6.2.1

| NOVEMBER 2025 REFUNDS | | | | | | | |
|---|---|---|---|---|---|---|---|
| TO BE APPROVED | | | | | | | |
| | | | | | | | |
| NAME | REQUESTOR | ADDRESS | DESCRIPTION | BILL NUMBER | TYPE | REASON | AMOUNT |
| BROWN CRYSTAL | TAXPAYER | 7224 S ELWOOD AVE, TULSA, OK 74132-2463 | 354617 | 2024-03-51097 | MV | OVERPAYMENT | ($27.17) |
| BRUNO PEDRO S | TAXPAYER | 271 MARSHALL LN, DERBY, CT 06418-2328 | 290261 | 2024-03-51117 | MV | OVERPAYMENT | ($74.57) |
| CAPPIELLO STEPHEN R | TAXPAYER | 25 PARK AVE, DERBY, CT 06418 | 123127 | 2024-03-51356 | MV | OVERPAYMENT | ($11.23) |
| HONDA LEASE TRUST | LEASING COMPANY | 11675 GREAT OAKS WAY SUITE 200, ALPHARETTA, GA 30022 | VARIOUS | 2024-03-VARIOUS | MV | OVERPAYMENT | ($751.92) |
| USB LEASING LT | LEASING COMPANY | 1850 OSBORN AVE, OSHKOSH, WI 54902 | VARIOUS | 2024-03-VARIOUS | MV | OVERPAYMENT | ($435.45) |
| VAULT TRUST | LEASING COMPANY | CHARLOTTE PPC, PO BOX 71119, CHARLOTTE, NC 28272-1119 | VARIOUS | 2024-03-VARIOUS | MV | OVERPAYMENT | ($796.62) |
| WANAGEL ALEKZANDRA M | TAXPAYER | 4 TWOEY DR, WINDHAM, ME 04062-4679 | 121225 | 2023-03-59413 | MV | OVERPAYMENT | ($347.95) |
| 58 DERBYSHIRE LLC | TAXPAYER | 29 MESA DR, BETHANY, CT 06524 | 58 DERBYSHIRE | 2025-17-1512 | CF | OVERPAYMENT | ($27.00) |
| GUERRIERO CARMELLINA & RICHARD | TAXPAYER | 135 PLEASANT VIEW RD, DERBY, CT 06418 | 135 PLEASANT VIEW RD | 2025-17-1439 | CF | OVERPAYMENT | ($128.50) |
| SROA 86 PERSHING CT LLC | TAXPAYER | PO BOX 5651, BISMARCK, ND 58506 | 86 PERSHING DRIVE | 2025-17-2956 | CF | OVERPAYMENT | ($128.50) |
| | | | | | | | |
| | | | | | | | ($2,728.91) |

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# STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt Governor

**Office Of Emergency Medical Services**

June 30, 2025

Mr. Joseph DiMartino, Mayor
City of Derby
1 Elizabeth Street
Derby, CT 06418

Dear Mayor DiMartino,

In accordance with Connecticut General Statute 19a-181b, your municipality is required, by the Department of Public Health (DPH) Office of Emergency Medical Services (OEMS), to submit an updated Local Emergency Medical Services Plan.

**This document should be sent to our office no later than January 1, 2026.**

Connecticut General Statute 19a-181b, stipulates the following requirements concerning emergency medical services, Local EMS plans and municipal responsibilities effective October 1, 2014:

- The Statute requires the Department of Public Health (DPH) to review local EMS plans and Primary Service Area Responders (PSAR) provision of services under them at least every five years.
- The Statute requires each municipality to update its plan as it determines necessary and, in updating its plan, a municipality must consult with its PSAR.
- Upon request, DPH must assist municipalities with the review process by providing technical assistance and helping to resolve issues between the municipality and PSAR concerning the plan.
- The complete text of this Statute can be found here: https://www.cga.ct.gov/current/pub/chap_368d.htm#sec_19a-181b

In addition, Connecticut Public Act 16-43 Section 1 requires the inclusion of the following:

> (e) Not later than October 1, 2016, each municipality shall amend its local emergency medical services plan, as described in section 19a-181b, to ensure that the emergency responder, including, but not limited to, emergency medical services personnel, as defined in section 20-

DPH
Connecticut Department of Public Health

Phone: (860) 509-7975 • Fax: (860) 730-8384
Telecommunications Relay Service 7-1-1
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
*Affirmative Action/Equal Opportunity Employer*

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206jj, or a resident state trooper, who is likely to be the first person to arrive on the scene of a medical emergency in the municipality is equipped with an opioid antagonist and such person has received training, approved by the Commissioner of Public Health, in the administration of opioid antagonists.

There are additional resources available at www.ct.gov/dph/ems to assist you with the critical elements that should be included in the plan. **Once completed please submit your plan electronically to Steven Hotchkiss** at steven.hotchkiss@ct.gov. If you have questions about these new requirements please contact Steven Hotchkiss, Health Program Assistant via email or telephone (860)509-7832.

Sincerely,

Raffaella Calciano, RN, MEd. Paramedic
Director, Office Of Emergency Medical Services

CC: Steven Hotchkiss HPA2
Judith Reyolds, Region 2 EMS Coordinator
STORM ENGINE CO. AMB. & RESCUE CORPS - PSAR - Basic Ambulance
VALLEY EMS - PSAR – Mobile Intensive Care - Paramedic

8.2

# City of Derby, Connecticut

## Local Emergency Medical Services Plan

Prepared by the Storm Ambulance and Rescue Corps Inc.:

Revised 10/2025

Approved by the Mayor of the City of Derby:

Ems Plans per OEMS April 2006 in accordance with Connecticut General Statute 19a-181b, et.seq.

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# City of Derby, Connecticut

## Local Emergency Medical Services Plan

Table of Contents

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## INTRODUCTION

The City of Derby, Connecticut in accordance with Connecticut General Statutes as amended by CGS #19a-181b, et.seq. has prepared this local Emergency Medical Services (EMS) Plan. This plan was written by EMS Chief of Service for Storm Engine Company Ambulance & Rescue Corps Inc. and has been reviewed and approved by the Mayor of City of Derby. The plan has been written in consideration of the public safety, health and well-being of the residents, taxpayers and businesses residing within the limits of the City of Derby. Its purpose is to outline and detail an emergency medical services response system that complies with all of the laws of the State of Connecticut, Regulations of the Connecticut Department of Public Health Office of Emergency Medical Services and will provide for the EMS and Rescue needs of City of Derby in a safe and efficient manner.

## PREVENTION, CITIZEN RECOGNITION and ACTION

The City of Derby is blessed with a highly active injury prevention program and system and through the Storm Ambulance & Rescue Corps Inc. These injury prevention programs, first aid training programs are sponsored by, and a part of the Storm Ambulance and Rescue Corps Inc. Storm Ambulance conducts First Aid/CPR training for local little league, Pop Warner programs and local businesses through the American Heart Association. The Safe Communities Program of the Lower Naugatuck Valley is based on the National Highway Traffic Safety Administration and the Center for Disease Control models for Safe Communities. Storm Ambulance provides car seat safety programs, fire safety programs and safe kind programs. The goals are to build coalitions of concerned parties across the City of Derby, the Lower Naugatuck Valley and Southern Connecticut to design programs and increase safety awareness through the creation of educational programming and public service marketing. These programs have been nationally acclaimed as EMS based models for the entire nation to replicate and have received many national awards for their excellent programming. The Storm Engine Company Ambulance and Rescue Corps is responsible for planning and running public education and educational programs such as Citizen CPR and First Aid, Safe Sitter Baby Sitting, First There – First Care and the Enhanced 9-1-1 access system. Storm ambulance also provides Stop the Bleed classes. The Corps also provides training to local business and

public safety agencies in a variety of venues promoting workers' health and safety and employer involvement.

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## NOTIFICATION and DISPATCH

The City of Derby uses the enhanced 9-1-1 (E 9-1-1) made available through the statewide system. This system immediately pinpoints the address and telephone numbers of the calling party on a computer screen located at the City of Derby Police Department, which is the designated Primary Service Answering Point (PSAP) for the City of Derby's public safety agencies, EMS, Fire and Police. Through public education programs run by all three public safety agencies and the Safe Communities and Safe Kids Programs, the public in the City of Derby has been educated how to maximize the E 9-1-1 system and when to and when not to access the E 9-1-1 system. Further, the local City of Derby ordinances require every residence and business inside the Town limits to be properly identified with four-inch numbers visible from the road. Derby also utilizes the Code Red notification system and has been used during the recent pandemic to relay emergency medical information.

The City of Derby Police Department is designated as the Primary Service Answering Point (PSAP) for the Town. Secondary PSAP designation has been given to the Northwest Regional Emergency Communications Center (CMED) located in Waterbury, Connecticut. The Primary PSAP upon recognition that the 9-1-1 call is for a fire, rescue or medical emergency immediately switches the caller to the Secondary PSAP. The Secondary PSAP at NWCMED is staffed with highly trained certified emergency medical technician dispatchers. There is also a radio transmitter at Storm Ambulance Headquarters. which also can provide limited dispatch capabilities. The Northwest CMED compact and the protocols for dispatch are available at NWCMED hq. The dispatchers are trained in the use of Emergency Medical Dispatch computer aided systems.

The Storm Ambulance and Rescue Corps, Inc. is notified that there is a need for an EMS, Rescue or Haz-Mat response within the PSAR by a radio alert and pager system operated at and 453.050 MHz and maintained by the City of Derby. The tone system is activated by the C-MED and dispatched from the secondary PSAP located at Waterbury Hospital. The priority of the EMS response to the call is determined by the EMD system implemented by NWC-MED. CMED call takers use Medical Priority Dispatch System to obtain caller information and level of service needs.

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## THE EMS RESPONSE SYSTEM

Operation of the EMS system and the responses to medical emergencies, rescues and haz-mat emergencies within the City of Derby are managed by the Storm Ambulance and Rescue Corps, Inc. The Corps is a non-profit 501-(c)-3 Corporation founded in 1948 and organized as a Connecticut Corporation in 1961. The Corps has been the only designated Primary Area Service Responder (PSAR) for basic ambulance and rescue services in City of Derby since the State of Connecticut began to assign PSARs. In addition, the Storm Ambulance Corps has assembled and built a model EMS/Search & Rescue/Haz-Mat/Water Rescue response system in City of Derby over the last 7 decades, working in concert with the city and community.

The EMS/Search & Rescue system built by the Storm Ambulance & Rescue Corps has been on the forefront of technology since its inception, in 1954 Storms had the only rescue boat in the Lower Naugatuck Valley when the floods hit. In 1973 Storm Ambulance acquired the first "Jaws of Life in Connecticut", this was only the third set of "Jaws" in the nation, also in 1973 Storms trained the first personnel in the valley to meet what is known today as DOT Emergency Medical Technician standards. In 1980, Storm Ambulance was given Intermediate Advanced Life Support designation by the State of Connecticut ( now known as Mobile Intensive Care) and brought the C-MED radio system to the valley allowing doctors from Griffin Hospital for the first time to speak directly to Emergency Medical Technicians in the field. In 1989 Storms was the first to train its personnel to use Automated Electronic Defibrillators.

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Storm Engine Company Ambulance and Rescue Corps Inc. Currently owns and operates 2 Type II Mobile Intensive Care ambulances ((FD-10), FD-9) , 1 First Responder Mobile Intensive Care vehicle (1Kilo10), 1 Heavy Rescue Mobile Intensive Care Vehicle (Rescue 18), one Haz-Mat Response Mobile Intensive Care Vehicle (Haz-Mat 19) and two Watercraft Certified as a first Responder vehicles (Marine 1 & 2). All vehicles and offices for the ambulance service are housed at 151 Olivia St in Derby, CT.

**Mobile Intensive Care Defined**

**19a-179-1. Emergency medical services regulations. Definitions**

**MIC SERVICE DEFINED**

"Mobile Intensive Care Service" means the organized provision of intensive, complex prehospital care, consistent with acceptable emergency medical practices, utilizing qualified personnel supervised by physicians and hospitals as part of a written emergency medical services agreement with the mobile intensive care provider.

(u) "Mobile Intensive Care Unit" means an emergency vehicle equipped in accordance with Sec. 19a-179-18 (b) of these regulations and operated by a mobile intensive care provider.

**19a-179-12. Mobile intensive care services (MICS): MICS authorization for patient treatment and establishment of mobile intensive care services**

(a) Establishment of Mobile Intensive Care Services

(1) A proposal for the establishment of a mobile intensive care service (MICS) shall be submitted to OEMS at least 45 days prior to its anticipated implementation. This proposal must contain:

(A) A plan identifying the relationship between the MICS applicant and the sponsor hospital. This relationship shall be documented by a written agreement between the MICS applicant and the hospital's chief executive officer, and the proposal shall include a copy of this agreement. This agreement shall specifically include the standards for MIC personnel and programs set forth in Secs. 19a-179-10, 19a-179-16 and 19a-179-17 of these regulations.

2017 NOV 13 P 4:57

(B) A statement that the MICS will provide adequate and qualified personnel to ensure that the MICS will be continuously available on a 24 hour a day, 7 day a week, basis.

(2) OEMS will notify the appropriate regional council within five (5) days of receipt of a MICS application. Each regional council will consider the application and make its recommendations to OEMS within forty (40) days. Where a regional council recommendation is not adopted, OEMS will provide written comments to the appropriate regional council.

(3) MIC activities shall be subject to medical control and direction by sponsor hospitals.

(4) MIC personnel shall be under the supervision and direction of a physician at the sponsored hospital from which they are receiving medical directions.

(5) MIC services shall be under the control of the MIC medical director, or his or her designer, such as an on-line emergency department staff member.

(6) To be approved by the OEMS as a sponsor hospital, a hospital must:

(A) Be licensed under C.G.S. Sec. 19a-490 through Sec. 19a-493, inclusive.

(B) Appoint an emergency department staff person as liaison to the MIC personnel.

(C) Have a two-way radio communications system interface with the capability to provide prehospital medical direction.

(D) Appoint an MIC medical director who shall be responsible for the following:

(i) Appropriateness of current operating protocols.

(ii) Assurance of medical supervision and training of MIC personnel.

(iii) Review of MIC personnel medical performance.

(iv) Withholding of medical authorization and the recommendation of suspension of MIC personnel from the system when in the interest of patient care, in accordance with Sec. 19a-179-15 (c) of these regulations on licensure and certification.

(7) Each sponsored hospital must provide OEMS with documentation that shall include:

(A) A description of the role that the hospital is to have in the MIC system.

(B) A description of the procedures to be followed by MIC personnel in obtaining medical direction.
(C) The treatment protocols to be used.
(D) Procedure for modification of treatment protocols.
(E) A description of the quality assurance function.

(8) Upon completion of the requirements of subdivisions (5) and (6) above, OEMS shall approve the hospital as a sponsor hospital. Such approval shall continue so long as:
(A) The hospital continues to meet the requirements of subdivision (5) above, and
(B) The hospital notifies OEMS of any changes in the information supplied to OEMS pursuant to subdivision (6) above within thirty (30) days thereof.

(9) Any service providing mobile intensive care on the effective date of these regulations shall have twelve (12) months to comply with these regulations.

(b) MICS Authorization for Patient Treatment

(1) Certified MIC personnel functioning with an approved MICS are authorized to perform the following medical care treatments under medical control:

(2) Persons other than certified MIC personnel who function with an approved MICS may be authorized to perform any of the medical care treatments under medical control set forth in subsection (b) (1) above provided that:
(A) all other criteria of this section are met; and,
(B) Prior application is made and written approval of OEMS is obtained based on its determination that such personnel can perform said treatments at least as proficiently as people who are certified. Such people shall be registered but not certified by OEMS.

(3) Prior to licensure or certification, a MICS must submit a roster of its mobile intensive care personnel to its sponsor hospital and to OEMS. The roster must be corrected as changes occur.

(c) Any service licensed or certified on the effective date of these regulations shall have twelve (12) months to comply with Sec. 19a-179-12 (a) of these regulations.
(Effective June 14, 1988.)

**19a-179-10. Categorization of and staffing requirement for services**

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**STAFFING MIC**

Basic Ambulance Service. A basic ambulance service has the capability of providing at least the following at the scene of each EMS call to which it responds:

(1) Minimum Personnel

(A) One medical response technician (MRT) who is certified in accordance with Sec. 19a-179-16 (a) of these regulations; and

(B) One emergency medical technician (EMT) who:

(i) Is certified in accordance with Sec. 19a-179-16 (b) of these regulations; and

(ii) Shall always attend the patient in the patient compartment of the ambulance.

(2) Basic ambulance service vehicles shall comply with Sec. 19a-179-18 (a) of these regulations.

Shall always attend the patient in the patient compartment of the ambulance.

**19a-179-18. Minimum vehicle standards**

(a) Basic ambulance vehicles shall be inspected at least annually by OEMS and shall conform to the following design and equipment standards:

(1) Design.

(A) Minimum 60" headroom in patient compartment measured from floor aisle space to head liner.

(B) Minimum 114" interior length in patient compartment from inside back door to rear of driver's compartment.

(C) Minimum 12" unobstructed aisle space between primary patient stretcher and any obstruction for full length of primary patient stretcher on one side.

(D) Ability to achieve and maintain an average patient compartment temperature of 65 degrees - 70 degrees regardless of weather conditions.

(E) Electrical intercom or signal lights or an open partition to permit exchange of patient condition information between patient compartment and driver.

(F) Sufficient secure storage to permit secure loading and confinement of all items which could move freely about patient area in the event of a collision or roll over.

(G) 3600 vehicles were visible to rotating or flashing warning lights.

(H) Mechanical and/or electrical siren.

(I) Two-way radio communications that are compatible with the state approved communications system and will allow communicating with communications coordinating centers (e.g., regional communications centers, central emergency medical dispatch), dispatch and/or directly to the hospital.

(J) Exterior identification visible on two opposite sides of vehicle showing the name of the service the vehicle is operated by.

(K) Any basic ambulance vehicle shall meet or exceed the design criteria of General Services Administration Specifications KKK-A-1822, as amended, with the following exceptions and/or substitutions [Federal specification number shown in parenthesis ()]:

(i) Spare tire (3.6.10)
(ii) Tire changing tools (3.6.3)
(iii) Engine high idle speed control, automatic (3.7.6.1)
(iv) Internal 12-volt D.c. power (3.7.7.3)
(v) 115-volt a.c. utility power (3.7.8)
(vi) Utility power connector (3.7.8.1) - optional
(vii) Electrical 115-volt a.c. receptacles (3.7.8.2)
(viii) Solid state inverter (3.7.8.3)
(ix) Override front bumpers (3.9.6.1)
(x) Interior storage accommodations (3.11)
(xi) Exterior storage accommodations (3.11)
(xii) Extrication equipment and storage (3.11.2.1)
(xiii) Storage compartments and cabinet design transparent doors (3.11.3)
(xiv) Color, paint and finish (3.16.2)
(xv) Color standards and tolerances (3.16.2.1)
(xvi) Emblems and markings (3.16.4)-substitute the following:
  a. Front of vehicle - the word "AMBULANCE" in block, reflectorized letters, not less than four inches high shall be mirror image, centered above the grill.
  b. Sides and rear of vehicle - the work "AMBULANCE" shall be in block, reflectorized letters, not less than six inches high, centered on each side and rear of vehicle body.
(xvii) Rustproofing (3.18)

(xviii) "Star of Life" (4.3)
(xix) Intended Use (6.1)

(2) Equipment

(A) Oxygen administration apparatus with 2 hours supplies at 7 lpm flow rate, regulator-controlled flow rate permitting adjustment from a minimum of 2 lpm - 10 lpm with visual indication of flow rate. Adaptors so that a minimum of 2 patients may be provided with O (2) at the same time. A minimum of 2 each, nasal cannulas, and mouth/nose masks.

(B) Portable oxygen administration apparatus with 30 minutes supply at 7 lpm flow rate, which is operable totally detached from parent vehicle. Such a unit shall be capable of accepting attachment to a nasal cannula, mouth/nose mask or as enrichment feed to a forced ventilation unit.

(C) Suction apparatus capable of drawing a vacuum of 300mm of mercury. Such a unit shall be operable completely independent of parent vehicle for a minimum period of 15 minutes. Such suction apparatus shall be compatible with both rigid and flexible catheters and a minimum of 1 catheter, and 1 spare shall be carried.

(D) Mechanical forced resuscitation unit which is either hand operated (bag mask) or cycled only by operator manual control. Pressure cycles units are not acceptable. Such units shall be compatible with O (2) apparatus carried in the subject vehicle for purposes of oxygen enrichment. Such units shall be compatible with infant, child and adult masks which shall be made of transparent material and shall be carried.

(E) Nonrigid, mouth-to-mouth, oropharyngeal airway maintenance devices in infants, child, and adult sizes. A minimum of 1 and 1 spare for each size.

(F) Bite sticks for maintaining an open-jawed position on an unconscious patient.

(G) A minimum of six large dressings of the ABD or multi-trauma type.

(H) Assorted dressings and bandages to facilitate hemorrhage control by direct pressure bandage on any area of the human body regardless of severity of hemorrhage.

(I) Aluminum foil, sterile vaseline gauze or other air excluding dressing material to permit airtight seal of wounds to the chest cavity.

(J) Two sterile sheets for isolating burn patients from external sources of contamination.

(K) A splinting device suitable for providing prolonged traction to a lower limb on a child or adult.

(L) Splinting material to permit immobilization and protection to any portion of a child or adult limb in any position. A minimum of 1 spare shall be carried for each size of splint.

(M) Short extrication device (e.g., short backboard with 2 straps minimum of 9' by 2", forehead and chin restraints) to permit the immobilization of suspected cervical fracture of a child or adult patient during removal from a confined space while in a seated position and during transport.

(N) A long extrication device (long backboard with 2 straps minimum 9' by 2") to permit the immobilization and transport of a spinal column fracture without vertical or horizontal expansion, contraction or twisting. A scoop stretcher is not a suitable device for this requirement.

(O) cervical immobilization collars of assorted sizes (extrication type collars are recommended).

(P) Commercial stair chair to permit the movement of a patient either up or down within a confined stairway.

(Q) Adult and pediatric blood pressure manometers, and cuff, and stethoscope for determining patient blood pressure both outside and inside of vehicle.

(R) Restraint devices of sufficient strength to restrain a violent adult and sufficiently padded to prevent chafing or injury to patient.

(S) A poison treatment kit in addition to one half gallon potable water.

(T) An obstetrical kit containing a minimum of 1 pair of sterile gloves, scissors, umbilical cord clamps or tapes, sterile vaginal dressings, 2 towels, a large plastic bag, and swaddling material.

(U) One emesis basis, 1 bed pan and 1 urinal.

(V) Not less than 2 pillows and 2 sets of linen to include 2 sheets, 2 pillowcases, and 1 blanket per set.

(W) A minimum of 210 lb. ABC UL fire extinguishers, 1 carried in a driver compartment and 1 in patient compartment.

(X) At least two batteries operated, hand carried portable lights.

(Y) One wrecking bar is at a minimum of 24" in length.

(Z) At least one cot with 2 patients securing straps. Such a cot shall be removable from the ambulance, and provision shall

be made for positive locking when the cot is positioned in the vehicle.

(AA) Glucose in a form easily ingested orally.

(BB) A rebreathing device for use in treating hyperventilation syndrome.

(CC) Highway distress signaling devices, either a minimum of 3 hours duration red burning flares, or four reflectorized road marking triangles.

(DD) Two sets of sandbags.

(EE) Disposable procedure gloves, gowns, masks, and goggles.

(3) Each basic ambulance vehicle shall display decals supplied by OEMS on the rear exterior and in the patient compartment of the vehicle indicating it is certified by OEMS. Such decal shall be easily visible in the patient compartment and on the rear exterior of the vehicle.

(4) All required equipment shall be in working order, and each crew member shall be knowledgeable in the operation of such equipment. Substitution for equipment may be made only with the prior written approval of OEMS, upon its determination that the substituted equipment will function at least as well as that which is specified in subsection (2) above.

(5) Each basic ambulance certified vehicle shall be registered by the Connecticut department of motor vehicles as an ambulance.

**(b) MIC Units shall conform to the following design and equipment standards.**

**(1) Design.**

**(A) Compliance with all safety and design requirements of the Connecticut department of motor vehicles.**

**(B) Compliance with all federal requirements for vehicle safety design.**

**(2) Equipment.**

**(A) Must comply with applicable requirements for basic certification either first responder or basic ambulance.**

**(B) Airway maintenance equipment as defined by the RMAC and approved by OEMS.**

(A) For EMT-Paramedic units only.

as defined by the RMAC and approved by OEMS.

(3) All equipment including that used for invasive therapies shall be cleaned and maintained between uses to assure protection from infection in subsequent use.


(c) Four 30-minute road flares or warning reflectors.

(A) Separate seat restraints for securing patients in wheelchairs prior to loading, in the same quantity as the maximum number of patients the vehicle is designed to accommodate.

(B) Either motion sickness bags or plastic containers with covers in sufficient number equal to the maximum number of patients the vehicle is designed to accommodate.

(F) Blankets made of nonflammable material in sufficient number equal to the maximum number of patients the vehicle is designed to accommodate.

(8) Exterior Vehicle Identification:

(A) Utilize the state approved handicapped sticker minimum of 4" height and located on each side of the vehicle.

(B) Exterior identification visible on each side of the vehicle identifying the service which operates the vehicle with a minimum 4" lettering.

(C) Seating capacity shall be displayed in 2" lettering at curb side of the vehicle.

(9) All replacement invalid coach vehicles shall follow these regulations.

(10) All invalid coach vehicles currently in use shall follow these regulations by January 1, 1990.

(d) (d) Emergency medical service vehicles shall be inspected every two years by OEMS at formally designated biennial inspections in addition to unannounced inspections or at hospital spot checks of ambulance vehicles. At such inspections, the OEMS inspector shall examine the vehicle for compliance with the above requirements and may also inspect for the following:

Tires--for minimum tread depth as required by the Department of Motor Vehicles or for structural damage to the body of the tire.

(2) Holes in the body of the vehicle into the driver or patient compartment.

(3) Broken or missing windows.

(4) Malfunctioning doors or door latches.

(5) Missing door seals.

(6) Missing or broken safety equipment including lights, mirrors, horns, or other devices required by law or regulation necessary to ensure the safe operation of the vehicle

(e) By virtue of the inspection as called for in Sec. 19a-179-18 (d) of these regulations, should an OEMS inspector determine that an ambulance vehicle is unsafe for any reason cited in the aforementioned section, the OEMS inspector shall affix a sticker to the outside of the window in the


rear door which reads: "THIS VEHICLE IS UNSUITABLE FOR PATIENT TRANSPORTATION." The sticker shall be removed only by an OEMS inspector upon the reinspection of the vehicle and determination that the missing or damaged equipment has been repaired or replaced. During the period when the sticker is affixed to the vehicle, said vehicle shall not be used for patient transportation. The owner may request a hearing before the commissioner of health services or his designee to petition for reconsideration, stating upon what grounds such petition is based. Said hearing shall be conducted within forty-five (45) days of the request unless otherwise agreed by the requester and the commissioner.
(Effective June 14, 1988; Amended effective September 30, 2003.)

**Mutual Aid**

Another layer of the system is that if the primary Storm Ambulance transporting vehicles are committed to calls and another one comes in one of the Storm Ambulance rescue vehicles will function as a first responder to managing medical care until a transporting service arrives. It is recognized in this plan that the officers of the Storm Ambulance and Rescue Corps are responsible for medical incident command at all EMS scenes to which it responds and acts in concert with the fire and police incident commanders, as necessary. Response time criteria and response protocols and activity reports are supplied to the City of Derby office of the Mayor and the PSAR provider (Storm Engine Company Ambulance & Rescue Corps Inc.) monthly. Storm Ambulance annually presents its needs for financial assistance to the Derby Board of Apportion and Taxation. The presentation includes an annual financial report from the organization. The City of Derby provides in kind insurance, facility support, and capitol purchases such as apparatus.

Currently, the Public Safety Area Response for the City of Derby for Paramedic level services is held by Valley Emergency Medical Services, Inc. (VEMS) as part of a larger regional PSAR covering the five Valley towns of Ansonia, City of Derby, Oxford, City of Derby, and Shelton. VEMS is a non-profit 501-(c)-3 non-profit corporation founded in 1981 and organized as a Connecticut Corporation in 1984. Storm Ambulance and Rescue Corps, Inc., currently hold a seat on the VEMS Board of Directors as does the City of Derby. Response time criteria and response protocols will be spelled out in the individual contract yet to be agreed to by the Town and the PSAR provider, who in this case is Valley Emergency Medical Services, Inc. later.

The City of Derby and Storm Ambulance & Rescue agree that they will work in concert to return to PSAR at the paramedic level Storm Ambulance upon their request and demonstration of a plan that will competently provide for paramedic services to the residents and visitors to the City of Derby and CT OEMS.

This EMS response plan specifically requires that the first responder respond and arrive within 8 minutes of dispatch which is the Connecticut average response time, (due to the lack of a designated first responder, Storm Ambulance Fills that role.) Basic/intermediate ALS level primary service area responder, in this case the Storm Ambulance and Rescue Corps, Inc., secure a response crew to manage an EMS emergency within the PSAR within six (8) minutes from time of dispatch a minimum of 75% of the time. If a crew cannot be secured, then the call should be passed to a mutual aid responder Through NWCMED. This plan requires that the average response times for calls responded to by the PSAR holder be within acceptable industry standards and not more than ten minutes on average per month. These areas should be specified in a future contract between VEMS, Storm Ambulance and City of Derby. Mutual aid to the City of Derby is agreed upon through the Northwest CMED system.
The EMS response plan for the paramedic ALS level primary service area responder will be at the discretion of the protocols established within the emergency medical dispatch system and standards established by the Northwest Regional Emergency Medical Dispatch System (NWCMED). In addition, any emergency medical BLS/ALS personnel on scene or the medical incident command system may request an ALS level response from the PSAR holder, in this case Valley Emergency Medical Services, Inc. at any time.

A Mass Casualty/Multiple Casualty Plan for the City of Derby was written in 1978, revised in 1986 and 1995 and 2003 and has been in file with the State of Connecticut Department of Public Health, the South-Central Regional EMS Council and State of Connecticut Emergency Management since it was written. C-MED dispatch policies for mutual aid will be utilized for MCI Incidents per C-Med compact and C-MED Dispatch Protocols)

Mutual aid plans are established in the Computer Aided Dispatch System (CAD) that is operated by the City of Derby by the Northwest Regional Emergency Medical Dispatch System (CMED). Agreements are set forth by the CMED Compact which is to be adopted by the City of Derby with this plan for specific mutual aid commitments as part of the CMED system.
Storm Engine Company Ambulance & Rescue Corps Inc. is compliant with the National Incident Management System.

This plan is to be reviewed and revised as necessary by the City of Derby and Storm Engine Company Ambulance & Rescue Corps Inc. every 5 years, (last review in 2024 and the results are available in the City of Derby Clerk's office.

## OVERSIGHT

It is recognized that the authority for providing Emergency Medical Services, Rescue Services and Haz-Mat responses for the City of Derby falls under the home rule statutes of the State of Connecticut. Storm Engine Company Ambulance & Rescue Corps Inc. is the Primary Service Area Responder for the city of Derby. Therefore, oversight of the Emergency Medical Services System is the responsibility and the Chief of Services of Storm Ambulance and Rescue Corps Inc, the mayor of the City of Derby is an advisor to Storm Ambulance.

Sign Here
Date

Approved by :

Joseph DiMartino _____ Date _____
Mayor City of Derby

Thomas Lenart Thomas Lenart Date 10/26/2025
Chief of Emergency Medical Services
Derby Storm Ambulance & Rescue Corps Inc.

All attachments are available upon request to Storm Ambulance

8.2

# STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

CERTIFICATE OF OPERATION C037B1

FOR
STORM ENGINE CO. AMB. & RESCUE CORPS
151 OLIVIA ST
DERBY, CT 06418-1712

Is hereby authorized to operate **6** vehicle(s) in a BA category beginning **07/01/2025** and ending **06/30/2026**.

Of the **6** authorized vehicles, the certificate holder will be permitted to equip and use not more than **2** ambulance(s), **0** invalid coach(es), as defined by Chapter 368d, Section 19a-175 of the Connecticut General Statutes, and **0** as non-transporting emergency medical service vehicle(s) as defined in Section 19a-180-1(b)(4) of the Regulations of Connecticut State Agencies. The applicant is also authorized to operate **0** branch locations. Addresses of the authorized branch locations are on file in the Department of Public Health.

Applicant has furnished evidence of financial responsibility as required by Section 19a-180 of the Connecticut General Statutes, as amended

Applicant has met the minimum standards of the State Department of Public Health in the areas of training, equipment and personnel for operation of an emergency medical service or is presently operating under a waiver of certain provisions of the regulations.

Applicant has demonstrated its suitability to provide emergency medical service.

A copy of this certificate shall be displayed prominently in the above-stated operational headquarters and at each location from which the provider is granted to operate under this certificate.

Dated: June 27, 2025

Manisha Juthani, MD
Commissioner

*Phone: (860) 509-8100*
*Telephone Device for the Deaf (860) 509-7191*
*410 Capitol Avenue - MS # 12EMS*
*P.O. Box 340308 Hartford, CT 06134*
*An Equal Opportunity Employer*

8.2

# DERBY CT
# Mass Casualty Care Plan

Thomas Lenart
Chief Storm Ambulance & Rescue Corps Inc. 10/26/2025

8.2

# CITY OF DERBY EMS MASS CASUALTY CARE PLAN

**ORGANIZATION AND STRUCTURE OF OPERATIONS**

Orig. May 1978 (Rev. Nov.22,1986) (Rev. Nov. 17,1995) (REV. December 2003) (Rev. Sept 2010) (Rev. Oct. 2015) (REV 2025)

## Introduction

Mass casualty incidents (MCIs) present formidable challenges to the emergency response systems of any community. In Derby, Connecticut, protecting the lives and health of residents and visitors during such events requires a coordinated, rapid, and effective approach, especially when the number of casualties exceeds the resources available for routine emergencies. The City of Derby Mass Casualty Care Plan provides a comprehensive framework designed to facilitate the management of these incidents. It ensures seamless collaboration among emergency medical services (EMS), fire, police, hospitals, and all supporting agencies.

This plan establishes clearly defined response levels based on the estimated number of casualties and details of the roles and responsibilities of each participating organization. It includes protocols for triage, patient treatment, and transportation, emphasizing effective communication and effective resource allocation. By following this plan, Derby's emergency responders can optimize the use of available resources, deliver prompt care, and uphold the highest standards of patient safety during times of crisis. Routine reviews and ongoing training guarantee that the Mass Casualty Care Plan remains current, reflects best practices, and incorporates lessons learned from previous incidents. Through continued preparedness and partnership, Derby is dedicated to safeguarding its community during mass casualty events.

## Levels of Response

There are three levels of community response defined in this plan. The threshold for each level is determined by the estimated number of casualties and the ability to bring sufficient ambulances and crews to reach all victims within the initial 15 minutes of operations.

## Level I Response

Level I covers incidents with three to threshold number of casualties, as calculated and documented by Storm Ambulance personnel. This threshold is based on the capacity to provide necessary resources to all victims within the first 15 minutes. If calculations are unavailable, Level I applies to incidents involving 3 to 15 victims. Routine backup units are utilized as needed, and patient care is organized as follows:

1. Single Step Triage
2. Primary Survey
3. Secondary Survey
4. Load Patients
5. Transport

## Level II Response (More Than 15 Casualties)

Level II applies to incidents with casualties exceeding the Level I threshold (more than 15 victims) and up to 150 estimated casualties. Response actions include:

1. Single sector mutual aid dispatch, including a call for 10 additional ambulances to the scene.
2. Primary Triage
3. Secondary Triage
4. Secondary Triage and Tagging (metatag)
5. Establishment of a separate area for EMT-level treatment
6. Triage Master receives medical direction from the Resource Unit and Medical Director
7. Loading Officer oversees the ambulance holding area.
8. Inter-hospital activity coordinated by the Medical Director

## Level III Response (More Than 150 Casualties)

Level III involves incidents with more than 150 casualties. The initial setup mirrors Level II (steps 1-8), with additional measures:

1. Second sector wide mutual aid calls to bring additional ambulances to the scene in units of 10 as needed.

# On-Scene Organization

On-scene organization is determined by the response level. For Level II and Level III incidents, the following procedures are followed:

1. First Responding Storm Ambulance Unit: Units such as 4Kilo 1, FD-9, FD-10, Rescue 18, or Haz-Mat 19 must:
2. Obtain authority to access the scene from the Incident Commander

3. Estimate the number of victims and communicate this to Northwest Public Safety
4. If fewer than 16 patients are present, proceed with standard patient identification, surveys, prioritization, treatment, loading, and transport, aiming for all victims to be under care within 15 minutes.
5. If 16 or more victims are present, delay transport for 15-30 minutes to complete patient triage and sequencing.
6. Scene Control Officer: The crew chief of the first Storm Ambulance unit assumes medical command as the Scene Control Officer until relieved by a senior officer. This officer maintains contact with medical control via Northwest Public Safety (NWPS) and the fire officer at the command post, utilizing START and JUMP START triage protocols as well as Step Up protocols for EMS.
7. Primary Triage Officer: The first responding paramedic unit assumes the role of Primary Triage Officer, working under the Scene Control Officer to direct and manage medical treatment in the triage area.
8. Secondary Triage Officer: An EMT from the first Storm Ambulance unit assists the paramedic as Secondary Triage Officer, inventories the scene, and applies METTAGS to patients. Up to three Secondary Triage Officers may be assigned, based on available METTAG resources.
9. Triage Master: The next responding EMT from Storm Ambulance serves as Triage Master, establishing staging and triage areas, coordinating incoming ambulance and emergency personnel, setting up treatment and loading access.
10. Loading Officer: Appointed by the Triage Master, the Loading Officer receives arriving ambulances (notified by NWPS) and oversees the orderly transport of patients, typically beginning after the first 15 minutes of organization.
11. Other Responders: Fire department, civil defense, police, and other trained medical personnel report to the Scene Control Officer for instructions and patient care activities.

## Hospital Integration

Hospitals are linked to the system via Northwest Public Safety. NWPS notifies appropriate medical and trauma facilities according to their MCI protocols.

1. Griffin Hospital / Medical Control: Griffin Hospital determines when to activate inter-hospital disaster coordination. The hospital requests all necessary information from the scene to calculate resources. Medical control is managed directly from the scene through the Primary Triage Officer

via NWPS, including regular updates on casualty numbers, priorities, and transport times.

2. No formal arrangements exist for dispatching hospital medical teams to the scene.

### General Requirements

- The METTAG system and nomenclature will be used.
- Helicopter use at the scene is discouraged unless ground transport is unavailable; helicopters may be used to transfer critical patients between hospitals.
- The terms "LEVEL I, LEVEL II, and LEVEL III" are dispatch protocols for response. On-scene and hospital personnel should refer to incidents by specific casualty counts and the need for patient sequence.
- All responding units must comply with the City of Derby Incident Command System and communicate through the established chain of commands.

## Ambulance Dispatch Protocol for Mass Casualty Response

### Level I Response (3-15 Estimated Casualties)

Upon authorized command from the scene, backup ambulance dispatchers are contacted in priority order to supply the requested number of ambulances.

### Level II Response (16-150 Estimated Casualties)

Upon authorized command, local ambulance dispatchers are contacted in the following order, with dispatch to the identified scene:

1. Storm Ambulance Corps: 2 transporting vehicles (NWPS or 203-732-1963), 3 first responder vehicles
2. Ansonia (ARMS): 1 vehicle & MCI Unit (NWPS or 203-735-6893)
3. Echo Ambulance: 1 vehicle (SW C-MED or 203-338-0762)
4. Seymour Ambulance: 1 vehicle (NWPS or 203-758-0050)
5. AMR: 1 vehicle (SW C-MED or 203-332-4080)
6. Oxford Ambulance: 1 vehicle (NWPS or 203-758-0050)
7. Ansonia (ARMS): 1 vehicle (NWPS or 203-735-6893)
8. Seymour Ambulance: 1 vehicle (NWPS or 203-758-0050)
9. Echo Ambulance: 1 vehicle (SW C-MED or 203-338-0762)
10. AMR: 1 vehicle (SW C-MED or 203-332-4080)

11. Beacon Hose Ambulance: 1 vehicle (NWPS or 203-758-0050)
12. Bethany Ambulance: 1 vehicle (NWPS or 203-758-0050)

VEMS units are automatically dispatched with the first Derby units. Remaining paramedic units are sent as needed by C-MED upon request from the scene.
When units 1-5 are dispatched, a second ARMS vehicle is stationed at Griffin Hospital to cover Ansonia, Derby, and Seymour. When units 6-10 are dispatched, Prospect sends a unit to cover Seymour, Oxford, and Bethany.

## Level III Response (Over 150 Estimated Casualties)

For Level III, ambulance dispatching follows Level II procedures. Additionally, a second statewide call-up is made for the required number of vehicles arriving at Derby, coordinated through all statewide C-MED systems.
All actions for each section must be confirmed by the authorized command officer at the scene upon completion.

## Mass Casualty Resource Inventory

| Name of Service | METTAGS | Backboards |
|---|---|---|
| Storm Ambulance | 300 | 20 |
| ARMS | 200 | 10 |
| Echo Ambulance | 200 | 10 |
| Seymour Ambulance | 200 | 10 |
| Oxford | 200 | 10 |
| American Medical Response | 500 | 20 |
| Beacon Falls Ambulance | 100 | 8 |
| Bethany | 200 | 10 |

Signed
Thomas Lenart 10/20/2025
Thomas Lenart
Chief of Service
Storm Ambulance & Rescue Corps Inc.

9.1

**Rescind the motion below from July 10,2025 BOA Meeting.**

8.4 Empower Retirement 457 Savings Plan

Move to authorize removal of restriction prohibiting access to a participant's own personal funds prior to retirement, specifically excluding any City of Derby funds.

Summary:

The restrictions are designed to:

- Preserve the tax-deferred status of the plan.
- Ensure funds are used for retirement or true emergencies.
- Comply with IRS regulations.

Removal of these restrictions would put the tax-deferred status for the entire 457 Plan in jeopardy.

**New Motion**

Empower Retirement 457 Savings Plan

Move to authorize participants in the Empower Retirement 457 Savings Plan to take loans against their own personal contributions prior to retirement. This authorization explicitly excludes any funds contributed by the City of Derby.