LUCAS COUNTY

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TO: ALL LUCAS COUNTY PARAMEDICS

FROM: Brent Parquette, NRP
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DATE: August 12, 2016

SUBJECT: **Continuing Education – September 2016**
RTF-Active Shooter Training

In the wake of Columbine, Virginia Tech, Aurora, Sandy Hook and other recent active shooter/mass casualty incidents (ASI/MCIs), there are numerous federal, state and local agencies scrambling to establish operational guidelines for combining law enforcement, fire and EMS first responders into Rescue Task Forces (RTFs) prior to the arrival of tactical teams.

At the same time, thousands of law enforcement officers (LEOs) are being violently assaulted each year and, as a result, there's a national call for training and equipping all officers for self-aid and buddy aid. However, unified command and interagency emergency operations plans will only work if first responders are properly equipped and trained to assess, treat and extract casualties much faster than normal EMS operations.

We must identify core skills, training and equipment necessary to assure that the RTF brings assets, rather than liabilities, into an ASI/MCI. This will increase efficiency of operations, thereby decreasing preventable deaths, rather than adding more potential casualties.

Considering the past few years and the subsequent knowledge first responders have on both the threat and the rapid nature of the fatalities, it would be reasonable to wonder if the first responders will actually follow the safe staging guidance.

The vast majority of fire and EMS responders, as has been demonstrated several times over the past few years, aren't satisfied to stand by. They know there are injured in need of immediate care.

A Paradigm Shift for EMS: The EMS response mindset is undergoing change; rather than asking, "Is the scene completely safe?" the more appropriate question should be, "Is the scene safe enough?" based upon what's known at the time.

EMS agencies need to consider how they will operate in the warm zone environment with other responding agencies. Regular training with law enforcement partners is a key component to a successful response, with all agencies knowing how they'll work with one another. This is done through the sharing of ideas, understanding common tactics, techniques and procedures, developing common terminology and understanding both capabilities and limitations.

Lucas County EMS, in conjunction with its law and EMS agency partners, has been working on a county-wide plan that would allow for the formation of Rescue Task Force Teams to deploy in the unfortunate circumstance of an active shooter event in our area.

During the month of September we will provide information to all of the county paramedics on the current status our active shooter plan that has been in the making for the last 3 years. We will also get you acclimated to the safety equipment (ballistic gear / triage-bandaging) that will be carried on each of the county life squads.

I have attached the **DRAFT** Lucas County Response to Active Shooter Incidents – SOP for you to review prior to class attendance in September. Please remember that this is a working document and has not been finalized. My plan is to use the draft procedure to help garner discussion and feedback as we work through the process of finalization and implementation

I look forward to seeing all of you as classes commence once again in the coming month. I hope that the summer months were good, and the break from training welcomed. As always, if you have any questions or comments please do not hesitate to contact me.

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DRAFT

Lucas County Response to Active Shooter Incidents
Standard Operating Procedure

PURPOSE:

Law Enforcement (LE) agencies have dramatically changed the way they respond to "active shooter" incidents. Prehospital medical response must change from waiting for the area to be declared safe in these situations. Using this plan, EMS will enter "Warm Zone" of Active Shooter Incidents (ASIs) to provide care for the wounded while under the protection of LE officers. A review of previous incidents shows that this approach will save lives.

The Lucas County Active Shooter Rescue Task Force (RTF) program takes the best of numerous other protocols, provides Personal Protective Equipment (e.g., EMS – ballistic helmet and vests), allowing EMS and LE agencies to collaborate to provide rapid treatment for casualties in an active shooter incident. The Rescue Task Force (RTF) concept, pioneered in Arlington, VA, has been endorsed by the International Association of Firefighters, the International Association of Fire Chiefs, and the United States Fire Administration, among other agencies. The collaborative efforts of separate disciplines in the RTF program necessitate the use of a Unified Command structure.

The RTF will mitigate risk to first responders by using procedures, training, and EMS Tactical PPE, while providing for rapid stabilization, treatment, and evacuation of the wounded despite hazardous conditions that would otherwise delay treatment. This plan delineates the responsibilities for LE and EMS personnel functioning as members of a unified law enforcement/EMS response to an active shooter incident.

This is designed as a county-wide plan. This Standard Operating Procedure (SOP) is disseminated to participating departments electronically with sections highlighted in yellow that should be modified to meet the needs of each department. Operational sections, on the other hand, need to be consistent to provide for effective functioning of Rescue Task Forces involving personnel from multiple jurisdictions.

CONFIDENTIALITY:

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DEFINITIONS:

Active Shooter(s): An armed person or persons who continue(s) to use deadly force while having unrestricted access to additional victims. The means of deadly force include the use of firearms, knives, explosive devices, etc.

Area(s): Lucas County, or sections of Lucas County which are the primary response area.

- This enables personnel from different agencies to train and exercise together.

Casualty Collection Points (CCPs): Depending on circumstances, and at the option of Unified Command (UC), there may be up to three echelons of CCPs:

- Warm Zone or Tactical CCP: If there are large numbers of patients/victims that cannot be evacuated immediately, a CCP may be established inside a warm zone, where the RTF is operating.

- Extraction CCP: A CCP may be established near an entry/exit point. Since this will most likely also be in the warm zone, it will be operated by one or two RTFs, and may be co-located with a supply depot to allow for quick re-supply and turnaround for RTFs.

- Cold Zone CCP: Also known as the Treatment Area, this is the standard Mass Casualty Incident (MCI) Treatment Area. It must be located in a safe area (according to available information) and should be relatively close to the Transport Area.

Cold Zone: An area where Unified Command does not reasonably anticipate a significant danger or threat to the providers or patients. The Treatment Area, command assets, and staged non-tactical Fire/EMS personnel and apparatus will be located in the Cold Zone.

LE Contact Teams: Teams of up to four or five law enforcement officers (LEOs) who form a Contact Team which immediately enters the building or site, moving rapidly towards the threat, with the goal of containing or eliminating the active shooter to prevent further injury or loss of life.

Depending on the size of the area to be searched, the number of perpetrators, and other factors, LE may use multiple Contact Teams prior to establishing or utilizing Rescue Task Forces.

DWJ: department with jurisdiction. The agency in whose area the incident occurred.

Hot Zone: Any area in which there is a direct and immediate threat to persons or - first responders. RTF plans and training are not intended for response into a Hot Zone where active aggression is likely.

Mass Casualty Incident (MCI) – Incident involving more than six (6) casualties which require EMS transport to a hospital. Further divided into different response levels:

MCI 1 – incident involving 6 to 15 casualties that require EMS transport to a hospital

MCI 2 – incident involving 16 or more casualties that require EMS transport to a hospital

Northwest Ohio Bomb Squad (NOBS) – Officers specially selected, trained and equipped to perform high-risk operations involving explosives and explosive materials.

Rescue Task Force (RTF): Minimum of Two RTF-trained EMS personnel in tactical PPE with two LE personnel, who may operate in the Warm Zone at ASIs.

- There may be a need to use multiple RTFs.

RTF EMS Equipment Cache: Each cache contains two (2) sets of RTF gear (both medical and tactical Personal Protective Equipment), and will be stored on every Lucas County EMS Life Squad. One set of equipment will outfit one EMS member, so each cache provides enough equipment for one (1) Rescue Task Force.

RTF Personnel: LE and EMS personnel who have been appropriately trained for RTF activities.

Single Officer Response: Single officer immediately enters into the building or site, moving rapidly with the goal of containing or eliminating the active shooter to prevent further injury or loss of life. Multiple single officers may enter the scene from different locations and may link up to form a LE Contact Team.

Special Weapons And Tactics Team (SWAT): Officers specially selected, trained and equipped to perform high-risk tactical operations that fall outside the capabilities of regular patrol officers.

Task Force – Any combination of resources assembled to support a specific mission or operational need. All resource elements within a Task Force must have common communications and a designated leader.

Unified Command (UC): An Incident Command System application used when more than one agency has incident jurisdiction or when incidents cross political jurisdictions. Agencies work together through the designated members of the UC, often the senior person from agencies and/or disciplines participating in the UC, to establish a common set of objectives and strategies and a single Incident Action Plan.

Warm Zone: An area where the potential for hostile threats exist, but the threat is not direct and immediate. This is the main zone of operations for RTFs.

PROCEDURES:

General - Law Enforcement Response to Active Shooter Incidents

- There may be multiple Single Officers responding or LE Contact Teams used, especially in large, complex settings.
- Single Officer/Contact Team officers move quickly through unsecured areas, bypassing the dead, wounded, and panicked citizens with the single goal of eliminating the active threat by "moving toward the sound of shooting."
- Work with other responders on scene, activate UC, and develop unified objectives.
- Call for additional resources (e.g., EMS, Fire, LE, and RTF).
- Entry officers relay reconnaissance information, including data about victims, to UC. This will help RTF quickly and easily locate casualties.
- LE personnel should not become engaged, in any degree, in care or movement of victims, until it is confirmed by UC that all perpetrators have been contained.

Notification and Response:

PSAPs and Dispatch Centers:

Each public safety dispatcher in Lucas County will be provided with a brief protocol for the RTF incidents and response. In the event of an active shooter situation, the dispatch center and/or command may declare an "RTF" incident.

- A RTF incident is considered MCI. A MCI shall be further designated as an MCI 1 or an MCI 2:
  - ü Declaration of a MCI 1 (6-15 casualties) will generate the following Fire/EMS response:
    - Two (2) Life Squads
    - Four (4) EMS Transport Units
    - Three (3) Fire Engines - minimum of 9 personnel with extrication and water pump capabilities
    - Fire/EMS Safety Unit
    - Fire/EMS Command Unit
  - ü Declaration of a MCI 2 (16 or more casualties) will generate the following Fire/EMS response:
    - Same resources as a MCI 1(listed above)
    - Lucas County EMS MCI trailer
    - Any additional resources requested
- Command can also request the RTF at any time, including for other types of incidents. Because of equipment and training, the RTF may be considered for response to incidents including IED or other WMD incidents, civil disturbances, downed officer tactical responses, and others.
- Jurisdictions can request that an RTF be pre-staged to stand by at large or high risk events. Such events should operate under Unified Command, so that the event also functions as an RTF exercise.

On-site Communications:

- Radio equipment will typically be brought by responding RTF personnel, but in the event those radios are not available or not compatible with the DWJ's radios, the RTF may need to borrow equipment at the site.
- OSC will establish a Communications Plan for the RTF.
- EMS/ Fire will stay on their own talkgroups; LE will also stay on their own talkgroups. Communications within the RTF between LE and EMS personnel will occur face-to face.
- After the acute phase of the operation, UC may combine LE and Fire/EMS operations on a single talkgroup.
  - ü Consider radio equipment, radio talkgroups, who teams report to via radio, emergency procedures, etc.

- ü Recognize that there is a sensory overload point when people simply stop hearing the messages. Repeat messages, ask for read-back, and consider deploying runners for critical information.
- ü Determine what the evacuation signal is in the DWJ, and inform all RTF personnel

- RTF team communications will function on different radio talkgroups with RTF LEOs communicating with one Branch, and RTF EMS personnel communicating with another Branch.
- Communications within a single RTF are typically face to face.
- In any case, it is important to relay information to UC such as:
  - RTF location within the building
  - Number of casualties and injuries
  - Updates on location of the injured, the activities of LE single officer response/contact teams, and possible threats.
  - This allows for accountability and effective use of the RTFs as well as for planning and management of both the external casualty collection point and additional EMS resources.
- Nearly any incident of this type will require multiple RTFs. Assign each RTF a number as they are formed (e.g., RTF-1, RTF-2).
- RTF members must be aware that LE uses different nomenclature for building descriptions than Fire/EMS (Side 1 vs. A side).
- Given the number of different disciplines and agencies responding to such incidents, it is crucial that ALL communications be in plain language.
- Communications from an RTF to Command are typically via the LE personnel.

Supervision:

- ASIs necessitate close coordination of LE and EMS personnel in a high hazard environment.
- It is incumbent upon supervisors to form Unified Command as quickly as feasible, including LE, EMS, and other appropriate disciplines.
- Unified Command will support RTF entry by assigning personnel and communications.
- Any incident that warrants RTF activation shall have a Unified Command (UC) with law enforcement, EMS, and other disciplines as needed, as quickly as possible.
- Any incident that warrants RTF activation demands notification of the region's hospitals, whether expected to receive patients or not.
- Request activation of the local Emergency Operations Center (EOC) through UC for long-term multiagency response, recovery, investigative, and support efforts.
- Recommend that UC establish a joint information center (JIC) involving all key agencies and players to manage media efforts.
- Recommend that UC consider family assistance centers (FACs) near the site and in other locations.

General RTF Procedures

- Authorization for entry must be obtained from Unified Command.

- Entry into Active Shooter scenes should not occur until RTF EMS personnel have the appropriate Personal Protective Equipment (PPE from an RTF Cache).
- Subsequent RTFs, with the goal of evacuation and (possibly) initial treatment, will be established as additional personnel arrive.
- The RTF will typically deploy after law enforcement initiates entry with single officer response/contact teams. Risk is decreased, even though the scene is not completely secure.
- Each RTF is comprised of two RTF-trained EMS personnel equipped with RTF tactical PPE and medical gear, and LEOs.
- LEOs provide force protection/security, while medics attend to casualties. The goal is to get medical resources to patients within minutes of being wounded while continuing to mitigate risk to responders.

RTF LE Personnel Procedures

- The roles of RTF LE personnel are force protection/security and control of team movement.
- RTF LE personnel will not assist in lifting, carrying, or treatment of any patient until it is confirmed by UC that all perpetrators have been contained.
- Safety of the RTF is the primary concern for LEOs, including searching for other secondary threats (e.g., IEDs, tripwires).
- One LEO will have 180 degree front security and one will have 180 degree rear security.
- RTF LE personnel will communicate with OSC to ensure the RTF operates within the warm zone.
- At no time will the RTF LE personnel 'freelance' or move outside of their directed destination/area of operation.
- RTF LE personnel shall, at all times, remain within line of sight of RTF EMS personnel and provide force protection for all RTF personnel.
- The RTF will move as a team, with the RTF LE personnel controlling the RTF area of operation and speed of movement.

RTF EMS Personnel Procedures:

Response will follow each agency's procedures, including use of duty crews, call-in personnel, or a combination. Within those guidelines, RTF activation will be considered a mutual aid request, and personnel will respond on that basis. Emergency response is not authorized unless the vehicle is equipped to Ohio Revised Code standards.

- Arriving RTF EMS personnel will report to the Staging Area.
- First arriving RTF trained Fire/EMS Officer will meet with Operations Section Chief (OSC):
    - All RTF personnel will report to OSC.
        - ü At no time will free-lancing of RTF personnel be permitted.
    - The RTF trained Fire/EMS Officer will ensure that OSC is aware of the presence of the RTF EMS personnel and their capabilities.

- The OSC will form RTFs as EMS and LE personnel and RTF equipment become available. If feasible, RTF composition should include an ALS provider.
- The OSC and RTF trained Fire/EMS Officer will discuss the location for staging area for RTF personnel.
- Considerations should be made to:
  - Request additional RTF EMS personnel or equipment caches
  - OSC should develop accountability for all personnel on scene.
- Non-RTF EMS personnel should not generally enter warm or hot zones.

Entry Procedures

- An RTF may approach the scene in a vehicle such as an ambulance or tactical vehicle, on foot, or by other means as directed by UC.
- RTF ingress and egress corridors will be designated by UC, and RTFs will move in and out of the building only through entrances and corridors primarily cleared by LE.
- The first one or two RTFs that enter the building or site move deep inside to stabilize as many casualties as possible before any victim is evacuated.
- As victims are reached, the RTF LEOs provide force protection/security while the medics treat the casualties. RTF EMS personnel stabilize only immediately life-threatening wounds on each casualty they encounter, but leave casualties where they are found and move on.
- Emphasis is on treatable immediate life threats. Casualties are treated in place, and the RTF moves on.
- Walking wounded and uninjured individuals are directed to exits away from the direction of shooting, if it is reasonably safe to do so. Communications with UC concerning this are essential.
- Additional RTFs are formed as personnel and equipment caches arrive on the scene, and enter the building as directed by UC.
- A supply depot may be set up near a secured entry point to allow for quick re-supply and turnaround for RTFs. This area may also serve as the Extraction CCP.
- RTF personnel must be aware of surroundings, potential threats such as IEDs, and open routes of rapid egress.

Emergency Evacuation Procedures

- If the Zone in which the RTF is operating changes from Warm to Hot due to a direct and immediate threat, immediate evacuation of the RTF will occur according to direction from the RTF LE personnel or UC.
  - This may include partial or complete evacuation of the RTF from the building.
- If any member of the RTF is injured during operations, immediate evacuation of the RTF will occur.

Secure Scene

- Once it is determined by UC that the scene is secure (i.e., all perpetrators are under control and there is no risk of secondary threats), RTF procedures will cease. The

scene will revert to standard MCI procedures (in accordance with the Regional MCI Plan) using all available EMS personnel for treating and transporting patients regardless of location.

- However, remember that RTF personnel have likely learned more about issues with ASIs than most personnel on the scene, and their advice and assistance will be invaluable even after the threat has been eliminated.

TRAINING: - APPENDIX

Drills and Exercises

- Exercises and drills will be organized and provided as often as possible.
- More importantly, each agency is encouraged to participate in local drills (schools, hospitals, businesses, EMS, Fire, LE, etc.) at every opportunity.
- Every agency that participates in the Lucas County Response to Active Shooter Incidents Plan is strongly encouraged to participate in multidisciplinary (LE, Fire, and EMS) and multijurisdictional exercises and drills at every opportunity. ASIs will always involve mutual aid responses for Law Enforcement, Fire and EMS. If you're having a drill, invite your neighbors, especially other agencies.
- Whenever possible, involve EMS, Fire and Law Enforcement personnel in UC.
- Whenever possible, improve interdisciplinary communications and relationships with EMS, Fire and LE.

Awareness Training: Fire and EMS Personnel

- A training video and Job Aid will be provided for Fire and EMS personnel other than those in the RTF.

Awareness Training: Law Enforcement Personnel

- A training video and Job Aid will be provided for area law enforcement.

Awareness: Dispatch Personnel

- A Job Aid will be made available for public safety dispatchers (i.e., Fire, EMS, LE).

EMS EQUIPMENT: (APPENDIX)

EMS Tactical Equipment:

- Level IIIA Tactical Vest
  - Large amount of overall chest and back coverage Adjustable in size to fit multiple medics.
  - Identification with Rescue TF patch on front and back
- Level IIIA ballistic Helmet
  - Lightweight with high-cut back for greater range of motion
  - Four-point harness to prevent helmet from sliding over eyes during casualty care or falling off.

EMS Medical Equipment: (Area Not Complete-Further Update Needed)

- Each RTF EMS member carries a bag equipped with enough supplies to treat multiple casualties, depending on injuries, including:
  - NAR QuickLitter (Disposable Litter) 1
  - Triage Ribbon Kit 1
  - Sharpie Pen 1
  - Grease Marker 1
  - CAT Tourniquets 4
  - Glow Sticks 2
  - LG Nitrile Gloves 10 pair
  - Alcohol Preps 30
  - Nasopharyngeal Airways 20FR 2
  - Nasopharyngeal Airways 36FR 2
  - 4X5 Elastic Wraps 6
  - 4.5" Sterile Kerlix Dressings 12
  - HyFin Vented Chest Seals 4
  - Abd Pads 8X10 4
  - ARS Decompression Needles 4
  - LA Police Gear Bail Out Bag 1
  - Trauma Shears on Vest with Retractor 1

EMS MEDICAL TREATMENT PROTOCOL (APPENDIX)

SCAB-E MEDICAL TREATMENT PROTOCOL

- RTFs when functioning in the WARM Zone will only provide stabilizing treatment, primarily following TECC and the SALT Triage Life-Saving Interventions (LSIs).
- Airway control is not first priority. Exsanguinating extremity wounds are more common in active shooter situations, and a person can bleed to death from a large arterial wound in just two to three minutes. Life-threatening bleeding is addressed first, followed by airway control. Open chest wounds and tension pneumothorax are addressed third, following the Circulation-Airway-Breathing sequence (CAB).
- Tourniquets are emphasized and prioritized as a quick and effective method to control extremity hemorrhage.
- For non-exsanguinating hemorrhage, mechanical pressure dressings with wound packing are used. Some wounds, including those in the femoral triangle or in the neck, are not amenable to tourniquets.
- All patients within a reasonable geographic area, not more than earshot of a quiet voice and direct line of sight from the RTF, will be rapidly triaged using SALT triage, applying triage ribbons to indicate their status (including ribbons for deceased victims to prevent teams from wasting time re-triaging them).
- S – Maintain Situational Awareness:
  - Be aware of surroundings, potential threats such as IEDs, and always maintain open routes for rapid egress.
  - Be constantly mindful of the possibility of multiple attackers, or the potential for an attacker to circle around and turn your warm zone into a hot zone.
  - Ambulatory patients should be directed to evacuate the area down corridors used for RTF ingress.
  - Non-ambulatory patients should be medically stabilized and either evacuated or placed in proper position while awaiting evacuation.
  - Understand the difference between cover and concealment, and consider appropriate tactical positioning in case the team should come under fire.
  - Consider the need for forcible entry equipment.
  - Consider the possibility of a chemical or IED threat at the scene (and at other related scenes, e.g., the perpetrator's home).
- C – Circulation – Assess for and treat life threatening extremity bleeding
  - Direct pressure on the proximal brachial or femoral artery should be immediately applied by kneeling on the artery with body weight. This allows for both hands to be free to apply the intervention.
  - Tourniquets are to be placed immediately on extremity wounds including total or near-total amputations, large vessel arterial bleeding, massive vessel venous bleeding, and any wound with bleeding that cannot be adequately controlled with a pressure dressing

- Mechanical pressure dressings may be applied for anatomically amenable extremity wounds.
- Deep wounds should be packed with gauze to transmit pressure deep into the wound to site of bleeding.

- A – Airway
  - Any patient with an occluded airway or altered mental status will have a nasopharyngeal airway placed.
  - Place victim in any position that best protects the airway, including seated.
- B – Breathing
  - Assess for any open or sucking chest wounds, and place an occlusive chest seal to any trunk wound (anterior or posterior) from the umbilicus to the trapezius muscles.
  - Assess for and treat tension pneumothorax.
- E – Evaluate and Evacuate
  - Assess effectiveness of applied interventions and initiate evacuation.
  - Check tourniquets and pressure dressings for adequacy.
  - Assess for unrecognized hemorrhage.
  - Reassess for respiratory distress and proactively treat if present.
  - Roll patient and examine posterior for injury.
  - Place conscious patient in position of comfort and unconscious patient in recovery position while awaiting evacuation.
  - If adequate supplies remain and there are untreated patients further in the building, RTF should continue into the building toward those patients, remaining in the Warm Zone.
  - If no supplies remain, or all patients are treated, initiate evacuation to a CCP according to triage categories, using appropriate patient movement technique. Evacuate to CCPs, and as feasible, communicate with the CCPs or Triage.
    - Within the same triage category, public safety personnel should receive priority assessment and evacuation since they may not fully comprehend the extent of their injuries.
  - The four members of the RTF, including LE members, remain together during egress.

Patient Evacuation

- Communicate with Operations Section Chief, advising of team status and patient information.
- Once RTF EMS personnel are out of supplies, they begin to move out of the building, evacuating treated casualties.
- Additional RTFs can either be tasked with the primary mission of evacuating stabilized casualties, or with moving further into the building in a “stabilizing but not evacuating" mode to take over for the initial RTFs that have run out of supplies and begun evacuation.

- If needed, a Warm Zone CCP may be set up within the building, or an Extraction CCP set up near a secure exit point, where casualties can be grouped to allow for faster and more efficient evacuation. Both should be staffed by RTF-equipped and trained personnel.
- Standard triage, treatment, and transport areas must be established far enough away from the scene to afford protection to casualties and medical personnel. Utilize a single Transport Supervisor if at all feasible to ensure appropriate hospital allocation.
- Patients will be moved from the scene to the triage location by ambulance or other means. Once triaged, patients should be moved to the treatment and transport areas as necessary and treated and transported as rapidly as resources allow.
- RTFs may consider establishing an internal, Warm Zone (tactical) CCP in a hardened area approved by UC.
- RTFs may also consider establishing an Extraction CCP to serve as a temporary way station at the location of the external RTF supply depot.
- Victims will be evacuated as quickly as feasible and safe to the Treatment or Transport Areas operated by non-RTF EMS personnel and located in the Cold Zone.

BACKGROUND: (APPENDIX)

Columbine in 1999, Virginia Tech in 2007, Mumbai in 2008, Fort Hood in 2009 are just a few of the ASIs that have been studied. In 2012, more were added: Aurora, CO, Oak Creek, WI, and Newtown, CT, and still more in 2013.

The number of incidents involving active shooters – defined for our purposes as an armed person who continues to use deadly force while having unrestricted access to additional victims – has increased dramatically. Since 1966, there have been over 200 active shooter events in the US with a total of 600 dead and 700 wounded. Over 200 deaths have been caused by active shooters in schools in the past 25 years. They occur in urban, suburban, and rural settings.

Following the shootings at Columbine and other incidents, police response to these situations underwent a paradigm shift. In many, if not most agencies, law enforcement (LE) personnel are trained to respond aggressively to immediately pursue, establish contact with, and stop the shooter. Rapid response and takedown results in fewer casualties.

However, emergency medical services (EMS) response to active shooter situations in most areas has not followed suit. Often, the current Fire/EMS response to the active shooter is to stage in a secure location until police mitigate the threat and secure the area. Unfortunately, securing such a complex scene can take hours. When EMS is waiting outside, casualties are not receiving care.

The often quoted statistic that ASIs are over within seven minutes is misleading. In the majority of those incidents (even including Newtown), uncertainty over who the shooter was, whether there were additional perpetrators, and whether IEDs or other hazardous devices existed, extended much longer than seven minutes, and those issues frequently delayed or impeded rescue and medical care.

Agencies in Colorado, Virginia, Kentucky, North Carolina, California, and other locations have developed protocols to provide a more rapid EMS response. While entailing some new risk for EMS, this type of response fits within the typical fire and EMS risk management paradigm:

- Accept no significant risk when no lives or property can reasonably be saved at an emergency incident.
- Accept some limited level of risk, within normal operational procedures, when it is likely that lives or property can reasonably be saved.
- Accept a significant amount of risk, again within operational guidelines, when it is likely that a life can be saved.