Reynolds High School Active Shooter Response:

An analysis of the response to the Reynolds High School Shooting on June 10, 2014

After-Action Report

Summer of 2015

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EXECUTIVE SUMMARY

On the morning of Tuesday, June 10, 2014, a student entered Reynolds High School, where he shot and killed a fellow student and injured a teacher before ending his own life with a self-inflicted gunshot. Local, state, and federal agencies, along with non-governmental organizations, responded to the shooting.

This incident provides an opportunity to objectively evaluate the actions taken (including validating plans and identifying areas for improvement) by the Cities of Troutdale and Gresham, Multnomah County and all responding partners. For this reason, the Multnomah County Office of Emergency Management (MCEM) requested assistance through the Federal Emergency Management Agency's (FEMA) National Exercise Division (NED) for evaluative support in developing an after-action report of the multi-jurisdictional and multi-disciplinary response.

This report is the result of a collaborative after-action review process that engaged multiple agencies and their response partners in order to strengthen preparedness for future incidents that require a multi-disciplinary and multi-jurisdictional response. As part of this process, MCEM established a review team that met with local agencies and non-governmental organization partners. At these meetings, the review team interviewed individuals directly responsible for the response, and collected additional data to support this review.

Major Findings

As with any critical incidents there are many lessons learned from this tragedy. The speedy and decisive action by first responders, and the quick actions to initiate the school lockdown procedure, saved many lives. Other best practices/strengths include:

Initial Notification Strengths

- Having School Resource Officers (SRO) onsite was critical for mitigating loss of life in response to the active shooter incident.
- The initial notification and response to the Reynolds High School incident was swift and timely.
- Both the City of Gresham and the Multnomah County Office of Emergency Management (MCEM) activated their Emergency Operations/Coordination Centers (EOC/EOC) upon notification of the active shooter incident.

Operational Coordination Strengths

- Federal, state, county, and city agencies worked together to respond to the active shooter incident, safely evacuating approximately 2,200 students and staff, and reunifying the students with their families.
- Prior planning on active shooter response facilitated the response by Troutdale Police Department (TPD), Gresham Police Department (GPD), and Gresham Fire and Emergency Services (GFES).

Operational Coordination Strengths Continued

- The development and execution of the tactical operation plan by TPD resulted in a quick take-down of the suspect, and likely mitigated loss of life.
- Staff in the Multnomah County EOC worked quickly to fill resource requests and to document the event.
- MCEM quickly activated the EOC and staffed Emergency Support Function (ESF) #8 (Public Health & Medical Services).

Operational Communications Strengths

- Although TPD and its response partners were on different radio frequencies, and therefore unable to communicate directly by radio, the appointment and utilization of a liaison ("runner") to coordinate communications between response agencies allowed for continued communications.
- Reynolds School District's (RSD) public messaging strategy was quickly developed and implemented – and included some key best practices that should be formalized into emergency plans and utilized during such incidents.

Fire/Life-Safety Operations Strengths

- TPD and its response partners were able to leverage their strong working relationship to expedite response.
- GPD was quick to integrate with GFES and deploy rescue teams and was very receptive to their use.
- The inbound fire and emergency medical personnel dropped medical equipment at the rescue team staging area.
- GFES used fire engines and vehicles to create a shield/protective barrier for the MCP.

Reunification and Victim Services Strengths

- SROs, Reynolds High School personnel, and behavioral health support resources were sent to the reunification site.
- The presence of medical services at the reunification site was beneficial.
- Communication and coordination among the various organizations that provided emotional support services to victims included a broad spectrum of providers and levels of services.
- Creating a Community Support Center and naming it as such as opposed to a mental health center contributed to its success.
- The CSC was adequately staffed with personnel from Multnomah County Department of County Human Services (DCHS), victim advocates, chaplains, Red Cross, Trauma Intervention Program (TIP), school counselors and others.
- Special needs students were evacuated first with their teachers and aides[1].

[1] Special equipment was left behind and proved a challenge to return to owners in a timely manner. While evacuating this population first, worked well for this incident, school and district administrators are consulting with subject matter experts regarding best practices. This action was likely due to proximity only.

Public Information Strengths

- The Public Information Officers (PIOs) in the Multnomah County EOC had the adaptability to deliver prompt, reliable, and actionable information to the affected community.
- RSD used VoIP technology to route calls from concerned parents/citizens to the district office.
- The PIOs used appropriate methods to relay potentially sensitive information regarding the shooting.

In carrying out the response, some challenges emerged. This report examines those challenges and provides recommendations to help improve multi-jurisdictional preparedness for future events. Highlights of these challenges and recommendations include the following:

Initial Notification Areas for Improvement

- Activation of the school's lockdown procedures.
- Notification procedure for activation of MCEM's EOC.

Operational Coordination Areas for Improvement

- Establishment of an Incident Command Structure at the incident site.
- Non-traditional response partners in the Incident Command Structure.
- Staging area for incoming resources.[2].
- Personal belongings during evacuation of school.
- Existing plans for participating agencies and jurisdictions.
- Coordination capacity of the Multnomah County EOC.
- Roles and responsibilities of elected officials, external organizations, Departments/Divisions, and EOC staff, including delegation of authority.
- Staffing of sections in the EOC.
- Process for development of Common Operating Picture, shared situational awareness and critical information requirements.
- Roles and responsibilities of each section within the EOC and their interoperability across sections.
- Assistance request process.
- Facilitation for debriefings and After Actions.
- Accountability and resource management.

Operational Communications Areas for Improvement

- Use of unique unit monikers that can be input into the Computer Aided Dispatch, CAD system without necessitating the creation of additional calls.
- Radio and cellular phone reception.
- Process for development of Common Operating Picture, shared situational awareness.
- Ability of dispatchers to identify the nature of the call.
- Wireless data system coverage.
- Access to School's secured wireless networks.
- Cache of communications supplies and auxiliary equipment.
- Communications between MCEM, the school district, and the responders on scene.

[2] A staging area was eventually chosen by BOEC for the school incident site.

Fire/Life-Safety Operations Areas for Improvement

- Patient extraction with long backboards, mega movers, and skeds.
- Understanding of how emergency response personnel will operate during acts of violence.

Reunification and Victim Services Areas for Improvement

- Reunification plans.
- Methods for verifying custody.
- Organizational structures for reunification locations.[3]
- Survivor Support Services (Behavioral Health/Emotional First Aid).

Public Information Areas for Improvement

- Establishment of a Joint Information System (JIS).
- Coordination between JIS and County and County messaging to staff during acts of violence.
- Utilization of Social Media.

Next Steps

Several debriefings, investigative reports, and interviews were utilized in composing this After-Action Report (AAR). MCEM will conduct an After-Action Review Meeting to discuss the observations and recommendations made in this report. During this meeting, the agencies/personnel that contributed to this report will review the observations made herein and develop corrective actions.

[3] Several people stated they were the Incident Commander for the reunification location.

SECTION 1: INTRODUCTION

This section describes the purpose and scope of this After-Action Report (AAR), the review team's methodology, and the organization of the report.

1.1 Purpose

The purpose of this report is to describe and constructively evaluate the response to the active shooter incident at Reynolds High School, including the actions taken by first responders and coordination among various local and non-profit agencies in Troutdale, Oregon on June 10, 2014. This AAR provides meaningful information regarding the best practices and lessons learned as a result of the response, along with practical recommendations. The ultimate goal of this report is to provide insight that will better prepare response agencies and their partners across Multnomah County in the event of future incidents.

It is not our intent to understand the motives behind the shooter's actions, or to second-guess the actions of the officials and officers at the scene. These are beyond the scope of and unnecessary for our review. That the police response was effective in ending the threat, without the further loss of life is a testament to the professionalism, training, and bravery of the officers who responded to the scene that day.

1.2 Scope

The scope of this review is mainly limited to the multi-jurisdictional response on the day of the shooting. It will focus primarily on the capabilities and core competencies identified in Table 1.

Table 1. Capabilities/Core Competencies

Capability	Description
Initial Notification	Provide timely, accurate, and actionable information resulting from the incident.
Operational Coordination	Establish and maintain a unified and coordinated operational structure and process that appropriately integrates all critical stakeholders and supports the execution of core capabilities.
Operational Communications	Ensure the capacity for timely communications in support of security, situational awareness, and operations by any and all means available, among and between affected communities in the impact area and all response forces.
Fire/Life-Safety	Provide lifesaving medical treatment via emergency medical services and related operations and avoid additional disease and injury by providing targeted public health and medical support and products to all people in need within the affected area.
Reunification, and Victim Services	Restore and improve health and social services networks to promote the resilience, independence, health (including behavioral health), and well-being of the affected community.
Public Information and Warning	Deliver coordinated, prompt, reliable, and actionable information to the affected community through the use of clear, consistent, accessible, and culturally and linguistically appropriate methods to effectively relay information regarding any threat or hazard, as well as the actions being taken and the assistance being made available, as appropriate.

1.3 Methodology

Our methodology for this review included the following steps:

1. **Data Collection and Compilation:** The review team met individually with various local and non-profit agencies to collect data on the actions each agency took in response to the event and to discuss best practices and lessons learned from their perspective. Table 2 lists the agencies and organizations interviewed. The review team compiled the data into a timeline of events and actions taken in response to the shooting. The focus of this timeline is on high-level actions and coordination activities. It does not include details about the tactical actions of individual agencies, which are not relevant to this review. The review team also collected agency's notes from internal after-action reviews and debriefings and incorporated these insights into this report. Information was also collected and compiled on best practices and lessons learned to develop an initial set of issue areas for further discussion in improvement planning.

2. **Analysis and After-Action Report:** The review team developed a list of key observations, including both strengths and areas for improvement, in each of the six capabilities/core competencies identified in Table 1. The review team compared the data collected from the interviews to existing plans, and developed general recommendations for addressing the issues. These observations, analyses, and recommendations are detailed in this report.

3. **After-Action Review Meeting:** In collaboration with the Multnomah County Office of Emergency Management (MCEM), the review team conducted an After-Action Review Meeting with the local and non-profit agencies involved in the response to the shooting at Reynolds High School. At the meeting, participants reviewed and refined the observations and recommendations described in Section 3. A note-taker from the review team documented the discussion.

4. **Improvement Planning:** As part of the After-Action Review Meeting, participants developed corrective actions. These actions are listed in the accompanying Improvement Plan. MCEM will work with partners to track improvement plan items and ensure completion.

Table 2. Interview List

Organization Type	Name
Local agencies	Multnomah County Office of Emergency Management Multnomah County Department of Human Services Multnomah County Health Department Multnomah County Sheriff's Office Multnomah Education Service District Gresham Emergency Management Gresham Police Department Fairview Police Department Multnomah Education Service District Troutdale Police Department Gresham Fire Department Beaverton Police Department Victim Services Reynolds School District
Non-governmental organizations	American Red Cross Trauma Intervention Programs, Inc. Public Safety Chaplaincy

1.4 Report Organization

The next section of this report (Section 2) presents a narrative of the key events and response actions that occurred at Reynolds High School on June 10, 2014, as well as the following days. Section 3 provides observations, analysis and recommendations grouped by capability/core competency that are the focus of the report.

A set of appendices provide additional material for reference:

- Appendix A provides a timeline of the data collected about the event.
- Appendix B lists all of the agencies and organizations that participated in the response.
- Appendix C lists the improvement plan and correlating corrective actions.
- Appendix D provides a list of acronyms presented in this report.

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SECTION 2: KEY EVENTS NARRATIVE

This section presents a high-level narrative of the response actions taken by local and non-profit agencies following the active shooter incident that occurred at Reynolds High School on June 10, 2014. This narrative begins with the first shot that was fired at 8:05 a.m. on June 10, 2014, and concludes with the candlelight vigil on June 17, 2014. See Appendix A for a brief timeline of the initial response.

This narrative is organized into to the following three phases:

- Life Safety – Initial Response
- Life Safety – Ongoing Response
- Reunification and Victim Services

2.1 Life Safety – Initial Response

At 8:05 a.m. on June 10, 2014, a student fired shots inside Reynolds High School in Troutdale, Oregon. The student, a lone gunman, entered the boy's locker room adjacent to the school's gymnasium and used a rifle to shoot and kill a fellow student. The gunman also shot at and injured a teacher as he ran to initiate the school's lockdown procedures.

One minute later, at 8:06 the Bureau of Emergency Communications (BOEC) received a 9-1-1 call and dispatched responders to the scene. Three minutes after the initial shots were fired, two School Resource Officers (SROs) entered the gymnasium building (where approximately 90 students were gathered in attendance for the first period of the day) and likely interrupted the shooter, who fled into the boy's bathroom located just outside the gym.

Having heard the radio transmission for shots fired at the school, the Chief and Lieutenant of the Troutdale Police Department (TPD) self-dispatched to the scene at approximately 8:09 a.m. and quickly set up an incident command post outside the north corner of the school where the shots were fired.

Five minutes later, the first search team entered the high school through the north doors and then entered the boy's bathroom where the shooter had remained. Upon entering the bathroom, the search team found the shooter in the stall and the lead officer engaged in fire with the suspect. At that point, the officers approached the shooter and determined that he had been fatally wounded in what appeared to be a self-inflicted gunshot wound.

2.2 Life Safety – Ongoing Response

Special Weapons and Tactics (SWAT) team members and several other tactical teams began evacuating the school

Shortly thereafter, the grounds of Reynolds High School became flooded with first responders as over 200 individual law enforcement officers responded. The roads surrounding the school were quickly crowded with first response vehicles.

Law enforcement officers evacuated students through designated corridors. Some students and teachers brought belongings with them.

Students were escorted across the street to the search area, where they were searched by officers and examined by fire and emergency responders for medical needs.

Students and teachers were told to leave their belongings at a designated spot in the staging area. A large pile of backpacks and other belongings soon formed in the area between the school and the waiting buses. After all students were taken to the reunification area, bomb dogs were used to clear the belongings. Once belongings were cleared, cadets helped load them into buses for transport to Reynolds Middle School.

After being searched and examined, students were moved to a secure area and separated into witness and non-witness groups. Detectives interviewed witnesses, while non-witnesses were staged to be loaded onto buses departing for the reunification site. Students were then loaded onto buses and transported to the reunification site at the Fred Meyer grocery store in Wood Village.

2.3 Reunification and Victim Services

When students arrived at the Fred Meyer grocery store in Wood Village, they were held until the school administration could release them to their legal guardian/custodial parent. In effort to do this, school staff used a paper roster[4] that contained a list of students and their custodial parent(s).

In the parking lot, numerous crisis counselors were available from Multnomah County Department of County Human Services (DCHS), FBI and other victim advocates, school district flight teams, the Trauma Intervention Program (TIP), Red Cross behavioral health providers, and chaplains. DCHS and the school district flight teams did not have identifiable clothing that would have distinguished them from teachers and parents.

A Red Cross Emergency Response Vehicle (ERV) was requested from the scene and dispatched by MCEM to provide water and snacks. Scene personnel worked with Fred Meyer to secure water and snacks. MCEM also received a request for lunch and purchased pizzas and at some point in the day the Salvation Army self-dispatched and began providing feeding services as well.

Multnomah County Emergency Coordination Center (EOC) and Gresham Emergency Operations Center (EOC), both of which had been activated, worked to establish a common operating picture and provide requested resources to responders.

MCEM received a request to secure a *Community Support Center*[5] (CSC) facility to enable the provision of crisis counseling for the community. The Mount Hood Community College (MHCC) gymnasium was chosen, opened at 1:00 p.m. and remained open until 7:00 p.m. on

[4] Electronic systems were down and could not be accessed outside of the school. Paper system had a space for a parent/guardian signature – this was an important element that would not have been available with the electronic system.
[5] Community Support Center is a new term that serves as the hub for Survivor Support Services.

June 10th. The CSC re-opened on June 11, 2014 at 7:00 a.m. and closed at 7:00 p.m. The CSC was coordinated by DCHS and victim advocates and incorporated multiple behavioral health organizations. On June 12th these organizations formed a Behavioral Health Leadership Task Force (BHLTF). This multidiscipline, multijurisdictional leadership team worked together to ensure gaps in services were identified and addressed by the most appropriately trained resources. This BHLTF remained operational for three weeks and helped coordinate and staff memorials, retrieval of belongings from the high school, and follow-up services for students and their families. Eventually, the CSC became a staging area for behavioral health resources and the BHLTF assigned resources to recreational activities (when requested) and other events and areas as needed during and after the initial incident.

Prior to the establishment of the BHLTF, (June 11th) victim advocates were asked to support students, faculty, and staff at Reynolds Middle School to help with the retrieval of belongings left behind during evacuation of the school.[6]

The school district requested that MCEM not provide assistance on June 12th (graduation) due to a concern that too much behavioral health support was being given[7]. The Veterans Memorial Coliseum (location of graduation ceremonies) developed a complex media management plan and assisted the school district with implementation. Board members and student leadership members provided interviews.

On June 13, 2014, students were allowed back into the High School to return school property and empty their lockers. The BHLTF supported this effort by providing over 100 behavioral health support personnel[8] to escort students and their parents through the school.

During the weekend following the incident, June 14th and 15th, 2014, a CSC was open at Reynolds Middle School (12:00 p.m. until 5:00 p.m.).

On the night of June 17, 2014 the BHLTF arranged support staffing for the candle light vigil at Reynolds High School. MCEM and Red Cross completed IAPs for this event.

[6] This request was made directly to the victims' advocates and did not route through the ICS of the EOC. Victim advocates stated they were understaffed and would have benefitted from more behavioral health providers as well as security for the June 11th assignment.
[7] Behavioral health support was provided by TIP at the graduation events. This resource request was not routed through the EOC.
[8] The original request from the school was for 15, the BHLTF recommended 50 and put an additional 50 on standby. The school originally accepted 30. Soon after arrival the school acknowledged the need for 100 and increased their request.

SECTION 3: OBSERVATIONS AND RECOMMENDATIONS

This section provides observations, including strengths and areas for improvement, for the six core capabilities selected for analysis. Recommendations are also provided for those observations that are listed as an area for improvement.

3.1 Initial Notification

Strengths

3.1.1 Having School Resource Officers (SRO) onsite was critical for mitigating loss of life in response to the active shooter incident. At the time of the incident, there were two SROs assigned to Reynolds High School. These SROs are sworn law enforcement officers that are specially trained to look for indicators that could jeopardize school/student safety. Their training, as well as their familiarity with the school population and environment, allowed them to quickly respond to the incident.

3.1.2 The initial notification and response to the Reynolds High School incident was swift and timely. Once the Troutdale Police Department (TPD), Gresham Police Department (GPD) and the Gresham Fire and Emergency Services (GFES) heard the announcement of "shots fired" over the radio, both departments immediately dispatched assets and equipment to the scene. TPD was in the immediate area and arrived onsite approximately two minutes after hearing the radio transmission; with GPD and GFES arriving soon thereafter.

3.1.3 Both the City of Gresham and the Multnomah County Office of Emergency Management (MCEM) activated their Emergency Operations/Coordination Centers (EOC/EOC) upon notification of the active shooter incident. While the resource requests to both Gresham and Multnomah were relatively few in this incident, it was noted by many that it could have been utilized to a greater extent and that a larger incident would have necessitated a more robust involvement by emergency management. Regardless, these coordination centers were able to provide food, water, basic supplies and behavioral health coordination to the incident site, reunification site and community support center.

Areas for Improvement

3.1.1 Activation of the school's lockdown procedures.

Analysis: The initial notification to activate the school's lockdown procedures was broadcast over the school's public address (PA) system. Although this was a good method for providing information to those individuals inside the building, the system does not have external speakers, and students still arriving to campus entered the building (as shots were being fired) unaware of the incident unfolding and/or the lockdown.

Lockdown proved to be an imperfect solution for this situation. When students are not already in classrooms (prior to school starting, between classes, during lunch) lockdown requires teachers to gather students into their classrooms without knowing who the shooter(s) is/are.

Recommendation: The Reynolds School District (RSD) in cooperation with law enforcement should review best practices and develop procedures that could be employed when students are not already in classrooms. This may or may not be 'lockdown'. Review procedures to consider messages provided to adults (Run – Hide – Fight) and determine validity for a high school

student population.[9] RSD should also consider purchase and placement of outdoor speakers for broadcasting emergency-related information to students and staff outside of school buildings.

3.1.2 Notification procedure for activation of MCEM's EOC.

Analysis: The MCEM EOC was activated immediately upon notification of an active shooter and staffed within approximately 30 minutes likely due to the incident being at the beginning of a workday while staff were reporting to work. It was noted by several individuals that clear procedures for activating the EOC, would help identify EOC equipment and staffing needs. In addition, development and a robust understanding of call-down lists, and an activation of the EOC outside of normal business hours would be helpful. Part of activation is notification of partners many of whom would require phone calls/texts versus having the capability of being dispatched via a PSAP.

Recommendation: Create activation procedures and notification checklists to ensure that all staff understand the notification and activation process and their immediate roles and responsibilities during activation. Hold training and exercises with the full spectrum of responders. Additionally design a system to notify non-traditional response partners (TIP, Red Cross, VOAD, etc.). Maintain a list of non-traditional response partners and ensure accessibility to Logistics Section.

3.2 Operational Coordination

Strengths

3.2.1 Federal, state, county, and city agencies worked together to respond to the active shooter incident, safely evacuating approximately 2,200 students and staff, and reunifying the students with their families. Securing the scene of an active shooter can be an extensive undertaking requiring officers and tactical teams to search every room, hallway, and office. TPD, in conjunction with their law enforcement partners, were able to safely evacuate approximately 2,200 students and staff from the school in less than four hours with no additional loss of life or safety issues. In addition, the establishment of specific ingress and egress routes ensured the continued safe evacuation of students and staff off the school premises

3.2.2 Prior planning on active shooter response facilitated the response by TPD, GPD, and GFES. Prior to the incident, TPD, GPD, and GFES had been working to develop Standard Operating Guidelines (SOGs) for an Active Shooter Response. Many interviewees felt that this work and the resulting professional relationships likely aided the response.

3.2.3 The development and execution of the tactical operation plan by TPD resulted in a quick take-down of the suspect, and likely mitigated loss of life. Law enforcement and fire/emergency personnel cited their recent training on active shooter response as beneficial in bringing the event to a quick conclusion. Moreover, the use of SROs and the professionalism/knowledge of the first responding police officers in forming initial strike/entry teams was also an asset. This training and the police officers' ability to end the situation quickly disrupted the shooter's movements, forcing him into a barricade situation in the boy's bathroom and ending the incident.

3.2.4 Staff in the Multnomah County EOC worked quickly to fill resource requests and to document the event. Multnomah County EOC staff filled resource requests despite a general

[9] If students are being told to evacuate, consideration needs to be given for a method of accountability (Safe and Well was discussed as an option).

lack of training regarding this process. The staff quickly leveraged their partnerships with County agencies and knowledge of available resources to fill requests from the incident sites.

3.2.5 MCEM quickly activated the EOC and staffed Emergency Support Function (ESF) #8 (Public Health & Medical Services). Once MCEM received the notification of an active shooter at Reynolds High School, the decision was made to activate the EOC and to staff ESF #8 to prepare for a possible mass casualty incident (MCI) and for behavioral health needs. As it became clear that the incident would not rise to the level of an MCI, the EOC Manager released hospital liaison, but kept behavioral health coordinators. Many felt that this "lean forward" posture worked well to ensure adequate staffing for the potential scenario, while also remaining flexible to deactivate ESF liaisons if the support was not needed.

Areas for Improvement

3.2.1 Establishment of an Incident Command Structure at the incident site.

Analysis: TPD was the first agency to arrive at the incident site and established an incident command. This structure functioned like an Operations Section.

When GFES arrived at the incident they established an additional Incident Command Post (ICP), which was co-located with their Medical Care Point (MCP). The school district established an additional ICP at the district office.

There were three geographically disparate scenes, each had distinct objectives: Reynolds High School (threat neutralization and school evacuation), Fred Meyer (Reunification of parents and students), and Mt Hood Community College (the location of the Community Support Center - behavioral health support for community. This location also became the staging area for all scenes behavioral health resources).

Unified Command or an Area Command structure could bring together the various elements and help contribute to situational awareness, accountability, and prioritization, as well as reduce duplication.

Recommendation: Hold periodic refresher training on the basics and benefits of ICS. Incorporate all response partners in future drills and exercises with an explanation of roles and responsibilities for each. Leverage emergency management personnel to build out the Incident Command Structure. Consider separating scenes that are geographically disparate and have completely different operational objectives into their own command structure.

3.2.2 Non-traditional response partners in the Incident Command Structure.

Analysis: Representatives from Reynolds High School and Reynolds School District at the ICP could have provided first responders with specific information regarding what actions the school was taking. Without the full spectrum of response partners present in the ICP, duplication of efforts, and a general lack of situational awareness with regard to reunification and other operational elements can occur

There were a significant number of behavioral health providers assisting students, teachers and faculty. A liaison to this group present at the ICP would be able to advise the IC on additional needs of that group, as well as considerations for the reunification site.

A resource list that includes contact information for these non-traditional partners, as well as their roles, responsibilities, and subject matter expertise would allow for better integration and capitalization of skills. Additionally, increasing the level of familiarity with ICS and existing

plans, and incorporating non-traditional partners (what FEMA refers to as 'Whole Community) into trainings and exercises could increase their confidence and competence in response operations.

Recommendation: Hold joint training and exercises that allow both traditional and nontraditional responders the opportunity to engage in establishing ICS (Unified Command, Area Command, and other ICS concepts). Training in the operational realities/aspects of emergency response would also be beneficial.

3.2.3 Staging area for incoming resources.

Analysis: A staging area was not established by on scene personnel[10]. A staging area would have allowed for staff accountability.

Recommendation: Include the assignment of a Staging Area Manager; and a Resource Unit leader to track assignments. Consider leveraging emergency management personnel to build out the ICS and make position assignments.

3.2.4 Personal belongings during evacuation of school.

Analysis: As students and staff were evacuated from the school, identified for further interviews, and cleared by emergency medical services, their personal belongings and backpacks were placed within close proximity to the evacuation collection point. The belongings created a large pile. Two civilians and three police officers pulled the belongings from the pile to create a line of belongings for the bomb dogs to search.

Recommendation: Direct students and staff to leave their belongings inside of the building during evacuations[11]. Incorporate procedures for searching and clearing personal belongings into emergency plans to ensure the security of students, staff, and first responders during the evacuation and initial interrogation/interview processes. Only utilize personnel with proper protective equipment and training to handle potentially hazardous items.

3.2.5 Existing plans for participating agencies and jurisdictions.

Analysis: Given the complex nature of responding to an active shooter incident, it is essential that responders have a familiarity with and an understanding of their own agency/organization's policies and procedures, as well as how their agency/organization fits into the broader multi-agency/multi-jurisdictional response effort.

Recommendation: Review the roles of the EOC and implement a training program for constituent jurisdictions to demonstrate the role of emergency management in emergency response. Include how the Multnomah County EOC can be leveraged during complex response to alleviate the burdens on ICs and coordinate resource support.

Review the county's existing formal agreements, Memorandums of Understanding, Intergovernmental Agreements, etc. Determine if additional agreements need to be drafted. Create buy-in from constituent jurisdictions for the Multnomah County EOP.

3.2.6 Coordination capacity of the Multnomah County EOC.

Analysis: Ensuring all response agencies involved understand the EOC's role in coordinating resources and other support is pivotal. Sharing situational awareness and response activities with

[10] BOEC identified the tennis courts as a staging area for incoming law enforcement resources.
[11] Cell phones and special needs items should accompany individuals.

the county EOC allows for the development of a robust Common Operating Picture. Throughout this response, many of the non-traditional response partners filled requests from on scene personnel without the benefit of prioritization, duplication of efforts and unanticipated costs resulted. With the determination of multiple Incident Command Structures and the lack of a Logistics Section in the field, the Operations Chief at the EOC made the decision to approve all reasonable requests. The lack of EOC activation notifications contributed to a lack of consideration for the role of, and coordination with operating EOCs.

Recommendation: Incorporate the role of the county EOC into emergency plans and sub-county response plans. Ensure training, exercises, and emergency plans reinforce this role.

3.2.7 Roles and responsibilities of elected officials, external organizations, Departments/Divisions, and EOC staff, including delegation of authority.

Analysis: This was the first day of office for the Chair of Multnomah County and the incident occurred at the start of the business day. The MCEM Director self-dispatched to the incident site. This decision was meant to engage the County EOC in coordinating response efforts. Prior to departing the EOC, the MCEM Director asked the Emergency Manager for Multnomah County Health Department to serve in the role of EOC Manager. This transition did not include a delegation of authority.

Recommendation: Review EOC procedures and ensure they incorporate procedures for delegation of authority necessary to operate the EOC. Consider formalizing on-site incident management support that could help facilitate communication and information sharing between the incident site and the EOC as well as lend support to on scene personnel. Update contact lists on a regular basis. Provide on boarding training to elected officials and staff to include: delegation of authority, public information management during EOC activation, cost ceilings, resource allocation, plans, policies and procedures, and frequency of executive official briefings.

3.2.8 Staffing of sections in the EOC.

Analysis: During its activation the EOC produced several Incident Action Plans (IAPs). However, the Planning Section was understaffed.

Recommendation: Consider developing a staffing roster that would support a more robust Planning Section. In a larger event it likely would have been necessary to establish a Documentation Unit and a Situational Status Unit to keep up with information flow and verification. Given the role of the EOC as a coordinating cell, the planning unit is critical for tracking the incident and for promulgating situational awareness. See also 3.3.8

3.2.9 Process for development of Common Operating Picture, shared situational awareness and critical information requirements.

Analysis: The team working in the EOC was comprised of various county department representatives and NGOs who had little practice working together and who were unfamiliar with ICS and/or EOC procedures. In interviews with these EOC staff members, many stated that the physical set-up in the MCEM EOC was not optimal for ensuring all EOC staff stayed up to date on the changing status of the incident.

Planning and Logistics was separated from Operations and the EOC decision-makers worked in a separate conference room. Some of the EOC personnel stated that this separation limited their interactions with the other members of the organizational structure. Sections within the EOC largely operated autonomously of the whole.

Different agencies use different systems for relaying and updating information. For example, the Gresham EOC and Multnomah County EOC have limited WebEOC capability, but did not use it during the event. Troutdale does not have WebEOC capacity or access, which limits its use for multiagency information sharing. The State of Oregon uses the OpsCenter system. Interviewees felt that a system that can be used and accessed by all for information sharing would support a more unified and streamlined response.

Without a shared system, the Multnomah County EOC used email to distribute situation reports. Although this method was effective for sending incident-related information to known entities, it requires up to date contact information for all involved or interested personnel/agencies.

Recommendation: Develop a training program for personnel that are assigned to staff the EOC. This training should fully describe the organizational structure, as well as the roles and functions of each entity in the EOC, and the procedures for communication and coordination. MCEM should review current situational awareness tools in the EOC and consider procuring any additional necessary to maintaining internal awareness, as well as ensuring their use by inclusion in SOPs, trainings and exercises.

Develop the capacity for a shared communications process to ensure that critical incident related information is relayed to all stakeholders in a timely fashion and that stakeholders are responding based on factual information. This communications process can include liaisons, radio monitoring, essential elements of information, and the like.

3.2.10 Roles and responsibilities of each section within the EOC and their interoperability across sections.

Analysis: Some of the EOC staff indicated that they had a difficult time differentiating between their day-to-day tasks and those they were expected to perform when the EOC is activated. Moreover, many of the personnel that staffed the EOC during this activation do not routinely work together and were not sure what the roles and responsibilities of other staff members were or should be. Some staff members expressed concern regarding possible friction with colleagues and supervisors when response roles and responsibilities differ from normal roles and responsibilities.

Recommendation: Provide additional training for personnel that could be assigned to the EOC. Include in training, Multnomah County EOP and the roles and responsibilities of staff members during a response. Develop position-specific job aids (e.g., checklists, guides) that outline the discreet tasks required of each position. Develop a roster that lists EOC personnel along with their training and experience to match personnel with ICS assignments. Host training for supervisors/managers and elected officials to ensure support for staff working in roles outside their normal daily positions.

3.2.11 Assistance request process.

Analysis: During the EOC activation, the Logistics and Operations Section Chiefs received resource requests from a variety of sources. It was difficult for the logistics section to determine which resource requests were new, and which were already filled by other agencies and EOCs. The majority of these requests were made verbally and not documented using ICS resource request forms (ICS 213RR). Those filling resource requests did not understand the approval process. The EOC procured resources that were already filled by other sources.

Those staffing the EOC were not aware of the many resources available from agencies and sources within the County and surrounding areas. To the extent that these resources were known,

staff members mentioned that they would not know how to contact the appropriate person within these agencies/outlets.

Recommendation: Review and formalize resource request procedures and ensure they adequately support the request and tracking of resources. Consider developing a resource list (with contact information). Develop training to educate County leadership and staff (particularly those that could potentially staff the EOC) on the resources available throughout the County and surrounding area.

3.2.12 Facilitation for debriefings and After Actions.

Analysis: At least one organization hosted a debriefing during school response operations that indicated the need for Reynolds High School and Reynolds School District's participation. Members of the media were present at the debriefing. For many individuals this was their first experience with the After Action process. There was no formal explanation and this may have influenced lack of participation in the county's official After Action.

Recommendation: Create local protocols for Debriefings and After Actions. Ensure school districts and other non-traditional partners are included in training and exercising these protocols. Ensure improvement plans are well understood and include actions needed by non-traditional partners.

3.2.13 Accountability and resource management.

Analysis: Many responders self-dispatched and were not assigned roles by command. Once on scene at Reynolds High School, Reynolds School District Office, and Fred Meyer Reunification, these responders took on responsibilities without adequate reporting structures, this led to duplication[12], and a lack of accountability. Self-dispatched responders were not in communication with the EOC nor Command. This hampered the prioritization of the use of on-scene resources. Safety is the most important element of accountability and while there were no reported incidents within this incident, the potential is worthy of note.

Recommendation: Develop a volunteer management plan.

3.3 Operational Communications

Strengths

TPD and its response partners made decisions regarding operational communications that proved beneficial to this incident, and that will likely be used again in future incidents. These strengths are noted below.

3.3.1 Although TPD and its response partners were on different radio frequencies, and therefore unable to communicate directly by radio, the appointment and utilization of a liaison ("runner") to coordinate communications between response agencies allowed for continued communications. During the response, first responders and coordinators could not use cell phones since the cellular service network was over-saturated. In addition, the radio traffic was at times overwhelming in the ICP, so the IC determined that face-to-face communication would be more expedient than attempting to sort out the radio traffic.

[12] Salvation Army self-dispatched and set up feeding operations. Food had already been purchased by MCEM.

3.3.2 RSDs public messaging strategy was quickly developed and implemented – and included some key best practices that should be formalized into emergency plans and utilized during such incidents.

As the incident unfolded, the schools became quickly overloaded with incoming calls from parents/guardians and worldwide media seeking information. To alleviate this, RSD decided to switch the phone lines over to an ad-hoc call center in the district office. Call-takers at the district office were given scripts so as to unify communication. In addition, there were family advocates as well as translators and interpreters from Portland Public Schools to address special needs as well as the need for multiple languages. The district office also utilized an auto-dialer that broadcasted a recording to student homes. Both of these efforts likely helped to provide incident related information to concerned citizens in a more timely fashion.

Areas for Improvement

3.3.1 Use of unique unit monikers that can be input into the Computer Aided Dispatch, CAD system without necessitating the creation of additional calls.

Analysis: Dispatchers have the capability to assign any units that exist within the CAD unit number tables. The tables include the complete rosters of all contracted partner agencies, as well as a series of unit numbers for each agency that might provide mutual aid within Multnomah County. For those secondary agencies, the unit numbers assigned in BOEC's CAD system may be different than what are designated in their own CAD system. There are two reasons for this: 1) Secondary agencies operating in Multnomah County need to be distinctive so there is no confusion regarding agency affiliation. (2) There are duplicate numbers across agencies and the surrounding jurisdictions, (i.e. Clackamas Sheriff Officer Unit 223 would have to be designated something else to differentiate from Troutdale PD Unit 223). Assigning a moniker unit number for mutual aid agencies is an industry standard.

Recommendation: Ensure all mutual aid agency responders are aware that they may be assigned a moniker unit number when working in another jurisdiction. Ensure all BOEC dispatchers are familiar with this procedure.

3.3.2 Radio and cellular phone reception.

Analysis: The radio reception in the school buildings was poor because the building was not equipped with repeaters. Although TPD and the other response entities onsite used runners as a work around for the poor radio communications, this alternative may not be possible in all situations. Some interviewees stated that their cell phones did not download voice messages until the evening, but that text messages were received immediately.

Recommendation: Consider equipping the school with repeaters so that radios work throughout the various school buildings as law enforcement and fire/emergency responders did not have cellular access as the reception was poor given the network overload, and they did not have phone chargers to charge phones once they had died. Also consider equipping response personnel (or the Mobile Command Vehicle) with USB battery pack phone chargers to allow for personnel to charge phones and be mobile during such incidents, instead of having to be near an electrical outlet.

3.3.3 Ability of dispatchers to identify the nature of the call.

Analysis: Dispatchers had difficulty providing updates to first responders and coordinators because as dispatchers were scrolling up to retrieve information regarding the nature of the call,

new updates were continuously coming in, forcing the screen to return to the bottom of the page in the system.

Recommendation: Explore alternatives to adding every update to the primary incident history.

3.3.4 Wireless data system coverage.

Analysis: Communications impacted by lack of wireless internet availability. The wireless internet connection available at the school was password protected and the existing satellite equipment in the MCSO mobile command post does not have a current subscription and would not lock onto a connection. As a result, personnel in the MCSO mobile command post were not able to connect to the internet. Instead these staff members relied on cell phones and wireless data that was over-saturated and spotty during the response.

Recommendation: Consider updating subscription to the existing satellite data provider or subscribe to another satellite and/or terrestrial (cellular) data provider. As satellite data plans are more expensive than cellular data plans, one option would be to subscribe to a cellular data service for day-to-day use, but have an as needed satellite plan for times when cellular is not available due to overloading or being out of range. In addition, consider configuring the wired and wireless networking in the mobile command post for use with MCSO devices, as well as with devices brought in by outside agencies.

3.3.5 Access to School's secured wireless networks.

Analysis: Several attempts were made to connect to the Reynolds High School secure wireless network in order to access network service. However, non-school personnel did not have the passphrase/key. RSD's current operational plan eliminates access after 2200hrs. During an incident, access needs to be reliable and continuous.

Recommendation: Create guest user access to school wireless Internet. Ensure this system is functional during the hours of incident operations.

3.3.6 Communications equipment.

Analysis: The MCSO information technology (IT) officer noted several issues related to auxiliary communications equipment. Although these issues are particular to the MCSO mobile command vehicle, it is highly probable that these issues may carry over to the other agencies that responded to the incident. The following issues/shortfalls were noted:

- Cell phone chargers. At least one person from another agency arrived with a depleted phone battery. This issue is likely one that was more widespread particularly for those individuals that are not traditional first responders.
- Clocks. Several responders in the MCSO command vehicle made repeated inquiries regarding the time. Command vehicles should have a clock that is readily visible to all personnel.
- Laptop chargers. One officer from another agency had a Toughbook laptop with a depleted battery. Although the MCSO was able to find a 120V charger that was connected to an unused Toughbook in the mobile command vehicle, this would not have been possible had the MCSO laptop been in use at the time.

- Rechargeable flashlights. When checked, the bank of rechargeable Streamlight flashlights failed to operate[13].
- TV tuners. A local government official in the MCSO mobile command wanted to watch the press conference on live TV. Both TVs have analog-only tuners and are unable to receive the current digital over-the-air TV signals. Consequently, the official was unable to watch the press release or news coverage of the event.

Recommendation: The following recommendations were made by the MCSO IT officer:

- Stock a number of universal 120V to USB chargers and 3-5 each of several popular USB charging cords for cell phones and tablets in the MCP. Also stock several common 120V six-outlet power strips, possibly with the USB charging cubes already plugged and ready to deploy.
- Procure and install several easily-readable 24-hour-capable clocks at strategic locations above desks, on walls, etc.
- Stock several extra laptop chargers for Panasonic, Dell and other popular law enforcement and government laptops and ruggedized tablets in the MCP. Contact other local government agencies to verify what equipment they are using and at least stock chargers for their equipment.
- Replace bad flashlight batteries as necessary and assure that the charger is plugged in often enough to keep the flashlights charged and ready for use.
- Replace both TVs with new units that have digital tuners. Verify functioning of existing DVD/VCR units and replace as necessary.
- Utilize existing VHF radios.
- Replace radios in MCSO Command Vehicle with narrowband-compliant radios and program them with the current UASI template, as available.

3.3.7 Communications between MCEM, the school district, and the responders on scene.

Analysis: Although the school district had created and posted an organizational structure[14] MCEM did not have access to it. MCEM did not have contact information for school district personnel involved in response operations. The school district did not have MCEM EOC contact information, nor were they familiar with the capabilities of the EOC therefore did not know who to call to assist with their logistical, planning, and operational needs.

The school district did not have the same radios[15] as law enforcement and were short staffed. When the school liaison was called into a decision-making meeting for the school district related to the incident, she had to decide between staying connected with law enforcement operations and going to the meeting.

Recommendation: Create and maintain a contact list for the EOC ensure that it includes all school districts' main emergency contacts. Ensure that all responding agencies receive organizational charts with contact information for each other. Determine best method for on scene communications between school, law, fire, and EMS. This may involve schools using a

[13] Need to determine if the Mobile Command Vehicle is plugged in where it is stored.
[14] The school district's incident response organizational chart was posted in the PIO area at the high school scene.
[15] School district personnel will need training on 800 MGHz and VHF radios.

borrowed first responder radio. Host radio operations courses and ensure school district staff are included.

3.4 Fire/Life-Safety Operations

Strengths

3.4.1 TPD and its response partners were able to leverage their strong working relationship to expedite response. East County response agencies routinely train together and communicate with each other on a daily basis. This allows them to quickly and effectively handle incidents due to familiarity with plans, tasks, and roles, thereby saving critical time.

3.4.2 GPD was quick to integrate with GFES and deploy rescue teams and was very receptive to their use. The rescue team is typically comprised of three emergency medical personnel with two law enforcement officers providing security. These teams allowed for emergency medical response partners to respond and enter the school along with the law enforcement tactical teams. Utilizing the rescue teams allowed for quick entry and the potential to treat victims.

3.4.3 The inbound fire and emergency medical personnel dropped medical equipment at the rescue team staging area. This provided the teams with the equipment they needed and could potentially need as they conducted rescue operations.

3.4.4 GFES used fire engines and vehicles to create a shield/protective barrier for the MCP. During the response, GFES used three fire engines to create a protective barrier to shield potential casualties from threats posed by the shooter, as well as from media coverage that would compromise responder safety. Fire/emergency personnel noted that this procedure should be included in emergency response plans for similar incidents.

Areas for Improvement

3.4.1 Patient extraction with long backboards, mega movers, and skeds.

Analysis: Although responses involving the need to extract victims with long backboards, mega movers, and skeds were not needed, familiarity with and utilization of these transport devices would have assisted GFES personnel with transporting victims from the building to the MCP. In the Reynolds High School response, the MCP was located 200 feet away from the school building. Fire personnel noted that transporting victims at this distance would have quickly fatigued response personnel. Moreover, in incidents involving mass casualties, it is possible that equipment other than mega movers and skeds could be necessary to expedite patient extraction.

Recommendation: Conduct training on how to use patient extraction/movement apparatus and equipment. This training should also include setting up the MCP and serve to identify ancillary methods for transporting patients from the extraction point to the MCP.

3.4.2 Understanding of how emergency response personnel will operate during acts of violence.

Analysis: Active Shooter SOGs/SOPs do not exist. Roles and responsibilities during such incidents have not yet been clearly identified. An understanding of these roles and responsibilities is important to ensure a coordinated response, evacuation, and investigation, as well as the safety of all persons involved.

Recommendation: The following was identified to be included in their Active Shooter plan.

- Ensure continuity and provision of detailed instructions to the students as they leave building, such as "put your phones in your pocket, keep your hands up, leave your backpack and all other belongings besides special medical equipment behind."
- Have a questionnaire for the student interviews in order to ensure timeliness and consistency for investigation purposes.
- Search school faculty and staff first, so that they can then stay with students as they are being evacuated, potentially calming nerves.
- The search process should include questioning students so as to begin separating them into witness and non-witness groups, such as "Where were you in the building?"

3.5 Reunification and Victim Services

Strengths

3.5.1 SROs, Reynolds High School personnel, and behavioral health support resources were sent to the reunification site. Many interviewees noted that having persons with whom the students are familiar present at the reunification site provided them with a sense of security and comfort. Having these key personnel present at the reunification site should be included in reunification site plans.

3.5.2 The presence of medical services at the reunification site was beneficial. Many interviewees noted that medical services at the reunification site were utilized and should be included in reunification site plans.

3.5.3 Communication and coordination among the various organizations that provided emotional support services to survivors went well. A multi-disciplinary behavioral health leadership task force (BHLTF) was utilized in order to restore and improve the well-being of the community affected by the shooting at Reynolds High School. The variety of organizations ensured those who sought assistance were able to find the type of support they were looking for. In many cases, this meant personnel trained for and experienced with traumatic incidents supported individuals with short-term assistance needs. There were also behavioral health personnel who are trained to provide follow up services for those who demonstrated a need for longer term support. Spiritual support and animal services were provided as well.

3.5.4 Creating a Community Support Center and naming it as such as opposed to a mental health center contributed to its success. The name of the CSC was important because it made no reference to "mental health," which likely allowed those affected by the shooting at Reynolds High School to seek services without the fear of a social stigma.

3.5.5 The CSC was adequately staffed with personnel from Multnomah County Department of County Human Services (DCHS), victim advocates, chaplains, Red Cross, Trauma Intervention Program (TIP), school counselors and others. The personnel at the CSC provided hydration, feeding, transportation, crisis counseling services, crime-victim assistance, and support for students, teacher, faculty, families of students and the general community. Multi-language resources (e.g., interpreters) were also cited as helping to fulfill the key/critical needs of the community that sought assistance at the CSC.

3.5.6 Special needs students were evacuated first with their teachers and aides. Many interviewees noted that the special needs population was cared for and plans should ensure such care is provided during future incidents.[16]

Areas for Improvement

3.5.1 Reunification plans

Analysis: The school plan called for the reunification site to be located at Mt Hood Community College. The school district office was working with the college and set up of Mt Hood as the reunification location had begun. On scene however, the law enforcement officer tasked with establishing the reunification location was informed that Mt Hood was not a viable option.[17]. The new model for school emergency response plans is to have more than one reunification location option.

The reunification center at Fred Meyer had a permeable perimeter. Its layout exposed students and their families to the media and allowed media access to hear information being exchanged regarding the specifics of the shooting.

Recommendation: Revise the reunification plans for incidents involving mass evacuation of students. At minimum, the plan should seek to address the following:

- Selecting a reunification site by creating a list of a minimum of three agreed upon, pre-determined locations to be chosen by the IC at the appropriate time during such incidents, bearing in mind that a reunification site should provide privacy, security and functionality depending on event and weather.
- Separating each step of the reunification process, so that students and their custodial persons are not interacting with the media during this process in case custodial persons of the victims(s)/suspect(s) have not yet been notified.
- Ensure procedures are included to treat parents of any injured or deceased children with appropriate care, comfort, and compassion – specifically shielding them from reunions if at all possible. Ensure proper behavioral health support is present.
- Ensure protocols are developed to inform school district staff of any injuries or deaths as soon as possible.
- Staff the Reunification site with an adequate number of PIOs to assist students and family members with handling media interviews.

3.5.2 Methods for verifying custody.

Analysis: The phone application for Synergy (an electronic community roster used by RSD) was not working. Reynolds High School faculty only had access to paper rosters with limited information. The paper rosters only list student's first and last names, and not the names of their custodial parents or legal guardians.

Recommendation: Plan for paper rosters at the reunification site stating persons legally responsible for picking up students in the event that electronic systems are not accessible.

[16] See footnote #2
[17] The Lt was informed that Mt Hood Community College, MHCC was in the midst of finals and there was no available space (including parking) for MHCC to serve as the reunification location. It is unknown where the person providing this information obtained it.

3.5.3 Organizational structures for reunification locations.

Analysis: The set-up of the reunification site was a joint effort by TPD, MCSO, Beaverton Police Department, RSD, and staff from Reynolds High School. While the site was quickly established for the purpose of reuniting students with their custodial parent/guardian, it was not entirely clear who was in charge of the site. As a result, a number of issues were noted by interviewees that should be considered when establishing a reunification site. These issues include:

- There were a number of unidentified personnel wearing plain clothes. This made it difficult for students to know who to go to for help.
- Response personnel did not know who the appropriate school representatives were, which was further complicated by the willingness of school personnel to step up to assist whenever requested. This resulted in school staff filling roles that district personnel were more appropriate to fill.
- Command did not deploy a liaison to the reunification site. As there were no liaisons, there was limited communication between the reunification site and Command, which resulted in a lack of situational awareness.
- As many of the organizations have not trained together, they were not aware of what services and resources the other organizations provided. As such, personnel staffing the reunification site were unable to direct students and their families to the appropriate personnel to receive resources and services.
- LE can keep media out of a designated/excluded area but has no authority to keep them from interviewing people after they leave that designated/excluded area.
- There were not enough bi-lingual personnel or translators at the reunification site to provide information to concerned parents. Given that the Reynolds High School has a high demographic of Hispanic students, it would have been helpful to have translators on hand to provide information to those to whom English is not their first language.

Recommendation: Consider the issues experienced at the reunification site and work with county schools and local first responder agencies on revised reunification plans in the event of an active shooter incident. Ensure that it is clear to all agencies and organizations that the school district is in command of the reunification location with law enforcement as a support agency for safety and security. Host ICS courses for school district personnel to increase their understanding of the capabilities of the EOC. Ensure that vests and other methods[18] are used to identify the individuals who are serving in various roles on scene. Establish the reunification location as its own ICP with a separate command structure or as a branch or division within the ICS established for the incident.

3.5.4 Survivor Support Services (Behavioral Health/Emotional First Aid).

Analysis: The Multnomah County Department of County Human Services (DCHS) at the request of the IC activated the CSC at Mount Hood Community College at 1:00 pm on the same day as the shooting. This facility type does not exist in ICS/NIMS and therefore all

[18] Behavioral health providers will need a method of identification that addresses the possibility of stigmatization of those seeking this kind of service.

characteristics necessary were unclear[19]. By all accounts, this resource was seen as extremely beneficial for providing much needed emotional support services to those affected by this incident. Since this was the first time such a center was activated, there were a number of lessons learned noted by interviewees. These issues include:

- How behavioral health responders are incorporated into the ICS should be part of training and exercises for both traditional and non-traditional responders.
- A method of communicating the transition from local incident response (resource request from on-scene responders) to county EOC incident level operations (coordination of overall behavioral health response – long and short term) needs to be developed.
- Subject matter experts are best for determining adequate staffing levels and associated appropriate training levels of those responding. Requests for behavioral health resources seemed inadequate for the need. Fortunately behavioral health specialists recommended higher numbers and then placed additional providers on standby. The majority of providers on standby were used.
- Determination of which behavioral health resource is best suited to provide what service is important to establish early (best if it is in plans that are exercised with all partners).
- Although the leadership team was able to invest some time to plan for future needs[20] more time should have been devoted to this effort.
- Use of Task Forces and Strike Teams to organize individual resources was instrumental to success. Organizations wishing to support this type of response will need to be organized with their own supervisory structure (preferably in Task Force/Strike Team formation).
- Contact with individual members of organizations was problematic. Identification of supervisor/leads and use of these individuals as sole contact was pivotal to success, streamlined the process and reduced confusion and duplication.
- The CSC lacked private space to provide mental health counseling.
- Confusion regarding what services and resources other organizations provided, which resulted in the inability of staff to direct students and their families to the appropriate personnel to receive resources and services.
- There were not enough informational materials about active shooter incidents for students and their families.
- There were too many materials for students and their families to choose from.
- A list of tips for how to deal with survivors, what may (or may not be) helpful would have been a valuable tool.
- Development of a list of treatment/services available for individuals struggling to recovery months or a year or more later is needed.

[19] The basic parameters provided were: capacity to hold 500 people, potential to be open throughout weekend.
[20] Anniversaries, memorials, vigils, triggers, celebrations, long term follow up care, etc.

Recommendation: the BHLTF needs to consider the issues experienced at the CSC in developing and finalizing a plan for organizing and maintaining operations for this type of resource. According to interviewees, this plan should include:

- MCEM providing assistance in organizing an ICS model during such incidents.
- A matrix for determining the number of behavioral health providers should be developed. Best practices and research should help guide the matrix development.
- Consideration of where the CSC falls within the overall incident command structure.
- Creation of a list of characteristics of a CSC (adequate private space for the mental health community to provide counseling services may just be one of many features needed).
- An intentional follow-up plan for the mental health community for clients.
- A county Disaster Behavioral Health Response Plan that includes policies and procedures as well as a list of best practices, descriptions of which organizations/agencies provide what services, and an accepted/consensus 'Concept of Operations' that covers topics like: when diffusing versus counseling is appropriate, who should coordinate, who is qualified to provide, etc.
- Disaster/Crisis Response backpacks (or other method) to ensure that agreed upon resources and informational materials such as handouts that include a list of resources, services and service providers, as well as, information regarding the incident type are accessible to those who need them.

3.6 Public Information

Strengths

3.6.1 The Public Information Officers (PIOs) in the Multnomah County EOC had the adaptability to deliver prompt, reliable, and actionable information to the affected community. The PIOs served as a support function within the EOC, monitoring various media and television reports for information. PIOs utilized texting when all other forms of communication failed. In addition, PIOs handled the change in reunification site three times through FlashAlert messages promptly alerting the public each time.

3.6.2 RSD used VoIP technology to route calls from concerned parents/citizens to the district office. RSD quickly realized that some parents may be calling the schools directly for information. In order to ensure that these calls did not go unanswered, the RSD leveraged VoIP technology to route all calls to the district office. RSD staffed phones with district staff, as well as mutual aid partners, to answer questions, and thereby provide consistent information.

3.6.3 The PIOs used appropriate methods to relay potentially sensitive information regarding the shooting. The PIOs successfully prepared a press release that considered police input, such as separating the perpetrator and victim so as to not be included in the same paragraph, and mentioning the shooter's name only once, and from then on referring to him as "the shooter."

Areas for Improvement

3.6.1 Establishment of a Joint Information System (JIS).

Analysis: A JIS was not established during the response to this incident. A cluster of law enforcement PIOs did work together, and occasionally a school district PIO was also present. As a result, many of the PIOs noted that they were not clear on their tasking, and uncertain as to their role in this response. PIOs at each of the response nodes (i.e., at the incident site, school district operations, and the EOC) reported that they received multiple tasks, and were not clear on the information release process.

PIOs also noted that they were unaware of who the lead agency was for overall public messaging, or who had final approval for the release of incident-related information. Without organization of the JIS, PIOs were unable to develop a coordinated message on behalf of all of the response partners/stakeholders. Within their own discipline (Law, School, and County) these individual PIOs functioned well, it was the interconnection between the different sites and disciplines that was lacking. In the first few days, there was no clear path for the behavioral health subject matter experts to assist with and contribute to messages. Their subject matter expertise could have provided the public with resources as well as directed individuals to the CSC. Because no JIS or JIC was established, follow up actions[21] usually assigned to the PIO section either did not occur or were greatly delayed.

Recommendation: Establish training for PIO's that includes scenarios involving multiple jurisdictions with cross over authorities. Training for PIOs should include a review of the Regional PIO Concept of Operations Plan, Joint Information Systems, Public Information Officer duties, as well as the overall Incident Command Structure.

3.6.2 Coordination between JIS and County and County messaging to staff during acts of violence.

Analysis: The EOC staff received numerous calls from county staff asking for status updates on the incident. The EOC began developing a message to provide to county staff, however the EOC PIO roles and responsibilities were not in line with Communications Office operations.

Recommendation: Provide ICS training that includes the importance of coordinated public messaging. Review and where necessary create policies and procedures that cover early departure from work during events of this nature and incorporate into supervisor and manager refresher training. Ensure these policies and procedures meet the intent of the county and safe guard the needs of county staff. Include a review from behavioral health subject matter experts in message development.

3.6.3 Utilization of Social Media.

Analysis: While information regarding the incident was posted to Facebook by RSD, other forms of social media were not fully utilized. #reynoldsshooting was declared an official hashtag at a press conference, but consisted of information posted by parents. This information was then perceived by the public as official information in the initial phases of the response.

This underutilization of social media, coupled with the failure to establish an internet connection (at the high school incident site), may have contributed to the lack of public information regarding the reunification site and the distribution of erroneous information regarding such.

[21] Thank you letters to responders and agencies/organizations that assisted were assigned to Troutdale PD instead.

PIOs utilized resources that existed prior to the event but did not capitalize on the resources available (VOST, etc) to amplify messages. The FBI took the lead in handling social media therefore the pages of some of the agencies involved (MCSO and others) had unrelated and outdated content.

Recommendations:

- PIOs need to develop a plan to capitalize on social media to distribute important information regarding the incident to affected persons, as well as prevent the spread of false information.
- All involved agencies should consider updating their social media accounts in a coordinated manner using the JIS to ensure there is no contradicting information.
- PIOs need to acquire resources to, or develop a plan to overcome communications systems failures during such incidents.
- PIOs, MCEM and the county Communication Office should investigate the use of a VOST.
- Training for PIOs, MCEM, and the Communication Office, as well as elected officials should include a review of the Regional PIO Concept of Operations Plan, Joint Information Systems, Public Information Officer duties, as well as the overall Incident Command Structure.
- A county Public Information Communications plan should be developed that includes policies and procedures related to complex incidents that cross jurisdictional, discipline and authority boundaries. These plans should be exercised and updated on a regular basis so that PIOs, the county Communications Office, response partners, and elected officials are all familiar and comfortable with implementing/following them.

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APPENDIX A: RESPONSE TIMELINE – KEY EVENTS

The following table provides a response timeline of the key events taken by first responders and school district as a result of the Reynolds High School shooting.

Table 3. Response to the Reynolds High School Shooting

Time	Action
June 10, 2014	
8:05 a.m.	5 minute warning bell for start of school (8:10 a.m. would have been start of school day).
	Initial shots fired in the boys' locker room in the gym building east of the main school building; first victim killed.
	Gym teacher runs out of the gym towards the front office to initiate school lockdown and is shot by shooter; teacher sustains non-life threatening injuries.
8:07 a.m.	9-1-1 call received; officers dispatched to the scene, Code 3 requesting all available units.
08:07:48 a.m.	Troutdale Police were dispatched
08:07:57 a.m.	EMS responders were dispatched
8:08 a.m.	SROs enter gym.
8:09 a.m.	TPD Chief and Lieutenant arrive on scene having been notified by SROs.
8:13 a.m.	1st search team enters the high school through the north doors.
8:13 a.m.	Shot fired by shooter.
8:13 a.m. – 8:14 a.m.	Four shots fired by a responding officer; declared threat eliminated.
8:30 a.m.	Evacuation of school begins
8:30 a.m.	Gresham EOC activated
8:45 a.m.	Multnomah County EOC activated
10:30 a.m.	Multnomah County EOC issued first situation report.
12:30 p.m.	Last bus with students sent from school to reunification site.
1:00 p.m.	A CSC was established Multnomah County Human Services and other emotional first aid providers.
1:20 p.m.	The reunification of students with their families well underway with 12 students remaining at this point.
2:20 p.m.	Gresham EOC deactivated.
6:00 p.m.	'Student belonging retrieval' at Reynolds Middle School begins (for items left outside school post evacuation)
7:00 p.m.	Multnomah County EOC demobilized; duty officer available after hours.
9:00 p.m.	Student belonging retrieval at Reynolds Middle School is complete. Estimated 3,000 people provided services by Victim Advocates/Behavioral Health
June 11, 2014	
7:00 a.m.	CSC activated, to close at 7:00 p.m.; EOC partially activated.
8:00 a.m.	School district staff emptied gym lockers and numbered and bagged belongings to avoid staff and students having to enter into gym area on Friday.
9:00 a.m.	Belonging retrieval of remaining items not collected from Reynolds Middle School on June 10.
June 12, 2014	
5:00 p.m.	Reynolds High School graduation ceremony, complex media plan developed for and supported by Veterans Memorial Coliseum, TIP provided behavioral health support at graduation.

Table 3. Response to the Reynolds High School Shooting Continued

Time	Action
June 13, 2014	
8:00 a.m.	Staff breakfast. Students and families begin arriving and are escorted by 100 behavioral health providers to retrieve their belongings from Reynolds High School; Multnomah County EOC partially activated.
3:00 p.m.	Remaining belongings retrieved. Estimated over 5,000 people served.
June 14 – 15, 2014	
12:00 p.m.	CSC operates at Reynolds Middle School until 5:00 p.m.
June 17, 2014	
9:00 p.m.	Candlelight vigil held at the football stadium at Reynolds High School.
June, 2014	
Summer	School district requires all schools to participate in a community event of their choosing during the summer.

APPENDIX B: ORGANIZATIONS PARTICIPATING IN THE RESPONSE

Table 4 below lists federal, state, county, and city agencies that participated in the response to the shooting at Reynolds High School.

Table 4. Participating Agencies

Federal Response Partners
Alcohol, Tobacco, and Firearms Bureau
American Red Cross
Department of Homeland Security
Federal Bureau of Investigation
Regional FBI Field Offices
Secret Service
U.S. Forest Service
U.S. Marshals
State Response Partners
Oregon State Police
Regional Response Partners
Cascade Chapter American Red Cross
Cascade Canine Crisis Response Team
Clackamas County Sheriff's Office
East Metro SWAT
Fred Meyer
Mt Hood Community College
Northwest Regional Computer Forensics Lab
Port of Portland Police
Public Safety Chaplaincy
Salvation Army
School Districts' Flight Teams
Trauma Intervention Program, Inc.
Trimet
Victim Advocates (federal, city, and county)
County Response Partners
Clackamas County Sheriff's Office
Clark County Sheriff's Office (WA)
East County Major Crimes Team
Multnomah County Department of County Human Services
Multnomah County Office of Emergency Management
Multnomah County Sheriff's Office
Washington County Sheriff's Office

City Response Partners
Beaverton PD Crisis Response
Beaverton Police Department
Buffalo Wild Wings
Camas Police Department (WA)
Fairview Police Department
Gresham Emergency Management
Gresham Police Department
Gresham Fire and Emergency Services
Gresham Department of Environmental Services
Hillsboro Police Department
Milwaukie Police Department
Oregon City Police Department
Portland Police Bureau
Portland Public Schools (translation services)
Reynolds High School Counselors
Safeway
Sandy Police Department
Troutdale Police Department
Tualatin Police Department
Vancouver Police Department (WA)

APPENDIX C: IMPROVEMENT PLAN

This Improvement Plan has been developed specifically for the response to the Reynolds High School shooting on June 10, 2014 for use in planning the law enforcement, school, and MCEM's response to future school shooting incidents. These recommendations draw on both the After-Action Report and the After-Action Meeting.

Table 4. Improvement Plan Matrix

Issue Area	Observation	Corrective Action Description	Primary Responsible Agency	Implementation Timeline
Initial Notification	3.1.1 Activation of the school's lockdown procedures.	3.1.1.1 Consider purchase and placement of outdoor speakers.	RSD	Dec 2015: RSD will research cost of purchase and placement of outdoor speakers.
		3.1.1.2 Ensure lessons learned from this After Action are shared widely.	MCEM	On-Going: MCEM will coordinate with internal and external partners to ensure that lessons gleaned from this review are shared with local responders and incorporated into applicable response plans.
		3.1.1.3 Review best practices and develop procedures that could be employed when students are not already in classrooms. This may or may not be 'lockdown'.	RSD GFES and MCSO - support	Completed: RSD completed a safety review of the schools in its district. Dec 2015: RSD will schedule a meeting with MCSO and GFES to discuss best practices.
	3.1.2 Notification procedure for activation of MCEM's EOC.	3.1.2.1 Develop an EOC activation procedure and checklist that incorporates	MCEM	Jan 2016 Everbridge system has been implemented. The

		non-traditional partners. This checklist should include notification lists and be included in plans, the Duty Officer Manual and/or be distributed to all EOC/MCEM staff.		EOC Activation notification list has been created in the Duty Officer Contacts. Draft language for Everbridge templates has been created. Dec 2016 – Complete Duty Officer Manual.
		3.1.2.2 Work with non-traditional partners to determine the best method of notification for an EOC activation. Incorporate these methods into the EOC activation procedures (see also 3.1.2.1)	MCEM	Mar 2016 Completed
		3.1.2.3 Training and exercises should include the full spectrum of potential responders. Create a County EOC staff list that includes non-traditional partners.	MCEM	Mar 2016 Completed
		3.1.2.4 Behavioral health experts should create and maintain a contact and activation list of approved providers with core competencies and provide to EOC Logistics.	MCHD, MHAS – Lead BHLTF – support	Jan 2016
Operational Coordination	3.2.1 Establishment of an Incident Command Structure at the incident site.	3.2.1.1 Determine if county IMTs would be an effective way to assist with on scene incident management	MCSO Support: GPD, MCSO, GFES, FPD, and GEM and	Dec 2016: There is a standing law enforcement task force that is working to identify issues related to ICS. TPD, GPD, GFES

		(sending a Logs Chief or a liaison to an incident site may help alleviate some of the ICS and other cascading challenges).	MCEM	will coordinate with GEM and MCEM to notify them of action items.
		3.2.1.2 Identify the possible Command Structures that could have been utilized in this type of response. Host TTX / Workshop to discuss.	MCEM Support: MCSO, GFES, GEM, GPD, others	Dec 2016: TTX/Workshop
		3.2.1.3 Determine the best method for integrating ICS training and exercises into law enforcement agencies. Schedule training and exercises	MCSO Support: MCEM (provide training, and exercise coordination)	MCSO has been added to MCEM's monthly meeting. Robust discussions and coordination have been the result.
		3.2.1.4 Ensure adequate ICS and crisis response training and exercises are available to school districts..	MCEM	Nov 2015 Completed. A monthly training announcement is sent to school district representatives (this list also includes 'whole community' partners)
		3.2.1.5 Ensure ICS training includes various organizational structure configurations to include consideration being given to establishing separate Command Structures for incidents that are geographically disparate and that have different operational objectives	MCEM	Dec 2015 Discussions have occurred and are ongoing.

	3.2.2 Non-traditional response partners in the Incident Command Structure.	See 3.1.2.3 and 3.2.1.3	MCEM	Mar 2016 Completed. Training group created in contacts.
		3.2.2.2.Determine how behavioral health providers will be incorporated into the ICS.	MCHD – MHAS Support: MCEM, TIP, NOVA, CISM, chaplains, Red Cross, Canine Response Teams, ORVOAD, OHA, and other emotional first aid provider stakeholders	Mar 2016: A Behavioral Health Task Force is currently working on developing a Behavioral Health Disaster Response Plan. This group is called the MOU group. Additionally, Victim Advocates are holding meetings to develop a response framework.
		3.2.2.3 Determine method of transition from local incident response to county EOC incident level operations and coordination.	MCEM Support: MCSO, GFES, PBEM, GEM, others	Dec 2016 Completed. Multnomah County EOP describes thresholds for activation.
		3.2.2.4 Create curriculum and implement training for tactical and other aspects of emergency response (radio use, scene orientation, deployment basics)	MCEM	Mar 2016 Completed and ongoing. Quarterly radio drills are on the calendar and the participant list is steadily growing.
	3.2.3 Staging area for incoming resources.	3.2.3.1 Develop a plan for how to handle the influx of spontaneous responders that usually occur in response to an active shooter (focus on resource management) see also 3.2.1.1 .	MCSO Support: MCEM (volunteer management plan)	Mar 2016 Local and regional law enforcement partners to leverage their participation in the regional law enforcement task force Jan 2017: MCEM Volunteer Management Plan.

		3.2.3.2 Determine the best method to provide for accountability on scene of all resources. Include discussion re staging areas, multiple ICPs, Area Command and other topics. See also 3.2.1.1 and 3.2.1.5	MCEM Support: MCSO (others)	Apr 2016 A statewide task force has been created to address this and many other issues related to acts of violence.
	3.2.4 Personal belongings during evacuation of school.	3.2.4.1 Create protocol/procedures for law enforcement (include training and exercises) that directs evacuating individuals to leave all belongings (with the exception of cell phones and any special needs items).	MCSO Support: MCEM, FPD, GPD	Mar 2016 A statewide task force has been created to address this and many other issues related to acts of violence
		3.2.4.2 Procedures for searching and clearing personal belongings should be included in plans and outreach education	MCSO Support: RSD, MCEM	Once protocols are finalized, this element can be incorporated into outreach efforts
		3.2.4.3 Only personnel with PPE and training should be used to handle potentially hazardous items	MCSO Support: School Districts, Fire Departments, law enforcement agencies	This guidance exists
	3.2.5 Existing plans for participating agencies and jurisdictions.	3.2.5.1 Identify training and exercise needs and develop a schedule (ensure multi-jurisdictional and multi-discipline involvement).	MCEM Support: MCSO, GEM, others.	Apr 2016 Completed and ongoing

		3.2.5.2 Create an EOP Orientation course.	MCEM	Oct 2015 Completed.
		3.2.5.3 Review formal agreements and consider development of training that outlines roles and responsibilities of various agencies	MCEM	Apr 2016 A statewide task force has been created to address this and many other issues related to acts of violence
	3.2.6 Coordination capacity of the Multnomah County EOC.	3.2.6.1 Establish role clarity around activation, and response and recovery operations. Obtain buy-in regarding duration of response support. See also 3.1.2.1 – 3.1.2.4	MCEM	Mar 2017
	3.2.7 Roles and responsibilities of elected officials, external organizations, Departments/Divisions, and EOC staff, including delegation of authority.	3.2.7.1 Review and update/create procedures for delegation of authority and provide training for staff and management. See also 3.2.1.1	MCEM	Dec 2016
		3.2.7.2 Ensure clarification regarding how EOC and scene IC/UC (or Area Command) will communicate – share information during incident operations	MCEM	Mar 2017
		3.2.7.3 Ensure EOC contact lists are up to date and include cell phones for all on	MCEM	Jan 2016 Completed and ongoing

		notification lists as well as EOC staff. See also 3.1.2.1		
		3.2.7.4 Ensure onboarding training regarding incident response and EOC activation (roles/responsibilities) is provided to incoming elected officials and their staff.	MCEM	Jul 2014: completed for current administration.
		3.2.7.3 Assess current systems and tools used for situational awareness, and determine additional resource(s) that should be acquired. Create training for chosen system and exercise.	MCEM	Mar 2017
	3.2.8 Staffing of sections in the EOC.	3.2.8.1 Ensure EOC staff members are empowered to properly staff each section based on incident demands.	MCEM	Mar 2017
		3.2.8.2 Develop a recruitment, retention and training and exercise program for EOC staffing. Consider the incorporation of volunteers.	MCEM	Mar 2016 Completed draft training requirements. Exercise plans are updated annually. Mar 2017 Volunteer program framework
	3.2.9 Process for development of Common Operating Picture, shared situational awareness and	3.2.9.1 Review EOC layout to help facilitate optimal info sharing See also 3.2.8.2	MCEM	Feb 2016 Completed. EOC in process of being relocated.

	critical information requirements.	3.2.9.2 Develop robust training and exercise program for EOC Staff. Include the methods for and importance of, capturing of Essential Elements of Information/Critical Information Requirements		Mar 2016 EEIs completed. Training ongoing. EOC staff recruitment ongoing. 75 EOC staff members have been trained in basic EEIs.
	3.2.10 Roles and responsibilities of each section within the EOC and their interoperability across sections.	3.2.10.1 Develop training and exercise program for EOC staff that includes EOP, basic ICS, support materials (position checklists, etc), and an EOC overview. See also 3.2.8.2	MCEM	Mar 2016 Completed
		3.2.10.2 Create and implement training for supervisors and managers that explains expectations of EOC staff with a goal of increasing support for EOC staff.		Mar 2017 Provided training and exercises for Directors and portion of leadership in MultCo.
		3.2.10.3 Create training tracking system that identifies EOC staff training and experience.		Mar 2017 Currently using Google documents.
	3.2.11 Assistance request process.	3.2.11.1 Develop a resource list with contact information for logistics staff use.	MCEM	Mar 2017
		3.2.11.2 Incorporate the use of the Assistance Request Form into all EOC	MCEM	Mar 2016 Completed and ongoing.

		activations that include resource management. See also 3.2.8.2		
		3.2.11.3, Create an SOP re assistance requests. Obtain approval and provide training and exercises that include internal and external partners.	MCEM	Mar 2016 Completed
	3.2.12 Facilitation for debriefings and After Actions.	3.2.12.1 Consider creation of county-wide protocols/ SOPs for debriefings and After Actions See also 3.1.2.3	MCEM	Mar 2017
		3.2.12.2 Ensure Improvement Plans are well understood and include actions needed by non-traditional partners. Ensure Improvement Plans have some method for accountability.	MCEM	Mar 2016 Completed and ongoing
	3.2.13 Accountability and resource management.	3.2.13.1 Develop a plan for volunteer management. See also 3.1.2.3, 3.2.1.4, 3.2.5.1, and 3.2.8.2	MCEM	Jan 2017
Operational Communications	3.3.1 Use of unique unit monikers that can be input into the Computer Aided Dispatch, CAD system without necessitating the creation of additional calls.	3.3.1.1 Ensure all mutual aid agency responders are aware that they may be assigned a moniker unit number when working in another jurisdiction. Ensure all BOEC dispatchers are	BOEC	Dec 2015

		familiar with this procedure.		
	3.3.2 Radio and cellular phone reception.	3.3.2.1 Ensure that responders and/or response vehicles are equipped with back up USB battery packs to charge cell phones during prolonged responses.	MCSO Support: GEM, GFES, MCEM	Dec 2017
		3.3.2.2 Upgrade communications capabilities of MCSO Command Vehicle.	MCSO	Dec 2015 Completed
	3.3.3 Ability of dispatchers to identify the nature of the call.	3.3.3.1 Explore alternatives to adding every update to the primary incident history .	BOEC	Jan 2016
	3.3.4 Wireless data system coverage.	3.3.4.1 Update subscription to existing satellite provider. Determine any additional updates and/or improvements needed for the Command Vehicle. Ensure they are put in place (chargers – phone and computer, clock, TV tuners, flashlights)	MCSO	Dec 2015 Completed
	3.3.5 Access to School's secured wireless networks.	3.3.5.1 Create guest user access to school wireless Internet. Ensure this system is functional during the hours of incident operations.	RSD	Dec 2015 Completed RSD is working to ensure this is applicable at all RSD schools and districts to ensure guest user access to their wireless Internet

				and that school liaisons to the ICS have the information. Schools may need to create checklist for incidents that include keeping wireless access on throughout during of response operations.
		3.3.5.2 Ensure local response agencies can get unrestricted access to the internet through all the Multnomah County schools' WiFi.	MCSO	Jan 2017
	3.3.6 Communications equipment.	3.3.6.1 Develop/update protocols to share VHF radios for utilization during such incidents. See also 3.3.5.1 and 3.2.2.4 and pages 20 & 22 of this AAR.	MCSO	Apr 2017 Interoperable Communications Group has been established.
		3.3.7.1 Replace radios with narrowband-compliant radios and program them with the current UASI template. See also 3.3.5.1	MCSO	Dec 2015 Completed
	3.3.7 Communications between MCEM, the school district, and the responders on scene.	3.3.8.1 Determine the best method to create and maintain a contact list for the EOC that includes school districts' personnel (cell phones included).	MCEM	Mar 2016 Completed, using Duty Officer Contact List and Everbridge
		3.3.8.2 Ensure all responding agencies receive	MCEM	Mar 2017

		organizational charts (for county EOC and each other). See 3.2.8.2 and 3.2.1.3		
		3.3.8.3 Determine best method for on scene communications between school, law, fire, and EMS. This may involve schools using a borrowed first responder radio. See also 3.2.2.4	MCSO Support: GFES, MCEM	Jan 2017
Fire/Life-Safety Operations	3.4.1 Patient extraction with long backboards, mega movers, and skeds.	3.4.1.1 Review current training plans to identify training opportunities for LE and fire/rescue personnel to practice patient extraction.	GFES Support: MCSO, GPD	Dec 2015
	3.4.2 Understanding of how emergency response personnel will operate during acts of violence.	See 3.2.1.4 and 3.2.2.4		Apr 2016 A statewide task force has been created to address this and many other issues related to acts of violence
Reunification and Victim Services	3.5.1 Reunification plans	3.5.1.1 Develop a list of potential reunification sites for each school.	SERRA Support: must incorporate law enforcement personnel	Mar 2016
		3.5.1.2 Update reunification plans to reflect elements listed on page 24 of this AAR	SERRA	Mar 2016

	3.5.2 Methods for verifying custody.	3.5.2.1 Ensure that custodial parents are listed on back-up methods such as paper rosters.	RSD	Oct 2015
	3.5.3 Organizational structures for reunification locations.	3.5.3.1 Ensure that reunification plans adequately delineate and detail the management structure for these operations (see page 25 of this report for related issues). See also: 3.2.1.4, 3.2.2.4, and 3.2.1.5	SERRA	May 2016
	3.5.4 Survivor Support Services (Behavioral Health/Emotional First Aid).	3.5.4.1 Create a Disaster Behavioral Health Response Plan. Ensure that the organizational structure, staffing type and levels, and the characteristics of CSC facilities are included in the plan. The associated policies and procedures need to include the establishment and running of ancillary crisis support lines. (see also pages 25 - 27 of this AAR).	MCHD – MHAS (MOU group)	May 2016
Public Information	3.6.1 Establishment of a Joint Information System (JIS).	3.6.1.1 Provide training for pertinent County agencies and the CCO and COO offices. Ensure that this training includes: a review of	MCEM	May 2016

		the Regional PIO Concept of Operations Plan, Joint Information Systems, Public Information Officer duties, as well as the overall Incident Command Structure, and situations that involve multiple jurisdictions and disciplines. See also: 3.2.13.2		
	3.6.2 Coordination between JIS and County and County messaging to staff during acts of violence.	See: 3.1.2.1 and 3.2.13.2		
		3.6.2.2 Ensure policies and procedures that cover early departure from work during events of this nature are incorporated into supervisor and manager refresher training. Reviews existing policies and procedures to ensure they meet the intent of the county and safe guard the needs of county staff. The inclusion of advice from behavioral health subject matter experts may also be beneficial in message development.	MCEM Support: COO and CCO	Jan 2016
		3.6.2.3 Consider creating a template pre-approved message (comfort/calming, rules as they relate to early departure, etc) that can be sent out to staff with very	Multnomah County Communications Office Support: MCEM	Feb 2016

		little alteration.		
	3.6.3 Utilization of Social Media.	3.6.3.1 Ensure a region-wide strategy/plan for utilizing social media during response (see also pages 28 - 29 of this AAR)	Communications Office Support: MCEM	Mar 2016
		3.6.3.2 Develop a county Public Information Communications plan that includes policies and procedures related to complex incidents that cross-jurisdictional, discipline and authority boundaries. Exercise these plans and update on a regular basis so that PIOs, the county Communications Office, response partners, and elected officials are all familiar and comfortable with implementing/following them.	Communications Office Support: MCEM	Mar 2016
		3.6.3.3 Develop a plan to overcome systems failures.	Communications Office	Mar 2016
		3.6.3.4 Develop plans (and support materials – Job Action Sheets, Checklists, Resource Lists, Contact Lists, etc) related to PIO operations. Create ESF 14 Annex.	Communications Office	Mar 2016

APPENDIX D: ACRONYM LIST

Table 6. List of Acronyms

Acronym	Term
AAR	After-Action Report
AC	Area Command
BOEC	Bureau of Emergency Communications
BHLTF	Behavioral Health Leadership Task Force
CAD	Computer Aided Dispatch
CCO	City Controller's Office
COP	Common Operating Picture
CSC	Community Support Center
EOC	Multnomah County Emergency Coordination Center
EDRO	Explosive Device Response Operations
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
ESF	Emergency Support Function
FBI	Federal Bureau of Investigation
FCC	Federal Communications Commission
FEMA	Federal Emergency Management Agency
GFES	Gresham Fire and Emergency Services
IAP	Incident Action Plan
IC	Incident Commander
ICP	Incident Command Post
ICS	Incident Command System
IT	Information Technology
JIS	Joint Information System
MCI	Mass Casualty Incident
MCP	Medical Care Point
MCP	Mobile Command Post
MCSC	Multnomah County Sheriff's Office
MCEM	Multnomah County Emergency Management
MCHD	Multnomah County Health Department
MESD	Multnomah Education Services District
MHAS	Multnomah County Mental Health and Addictions Division
MHCC	Mount Hood Community College
NED	National Exercise Division
NGO	Non-Governmental Organization
NIMS	National Incident Management System
OEM	Office of Emergency Management
PA	Public Address

PIO	Public Information Officer
RegJIN	Regional Justice Information Network
RSD	Reynolds School District
SERRA	School Emergency Response and Recovery Alliance
SOG	Standard Operating Guidelines
SOP	Standard Operating Procedure
SROs	School Resource Officers
SSID	Service Set Identifier
SWAT	Special Weapons and Tactics
TIP	Trauma Intervention Program
TPD	Troutdale Police Department
UASI	Urban Areas Security Initiative
UHF	Ultra High Frequency
VHF	Very High Frequency
VoIP	Voice over Internet Protocol
VOST	Virtual Operations Support Team