1 October After-Action Report

August 24, 2018

FEMA

This report was compiled by the Clark County Fire Department and the Las Vegas Metropolitan Police Department in collaboration with the Federal Emergency Management Agency National Exercise Division with the intent of distributing best practices and lessons learned for other communities around the country to better prepare for a mass casualty incident should one occur. Given the ongoing threat environment throughout the country, it was the intent of the agencies involved to provide this information as timely as possible.

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Executive Summary

On October 1, 2017, over 22,000 people attended the Route 91 Harvest Festival in Las Vegas, Nevada. On the third and final night of the festival, a lone gunman opened fire into the crowd from the 32nd floor of the Mandalay Bay Resort and Casino. The gunfire continued for over ten minutes, resulting in the deaths of 58 people and injuring more than 850, including first responders. Two local police officers responding to the incident were among those wounded by gunfire.

As the shooter engaged in this horrific act of mass violence, first responders made quick decisions, acting with bravery and professionalism to secure the scene and save lives. The cooperation between local fire departments, law enforcement agencies, and local private ambulance companies at the scene was exceptional. Off-duty public safety personnel also assisted in the response, providing valuable surge support for local responders. The Las Vegas community as a whole came together in response to this unprecedented situation to assist the survivors and responders of the shooting.

In the wake of this incident, it is important to evaluate the strengths and areas for improvement observed during the response—both to enhance the internal response capabilities of the Clark County Fire Department (CCFD) and the Las Vegas Metropolitan Police Department (LVMPD), as well as to share the knowledge gained from this incident with public safety agencies from across the country to assist in their preparedness efforts. Key conclusions from this report include:

- Strong cross-agency collaboration is critical for a quick and effective response.
- Response training that is tailored to address an incident of mass violence is an especially valuable preparedness investment.
- Coordinated, cross-agency planning for an incident of mass violence is necessary for successful outcomes.

The response brought together 13 responding agencies and three private ambulance companies to address a highly chaotic scene, neutralize the threat, and tend to the hundreds of victims. The responding law enforcement and emergency service agencies coordinated efficiently to clear civilians from the area, establish an Incident Command structure, and organize an effective response. Across several elements of the response, strong collaboration among these organizations was critical to the speed and effectiveness of their efforts. Conversely, when responders encountered communication barriers, these barriers hindered some aspects of their response coordination.

Heavy local investment in Multi-Assault Counter-Terrorism Action Capabilities (MACTAC) and Hostile Mass Casualty Incident (MCI) training, as well as other formal training investments by CCFD, LVMPD, and surrounding jurisdictions, also proved especially valuable. Responders cited training and exercises as being responsible for their ability to mount an effective response. Responders also identified additional training, such as emergency medical care, that would be of value to local agencies. Training and mass casualty exercises played a vital role in response efforts, prompting agencies to consider how best to prepare their personnel for potential future incidents.

The importance of coordinated planning across agencies cannot be understated in terms of its impact on this response. When agencies followed pre-established plans and procedures, they improved communication and strengthened the response. Where plans were not integrated or not widely known and understood by responders across all responding agencies, difficulties arose. Strengthening plans, policies, and procedures across Southern Nevada public safety agencies will reinforce their capabilities, allowing them to respond as effectively as possible in future emergencies.

Methodology

This report was developed through close collaboration between CCFD, LVMPD, and the Federal Emergency Management Agency (FEMA) National Preparedness Directorate. The FEMA After-Action Report (AAR) development team conducted extensive research to ensure that the assessment of the fire department and law enforcement response to the shooting at the 1 October 2017 Route 91 Harvest Festival was both comprehensive and accurate to the best degree possible. In the early morning of 2 October, CCFD and LVMPD created the Route 91 Task Force, which included four members from CCFD and three members from LVMPD. The task force gathered information by conducting hundreds of interviews, issuing surveys, and reviewing hours of dispatch tapes and hundreds of pages of dispatch notes. 24 departments and/or offices participated in interviews related to the 1 October response. The CCFD *Route 91 After Action Administrator Report* outlines responses of fire department personnel to interview questions regarding what went well and what could have gone better during the 1 October response. LVMPD also conducted a department-wide survey of personnel with an assignment on 1 October and received 672 responses. This information was provided to the FEMA AAR development team to support the After-Action analysis.

The FEMA AAR development team also reviewed a wealth of documents, reports, and plans to provide insight into Clark County's existing preparedness efforts and the resources available to address mass violence of this scale and complexity. They incorporated background information provided by responding agencies by analyzing internal training records and standard operating procedures (SOPs). In addition, they reviewed AARs from similar incidents of mass violence to identify any recurring issues and challenges, as well as to understand how this incident's response may have differed. Lastly, the team conducted open-source research on the response, including reviewing accounts of radio communications and 9-1-1 calls, to ensure consistency within reports.

From this information, the team synthesized observations and recommendations with an emphasis on identifying strengths and areas for improvement related to the response. The team organized these observations under 11 broad focus areas pertaining to the response, which were then mapped to FEMA's core capabilities (See **Appendix C**). These observations were also mapped to the relevant discipline(s) or organization(s) and are denoted within the report as follows:

- Law Enforcement
- Fire
- Regional/Statewide Agencies

This report is intended to assist both Clark County public safety agencies, as well as jurisdictions across the country, to improve their preparedness for incidents of this type.

Much of what is included within this report is based on the feedback and materials provided by responding partners. The FEMA AAR development team carefully examined the materials provided by responding agencies. The following local agencies and organizations were involved in the response to 1 October: CCFD, LVMPD, the Henderson Police Department (HPD), the Henderson Fire Department (HFD), the North Las Vegas Police Department (NLVPD), the North Las Vegas Fire Department (NLVFD), Las Vegas Fire & Rescue (LVFR), the Clark County School District Police Department (CCSDPD), the University of Nevada Las Vegas Police Department (UNLVPD), the Boulder City Police Department (BCPD), Nevada Highway Patrol (NHP), the Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATF), the Federal Bureau of Investigation (FBI), Community Ambulance, American Medical Response (AMR), and MedicWest Ambulance.

Background and Timeline

Assets and Capabilities

Clark County Fire Department

CCFD is the largest paid fire department in Nevada and is responsible for protecting the famed Las Vegas Strip, the largest part of the Las Vegas Valley spanning 293 square miles, and a county covering 7,790 square miles. The department is led by Fire Chief Greg Cassell, CCFD's 10th chief. CCFD aims to respond with integrity, serve with compassion, and uphold their mission to provide for the safety and health of their Southern Nevada communities and visitors through professional emergency response, fire prevention, and public education.

The department has 30 full-time fire stations maintained by 705 personnel, including 638 suppression personnel and 67 authorized support staff positions. All CCFD rigs provide Advanced Life Support (ALS) services. CCFD also oversees the state's largest volunteer force with 170 volunteers, who serve in the rural parts of the county at 13 volunteer stations. Additionally, CCFD sponsors Nevada Urban Search and Rescue (US&R) Task Force 1, one of only 28 US&R teams in the country. Nevada US&R Task Force 1 is capable of deploying 80 personnel and over 80,000 pounds of equipment in less than four hours by military airlift or by mobilizing 11 vehicles on the ground. This team brings an all-hazards capability to an incident commander and has done so on eight federal missions and one state mission to date.

CCFD responded to 132,938 calls in 2016 – 3,805 fires, 122,408 medical calls, and 6,725 other calls, including false alarms and mutual aid responses in other jurisdictions. In addition, the department provides fire and rescue services to the nation's ninth-busiest airport.

Dispatching for CCFD is managed by the Fire Alarm Office (FAO). This dispatch center is a joint, auto-aid collaboration between CCFD, LVFR, and NLVFD. FAO is a secondary public safety answering point (PSAP). LVMPD is the primary PSAP. 9-1-1 calls for service go through LVMPD's 9-1-1 Center initially and then are sent to the FAO based on the need for service.

CCFD Deputy Chief John Steinbeck serves as the Emergency Manager for Clark County and oversees the Office of Emergency Management (OEM). OEM provides a single point of coordination for Clark County public safety projects, including planning, training, exercises, and response and recovery efforts. In this capacity, OEM works closely with Clark County public safety organizations to facilitate a coordinated approach to multi-agency activities.

Las Vegas Metropolitan Police Department

LVMPD is an independent agency and joint city-county police force for the City of Las Vegas and Clark County, Nevada and is the largest law enforcement agency within the state. The department is led by Sheriff Joseph Lombardo, the 17th elected Sheriff for Clark County, and is responsible for an area of 7,560 square miles.

LVMPD's vision is to be the safest community in America, and its mission is to serve people, strengthen relationships, and improve the quality of life. In 2016, the department answered 1,127,169 9-1-1 calls, participated in 468,543 dispatched events, performed 1,453 Homeland Security special investigations, and had an average response time to emergency calls of 6.4 minutes from the time the call was dispatched. LVMPD has nine area commands, one airbase, and three detention centers all maintained by 5,533 personnel that were employed the day of the event.

LVMPD's Homeland Security Division addresses terrorism and multi-hazard events at the local law enforcement level. The division is comprised of the Organized Crime Bureau, the Emergency Operations Bureau, the Southern Nevada Counter Terrorism Center (SNCTC), K9, Air Support, the Special Weapons and Tactics (SWAT) Bureau, and the LVMPD All-Hazard Regional Multi-agency Operations and Response (ARMOR) Section, which handles Chemical, Biological, Radiological, and Nuclear (CBRN) response. SNCTC's Emergency Management Section provides preparedness planning and response actions, including operational support during incidents.

Housed at LVMPD's headquarters, SNCTC is a 24/7 all-crimes and all-hazards fusion center that is comprised of staff from 27 different partner agencies. SNCTC's Counter Terrorism Section (CTS) is responsible for mission areas that support the prevention of terrorism and mass casualty attacks.

Preparedness Investments

The MACTAC program is a prime example of the community's commitment to integrated preparedness and training across jurisdictions and disciplines. Formed in 2009 in response to the attacks that occurred in Mumbai, India, the program was put in place to provide a regional, coordinated response to prevent over-convergence. The MACTAC regional concept allows a multi-discipline (e.g., police, fire, emergency medical services (EMS)) and a multi-agency (e.g., valley-wide first responders) coordinated response. The LVMPD MACTAC Section facilitates training to all Las Vegas Valley first responders, including critical infrastructure operators and community education personnel.

Multi-Assault Counter-Terrorism Action Capabilities (MACTAC)

Developed in response to the 2009 coordinated attacks in Mumbai India, MACTAC is a counterterrorism response strategy that employs advanced tactics for first responders to respond to and mitigate a high-threat situation across multiple locations.

The LVMPD Emergency Management Section and the Clark County Office of Emergency Management strive to achieve and maintain community resilience through various activities, including ongoing training and exercises to prepare for, respond to, and mitigate possible critical incidents in the community. These training and exercises also encourage collaboration among community stakeholders. Annual seminar and tabletop exercises are conducted in conjunction with the LVMPD Events Planning Section for large-scale events in the Las Vegas Valley, including NASCAR, Electric Daisy Carnival, Life is Beautiful, Rock 'n' Roll Marathon, and New Year's Eve. The LVMPD Emergency Management Section also conducts an annual functional communications exercise with community partners' mobile command vehicles, dispatch centers, and emergency operations centers. This exercise ensures efficient use of interoperable radio channels and alternate communication methods on a day-to-day basis and during a critical incident. Additional exercises are conducted on an as-needed basis, which is determined by the current threat environment and requirements of the community.

A whole community approach has been taken to improve operational coordination across agencies. Enhancing this coordination is accomplished by bringing together public and private sector partners at federal, state, and local levels. These stakeholders include law enforcement, fire, the military, federal agencies, tribal entities, EMS providers, emergency management agencies, and private sector partners. Integrating these agencies during the preparedness phase allows for a unified approach to incident response.

To prepare their community for a complex coordinated attack (CCA), CCFD and LVMPD have made the preparedness investments included in **Table 1.**

Table 1: Clark County Preparedness Investments

Year	Action
2005	LVMPD created the ARMOR Section, which is a collaborative effort integrating multiple law enforcement agencies of Southern Nevada in the detection, response, mitigation, and investigation of CBRN incidents.
2006-Present	LVMPD created SNCTC. This center has an all-crimes, all-hazards approach and is operational with a 24/7 watch station that implements the National Suspicious Activity Reporting Initiative.
2007-Present	LVMPD established the Silver Shield program, which is a statewide critical infrastructure protection program for information.
2007-Present	LVMPD conducts critical infrastructure drills on an as-needed basis to include critical infrastructure and key resources, hotels, utilities, schools, and other entities. The purpose of these drills is to gauge response times and reinforce training and trends.
2009-Present	LVMPD has been conducting private sector training on active assailants, utilizing "Run, Hide, Fight" concepts from the U.S. Department of Homeland Security.
2009-Present	LVMPD conducts no-notice drills with every patrol squad on an annual basis. The purpose of this test is to gauge response time and readiness to respond to a MACTAC-style incident.
2009-Present	LVMPD established train the trainer MACTAC cadre training schools to create a pool of additional trainers that can instruct on active assailant response tactics. There are currently instructors in all local jurisdictions from first responding agencies.
2012	CCFD appointed a full-time captain to the SNCTC Fusion Center and MACTAC cadre.
2012	Clark County participated in the Joint Counterterrorism Awareness Workshop Series (JCTAWS) sponsored by the National Counterterrorism Center, the U.S. Department of Homeland Security, and the FBI. JCTAWS is a nationwide initiative designed to improve the ability of local jurisdictions to prepare for, protect against, and respond to complex terrorist attacks.
2013-Present	Quick response teams, composed of police, fire, and EMS, worked New Year's Eve events.
2013-2014	The Southern Nevada Fire Operations (SNFO) Hostile MCI working group was established in 2013. It consisted of 14 representatives from all Southern Nevada fire and law enforcement agencies. The working group met monthly to develop an integrated fire response policy and Incident Command System (ICS) training to augment law enforcement's existing response policies addressing active shooter incidents (ASIs) and CCAs.
2014	All Southern Nevada fire departments adopted the Hostile MCI response policy, which outlines the integration of fire with law enforcement on incidents with a hostile element and potential for large loss of life. Nearly 5,000 Southern Nevada fire and law enforcement personnel will utilize this policy in the event of a large-scale hostile incident and/or CCA.
2014	All LVMPD lieutenants attended a mandatory LVMPD tabletop exercise (TTX) where players encountered an MCI or ASI.
2014-2016	CCFD developed the Street Level ICS for LVMPD, NLVPD, NHP, HPD, and Las Vegas Marshals. Street Level ICS is a simplified approach to ICS and advocates for CCFD personnel as a support mechanism in training and on incidents. By the end of 2016, approximately 200 law enforcement officers from various departments attended the training.

2014-2016	CCFD and LVMPD jointly delivered emergency response training to Harrah's Las Vegas Hotel, Palms Casino Resort, SLS Las Vegas Hotel & Casino, Rio All-Suite Las Vegas Hotel & Casino, and MGM Grand Las Vegas Hotel & Casino. This training was presented to approximately 300 hotel and casino staff in security, risk management, and supervisory roles. The presentation covered CCAs, fire and law enforcement response, and Southern Nevada resource capabilities.
2014-2016	Fire and law enforcement companies and squads conducted training on coordinated communication and movements within a Rescue Task Force configuration. Approximately 500 personnel from all Southern Nevada fire and law enforcement agencies participated.
2014 (August)	Fire and law enforcement participated in a collaborative incident critique of an ASI that resulted in the deaths of two LVMPD officers. 40 personnel attended the incident critique.
2015-2017	CCFD began working with private sector fire protection engineers to address sabotaged life safety systems in a CCA in which attackers use fire as a weapon.
2015-2017	CCFD presented Hostile MCI response policy to LVMPD MACTAC cadre members. Approximately 200 personnel attended this presentation.
2015-2016	Subject-matter experts from CCFD, LVMPD, and the LVFR Communications Division assisted in the development of a report by the InterAgency Board titled "Active Shooter/Hostile Event Guide Book for Fire, Law Enforcement and EMS."
2016 (March-December)	CCFD assisted in conducting LVMPD's reality-based training. Law enforcement officers were instructed by fire personnel, with CCFD embedded into LVMPD's training division. 40 LVMPD lieutenants participated in the training.
2016 (March-December)	CCFD formed a cadre of 19 captains to assist in proctoring reality-based training scenarios as ICS subject-matter experts.
2016 (September)	CCFD conducted training on tactical elevator operations for LVMPD MACTAC training officers.
2016-2017	LVMPD MACTAC created specialized training for officers working in the Tourist Safety Division, to include active assailant response training for the tourism corridor.
2017	LVMPD MACTAC presented a class to CCFD on training, culture, and informational awareness related to emergency response for cross-training purposes.
2017 (January/February)	CCFD co-instructed training to LVMPD officers of all ranks on command and control.
2017 (March)	CCFD presented an informational class to the LVMPD Academy on CCFD's emergency response models, training, culture, available resources, and mission in assisting law enforcement. Participants also discussed the future of fire and law enforcement's working relationship. 55 academy recruits received this training, and the training is now part of the academy curriculum.
2017 (April)	CCFD ICS subject-matter experts assisted in proctoring LVMPD's MACTAC scenario-based training. They developed scenarios to improve the working relationship between CCFD and LVMPD. Approximately 240 CCFD personnel and 60 LVMPD lieutenants attended the 2017 training.
2017 (June)	CCFD presented an informational class to the LVMPD Academy on CCFD's emergency response models, training, culture, available resources, and mission in assisting law enforcement. Approximately 35 academy recruits received this training.

Route 91 Harvest Festival

The Route 91 Harvest Festival is one of approximately 21,300 events and conventions that take place in Las Vegas per year. In 2017, 6,646,200 people attended conventions in Las Vegas.[1] The Route 91 Harvest Festival is a country music festival organized annually since 2014 and staged at the Las Vegas Village concert venue in Las Vegas, Nevada. Route 91's approximately 17.5-acre venue plot is assembled directly across from the Mandalay Bay and the Luxor Hotel & Casino and is one of two open-air venues on the Las Vegas Strip. The fourth annual Route 91 concert series was held between September 29, 2017 and October 1, 2017. The venue was accommodating over 22,000 attendees when Stephen Paddock opened fire on the crowd on the night of October 1, 2017.

Figure 1: Mandalay Bay and Las Vegas Village

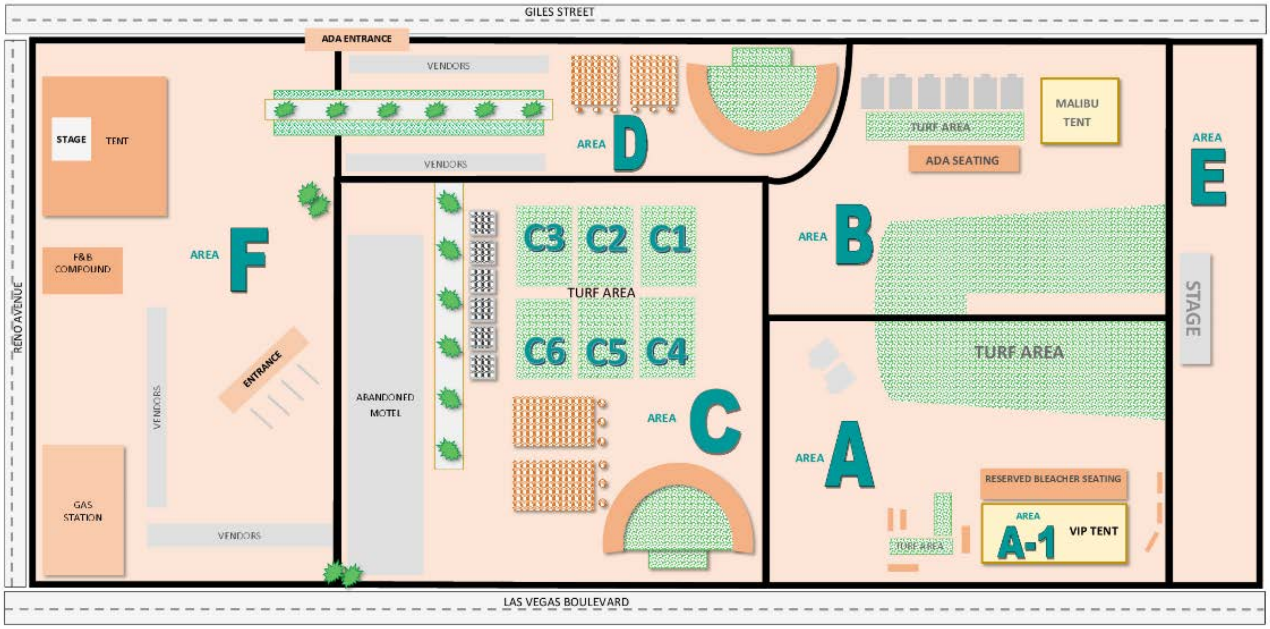

Figure 2: Route 91 Harvest Festival Site Map

[1] http://www.lvcva.com/stats-and-facts/visitor-statistics/

The Shooter: Stephen Paddock

Figure 3: View of the Las Vegas Village from room 32-135

The perpetrator of the 1 October 2017 shooting, Stephen Paddock, was born in Clinton, Iowa in 1953. His father, Benjamin Hoskins Paddock, was a convicted bank robber who escaped prison and was considered one of the FBI's most wanted in 1969. In 1977, Stephen Paddock received a degree in business administration from California State University, Northridge. He then worked as a government employee for the U.S. Postal Service and the Internal Revenue Service. Later, Paddock worked as an internal auditor for a company, which later became the defense contractor Lockheed Martin, and then in the real-estate business.

Paddock did not have any criminal record prior to the shooting, save receiving a minor traffic citation, and had no known military experience. In 2016, Paddock moved to Mesquite, Nevada located approximately 80 miles northeast of Las Vegas. Paddock lived in a home with his girlfriend for several years. Residents of the community claimed Paddock was a private individual who deliberately kept a low profile.

Paddock gambled regularly and frequented casinos in Las Vegas, including the Mandalay Bay, which he would visit as often as twice a month. Six days prior to the shooting, Paddock checked into the Mandalay Bay, staying in a room on the 32nd floor. Paddock, unbeknownst to his neighbors and family members, legally and discreetly amassed an arsenal of weaponry, 33 items of which he acquired in the year prior to the incident. Law enforcement would discover 23 firearms inside Paddock's Mandalay Bay corner suite, which overlooked the Route 91 Harvest Festival.

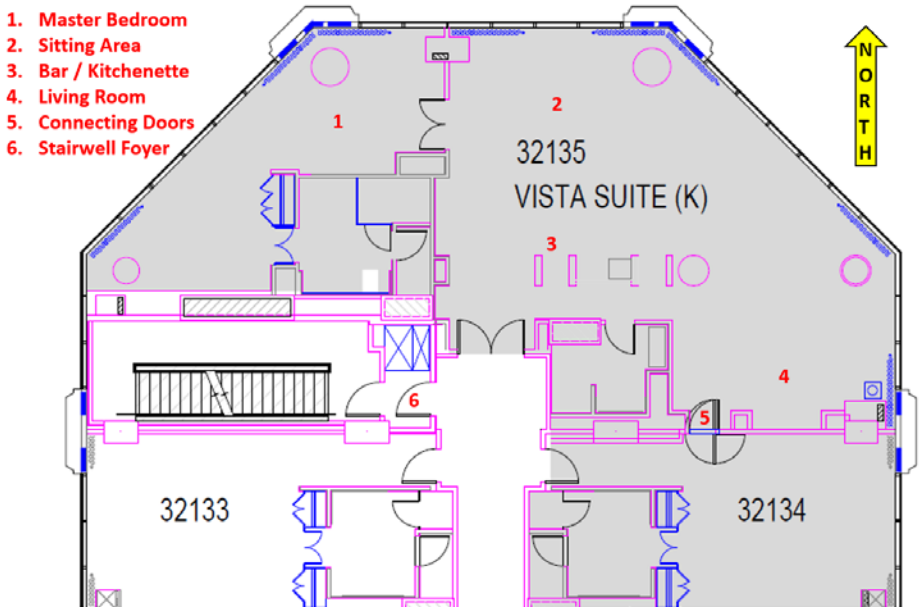

Figure 4: Mandalay Bay 32nd Floor

Timeline

The table below provides a timeline of key events leading up to the shooting and during the subsequent response effort. The timeline highlights events and actions that significantly impacted the response or that offer the context necessary for a high-level overview of the incident. See **Appendix B** for a comprehensive timeline.[2]

Table 2: Timeline of Key Events of Response

Time	Event
October 1, 2017	
9:40 PM	Jason Aldean begins his performance on the Main Stage at the Route 91 Harvest Festival.
10:05 PM	Paddock fires his first shots into the Las Vegas Village area from his room on the 32nd floor of Mandalay Bay.
10:06 PM	Dispatch receives the first radio traffic from an officer and phone call from a civilian referencing the incident.
10:11 PM	LVMPD officers arrive on the 31st floor along with armed Mandalay Bay security officers.
10:13 PM	CCFD Battalion 2 establishes Incident Command on Las Vegas Boulevard.
10:15 PM	Paddock fires his last shots into the Las Vegas Village area.
10:16 PM	Paddock self-terminates between 10:16 and 10:18 PM.
10:17 PM	First responding officers arrive on the 32nd floor of Mandalay Bay.
10:18 PM	Officers make contact with a wounded security guard and cover down on Paddock's hallway.
10:18 PM	CCFD T11 establishes a triage area and is assigned South Division at Russell and Las Vegas Boulevard South (LVBS). Patients begin arriving in the South via private vehicles.
10:22 PM	CCFD E11 establishes a triage area and is assigned North Division at Tropicana and Koval.
10:23 PM	Additional officers arrive on the 32nd floor of Mandalay Bay.
10:24 PM	CCFD E18 sets up a triage, treatment, and transport area at Tropicana and LVBS with E33 and R33.
10:26 PM	Additional officers arrive on the 32nd floor of Mandalay Bay.
10:26 PM	Unified Command is established at South Central Area Command.
10:35 PM	The Clark County Multi-Agency Coordination Center and the LVMPD Department Operations Center are established.
10:40 PM	Distraction Call #1: There is a person wearing fatigues entering an RV at Tropicana and Koval.
10:41 PM	A Strike Team ascends the stairs from the 30th floor and clears the 31st floor.
10:56 PM	The Strike Team reenters the stairwell from the 31st floor and walks up to the 32nd floor.
10:56 PM	CCFD C2 establishes a triage area and is assigned East Division. This triage area is located on the east side of the venue on Giles near gate 4A.
11:01 PM	The first CCFD Rescue Task Force is assigned to enter the Route 91 venue.
11:20 PM	The Strike Team conducts an explosive breach into room 32-135 and makes entry. The team reports that Paddock is down from an apparent self-inflicted gunshot wound.
October 2, 2017	
12:00 AM	Rescue Task Force teams assist with searches and sweeps of Mandalay Bay and the venue.
1:00 AM	A temporary Family Assistance Center opens at the Thomas & Mack Center.
7:32 AM	Command is terminated for CCFD.
1:00 PM	The Family Assistance Center opens at the Las Vegas Convention Center.

[2] For a full timeline of events beginning on September 25th when Paddock checked into the Mandalay Bay and ending when LVMPD officers made entry into his hotel room, see the LVMPD preliminary investigative report: https://www.lvmpd.com/en-us/Documents/1_October_FIT_Report_01-18-2018_Footnoted.pdf

Overview of Response

The response to the shooting at the Route 91 Harvest Festival required coordination among:

9 Law Enforcement Agencies

- LVMPD
- HPD
- NLVPD
- NHP
- CCSDPD
- UNLVPD
- BCPD
- ATF
- FBI

4 Fire Departments

- CCFD
- HFD
- NLVFD
- LVFR

3 Private Ambulance Companies

- Community Ambulance
- AMR
- MedicWest Ambulance

Fire Department Personnel

- 15 engine companies
- 3 truck companies
- 7 battalion chiefs
- 1 MCI unit
- 1 air resource / rehab unit
- 161 valley-wide fire department personnel
- 90 CCFD personnel
- 2 EMS supervisors
- 26 rescues / 1 squad

FAO Communications

- 4 dispatchers at onset of incident
- 10 communications specialists
  - 1 senior communications specialist
- 8 radio channels
- 786 ingoing and outgoing calls placed
- 60-70 incident-related calls holding at any given time

EMS Response

- More than 800 victims
  - More than 400 gunshot wound victims
- 3 private ambulance companies
  - Approximately 130 private ambulances / response vehicles
  - Approximately 250 patients transported
- 4 CCFD triage areas
  - Hundreds treated

Law Enforcement Personnel

- 51 personnel worked special events overtime
  - 1 lieutenant, 5 sergeants, 44 officers, 1 civilian
- 9 responding agencies
- 4 SWAT teams
- 50 strike teams
- 2 air units
- LVMPD ARMOR team
- Several hundred responding officers
- 1 bearcat and 1 drone deployed
- 2 uniformed officers and 4 LVMPD vehicles struck by gunfire

Law Enforcement Communications

- 11 dispatchers at the onset
  - 7 additional dispatchers used for backup channels, patrol response, and other calls for service
- 18 communications specialists at the onset
  - 27 additional communications specialists responded within the first hour
- 1,502 related calls answered in the first 2 hours
- 50 calls holding within the first 2 minutes

Observations and Recommendations

Pre-Incident Special Events Planning

Core Capability: Planning

Observation 1

The LVMPD Special Events section did not assign a dedicated dispatcher to monitor the Route 91 Harvest Festival special events channel, contributing to delayed, disorganized communications.

LVMPD Special Events determined that the Route 91 Harvest Festival would not require a dedicated dispatcher. Historically, there has never been a dispatcher assigned to special events with less than 25,000 people in attendance. However, LVMPD Communications and LVMPD Special Events do work closely together. When Special Events determines that an event requires a dedicated dispatcher, Communications is made aware and assigns one accordingly. The dispatcher assignment is included in the associated Incident Action Plan (IAP). LVMPD Communications dedicates five consoles on their main dispatch floor to the support of expanded radio operations for special events and critical incidents. However, all consoles on the floor can dispatch should the need arise to expand past the primary five.

Recommendations:

Law Enforcement

- Develop a threshold for assigning a dispatcher to a special events channel based on anticipated crowd size and/or number of officers assigned to the event. The dispatcher should be included in staffing (reimbursable overtime) for these types of events as a required resource.
- Continue to circulate a monthly special events calendar across all local emergency response agencies for events occurring within each jurisdiction.

Observation 2

Prior to the incident, command was not unified at the Route 91 Harvest Festival. LVMPD and Community Ambulance were both operating in the venue as planned; however, CCFD was not integrated into the special event plans or operations.

The Route 91 Harvest Festival did not integrate CCFD into the on-scene festival command post for the special event, as there is no ordinance or requirement that mandates a venue to include fire personnel in event plans or operations. CCFD was not involved in the planning process for the IAP, and event promoters did not staff the event with CCFD personnel. Without fire presence at the event, command and control were fractured, independent, and only involved LVMPD and Community Ambulance. For a special event of this scale, a unified special events command post should be established among all agencies with one IAP and a clear plan for emergency operations.

Recommendations:

Fire Department

- Encourage partnerships with special event promoters to better coordinate pre-event planning.

Fire Department and Law Enforcement

- Encourage venue promoters and operators to hire not only law enforcement, but fire departments as well, so that they can be on hand and included in a unified command post.

- Develop plans, policies, and procedures for integrating CCFD, LVMPD, and private ambulance companies into a unified command structure during special events with a single IAP.
- Disseminate a thorough and integrated special event IAP and map to all participating and responding agencies prior to the event, even if they are not contracted by the event promoters themselves.

Observation 3

The Fire Alarm Office and fire department line personnel were not aware that the festival was occurring.

LVMPD Communications was aware of the Route 91 Harvest Festival; however, the FAO was not. Dispatchers and first responders should be made aware of large or high-profile events occurring in their jurisdiction to enhance their agency's readiness posture for a potential incident. This information gap was particularly impactful for CCFD, which had no prior knowledge of or planning for the event at a suppression level. Only the captain at Station 11 was aware of the event, as he took the initiative to reach out to LVMPD Special Events for information regarding the festival. The captain was then briefed on the active shooter plan and provided with a map of the festival by LVMPD Special Events lieutenants. During the Station 11 shift change, the captain briefed the incoming captain, gave him the map, and cautioned the need for awareness due to the sheer number of individuals that would be at that location that evening.

Once on scene after the onset of the incident, CCFD had to quickly set up their command structure based solely on what they faced upon arrival. Thousands of concertgoers fleeing the area and no foreknowledge that over 60 fellow responders were inside the venue affected CCFD's incident response strategy. The first engine on scene, Engine 11, notified the FAO of the incident.

Recommendations:

Fire Department

- Continue to enhance communication of planned special events throughout the fire department to include both suppression and fire prevention.

Fire Department and Law Enforcement

- Continue to circulate a monthly special events calendar across all local emergency response agencies for events occurring within each jurisdiction.
- Conduct training that tests flexibility and adaptability upon arrival on scene and encourage players to train in their most likely role.

Observation 4

The tent size and pre-staged medical supplies for the festival's medical tent were insufficient for a mass casualty incident of this scale. Personnel were quickly overwhelmed, as trauma equipment was exhausted within minutes of treating initial patients. Community Ambulance, overtime (OT) officers, and multiple off-duty first responders assisted in making improvised tourniquets, treating patients, and loading them into ambulances and private vehicles.

Although the size of the medical tent may have been sufficient for the festival itself (roughly seven cots), it was not designed to handle an MCI. While there were many trained personnel at the medical tent, a lack of equipment hindered treatment efforts. To compensate, OT officers gave up their personal tourniquets and requested additional medical supplies to assist victims. Civilians also used their own belts and shirts as makeshift tourniquets.

Officers and special event medical personnel could have distributed simple supplies like pressure bandages and throw kits to victims if those supplies had been available. Officers agreed that it would have been useful for them to have access to more robust medical kits or supplies to carry on them, since they were unable to retrieve and use the ones in their cars. Acquiring medical supplies proved to be a challenge for responding officers and special events medical personnel. Ambulances that arrived on the scene were overrun due to a desperate need for additional supplies. Responders had to improvise tourniquets, stretchers, and ways to move patients. After 1 October, LVMPD invested heavily in medical kits that are now deployed at special events.

Figure 6: MCI Throw Kit

Recommendations:

Law Enforcement

- Continue to provide supervisors and officers assigned to special events with robust MCI/medical kits, including sufficient numbers of tourniquets and pressure bandages to have on hand.
- Require special events promoters to provide a pre-determined amount of MCI equipment for all future special events.

Fire Department and Law Enforcement

- Require throw/first-aid kits to be pre-staged at all special events of a pre-determined size. Kits can be given to people on scene for treatment, creating a force multiplier of first responders.
- Consider providing Tactical Emergency Casualty Care (TECC) training for officers.

Tactical Emergency Casualty Care (TECC)

TECC is a set of trauma care guidelines for pre-hospital providers in civilian, tactical environments.

Emergency 9-1-1 Services and Notification

Core Capabilities: Operational Communications, Situational Assessment

Observation 5

The 9-1-1 calls coming into the LVMPD Communications Center were handled appropriately given the technology and staffing that was in place at the time. However, some 9-1-1 calls were disconnected or did not reach the network.

LVMPD Communications is capable of handling 96 simultaneous 9-1-1 calls. The department houses 184 administrative lines that support 3-1-1 and other dedicated administrative calls. These lines support both inbound non-emergency calls and all outbound calls, including 9-1-1 callbacks.

During the incident, any 9-1-1 calls that reached the 9-1-1 network were either answered or placed in the 9-1-1 queue. On the evening of 1 October, this queue process resulted in a constant flow of calls coming into the LVMPD 9-1-1 network. All calls that reached the network were logged; however, LVMPD could not determine the number of 9-1-1 calls that exceeded the capacity of the cellular carrier network and therefore were not forwarded to the LVMPD 9-1-1 network. Tracking all 9-1-1 calls is crucial for investigative and accountability purposes.

Recommendations:

Law Enforcement

- Continue to track and log all calls to the best of the dispatching center's ability.

Observation 6

The LVMPD Communications Bureau does not have a policy to guide dispatchers during a mass casualty incident. Nonetheless, dispatchers made real-time decisions to support communications operations during the incident response.

LVMPD Communications has a policy for handling active assailant events but does not have a policy for handling MCIs. All LVMPD call-taking personnel have reviewed two written training publications detailing the kinds of questions call takers should ask and the kind of information to provide the caller during an active assailant event. Both publications apply the "Run, Hide, Fight" methodology developed by the Department of Homeland Security. In addition, the documents provide guidance as to what actions not only dispatchers, but floor supervisors, should take during an active assailant event.

Despite the lack of a formal MCI policy, LVMPD dispatchers and call takers on 1 October acted as a cohesive team and were decisive in managing issues with the dispatch system. Dispatchers made a concerted effort to receive and record pertinent information from callers and get off the phone quickly to answer more incoming calls. Dispatchers benefitted from extra staff presence during a shift change, coincidentally overlapping with the incident.

LVMPD Communications dispatch supervisors took additional steps that were commended by officers at the scene, including activating MACTAC squads from South Central Area Command (SCAC) and Enterprise Area Command (EAC) and sending out the communicator to command staff.

Recommendations:

Law Enforcement

- Develop an internal policy to address radio communications procedures during a significant event, while acting in support of ICS.
- Reach out to agencies with similar experiences in responding to MCIs and request information regarding training that was developed because of the incident.
- Coordinate and conduct interagency, scenario-based training that tests or incorporates non-tactical elements, such as dispatch, and encourages players to train in their most likely role.
- Provide an internal mass casualty preparedness training to dispatchers.

Observation 7

The LVMPD Communications supervisors and managers on duty on the evening of the incident could have benefited from additional training and support to effectively manage an incident of this magnitude. Additionally, some Fire Alarm Office dispatchers mistakenly communicated with the Operations Section and branches directly instead of Incident Command.

Prior to the unprecedented events on 1 October, the LVMPD Communications Bureau conducted internal discussions on how to manage an incident of a magnitude similar to the mass violence on 1 October. These discussions were preliminary and had not reached a policy development phase at the time of the incident. Managers and supervisors within this bureau had previously participated in TTXs involving active assailants in the Las Vegas Strip corridor.

All LVMPD employees are required to complete mandatory ICS training (ICS-100, ICS-200, and ICS-700), all sergeants and ranks above are required to complete ICS-300, and all lieutenants and ranks above are required to complete ICS-400. However, practical applications of ICS and the National Incident Management System (NIMS) are limited to setting up a command post and establishing Incident Command. Although some level of readiness was obtained through prior training, there is a need for further planning, training, and preparedness efforts. On the fire department side, there were several instances in which FAO dispatchers communicated directly with the Operations Section and branches, causing confusion with command and control. To address this issue, the CCFD Incident Commander advised FAO dispatch of the communications plan and provided a brief ICS operational overview.

Recommendations:

Fire Department and Law Enforcement

- Create a one-page handout summarizing the fundamentals of ICS and NIMS, including roles and responsibilities during an incident, which dispatchers can keep at their consoles for reference.
- Develop policies within the LVMPD Communications Bureau and the FAO that incorporate best practices from ICS and NIMS into internal communications operations during both major and regularly occurring incidents.

Observation 8

The Nevada Core Systems Network (NCORE) was established an hour into the incident, but this channel was not utilized by operations. The dispatch centers used this system for communication between the disparate centers.

Nevada Core Systems Network (NCORE)

NCORE is a network of radio channels across the state of Nevada, accessible by multiple agencies via all platforms. NCORE provides the state of Nevada vital public safety communications interoperability.

The NCORE channel was activated within an hour of the incident, as directed by LVMPD Communications Bureau leadership. In the past, NCORE networks were solely used for scheduled tests and multi-agency TTXs. At present, the LVMPD Radio Bureau tests NCORE daily. It is important for this system and its users to continue to be tested in both technical and operational capacities.

Although public safety agencies across the area achieved interoperability through other means, the NCORE channel could have been used to facilitate a collaborative emergency response effort. The network establishes effective mutual aid communications and coordination with other emergency communications centers.

Recommendations:

Regional

- Continue to use NCORE during MCIs and, more generally, special events.
- Conduct multi-jurisdictional joint training on NCORE, its practical usage, and its capabilities. This training should include hands-on practical drills, as well as TTXs.

Observation 9

The LVMPD Communications Bureau supervisors established a direct telephonic line of communication with the Fire Alarm Office and kept the line open for the immediate duration of the incident, enhancing coordination between the dispatch centers.

The FAO maintains a limited number of 9-1-1 trunks and administrative lines. For planned, large-scale events such as New Year's Eve and the Fourth of July, this limitation is taken into account, and an open line is maintained throughout the event. This protocol was applied on 1 October to maintain communication between the LVMPD Communications Bureau and the FAO during the incident. Establishing a direct line between LVMPD Communications and FAO dispatch centers ensured coordination across agencies and created a common operating picture for resource allocation. Co-locating these dispatch centers would also allow for this coordination, while eliminating concerns related to any technical issues and geographical separation. Installation of a dedicated ring-down line between dispatch centers could also mitigate communication issues.

Recommendations:

Fire Department and Law Enforcement

- Install a dedicated ring-down line between the FAO and the LVMPD Communications Bureau.
- Consider merging the FAO and LVMPD Communications dispatch centers into one main Emergency Communications Center to prevent the potential loss of critical information and provide face-to-face communications during critical incidents.

Initial Response to the Scene

Core Capabilities: Planning, Situational Assessment

Observation 10

The first CCFD unit on scene, Engine 11 (E11), did not establish command. However, the captain on E11 quickly evaluated the scene and immediately recognized which resources would be needed. E11 requested a first alarm medical response, which deploys three engines, two rescue units, two private ambulances, one fire truck, one emergency medical services supervisor, and one battalion chief to the incident. In addition to the assigned first alarm vehicles and personnel, E11 requested MCI33, a unit designed for mass casualty response.

While the first CCFD unit on scene successfully requested resources, the captain did not establish command or a staging area. These actions are expected of a first arriving company officer at a mass casualty incident. However, it is worth noting that at large, chaotic incidents, it is necessary to focus on immediate response needs as well. The battalion chief arrived shortly after the onset of the incident and officially established CCFD command and staging locations.

Figure 7: CCFD MCI33

Recommendations:

Fire Department

- Continue to train and exercise to further enhance ICS and MCI response.

- Conduct ICS training and TTXs to reinforce the standard practice that the first unit to an incident scene requiring multiple units establishes command and a staging area.

Observation 11

Self-dispatching of law enforcement officers, fire personnel, and other external agency personnel created staffing challenges and hampered the Incident Commanders' and dispatchers' ability to maintain personnel and unit accountability.

Self-deployment of public safety personnel is a common issue at all levels during the response to critical incidents, mass causality incidents, and other major disasters. In the initial stages of this incident, personnel converged on the scene and assumed response roles without first reporting to the staging area. This self-dispatching created a staffing challenge for the next operational shift, as the intention was for some of these personnel to relieve others the following morning. In total, several hundred off-duty police officers self-dispatched to the scene. One in-service LVFR unit also self-dispatched to the scene. Overall, this self-dispatching made it difficult for dispatchers and commanders on scene to maintain personnel accountability.

Recommendations:

Fire Department and Law Enforcement

- Recognize that off-duty personnel may respond and encourage them to respond to staging.
- Continue to teach and encourage crews and teams to remain disciplined when responding to emergency scenes.
- Establish a documentation process to pass current information and status of teams in the field more efficiently and effectively.

Fire Mutual Aid and Scene Management

Core Capabilities: Mass Search and Rescue Operations, Public Health, Healthcare, and Emergency Medical Services

Observation 12

Security in the medical tent became an issue due to crowd panic, exacerbated by intoxicated festival attendees wanting to assist. This led to multiple altercations inside the medical tent that hampered patient care and treatment.

There were multiple instances inside and around the medical tent of physical confrontations and altercations involving concertgoers. In one case, an off-duty first responder from an outside, non-local jurisdiction assaulted a medical provider in the tent because he disagreed with the medical provider's treatment decision. LVMPD personnel had to physically intervene and restrain the individual to de-escalate the situation.

Recommendation:

Law Enforcement

- Incorporate medical tent security protocols in special event IAPs.

Observation 13

Early in the incident response, some law enforcement personnel took on the role of EMS, conducting staging and making medical triage decisions. They performed well but lacked coordination with wider response efforts.

Early in the response, police officers on scene conducted rapid triage and loaded critical patients in their cruisers for transport to medical facilities. Private ambulances arrived at the triage area within the first 30 minutes of the response; however, some ambulances only transported one patient at a time when they could have taken multiple patients. A Convention Center Area Command (CCAC) sergeant also established a triage area himself, near the Hooters Casino Hotel. The sergeant used the administrative channel as a medical triage channel, unbeknownst to some police responders. This triage area was able to coordinate successfully with private ambulance companies; however, CCFD was not able to assist this triage area for over two hours because they were not aware that this location existed. Unified Command was also initially unaware of the triage location's existence or that patients were being processed there. When CCFD Engine 23 came across this location after midnight, they treated patients and called for ambulances.

Recommendations:

Law Enforcement

- Conduct training with officers on the proper chain of communication to request resources.
- Conduct training to ensure that officers are prepared to fill nontraditional roles should the need arise prior to the arrival of EMS.
- Consider providing MCI response training for officers.

Fire Department and Law Enforcement

- Develop plans to coordinate law enforcement efforts to provide medical response with other EMS response entities, including private ambulance companies.

Observation 14

Venue participants and local civilians volunteered their assistance to firefighters, police officers, and ambulance personnel. While these volunteers caused some confusion, they also assisted greatly in transporting victims out of the area and provided some basic first aid to victims.

Civilians were heavily involved in providing first aid to victims—making makeshift tourniquets out of belts and transporting patients to local hospitals in privately owned vehicles. They provided festival attendees with food, blankets, and offers to house people. Ride-sharing service drivers also suspended fees and offered rides to individuals attempting to get out of the area.

In a *New York Times* article, a surgeon from nearby Henderson, Nevada is quoted as saying, "The city functioned as a trauma center…What really makes this unique is the volume."[3]

Figure 8: Bystanders carried a wounded woman at the Tropicana Hotel

[3] https://www.nytimes.com/2017/10/15/us/las-vegas-shooting-civilian-first-aid.html
Figure 8 sourced from Chase Stevens/Las Vegas Review-Journal, via Associated Press

The high numbers of wounded as well as the volume of fleeing concertgoers created challenges for first responders trying to quickly access the scene. Without emergency medical care, the first aid provided by concertgoers served an essential life-saving function for some victims.

Good Samaritan stories of civilians—as well as many off-duty first responders and military—aiding, protecting, and providing care to the wounded were a major success observed in this response. These efforts were essential to saving many lives before emergency medical crews were able to access the site. A medical director for emergency preparedness at a trauma center that received patients from the Boston Marathon bombing in 2013 explained, "Time is the most critical factor…People would talk about the golden hour. Really, what we're talking about is the golden minutes."[3] Transportation and basic first-aid "Stop the Bleed" care provided by local citizens and other concertgoers enabled many wounded to later access the life-saving care they needed (**Figure 9**).[4]

Some CCAC officers coordinated with civilian volunteers to transport people away from the scene. Additionally, bus drivers voluntarily picked up patients from the Thomas & Mack Center, where the temporary Family Assistance Center (FAC) was established, and transported them to hospitals and hotels.

Figure 9: Concertgoers helped a wounded person

Recommendations:

Fire Department and Law Enforcement

- Ensure that response agencies have mechanisms in place to coordinate with civilian volunteers and organize donations, efficiently incorporating these resources into operations.
- Support community "Stop the Bleed" first-aid training and education programs.

Observation 15

Communication difficulties with key medical providers complicated response efforts.

Initial communication was being relayed from LVMPD Communications, the FAO, and private ambulance dispatch centers back and forth to each other. Multiple local hospitals did not answer the radio when FAO dispatch initially attempted to notify them of the MCI at the Route 91 Harvest Festival. Additionally, responders had limited knowledge of the actions of private medical companies during the response and did not communicate with them. These communications gaps occurred because LVMPD Communications, the FAO, and private ambulance dispatch centers were overwhelmed with incoming calls and radio traffic.

Recommendations:

Regional

- Develop policies and procedures for communications among dispatch, local hospitals, and private medical companies responding to an MCI to ensure interoperability of communications.
- Conduct joint training and exercises with all medical providers, including fire departments, private ambulance companies, hospitals, FAO dispatchers, and FAO call takers, to ensure awareness of when and how to use these communications mechanisms.
- Conduct integrated ICS training with all responding agencies.

[4] Figure 9 sourced from David Becker/Getty Images

Observation 16

Some fire department responders were confused by the use of cardinal directions, rather than local landmarks, to define divisions under branches.

Incident Command used cardinal directions to designate divisions under branches, rather than landmarks or street names. In some cases, it created confusion regarding radio traffic and proper chain-of-command reporting. It would have been beneficial to designate specific names to the area of operation to ensure that all personnel understood the location of each division (e.g., Tropicana, Hooters). While switching over from divisions to branches was a good decision due to the size, geography, and complexity of the incident, it caused initial confusion. Ensuring that responders had familiarity with the layout, location, and size of the festival could have mitigated these issues. Responders should also be aware of NIMS and ICS terminology associated with naming branches and divisions.

Recommendation:

Fire Department

- Conduct further departmental training to encourage Incident Commander use of terminology that clearly defines areas of operation (i.e., landmarks) as situationally dictated. This protocol is especially critical when managing incidents of this geographic size, magnitude, and complexity.

Observation 17

The fire department EMS branch director role was assigned twice. However, both branch directors were operationally ineffective, as EMS was being handled in the North and South branches. The branch directors failed to notify Incident Command or Operations of their operational ineffectiveness.

The EMS branch director was assigned twice during the incident, once by command to a CCFD member and then later by the Operations Section to an NLVFD chief. Command gave this assignment via cellphone, whereas Operations gave it over the tactical (TAC) radio channel. The EMS branch director role should have been assigned by Operations. The first EMS branch director did not communicate to Incident Command or Operations that the branch was operationally ineffective. The first EMS branch director took on the role of bed allocation during the incident and would have been more useful at the command post.

The second EMS branch director began setting up his branch when he discovered the first EMS branch director on the same radio channel. Realizing there was no need for his position, the second EMS branch director advised Operations and was used in another capacity going forward.

Recommendations:

Fire Department

- Develop protocols for pre-designated C-Staff assignments to be used on all MCI responses.
- Review plans and procedures related to the location of and need for various assignments based on the incident.
- Continue to conduct training on large incidents with the Operations Section in place to ensure that branch directors know how and when to advise command that they are ineffective.

Observation 18

The fire department's North and South staging areas were not managed effectively and had difficulty coordinating with one another.

Two staging areas—North and South—were defined. This decision proved beneficial because it allowed resources to be staged near where crews were treating patients and on both sides of the Mandalay Bay. However, the staging manager was unable to exhibit effective command and control of fire department and private ambulance resources in both staging areas. Without situational awareness and command and control, the staging manager did not recognize that the North staging area lacked a permanent staging officer. As such, resources between North and South staging areas were not balanced.

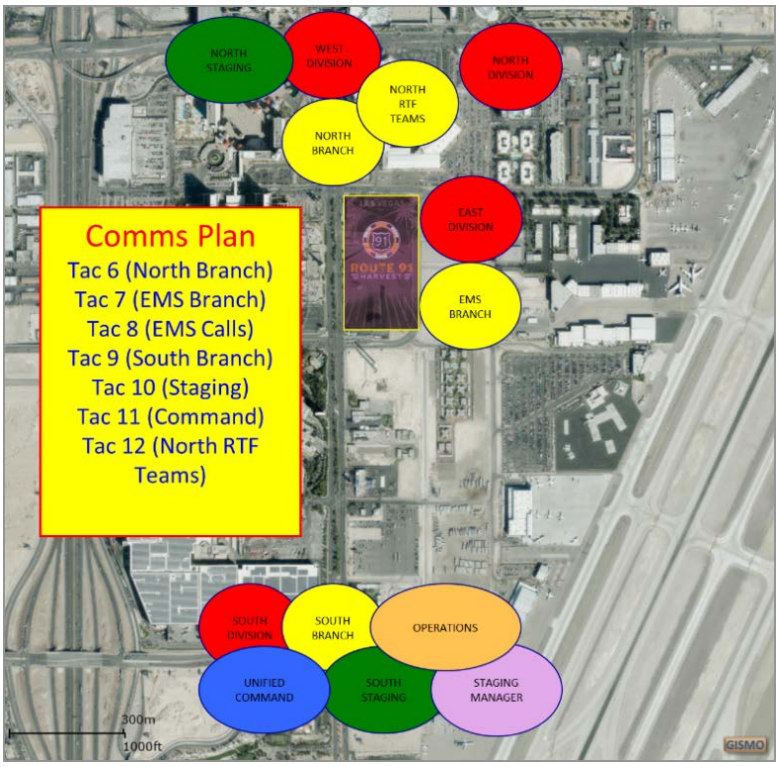

Figure 10: Fire Command Layout

Additionally, some fire department units encountered patients upon arrival and stopped to render aid, while other units responded directly to the scene instead of reporting to the staging area first. While the majority of responding units did so appropriately, some personnel also redeployed to the scene from transporting patients to the hospital without receiving assignments from the staging area. Proper and timely patient care is critical for any incident, but some fire department units that assisted patients did not communicate to command or staging that they were occupied and unable to report to the staging area to receive an assignment.

Recommendations:

Fire Department

- Encourage staging managers to bolster staff with an aide and/or crew to assist with liaison, scribe, radio traffic, and tracking duties.
- Conduct multidisciplinary staging and MCI training for large-scale incidents.
- Provide refresher training for fire department personnel on the role and responsibilities of the staging manager (e.g., unit tracking, tactical worksheet usage).
- Provide clarification on the communications plan and policy for units leaving the scene to transport patients to the hospital and subsequently returning to the scene.

Observation 19

The large number of ambulances provided by multiple private transport companies facilitated transport of victims but also made command and control difficult.

Three private ambulance companies supported the response with approximately 130 ambulances and vehicles. This influx of vehicles led to a lack of ambulance tracking and difficulties redeploying resources. Without central coordination, determining which hospital to transport patients also became inefficient.

Furthermore, because the initial ambulance triage area on the east side of the venue was so close to the scene, it was difficult to keep the triage area clear. As ambulances arrived, responders, concertgoers, and well-intentioned bystanders removed medical supplies from them to support on-scene response; however, the ambulances in turn were being rendered less effective without these supplies.

Recommendations:

Fire Department

- Develop joint policies and procedures and conduct TTXs that reinforce the need for integrated coordination of both public and private ambulance assets during an MCI.
- Require that all private ambulance companies responding to critical incidents are a part of the Incident Command structure.
- Incorporate private ambulance companies in all future MCI and ICS training and exercises.
- Include supervisors or a liaison from private ambulance companies at the command post.
- Ensure that all private assets report to a staging area that is coordinated with Unified Command.

Observation 20

There was poor accountability regarding the number of patients and the area hospitals to which they were transported.

Many private ambulances responded quickly to the scene. Of the approximately 250 patients transported via ambulance, approximately 200 were transported in the first hour. Patient documentation was a low priority relative to life safety and the imperative to transport victims rapidly, so many ambulances simply transported multiple victims without performing the usual documentation process. While foregoing patient documentation on scene allows for an expedited transport process, it complicates patient accountability at the hospital and possibly hinders family reunification. Due to the size, scope, and complexity of this incident, it is an acceptable deficiency. Delaying patient transport and care to obtain patient information is not necessarily in the best interest of care and survivability, although in smaller incidents, ambulance services should assign personnel to track patients.

Recommendation:

Fire Department

- Coordinate and jointly conduct training and TTXs with hospitals, private ambulance companies, and law enforcement to improve patient tracking during a large-scale incident.
- Create a tracking system that is routinely sent back to Incident Command and the LVMPD Department Operations Center (DOC) for timely consumption of actionable information.
- Establish a consistent policy with all partner agencies, both public and private, for sharing Health Insurance Portability and Accountability Act (HIPAA) information.

Tactical Operational Response

Core Capabilities: On-scene Security, Protection, and Law Enforcement, Situational Assessment

Observation 21

LVMPD is one of the few agencies in the country that has a dedicated MACTAC training cadre that educates first responding agencies regionally and engages in community education. Many responders cited this MACTAC training as helping contribute to a more effective response to the shooting.

MACTAC protocols are utilized to prevent over-convergence into critical incidents, such as an MCI, by using designated "in-the-box" squads. The LVMPD MACTAC Section conducts regular community active assailant preparedness training for critical infrastructure, private organizations, and both private and public schools. The training consists of law enforcement response, "Run, Hide, Fight," and drills. Because of the regional MACTAC program, personnel across multiple agencies and jurisdictions were able to respond to staging and be placed on strike teams. These teams used their training to execute an efficient, coordinated response. For this reason, officers regarded their prior training as a critical asset and suggested that it be made more readily available for all officers. While some LVMPD officers received MACTAC training as early as a year ago, others had not completed a formal training in years or at all. Additionally, officers emphasized the value of CCFD and LVMPD MACTAC's no-notice Rescue Task Force (RTF) drill, active shooter drills, reality-based training (RBT), and high-rise assault training in preparing them for an incident of this type and scale. Officers also expressed the need for formal tactical commander's training, in addition to training provided by the National Tactical Officers Association. While training is frequently offered by LVMPD, officers are sometimes unable to attend due to other duties taking precedence. Additionally, officers emphasized the need to expand training beyond simply neutralizing the threat to assisting with casualties and integrated response.

"In-the-Box" Squads and "Stay-at-Home" Squads

"In-the-box" squads are pre-designated patrol squads used for response to a major violent incident. They are pre-identified and scheduled 24 hours per day, 7 days a week.

"Stay-at-home" squads are assigned to Area Command priority, Area Command critical infrastructure protection, and multiple incident/attack response incidents.

Recommendation:

Law Enforcement

- Review potential policy changes to ensure both law enforcement and fire department personnel participate in mandatory joint Active Assailant, MACTAC, and ICS training on an annual basis.

Observation 22

Operational readiness was hindered for the overtime officers assigned to the interior of the event, as their equipment was in vehicles parked at a church approximately 250-350 yards away.

OT officers often receive assignments for special events that are not near their vehicles. LVMPD officers are permitted to purchase their own rifles for duty and are required to qualify on the range before using them. However, officers were not permitted to carry their rifles during the event and stored them, along with other critical gear and personal protective equipment (PPE), in their vehicles. When the shooting began, many officers were positioned far away from their vehicles. While officers suggested carrying rifles to prevent this lag in response, they noted some challenges related to public perception.

Recommendations:

Law Enforcement

- Ensure that, when possible, OT officers' vehicles are in close proximity to their assignments during special events.
- Consider allowing officers to carry rifles and other needed gear depending on the event, as well as wear tactical vests, to ensure equipment and situational readiness.

Observation 23

Law enforcement officers at the scene did not have access to or authorization to use equipment that could have been helpful in the response, including tactical vehicles and shields.

Tactical vehicles were unavailable on 1 October and thus were not deployed at the scene. Officers also did not have access to shields, as they were located inside of the tactical vehicles. Tactical vehicles have since been deployed in the field for special events, and these vehicles now include additional medical bags and gear.

Recommendations:

Law Enforcement

- Provide for the full capability to use tactical vehicles on a day-to-day basis.

Observation 24

LVMPD policy requires overtime officers to wear reflective vests for special events; however, the vests made them easy targets for the shooter. As a result, these officers removed or covered up their reflective gear.

During special events, the reflective vests are used to clearly identify officers and their locations. While this policy is normally beneficial for both civilians and officers, officers should be instructed to immediately remove their reflective vests in an incident where using the vests will negatively impact their safety.

Recommendation:

Law Enforcement

- Consider revising LVMPD policy on OT officers wearing reflective vests when not conducting traffic control during special events.

Observation 25

Several active duty military and other off-duty public safety personnel augmented response efforts in critical ways. However, there were also some cases in which off-duty public safety personnel complicated the response by attempting to assist when they were unable to do so.

Some off-duty officers and personnel from outside jurisdictions and organizations assisted in response efforts. They were instructed to get people safely out of the venue, and they successfully assumed and executed these roles. This additional support was crucial, as officers at the scene did not have sufficient personnel to assist with crowd management.

However, there were also several instances in which off-duty public safety personnel and those with public safety experience attempted to take command and/or seize officers' weapons. While well intentioned, these individuals at times hindered the response.

Recommendation:

Fire Department and Law Enforcement

- Consider offering training on crowd mitigation for all public safety officials, as well as private security officers, to provide additional capacity in the event of an MCI.

Observation 26

There were multiple, conflicting reports on the shooter's location and profile, as well as false reports of active shooters in alternate locations. Because of historical training of key staff, the command post was anticipating false distraction calls[5] and acted accordingly.

In the first minutes of the incident, there was confusion over the shooter's location and profile. Public safety personnel reported over the radio that there were shots fired from multiple, disparate locations in the venue. Additionally, between 10:40 PM and 1:21 AM, the fire department received 16 distraction calls broadcast over multiple TAC radio channels by FAO dispatch and personnel on scene. Most of them came in between 11:00 PM and 12:00 AM. Reports referenced incidents at the Bellagio Hotel & Casino, the Planet Hollywood Las Vegas Resort & Casino, the Paris Las Vegas Hotel, Tropicana Las Vegas, the New York New York Hotel & Casino, Hooters, MGM Grand, Caesars Palace Las Vegas Hotel & Casino, and the Aria. These distraction calls, commonly reported after mass shootings, ranged from shots fired/heard, active shooter(s), fires, possible explosive devices, and hostages. The calls caused a heightened sense of alert, and in some cases, the fear of a multi-pronged, coordinated attack near the initial shooting. While none of these calls proved to be further threats, they did create issues at the command and ground levels.

Unified Incident Commanders at CCFD and LVMPD acted appropriately by vetting these distraction calls in real time before committing resources. From prior experience, Incident Command was prepared for the possibility that there may be additional, inaccurate calls of shooters in other locations. The Incident Commander on scene was very experienced with large-scale, critical incidents. He had served as the SWAT commander for numerous SWAT operations, the most dynamic that the department handles during a standard patrol response. Such operations include hostage rescues, barricades, and other dynamic situations which standard patrol operations are not equipped to handle. The Incident Commander on scene previously served as Incident Commander during an incident in which two LVMPD officers were murdered. He was also the first Incident Commander at the scene and the LVMPD representative in Unified Command for the largest fire the Las Vegas Valley has experienced in years. Additionally, he worked a false active shooter call that occurred at the Cromwell Hotel & Casino the previous month. During that incident, several false reports of additional shooters were broadcasted.

The MACTAC supervisor assisting at the command post on 1 October had participated in debriefs related to this false active shooter call. Additionally, the MACTAC Section had reviewed AARs from past shootings, such as the incident at the Washington Navy Yard in 2013, and was aware of the possibility for distraction calls. In anticipation of these calls, the command post made sure to vet all information coming in, as well as pre-deploy strike teams to critical infrastructure to provide site security.

[5] For the purpose of this document, a "Distraction Call" will be defined as: any false or unfounded incident or situation that was vocalized over the radio and required vetting or action to be taken by Unified Command. These echo calls divert resources away from the actual incident and distract first responders from their primary duties. As a result of these echo calls, Unified Command as well as personnel at the incident considered the possibility of a complex coordinated attack.

Recommendations:

Law Enforcement

- Continue to deploy teams to harden critical infrastructure in preparation for a multi-assault attack or distraction calls.
- Conduct further training and exercises to reinforce the potential and probability of distraction calls during critical incidents.

Observation 27

Interstate 15, the main freeway adjacent to the Las Vegas Boulevard, was shut down to all drivers. This decision both helped and hindered the response.

Nevada Highway Patrol shut down all access from Interstate 15 to the Las Vegas Boulevard both northbound and southbound. This decision allowed for quick and efficient medical transports to the hospitals. However, shutting down the freeway also made it difficult for some responders in personal vehicles without emergency equipment to get to the command post located on Las Vegas Boulevard South.

Recommendations:

Law Enforcement

- Consider using alternate routes when responding to an incident of this magnitude.
- Continue to make medical transports a priority during MCIs.

Observation 28

LVMPD captains were immediately deployed to the area hospitals that were receiving the greatest number of patients to support on-scene security, information flow, and target hardening.

LVMPD captains reported to hospitals and immediately began blocking off streets. They made the perimeter as large as possible and ensured that the ingress and egress were clear to receive an influx of patients. About 15 minutes after the perimeters were set, large groups of patients started arriving. Teams started gathering information from victims at the hospitals and identifying who was at the venue. All information was fed back to the command post for intelligence and awareness. Partner agencies also assisted with the target hardening and were greatly needed for this effort. These captains remained in constant contact with the LVMPD DOC and Incident Command.

The influx of family and friends of patients caused a great deal of congestion. This issue should be addressed in the future to allow critical patents to be seen and cut back on unnecessary visitors.

Recommendations:

Law Enforcement

- Continue maintaining relationships with area hospitals to ensure a seamless response with law enforcement.

Fire Department and Law Enforcement

- Assist with triage and temporary intake sites at local hospitals.
- Continue to plan, train, and exercise on target hardening of critical infrastructure to counter a complex coordinated terrorist attack.

- Develop policies and procedures for on-duty and recall fire personnel to support hospitals with patient triage and moving during times of extraordinarily high patient volume.

Observation 29

Fire department Rescue Task Force team members operated outside of the Southern Nevada Fire Operations Hostile MCI policy to address supervisor shortages.

Crews were assigned with the designation of Force Protection (Force Pro) units during this incident. The Incident Commander used the Force Pro title as a matter of habit instead of RTF, as initial training conducted with CCFD personnel used that terminology. This terminology was changed to RTF and adopted in the 2016 Hostile MCI policy. This policy was designed and written with an enclosed, defined "box" space in mind, not an open venue like the Route 91 Harvest Festival. Additionally, due to a shortage of captains, the West Division supervisor appointed two firefighters to be supervisors for RTF teams. Although the policy requires that the RTF team supervisor be a captain, the division supervisor recognized the ability of these individuals and acted outside of policy to fill the personnel gap. Hostile MCI policy should be broadened to allow for this kind of flexibility on scene during an incident.

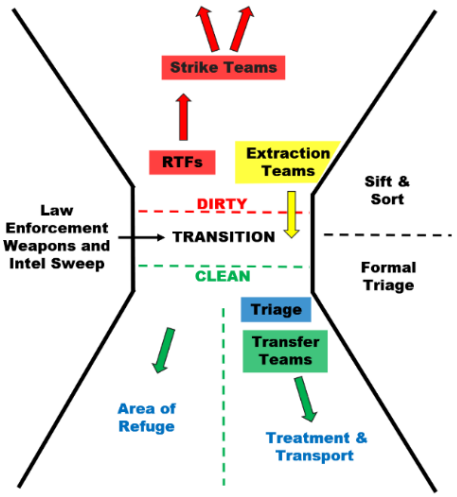

Figure 11: Hostile MCI Policy Diagram

Recommendation:

Fire Department

- Modify Hostile MCI policy to allow more flexibility for Incident Commanders to use the best assets available to them during a critical incident.

Observation 30

Fire department span of control issues hindered information sharing, which in turn resulted in challenges for Rescue Task Force teams in locating and treating patients.

RTF teams are deployed when a warm zone with victims has been identified and there is a need to deploy fire personnel into the area to locate victims and provide a minimum level of care. According to Hostile MCI policy, RTF teams are comprised of a minimum of three personnel, including a captain, firefighter paramedic, and one additional member, as well as a minimum of two, armed law enforcement officers. The South Branch director did a good job managing seven RTF teams, giving clear direction and tracking accountability. However, the North Branch director struggled to manage 12 RTF teams, which resulted in some RTF teams calling dispatch to gather information while dedicated to a tactical assignment.

Recommendation:

Fire Department

- Provide additional staff for branch directors to help coordinate where RTF teams are required to go during a large-scale incident.

Observation 31

In an attempt to release outside jurisdictional fire department resources, the Operations Chief advised South Branch to release HFD units to clear and return to service. Some of these crews were actively conducting floor sweeps at Mandalay Bay when this order was issued. This decision left the remaining law enforcement component of the Rescue Task Force teams understaffed with several hundred more rooms to search.

From a law enforcement perspective, the decision to release HFD units caused issues as RTF teams were left without a fire department element. This shortfall stemmed from lack of communication. The Operations Chief should ensure that both fire department and law enforcement needs are met when making decisions to demobilize personnel.

Recommendation:

Fire Department

- Build a demobilization plan with a consideration of current and forecasted operational needs. This plan must be approved by the Incident Commander prior to units being released.

Observation 32

There were communication and coordination shortfalls among officers related to clearing the venue due to the lack of a forward command.

Following the shooting, a law enforcement branch director was assigned by the Incident Commander to the Route 91 venue to assist with coordination and stabilization of the scene. Due to the size and complexity of the incident, there was a need to establish a forward command post to facilitate tracking and deployment of responding resources. An additional law enforcement lieutenant was assigned to coordinate locking down the perimeter of the event, tracking resources, and relieving officers. The number of OT officers and their accountability was established hours after the incident once this additional supervisor was assigned to the Route 91 venue.

Civilians continued to emerge from hiding places as late as four hours into the response, even as the Homicide Crimes Bureau was conducting their investigation on the scene. Given the size and layout of the venue and the large number of attendees, clearing the venue proved to be challenging for officers. Additionally, there was no interoperability of radio communications among agencies at the tactical level.

Recommendations:

Law Enforcement

- Consider a physical location within the inner perimeter for assets to check in during a large-scale incident.
- Emphasize the importance of, and conduct training on, secondary searches following incidents of mass violence.
- Use a bullhorn or other sound amplification device to make announcements that it is safe for civilians to come out of hiding and approach law enforcement officers.
- Ensure that officers are clearly identifiable to civilians during the venue clearing process.
- Create one computer-aided dispatch (CAD) event number for LVMPD Communications during MCIs to list all the callers who may be injured or sheltered in place, including their location and contact information.

Observation 33

The lack of a standardized protocol for processing tips and leads resulted in a redundancy of effort by local and federal investigative entities at the onset of the incident.

Upon notification of the incident in progress, SNCTC's CTS and Counterterrorism Analysis Group (CTAG) leaders responded to the fusion center. CTS leadership immediately deployed detectives throughout the valley to conduct field collection as leads began to come into the LVMPD DOC and SNCTC. The volume of leads overwhelmed the existing process, resulting in the use of a new process. Information was able to be shared via meetings, and logged by staff with appropriate access.

Tips and leads were reported to LVMPD, NLVPD, HPD, ATF, and the FBI, and as a result, several of those tips were fielded separately by multiple jurisdictions. Various jurisdictions conducted multiple interviews with the same individual until a process was put in place with federal partners to deconflict the handling of all tips and leads. LVMPD CTS also hosted a morning briefing with investigative agencies to share information and deconflict legal processes.

SNCTC transitioned to the FBI's Law Enforcement Enterprise Portal (LEEP) days into the follow-up effort, but only people with LEEP accounts could access the site. Additionally, not all law enforcement personnel were familiar with the process for entering findings on the site. All the leads previously entered into the log had to be entered into this system. One week into the follow-up effort, LVMPD made the decision to transition to the FBI's leads processing tool. Once leads were reentered into this system, it provided a common lead platform.

Recommendations:

Law Enforcement

- At the onset of an incident, ensure that federal, state, and local partners are incorporated in a process for vetting and deconflicting incoming tips, leads, and suspicious activity reports (SAR).
- Continue to ensure that the fusion center is incorporated within the LVMPD DOC and providing the critical intelligence function to Incident Command.
- Continue to maintain LVMPD representation on the FBI Joint Terrorism Task Force.
- Ensure leadership has active LEEP accounts.

Observation 34

Fire department personnel on Rescue Task Force teams did not use black and orange tape to mark victims per Southern Nevada Fire Operations Hostile Mass Casualty Incident Policy, creating duplication of effort.

Roughly 10 minutes after the final shots were fired, officers and special events medical personnel began checking for pulses and clearing the area. These personnel were unaware of the RTF and fire personnel practice of marking victims in the warm zone with black and orange tape using the process of "sifting and sorting." Sifting involves determining which victims can self-extricate, which require an extraction (orange tag), and which will be left in place (black tag). These tags should be clearly visible and placed on the victim's ankle or wrist, if the legs are not available. Sorting is the process of assessing a victim's injuries. Sorting differs from formal S.T.A.R.T. triage in that it provides a more rapid determination of injury and categorizes victims into three groups: 1) requires immediate life-saving interventions, 2) has injuries that are not immediately life threatening, and 3) has injuries incompatible with life. Once victims are sifted, sorted, and moved out of the warm zone, they should be more formally triaged, treated, and transported.

The primary responsibility to flag and tag victims and patients lies with fire department personnel, who entered the venue as members of RTF teams. Fire department personnel performed multiple searches of

the venue but did not tag victims. Some officers raised concerns that the tape would not be visible in the dark. Proper and expedited sifting, sorting, triage, and transport are critical for trauma patients. It is widely regarded in the EMS community and emergency medicine, broadly, that a trauma patient's chances of survival are greatest if they receive appropriate pre-hospital care, rapid transport, and definitive care within the first hour that the injury is sustained, known as the Golden Hour.

Recommendations:

Fire Department

- Ensure that multidisciplinary response practices are shared among response organizations.
- Provide training on this practice in future Hostile MCI/MACTAC training with law enforcement, private ambulance companies, and special events personnel.
- Consider using reflective tape to mark victims.

Operational Coordination

Core Capability: Operational Coordination

Observation 35

The LVMPD CCAC Captain notified officers over the radio that he was en route to South Central Area Command, which was the location he chose for the formal Incident Command Post (ICP). He also communicated initial information to Las Vegas Strip properties. Upon arrival at South Central Area Command, he assumed the role of Unified Incident Commander with CCFD personnel.

The LVMPD CCAC Captain was successful in providing initial guidance and direction to officers while on his way to SCAC to assume command. He also aligned his response appropriately with ICS by not assuming command until he arrived on scene. An LVMPD patrol supervisor served as the Incident Commander until the LVMPD CCAC Captain arrived at SCAC. While en route, he was also communicating initial information regarding the critical incident with the Las Vegas Strip properties. Providing a command post location and staging directions for responding officers and resources was crucial for preventing additional over-convergence on scene.

Recommendation:

Law Enforcement

- Conduct training and exercises that incorporate and reinforce ICS and MCI response.

Observation 36

The CCFD Incident Commander was unable to leave his command vehicle because he needed to monitor radio traffic on multiple channels simultaneously. This confinement to his vehicle created initial challenges in establishing Unified Command with LVMPD.

The CCFD battalion chief assumed command at SCAC during the incident. However, he did not feel that he could not leave his rig, as he was running command from his vehicle. The CCFD deputy chief arrived and assumed CCFD Incident Command once a face-to-face transfer was completed from the battalion chief. This transition of command was executed smoothly. This issue points to a discrepancy in command culture between CCFD and LVMPD. CCFD applied the "sterile cockpit doctrine" for conducting operations in an isolated environment to their approach to Incident Command. However, the LVMPD Incident

Commander believed that this incident required more than a chief in a sterile environment because of the magnitude of the incident and the number of agencies involved.

Recommendation:

Fire Department

- Battalion chiefs should use available personnel such as staged engine or truck companies to assist the fire department Incident Commander, Operations Section Chief, or branch directors as needed. If additional resources are required, strike additional alarms.

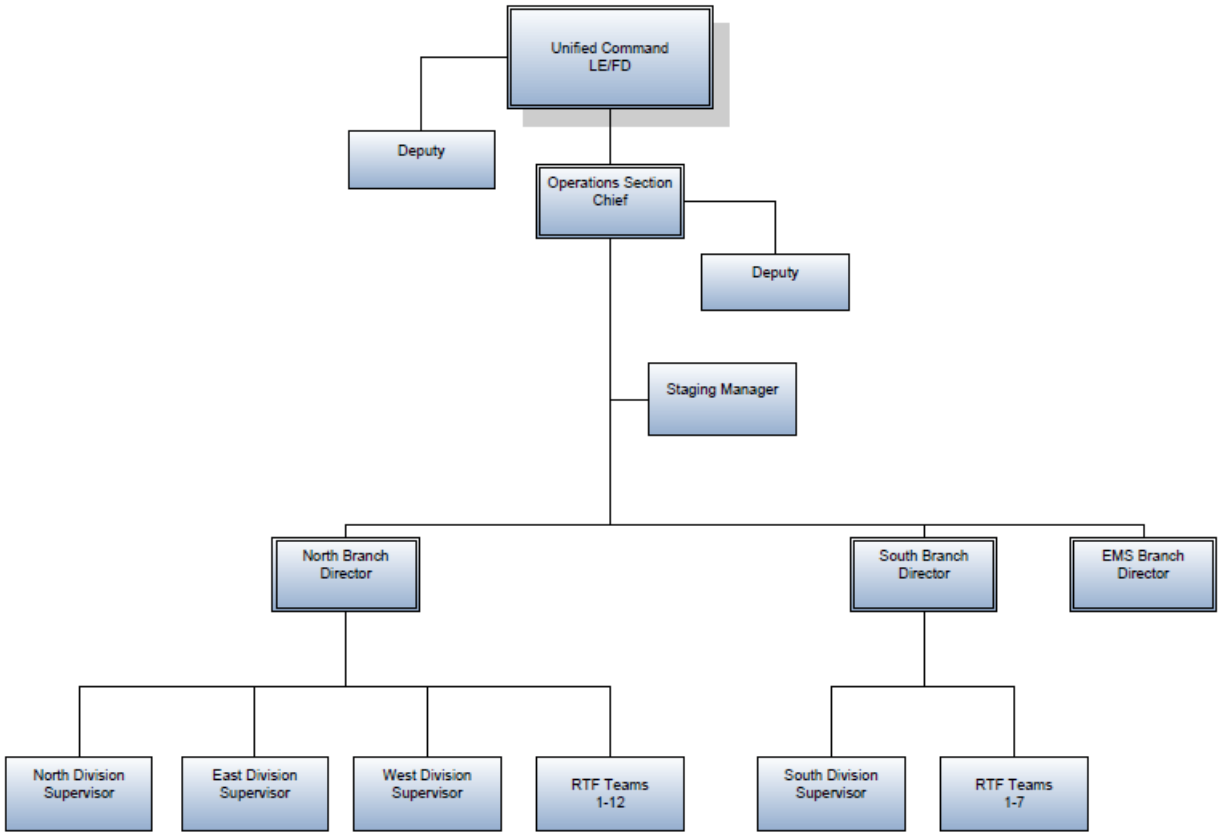

Figure 12: CCFD Unified Command Structure for 1 October

Observation 37

The Incident Command Post was initially located within the briefing room and became overcrowded with non-essential personnel, creating management issues for Incident Command.

The presence of many non-essential personnel at the command post created a chaotic environment that made it difficult for Incident Commanders to coordinate and give directions. Radio communications during the incident experienced frequent background noise, creating confusion. Unified Command fire department personnel needed to wear earpieces to compensate for the lack of clear voice communication. The LVMPD Incident Commander eventually determined that he could not operate the command post from the briefing room and relocated to a smaller room with the CCFD Incident Commander and a small cadre of key staff. The ICP should be limited to decision-makers and scribes only, with liaisons occupying a space close to, but not inside, the ICP.

Recommendations:

Fire Department and Law Enforcement

- Provide additional ICS training to minimize confusion surrounding roles and responsibilities.
- Consider relocating additional staff to minimize overcrowding.
- Provide ear buds in the ICP to lower background noise if multiple radios are in use.

Observation 38

When the fire department Operations Section was established, there was a brief period of confusion for personnel operating on the tactical radio channels.

CCFD rarely uses the Operations Section assignment within ICS. However, personnel on scene felt that it was essential to establish the Operations Section for this incident. Incident Command provides the strategic objectives for each incident. The Operations Section Chief's responsibility is to provide the tactical means to support the Incident Commander's strategic objectives.

Recommendation:

Fire Department

- Conduct additional TTXs and upper-level ICS training on the command structure and communications plan for large incidents with all ranks, including line personnel and administrative and C-staff personnel.

Observation 39

The fire department Operations Section Chief and branch directors would have benefitted from representatives from outside agencies assisting them.

North Branch had an ambulance supervisor on scene early in the incident, which facilitated effective resource coordination. However, the ambulance supervisors sent to the command post and South Branch were not fully utilized due to coordination challenges. In other cases, representatives were altogether absent at branches or within the Operations Section. Their absence resulted in limited or fractured information sharing and coordination. Having an LVMPD officer with a radio co-located with branch directors would have improved situational awareness. To address this issue, LVMPD and CCFD should host joint training with dispatch centers and private ambulance companies to define their role as it relates to ICS.

Recommendations:

Fire Department

- Incorporate the request for liaisons from relevant agencies based on the needs of the incident into protocols for establishing branches and the Operations Section.
- Coordinate quarterly or biannual drills or TTXs with all regional public safety agencies to establish clear lines of authority and responsibilities on emergency scenes.

Observation 40

As the scope of the incident expanded on the Las Vegas Strip, there became a need to expand Incident Command System roles and assignments.

As the incident grew and more personnel reported to the scene, Incident Commanders were required to split divisions, branches, and groups to keep the span of control manageable. LVMPD should incorporate a command and control system conforming to ICS which is specific to the needs of law enforcement. Just as ICS developed from wildland firefighting to structure firefighting, ICS command and control needs to incorporate and meet the needs of specific law enforcement situations.

Recommendations:

Law Enforcement

- Reach out to progressive law enforcement partners to model off of systems that are utilized to make ICS more efficient for law enforcement.
- Contribute to the national conversation and propose policy changes needed at the NIMS level, with an emphasis on law enforcement emergencies and situations.

Fire Department and Law Enforcement

- Consider creating a committee of LVMPD and CCFD personnel who have commanded critical incidents within the organization.

Observation 41

The established relationships between CCFD and LVMPD personnel allowed for the execution of an effective, integrated response to the incident.

CCFD and LVMPD personnel noted that a major strength of the response was their ability to easily integrate into a joint command structure because of their familiarity with each other. Unified Command included a representative from all relevant agencies. Law enforcement officers also quickly coordinated and formed RTF teams with fire personnel, as many of them recognized each other from past MACTAC training and had coordinated response efforts in the command post and the field during past incidents.

Recommendations:

Fire Department and Law Enforcement

- Continue to pursue and promote joint planning, training, and exercise initiatives that foster relationships and mutual understanding of roles and responsibilities across public safety agencies.
- Expand on this relationship and training philosophy to incorporate private ambulance companies, dispatch personnel, hotel security, and outside agencies.

Public Information Notifications
Core Capability: Public Information and Warning

Observation 42

Public information officers (PIOs) frequently released information on social media, which is a good practice for reducing panic and minimizing the spread of misinformation.

LVMPD first tweeted about the shooting approximately 30 minutes after the shooter fired his first shots into the crowd. This tweet was one of over 20 sent between 10:38 PM and 4:45 AM. The tweets provided guidance on areas to avoid, the location of media staging areas, road closures, the hotline for missing persons, and updates on the shooting investigation.

Public Information Officer (PIO)

The PIO is responsible for communicating with the public, media, and/or coordinating with other agencies, as necessary, with incident related information requirements.

Recommendations:

Law Enforcement

- Consider pre-scripting messages that expedite communication with the public during instances in which no new information is available.
- Determine the optimal time intervals for releasing information on social media during a large-scale incident.

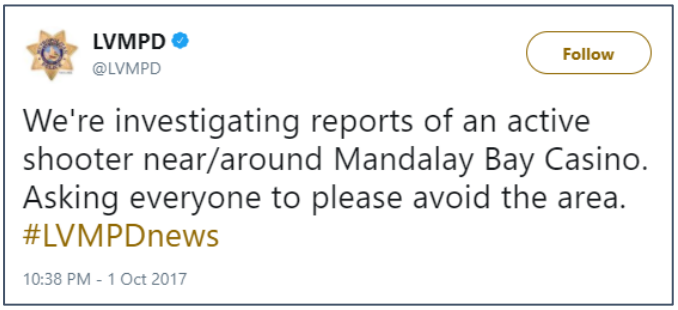

Figure 13: LVMPD Tweet

Observation 43

The LVMPD Office of Public Information possessed an inadequate amount of staff to efficiently conduct operations for an incident of this magnitude.

The LVMPD Office of Public Information did not possess a large enough staff to handle the number of operational requests and to process the amount of donations received for victims and first responders. Back-up PIOs, those personnel with prior experience, were slated to support operations such as answering phones. However, most of these individuals were deployed in the field. Additionally, more personnel were required to monitor social media and respond to questions posed during the incident.

Recommendation:

Law Enforcement

- Identify additional support personnel to assist with answering phones and monitoring social media at the onset of a large-scale incident.

Observation 44

CCFD does not have a designated public information officer, which would be a valuable position to have for an incident of this type.

LVMPD PIOs received numerous fire department-specific questions, which they felt would have been more adequately answered during the response by CCFD itself.

Recommendation:

Fire Department

- Consider appointing a CCFD PIO.

Observation 45

Prior experience of LVMPD public information officers contributed to their ability to release frequent, coordinated messages during the incident.

While PIO training and experience is generally limited nationwide, LVMPD PIOs have more responsibilities on a day-to-day basis than the average PIO. The office has a mix of officers and civilians who have experience in media relations. Because of their collective experience, PIOs were able to quickly respond to the incident and adjust course as required. PIOs were present at LVMPD headquarters, the command post, and the hospitals to provide vital information to the public. The LVMPD Sheriff was quickly out in front of the media and provided frequent updates on the shooting investigation in the days following.

Recommendations:

Law Enforcement

- Establish a PIO setup in the command post to aid in pushing out timely press releases.
- Ensure that the individual writing talking points for press briefings can shadow the PIO director in meetings and provide that information directly to those responsible for press releases.

Observation 46

Public information officers did not have an emergency splash page website to provide a hub of information to the public until the day after the incident.

While Twitter proved to be an effective platform to disseminate information quickly and effectively in the early hours of the response, LVMPD, CCFD, and Clark County OEM did not possess a singular website dedicated to the incident. The following day, a website was established to release information related to the incident. This website was updated regularly with relevant press conferences, as well as kept current with the county's information page. This website ensured that there was unified messaging throughout the county, as citizens knew to visit the page for the most up-to-date information regarding the incident.

Recommendation:

Law Enforcement

- Design an emergency splash page template for use at the onset of large-scale incidents.

Observation 47

Requests from international media outlets and embassies posed a challenge for LVMPD public information officers.

The LVMPD Office of Public Information received several information requests from international entities during the incident. Officers appropriately directed these individuals to the social media website and advised them to be aware of press conferences. PIOs found that their local media communication chains did not possess contacts for international media, which could have assisted them in answering specific questions. In the days after the incident, PIOs received information requests from embassies asking for

information pertaining to international victims and hospitals. Agents from the State Department assisted in handling these embassy requests.

Recommendation:

Law Enforcement

- Consider implementing training for PIOs related to handling questions that are likely to be asked by international media outlets.

Observation 48

LVMPD headquarters was overcrowded with non-essential personnel during the incident, impeding operations of PIOs and the LVMPD DOC.

Many members of the media camped out in the lobby of the LVMPD headquarters, where they could easily identify PIOs and livestream questions as the incident was unfolding. The media staging area was moved at the last minute, which may have contributed to the overcrowded headquarters.

The DOC also became crowded from the presence of non-essential personnel. Several elected officials were not directed elsewhere and remained in the DOC. It is important to vet personnel before they are permitted entry into the DOC. Staff must also be aware of private sector employees, media representatives, and elected officials without an ICS role in the DOC, especially as it relates to the distribution of sensitive information.

Recommendations:

Law Enforcement

- Pre-designate a space for media presence at LVMPD headquarters away from active incident management operations.
- Verify credentials of all individuals in the DOC.

Observation 49

Public information messaging platforms encouraged victims to seek available assistance.

The Nevada 2-1-1 system, the Clark County Call Center, and the Clark County government website all provided information for citizens regarding the FAC and donations. Additionally, a series of press releases were distributed, and daily news conferences were held to keep the media and public informed of new developments and progress on the response and recovery efforts.

Joint Information Center (JIC)

The JIC is a central location to facilitate operation of the Joint Information System during and after an incident. The JIC enhances information coordination, reduces misinformation, and maximizes resources by collocating PIOs as much as possible.

Recommendation:

Fire Department and Law Enforcement

- Use the Joint Information Center (JIC) to coordinate messaging across the LVMPD Office of Public Information, Nevada 2-1-1, and phone banks.

Observation 50

The 2-1-1 hotline was insufficient to address the volume of calls, and 2-1-1 personnel lacked training on how to process and distribute information.

The 2-1-1 call center was established right away but was not staffed sufficiently to handle the level and volume of calls received. 2-1-1 staff also did not know how to surge their operations to use out-of-state 2-1-1 networks to handle overflow calls. Because of this issue, LVMPD set up a second line that was staffed with detectives to receive, vet, and provide information. This decision posed additional issues, as the second hotline did not use the Unified Victim Identification System (UVIS) to track missing persons. Consequently, the Clark County Office of the Coroner/Medical Examiner (CCOCME) set up a third line at the Multi-Agency Coordination Center (MACC) and staffed it to mirror the 2-1-1 infrastructure.

These hotlines lacked coordination and did not work in unison, which resulted in their failure to alleviate non-essential calls from LVMPD dispatch. Consequently, LVMPD dispatch continued to receive calls on missing persons, lost possessions, and general information requests. It is essential that 2-1-1 call centers are briefed on critical processes and included in regular briefings, so they can begin to field non-vital calls to the appropriate location and the FAC.

Recommendations:

Fire Department

- Ensure 2-1-1 receives the necessary training on how to surge operations when needed and to have out-of-state networks assist with overflow calls.
- Consider using the JIC to ensure consistent messaging from these call centers.
- Continue to train on MCIs and ensure all personnel are familiar with plans and policies.
- Have an established webpage available for emergency information and necessary call-in numbers to be deployed at the onset of an incident.

Resource Management

Core Capabilities: Planning, Situational Assessment

Observation 51

The LVMPD staging area worked efficiently and effectively—staging resources and deploying a complete team within minutes.

The LVMPD staging area was established by 10:30 PM, and officers from several jurisdictions arrived there to await assignments. Hundreds of officers from multiple agencies around the valley were deployed on different strike teams. Early communication between Incident Command and the LVMPD staging area improved situational awareness on the incident's scope and the resources required. While the staging area manager was not present at the command post's hourly briefings, they provided constant updates to the command post, such as the number of officers ready to deploy. Including the staging area manager in hourly briefings would be beneficial to ensure consistent communication between the two locations. An online resource tracking system could also assist in accounting for available resources and personnel.

While leadership did a good job tracking the hundreds of personnel that reported to the LVMPD staging area, there were several individuals that were given assignments at the request of high-ranking LVMPD personnel without the Incident Commander's knowledge or approval.

Recommendations:

Law Enforcement

- The staging area manager should communicate with Incident Command as early as possible to gain a full understanding of the scope of the incident and resources required.
- Consider using a computer program to assist in tracking resources.
- Ensure that all requests for personnel and resources go through the Incident Command structure, regardless of the rank of the individual issuing the request.

Fire Department and Law Enforcement

- The staging area manager must take into consideration the access and egress abilities of staged units.
- The staging area manager should consider requesting assistance (i.e., engine or truck companies) in large-scale incidents.

Observation 52

LVMPD command personnel were effective in using required resources, as well as diverting resources and personnel when they were not needed at the scene.

Command diverted CCSDPD, NHP, HPD, and NLVPD officers to critical infrastructure, hospitals, hotels and casinos with reports of active shooters, and other areas to prevent over-convergence on the Las Vegas Strip. These officers were also used on quick-reaction forces at staging. All other jurisdictions were used in nearly every capacity during the response. Dispatch successfully put out notifications on where resources were needed.

Recommendation

Law Enforcement

- Continue to maintain relationships with local public safety agencies and conduct joint training.

Observation 53

Individual responders circumvented command and requested resources to the scene without Incident Command knowledge or approval.

Individual responders requested resources, including ambulances, fire department resources, and buses, to the scene. The request for buses was regarded as a good decision; however, it should have been requested through command. An LVFR unit also circumvented command and requested a strike team of five city ambulances to report to the incident. It should be noted that these resources were in another jurisdiction and were not the closest resources to the scene. This unit only informed command of this request after the fact and did not record the number of rescues that were dispatched to the scene. In addition, a local firefighter from an outside jurisdiction called dispatch via phone and ordered rescues to a specified location near the venue. FAO dispatch received the request and added four rescues from that firefighter's jurisdiction to the call. These *ad hoc* resource requests made it difficult for Incident Command to track deployed resources. To maintain accountability, all resources must be requested by command.

Recommendations:

Fire Department

- Continue to conduct ICS training and ensure that command and control is maintained in the field.

- Conduct training at the supervisory level between CCFD and partner agencies to include TTXs and multi-agency drills.
- Fully integrate private ambulances and outside agencies into coordinated training and exercises.
- Establish policies and procedures that clearly define dispatch's role and the appropriate response to resource requests from parties other than command.

Observation 54

The Joint Information Center was not fully staffed and functioning as planned until the second operational period.

The JIC was staffed at the MACC during the second operational period. Various agencies provided representatives to staff it and ensure a unified message. However, at the onset of the incident, the JIC was split into two separate locations because of staffing limitations and the immense workload that remained at LVMPD headquarters. All briefings were conducted out of the LVMPD briefing room. Having the MACC/JIC located miles away proved problematic for PIOs that were offsite.

Recommendations:

Fire Department

- Update policy to reflect expectations during a law enforcement incident, including where the JIC should reside and the proper staffing levels.
- Train and exercise on the expectations and operations of the JIC with all agencies.
- Consider creating infrastructure to house the JIC at LVMPD headquarters when necessary.

Observation 55

Despite some staffing challenges, the Clark County Office of Emergency Management and LVMPD Emergency Management worked closely together to ensure the Multi-Agency Coordination Center and the Department Operations Center received timely and updated information.

The MACC was activated at a Level 1 by 10:15 PM on the night of 1 October, with personnel en route to the scene. Personnel staffing the MACC were well prepared for their roles, as Clark County had previously conducted training and exercises for command staff within the MACC. By 10:35 PM, the MACC was activated at a Level 2. A Level 2 activation occurs for an emergency that does or could (1) involve a large area, significant population, or critical facilities, (2) require implementation of a large-scale evacuation or in-place sheltering, (3) require temporary shelter and mass care operations, and (4) require community-wide warning and public instructions.

Department Operations Center (DOC) and Multi-Agency Coordination Center (MACC)

A DOC coordinates an individual agency's incident management and response. A DOC is linked to and, in most cases, physically represented in the Emergency Operations Center by authorized agent(s) for the agency.

The MACC is a physical location established during an incident to align response efforts in support of the agencies in command by completing core objectives. The MACC provides logistical support to incident leaders by gathering and disseminating information to relevant partner agencies, typically using a common operating platform.

LVMPD usually fills Emergency Support Function (ESF) 13, Law Enforcement—a key position within the MACC—but was unable to provide staff during this incident due to limitations on personnel. LVMPD's emergency management staff were all utilized at LVMPD's DOC. As such, there was no law enforcement

component in the MACC, making operational coordination difficult for this law enforcement-centric incident. However, the CCFD Emergency Manager and the LVMPD Emergency Manager were in constant contact and facilitated hourly video teleconference briefings between the DOC and the MACC to maintain information flow. LVMPD was also able to provide a PIO to the JIC embedded within the MACC during the second operational period.

The MACC had representation or direct contact with all necessary county agencies, the State of Nevada, the cities of Henderson, Las Vegas, and North Las Vegas, all public utilities, the Southern Nevada Health District, and the Clark County School District. The Medical Surge Area Command (MSAC) embedded within the MACC had extensive participation with representatives from many hospitals and the health district.

Recommendations:

Fire Department

- Provide clarification and possible policy changes related to a declared emergency in Clark County that has law enforcement as the lead agency. Specifically, policies should address MACC and JIC functions as well as the policy group.
- Provide additional training for local departments in Clark County to fulfill ESF and ICS positions in the MACC to cover prolonged, multi-operational periods.

Observation 56

The Multi-Agency Coordination Center completed all requested support functions, except for establishing a complete and accurate patient list.

Information was disseminated to partner agencies within acceptable standards through WebEOC, resource requests were filled without delay, and the MACC logistically supported Unified Command, LVMPD's DOC, and the FAC. Personnel completed proper documentation for resource deployment, authorization, and financial responsibilities. Though well staffed, the MACC's JIC was not used extensively until after the FAC opened on 2 October. However, from that point, the JIC was very active on all information sharing platforms.

Medical Surge Area Command (MSAC)

The MSAC has three core objectives: (1) Coordinate with and provide resources to area hospitals, (2) Provide information to Unified Command, the Operations branch, or triage officers to determine the most appropriate hospital to send transport resources back to the scene, and (3) Obtain accurate patient counts, injury types, and patient contact information/location. The MSAC is typically comprised of representatives from area hospitals and the surrounding health district.

While the MSAC was successful in providing coordination and necessary resources to area hospitals, they were unable to obtain an accurate patient list including patient count, injury types, contact information, and patient locations. LVMPD requested this patient list early in the incident, and they were unable to fulfill it. This failure stemmed from challenges with patient tracking for an incident of this magnitude and complexity. Many patients self-transported or were brought to the hospital in personal vehicles. Hospitals may also not have tracked patients or communicated their tracking with the MACC. Perceived restrictions for sharing personally identifiable information made completing a deconflicted patient and deceased list very difficult. This issue occurs at the local, state, and federal level and is being addressed through training and exercises and possible administrative and legislative changes.

Recommendations:

Fire Department

- Conduct additional training and clarify policies for patient tracking and information sharing for MSAC representatives, ESF 8, EMS providers, hospitals, the coroner, and law enforcement.
- Conduct additional training for fire and law enforcement on available MACC support.

Observation 57

The LVMPD Department Operations Center was able to provide essential logistical and coordination support because of LVMPD's experience with pre-planned events, quarterly training, and effective leadership.

The LVMPD DOC was mobilizing and standing up operations within 15 minutes of the initial shots fired at the Route 91 Harvest Festival, with all partner agencies sending representatives to assist. The DOC was fully operational within 30 minutes of the incident. The DOC coordinated all response efforts, frequently communicating with Incident Command to provide necessary resources and personnel. The DOC also gathered information to provide regular updates to the Sheriff. Additionally, the DOC conducted hourly internal briefings that helped maintain situational awareness among different agency personnel. The DOC called Incident Command for updates 10 minutes prior to these briefings to ensure dissemination of the latest information. The DOC was also useful in ensuring continuity of operations for the following day. While the DOC was successful in its operations, it would have benefitted from additional personnel to assist in answering phones and gathering critical information.

Recommendations:

Law Enforcement

- Update the checklist for the DOC to consult during a critical incident.
- Consider projecting CAD screens of partner agencies in the DOC.
- Continue to provide training for officers to more quickly put together and release the A/B roster.

Observation 58

The LVMPD Department Operations Center's inclusion of representatives from University Medical Center facilitated coordination with this hospital.

The DOC had previously identified hospital points of contact (POCs), and LVMPD regularly trains with these entities. Additionally, the SNCTC manages a robust critical infrastructure protection program called Silver Shield that regularly works with the area hospitals and maintains relationships with each hospital for information sharing, planning, and exercising. During an incident response, LVMPD can leverage these relationships to obtain critical resources and information from these key partners.

There were several challenges identified with patient tracking and MSAC coordination. Having the necessary points of contact in the DOC proved invaluable and facilitated the communication of critical information to command staff and decision-makers amid some of the challenges.

Recommendation:

Law Enforcement

- Continue to conduct training and exercises with local area hospitals.

Operational Communications
Core Capability: Operational Communications

Observation 59

All officers were not initially alerted to the shooting over the radio, as they were operating on multiple channels or did not hear the initial radio traffic.

Table 3: Channel Broadcast Times

Channel	Time
Administrative	10:07 PM
Wants	10:07 PM
Downtown Area Command	10:07 PM
Enterprise Area Command	10:07 PM
Northwest Area Command	10:07 PM
South Central Area Command	10:07 PM
Southeast Area Command	10:07 PM
Northeast Area Command	10:08 PM
Spring Valley Area Command	10:08 PM
Bolden Area Command	10:09 PM

All OT officers were operating on the special events channel, whereas other patrol and fire personnel were not communicating on this channel. Some OT officers either forgot to set the home button on their radios to an operational channel, or they were unaware of the need to do so. This oversight resulted in these OT officers communicating on this channel initially, even though other first responders were not on the channel and thus missing potentially important information. LVMPD dispatch notified all other channels of an active shooter between 10:07 PM and 10:09 PM, as shown in **Table 3**.

Many officers communicated on various channels to alleviate congestion on the main CCAC channel during the incident. For example, an LVMPD supervisor requested medical on an administrative channel that was less congested in an attempt to get vital resources to his medical triage area that was being established. This information was not relayed to Incident Command. Establishing an SOP for use of radio channels related to an incident occurring during a special event will prevent delays in communicating critical information and the confusion of switching channels for officers operating in a hot zone at the time of the incident.

Recommendations:

Law Enforcement

- Develop clear communications plans to assign common radio channels.
- Consider establishing an SOP that the special events channel becomes the police operations channel if a large-scale event or MCI occurs, until Incident Command formally assigns the operations channels.

Observation 60

LVMPD personnel made timely notifications to specialized units and outside agencies, shortening the response timeline.

At the onset of the incident, LVMPD Communications notified critical and specialized units, including K9, CTS, and ARMOR. Additionally, the LVMPD SWAT captain made rapid, direct notifications to the LVMPD SWAT team and outside agencies. He sent a group notification to all LVMPD SWAT sergeants and lieutenants, and they began to mobilize immediately. He also directly notified the NLVPD SWAT commander, the Henderson SWAT lieutenant, and the FBI SWAT team leader.

Recommendation:

Law Enforcement

- Continue to reinforce the importance of timely notifications during an MCI.

Observation 61

CCFD's use of multiple tactical radio channels facilitated the setup and expansion of the Incident Command System and command framework. However, expansion of the communications plan led to confusion among some crews on scene and inbound, as well as among Fire Alarm Office dispatchers.

Fire department communications began on the main battalion channel, Battalion 2, and were switched over to a single TAC channel after the addition of first alarm medical and MCI units to the incident. Early on, command recognized the need for a larger communications plan and requested additional TAC channels from the FAO. At the height of the incident, responders were communicating on as many as seven TAC channels simultaneously. While multiple channels allowed for Unified Command, the Operations Section, branches, divisions, and groups to communicate effectively without overwhelming a single channel, they also created confusion for some personnel who were unsure on which channel(s) to communicate or to monitor.

Recommendations:

Fire Department

- Incorporate communications plan and ICS framework expansion into training and TTXs, which include fire department line personnel and members of the FAO.
- A communications plan should be clearly communicated across all channels to personnel on scene, as well as FAO dispatch, during a large-scale incident.

Observation 62

Fire department Mobile Computer Terminals (MCTs) experienced issues with information uploading and unit incident times throughout the event.

MCTs rely on cell tower signals to relay information from the FAO to fire department units. This information is critical for incoming units to gain information about the response and to know which radio TAC channel is being used for the incident. Because of the overwhelming usage of cell towers in the area in and around the Route 91 Harvest Festival following the shooting, information delivered to those terminals was sporadic and, in some cases, non-existent for extended periods of time. Some crews never saw critical updated incident information in the MCT dispatch notes. In several instances, that information was not broadcast over the radio channel. This technical issue occurs several times a year when major events are held in the area.

Recommendations:

Fire Department

- As FirstNet becomes available in the Las Vegas Valley for first responders, funding should be secured to facilitate fire department involvement.
- Ensure that first responders are aware of the technical challenge posed by cell tower-based communications during incidents or events involving a high concentration of people.

Observation 63

Radio signal issues in certain areas of the Mandalay Bay prevented first responders from transmitting or receiving crucial information in some cases.

CCFD has established repeaters in most casino hotels and has good radio coverage in these buildings. However, LVMPD operates on a different radio system and identified that their portable radios did not function in some buildings and areas during response operations. The SWAT officer who was clearing from the top floor down in the Mandalay Bay was unaware that the shooter's room had been identified and breached due to radio signal issues. SWAT officers had to improvise by using cross-discipline radios or getting close to the windows to pick up a better signal. LVMPD department phones have Wireless Priority Service (WPS), providing officers with priority access and prioritized processing in cellular networks and greatly increasing the probability of call completion.

Recommendations:

Fire Department and Law Enforcement

- Casinos and hotels in the area should consider installing repeaters to enhance radio traffic for first responders within their buildings.
- Casino properties should install the appropriate systems to bring in and distribute 700 and 800 MHz frequencies throughout their properties.

Observation 64

Congested radio traffic made coordination difficult for response agencies.

Early in the incident, radio traffic was congested with numerous reports of casualties, medical transports, and active shooters in alternate locations. One officer using binoculars saw the shooting platform on Mandalay Bay but was unable to relay this information because of radio congestion. An officer also got on the radio and directed fellow officers to stop congesting radio traffic with casualty information. Fire department personnel addressed these challenges by expanding their communications plan to multiple radio TAC channels, limiting radio congestion, and supporting ICS framework expansion.

Recommendations:

Fire Department and Law Enforcement

- Continue to conduct joint training between CCFD and LVMPD in communications plan expansion and the importance of using multiple radio channels to assist in limiting radio traffic.
- Ensure personnel in command and supervisory roles consider requesting additional personnel to assist in unit tracking, radio channel monitoring, and charting of the communications plan.
- Stress importance of only communicating necessary information and maintaining radio discipline.

Observation 65

SWAT communications were strained because of the distance between where operations were taking place. Communication is normally conducted over digital simplex channels that are limited to line of sight.

LVMPD's Technical and Surveillance Section (TASS) assisted SWAT with communications during the incident, deploying equipment to the Cameron Communications Annex. SWAT had communication issues due to proximity and distance from their Tactical Operations Center (TOC). TASS did not have the

necessary equipment to address the communications problem and had to request assistance from radio shop personnel.

Recommendations:

Law Enforcement

- The tactical response vehicle (TRV) should be outfitted to function as a communication and surveillance vehicle, as well as a backup TOC, should the SWAT TOC be out of commission.
- Conduct additional training with radio shop staff on deploying radio equipment during tactical operations.

Observation 66

In limited instances, some SWAT officers determined that their most effective method of communication was through their fire department liaisons via their radios because of poor LVMPD radio signals inside the Mandalay Bay.

Some SWAT officers relayed information through fire department personnel to the FAO because of poor LVMPD radio signals inside the Mandalay Bay. FAO personnel were not accustomed to receiving police communications or information directly. Therefore, they were unsure of what to do with this information.

Recommendation:

Fire Department and Law Enforcement

- Conduct joint training and TTXs with CCFD, LVMPD, and LVMPD/FAO dispatchers and call takers to familiarize agencies with large-scale incident communications challenges and solutions.

Family Assistance and Victim Services

Core Capability: Mass Care Services

Observation 67

The Family Assistance Center was extremely effective in assisting victims and their families in the days following the incident.

In the initial hours following the incident, several locations became points of assistance for those affected, including the LVMPD headquarters, the Thomas & Mack Center, and local hospitals. The FAC opened at the Las Vegas Convention Center on October 2, 2017, under the leadership of CCOCME and CCFD. For the first three days, the FAC worked in 24-hour operational periods, functioning primarily as a victim/family information center. During this time, the FAC conducted investigations to positively identify victims, provided notifications to next of kin, and supported the families of victims with crisis counseling services.

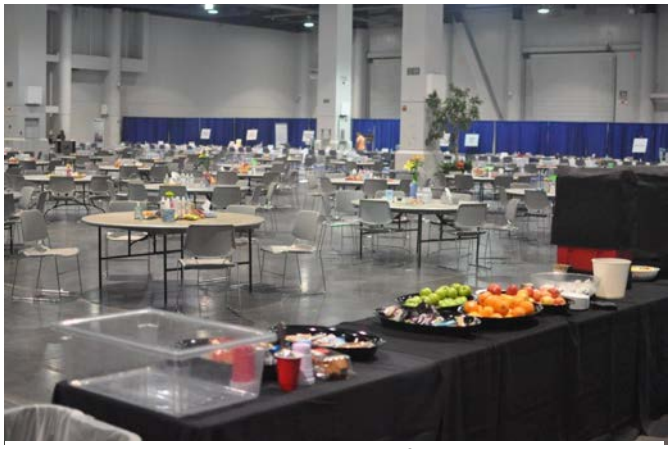

Figure 14: Main hall of the FAC

Several days after the incident, the Las Vegas Convention Center FAC adjusted to a nine-hour schedule and transitioned into a more traditional FAC, providing services and making resources available to victims and victims' families. A true family information center was set up at the CCOCME. The FAC began providing a wider range of services including ground and air transportation, onsite childcare, lodging, crime victim benefits and compensation, legal aide, identification services, counseling and spiritual care, therapy using service dogs, consulate services, personal effects return, and donation management. Over its operational lifespan, the FAC operated three separate phone banks, had over 14,000 calls go into their call centers, and assisted over 4,200 individuals. On October 20, 2017, the FAC was shut down and a "Vegas Strong" Resiliency Center (VSRC) was established.

Recommendations:

Fire Department and Law Enforcement

- Reinforce the use of the UVIS system to facilitate collection of victim information and the circulation of that list with LVMPD, CCOCME, and local area hospitals.
- Ensure that a website and phone bank are ready to be stood up at any given time to assist in pushing information out to the community during an incident.
- Consider including the FAC in the hourly briefings with the MACC and the LVMPD DOC during a large-scale incident.
- Establish Memoranda of Understanding (MOUs) with local agencies and community organizations to support FAC operations when an incident occurs.
- Consider including the FAC in the hourly briefings with the MACC and the LVMPD DOC during a large-scale incident.

Observation 68

The Federal Bureau of Investigation provided critical assistance to Family Assistance Center operations.

Figure 15: Intake area in the FAC

Agents who had deployed from the FBI's Orlando resident agency worked closely with fire captains at the FAC in the week following the incident. During response, FBI personnel were invaluable in providing operational support to CCFD—employing lessons learned from the Pulse Night Club shooting. Existing relationships between CCOCME and FBI personnel were also beneficial for joint recovery efforts at the FAC. The FBI handled returning all property to the victims and provided codes to individuals to access an online portal for missing items. The FBI Victim Services Division established a secure area at the FAC to catalog and recover thousands of items left behind at the concert site, including purses, cell phones, clothing, and other belongings. This process was even successful in returning both indefinable and non-identifiable items. Upon arrival at the FAC, visitors seeking their personal effects were checked in and partnered with a victim advocate who walked them through the process. An FBI victim specialist also assisted individuals in the FAC as needed.

Recommendations:

Law Enforcement

- Document FBI property recovery processes for future responses.
- Assign additional LVMPD personnel to conduct FAC operations for large-scale incidents.

Observation 69

The Vegas Strong Resiliency Center is providing valuable long-term support to victims. This support would benefit from increased cross-agency and inter-state communication.

With support from the community and responding agencies, particularly CCFD, the VSRC opened on October 23, 2017. It provides long-term support to victims, many of whom were not injured but experienced mental health problems and associated issues, including lost wages due to post-traumatic stress disorder. Because many of the victims were from out of state, victim advocates are working with partners across state lines. Support services for victims include connecting them with licensed therapists, legal aid, long-term financial help for medical and mental health services bills, and FBI Victim Services.

Challenges the VSRC has faced include the lack of an appointment-based system, the lack of a vetted database of licensed therapists, inter-state communication issues in states that have not joined the program, and transparency issues with law enforcement. Due to communications challenges, the VSRC was not initially provided with lists of known concertgoers from either LVMPD or the FBI. It was, however, provided with a database from the FAC, which was not tailored to long-term victim coordination. Using this database, the VSRC was able to reach out to 58 families. Overall, the center has taken over 2,400 calls to victims and families.

Recommendations:

Fire Department and Law Enforcement

- Develop an appointment-based system to enable case workers to effectively assist clients.
- Develop a state-wide, vetted network of licensed mental health professionals by local area.
- Improve communication and collaboration with inter-state operations.
- Improve law enforcement transparency with victim information.

Responder Wellness

Core Capabilities: Public Health, Healthcare, and Emergency Medical Services

Observation 70

The Police Employee Assistance Program (PEAP), a well-established resource for officer wellness, was made available to first responders following the incident.

Staffed by LVMPD commissioned and civilian employees, PEAP is a crisis intervention, counseling, and referral service set up to prevent and treat the personal and family casualties that are caused directly or indirectly by the stress of the law enforcement profession. This service is available to all LVMPD employees and their immediate family members. PEAP was available to provide immediate emotional support to those officers who responded during the incident. In addition, visiting chaplains, as a part of the Police Chaplain Program, worked in conjunction with PEAP to provide counsel and emotional support.

Recommendations:

Law Enforcement

- Provide PEAP services beyond immediate emotional support to include long-term counseling and care.
- Consider offering alternative forms of counseling, such as therapy dogs and art therapy.
- Require mandatory debriefs when officers return from command areas.
- Emphasize the importance of continued attention to wellness for first responders in the months and years following an incident.

Observation 71

LVMPD leadership encouraged responders to tend to mental and physical welfare following the incident, referring to and augmenting established wellness programs.

In addition to offering valuable words of encouragement to officers, LVMPD provided six free counseling sessions for officers, an increase from the usual three sessions guaranteed per year. Additionally, officers wishing to attend sessions were not required to provide co-pays through the end of the year (2018).

Recommendation:

Law Enforcement

- Establish policies for adjusting the number of free counseling sessions and waiving co-pays based on the severity of an incident.

Observation 72

CCFD required all personnel who responded to the incident to report to the training center at 8:30 AM on 2 October for a critical incident stress debriefing.

A brief critical incident stress debriefing was given prior to crews going home the morning after the incident. Subsequent counseling and assistance was offered to personnel, and this support will continue to be offered in the future. The International Association of Firefighters (IAFF) critical incident stress debriefing team personnel were also integrated into the post incident response and provided valuable support.

Critical Incident Stress Management (CISM)

A CISM program is a multi-tactic early intervention program of crisis intervention services that usually includes pre-crisis training, individual crisis counseling, a group debriefing, and a post-incident referral for primary and secondary victims. CISM is designed to provide interventions to address disaster-related mental health issues.

Recommendation:

Fire Department

- Continue to provide counseling services to CCFD personnel affected by the 1 October incident.

Tribute

This report is dedicated to all those who lost their lives and to the thousands of survivors who bravely risked their lives to save others during the 1 October tragedy. The 58 people killed at the Route 91 Harvest Festival came from across the United States and Canada to share a celebration of music with friends and family. They worked across the public and private sectors. Some were teachers, police officers, military, and small business owners. Some were grandparents, and some had just graduated high school. These 22 men and 36 women were husbands and wives, mothers and fathers, daughters, sons, sisters, and brothers. They are mourned by their home communities as well as the communities of Las Vegas and Southern Nevada. This report is dedicated to their memories, and their names are listed below.[6]

Hannah Lassette Ahlers, 34	*Charleston Hartfield, 34,*	*Melissa V. Ramirez, 26*
Heather Lorraine Alvarado, 35	*Christopher Hazencomb, 44*	*Jordyn N. Rivera, 21*
Dorene Anderson, 49	*Jennifer Topaz Irvine, 42*	*Quinton Robbins, 20*
Carrie Rae Barnette, 34	*Teresa Nicol Kimura, 38*	*Cameron Robinson, 28*
Jack Reginald Beaton, 54	*Jessica Klymchuk, 34*	*Tara Ann Roe, 34*
Stephen Richard Berger, 44	*Carly Anne Kreibaum, 34*	*Lisa Romero-Muniz, 48*
Candice Ryan Bowers, 40	*Rhonda M. LeRocque, 42*	*Christopher Louis Roybal, 28*
Denise Burditus, 50	*Victor L. Link, 55*	*Brett Schwanbeck, 61*
Sandra Casey, 34	*Jordan McIldoon, 24*	*Bailey Schweitzer, 20*
Andrea Lee Anna Castilla, 28	*Kelsey Breanne Meadows, 28*	*Laura Anne Shipp, 50*
Denise Cohen, 58	*Calla-Marie Medig, 28*	*Erick Silva, 21*
Austin William Davis, 29	*James Melton, 29*	*Susan Smith, 53*
Thomas Day, Jr., 54	*Patricia Mestas, 67*	*Brennan Lee Stewart, 30*
Christiana Duarte, 22	*Austin Cooper Meyer, 24*	*Derrick Dean Taylor, 56*
Stacee Ann Etcheber, 50	*Adrian Allan Murfitt, 35*	*Neysa C. Tonks, 46*
Brian S. Fraser, 39	*Rachael Kathleen Parker, 33*	*Michelle Vo, 32*
Keri Galvan, 31	*Jennifer Parks, 36*	*Kurt Allen Von Tillow, 55*
Dana Leann Gardner, 52	*Carolyn Lee Parsons, 31*	*William W. Wolfe, Jr., 42*
Angela C. Gomez, 20	*Lisa Marie Patterson, 46*	
Rocio Guillen, 40	*John Joseph Phippen, 56*	

[6] http://www.latimes.com/projects/la-na-las-vegas-shootings-victims-list-20171002/
http://www.independent.co.uk/news/world/americas/vegas-shooting-victims-names-released-58-dead-mandalay-bay-stephen-paddock-a7986141.html

Conclusion

On October 1, 2017, public safety agencies worked together to mount a collaborative, coordinated response to an incident of mass violence unlike any the nation had ever seen. Responders from CCFD, LVMPD, and their many partners arrived to a scene of devastation and chaos. Without hesitation, they met challenges with courage and knowledge gained from prior training and experience. In doing so, these men and women placed themselves in the line of fire to save countless innocent lives.

Two responding LVMPD officers were wounded in the line of duty, and one off-duty officer who was attending the concert was killed. Many men and women from agencies that responded were among the concertgoers, as were many of their friends and family. The brave men and women who responded to this incident rose above the danger and disorder they encountered to protect their community. Their successes were the product of an investment in joint training by public safety leadership, the decisive actions of first responders, and an outpouring of support from federal, state, and local partners, private entities, and individual citizens.

The observations and recommendations found within this report identify, highlight, and document the numerous lessons learned during this unprecedented incident. This report is a resource for Southern Nevada public safety agencies, as well as for public safety agencies across the country, in their continued efforts to improve response capabilities related to incidents of mass violence.

October 1, 2017 will be remembered by the nation, especially within the communities of Las Vegas and Southern Nevada, as a day of inordinate loss. This report is dedicated to the victims of the 1 October incident, in the hopes that it can inform future response efforts and protect responders and the communities they serve. For many survivors of the 1 October incident, recovery remains a long road ahead. The communities of Southern Nevada, alongside the nation, remain committed to helping those affected to recover and rebuild.

Appendix A: Abbreviations and Acronyms

Table 4: List of Abbreviations and Acronyms

Acronym	Definition
AAR	After-Action Report
ALS	Advanced Life Support
AMR	American Medical Response
ARMOR	All-Hazard Regional Multi-agency Operations and Response
ASI	Active Shooter Incident
ATF	Bureau of Alcohol, Tobacco, Firearms, and Explosives
BCPD	Boulder City Police Department
CAD	Computer-aided Dispatch
CBRN	Chemical, Biological, Radiological, and Nuclear
CCA	Complex Coordinated Attack
CCAC	Convention Center Area Command
CCFD	Clark County Fire Department
CCOCME	Clark County Office of the Coroner/Medical Examiner
CCSDPD	Clark County School District Police Department
CISM	Critical Incident Stress Management
CTAG	Counterterrorism Analysis Group
CTS	Counter Terrorism Section
DOC	Department Operations Center
EAC	Enterprise Area Command
EMS	Emergency Medical Services
ESF	Emergency Support Function
FAC	Family Assistance Center
FAO	Fire Alarm Office
FEMA	Federal Emergency Management Agency
FirstNet	First Responder Network Authority
Force Pro	Force Protection
FBI	Federal Bureau of Investigation
HFD	Henderson Fire Department
HIPPA	Health Insurance Portability and Accountability Act
HPD	Henderson Police Department
IAFF	International Association of Firefighters
IAP	Incident Action Plan
ICP	Incident Command Post
ICS	Incident Command System
JCTAWS	Joint Counterterrorism Awareness Workshop Series
JIC	Joint Information Center
LEEP	Law Enforcement Enterprise Portal
LVBS	Las Vegas Boulevard South
LVFR	Las Vegas Fire & Rescue
LVMPD	Las Vegas Metropolitan Police Department

MACC	Multi-Agency Coordination Center
MACTAC	Multi-Assault Counter-Terrorism Action Capabilities
MCI	Mass Casualty Incident
MCT	Mobile Computer Terminals
MOU	Memorandum of Understanding
MSAC	Medical Surge Area Command
NCORE	Nevada Core Systems Network
NHP	Nevada Highway Patrol
NIMS	National Incident Management System
NLVFD	North Las Vegas Fire Department
NLVPD	North Las Vegas Police Department
OEM	Office of Emergency Management
OT	Overtime
PEAP	Police Employee Assistance Program
PIO	Public Information Officer
POC	Point of Contact
PSAP	Public Safety Answering Point
PPE	Personal Protective Equipment
RBT	Reality-Based Training
RTF	Rescue Task Force
SAR	Suspicious Activity Report
SCAC	South Central Area Command
SNCTC	Southern Nevada Counter Terrorism Center
SNFO	Southern Nevada Fire Operations
SOP	Standard Operating Procedure
SWAT	Special Weapons and Tactics
TAC	Tactical
TASS	Technical and Surveillance Section
TECC	Tactical Emergency Casualty Care
TOC	Tactical Operations Center
TRV	Tactical Response Vehicle
TTX	Tabletop Exercise
UNLVPD	University of Nevada, Las Vegas Police Department
US&R	Urban Search and Rescue
UVIS	Unified Victim Identification System
VSRC	Vegas Strong Resiliency Center
WPS	Wireless Priority Service

Appendix B: Timeline of Response

The FEMA AAR development team integrated information on the response timeline provided by CCFD and LVMPD into the timeline below. For the purposes of this report, the incident timeline begins at 2:45 PM on Sunday, October 1, 2017 and spans through 1:00 PM on Monday, October 2, 2017. The temperature was 90°F at 2:56 PM and dropped to 79 °F by 9:56 PM on October 1, 2017. Skies were partly cloudy but cleared by early evening, with wind speeds reaching a high of 21.9 MPH at 3:56 AM on October 2, 2017. All times are Pacific Daylight Time.

Table 5: Timeline of Response

Time	Event
October 1, 2017	
2:45 PM	▪ The first performance begins on the third day of the Route 91 Harvest Festival on the "Next From Nashville" Stage.
8:40 PM	▪ A HotSOS alarm is generated for room 32-129 in the Mandalay Bay.
9:18 PM	▪ The HotSOS call is assigned to the Security Officer via his cellphone. ▪ Security Officer is assigned five HotSOS calls during this call.[7] ▪ Security Officer handles the HotSOS call for room 32-129 last.
9:36 PM	▪ The dead bolt to room 32-135, one of Paddock's hotel rooms, is engaged.
9:40 PM	▪ Performer Jason Aldean starts his performance on the Main Stage at the Route 91 Harvest Festival.
9:46 PM	▪ The dead bolt to room 32-134, Paddock's second hotel room, is engaged.
9:46-10:00 PM	▪ Security Officer enters the service elevator at 9:46 PM and gets off on the 30th floor approximately a minute later. ▪ Security Officer walks to the stairwell in the 100-wing of the 30th floor and walks up to the 32nd floor. ▪ Security Officer cannot gain entry to the 32nd floor due to the door being barricaded.[8] ▪ Security Officer walks up the stairs to the 33rd floor and walks down the 100-wing of the 33rd floor to Center Core. Security Officer takes a guest elevator to the 32nd floor.
10:00 PM	▪ Security Officer exits the guest elevator and walks up to the 100-wing toward room 32-129. ▪ Security Officer checks room 32-129 and finds it is secure. ▪ Security Officer walks into the foyer leading to the stairwell and observes the "L" bracket screwed into the door and frame.
10:04 PM	▪ Security Officer picks up a house phone located inside the small foyer leading to the stairwell and calls security dispatch to report the "L" bracket on the door to the stairs. ▪ Security dispatch transfers the call to maintenance dispatch. ▪ Maintenance Dispatcher then transfers Security Officer to Maintenance Supervisor's cell phone.
10:05 PM	▪ Engineer is contacted by the maintenance dispatcher via his radio. ▪ Paddock fires two single gunshots into the Las Vegas Village area. ▪ Paddock fires an undetermined amount of gunshots into the Las Vegas Village Area. ▪ CCFD Engine 11 (E11) is driving on the east side of the venue on Giles street when they hear gunfire.

[7] According to interviews of hotel staff, it is common practice to assign HotSOS calls to security officers and then immediately close out the HotSOS tickets prior to a security officers actually checking out the room.
[8] The investigation would reveal the door leading from the stairwell to the 32nd floor was barricaded by an "L" bracket screwed into the door and the door frame.

	▪ E11 contacts FAO dispatch and reports that they hear gunfire. FAO dispatch advises that they have no call yet.
10:06 PM	▪ Security Officer ends the phone call and hangs up the house phone. After hanging up the phone, Security Officer hears what he describes as rapid drilling noises. ▪ Paddock fires approximately 100 rounds into the Las Vegas Village area. ▪ Security Officer begins walking down the 100-wing toward Center Core. ▪ Engineer is told by his supervisor to go to the 32nd floor. ▪ First notification is made via radio on Event5 by 180SE. ▪ LVMPD unit 169SE broadcasts over the CCAC radio channel, "169SE, we got shots fired, 415A at the Route 91. Sounded like an automatic firearm." ▪ Paddock fires rounds down the hallway at Security Officer. Security Officer is struck in the left calf with a bullet fragment. He takes cover in the alcove between rooms 32-124 and 32-122. ▪ Security Officer tells his dispatcher via his radio, "Hey there's shots fired in, uh, 32-135." ▪ Engineer's dispatcher tells him specifically where to go on the 32nd floor. Engineer leaves room 62-207 and walks to the service elevators with his equipment cart. The service elevators are located in the 200-wing of the hotel. ▪ Dispatch receives the first phone call from a civilian referencing the incident. ▪ The event is called out on the special events channel.
10:07 PM	▪ Paddock fires approximately 95 rounds into the Las Vegas Village area. ▪ LVMPD Officers leave the Mandalay Bay Security Office with two armed Mandalay Bay Security Officers. ▪ Paddock fires approximately 100 rounds into the Las Vegas Village area. ▪ Paddock fires approximately 94 rounds into the Las Vegas Village area. ▪ CCFD Battalion 2 (B2) is monitoring the radio and hears the call. He heads to the scene immediately from Station #18.
10:08 PM	▪ Paddock fires the 1st round at the fuel tank. (Missed tank) ▪ LVMPD CAD event #171001-3519 is generated for the shooting incident. ▪ CCFD E11 is officially placed on the call and requests full medical alarm and MCI unit.
10:09 PM	▪ Paddock fires the 2nd round at the fuel tank. (Missed tank) ▪ Paddock fires the 3rd round at the fuel tank. (Missed tank) ▪ Paddock fires the 4th round at the fuel tank. (Missed tank) ▪ Paddock fires the 5th round at the fuel tank. 1st strike into the fuel tank. (Top strike) ▪ Paddock fires the 6th round at the fuel tank. 2nd strike into fuel tank. (Lower strike) The investigation was unable to determine when the 7th and 8th rounds were fired at the fuel tank.[9] ▪ Paddock fires an undetermined number of rounds into the Las Vegas Village area. ▪ The first alarm medical units are dispatched to the scene. These include E11, E18, E32, T11, R11, R218, EMS1, and B2.
10:10 PM	▪ Engineer arrives at the Center Core of the 32nd floor and walks up the 100-wing toward room 32-135. Engineer hears what he believes to be a jack hammer sound in the distance. Engineer quickly realizes it was automatic gunfire.[10] After the gunshots stop, Security Officer yells at Engineer to take cover. ▪ Engineer turns and takes cover in the alcove between rooms 32-119 and 32-117. Paddock fires rounds down the hallway at Engineer. He is not struck by gunfire. Engineer attempts to open room 32-117 with his master key card; however, the dead bolt lock is engaged and he is unable to gain entry into the room.

[9] There were eight .308 casings located inside of room 32-134.

[10] The investigation determined at the time Engineer heard the gunfire, Paddock fired the approximately 21 rounds, referred to above, at the Las Vegas Village area.

	▪ Engineer states over his radio, "Call the police. Someone's firing a rifle on the 32nd floor down the hallway."
10:11 PM	▪ LVMPD Officers arrive at the Center Core area of the 31st floor and begin walking up the 100-wing along with armed security officers from Mandalay Bay. ▪ Paddock fires approximately 80-100 rounds into the Las Vegas Village area. ▪ Paddock fires approximately 95 rounds into the Las Vegas Village area. ▪ CCFD calls LVMPD's internal switchboard to confirm the report of a subject shot in the leg with a pellet gun.
10:12 PM	▪ Two, armed Mandalay Bay security officers exit the guest elevator on the 32nd floor and go to the Center Core. ▪ Paddock fires approximately 80-90 rounds into the Las Vegas Village area. ▪ Paddock fires an unknown number of rounds into the Las Vegas Village area. LVMPD Officers are struck by gunfire during this volley. ▪ A Mandalay Bay security officer who is with LVMPD officers advises over his radio, "We can hear rapid fire above us. We are on the 31st floor. We can hear it above us." ▪ CCFD R19 is added to the call.
10:13 PM	▪ Paddock fires an unknown number of rounds into the Las Vegas Village area. ▪ CCFD B2 establishes Incident Command on Las Vegas Boulevard just south of Tropicana. He begins the process of locating an LVMPD sergeant/lieutenant and attempting to unify command while monitoring radio traffic and setting up the initial ICS structure. ▪ CCFD E33, R33, and MCI33 are added to the call. MCI33 is a cross-staffed unit with E33 personnel. E33 was on a call in an adjacent station's area when they heard the dispatch and went en route. ▪ CCFD T11 reports to Command (B2) that "I'm getting reports that the shooter is shooting from Mandalay Bay into the crowd at Route 91."
10:14 PM	▪ Mandalay Bay security dispatch calls LVMPD dispatch to report an active shooter.
10:15 PM	▪ Paddock fires two separate volleys of an unknown number of rounds into the Las Vegas Village area.
10:16 PM	▪ LVMPD Officers along with Mandalay Bay security officers make entry into the stairwell on the 31st floor.
10:18 PM	▪ The heat detection indicator from inside room 32-135 detects no further readings from inside of the room. ▪ CCFD T11 establishes triage area and is assigned South Division at Russell and LVBS. Patients begin arriving in the South via private vehicle.
10:22 PM	▪ CCFD E11 establishes triage area and is assigned North Division at Tropicana and Koval. ▪ E32 reports multiple victims at Reno and Koval.
10:24 PM	▪ CCFD E18 sets up triage, treatment, and transport area at Tropicana and LVBS with E33 and R33.
10:26 PM	▪ Unified Command is established. B6 and LVMPD unify command at SCAC.
10:29 PM	▪ CCFD E18 is assigned West Division at Tropicana and LVBS. This includes E18, E33, MCI33, R18, R218, and SQ32.
10:30 PM	▪ CCFD B2 is assigned North Branch. ▪ North Division reports that an LVMPD officer is shot in the neck near the main stage. ▪ CCFD ARFF Station #13 reports multiple shooting victims on the airfield at McCarran Airport.
10:31 PM	▪ 2nd Alarm Medical is called.
10:32 PM	▪ Command requests two more TAC radio channels. These channels include TAC 6 North Branch, TAC 9 South Division, and TAC 10 Staging.
10:35 PM	▪ The Clark County Multi-Agency Coordination Center is established.
10:36 PM	▪ Command requests Command Channel TAC 11. ▪ West Division reports off-duty LVMPD officers bringing patients to them in private vehicles.

10:38 PM	▪ E32 gives North Branch an Exception Report stating that they have been flagged down in front of Hooter's Hotel/Casino with multiple gunshot victims.
10:39 PM	▪ LVFR personnel requests an "ambulance strike team."
10:40 PM	▪ Distraction Call #1: There is a person wearing fatigues entering an RV at Tropicana and Koval.
10:41 PM	▪ A Strike Team which includes a K9 sergeant, a K9 officer, a SWAT officer, and a detective ascends the stairs from the 30th floor. The Strike Team makes entry and clears the 31st floor. ▪ CCFD B1 formally assumes staging manager for North and South staging. ▪ CCFD E32 reports multiple shooting victims that have been brought to them in a vehicle. E32 requests LVMPD and additional fire department resources.
10:44 PM	▪ HFD offers and sends a mutual aid medical alarm (3rd Medical Alarm).
10:48 PM	▪ North Division reports that they are out of ambulances. He states that they are getting pickup truck loads of patients and are loading others in private vehicles.
10:56 PM	▪ The Strike Team reenters the stairwell from the 31st floor and walks up to the 32nd floor. ▪ CCFD C2 establishes triage area and is assigned East Division. This triage area is located on the east side of the venue on Giles near gate 4A.
10:57 PM	▪ K9 Sergeant and SWAT Officer manually breach the door barricaded with the "L" bracket.
10:58 PM	▪ Distraction Call #2: There are reports of an active shooter at the top of Mandalay Bay at the bar.
11:01 PM	▪ The first CCFD RTF is assigned to enter the Route 91 venue. ▪ MCI33 gear is split into two locations, Tropicana and LVBS and in front of the Hooters hotel.
11:08 PM	▪ Distraction Call #3: There are reports of an active shooter at New York New York and shots heard at Hooters.
11:11 PM	▪ Distraction Call #4: There are reports of an active shooter at Hakkasan and New York New York.
11:12 PM	▪ Distraction Call #5: There are reports of shots being fired at MGM.
11:15 PM	▪ Distraction Call #6: There are reports of an active shooter at Tropicana Hotel.
11:16 PM	▪ Distraction Call #7: There is emergency traffic regarding two people on the roof of the Tropicana Hotel.
11:17 PM	▪ CCFD C4 assumes Unified Command role from B6. B6 becomes operations.
11:20 PM	▪ The Strike Team conducts an explosive breach into room 32-135 and makes entry. The Strike Team reports Paddock is down from an apparent self-inflected gunshot wound to the head.
11:21 PM	▪ Fire Department South Branch is established.
11:23 PM	▪ Distraction Call #8: There is emergency traffic regarding shots fired in the Tropicana Hotel. ▪ Distraction Call #9: There is a fire reported in the Excalibur Hotel.
11:26 PM	▪ The Strike Team makes a second explosive breach from inside of room 32-135 into room 32-134 through the connecting doors. Immediately after the explosive breach, an LVMPD SWAT officer negligently fires a three-round burst from his rifle. The rounds fired from the SWAT officer's rifle strike a chair, an entertainment center/cabinet, and a wall. ▪ Dispatch advises command of approximately 60 pending medical calls in the area related to the shooting. ▪ Command begins the process of RTF formation.
11:27 PM	▪ Distraction Call #10: There are reports of shots fired in the Planet Hollywood.
11:28 PM	▪ Distraction Call #11: There are reports of shots fired in Caesars Palace.
11:30 PM	▪ Distraction Call #12: There is an active shooter reported at McCarran Airport.

11:31 PM	▪ The 4th Medical Alarm is called.
11:34 PM	▪ Distraction Call #13: There is an explosion reported on the 34th floor at Mandalay Bay, as well as reports of fires on the 32nd, 33rd, and 34th floors.
11:37 PM	▪ The LVFR Bomb Squad is assigned to the incident. They handle two vehicle calls and coordinate with LVMPD.
11:44 PM	▪ McCarran Airport announces that they have suspended all flights.
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12:00 AM	▪ North RTF teams, 12 in total, begin the process of clearing/handling the approximately 60 pending medical calls in and around the area. They then transition to Mandalay Bay to assist with floor by floor, room by room search/sweeps.
12:04 AM	▪ Distraction Call #14: There is an unattended backpack reported at the EMS Branch.
12:06 AM	▪ South RTF teams, seven in total, begin secondary sweeps of the Route 91 venue. They then transition to Mandalay Bay to assist with floor by floor, room by room search/sweeps.
12:10 AM	▪ Distraction Call #15: There is a report of 20 hostages being held at New York New York.
12:21 AM	▪ Distraction Call #16: There is a report of shots fired in the New York New York.
1:00 AM	▪ A temporary Family Assistance Center opens at the Thomas & Mack Center located on the University of Nevada, Las Vegas campus.
3:30 AM	▪ Pending medical calls are vetted or cleared. ▪ Floor sweeps are nearing completion. Demobilization of RTF units begins.
5:00 AM	▪ All RTFs are cleared. ▪ The Fire Chief assigns four CCFD members to an AAR team. Several days later, LVMPD adds three members to this team and the Route 91 Task Force is created.
7:32 AM	▪ Command is terminated for CCFD.
8:30 AM	▪ CCFD C-Staff and Peer Support Teams hold a mandatory debriefing of all CCFD personnel on the incident.
1:00 PM	▪ The Family Assistance Center opens at the Las Vegas Convention Center.

Appendix C: Core Capability Mapping

FEMA's National Preparedness Goal defines what it means for the whole community to be prepared for all types of disasters and emergencies. The goal is as follows: "A secure and resilient nation with the capabilities required across the whole community to prevent, protect against, mitigate, respond to, and recover from the threats and hazards that pose the greatest risk."[11] The National Preparedness goal describes 32 activities, called core capabilities, that address the greatest risks to the nation. The FEMA AAR development team has mapped the focus areas included in this report to their associated core capabilities.

Table 6: Core Capability Mapping

Focus Area	Core Capabilities
Pre-Incident Special Events Planning	▪ Planning
Emergency 9-1-1 Services and Notification	▪ Operational Communications ▪ Situational Assessment
Initial Response to the Scene	▪ Planning ▪ Situational Assessment
Fire Mutual Aid and Scene Management	▪ Mass Search and Rescue Operations ▪ Public Health, Healthcare, and Emergency Medical Services ▪ Situational Assessment
Tactical Operational Response	▪ On-scene Security, Protection, and Law Enforcement ▪ Situational Assessment
Operational Coordination	▪ Operational Coordination
Public Information Notifications	▪ Public Information and Warning
Resource Management	▪ Planning ▪ Situational Assessment
Operational Communications	▪ Operational Communications
Family Assistance and Victim Services	▪ Mass Care Services
Responder Wellness	▪ Public Health, Healthcare, and Emergency Medical Services

[11] https://www.fema.gov/national-preparedness-goal