Agenda for RTF Group Meeting, April 16, 2019

1000 hours, Coordination Center in Bozeman

-Updates on discussion items from last meeting (Notes from last meeting will be handed out)

-Bring new attendees up to speed prior to table top ex. (quick intro)

-Table top Exercise

Please bring staffing schedule for the day of April 16, 2019

Discussion about responses, prior assumptions, communications (MCI Plan), etc.

-Discussion about dispatch piece mentioned at end of scenario

-Dispatch trying to work on Active Killer "button" for dispatching groups

-Discussion with Chris Randle about Ballistic PPE

-Next actions, taskings: SOPs to review for adaptation and eventual adoption

-Set date range for next meeting

-Close

Summary and afterthoughts

Great meeting, some really good, and necessary, discussions about a few different topics occurred, but we still kept on track and got through most of the scenario.

~Once again, we identified the criticality of initial LE command and FD command co-locating ASAP and establishing unified command.

~Discussion about SOPs- not re-inventing the wheel, etc. Tasking for the group: please try and find current SOPs from other agencies so we can

~Group discussed the two different training modules that are important to this groups focus: TECC and ALERRT Integrated Response. General agreement that the TECC training is more focused on providing medical treatment in tactical, warm zone settings, while the ALERRT training focuses on the integration of LE and FD/EMS resources, and providing the tactics for successful deployment of these teams. Next step might be to investigate bringing ALERRT back for this course, as their schedule might be more open if a facility other than a school is utilized.

~We discussed the Gallatin County MCI Plan and how the RTF group's work product can be, essentially, an annex to the plan. While most violent attack incidents can be considered MCIs, it is recognized that responses to them are specialized enough to warrant a separate classification.

~Good discussion and agreement on communications. Once LE and FD initial commanders are together, each discipline works within normal comms protocols (dispatch and tactical channels), and comms within the task forces occur face-to-face. This can't happen effectively (or at all) if unified command has not been established. Due to technological capabilities and constraints, different LE agencies will have slightly different channels, but plans are very similar.

~Scenario was designed to capture CURRENT tactics and capabilities, group did a great job of keeping that in mind. Working through the scenario raised some really good learning points:

1. Drove home the point that LE, AS SOON AS THEY'RE ABLE, needs to push out info that will trigger the "MCI-Large" activation through dispatch.
2. Initial LE IC (Usually number five responder of AHJ) should be located so that they are visible and accessible to initial FD IC; this will accommodate quicker co-location. This might be a little further away than LE is comfortable with and a little closer than FD is comfortable with…
3. Different side designation systems: LE uses numbers, FD uses letters. As long as this is recognized ahead of time, should be easy to work through (A = 1, etc.). Could get confusing as different floor levels enter into play.
4. Discussion of staging areas. LE tend to drive as close to scene as possible, this might not be best practice in violent attack situation. FD factors in larger vehicles with greater space requirements, tend to stage further away. This discrepancy will likely factor into formation of integrated RTFs.
5. Good discussion of capabilities of BDH in MCI setting. MCI Plan calls for transport of some patients to other hospitals, but the reality will likely be that

they will all go to BDH INITIALLY. BDH will then triage and determine best care.

6. Discussion of minimum personnel to form RTFs. This was at the end of the day, might be worthy of further discussion, but seemed to be general agreement that 2 LE (one point, one rear guard) would be sufficient. Also agreement that 2 FD/EMS would be bare minimum, situational dependent.
7. Scenario allowed us to assign actual staffing numbers to the event. LE response in first ten minutes (from time of broadcast of active killer event) is probably close to 30. FD and EMS will likely field closer to 50 (??) within 20 minutes of MCI activation.
8. Our meeting time ended just as we were beginning in-depth discussion as to the actual "nuts and bolts" of creating the RTF groups. General agreement for next meeting to start by picking up where we left off, and shift into thought process of what we should be doing, versus what we currently are doing. Scenario is designed to continue through some IMMEDIATE patients be transported to BDH.

~Day ended with discussion about dispatch involvement in this effort. Points raised about serious issues with dispatch performance, especially since the transition to Zuercher. All agreed that this is a systemic issue, not a personnel issue. It appears that dispatch is working on an Active Killer run card, but doing so in a vacuum. Emergency Management will attempt to connect with dispatch leadership in hopes of moving towards a collaborative effort in the creation of an Active Killer response plan for dispatch.

~Agenda items that we didn't get to, or didn't have enough time to explore properly:

1. Discussion with Chris Randle about Ballistic PPE
2. Further discussion about supporting dispatch in context of Active Killer incident dispatching
3. Should discuss definitions- cold, warm, hot zones; important to have this group on the same page when it comes to terminology. Other terms to consider for discussion: perimeter (inner, outer), clear and all clear. What else?

Sorry if I rambled, we discussed MANY different things that I've tried to capture. Again, I truly welcome your thoughts, ideas, concerns. We have gathered an exceptional group of people for this effort, everyone's input is truly valued.