

LaSalle Ambulance Service Inc.

Active Threat/Shooter Response Best Practice Guide

Purpose

The Active Threat/Shooter Response Best Practice Guide is included in the Green Book appendix for reference purposes. Application of the best practices should be reserved for our medical staff that has received the Active Threat/Shooter Best Practices training.

Introduction

According to FEMA, over 250 people have been killed between 2000 and 2012 because of active shooter incidents. Active shooters is defined as an individual or individuals actively engaged in killing or attempting to kill people in a confined and populated areas usually by the use of firearms with little pattern or method to the selection of their victims.

Historically, EMS procedure and protocols called for the EMS crew to operate only in the cold zone, which is an area in which no significant danger, or threat is reasonably anticipated. There has been extensive work by many agencies to enhance survivability from these mass-shooting incidents. The Department of Homeland Security states, "in order to maximize lives saved, there is a need to get life-saving medical attention to victims quickly".

This purpose of this document is to outline the expectations of LaSalle Ambulance EMS personnel that respond to such events once they have participated in the Active Threat/Shooter Training.

Definitions

Hot Zone: area wherein a direct and immediate life threat exists. In an active shooter event, this is the area in which the perpetrator is actively involved in violence and is dangerous until the threat has been neutralized and declared safe by law enforcement

Warm Zone: the area between the hot zone and cold zone in which a potential threat exists but it not direct or immediate. Area in which an indirect threat exist. This area is *clear* but not *secure* and can become a hot zone rapidly. Law Enforcement will typically refer to this as Code 4.

Cold Zone: area free of danger either by distance or after being deemed free of danger by law enforcement. EMS personnel will stage to triage, treat and transport victims once removed from the warm zone.

Cleared: area that has been searched and there is no perpetrator present.

Secured: an area that has been searched and is under direct law enforcement control.

Concealment: a structure that hides a person's exact location but can be penetrated by ballistic weapons.

Cover: An area generally impenetrable to ballistic weapons, such as a concrete wall. Something that prevents a responder from being observed by the perpetrator and provides direct protection from the threat.

Contact Team: A team of law enforcement officers who make immediate entry into active shooter scene to locate and neutralize the threat.

Rescue Task Force (RTF)*: The Rescue Task Force should consist of a minimum of four personnel: Two EMS and two-law enforcement. There should be a law enforcement officer for each EMS provider to deliver security. The purpose of the Rescue Task Force is to make entry in the warm zone to treat, stabilize and removal of injured patients to casualty collection points.

**If a medic does not feel safe serving the role of an RTF, they are not required to serve in this capacity.*

Point-of-Wound Care: The physical location where patient care is initiated at or near to where the victim was injured. Treatment should be limited to bleeding control and treatment of chest wounds.

Casualty Collection Point: Location where casualties are assembled. The location that triage and further stabilization is provided prior to transport.

Tactical Emergency Casualty Care (TECC): A set of best practice recommendations that provide a framework to prioritize medical care in areas of high-risk operations.

Procedure

First Arriving Unit(s)

- Determine as soon as practical if responding to a static or ongoing situation and relay information to the communications center.
- Initially stage in cold zone and communicate with Law Enforcement agencies to get information on situation. Prior to deployment of anyone into scene outside of the cold zone, face-to-face communications with law enforcement is required.
- Assume and announce Incident Command.
- Law enforcement will establish 1-2 contact teams of 1-4 officers in effort to engage and neutralize the threat.
- If possible, Incident Command should identify Casualty Collection Point prior to deploying. Depending on the size of the incident and location, injured victims may need to be placed in a Casualty Collection Point before transition to the cold zone.

Additional Resources Arrive on Scene

- Once the threat has been neutralized or a potential threat exists but it not direct or immediate, establish Rescue Task Force teams comprising of 2 EMS providers/fire department personnel and 2-4 law enforcement personnel and prepare for deployment. Law enforcement will be in front and in rear of the EMS providers (see diagram).
- The least number of personnel and teams should be deployed into the warm zone to achieve the goals.

Rescue Task Force Deployment

- Incident Command will deploy the RTF teams into the warm zone with armed law enforcement personnel to provide point-of-wound care prior to extrication of victims to a Casualty Collection Point. The goal of the initial RTF it to stabilize as many victims as possible.
 - Incident Command will dispatch RTF teams by number i.e. RTF 1.
 - RTF teams are not to deploy unless they have two personnel from law enforcement as security
 - RTF teams will NOT self-deploy into the warm zone

- The first RTF team in operation will enter the area and treat patients as they are assessed and they will continue to assess and treat patients until all patients have been treated or in need of resupply of equipment.
 - RTF teams will notify IC of their location and any victims encountered.
Communication between the IC and RTFs is essential for effective resource coordination and allocation
- In the unlikely event that the RTF team encounters a threat or suspect, the medical personnel must immediately:
 - Evacuate if safe to do so
 - Shelter in place that provides protection
- Patients that are encountered that can ambulate without assistance will be directed by the team to self-evacuate down the cleared corridor under law enforcement direction.
- Patient care should be based on the principles of Tactical Emergency Casualty Care guidelines and limited to the following treatments:
 - Bleeding control
 - Tourniquets
 - Hemostatics if available
 - Airway Management
 - Chin lift or jaw thrust
 - Place casualty in recovery position
 - Breathing
 - Open and/or sucking chest wounds should be treated immediately by applying an occlusive dressing or a commercial vented chest seal
 - If signs/symptoms of a tension pneumothorax, needle decompression should be performed
- Dead patients should visibly be marked with a black triage tag to allow for easy identification and to avoid repeated evaluations by additional RTF teams. Black tags are the only tags used by the RTF.
- Additional RTF teams that enter the area should be primarily tasked with extrication of the victims already treated by the initial team and brought to a Casualty Collection Point.
- While it is important to minimize the number of personnel and teams that are deployed in the warm zone, in large-scale events, it may be necessary to deploy additional RTF to provide assessment and treatment of victims.

Patient Care in the Warm Zone

- Patient care should be based on the principles of Tactical Emergency Casualty Care guidelines and limited to the following treatments:
 - Bleeding control
 - Tourniquets
 - Airway Management
 - Chin lift or jaw thrust
 - Place casualty in recovery position
 - Breathing
 - Open and/or sucking chest wounds should be treated immediately by applying an occlusive dressing or a commercial vented chest seal
 - If signs/symptoms of a tension pneumothorax, needle decompression should be performed

Casualty Collection Point

- Patients should be triaged and treated in this area consistent with the MCI protocol/policy.