

Integrating Law Enforcement, Fire, and Emergency Medical Services during Active Shooter / Hybrid Targeted Violence Incidents



EXECUTIVE SUMMARY

High-threat events, although not a new phenomenon for the first responder community, continue to increase in incidence and complexity. From “lone wolf” attacks to coordinated Hybrid Targeted Violence (HTV) incidents, these events pose significant operational challenges to public safety agencies. They are characterized by a spectrum of potential threats, including but not limited to:

- One or more perpetrators, often well-trained, operationally knowledgeable, and willing to die
- Well-planned operations using military tactics, often with effective communications and external coordination
- Multi-capacity high-velocity ballistic and explosive fragmentation weapons
- Hazardous, toxic materials requiring decontamination
- Fire, to increase damage and shape and complicate the response
- Intentional delayed secondary attacks on first responders
- Austere and complicated operational conditions created intentionally by perpetrators and compounded by limitations on number and capabilities of response personnel

The term HTV is defined as an intentional use of force to cause physical injury or death to an identified population through a coordinated and multifaceted approach using a multitude of conventional weapons and tactics (Frazzano & Snyder, 2013). Whereas the lone wolf attack represents an overall less complicated event, an HTV incident presents an operational range of hazards, confronting first responders with a wide range of weapons and coordinated small unit tactics, requiring a more complex response strategy that blurs the lines between traditional law enforcement, fire, and emergency medical service (EMS) duties and responsibilities.

To address this evolving and growing risk, new response paradigms and elevated levels of operational interagency coordination must be embraced among all public safety disciplines. The traditional linear “stovepiped” single-agency response is not only ineffective, it may even be dangerous in these unpredictable, chaotic, and fluid events. Response to high-threat events requires a fundamental shift in the mission space for all operational disciplines. Disciplines must be seamlessly integrated to prevent exploiting operational boundaries. An ad-hoc operational approach with “just in time” training between response agencies may result in catastrophic failure. Strategic plans and relationships must be in place, interoperable language and procedures must exist, and cross-disciplinary training must be completed prior to an event.

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Challenges to implementing new, interdisciplinary, coordinated, response paradigms are operational, historical, and political. Historically, police, fire, and EMS personnel have viewed their first responder roles as independent. In many jurisdictions, interagency rivalry and “turf battles”—some collegial and healthy, but many not—have developed as various public safety entities compete for budget, community recognition, and a long legacy of pride. Targeted high-threat attacks do not allow for operational lines to be “drawn in the sand.” Instead, success is predicated on a combined fire-EMS-law enforcement response; one coordinated team to neutralize threats and save lives. Egos must be set aside, and the call and commitment to integration must be from the top down. Leaders of each discipline must understand the roles, capabilities, and core competencies of other disciplines. First responder personnel must recognize the interchangeable aspects of their traditional roles and integrate their training, response, and mitigation activities.

This white paper introduces the first steps in implementing the concepts of integrated emergency services response to high-threat events, based on current best-practice operational models from Arlington, VA; Los Angeles, CA; and New York, NY. The concept, known as “escorted warm zone care,” often referred to as “Rescue Task Force,” utilizes an integrated team of law enforcement and fire/EMS personnel operating under a unified command structure to rapidly access, stabilize, and extricate the wounded. A further examination of these approaches will be conducted by the InterAgency Board and will produce follow-on documents.

BACKGROUND**Evolution of Law Enforcement Tactics**

Following the mass shooting at Columbine High School in 1999, law enforcement agencies around the country made a major change to their response efforts. Prior to Columbine, the standard law enforcement response to active shooter/active killing was centered on barricading suspects. The common perception was that perpetrators(s) always had specific objectives that could be resolved through negotiations; the concept that perpetrators might have violence and killing as their primary intent was not considered. Accordingly, the initial response of law enforcement was to contain the suspect, call specialized tactical teams, and establish communication to begin negotiations. Although the law enforcement response to the Columbine event was on par with the tactical doctrine at the time, strong criticism levied by the Columbine Review Commission (2001) drove a paradigm change in police response. Within a short period of time, the law enforcement paradigm shifted from anchoring on the specialized tactical teams to having the first arriving patrol officers shoulder the brunt of the tactical operations, through this rapid intervention. In this new response paradigm, the first arriving law enforcement officers, regardless of agency affiliation, immediately form a rapid response team and move to eliminate the active threat using simple, common tactics (Dino, 2009; Chicago Police Department, 2008).

**Integrating Law Enforcement, Fire, and Emergency Medical Services during
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In 1996, the United States military began seriously mining its combat injury data in an attempt to improve the survival rate of those wounded in battle. The research found that 90% of combat deaths occurred before a casualty received medical care—often within 30 minutes, but at times up to several hours after wounding (Bellamy, 1995). The data also demonstrated that at least 15% of battlefield fatalities occurred because of three traumatic etiologies that were easily treatable at or near the point of wounding: (1) exsanguinating extremity hemorrhage, (2) tension pneumothorax, and (3) airway obstruction. As a result, Captain Frank Butler and the Naval Special Operations community developed and introduced a battlefield medical care protocol, called Tactical Combat Casualty Care (TCCC), that allowed providers to balance tactical and medical priorities during combat operations and address, at the same time, the identified preventable causes of combat death by optimizing care rendered in the field (Butler & Hayman, 1996). Compared to standard pre-hospital treatment modalities, which are based on blunt trauma, TCCC emphasizes different traumatic pathophysiology by focusing primarily on penetrating trauma complicated by ongoing tactical operations and compounded by prolonged evacuation times. The TCCC initiative within the military has saved countless lives in combat since its inception, resulting in a combat fatality rate that is the lowest in the recorded history of warfare (Defense Health Board, 2011).

The ever-changing threat environment in domestic first response and the high incidence of ballistic and blast trauma in high-threat events rendered the civilian operational medical paradigm for high-threat events clearly inadequate. As was the case with the military in the 1990s, a new civilian medical paradigm was needed. Although the military TCCC model initially appeared to address the civilian operational medical response gap, further review revealed that the specifics of civilian/federal operations and civilian populations significantly differed from those of military combat operations. Consequently, TCCC could not be applied to civilian operations as a whole; it needed to be adapted to fit the domestic civilian police, fire, and EMS environment. In 2011, a group of civilian and military operational experts developed a consensus evidence- and best-practice-based set of civilian high-threat medical guidelines called Tactical Emergency Casualty Care (TECC) (MedTraining Group, n.d.). Built upon and translated from TCCC, the TECC guidelines account for the unique aspects of civilian medical and operational environments, evolving and changing on a regular basis through collaborative evidence-based review (Committee for Tactical Emergency Care, 2014).

Over the past four years, the high-threat TECC medical guidelines have been operationalized and applied in agency-specific operational response and training programs across America. In addition, multiple national committees, professional organizations, and federal and civilian consensus groups—seeking to develop strategies and provide guidance to improve casualty survival in active shooting/killing and similar HTV events—have recommended incorporating the TECC guidelines into response operations. Specific references to TECC can be found in consensus and position statements and guidance from the International Association of Fire

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Fighters, the International Association of Fire Chiefs, the National Urban Fire Forum, the Hartford Consensus Group, U.S. Fire Administration, and the Federal Emergency Management Agency.

COORDINATED MEDICAL RESCUE OPERATIONS AND RESCUE TASK FORCE CONCEPT

Timely, effective, and efficient mitigation, response, and rescue operations necessitate using the National Incident Management System (NIMS) and a unified command structure to coordinate multiple on-scene agencies and disciplines, successfully manage all necessary functions and ensure deliberate and effective communication between agencies. While law enforcement is often obligated to be the lead in these HTV incidents, a unified command structure offers coordinated decision-making and resource deployment.

New operational paradigms must be accepted across the public safety disciplines to mitigate active violence risk. Initial law enforcement responders must continue to form rapid emergency deployment teams. They must provide fire/EMS responders with a security element when they deploy into areas that have been cleared but not secured. Using TECC high-threat medical principles, the coordinated team will treat and rescue injured victims. These coordinated interagency medical rescue teams should comprise the first arriving law enforcement and fire/EMS assets, rather than specially trained law enforcement tactical officers and tactical medics. All personnel in the coordinated teams should be required to have a basic understanding of tactical movement and operations and appropriate personal protective equipment.

The NIMS defines a task force as “any combination of resources assembled to support a specific mission or operational need” (U.S. Department of Homeland Security, 2008). This definition can and should be applied to the new paradigm of integrated medical/rescue operations—a Rescue Task Force (RTF). In its original form, the RTF was intended to denote the rapid deployment of a team of two law enforcement patrol officers with two first arriving fire/EMS personnel. However, the term RTF is not limited to the original model. Any combination of law enforcement, fire, and/or EMS with the goal of medical stabilization and rapid extrication (e.g., escorted warm zone care, warm corridor care, protected island care) may be appropriately referred to as an RTF.

One critical element of the RTF concept is proper training for law enforcement officers. Training should include instruction in rescue procedures and interfacing with medical assets as well as how to recognize the need for and possibly begin initial medical stabilization of the wounded prior to the full deployment of the integrated medical rescue team. Training law enforcement officers in executing the initial steps of TECC could mitigate preventable causes of death as well as increase personal safety of the team. However, the emphasis on initially stabilizing the wounded should never supplant or dilute law enforcement’s priority to stop active violence. Once the violence is addressed, law enforcement can become a force multiplier for fire/EMS in

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providing victim care. Coordinated medical rescue operations relinquishes police assets to continue their primary law enforcement missions of security and investigation and assigns the tasks of medical assessment, rapid extrication, and triage/disposition to fire and medical professionals who have the education, experience, and equipment most appropriate for that assignment.

The current best practice model for responding law enforcement and fire/EMS is to jointly form an RTF in the first few minutes of an event, allowing EMS personnel to enter into safer areas of an incident under the protection of an armed escort. The RTF model has the following advantages (U.S. Fire Administration, 2013; Office of Medical Services, Federal Bureau of Investigation [FBI], 2014):

- EMS personnel are trained and equipped with a variety of patient-moving equipment that allows for the rapid transport of critically injured patients with limited resources (e.g., it is faster for two rescuers to move a supine patient with a designed extrication device than four rescuers with none).
- Medically trained personnel conduct a more thorough patient assessment and are able to recognize the subtle signs of significant internal injury. This allows point of wounding stabilization to address multiple causes of preventable death.
- Fire/EMS providers can make the best receiving facility and transportation decisions, identifying and prioritizing those patients with the most severe injuries for extrication from the scene to definitive surgical care, while continuing the process of robust stabilizing care medical care on-scene and during transport.

Risks to Fire/EMS Personnel

The most common argument against fire/EMS personnel operating in warm zone operations during high-threat scenarios is that scene safety is paramount above all other considerations. The amount of assumed risk for non-police personnel in active shooter scenarios has traditionally been thought to be too high to accept. However, an FBI analysis of active shooter incidents between 2000 and 2013 revealed that 69% of the incidents ended within five minutes or less (FBI, 2013). Since the greatest immediate threat—the shooter—is rapidly incapacitated, the true risk to EMS personnel working as part of an RTF in areas that are cleared but not secured may be far less than commonly perceived.

Risk assessment and active mitigation strategies are commonplace in fire/EMS operations; personnel apply risk-based response protocols when responding to every operational scenario. “Risk a lot to save a lot. Risk nothing to save nothing” is a common operational mantra used to simplify this operational risk assessment. Refusing to accept risk in one operational scenario while actively accepting risk in another is a contradiction. The perceived risk in responding to a high-threat incident may be mitigated in the same way that all operational risk is addressed.

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Examples include thorough introspection, incident review, training, equipment, solid operational protocols, and pre-existing interagency coordination to make judgments based on a continually sliding scale, weighing the true risk against the potential benefit to the wounded.

RECOMMENDATIONS FOR POLICY MAKERS

Policy makers tasked with integrating public safety response for medical rescue operations should begin the implementation process by gathering key stakeholders and representatives from affected agencies and organizations. These should include elected government officials, local and regional law enforcement, fire, and EMS agencies (to include mutual aid agencies), labor representatives (many of which have already utilize the concept) (International Association of Fire Chiefs, 2013; Urban Fire Forum, 2013), governmental legal representatives, and at least one subject matter expert intimately familiar with the strategic and tactical processes of integration. Once assembled, this group should be charged with the following responsibilities:

Develop a Strategic Integrated Response Policy and Plan/Procedure

- Identify existing plans and procedures within each response entity
 - Identify risks and operational capability/capacity for response to current and future threats
- Review current response industry best practices
 - Consult documents from reputable sources
 - Enlist the aid of subject matter experts
- Develop an Integrated Response Plan/Procedure
 - Notify response agencies about the HTV event
 - Build upon existing emergency response plans and guidance
 - Encompass all elements of the Emergency Management Cycle (preparedness, planning, exercises, training, public education)
 - Identify existing strengths and weaknesses
 - Identify silos in planning and disconnects in related plans
 - Clearly define roles, boundaries, and legal authority
 - Identify clear objectives for strategic and tactical task integration
 - Ensure compliance with NIMS
 - Ensure each entity's individual plan is a mirror of the others
 - Common mission goals
 - Common vocabulary
- Identify funding requirements for equipment, training, exercise, and evaluation

Disseminate the Integrated Response Plan/Procedure and make it operational

- Educate command-level staff and elected officials
 - Conduct outreach and education
 - Emphasize the benefit of implementing a unified command
- Provide training for emergency responders

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- Provide a conceptual understanding of the integrated response process
- Conduct training and drills on discipline-specific skill sets
- Execute integrated responses by developing cross-discipline training
- Provide visibility on relevant policy, plans, and authorities
- Conduct exercises regularly in accordance with Homeland Security Exercise and Evaluation Program guidelines with a focus on the integrated response capability
- Outline RTF roles and responsibilities
 - Develop common vocabulary
 - Incorporate TECC concepts in each discipline's training
 - Identify proper safety equipment
 - Establish evaluation considerations
- Conduct meaningful after action reviews (AAR) of exercises and incidents
 - Evaluate the response with regards to the plan (Did responders execute the plan?)
 - Evaluate the effectiveness of plan with regards to the incident (Did the plan work? Did the plan accurately reflect operational needs and requirements? Would the plan have worked?)
 - Identify gaps in plans and training from information gleaned from the AAR process
 - Develop an Improvement Plan and assign responsibilities to address noted gaps
 - Communicate with stakeholders about improvements and identified needs for additional planning

AUTHORS

This white paper was developed by a working group commissioned by the InterAgency Board. The group is comprised of subject matter experts and consultants from the emergency management, EMS, homeland security, fire, and police disciplines. This paper outlines the first phase of a multiphase project. An Active Shooter Summit will be convened to help develop support of best practices and steps forward. Following the Summit, areas will be identified for future documents as identified.

**Please contact the InterAgency Board at info@interagencyboard.us with any comments, feedback, and questions. Additional information on the InterAgency Board is available at www.IAB.gov.

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REFERENCES

- Bellamy, R.F. (1995). Combat trauma overview. In R. Zajtchuk & C. M. Grande (Eds.), *Textbook of Military Medicine, Anesthesia and Perioperative Care of the Combat Casualty* (pp. 1–42). Falls Church, VA: Office of the Surgeon General, United States Army.
- Butler, F. & Hayman, J. (1996). Tactical Combat Casualty Care in Special Operations, *Military Medicine*, 161(3) (Suppl.). Retrieved from http://www.valorproject.org/uploads/TCCC_Special_Operations.pdf
- Chicago Police Department. (2008). Active Shooter Incident Plan: GO 05-06.
- Committee for Tactical Emergency Care. *2014 Tactical Emergency Casualty Care (TECC) Guidelines*. Retrieved from <http://c-tecc.org/guidelines>
- Defense Health Board. (2011, June 14). *Tactical Combat Casualty Care Guideline for Deploying Personnel*. Retrieved from <http://www.health.mil/Reference-Center/Reports/2011/06/14/Tactical-Combat-Casualty-Care-Training-for-Deploying-Personnel>
- Dino, J. T. (2009). A Study in Police Preparedness to Respond to Active Shooter Situations to Provide a Safer Learning Environment in the Schools of Bergen County, New Jersey (Doctoral dissertation). Retrieved from Seton Hall University Dissertations and Theses (Paper 1).
- Frazzano, T. L. & Snyder, G. M. (2013, February 12). *Hybrid Targeted Violence: Clearly Defining Complex Attacks* [Web log post]. Retrieved from <http://www.hlswatch.com/2013/02/12/hybrid-targeted-violence-clearly-defining-complex-attacks/>
- Federal Bureau of Investigation. (2013). *A Study of Active Shooter Incidents in the United States Between 2000 and 2013*. Washington, DC: Government Printing Office.
- Governor Bill Owens' Columbine Review Commission. (2001). *The Report of Governor Bill Owens' Columbine Review Commission*. Retrieved from <https://schoolshooters.info/sites/default/files/Columbine%20-%20Governor's%20Commission%20Report.pdf>
- International Association of Fire Chiefs. (2013). IAFC Position Statement: Active Shooter and Mass Casualty Terrorist Events. Retrieved from http://www.iafc.org/files/1ASSOC/IAFCPosition_ActiveShooterEvents.pdf
- MedTraining Group. (n.d.). Tactical Emergency Casualty Care [website]. Retrieved from <http://medtraininggroup.com/tactical-emergency-casualty-care/>
- Office of Medical Services, Federal Bureau of Investigation. (2014). *Active Shooter Incidents: The Challenge for EMS*. Washington, DC: Government Printing Office.
- U.S. Department of Homeland Security. (2008). *National Incident Management System*. Retrieved from https://www.fema.gov/pdf/emergency/nims/NIMS_core.pdf
- U.S. Fire Administration. (2013). *Fire/Emergency Medical Services Department Operational Considerations for Active Shooter and Mass Casualty Incidents*. Washington, DC: Government Printing Office.
- Urban Fire Forum. (2014). UFF Position Statement: Active Shooter and Mass Casualty Terrorist Events. Retrieved from <http://www.nfpa.org/~media/Files/Member%20access/member%20sections/Metro%20Chiefs/UFFActiveShooterPositionStatement.pdf>

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- Bledsoe, B. E., Porter, R., & Cherry, R. A. (2012). *Paramedic Care: Principles and Practice* (4th ed.). Upper Saddle River, NJ: Prentice Hall.
- DeLorenzo, R. A. & Porter, R. S. (1999). *Tactical Emergency Care: Military and Operational Out of Hospital Medicine*. Upper Saddle River, NJ: Prentice Hall.
- Federal Bureau of Investigation. (2013). *A Study of Active Shooter Incidents in the United States Between 2000 and 2013*. Washington, DC: Government Printing Office.
- Fire Department, City of New York. (2014, August 5). *FDNY Tactics and Procedures, EMS OGP 105-01 Addendum 1, Emergency Response Plan, Addendum 3A*. Retrieved from [http://www.nfpa.org/~media/Files/Member access/member sections/Metro Chiefs/2014 Urban Fire Forum/FDNYInteragencyResponseProtocol.pdf](http://www.nfpa.org/~media/Files/Member%20access/member%20sections/Metro%20Chiefs/2014%20Urban%20Fire%20Forum/FDNYInteragencyResponseProtocol.pdf)
- Iselin, B. & Smith, R. (2009, November 30). Arlington County, Va., task force rethinks active shooter incident response. *Journal of Emergency Medical Services*. Retrieved from <http://www.jems.com/article/major-incidents/arlington-county-va-task-force>
- Jacobs, L. M., Jr. (2014, March). Joint Committee to Create a National Policy to Enhance Survivability from Mass Casualty Shooting Events: Hartford Consensus II. *J. Am. Coll. Surg.*, 218(3), 476–478e1.
- Lopez, R., & Welsh, B. (2013, November 22). New LAFD active shooter guidelines. *Los Angeles Times*. Retrieved from <http://documents.latimes.com/new-lafd-active-shooter-guidelines/>
- Maryland Governor's Office of Homeland Security. (2014, October 2). *Guidance to First Responders for the Active Assailant Incident*. Retrieved from http://www.mfri.org/announcements/maryland_active_assailant_guidance_final.pdf
- Mell, H. & Sztajnkrzyer, M. (2004). EMS Response to Columbine: Lessons Learned. *The Internet Journal of Rescue and Disaster Medicine*, 5(1). Retrieved from <https://ispub.com/IJRDM/5/1/12573>
- New York City Police Department. (2012). *Active Shooter Recommendations and Analysis for Risk Mitigation*. Retrieved from <http://www.nyc.gov/html/nypd/downloads/pdf/counterterrorism/ActiveShooter2012Edition.pdf>
- Police Executive Research Forum. (2014, March). *The Police Response to Active Shooter Incidents*. Washington, DC: Police Executive Research Forum. Retrieved from http://www.policeforum.org/assets/docs/Critical_Issues_Series/the%20police%20response%20to%20active%20shooter%20incidents%202014.pdf
- TriData Division, System Planning Corporation. (2014, April). *Aurora Century 16 Theater Shooting: After Action Report for the City of Aurora Colorado*.
- U.S. Department of Homeland Security. (2008, October). *Active Shooter, How to Respond*. Retrieved from http://www.dhs.gov/xlibrary/assets/active_shooter_booklet.pdf
- Virginia Tech Review Panel. (2007, August). *Mass Shootings at Virginia Tech April 16, 2007*. Retrieved from <https://governor.virginia.gov/media/3772/fullreport.pdf>