified command system.
(2) Evaluate the scene for emerging or re-emerging threats and recognize conditions that could cause the zone to change from cold to warm or hot.
(3) Evaluate the scene for threats and take measures to ensure personal safety as listed in 13.3.1.2.
(4) Provide appropriate care.
(5)* Triage, treat, and transport victims.
(6) Support associated off-site operations as directed by unified command.

13.3.4 Associated Off-Site Operations. Fire and EMS personnel who are assigned to operate in areas of associated off-site operations shall be able to perform the following tasks:

(1) Provide services as requested by unified command that are within their scope of practice and training
(2) Respond to off-site locations for any fire and EMS needs
(3) Participate in unified command
(4) Support recovery efforts, victim assistance, and family reunification/notification
(5) Recognize conditions that cause the zone to change to hot, conduct an evaluation, and take measures to ensure personal safety as listed in 13.3.1.2

13.4 Competencies.

13.4.1 Competencies for Fire and EMS Personnel when Operating at an ASHE Incident.

13.4.1.1 Fire and EMS personnel shall receive training commensurate with the tasks listed in Section 13.3.

13.4.1.2 Fire and EMS personnel shall have knowledge of local/regional plans, policies, and procedures, including, but not limited to, the following:

(1) Major incident notification procedures
(2) Available resources
(3) Procedures for activating the local ASHER plan
(4) Communications plan and procedures
(5) Hospital interface communications and procedures
(6) "Mayday" and/or emergency assist procedure
(7) Procedures for checking into the incident with unified command for accountability and assignment
(8) Procedures on threat-based care
(9) The use of specific or specialized equipment or tools that could be required to access victims
(10) Procedures for designating zones
(11) Patient distribution plans and procedures
(12) Available medical supplies and resources and their appropriate and prescribed uses within the adopted scope of practice
(13) Personal protective equipment (PPE) and ballistic protective equipment (BPE) and their appropriate and prescribed uses
(14) Policies and procedures for operating with responders from partner agencies and jurisdictions
(15) Participate as part of a functional task force, based on incident needs, function, and capability
(16) Warm zone care and rescue concepts, including, but not limited to, the following:
   (a) Rescue task force
   (b) Law enforcement rescue teams
   (c) Protected island operations
   (d) Protected corridor operations
(17) Local law enforcement interface procedures and techniques
(18) Vehicle positioning and staging plan
(19) Identification methods to identify responders and roles
(20) Recognizing and report known or suspected hazards
(21) Transition to recovery procedures
(22)* Situational risk-benefit analysis

13.4.2 Competencies for Fire and EMS Personnel when Operating at Vehicle as a Weapon Incidents. Fire and EMS personnel shall have knowledge of the following in addition to 13.3.1.2:

(1) Local integrated response procedures necessary to efficiently mitigate this threat
(2) Potential vehicle-borne improvised explosive device (VBIED) identification
(3) Chemical, biological, radiological, nuclear, and explosive (CBRNE) operations and awareness
(4) Building and vehicle stabilization
(5) Vehicle extrication and casualty removal

13.4.3* Competencies for Fire and EMS Personnel when Operating at an IED(s) Incident. Fire and EMS personnel shall have knowledge of the following in addition to 13.3.1.2:

(1) Local integrated response procedures necessary to efficiently and effectively mitigate this threat
(2) Blast effects and associated injuries
(3) Recognition and awareness of hazardous devices and operational considerations
(4) Local procedures for the deployment and positioning of vehicles

(5) Evacuation distance using the DOT *Emergency Response Guidebook* for IED safe stand-off distance and/or the DHS stand-off chart
(6) Local post-blast transition to fire event/structural collapse response procedures

13.4.4 Competencies for Fire and EMS Personnel when Operating at Fire and Smoke as a Weapon Incidents. Fire and EMS personnel shall have knowledge of the following in addition to 13.3.1.2:

(1) Local integrated response procedures or capabilities necessary to efficiently and effectively mitigate this threat
(2) Fireground operations consistent with NFPA 1710 and NFPA 1720 depending on role (fire vs. EMS only responders)
(3) Recognition and awareness of hazardous devices and operational considerations
(4) AHJ's requirements for incidents with fire and smoke as a weapon

13.4.5 Competencies for Fire and EMS Personnel when Operating within Immediately Dangerous to Life and Health (IDLH) Atmospheres.

13.4.5.1 Fire and EMS personnel shall have knowledge of the following in addition to 13.3.1.2:

(1) Local integrated response procedures necessary to efficiently and effectively mitigate this threat
(2) Proper use of PPE, to include respiratory protection, for the hazard that will be encountered
(3) "Mayday" or emergency assist procedures
(4) Rapid intervention crew procedures
(5) The hazardous atmosphere and the characteristics of the chemical
(6) Sign and symptoms of exposure
(7) Decontamination procedures

13.4.5.2 When operating in an IDLH atmosphere, personnel shall have the proper knowledge, skills, abilities, and appropriate personnel protective equipment in accordance with NFPA 1500 (Fire), NFPA 472 (Fire), and NFPA 473 (EMS).

Chapter 14 Personal Protective Equipment (PPE)

14.1 Administration.

14.1.1 Scope. This chapter applies to the AHJ responsible for deploying emergency responders as part of an ASHER program.

14.1.2 Purpose. This chapter provides guidance for the use and maintenance of responder personal protective equipment (PPE), to include ballistic protective equipment (BPE).

14.2 General Requirements.

14.2.1 The AHJ shall provide appropriate PPE and BPE in accordance with applicable standards to personnel exposed to ballistic risks or other hostile threats in accordance with expected duties.

14.2.2 Zones of operation are subject to dynamic and immediate change; therefore, unified command shall conduct continuous size-up and threat assessment during an incident. *(See Chapter 8.)*

14.2.3* Personnel shall utilize PPE, including but not limited to BPE, as dictated by the needs of the incident and in accordance with the following zones of operation:

(1) Hot zone. PPE shall include but is not limited to BPE, means of communication, and an identifying garment.
(2) Warm zone. PPE shall include but is not limited to BPE, means of communication, and an identifying garment.
(3) Cold zone. An identifying garment or visible identification and means of communication shall be required. Additional PPE shall be required.

14.2.4* The PPE deployment model shall be determined by the AHJ.

14.3 BPE Specification and Type.

14.3.1* BPE provided shall be at minimum a Level III-A ballistic vest as defined by the National Institute of Justice (NIJ) Standard-0101.06, *Ballistic Resistance of Body Armor.*

14.3.1.1* BPE shall be NIJ certified, and the model shall be on the NIJ compliant products list.

14.3.2* Personnel assigned to an integrated response team shall be equipped at a minimum with Level III-A body armor (BPE) tested to NIJ or other recognized certifying body standard.

14.3.2.1 Integrated response teams shall consider the use of a ballistic helmet, a flashlight, medical exam gloves, an individual first-aid kit (IFAK), a radio with shoulder strap, and remote microphones with earpieces for communication.

14.4* Identifying Markings. PPE and BPE worn externally shall be identified with the agency and/or responder role.

14.5* Ballistic Protective Equipment (BPE) Care, Maintenance, and Replacement. BPE care, maintenance, and replacement shall be done in accordance with NIJ Guide-0101.06, *Selection and Application Guide to Ballistic-Resistant Body Armor for Law Enforcement, Corrections and Public Safety,* or manufacturer instructions.

14.6 Deviations. Any deviation from this standard where immediate actions could prevent the loss of life and personnel are deployed without BPE into an area where BPE is required by this standard shall require a post-incident analysis and justification of the decision to the AHJ.

Chapter 15 Training

15.1 Administration.

15.1.1 Scope. This chapter applies to those organizations, departments, agencies, and jurisdictions (regardless of size) who are responsible for response to emergency incidents and who develop, plan, and train for an integrated response to ASHE incidents.

15.1.1.1* All responders shall receive training to meet applicable governmental regulations according to federal, tribal, state, and local standards.

15.1.1.2 A personnel training program shall be adopted and shall include a means for evaluating personnel competence.

15.1.2 Purpose. This chapter addresses training requirements, training program development, and training records management in support of an ASHER program.

15.2 Scope of ASHER Training. The AHJ shall determine the scope of training needed for the program and its support elements.

15.2.1* Training shall be conducted jointly between all anticipated responding entities and communications personnel.

15.2.2* Training shall be based on the risk assessment(s) performed by the AHJ and tasks to be performed.

15.2.3 The AHJ shall provide initial and periodic joint training for public safety responders for zone operations based on the competencies outlined in Chapters 12 and 13.

15.2.4* Elements of the ASHER program training plan shall include an HSEEP-compliant exercise no less than once annually, involving all agencies and organizations identified in the ASHER program.

15.3* Training Sites. The AHJ shall arrange, when possible, for training and exercises at sites within the response jurisdiction to enhance responder familiarization and operational efficiency and effectiveness.

15.4 Training Records Management.

15.4.1 The ASHER program manager shall ensure all training sessions and exercises are documented.

15.4.2 Each training session shall be documented to include the following information:

(1) Date(s), time(s), and duration of the training
(2) Location of the training
(3) Name, and qualifications of training instructor(s)
(4) Training topic or exercise title
(5) Overview of course content
(6) Participants of the training
(7) Competencies that were demonstrated
(8) Instructor and course evaluations

15.4.3 All training records shall be kept in accordance with the agency's record retention policy.

15.4.4 Frequency of Training. Frequency of training shall be determined by the AHJ.

Chapter 16 Public Education

16.1 Administration.

16.1.1 Scope. This chapter establishes a common set of criteria for considerations related to improving the public's knowledge for preparing and responding to an ASHER incident.

16.1.2 Purpose. This chapter provides the following public education information:

(1) Ways to improve preparedness of the community to assist in the mitigation, response, and recovery of ASHE incidents, apart from responders
(2) Assistance with terminology, expectations, and appropriate actions to increase the effectiveness of public information

16.1.3 Goal of Curriculum.

16.1.3.1 The goal of the curriculum shall be to create awareness and enhance the knowledge, skills, and abilities of the public to respond and take protective measures in an ASHE incident.

16.1.3.2 The frequency of instruction shall be determined by the AHJ.

16.2 Community Training and Education. Community education training curriculum shall be developed based on risk assessments conducted in accordance with Chapter 5.

16.2.1 Training shall be divided into the following categories:

(1) Discussion-based training — for public education on terminology and response
(2) Operations-based training — for public education on terminology and response where interactive exercises are used
(3)* Self-study training — prepackaged materials intended for individually paced training by the public

16.3* Public Education. The public education program shall be implemented to communicate the following:

(1) Different hazards (violence, fire as weapon, explosive, weapons of mass destruction, future threats)
(2) The potential impacts of a hazard
(3) Preparedness information, including the following:
   (a)* Survival strategies and actions
   (b)* Interventions aimed at preventable causes of death due to trauma
   (c) Recommended equipment as determined by the AHJ
(4)* Information needed to develop a preparedness plan
(5) Identification and communication of site/location emergency action plans
(6) Identification of ASHE incidents warning signs and how to report them
(7) What to expect from interactions with emergency communication centers and first responders

16.4 Scope and Frequency of Instruction. The scope of the curriculum and the frequency of instruction shall be identified by the AHJ.

Chapter 17 Public Information

17.1* Administration.

17.1.1* Scope. This chapter establishes a common set of criteria for public information during and after an ASHE incident.

17.1.2 Purpose. This chapter provides requirements for ASHER program officials facilitating the appropriate dissemination of information to the public and stakeholders as part of a joint information center (JIC) and joint information system (JIS). These individuals include the public information officer (PIO) or persons acting as part of the communications or media relations team with assigned duties.

17.2 JIC. Organizations shall have plans to establish a joint information center based on the needs of the incident.

17.2.1 The JIC shall be an early consideration of unified command based on the needs and escalation of the incident.

17.2.2 The JIC shall be established away from primary incident operations at an associated off-site operation area.

17.2.3* The PIO shall create, review, and finalize all forms of communication for the JIC as directed by unified command.

17.2.4 The PIO shall coordinate any press conference(s) or other public address event(s).

17.2.5 The PIO shall be responsible for ensuring an all clear is communicated across all notification systems.

17.3 JIC and JIS Activities. JIC and JIS activities shall include the following:

(1) Informing and educating the public through various media in adequate and appropriate means to protect public health and safety, for the duration of the ASHE incident including the appropriate response to inquiries and misinformation
(2) Action(s) to take to reduce risk and improve safety
(3)* Assistance for victims, families, and loved ones at the notification center
(4) Identification of official communications pathways (central contact for all media) for coordinating and authorizing the release of information, including, but not limited to, the following:
   (a)* All activities outlined in ASHER program development (Chapter 4)
   (b)* All risk assessment activities outlined in Chapter 5
   (c)* Planning and coordination activities outlined in Chapter 6
(5) Identification of official communications pathways for incoming informational inquiries from the public in order to ensure that emergency communication centers (e.g., 911) are not overwhelmed
(6)* Reduction or elimination of communication that jeopardizes operations
(7) Leveraging the use of information gained through public sources such as social media

17.4 Warning, Notification, and Crisis Communications. Organizations and the AHJ shall evaluate the need for and use of a mass notification system.

17.4.1* The system design shall follow the risk analysis as outlined in Chapter 5 and be integrated into the AHJ's or organization's emergency response plans.

17.4.2 Organizations shall evaluate and plan for people who are not regularly on mass notification systems, vulnerable populations, or people who don't have access to mass notification devices/conduits.

17.4.3 Organizations shall develop pre-scripted mass warning messaging that displays preparedness measures and protective actions.

17.4.3.1 Pre-scripted mass warning messaging shall include the following:

(1) Who is sending the alert?
(2) What is happening?
(3) Who is affected?
(4) What action should be taken?
(5) Date and time stamp

17.4.4 Organizations shall develop plans with the ability to enable internal and external communication.

17.4.5* Organizations shall maintain, test, and exercise notification systems and plans not less than once annually.

17.4.6* Organizations shall identify and plan for specific needs within communities with regulatory or legal obligation for notification.

17.5* Social Media. Social media shall be permitted to serve as an information and intelligence platform for unified command.

17.5.1* The PIO shall coordinate the flow of pertinent information for operations and operational security from external sources back to the JIC, if one is established, or to the unified command.

17.5.2* Social media used for the purposes of sharing of information shall be coordinated through the JIC if one has been established or through unified command if the JIC has not been established.

17.5.3* AHJs shall have a comprehensive social media and information sharing policy.

17.6 Establishing and Managing a Media Area.

17.6.1* In coordination with the JIC, the PIO or their designee shall establish an on-location media area in the cold zone for safety, and to enable the flow of approved communications through the official path.

17.6.2* The PIO or their designee shall manage the media area participants and coordinate the flow of information through the officially established central media contact for the ASHE incident

17.6.3* Unified command or the AHJ shall establish a plan for the communication of information to victims, families, loved ones, media, and the general public relative to the incident through the three recovery phases.

Chapter 18 Continuity of Operation

18.1 Administration.

18.1.1 Scope. This chapter establishes a common set of criteria for management and restoration of business continuity and continuity of operations of mission-critical services after ASHER incidents.

18.1.2 Purpose. This chapter provides the fundamental criteria for continuity of operation including the planning, implementation, assessment, and maintenance of programs for continuity.

18.2 Continuity.

18.2.1 Continuity plans shall include strategies to continue critical and time-sensitive processes.

18.2.1.1* Continuity plans shall identify and document the following:

(1) Stakeholders that need to be notified
(2) Processes that must be maintained
(3) Roles and responsibilities of the individuals implementing the continuity strategies
(4) Procedures for activating the plan, including the authority for plan activation
(5) Critical and time-sensitive technology, application systems, and information
(6) Security of information
(7) Alternative work sites

(8) Workaround procedures
(9) Vital records
(10) Contact lists
(11) Required personnel
(12) Vendors and contractors supporting continuity
(13) Resources for continued operations
(14) Mutual aid or partnership agreements
(15) Activities to return critical and time-sensitive processes to the original state

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18.2.1.2 Continuity plans shall address supply chain disruption.

Chapter 19 Health Care Receiving Facility Preparedness and Response for Off-Site ASHE Incidents

19.1* Administration.

19.1.1* Scope. This chapter applies to health care facilities with the expectations and capabilities to receive victims from an off-site ASHE incident.

19.1.2* Purpose. This chapter provides information and processes necessary to quickly and efficiently utilize a systematic approach to receiving and tracking of victims from an ASHE incident.

19.1.2.1* The processes required within Chapter 19 shall be scalable.

19.2* Preparedness and Emergency Management. Health care receiving facilities that have the potential to receive victims shall be included in the AHJ's ASHER program activities, including but not limited to training and exercises.

19.2.1 Exercises shall test the components outlined in this chapter.

19.2.2* Health care receiving facilities shall have emergency management plans and annexes that are integrated with the local AHJ's ASHER program plans.

19.2.3 Health care receiving facilities shall plan for a surge of spontaneous arrivals.

19.2.4 Health care receiving facilities shall ensure that they have adequate procedures, supplies, and equipment for managing multiple patients with injuries associated with ASHE incidents.

19.2.5* Health care receiving facilities shall partner with the AHJ for the purpose of requesting local resources to assist with the management and the provision of care during an ASHE incident.

19.3* Patient Distribution. Patient distribution shall be exercised by the AHJ and health care receiving facilities based on local mass casualty plans not less than once annually.

19.3.1 Patient distribution exercises shall include patient tracking, reporting, recall of key personnel/staff, logistical needs, and communications with on-site responders.

19.4* Communications. Health care receiving facilities shall have at least two means of communication with public safety entities responsible for patient distribution in ASHE incidents.

19.4.1 Written procedures for the activation and use of communication systems shall be developed in conjunction with the AHJs responsible for public safety.

19.4.2 Communications systems shall be tested on a monthly basis to ensure functionality.

19.4.3* Health care receiving facilities shall assign a dedicated staff member to communicate with patient distribution coordinators throughout the ASHE incident.

19.5* Victim Identification and Tracking. Health care receiving facilities shall work within applicable laws and regulations to identify victims and release this information to appropriate agencies based on prescribed practice and procedure.

19.6 Facility Security.

19.6.1* Restricted access protocols shall include provisions for existing physical security measures, on-duty staff members, additional first responders, and the availability of supplemental staff from external resources.

19.6.2* Restricted access protocols shall address the following:

(1)* How to limit access for the entire facility
(2) The persons authorized to activate and deactivate restricted access processes
(3) A situational risk assessment and implementation or measures

19.7 Facility Command Center/Incident Command System (ICS).

19.7.1* Health care receiving facilities shall activate and utilize an ICS to manage their response to the incident.

19.7.2 Health care receiving facilities shall activate their command center to manage the incident if one is available and capable.

19.7.3 Health care receiving facilities shall request an agency representative from the AHJ, if available, to assist in the coordination of the incident.

Chapter 20 Recovery

20.1* Administration.

20.1.1 Scope. This chapter applies to those organizations and jurisdictions responsible for the execution of recovery operations and victim services following an ASHE incident.

20.1.1.1* Recovery is organized sequentially into three major subcategories:

(1) Immediate recovery using the notification center
(2) Early recovery using the incident assistance center
(3) Continued recovery using the community resiliency center

20.1.1.1.1* Planning for the transition from response through each recovery stage to steady-state shall be included in ASHER program preparedness and operational plans.

20.1.1.2 Each ASHER program organization identified in the execution of recovery operations plan shall maintain SOPs and checklists that detail the logistical and administrative support arrangements internal to its organization in support of the ASHER program tasks, including current contact lists for key people within the organizations.

20.1.1.2.1 All ASHER program organizations shall decide a schedule for planning, training, and exercising recovery operations, as well as updating and distribution of plans.

20.1.1.2.2 The AHJ shall designate a person or team to oversee the establishment of an initial notification center, incident assistance center, and associated activities.

20.1.2 Purpose. This chapter provides framework necessary to respond to and address whole of community, business continuity, and victim needs following the ASHE incident.

20.2 Immediate Recovery. Immediate recovery shall be the operational period immediately following the mitigation of threat following the initial ASHE incident.

20.2.1* The establishment of a notification center shall be considered by unified command if not already activated.

20.2.2 Immediate recovery operation plans shall include, but are not limited to, the following:

(1) Operational security
(2) Coordination of primary agencies
(3) Utilization of a committee meeting protocol
(4) Accountability
(5) Damage assessment
(6) Primary victim notification and reunification at the notification center
(7) Victim assistance
(8)* Medical examiner or coroner operations
(9) Initial investigation and evidence collection operations
(10) Media and public information coordination

20.2.3* Coordination of primary agencies recovery strategies shall occur immediately following an ASHE incident in order to quickly determine processes, communication lines, and roles of primary agencies.

20.2.3.1 Primary agencies' recovery strategies shall include, but are not limited to, the following:

(1) Immediate victim reunification
(2) Awareness of evidence preservation
(3) Administration of the notification center

20.2.3.2* Responding organizations shall conduct joint meetings and establish protocols to ensure rapid and effective strategic planning, sharing, and communication of critical facts.

20.2.3.2.1 Any organization responsible for the management of recovery funds, including monetary assistance and compensation, shall work within the ICS system to meet as soon as reasonable following the ASHE incident to coordinate the disbursement of funds and claims applications.

20.2.3.2.2 This group shall continue meeting until all financial assistance is distributed or until the organization is no longer involved in the financial aspect of recovery.

20.2.3.2.3* Meetings shall provide for an orderly and controlled multidirectional communication system consistent with practices defined by unified command and the JIC.

20.2.3.3 Information from meetings shall be immediately reported to unified command.

20.2.3.4 During the immediate recovery phase, unified command shall be responsible for the following:

(1) Accountability of responders and victims
(2) Communication and joint information
(3) Resource sharing and logistics

20.2.3.4.1* The need for a recovery coordinator (RC) shall be determined and, if activated, placed inside unified command until unified command is disbanded.

20.2.3.4.1.1 The RC shall have responsibility for all recovery support activities, initiating and terminating as necessary.

20.2.3.4.1.2 The RC shall organize local, state, federal, tribal, and nongovernmental organizations (NGO) actions and coordinate requests for assistance from recovering communities.

20.2.3.4.1.3 The RC shall help direct local, state, federal, tribal, and other resources while staying in communication with unified command.

20.2.3.5 Preliminary damage assessment shall include the following:

(1) Civilian and responder casualties
(2) Bystander and witness effects
(3) Infrastructure
(4) Impacts to responding organizations
(5) Geographical area closures
(6) Business impact
(7)* Impact to victims

20.2.3.5.1 The damage assessment shall characterize the overall impact the event had on the organization/jurisdiction and be followed by a needs assessment if required.

20.2.3.5.2 Preservation of personal effects shall be considered.

20.2.3.6* Unified command and the notification center shall be included as part of associated off-site operations and be removed from the incident.

20.2.3.6.1 The notification center shall have a security plan, credentialing and check-in process for victim service providers and volunteers, and plan for checking-in victims and family members, loved ones, or other designated representatives.

20.2.3.6.2 At the notification center, notification and reunification shall be coordinated using an accountability system to determine which victims have been safely evacuated from the incident, building, or area.

20.2.3.7 Implementation of notification and reunification processes shall be incident dependent.

20.2.3.7.1* Unified command shall consider establishing a notification and reunification center that is removed from the incident that shall be included as part of associated off-site operations.

20.2.3.8* Death notifications shall be coordinated and implemented as early as practical by qualified individuals or teams who are familiar with laws regarding the protection of personal identifiable information.

20.2.3.8.1 Death notifications shall be coordinated with the law enforcement AHJ and the medical examiner or coroner.

20.2.3.8.2* Only law enforcement, the medical examiner or coroner, and other trained entities shall release death notification.

20.2.3.9 Injured victim notification shall be coordinated through the unified command via an identified branch or group in coordination with a victim assistance liaison.

20.2.3.10 The plan shall include a provision that organizations responsible for victim services shall be contacted immediately to deploy assistance in the event of an emergency as defined in the emergency response, as well as maintain a current contact list for those organizations.

20.2.3.11* Access and functional needs populations shall be considered in recovery plans.

20.2.3.12 Considerations shall be given to groups of people who qualify for special protection by law, policy, or similar authority.

20.3* Early Recovery. Early recovery shall be the operational period after immediate recovery where processes for agency coordination, meeting protocols, accountability, initial damage assessment, and primary victim assistance are actively and proactively being managed. The establishment of an incident assistance center, which follows the closure of the notification center, shall be considered by unified command or the AHJ if not already activated.

20.3.1 Early recovery operations shall consider the following:

(1) Operational security
(2) Damage assessment
(3) Public information coordination
(4) Resource needs analysis
(5) Analysis of consequences of the event
(6) Subsequent events
(7) Volunteer management
(8) Donations management
(9)* Victim advocacy, assistance, and services
(10) Federal emergency funding opportunities and grants
(11) Memorial preservation

20.3.2* Establishment of an incident assistance center (IAC) shall be for the purpose of coordinating long-term assistance.

20.3.2.1* The IAC shall provide the necessary services and permissable information, including, but not limited to, the following:

(1) Mental health counseling
(2) Health care
(3) Child care
(4) Crime victim assistance and compensation
(5) Assistance with legal matters
(6) Travel
(7) Financial planning
(8) Animal care
(9)* Medical examiner or coroner information
(10)* Assistance with organizing memorials as needed

20.3.3 Resource Needs Assessment.

20.3.3.1 The assessment process shall begin to estimate the impact the ASHE incident has on the organization/jurisdiction, region, state, and/or nation in terms of the following:

(1) Deaths and injuries
(2) Business impact
(3) Mental and emotional requirements
(4) Property damage
(5) System disruptions
(6) Investigation and scene control management
(7) Consideration of federal, state, local, and tribal resources for unmet needs

20.3.3.2 The assessment of consequences of an ASHE incident within an organization/jurisdiction shall include evaluating the likely events that could follow such an event.

20.3.3.2.1 This assessment shall include real and potential mental health and emotional needs of first responders, victims, families of victims, bystanders and witnesses, community members, businesses, and the general public.

20.3.3.2.2 This assessment shall focus on short-term consequences of the events until medium- and long-term consequences can be evaluated.

20.3.3.3* The AHJ shall consider that subsequent activities can compound the effects of an event of an incident by further taxing resources.

20.3.3.3.1 Subsequent activities shall require additional resources, management, security, and attention from the AHJ leaders with little or no advance notice.

20.3.3.3.2 The AHJ shall anticipate and maintain heightened awareness of these activities so that an appropriate and measured response can be executed.

20.3.3.4 Security shall be considered for post-incident operations at locations including, but not limited to, the following:

(1) Crime scene
(2) Investigation areas
(3) Areas closed to public as a result of incident
(4) Associated off-site operational areas such as the following:
   (a) Emergency operations center
   (b) Public or administrative buildings
   (c) Critical transportation access hubs or points
   (d)* Hospitals and health care facilities
   (e) Joint information center
   (f) Assistance centers
   (g) Other areas as determined

20.3.3.5 Early recovery communications within the unified command structure and through the public information officer (PIO) shall provide a framework for collecting, sharing, and disseminating necessary information in coordination with, but not limited to, the following:

(1) Other law enforcement organizations
(2) Prosecutors' office
(3) Healthcare facilities
(4) Mutual aid partners
(5) Lead agencies for emergency support functions and recovery support functions and federal, state, local, and tribal authorities

20.3.3.6 Information disseminated shall be vetted, approved, and communicated from a single source.

20.3.3.7 Volunteer and Donation Management.

20.3.3.7.1 The AHJ shall plan for the management, screening (which includes criminal background checks), and oversight of volunteers.

20.3.3.7.2* The AHJ shall consider implementing a volunteer reception center that can receive, organize, and direct volunteers.

20.3.3.7.3 A volunteer management system shall properly credential and deploy approved volunteers who have been identified, screened, and trained in advance.

20.3.3.7.4 When a need for utilizing volunteers who have not been previously identified, screened, or trained in advance arises, the ASHER program shall have a plan for a process to approve these volunteers at a designated location.

20.3.3.7.5 A volunteer management system shall have plans, policies, and procedures for the safe and appropriate use of licensed or credentialed emotional support or therapy animals.

20.3.3.7.6* Donations.

20.3.3.7.6.1 The AHJ shall plan for the acceptance, control, receipt, storage, distribution, shipping, and disposal of any donations, including monetary and other donor requests.

20.3.3.7.6.2 The coordinating of victim-related donation disbursements shall be done with the victim or their designee.

20.3.3.7.7* A donation management strategy shall be established during emergency planning, prior to the incident occurring, and in accordance with Chapter 10.

20.3.3.7.8* Where possible, a central donation system and site shall be established and run by an appropriate agency, which is frequently a third party.

20.3.3.7.8.1 A registered charity or NGO shall be used to receive monetary donations, rather than a local or state agency.

20.3.3.7.8.2 Cash donations shall not be accepted at unified command.

20.3.3.7.9* Volunteer and donation management shall extend into the continued recovery phase.

20.3.3.7.10* Unified command shall coordinate with the JIC regarding messaging about those wishing to donate, how that can best be accomplished, and what is or is not acceptable.

20.4 Continued Recovery.

20.4.1* Continued recovery shall be the operational period following early recovery.

20.4.1.1 There shall be a transition period from early recovery to continued recovery, which shall include regular meetings of the primary agencies and other key individuals, as necessary.

20.4.1.2 The need to establish a long-term recovery committee shall be considered.

20.4.1.3 Continued recovery shall include, but is not limited to, the following:

(1) Business impact analysis
(2) Coordination of the restoration, rebuilding, and replacement of facilities, infrastructure, materials, equipment, tools, vendors, and suppliers
(3) Restoration of the supply chain
(4) Reopening or relocation of vital facilities such as schools, grocery stores, and day cares that allow a community to return to their day-to-day schedule
(5) Continuation of communications with stakeholders
(6) Roles and responsibilities of the individuals implementing the recovery strategies
(7) Internal and external (vendors and contractors) personnel who can support the implementation of recovery strategies and contractual needs
(8) Adequate controls to prevent the corruption or unlawful access to the entity's data during recovery
(9) Investigation of fraud associated with disaster assistance and assurances of consumer protection
(10) Long-term victim services
(11) Long-term community resiliency
(12) Volunteer and donation management
(13) Identification of gaps that could require supplemental state or federal assistance

20.4.2 Victim Assistance. Continued victim assistance shall provide for ongoing assessment and services for victims and their families, first responders, and community members.

20.4.2.1* If utilized, a trained victim services, advocate, navigator, or liaison shall assist victims and families, including hospitalized victims.

20.4.2.2* Organizations shall ensure victim services advocates and navigators receive the necessary training and support to meet the comprehensive short- and long-term needs of victims and family members.

20.4.2.2.1 This training shall include the emotional and psychological needs by providing mental health support, counseling, screening, and treatment.

20.4.2.2.2 This training shall include atypical victim service providers who meet the unique needs of the population.

20.4.2.3 Continued victim assistance shall require coordination to assure the emotional and mental health needs are adequately assessed and served by facilitating timely notification and reunification and providing ongoing screening, counseling, and treatment.

20.4.2.4* Medical and mental health surveillance shall include evaluating, documenting, recordkeeping, and engagement of the physical and mental needs of first responders, victims, families, bystanders, and other community members.

20.4.2.5* Unified command or the AHJ shall consider, in cooperation with other stakeholders, the establishment of a community resiliency center (CRC) following the closure of the IAC.

20.4.2.5.1 A process for the transition from an IAC to a CRC shall be established.

20.4.2.6 The CRC shall consider access and functional needs populations in recovery.

20.4.2.7 The CRC shall ensure that victims receive the necessary support and services to address symptoms of secondary/vicarious trauma.

20.4.3 Response and Recovery Personnel Emotional, Psychological, and Behavioral Needs. The program shall consider public safety personnel, including first responders, law enforcement, fire, and EMS, as well as mental health providers, medical examiners, prosecutors, funeral directors, 911 operators and telecommunicators, and other response and recovery personnel when developing ongoing support systems.

20.4.3.1* Mental health restoration services shall include the following:

(1) Identifying needs for behavioral health and emotional/psychological care
(2) Emotional/psychological first aid for first responders, bystanders/witnesses, victims, loved ones, and families

20.4.3.2* The AHJ in collaboration with local behavioral health entities, community providers, and health care facilities shall coordinate the activities and services necessary to address the behavioral health needs of persons impacted by the incident.

20.4.3.2.1 Coordination shall include representatives and/or other resources to assist local mental health and/or joint alcohol, drug addiction, and behavioral health services in the provision of support services and treatment of victims.

20.4.4 Volunteer and Donation Management. Volunteer and donation management policies shall extend into the continued recovery phase.

20.4.4.1 The dispersing agency shall coordinate, but is not limited to, the following:

(1) The funding process
(2) Goods and services

20.4.4.2 Specific donor requests are likely, and a protocol to manage those shall be established.

20.4.4.3 Coordination between the primary agencies and the organization (s) designated to service the centralized collection, disbursement, and proper disposal entity for monetary donations and for the donation of goods and services shall continue.

20.4.5 Criminal Proceedings and Victim Support Legal Considerations. Criminal justice system and victim support shall be coordinated to assist with victim impact statements, media management, and other victim needs.

20.4.5.1* If there is a trial, then the criminal justice system or primary agency shall provide victims and family members with access to and updates on incident hearings, criminal justice proceedings, and their rights as victims.

20.4.6 Additional Grant Funding. The impacted area and relevant agencies shall identify funding that could be available through local, county, state, tribal, or federal government, as well as national nonprofit organizations and corporations.

20.4.6.1 As necessary, funding shall be applied for through the established channels.

20.4.6.2 State Victims of Crime Act compensation and assistance administrators shall coordinate with all other emergency assistance providers in the state to avoid duplication of services.

20.4.7* Unmet Needs. Unmet needs and unique issues in the community shall be identified, along with the appropriate agencies or funding mechanisms.

20.4.8* Lessons Learned and Best Practices. Lessons learned and best practices shall be captured in an AAR.

20.4.8.1* Baring security concerns, the AAR shall be shared among relevant stakeholders and emergency planners.

20.4.9* Restoring Critical Infrastructure. To coordinate the restoration, rebuilding, and replacement of facilities, infrastructure, materials, equipment, tools, vendors, and suppliers, AHJs shall utilize information and data from damage assessment and business impact analysis.

20.4.9.1 The AHJ shall coordinate assignment of necessary temporary or permanent repairs to facilities and infrastructure and facilitate coordination of continued supply chain elements.

20.4.10 Communications Plan. The AHJ shall develop and execute a communications plan that extends into the continued recovery phase of the ASHE incident.

20.4.10.1 The AHJ shall ensure all major elements of continued recovery have been delegated to qualified organizations, individuals, or authorities.

20.4.10.2 Each major continued recovery elements shall have a lead authority, an action plan, and a communications plan.

Annex A Explanatory Material

Annex A is not a part of the requirements of this NFPA document but is included for informational purposes only. This annex contains explanatory material, numbered to correspond with the applicable text paragraphs.

A.1.4 The number and types of agencies and individuals involved is wide and varied. Individuals and agencies can have multiple roles in the process. Those roles can, at the same time, range from being the AHJ in certain elements to a participant or cooperating agency in others. Application of the standard, and a cornerstone of its development, is collaboration, cooperation, and shared understanding among all participants.

A.1.4.1 Application of this standard cannot occur in an environment of isolation. ASHE incidents are generally not simple, geographically constrained, or effectively manageable without prior planning. Leadership, partnership, and integration across communities, organizations, and disciplines is vital to managing ASHE incidents.

A.1.4.2 Prevention falls under other disciplines that are outside the scope of this standard. For more information on prevention, see www.fbi.gov/file-repository/making-prevention-a-reality.pdf/view.

A.3.2.1 Approved. The National Fire Protection Association does not approve, inspect, or certify any installations, procedures, equipment, or materials; nor does it approve or evaluate testing laboratories. In determining the acceptability of installations, procedures, equipment, or materials, the authority having jurisdiction may base acceptance on compliance with NFPA or other appropriate standards. In the absence of such standards, said authority may require evidence of proper installation, procedure, or use. The authority having jurisdiction may also refer to the listings or labeling practices of an organization that is concerned with product evaluations and is thus in a position to determine compliance with appropriate standards for the current production of listed items.

A.3.2.2 Authority Having Jurisdiction (AHJ). The phrase "authority having jurisdiction," or its acronym AHJ, is used in NFPA documents in a broad manner, since jurisdictions and approval agencies vary, as do their responsibilities. Where public safety is primary, the authority having jurisdiction may be a federal, state, local, or other regional department or individual such as a fire chief; fire marshal; chief of a fire prevention bureau, labor department, or health department; building official; electrical inspector; or others having statutory authority. For insurance purposes, an insurance inspection department, rating bureau, or other insurance company representative may be the authority having jurisdiction. In many circumstances, the property owner or his or her designated agent assumes the role of the authority having jurisdiction;

at government installations, the commanding officer or departmental official may be the authority having jurisdiction.

The AHJ can also include entities such as law enforcement, emergency medical services (EMS), hospitals, educational facilities, or any other organization that has legal responsibility for the safety of the jurisdiction or facility. The AHJ will be determined by the specific context of the requirements set forth in this standard.

A.3.2.3 Listed. The means for identifying listed equipment may vary for each organization concerned with product evaluation; some organizations do not recognize equipment as listed unless it is also labeled. The authority having jurisdiction should utilize the system employed by the listing organization to identify a listed product.

A.3.3.2 Active Assailant(s) (AA). This could include, but is not limited to, explosives, toxic substances, vehicles, edged weapons, fire, or a combination thereof.

A.3.3.7 After Action Report (AAR). Documentation should be supported with the operational plan, related reports, and any other written or photographic material associated with the operation.

A.3.3.8 Associated Off-Site Operations. These sites typically require physical protection, responder support, and emergency management support. Some examples of areas that are associated off-site operations points include joint information center, health care facilities, notification center or incident assistance center, and witness and evidence collection points.

A.3.3.9 Ballistic Protective Equipment (BPE). BPE can include equipment such as ballistic vest, helmet, and/or shield. These items come in varying degrees of protective levels and design.

A.3.3.10 Building Sides. Further detail is available in the 2016 edition of NFPA 1561.

A.3.3.12 Casualty Collection Point (CCP). When designating a casualty collection point, a consideration should be having appropriate cover and concealment or protection for the location.

A.3.3.17 Complex Coordinated Attack. An attack involving multiple incidents that inundate resources, exceed conventional tactics and strategies, and often require a joint response involving members from multiple disciplines and jurisdictions. Examples include firearms, explosives, or fire as a weapon.

A.3.3.22 Control Zones. Examples of control zones are hot, warm, and cold zones.

A.3.3.30 Functional Task Force (FTF). Examples of FTF include suppression task force, breeching task force, lobby control, and elevator control.

A.3.3.32 Hazardous Device. A hazardous device can include but is not limited to improvised explosive device (IED), aircraft, unmanned aerial system, vehicle, and weapon or weapon component.

A.3.3.35 Incident Assistance Center (IAC). In some instances the name of the incident can be inserted for the term *incident* as determined by the AHJ.

A.3.3.40 Individual First Aid Kit (IFAK). IFAK equipment should be approved by the AHJ and can include, but is not limited to, the following:

(1) Tourniquet
(2) Pressure dressing
(3) Wound packing material (hemostatic dressing preferred)
(4) Vented chest seals
(5) Hypothermia blankets
(6) Permanent marker
(7) Protective gloves
(8) Trauma shears
(9) Means to document treatment

A.3.3.43 Loading Zone. This point can be located in the warm zone. It is sometimes called an *exchange point* or a *loading point*. It should be part of an incident management structure and have supervising personnel attached to it. Also, the means of transport can vary based on incident needs. Frequently, this is accomplished by ambulance but can also be by private vehicles, public transit, or other means, depending on the incident.

A.3.3.45 Mutual Aid. Formally executed mutual aid agreements should be established as part of the ASHER program and can assist with cost recovery.

A.3.3.47 Notification Center. The notification center was previously referred to as the reunification center. Because of the possibility that not all victims are going to be reunited, the nomenclature has shifted in favor of the term *notification*. However, reunification is a vitally important activity that should take place at the notification center or other designated location.

A.3.3.52 Public Access Trauma Kits. The preventable causes of death due to trauma can be found here: http://www.c-tecc.org/guidelines.

These kits, which are frequently co-located with AEDs and contain medical supplies as approved by the AHJ, should be easily identifiable to the lay person and can include but are not limited to the following:

(1) Instructional materials
(2) Tourniquets
(3) Gauze and bandages
(4) Pressure dressings
(5) Wound packing material (hemostatic dressing preferred)
(6) Vented chest seals
(7) Hypothermia blankets
(8) Permanent marker
(9) Protective gloves
(10) Trauma shears
(11) Means to document care

A.3.3.58 Secured. Secondary clear is a slow methodical, systematic search by law enforcement of the entire affected area ensuring no hostile hazards or threats exist.

A.3.3.60 Threat-Based Care. Threat-based care can occur in any zone.

A.3.3.64 Unified Command Post. Also known as a location within the cold zone where command and tactical objectives are set.

A.3.3.65 Victim. This is a broader term than *casualty* because it extends beyond just those that are physically injured or

killed. Some communities or organizations could choose to use the term *survivor*. However, federal law recognizes the term *victim* in regard to assistance and compensation. Therefore, *victim* is the necessary term for planning and documentation.

A.3.3.66 Victim Advocate. Advocates offer victims informatio-nand emotional support, and help find resources and fill out paperwork. Sometimes, advocates go to court with victims. Advocates might also contact organizations, such as criminal justice or social service agencies, to get help or information for victims. Some advocates staff crisis hotlines, run support groups, or provide in-person counseling. Victim advocates could also be called victim service providers, victim/witness coordinators, or victim/witness specialists.

A.3.3.67 Victim Navigator. A victim navigator's role can vary, depending on the nature and scope of the incident. A victim navigator can serve as the singular point of contact for law enforcement, victim service providers, media, and others wishing to contact the victims or families. Services can also include advising family caregivers; providing psychosocial support, education, and counseling; making referrals for other services; creating plans for treatment or recovery; and following client progress with treatment plans. Victim navigators could also be called victim liaisons.

A.3.3.68.1 Rescue Task Force (RTF). The law enforcement officers (LEO) or armed security are assigned as force protection for this team and should not separate from the fire and EMS personnel. Based on the scene, number of victims, and available emergency personnel, there could be more than one RTF assigned.

A.3.3.71 Zones. These zones are subject to change based on the incident evolution.

A.3.3.71.1 Hot Zone. A hot zone is any uncontrolled area where an active shooter/hostile threat could directly engage responders.

A.3.3.71.2 Warm Zone. A warm zone is an area where law enforcement has cleared or secured or is geographically isolated from the threat. This zone is clear of an obvious threat, but a threat could emerge or re-emerge.

A.3.3.71.3 Cold Zone. Some items that should be located in the cold zone are threat-based care and transport, patient loading, unified command post, and staging.

A.4.2(1) To ensure effective and efficient coordination it is recommended that an appointed program manager or committee of integrated/cross-functional membership be responsible for the overall coordination of the program.

A.4.2(18) Additional after action reporting guidance can be found in Annex C.

A.5.1.1 A risk assessment is the determination of quantitative or qualitative estimate of risk related to a well-defined situation and a recognized threat (also called hazard). Risk assessment requires calculations of two components of risk: the magnitude of the potential loss and the probability that the loss will occur.

A.5.2.1 Identifying at-risk locations, which is the first step in the risk assessment process, includes but is not limited to collecting information regarding the locations and types of targets within the organization/jurisdiction.

A.5.2.2 Examples of at-risk locations include, but are not limited to, sporting events, concert venues, malls and other shopping facilities, community festivals, public gatherings, religious facilities, protests/demonstrations, educational facilities, schools, and military installations.

A.5.2.2.2(2) Examples of critical facilities include homes, schools, hospitals, businesses, and offices. Examples of critical infrastructures include power, communication, and medical.

A.5.2.2.2(3) Examples of positions that would provide a tactical advantage include, but are not limited to, elevated viewing positions, underground garages, hiding positions, and nearby rooftops.

A.5.3 Estimated outcomes should be based on realistic worst-case scenarios, especially for high-frequency, high-risk events.

A.5.4 Operational performance is a function of three considerations: resource availability/reliability, agency capability, and overall operational effectiveness. Resource availability/reliability is the degree to which the resources are ready and available to respond. Department capability is the ability of the resources deployed to manage an incident. Operational effectiveness is the product of availability and capability. It is the outcome achieved by the deployed resources or a measure of the ability to match resources deployed to the risk level to which they are responding. The resources (personnel and equipment) needed for the response must consider the potential outcomes, including civilian injury and death, responder injury and death, and property loss. See Figure A.5.4.

A.5.4.1 The community risk assessment should be reviewed annually or when changes take place that affect the original assessment. Verifiable resources should be consulted to determine the most common types of threats in other incidents. This data should then be compared to the sites identified within the jurisdiction to determine if there is a high or low probability of an incident occurring.

Information on target locations and types can be found from the following sources:

(1) Local public safety agencies
(2) Local emergency management
(3) Homeland Security Intelligence Network (HSIN)

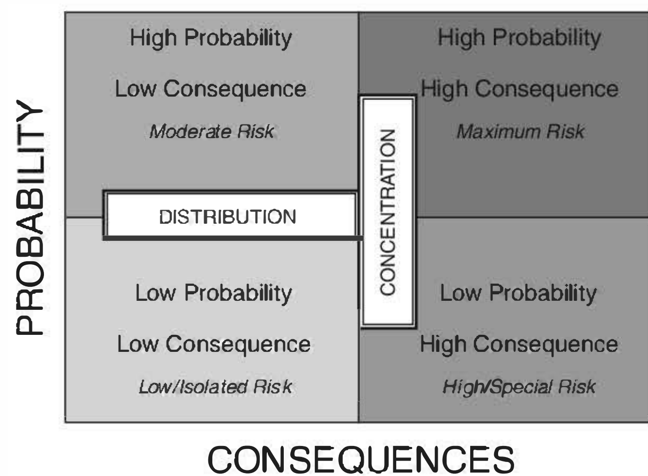

FIGURE A.5.4 Probability/Consequence Resource Distribution Chart.

(4) Fusion centers
(5) Joint counter-terrorism assessment teams
(6) Joint terrorism task force
(7) National organizations
(8) Federal Bureau of Investigation (FBI)
(9) Historical records

A.5.4.2 In locations consisting of multiple structures with similar configurations, uses, and capacities, a consolidated assessment can be conducted.

Examples of occupant/attendee preparedness measures include, but are not limited to, bleeding control kits, bleeding control training, "run, hide, fight/avoid, deny, defend," and an emergency action plan.

Facilities identified as needing an individual facility risk assessment should follow a prescribed risk assessment methodology such as, but not limited to, the following:

(1) NFPA 99
(2) NFPA 730
(3) *NFPA 1600*
(4) NFPA 1620
(5) ISO/ IEC 31010:2019
(6) CFAI *Risk Assessment Manual*
(7) ASIS *Standard for Risk Assessments*
(8) PASS, guidelines
(9) FEMA CPG 201

A.5.4.2(5) Examples of security capabilities of the venue include, but are not limited to, audio/visual monitoring, security personnel, threat detection systems, electronic premises security systems, and other measures to counter or restrict assailant access.

A.5.4.2(13) Protective features can include ballistic glass, impact glass, and fortified doors/locks.

A.5.4.2(19) Examples of emergency responder accessibility include, but are not limited to, lock box locations, access to fire control system(s), access to a gated community, access to a secure compound, and access to keys, key cards, codes, or credentials.

A.5.4.2(20) This can include public access trauma control kits for lay rescuers and specialized medical equipment for internal and trained/licensed personnel who are part of an internal response team.

A.5.4.2(21) This plan should assist with coordination between the facility/venue and the AHJ.

A.5.4.4 Geographic threat assessments utilize GISs that allow the user to better visualize, question, analyze, interpret, and understand interdependencies, patterns, and trends.

A.6.1.2 A useful tool for some pre-incident planning activities is NFPA 1620

A.6.2 Plans are not a scripting process to dictate specific actions but rather to scope the multi-agency coordination theme of the plan. The plan can be, but doesn't have to be, a component of a comprehensive all-hazards plan. Plans should identify goals, functions, and desired outcomes.

A.6.2.1 Multi-agency and multidiscipline relationships should provide a starting point for planning, training, exercising, on-scene, and recovery operations. This will improve integration, response, and recovery capabilities.

A.6.2.4 The planning team is a group authorized by the AHJ to develop the plan.

A.6.2.6 Developing relationships between agencies, as well as interdisciplinary emergency and nonemergency operations, is vital to the success of an organized mission-oriented response.

A.6.3 Plans should mirror the National Response Framework (NRF) and National Preparedness Goals and include emergency support functions (ESFs) in annexes. Every state should already have an EOP that complements the NRF and that works in concert with FEMA.

A.6.4 SOPs enable personnel to operate at an ASHE incident where hazards are identified, risks are assessed, and response options are chosen based on the AHJ's concept of operations, available resources and capabilities, and the responder's level of training. For plans related to specific facilities or structures, NFPA *101* and NFPA 1620 have additional requirements for SOPs that should be taken into consideration.

A.6.4.2 SOPs should contain at a minimum the following items:

(1) Introduction
(2) Scope
(3) Purpose
(4) Definitions
(5) Health and safety of responders
(6) Response information and mutual aid
(7) Operations
(8) Equipment
(9) Unique site-specific information
(10) Pre-incident plans
(11) Threat assessments
(12) Consideration of operational impacts on the community
(13) Training
(14) Exercises
(15) Recovery
(16) Continuity of operations
(17) Behavioral health support and recovery
(18) Incident documentation and after action reporting

A.6.5.3 Restoring personnel to operational readiness can include short- and long-term behavioral health resiliency.

A.6.5.4 Annex C contains guidance for developing an AAR.

A.6.7.2 The guidelines should focus on ensuring that an entire jurisdiction can respond to any threat or hazard, including those with cascading effects. Emphasis should be on saving and sustaining lives. Significant incidents demand a much broader set of atypical partners to meet the demands of the incident.

A.6.7.2(10) This can include but is not limited to wound care, critical actions (run, hide, fight/avoid, deny, defend, etc.), lockdown procedures, and pre-existing plans (meeting points, contact numbers, phone trees, etc.).

A.6.8 SOGs, SOPs, EOPs, and other response program documents can contain critical and sensitive information that can be used by adversaries against emergency responders.

A.6.9.1 Information and intelligence sharing can require an MOU between ASHER program participating organizations to ensure that material and information can be effectively distributed in accordance with classification policies.

A.7.1 Resource and team typing categories (such as those in NIMS) should describe resources by capacity and capability. Team and resource typing should provide AHJs and on-scene incident management with the following:

(1) Enhanced emergency readiness
(2) Guidance for equipment purchasing and subsequent training
(3) Ease in identifying, requesting, and tracking resources by type

A.7.3 Mutual aid resources should be a source of personnel, equipment, and support to address the incident and associated community needs.

Some mutual aid relationships might require advance agreements outlining the provision and sharing of services prior to deploying to incidents. An example of this is NIMS on the local, state, and national levels.

A.7.4 Proper documentation of inventory and use is an important aspect of supply management. An example of prestaging essential supplies for a mass casualty incident might include implementing a free-standing mobile care platform that contains all necessary supplies for treatment, PPE devices, and oxygen delivery. Pre-positioning of these supplies will allow flexibility of deployment from a single location where all aspects of care and safety are already assembled and ready to go. These carts can be positioned in hospitals, schools that are predesignated as shelters, and public venues such as sports stadiums and convention centers that can be used for evacuation locations.

NIMS also includes information on resource management.

A.8.2.1 While it is acknowledged that many incidents are primarily managed by one agency or type of service (law enforcement, fire, EMS) based on the needs of the incident, it should also be understood that at most incidents there is overlap, and the continued use of unified command at even the most minor incident will set a framework and existing practice for its use at a major cross-functional incident such as an ASHE incident. An example is to utilize unified command for the planning and management of community functions, special events, and high-threat venues.

A.8.2.3.1 Members of the unified command should be physically co-located to maintain constant communications and share pertinent information.

A.8.2.3.3(5) An example of direct supervision over a functional group would be a rescue group supervisor.

A.8.3.1(2) Examples of specific characteristics include whether it is an open area, the structure or facility type, security systems, alarm and signal systems, population characteristics, and other considerations.

A.8.4.1 These practices should ensure a face-to-face unified command with their functional counterpart(s).

A.8.4.2(5) Examples of this include, but are not limited to, facility managers, school principals, health care representatives, victim witness specialists, and special event planners.

A.8.4.3 Essential to a successful outcome is the focus on shared information.

A.8.6 As an incident evolves, the disciplines essential for a unified command could also evolve. Disciplines outside of the traditional response roles can be folded into unified command as they assume responsibility for components of the incident.

A.8.7 Annex C contains guidance on AAR development and content.

A.9.1.1 Requirements in building, fire, and life safety codes are intended to establish, among other things, a reasonable level of safety for occupants from fire, explosion, and other hazards, and to provide a reasonable level of safety to firefighters and emergency responders during emergency operations. Providing protection against ASHE incidents could require protection methods in addition to those required by building, fire, and life safety codes. The additional ASHE incident protection measures should complement, and not conflict with, protection measures in the legally adopted building, fire, and life safety codes. A comprehensive risk assessment is beneficial to ensure each potential hazard is addressed through an all-hazard approach that does not improve risk mitigation for one hazard while reducing the risk mitigation for other hazards.

A.9.1.2 It is ultimately the responsibility of the facility, the stakeholders, and the AHJ to determine that a facility is at risk for an ASHE incident.

A.9.2.1(2) The plan should consider the nature and character of the occupants. The capability of the occupants has a direct effect on the plan requirements of the building owner and manager. For example, school children (K–12) will need more faculty/staff guidance on the procedures and actions to take. Occupants in a business occupancy, however, are likely to act more independently based on the plan. Responses in a health care/supervised care occupancy would involve staff assistance to aid patients.

A.9.2.1(3) Facility training programs should consider multiple options for occupant preparedness actions. These expected actions should be determined based on risk assessment and resource availability and through the planning process with the AHJ. Examples include lockdown procedures, run/hide/fight, avoid/deny/defend, and so forth.

A.9.2.1(6) Protective features can include ballistic glass, impact glass, fortified doors/locks.

A.9.2.1(7) This encompasses physical security, electronic security, and cyber security.

A.9.2.1(8) This includes in-building mass notification systems such as voice evacuation systems, area of refuge intercom systems, panic/duress alarms, and visual and audible alerting systems.

A.9.2.1(10) Depending on system type, they should be compliant with NFPA 1221 and *NFPA 72*.

A.9.2.2 Mobility for this discussion is defined as the ability of an individual occupant to mentally comprehend and physically address the efforts required to evacuate, shelter, or defend in place in the case of an ASHE incident. The following guidelines can be used for evaluating this characteristic:

(1) *Limited mobility:* Individuals who possess access or functional disabilities who would require the assistance of another individual to evacuate, shelter, or defend in place
(2) *Mobile:* Individuals who possess the capability to evacuate, shelter, or defend in place on their own

A.9.3 EAPs, including which occupancy types are required to have an EAP, are specified in NFPA *101*. EAPs for hospitals should follow NFPA 99. Other facilities should follow guidelines specific to their occupancy or as directed by the AHJ.

A.9.3.1 Notification procedures can be found in Chapter 20. Facilities should implement a public access trauma kit program that addresses all of the preventable causes of death due to trauma.

A.9.3.1(1) Consider DHS cyber and infrastructure security assessment (www.cisa.gov) and the PASS guidelines (www.passk12.org). NFPA 1600 and NFPA 1620 also have risk assessment and pre-incident planning guidance.

A.9.4.2 Where the fire alarm system is used as the means of emergency communications, it should be in accordance with *NFPA 72* and NFPA 1221. Facilities should consider adding new technology to increase their preparedness for ASHE incidents. This could include, but is not limited to, the following:

(1) Increased surveillance, including video
(2) Threat detection systems
(3) Mass notification systems
(4) Increased radio frequency identification (RFID) badging
(5) Access control software
(6) Signage and signal systems that can change instructions in real time based on incident information and needs

For example, facilities should explore systems that can enhance detection and response capabilities in order to address threats faster and move people to safer locations. NFPA 730 describes construction, protection, and practices intended to reduce security vulnerabilities to life and property. Among other things, it covers administrative controls, security perimeters, accessory property, and occupancy-specific protection. Where provided, the electronic premises security systems should be installed tested and maintained in accordance with NFPA 731.

A.9.5 This should apply to any facility that has an EAP with an ASHER program annex or an individual ASHER program. Exercises can include any of the following:

(1) Discussion-based exercises including the following:
    (a) Seminars
    (b) Workshops
    (c) Tabletop exercises (TTXs)
    (d) Games
(2) Operations-based exercises including the following:
    (a) Drills
    (b) Functional exercises (FEs)
    (c) Full-scale exercises (FSEs)

This information was taken from The Homeland Security Exercise and Evaluation Program (HSEEP). Exercises should be conducted with partner agencies, facilities, and AHJs whenever possible.

A.9.5.1 First responders and representatives of the AHJ should be invited to exercises. The owner should try to accommodate AHJ participation whenever possible.

A.9.5.2 Examples of organizations with multiple buildings on a single campus include, but are not limited to, schools, college campuses, hospitals, and military installations. Effective exercises should involve different scenarios and portions of the facility or different buildings.

A.10.1.2 Financial management elements can vary based on the type of organization. Financial management elements encompass funding sources and processes, budgetary processes and procedures, capital and operations budgets, program costs, and cost recovery. A critical challenge for an ASHER program is to ensure adequate funding for assigned missions, tasks, training, and equipment.

A.10.3 Revenue sources can include, but are not limited to, response agency or organization budgets, state or federal grants, cooperative agreements, donations, fees, and cost recovery associated with events. Fiscal responsibilities for organizations participating in a multi-agency program agreement should be well defined and agreed on in advance. ASHER program managers should be aware of alternative revenue sources that might be available.

There could be federal funding available to assist the AHJ in supporting the costs of equipment, staffing, and training. The exact eligibility rules and funding provisions can vary depending on the agency, program, and fiscal year appropriation. Federal agencies such as the Department of Homeland Security and the Department of Justice could also offer technical assistance and training to first responder agencies at the state, local, and tribal levels that address the competencies outlined in Chapters 13 and 14.

The Catalog of Federal Domestic Assistance (CFDA) provides a listing of all federal programs that provide assistance or benefits available to state and local governments, federally recognized Indian tribal governments, and territories (and possessions) of the United States.

State and local grant programs vary from jurisdiction to jurisdiction. Some grant programs are supported by private industry, and others come from government agencies. Local agency and industry, stakeholders should be contacted to determine what grants are available.

A.10.4 These cost centers might include initial and ongoing costs related to supplies and equipment, training and exercises, personnel, education and outreach programs, administrative support and services, and fixed asset and capital item maintenance and replacement.

A.10.5 The AHJ can have ordinances or rules that allow for cost recovery where the responsible party provides reimbursement for certain supplies. (For more information, go to www.ovc.gov.)

A.11.2 911 public safety answering points (PSAPs) are often the first point of contact for victims experiencing or fleeing an ASHE incident. Calls can be received by voice, by text, or from other means. In addition to 911 services, communication centers can dispatch initial resources or make police, fire, EMS, mutual aid, and administrative notifications.

A.11.2.3 Training for communications center personnel can include exercises, scenarios, formal classes, and online training programs. AHJs are encouraged to include communications center personnel in tabletop exercises, drills, and any other multiagency training.

A.11.3 Such relationships should include managing emergency information, providing a unified communication control system, transmitting safe scene information cross agency with priority, transferring or handling (without duplicating) event

information, and ensuring compatibility of communication devices.

A.11.4 Many systems and AHJs are currently utilizing computer-aided dispatch (CAD) systems. The requirements, qualifications, and training referenced in NFPA 1221 and NFPA 1061 regarding incident/tactical dispatch are appropriate for any public safety telecommunicator managing an ASHE incident, even if that dispatcher does not physically respond to the scene.

A.11.4.1 Considerations should include the following:

(1) Implementation and support of text to 911
(2) Implementation and support of NG911
(3) Resiliency and continuity of operations
(4) Incident/tactical dispatch needs
(5) Increased volume of emergency and nonemergency calls
(6) Staffing of emergency communications center
(7) Robust and comprehensive backup and rollover process potentially to a larger center with greater ability to handle a large call volume
(8) Relief of communications personnel
(9) Behavioral health assistance

A.11.4.2 Chapter 6 of NFPA 1061 is being referenced here rather than extracting entire sections of the document. Communications personnel should also consider the use of an encrypted tactical channel if one is available and is part of their local policies and procedures.

A.11.5 All systems utilized for emergency incident communications management and support should be configured and enabled to facilitate sharing of incident data and related information.

A.11.7.1 This is where interoperability is important. Preplanning/testing the use and capability of radio communications amongst local and regional responding agencies is important, as is the ability for all (treatment, triage, transport, hospital, etc.) to talk on the radio to each other when they have shared responsibilities.

A.11.8 In many jurisdictions these have a specific name or level. They usually consist of a predetermined number of resources that a dispatcher can send at once to the incident so that resources are on scene in a more timely manner. Many jurisdictions call these packages specific names (alarm companies, task forces, strike teams, etc.). Some jurisdictions also allow first arriving resources and incident command to order these packages in an escalating manner as they manage the incident.

A.12.1.3.1 *Hot Zone Tasks.* Law enforcement personnel who operate in a hot zone should be able to perform the following tasks:

(1) Recognize the presence of the incident, conduct an evaluation, respond, and appropriately address the threat(s)
(2) Provide incident information to other responding personnel, which can include the following:
    (a) Size-up
    (b) Make a major incident notification
    (c) Identify the exact location of the incident (to reduce multi-incident confusion)
    (d) Identify the type of attack or incident
    (e) Announce the presence of known hazards
    (f) Provide access for incoming responders
    (g) Identify the potential number and location of casualties
    (h) Identify additional resources required
(3) Take measures to ensure their personal safety including donning appropriate PPE and identifiable garments
(4) Provide appropriate direction to victims while gathering information
(5) Establish a hot zone(s) perimeter.
(6) Be prepared to provide self-medical aid or buddy medical aid

Emphasis should be given to establishing an incident commander until command and control is established as detailed in Chapter 8.

Warm Zone Tasks. Law enforcement personnel who operate in a warm zone should be able to perform the following tasks:

(1) Establish command and control as detailed in Chapter 8, including the following:
    (a) Operate within in the unified command structure
    (b) Assemble contact teams and/or operate as part of the law enforcement branch within the incident command system
(2) Constantly evaluate the scene for emerging or re-emerging threats
(3) Be able to complete mission-specific tasks for each type of hazard and participate in mission-specific teams
(4) Be able to conduct casualty extraction techniques according to agency policies and procedures
(5) Be able to act as force protection for fire and EMS personnel (rescue task force)
(6) Provide security to a perimeter, corridor(s), or protected island(s) to facilitate emergency medical and fire operations
(7) Provide appropriate direction to victims — egress vs. shelter in place
(8) Communicate with and update unified command
(9) Support evidence and witness preservation
(10) Provide threat-based care

Cold Zone Tasks. Law enforcement personnel who operate in a cold zone should be able to perform the following tasks:

(1) Establish command and control as detailed in Chapter 8, including the following:
    (a) Operate within in the unified command structure
    (b) Operate as a component within the law enforcement branch within the incident command system
(2) Constantly evaluate the scene for emerging or re-emerging threats
(3) Be able to conduct casualty extraction techniques according to agency policies and procedures
(4) Provide security to a perimeter and to the unified command post
(5) Coordinate emergency vehicle ingress/egress, including helicopter landing zones, if needed
(6) Support evidence and witness preservation
(7) Screen individuals present for additional threats
(8) Provide security for personal possessions left behind by fleeing victims
(9) Gather victim information and provide support
(10) Provide threat-based care

Recommended Associated Off-Site Operations Tasks. Law enforcement personnel who operate in operational areas that are asso-

ciated but off-site, should be able to perform the following tasks:

(1) Operate as a functional position within the unified command post
(2) Assist with public information as detailed in Chapter 17
(3) Assist with family notification
(4) Conduct witness interviews
(5) Participate in evidence collection
(6) Provide security support to associated sites such as media areas and witness interview areas.
(7) Support emotional and behavioral support missions
(8) Serve as victim liaisons

Recommended Competencies.

Recommended Competencies for Law Enforcement Personnel When Operating at an ASHE Incident. Law enforcement officers should receive training to be able to conduct tasks in the hot zone. Officers should be knowledgeable of all local plans, policies, and procedures, including the following:

(1) Major incident notification procedures
(2) Available resources
(3) Procedures for activating the local ASHER plan
(4) Communications plan and procedures
(5) "Officer Down" procedure, or equivalent, based on local policy, protocol, and procedure
(6) Local procedures for clearing areas and designating zones
(7) Local procedures for establishing perimeters and providing security to other responders
(8) Available medical supplies and resources and their appropriate and prescribed uses within the adopted scope of practice
(9) Available PPE and their appropriate and prescribed uses
(10) Local policies and procedures for operating with responders from partner agencies and jurisdictions
(11) Warm zone care and rescue concepts, including, but not limited to, the following:
    (a) Rescue task force
    (b) Law enforcement rescue teams
    (c) Protected island operations
    (d) Protected corridor operations
(12) Principles of the law enforcement branch, including the following:
    (a) Contact teams (including solo and multi-officer response)
    (b) Security/rescue teams
    (c) Perimeter protection
    (d) Evidence collection
    (e) Witness identification and interviews
(13) Basic breaching techniques
(14) Local responder identification plans in order to differentiate responders from other parties
(15) Ability to clear traffic and roadways to support movement of victims and possible evacuations
(16) Local policies and procedures for the transition of active to recovery operations
(17) Basic improvised explosive devices (IED) recognition and considerations
(18) Basic recognition of perpetrator use of chemical munitions and protective measures
(19) Procedures for checking into the incident with unified command for accountability and assignment (no self-deployment without notification)
(20) Understanding of relevant associated off-site operations and providing security for these off-site operations, including the following:
    (a) Notification centers
    (b) Incident assistance center
    (c) Public information distribution
    (d) Hospitals
    (e) Witness interview and debrief locations
    (f) Transport zones
    (g) Mobile communications support
(21) Witness and victim identification
(22) Hazardous materials awareness level as defined in NFPA 472 or NFPA 1072

Recommended Competencies for Law Enforcement Officers When Operating at Vehicle as a Weapon Incidents. Law enforcement officers should have knowledge of local policies for vehicle as a weapon engagement. This should include the following:

(1) Vehicle immobilization techniques
(2) Vehicle-borne IED (VBIED) identification

Recommended Competencies for Law Enforcement Officers When Operating at an Active IED Incident. Law enforcement officers should have knowledge of local IED response policy. This should include the following:

(1) Time, distance, and shielding, using the Department of Homeland Security (DHS) stand-off chart
(2) Post-blast transition to fire event/structural collapse

For more information, see http://regulationspolicies.usf.edu/policies-and-procedures/pdfs/policy-6-002-bomb-threat-stand-off-chart-a.pdf.

Recommended Competencies for Law Enforcement Officers When Operating at Fire as a Weapon Incidents. Law enforcement officers should have knowledge of basic fire-fighting operations, which can include the following:

(1) The ability to recognize an immediately dangerous to life and health (IDLH) situations as pertains to respiratory and thermal protection
(2) Co-occurrence threats (fire as a weapon often occurs in tandem with a second hostile event)
(3) Local fire department capabilities and their specific operations
(4) AHJ's requirements for fire as a weapon incidents
(5) Movement techniques in a smoke environment, such as how to drop to the floor where there could be breathable air and how to move along the walls in order to find an exit
(6) Partnering with the local fire department to obtain basic fire-fighting training and instruction on how to properly use fire extinguishers to put out small fires

A.12.1.3.3 At a minimum this medical care knowledge should include the following:

(1) Hemorrhage control
(2) Basic airway
(3) Respiratory management
(4) Casualty extraction
(5) Hypothermia management

Examples of threat-based systems of care include, but are not limited to, the following:

(1) The system of care that is used to provide medical aid to self and others, including emergency patient care for the

civilian environment, should be in accordance with the Tactical Emergency Casualty Care (TECC) *Guidelines for First Responders with a Duty to Act* and *Guidelines for BLS/ALS Medical Providers.*

(2) The military equivalent is Tactical Combat Casualty Care (TCCC).

A.13.1.1 The intent of this section is to define competencies for both fire and EMS functions regardless of agency configuration. It is understood that some agencies provide dual services that are comprised of both traditional fire and medical service delivery while others are provided by separate entities with different command structures. It is important for agencies to apply the sections of this chapter that relate to the services delivered.

A.13.2.2 For more information, go to www.c-tecc.org.

A.13.3.1.1 Fire and EMS do not typically operate in a hot zone at ASHE incidents. It is understood that different municipalities and jurisdictions could have the ability to do so as part of a specialized team.

A.13.3.3(5) The federal government recommends using the Model Uniformed Core Criteria/Sort-Assess-Lifesaving Interventions-Treatment/Triage (MUCC/SALT) system. (https://www.ems.gov/nemsac/dec2013/FICEMS-MUCC-Implementation-Plan.pdf).

A.13.4.1.2(22) The risk model should be based on the AHJ's current risk analysis policy, procedure, or model.

A.13.4.3 For more information, see http://regulationspolicies.usf.edu/policies-and-procedures/pdfs/policy-6-002-bomb-threat-stand-off-chart-a.pdf.

A.14.2.3 Zone definitions follow the general location of the threat(s). Hot zone operations should also consider a ballistic helmet, a radio with shoulder strap, and remote microphones with earpieces, flashlight, and individual first-aid kit (IFAK). See Chapters 8, 12, and 13 for warm zone operation.

A.14.2.4 Deployment models can include, but are not limited to, the following:

(1) Individually issued
(2) Issued to each applicable responder or responder position on the vehicle
(3) Command and/or supervisory vehicles

A.14.3.1 The NIJ establishes minimum performance standards for body armor and administers a program to test armor for compliance. Type III-A ballistic panels provide ballistic penetration protection for most standard handgun and shotgun ammunition.

A.14.3.1.1 For more information on NIJ compliant products list go to www.nij.gov/topics/technology/body-armor/Pages/compliant-ballistic-armor.aspx.

A.14.3.2 Examples of integrated response teams include rescue task force, protected corridor, and protected island.

A.14.4 For PPE and BPE worn externally, additional marking can be used to designate rank officers and should be based on operational functions.

A.14.5 NIJ provides an explanatory video on care and maintenance at http://youtu.be/R85mWoCBR50.

A.15.1.1.1 Examples of available training can include, but are not limited to, Advanced Law Enforcement Rapid Response Training (ALERRT), Tactical Emergency Casualty Care (TECC), or Tactical Combat Casualty Care (TCCC).

A.15.2.1 The entities can include but are not limited to law enforcement, fire, EMS, private security, victim advocates, federal/state/local/tribal assets, health care, and emergency management.

A.15.2.2 Training can include scheduled or no notice sessions.

A.15.2.4 The lessons learned identified in the AAR of the exercise should be documented and distributed to all participant agencies for use in adjusting training plans, policy and procedures, logistic planning, and resource acquisition planning. These exercises can consist of one part of the program's plans or several.

Exercises that fall under the HSEEP scope include the following:

(1) Full scale
(2) Tabletop
(3) Functional

It is a best practice to exercise different portions or elements of the program each year in order to continuously improve the program's capabilities.

A.15.3 This training should be based on the risk assessment and partnerships formed with facility mangers as outlined in Chapters 5 and 9.

A.16.2.1(3) These materials can include videos, handouts, published papers, online learning, and other similar educational material.

A.16.3 More information can be found at www.stopthebleed.org and www.dhs.gov/sites/default/files/publications/active-shooter-pamphlet-2017-508.pdf.

Public involvement is vital to provide additional support to response personnel and can often be the primary source of response in the first hours or days after a catastrophic event. As such, the public should be encouraged to train, exercise, and partner with each other and emergency management officials.

A.16.3(3)(a) An example of a survival strategy is "run, hide, fight." The United States federal government recommends teaching the public to run, hide, and then fight. Another example is "avoid, deny, defend."

A.16.3(3)(b) Other interventions include civilian treatment for airway, respiratory, hypothermia, and extraction. The United States federal government also encourages teaching the public bleeding control measures via the "Stop the Bleed" campaign (www.dhs.gov/stopthebleed) and the "You Are the Help Until Help Arrives" program, which addresses the time interval before arrival of professional responders. (www.community.fema.gov/until-help-arrives).

A.16.3(4) Information specific to people with disabilities as well as others with access and functional needs should be included. For people who might have a physical or mental disability or language access issue, the following should be included in preparedness plans:

(1) Communication needs (not able to hear verbal announcements or alerts, see directional signage, communicate with respondents)

(2) Maintaining health (acute medical needs requiring support or trained medical professionals, medications, access)
(3) Independence (providing physical and programmatic access, durable medical equipment needs/service animal)
(4) Support and safety (loss of support of personal assistants, children and supervision)
(5) Transportation (not able to drive, assistance with evacuation)

A.17.1 Users of NFPA 3000 are encouraged to review the information in NIMS, specifically FEMA 517, *Basic Guidance for Public Information Officers (PIOs)*; Job Aid: Public Information Staffing and Skills Checklist; and FEMA Lesson 5: Public Information During the Incident.

A.17.1.1 Organizations should coordinate their public information messaging with their AHJ.

A.17.2.3 This communication includes press alerts and media advisories, press releases, briefings to victims, families, loved ones, and talking points.

A.17.3(3) Providing assistance with notification helps to reduce overwhelming resources at the scene with information requests and to provide for a secure and accessible gathering place in a cold zone where potential witnesses can be identified and interviewed to advance an ASHE incident investigation.

A.17.3(4)(a) The PIO should be involved in assisting in the creation of messaging appropriate to communicate the essential and timely information on the ASHER plan.

A.17.3(4)(b) The PIO should be involved in the risk planning and coordination to acquire the appropriate communications contacts and familiarity with agencies and partners who could be resources for mutual aid as well as all SOGs and SOPs developed as part of the planning process and post-incident procedures.

A.17.3(4)(c) The PIO should be involved in the risk assessment to acquire the appropriate communications contacts and familiarity for assessed organizations for information sharing, preparedness planning, analyzing consequences, and seamless information flow in the event of an ASHE incident

A.17.3(6) Operational security could be put in jeopardy by any of the following:

(1) Media helicopters divulging response team location and movements
(2) Misinformation on the current status of the ASHE incident
(3) Disclosing the number of casualties
(4) Disclosing the number of perpetrators

A.17.4.1 Accessing multiple layers (types and methods) of communication systems can increase effectiveness. Multiple layers provide an extra level of notification (a safety net). The overall mass notification system (MNS) application is likely to exploit a number of public and individual systems or components that combine to produce a reliable and robust solution to achieve emergency notification objectives. The IPAWS system consists of multiple layers.

Layer 1 could consist of elements such as the following:

(1) Emergency voice/alarm communications systems (EVACS)
(2) In-building MNS
(3) One-way voice communication systems (PA)
(4) Two-way voice communication systems
(5) Visual notification appliances
(6) Textual/digital signage/displays

Layer 2 could consist of elements such as the following:

(1) Wide-area outdoor MNS
(2) High-power loudspeaker arrays (HPLAs)

Layer 3 could consist of elements such as the following:

(1) Short message service (SMS)
(2) Email
(3) Computer pop-ups
(4) Smartphone applications (apps)
(5) Reverse 911/automated dialing
(6) Wireless emergency alert (WEA)

Layer 4 could consist of elements such as the following:

(1) Radio broadcast (satellite, AM/FM)
(2) Amateur radio (HAM)
(3) Television broadcast (satellite, digital)
(4) Location specific messages/notifications
(5) Weather radios
(6) Social networks

A.17.4.5 Test notifications should be appropriate and should not create panic. An example of this would be live social media posting of test events where they could be misunderstood as actual events

A.17.4.6 The Clery Act provides timely warning and crime notification requirements. See www.clerycenter.org.

A.17.5 Social media is valuable for refuting or verifying incident information. It should be monitored as much as possible by the JIC if one has been established.

A.17.5.1 External sources include social media and news reports.

A.17.5.2 Appropriate and trending social media hashtags should be used to ensure the consistent delivery of approved messaging and information. Where possible, the same message from one source across all social media platforms should be used.

A.17.5.3 This includes sharing operational information and data (e.g. pictures, video) that are not approved for release outside of the scene.

A.17.6.1 The on-location media area should be distinct from the notification center and later incident assistance center, but sufficiently close to allow the sharing of information with both. When possible, victims and families should receive information prior to release to media and the general public.

A.17.6.2 Managing the media area includes maintaining a general understanding of who is there, giving timely updates, and not letting them interfere with operations.

A.17.6.3 The recovery phases are detailed in Chapter 20.

A.18.2.1.1 Figure A.18.2.1.1 shows an example of continuity of operation.

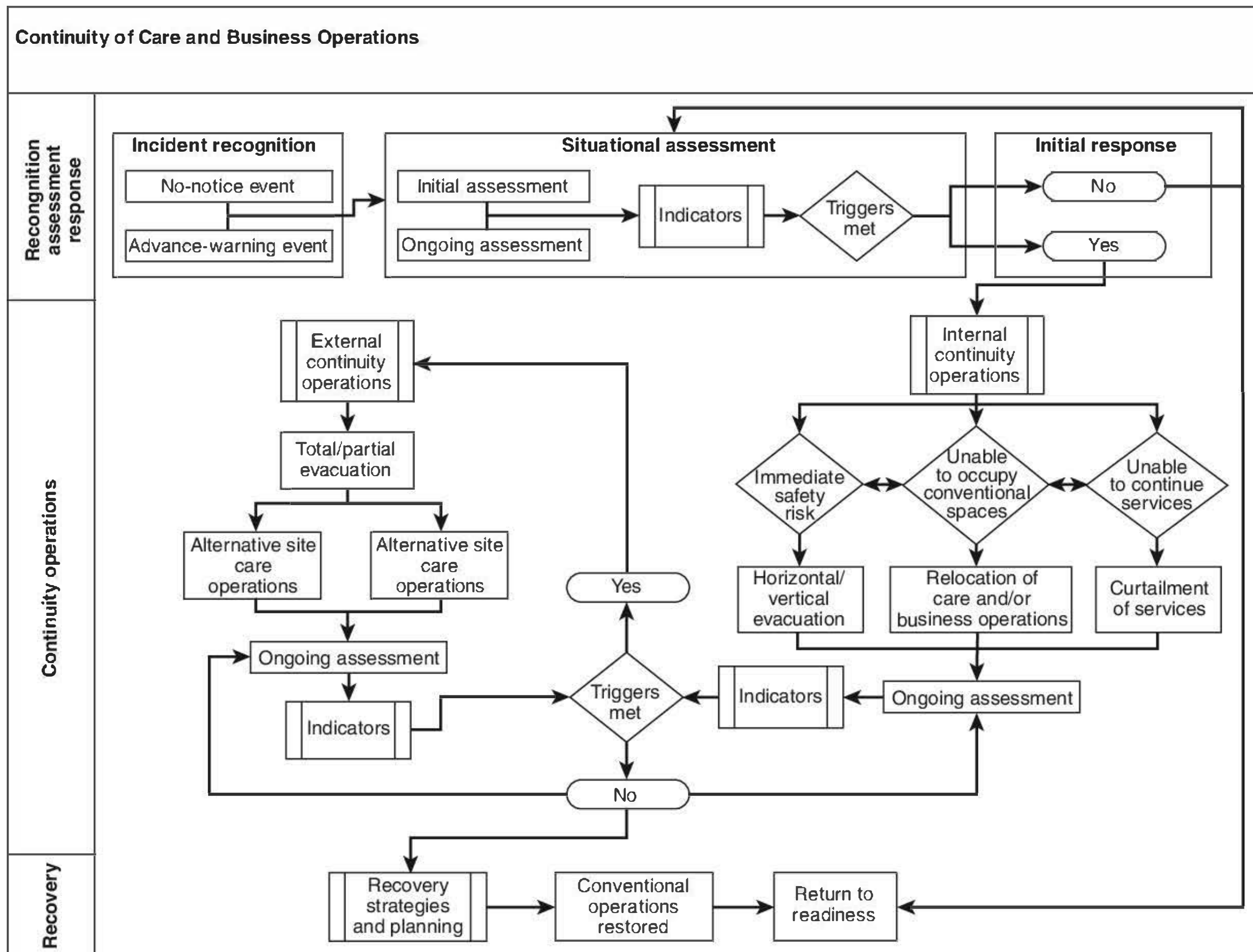

FIGURE A.18.2.1.1 Continuity of Care and Business Operations Decision Flow Chart. [1616:Figure A.6.5.1]

A.19.1 NFPA 99 contains dedicated chapters that provide the requirements for emergency and security management in health care organizations. The emergency management provisions require the development of an emergency operations plan based on an all-hazards approach, including mass casualty events that can greatly increase the demand for services. The security management requirements state that facilities must conduct a security vulnerability assessment that evaluates potential security risks to all individuals in the facility, and, as part of the plan, procedures must be identified for a number of incidents, including ASHE incidents. The requirements of NFPA 3000 are intended to supplement these overall plans by providing some of the specific recommendations health care receiving facilities must do in order to best support the integrated response to ASHE incidents.

A.19.1.1 Some facilities are not expected to receive victims from such events as they do not possess the capability to treat victims from an ASHE incident. Behavioral health facilities are one example.

A.19.1.2 Rapid categorization of severity during ASHE incidents is vital to reduce preventable loss of life.

A.19.1.2.1 Scalability allows facilities to adjust their response to meet the objectives of this standard.

A.19.2 Exercises should be scalable in nature and conducted once annually, at a minimum. Exercises should follow FEMA or facility-specific guidance for exercises.

A.19.2.2 Hospital emergency management plans should include establishment of a notification center that coordinates with AHJ notification center activities. The hospital notification center should be able to communicate freely and without disruption with the AHJ notification center. This is necessary because the public could overload the normal means of communication with the site.

A.19.2.5 Assistance can consist of integrated response teams, site management, site security, patient decontamination, patient triage, patient treatment, incident command system, command and control, and other relevant services.

A.19.3 While it is ideal that patient distribution takes place in an organized and coordinated manner, it is known that most frequently this is not the case.

A.19.4 These means of communication can include the following:

(1) Phone
(2) Dedicated radio frequency
(3) Separate dispatcher
(4) Satellite phones
(5) Electronic patient management systems

A.19.4.3 This assignment should consist of at least one staff member who is singularly assigned to the role, but facilities should be prepared to add additional staff as needed based on the scale of the incident.

A.19.5 Use of electronic, web-based systems for victim tracking, notification of families and loved ones, and hospital capabilities (i.e., numbers of victims per triage category that can be managed as the incident progresses) should be considered. More information on victim identification and tracking can be found in Chapter 20.

A.19.6.1 Existing physical security measures include electronic access control and traffic barriers. On-duty staff members include security and facility staff.

A.19.6.2 Measures for restricting access should include the following:

(1) Controlling access to security sensitive areas and high-risk departments
(2) The process for identifying health care facility (HCF) staff and others (fire, law enforcement, EMS, public health) that require access
(3) Communicating with on-duty and supplemental personnel
(4) Managing internal and external communications
(5) Establishing and maintaining perimeters and related visitor protocols
(6) Obtaining additional security and/or law enforcement staff
(7) Establishing secure passage routes and transportation for HCF staff
(8) Managing the internal environment during access restrictions
(9) Reversing the restricted access and opening areas
(10) Testing and evaluating controlled access plans during emergency exercises with other HCFs and community agencies

A.19.6.2(1) This can be accomplished in progressive stages and can involve the facility incident command structure.

A.19.7.1 It is highly recommended that the facilities use the hospital incident command system (HICS).

A.20.1 For details and a federal application, refer to the Victims of Crime Act and the Crime Victim's Fund at www.ovc.gov/about/victimsfund.html.

A.20.1.1.1 The Mass Violence Toolkit, created by the Office for Victims of Crime, U.S. Department of Justice, was developed to help communities prepare for and respond to victims of mass violence and terrorism—to include active shooters—in the most timely, effective, and compassionate manner possible. It is comprised of checklists, a compendium of resources, and other pertinent victim-related materials derived from operational procedures, best practices, and lessons learned throughout the victim services community.

A.20.1.1.1.1 Steady state is also commonly referred to as the "new normal."

A.20.2.1 The notification center is typically used from the start of the ASHE incident until the 24- to 48-hour mark.

A.20.2.2(8) The medical examiner or coroner's office should be considered for inclusion in the unified command, the notification center, and later, the incident assistance center. Their capabilities include gathering antemortem data and notifying the next of kin regarding the deceased. Placing the medical examiner or coroner in these places can alleviate the number of family members and victims arriving at other locations, as well as approaching the medical examiner or coroner's office.

A.20.2.3 This coordination includes the establishment of how all parties, both primary and supporting, can effectively accomplish the necessary common strategy while coordinating and supporting each other's missions.

In cases where multiple primary agencies share complementary capacities at the statewide level, a facilitating team can be constituted to serve the role of the facilitating agency.

A.20.2.3.2 All participating organizations are encouraged to sign a memorandum of understanding or memorandum of agreement prior to any ASHE incident.

A.20.2.3.2.3 Initial communication meetings should be conducted early following the event so that all organizations have consistent up-to-date information.

A.20.2.3.4.1 If possible, the RC should be previously vetted and part of emergency planning prior to the incident.

A.20.2.3.5(7) This should include considerations for persons with access and functional needs.

A.20.2.3.6 Establishment, use, and communication regarding the immediate use of a notification center, to be later followed by an incident assistance center, should be considered. The notification center allows for victims' family members and loved ones to be staged in a location removed from operations in order to receive timely and accurate information regarding victims and location of casualties if sent to a health care facility and to be reunified quickly with the uninjured who are delivered to the notification center. Unified command should consider preparing separate areas for victims to stage out of view from the public gathering at these locations.

The creation of a notification center should have a process to identify possible victims and witnesses during intake who might need to provide incident-related information to law enforcement. The establishment of a uniform statistical data collection process, in coordination with the primary agencies, should be considered to track outreach and services delivered. This data is often useful after the incident when conducting needs assessments and applying for grant funding.

A.20.2.3.7.1 This will allow for family members to be staged in a location removed from operations in order to receive timely and accurate information regarding casualties and location of casualties if sent to a medical facility and to be reunified quickly with the uninjured who are delivered to the reunification and notification center. The location should also take into consideration the media that will arrive and the possible need to shield victims and victim families from the cameras. Unified command should consider preparing separate areas for victims

to stage out of view from the public gathering at these locations.

A.20.2.3.8 A team might additionally include victim advocates, mental health professionals, crisis counselors, and faith or spiritual leaders whose members are trained in notification. The FBI offers a free online training on the proper protocol for death notification, which is available at www.fbi.gov/news/stories/death-notification-with-compassion.

A.20.2.3.8.2 Other trained entities can include clinicians in the health care setting communicating to families, loved ones, or next of kin. This is based on AHJ and regulatory practice.

A.20.2.3.11 Individuals could have additional needs before, during, and after an incident in functional areas, including, but not limited to, the following:

(1) Maintaining independence
(2) Communication
(3) Transportation
(4) Supervision
(5) Medical care

The following list is a group of individuals who should not be overlooked and could have unique needs following an ASHE incident:

(1) Children and youth
(2) First responders
(3) Tribal communities
(4) Elder populations
(5) Individuals with disabilities
(6) Individuals who are deaf or hard of hearing
(7) Individuals with limited English proficiency
(8) High-risk populations
(9) Lesbian, gay, bisexual, transgender, and questioning (LGBTQ) populations
(10) Military veterans
(11) Underserved and socially isolated populations including, but not limited to, those historically underserved due to race, socio-economic status, disability, or sexual orientation
(12) Foreign nationals (see State Department's Consular Notification and Access Manual in Annex D)
(13) Undocumented populations
(14) Individuals with religious and spiritual affiliations
(15) Other specialized populations

A.20.3 Early recovery typically lasts from the 24- to 48-hour mark post-incident until one or two weeks.

When transitioning from a notification center to an incident assistance center, it is best practices to close the notification center on a Friday evening, maintain a staff over the weekend, and open the incident assistance center on the following Monday morning.

The incident assistance center was formerly known as the family assistance center.

A.20.3.1(9) Victim advocacy, assistance, and services should include but not be limited to the following:

(1) Temporary housing and infrastructure repairs
(2) Area re-entry and belongings recovery
(3) Personal property replacement
(4) Transportation or vehicle replacement assistance
(5) Replacement of job-related tools and specialized/protective clothing
(6) Moving and storage assistance
(7) Legal assistance
(8) Insurance claims assistance
(9) Employment-related assistance
(10) Food replacement
(11) Assistance to mitigate against the effects, including vicarious, of future events
(12) Medical, dental, and mental health services
(13) Information regarding additional near- and long-term victim services

A.20.3.2 An IAC is intended to serve a variety of victims, to include those psychologically or vicariously traumatized, and not just families.

A.20.3.2.1 The term *permissable information* is used because some information cannot be shared, such as information relevant to a crime or investigation and personal medical information, which is confidential.

A.20.3.2.1(9) The medical examiner or coroner's role at the IAC includes gathering antemortem data (via the notification center) and notifying the next of kin regarding the deceased. Placing the medical examiner or coroner at the IAC can alleviate the number of family members and victims arriving to other locations, as well as approaching the medical examiner or coroner's office.

A.20.3.2.1(10) The discussion about memorial events should consider the community's needs, its desire for annual memorial services, and the potential impacts of media coverage. The needs and desires of victims versus those of the community should be determined. Organizers should be aware that a spontaneous memorial event could emerge in the community even if a formal, organized memorial service is not planned. A memorial plan might not preclude a spontaneous event.

A.20.3.3.3 These could include planned or spontaneous protests, rallies, vigils, and dignitary visits.

A.20.3.3.4(4)(d) Health care facility post-incident security plans should provide guidance for threat security, victim security, and health care facility and infrastructure security.

A.20.3.3.7.2 If there is a need to separate volunteers, including spontaneous, from the victims initially, then the volunteer reception center might need to be located away from the notification center, and later, the incident assistance center.

A.20.3.3.7.6 Input from the victims and their families should be elicited prior to the designation and distribution of funding and donated goods during the decision-making process.

A.20.3.3.7.7 This strategy could include the creation of a donations management database to help collect, track, disburse, and acknowledge monetary and nonmonetary donations. This strategy should be reviewed during the response phase to identify any necessary modifications arising from emerging and unanticipated needs, including community and victim needs.

A.20.3.3.7.8 Multiple sites could be necessary to receive, store, stage, and distribute donations. Donations, especially monetary, should be broadly dedicated toward victim services and recovery efforts rather than narrow and specific.

If a warehouse(s) is necessary, then state-level and/or private sector contract hauler transportation resources should be identified in order to secure appropriate cargo vehicles and drivers.

A.20.3.3.7.9 For more information, see the FEMA toolkit at https://www.fema.gov/media-library/assets/documents/32282.

Samples of volunteer and donation agreements can be found at the following web sites:

(1) http://ema.ohio.gov/Documents/Ohio_EOP/ESF_6_Tab_C_VolunteerManagementSupportPlan.pdf
(2) http://ema.ohio.gov/Documents/Ohio_EOP/EOP_Overview/ESF7_DONATIONS_MANAGEMENT_SUPPORT_PLAN_TAB_A.pdf

A.20.3.3.7.10 Communications and messaging on donations should reflect the diverse ways that funds and items can be used.

A.20.4.1 Specific to the incident, continued recovery is likely in the period two weeks to one month after the incident and is extended as needed by months, years, and possibly decades.

A.20.4.2 This could require a victim assistance liaison or advocate.

A.20.4.2.1 In some instances, a law enforcement officer has been assigned to each affected family to serve as the single point of contact for victim service information and media requests. Victims and families should be notified as to their rights with the media, which should be publically posted as well.

For a sample victim liaison job description go to the OVC victim toolkit: https://www.ovc.gov/pubs/mvt-toolkit/Sample_SampleVictimLiaisonJobDescription.pdf.

A.20.4.2.2 This can include assistance with death certificates, autopsy reports and information, and other documentation for legal needs and benefits.

A.20.4.2.4 This process should be proactive and managed by individuals or organizations that have a strong understanding and experience in post-incident recovery systems. This process should ensure that clinicians and service providers are licensed and trained with experience in ASHE incidents.

A.20.4.2.5 The IAC can transition to a CRC depending on the nature/scope of the event. CRC leaders should be aware that not all direct victims might want to participate.

The CRC can engage a holistic approach, which can include diverse faith or spiritual healing practices, to support survivors and surviving family members in the long term. It should be remembered that not all victims are religious or spiritual. The emotional and psychological needs of the community should be met by providing mental health support, counseling, screening, and treatment. The potential for increased risk of substance, physical, sexual, and emotional abuse should be addressed.

A.20.4.3.1 For example, the Behavioral Health Assistance Program (BHAP) through the National Fallen Firefighter Foundation is a comprehensive, integrated, multicomponent, systematic program for firefighter mental health/wellness and crisis intervention. Additional support is provided through CISM, chaplain programs, peer to peer, clinical response teams, therapy animals, and others.

A.20.4.3.2 Those who have experienced trauma directly or vicariously are likely to have recovery needs.

A.20.4.5.1 This could additionally include adjudication and prisoner status (e.g., prisoner location post-conviction, parole-related issues), victim's right to be present at trial, victim's right to be heard, victim's right to swift and fair resolution, victim's right to be informed, and victim's right to safety and protection of privacy. Information should be provided in lieu of trial if a trial does not occur.

Next of kin during medicolegal death investigations will have special needs. For more information, see "Principles for Communicating with Next of Kin during Medicolegal Death Investigations" from the Scientific Working Group for Medicolegal Death Investigation.

A.20.4.7 Affected populations might need specialized resources and/or case management assistance. This can be part of a victim assistance response plan assessment by primary agencies.

A.20.4.8 Annex C contains detailed guidance on developing an AAR.

A.20.4.8.1 If possible, victims and families should receive the AAR and other incident information prior to release to the general public.

A.20.4.9 Examples of infrastructure and facilities include, but are not limited to, the following:

(1) Health, medical, and dental
(2) Logistics
(3) Sanitary
(4) Human resources to continue operations and support continued recovery efforts
(5) Replacement and repair of facilities damaged by the event
(6) Restoration of the supply chain
(7) Provision of temporary housing/interim housing
(8) Repairing property
(9) Natural and cultural resources

Annex B Laws, Regulations, Consensus Standards, and Guidance Documents

This annex is not a part of the requirements of this NFPA document but is included for informational purposes only.

B.1 Scope. This annex applies to those organizations and jurisdictions responsible for organizing, managing, and sustaining an ASHER program.

B.1.1 Laws are enacted by legislative action of governmental bodies such as Congress, individual states, and local government. Laws typically provide broad goals and objectives, set mandatory dates for compliance, and establish penalties for noncompliance.

B.1.2 Regulations are official rules created by government agencies that detail how something should be done.

B.1.3 A consensus standard is a standard that has been adopted and promulgated by a nationally recognized standards-producing organization under procedures whereby it can be determined that persons interested and affected by the scope or provisions of the standard have reached substantial agreement on its adoption, it was formulated in a manner that affor-

ded an opportunity for diverse views to be considered, and it has been designated as such.

B.2 Purpose. This annex is provided as a law and regulation reference point for programs that are developing an ASHER Program.

B.3 Laws. The following federal laws are applicable to the management of active shooter/hostile events:

(1) Public Law 81-920, as amended, the Federal Civil Defense Act of 1950
(2) Public Law 83-703, as amended, the Atomic Energy Act of 1954
(3) Public Law 93-288, as amended, the Robert T. Stafford Disaster Relief and Emergency Assistance Act
(4) The Cooperative Forestry Assistance Act, 16 U.S.C. §§ 2101-2114, of 1978
(5) Public Law 99-499, the Superfund Amendments and Reauthorization Act of 1986
(6) Public Law 106-390, the Disaster Mitigation Act of 2000
(7) Public Law 107-56, the USA Patriot Act of 2001
(8) Public Law 107-188, the Public Health Security and Bioterrorism Preparedness and Response Act of 2002
(9) Public Law 107-296, the Homeland Security Act of 2002
(10) The Animal Health Protection Act (AHPA), 7 U.S.C. 8310, of 2002
(11) The National Oil and Hazardous Substance Pollution Contingency Plan (NCP), 40 CFR § 300, of 2006
(12) Public Law 109-295, as amended, the Department of Homeland Security Appropriations Act of 2006
(13) Public Law 109-295, Post Katrina Emergency Management Reform Act (PKEMRA) of 2006
(14) Public Law 84-99, Flood Control and Coastal Emergencies Act of 2007
(15) The Economy Act, 31 U.S.C. §§ 1535-1536, of 2007
(16) The Restoration Act, 10 U.S.C. §§ 331-335, of 2007
(17) The Small Business Act, 15 U.S.C. §§ 631-651e, of 2007
(18) The Office of Federal Procurement Policy Act, 41 U.S.C. § 428a, of 2007
(19) Defense Against Weapons of Mass Destruction Act, 50 U.S.C. §§ 2301-2368, of 2007
(20) The Comprehensive Environmental Response, Compensation, and Liability Act, 42 U.S.C. §§ 9601-9675, of 2007
(21) The Public Health Services Act, 42 U.S.C. § 201, et seq., of 2007
(22) 41 CFR 102-74.230 through 102-74.260
(23) Title 34/Subtitle I/Chapter 101/Subchapter XVI/§ 10381
(24) Public Law 112-265, The Investigative Assistance for Violent Crimes Act of 2012.
(25) Americans with Disabilities Act (ADA), 42 U.S.C. §§ 12101

B.4 NFPA Standards. This subsection contains a partial list of NFPA standards. To determine if other NFPA standards apply, review the complete list of NFPA standards at nfpa.org/codes-and-standards.

B.4.1 NFPA 99 addresses emergency management for health care facilities and Chapter 13 addresses security management for health care facilities.

B.4.2 NFPA *101* establishes the construction and design requirements for facility's preparedness.

B.4.3 NFPA 472 provides a framework by which an organization can meet the requirements of the OSHA HAZWHOPER regulation. By meeting this standard, compliance with OSHA 1910.120 is met or exceeded.

B.4.4 NFPA 473 identifies the levels of competence required of EMS personnel who respond to incidents involving hazardous materials or weapons of mass destruction (WMD).

B.4.5 NFPA 1500 contains minimum requirements for a fire service–related safety and health program. Items covered include PPE, staffing, medical requirements, and physical requirements.

B.4.6 NFPA 1561 contains minimum requirements for the incident command system.

B.4.7 NFPA 1582 provides guidance on annual physicals for fire fighters and members of hazardous materials response teams.

B.4.8 *NFPA 1600* contains the requirements for continuity of operations

B.5 Guidance Documents.

B.5.1 General. Guidance documents are publications typically prepared by regulatory agencies that provide instructions to establish the agencies' expectations.

B.5.2 National Response Framework (NRF). The NRF is a comprehensive how-to guide that spells out how the nation should conduct an all-hazard response. It is intended to capture all levels of government and all incident levels. Local plans feed into state plans, which feed into the NRF. Its use during a federally declared disaster is required by the Stafford Act.

B.5.2.1 Resource typing is the categorization and description of resources that are exchanged in disasters via mutual aid, by capacity and/or capability, for the purpose of ordering and tracking resources.

B.5.3 Presidential Directives. The following directives relate to the federal preparedness and response expectations for ASHER incidents:

(1) Homeland Security Presidential Directive 3, Homeland Security Advisory System, March 11, 2002
(2) Homeland Security Presidential Directive 5, Management of Domestic Incidents, February 28, 2003
(3) Homeland Security Presidential Directive 7, Critical Infrastructure Identification, Prioritization and Protection, December 17, 2003
(4) Homeland Security Presidential Directive 8, National Preparedness, December 17, 2003
(5) Homeland Security Presidential Directive 15, United States Policy and Strategy in the War on Terror, March 2006
(6) Homeland Security Presidential Directive 20, National Continuity Policy, May 9, 2007
(7) Homeland Security Presidential Directive 21, Public Health and Medical Preparedness, October 18, 2007
(8) Presidential Decision Directive 39, U.S. Policy on Counterterrorism, June 21, 1995
(9) Presidential Decision Directive 62, Combating Terrorism, May22, 1998

Annex C Recommended Information to Collect in After Action Reports for Active Shooter

This annex is not a part of the requirements of this NFPA document but is included for informational purposes only.

C.1 Scope. This AAR annex provides minimum guidance for AHJs to use after an ASHE incident and should be an assembly of data from all the disciplines and organizations that provided material support to the planning, response, and recovery after the ASHE incident.

C.1.1 It is understood that there can be limitations in sharing information due to investigations, litigation, laws, or other concerns related to the event.

C.1.2 This annex is not intended for liability or accountability, rather it should be used to improve preparedness for the AHJs involved and other communities who are trying to learn from the lessons of the event.

C.2 Purpose. The purpose of an AAR is to collect appropriate, pertinent, and actionable information and data related to all aspects of an ASHE.

C.2.1 The AAR should be a comprehensive document that highlights the facts surrounding an event and identifies the strengths and weaknesses of the planning, response, and recovery for the purpose of future improvement recommendations.

C.2.2 The document should be objective, void of politicization, and readily available to the first responder agencies involved in the event in a timely fashion.

C.2.3 It is never the purpose of an AAR to assign blame.

C.3 AAR Process and Intent.

C.3.1 The first step in preparing an AAR is selecting a team that is of a multidisciplinary nature and well versed in any applicable policies, procedures, rules, regulations, and laws.

C.3.2 Developing an AAR should be a multidisciplinary process involving all levels of those involved in the event, from the initial responders to incident commanders, to those involved in associated offsite operations, to senior positions up to and including the political leadership of the jurisdiction(s).

C.3.3 When possible, AARs should be completed by independent parties who can take an unbiased view of the AHJ's response.

C.3.4 The reviewers should be committed to institutional learning, be knowledgeable in public safety and agency response policy and practice, and understand the nuances of pending criminal and civil legal proceedings.

C.3.5 An AAR is not designed or intended to interfere with a criminal investigation, nor should lessons learned imply any level of liability.

C.3.6 The completion of the AAR should not be impeded by the possibility or reality of a criminal investigation.

C.4 AAR Distribution and Information Sharing.

C.4.1 AHJs should to the fullest extent possible while in accordance with state law, make the findings of an AAR public.

C.4.1.1 AARs should be used by other AHJs to assist in planning and revising their own preparedness, response, training, recovery, policies, and procedures.

C.4.1.2 The AAR should be used in developing or enhancing future best practices and research.

C.4.1.3 Should it not be possible to release a single report to all audiences at the same time, incremental and limited release also has value.

C.4.2 The standardization and sharing of data, lessons learned, and recommendations following an ASHE incident will assist with fundamental information collection priorities.

C.4.2.1 Standardization of data will assist with determining future capabilities or functional priorities.

C.4.2.2 The collection of objective data that is clearly, uniformly, and commonly defined should improve future response objectives and standards.

C.5 Information and Data Collection Points. In order to review incidents and be able to compare them across disciplines and jurisdictions, the following section should serve as a baseline set of data points and questions to ask during the AAR process.

C.5.1 The following minimum data and information should be collected about the AHJ in which the incident occurred:

(1) Describe the community where the event took place.
(2) Describe the agencies and organizations involved in the event response.
(3) Did the jurisdiction have an integrated capability to respond to an ASHE?
(4) What resources, plans, personnel, supplies, and training were in place in order to manage an ASHE incident prior to the event?
(5) Did the community have an ASHER program using the principals of NFPA 3000?

C.5.2 Location Information. The following minimum data and information should be collected about the location of the incident:

(1) Did the location have an ASHER program?
(2) What was the design, capacity, or layout of the facility?
(3) Was the public at the location given instruction, training, or other resources and capabilities prior to or during the incident?
(4) How many occupants self-evacuated?
(5) What security capabilities were used to improve life safety outcomes? (capabilities identified in the risk assessment)

C.5.3 Incident Information. The following minimum data and information should be collected about the incident:

(1) What weapons and tactics were used by the perpetrator(s)?
(2) What is the physical and psychological profile of the perpetrator(s)?
(3) Were the perpetrator(s) previously known to law enforcement?
(4) Was there any previously exhibited suspicious or threatening behavior towards neighbors/coworkers/etc. that was not reported to law enforcement?
(5) Were there any other indicators prior to the event?
(6) Was the incident a potential "copycat"?
(7) What was the outcome of the incident?

C.5.4 Initial Incident Response. The following minimum data and information should be collected about the response to the incident:

(1) What was the timeline of events (use Chapter 11 for reference)?
(2) What resources were utilized to manage the incident?
(3) How were resources distributed to the incident?
(4) What equipment was used to manage this response and how was it deployed?
(5) What plans, policies, and procedures were used to manage the incident?

C.5.5 Tactical Operations. The following minimum data and information should be collected about tactical operations at the incident:

(1) What resources were used to initially engage the threat?
(2) What was the time that the threat was determined to be stopped and how was this accomplished?
(3) Were any devices or tactics used by the perpetrator(s) to impede or thwart tactical operations?
(4) What aspects of training (if applicable) were most beneficial and least beneficial to individual/team performance?
(5) Did tactical operations transition to another function once the threat was stopped?

C.5.6 Command and Control. The following minimum data and information should be collected about command and control during the incident:

(1) Was unified command established according to Chapter 8? How was this accomplished?
(2) What aspects of training (if applicable) were most beneficial and least beneficial to unified command performance?
(3) What agencies were initially part of the unified command? Were additional agencies added and when?
(4) What aspects of unified command enhanced incident response?
(5) Were there any challenges to unified command, and how did they impact the overall response?
(6) Was a recovery coordinator appointed during the initial phases of the incident?

C.5.7 Communications. The following minimum data and information should be collected about communications among responders and dispatch at the incident:

(1) Did the responders have the ability to monitor and communicate with each other over dedicated or interoperable radio channels during the early phases of the incident?
(2) Was it possible to communicate between disciplines and health care facilities?
(3) Was the communications center able to communicate with all responding agencies?
(4) Were there any disruptions to communications such as issues with internet or the ability to call out?
(5) What other agencies, resources, or functions were connected via communications with responders at the incident?

C.5.8 Public Information. The following minimum data and information should be collected about public information sharing for incident:

(1) Who was assigned to oversee all external communications?
(2) Who was the spokesperson for the incident for the media and the public?
(3) Who was the spokesperson for elected/appointed officials?
(4) Were emergency notification systems used to distribute information early in the incident? If so, when, through what means, and were desired outcomes achieved?
(5) How were multiple agency PIOs coordinated? Were there challenges to maintaining a singular message?
(6) Was there a central social media account for all outward facing communications? If so, which platforms were used?
(7) Was public social media monitored? Did this effect response and management of the incident?
(8) Was a different resource, such as a website, used to provide a single source of trusted information? If so, what was the resource?
(9) Did victims and families receive information prior to the general public?
(10) What other public information and communication plans were used and what was their effectiveness?

C.5.9 On-Scene Medical Response. The following minimum data and information should be collected about on-scene medical operations at the incident:

(1) Did the public provide medical care prior to responders arriving and during the response? If so, what was done and what resources were used to do this?
(2) What warm zone care tactics were utilized?
(3) Was care provided by LE prior to arrival of the fire service and EMS into the warm zone?
(4) Was CCP established? Was it necessary?
(5) Did anything impede responders from following local policy, plans, and protocols? If so, how was this addressed?
(6) What medical equipment was used at the scene?
(7) What was the number of dead and wounded identified at the scene?
(8) What were the wounding patterns for both the injured and dead?
(9) Were there responder injuries and if so, how were they cared for?

C.5.10 Patient Transport. The following minimum data and information should be collected about patients transported from the incident in order to receive additional medical care:

(1) What kinds of transport resources were used? What methods were used to acquire them?
(2) Were receiving facilities able to communicate with responders? If so, what information was being shared and by what means?
(3) How were injured (or noninjured) victims who did not require transport to a treating facility identified and tracked?
(4) What plans, policies, and procedures were used to transport and account for patients? What were the outcomes of those efforts?
(5) Were multiple patients transported within a single resource?

C.5.11 Receiving Facilities.

(1) Were receiving facilities notified of incoming patients in advance of the first arrival?
(2) Was there sufficient capacity to accommodate the transported patients?
(3) What were the types and levels of the receiving facilities?

(4) Were there injured who self-transported to any treating facilities? Were they cross-referenced with on-scene tracking to ensure all injured victims were accounted for?
(5) Was there a patient tracking system utilized? Was this coordinated with on-scene response?
(6) Were any responder resources deployed to assist treating facilities?
(7) Were any treating facility resources deployed to the scene?
(8) Did the treating facilities have all the supplies and resources required to adequately respond to the incoming patients? If not, why?
(9) Were there any challenges with receiving patient information and securing needed supplies and equipment?
(10) Was there any redistribution of patients from the treating facility and how was that process managed?
(11) Were the treating facilities able to communicate and share information with the notification center?

C.5.12 Victim Information/Assistance. The following minimum data and information should be collected about incident related victim's information and assistance:

(1) Did the AHJ have an existing plan in place for notification and reunification?
(2) Were local and state victim-witness specialists and Victims of Crime Act (VOCA) administrators involved?
(3) At what point was a notification center established? Was it during response or after the end of tactical operations? How was the center managed?
(4) What resources were deployed to and what services were available at the center?
(5) What process was used for checking victims, families, and care providers in and out of the center?
(6) How many individuals sought services, and what services were provided?
(7) How were donations and volunteers managed?
(8) What process was followed for death notifications?
(9) Was a PIO, liaison, navigator, or advocate assigned to each impacted family?
(10) At what point did the center close or transition to an incident assistance center?

C.5.13 Witness Management.

(1) How were witnesses identified and tracked?
(2) Where did witness interviews take place?
(3) What was the interview process?

C.5.14 Recovery. The minimum data and information listed in C.5.14.1 through C.5.14.4 should be collected about recovery from the incident.

C.5.14.1 Responder Wellness.

(1) What services were available to first responders prior to the incident?
(2) What additional services were provided to responders in the aftermath of the incident? How were they identified and vetted?
(3) What methods of behavioral health assistance programs were offered and at what point? What were the utilization rates?
(4) How long were responders on duty as a result of the incident?
(5) What other services were made available to responders and their families and how were they promoted?
(6) What services were required versus optional as part of returning to duty?
(7) How long were incident-related services made available to responders?
(8) Were there responders that did not return to duty or required reasonable accommodation as a result of the incident?

C.5.14.2 Crime Scene Management.

(1) Who was in charge of crime scene mitigation, to include crime scene clean-up and returning of belongings?
(2) What process was followed for the returning of belongings?
(3) How long was the crime scene restricted from returning to normal use, if at all?
(4) Was there any impact to business, communities, and services, proximate to the crime scene? If so how long until they could return to normal operation, if at all? What was the economic impact?

C.5.14.3 Incident Assistance Center (IAC).

(1) How was the IAC managed?
(2) What resources were deployed to the IAC?
(3) How many individuals sought services and what services were provided?
(4) What process was used to checking victims, families, and care providers in and out of the IAC?
(5) At what point did the IAC close or transition to a resiliency center?
(6) What plans, policies, and procedures were used to manage the IAC? What was their level of effectiveness and were there any lessons learned?

C.5.14.4 Long-Term Resiliency Operations.

(1) What long-term support to victims and families was and is planned?
(2) If a transition occurred, at what point was a resiliency center established?
(3) Who was and is the resiliency center manage?
(4) What resources were deployed to the resiliency center?
(5) What process was used for checking victims, families, and care providers in and out of the resiliency center?
(6) Is there a plan for tracking center utilization rates? If so, what are the rates?
(7) Was there a post-incident assessment of ongoing or unexpected needs? Is there a needs gap for recovery?
(8) Will there be or have there been grant applications for supplemental funding for assistance and compensation with respect to response and recovery?

Annex D Informational References

D.1 Referenced Publications. The documents or portions thereof listed in this annex are referenced within the informational sections of this standard and are not part of the requirements of this document unless also listed in Chapter 2 for other reasons.

D.1.1 NFPA Publications. National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169-7471.

NFPA 72®, National Fire Alarm and Signaling Code®, 2019 edition.

NFPA 99, *Health Care Facilities Code*, 2021 edition.

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NFPA 730, *Guide for Premises Security*, 2020 edition.

NFPA 731, *Standard for the Installation of Electronic Premises Security Systems*, 2020 edition.

NFPA 1061, *Standard for Public Safety Telecommunications Personnel Professional Qualifications*, 2018 edition.

NFPA 1072, *Standard for Hazardous Materials/Weapons of Mass Destruction Emergency Response Personnel Professional Qualifications*, 2017 edition.

NFPA 1221, *Standard for the Installation, Maintenance, and Use of Emergency Services Communications Systems*, 2019 edition.

NFPA 1500™, *Standard on Fire Department Occupational Safety, Health, and Wellness Program*, 2020 edition.

NFPA 1561, *Standard on Emergency Services Incident Management System and Command Safety*, 2020 edition.

NFPA 1582, *Standard on Comprehensive Occupational Medical Program for Fire Departments*, 2018 edition.

NFPA *1600®*, *Standard on Continuity, Emergency, and Crisis Management*, 2019 edition.

NFPA 1620, *Standard for Pre-Incident Planning*, 2020 edition.

D.1.2 Other Publications.

ASIS *Standard for Risk Assessments.*

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CFAI *Risk Assessment Manual.*

C-TECC Tactical Emergency Casualty Care (TECC) *Guidelines for First Responders with a Duty to Act*, 2017.

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www.dhs.gov/sites/default/files/publications/active-shooter-pamphlet-2017-508.pdf.

www.ems.gov/nemsac/dec2013/FICEMS-MUCC-Implementation-Plan.pdf.

www.fbi.gov/news/stories/death-notification-with-compassion.

www.nij.gov/topics/technology/body-armor/Pages/compliant-ballistic-armor.aspx.

www.ovc.gov/pubs/mvt-toolkit/Sample_SampleVictimLiaisonJobDescription.pdf.

www.passk12.org.

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D.2 Informational References. The following documents or portions thereof are listed here as informational resources only. They are not a part of the requirements of this document.

NFPA 1521, *Standard for Fire Department Safety Officer Professional Qualifications*, 2020 edition.

NFPA 1584, *Standard on the Rehabilitation Process for Members During Emergency Operations and Training Exercises*, 2015 edition.

NFPA 1616, *Standard on Mass Evacuation, Sheltering, and Reentry Programs*, 2017 edition.

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www.dhs.gov/publication/ind-health-and-safety-planning-guide.

www.dhs.gov/publication/protecting-responders-health-after-wide-area-aerosol-anthrax-attack.

www.nrt.org/sites/2/files/Updated%20NRT%20JIC%20Model_4-25-13.pdf.

www.ovc.gov/pubs/mvt-toolkit/Sample_PIOLessonsLearned.pdf.

www.victimprovidersmediaguide.com/appendices.html.

D.3 References for Extracts in Informational Sections.

NFPA 1616, *Standard on Mass Evacuation, Sheltering, and Re-entry Programs*, 2017 edition.

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