Point of Wounding—Point of Care:

Creating an Active Shooter / Hostile Event Response Guideline for the Unified Fire Authority of Greater Salt Lake

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Certification Statement

I hereby certify that this paper constitutes my own product, that where the language of others is set forth, quotation marks so indicate, and that appropriate credit is given where I have used the language, ideas, expressions, or writings of another.

Signed: 

List of Abbreviations

ACFR – Arlington County Fire & Rescue
ACS – American College of Surgeons
ALS – Advanced Life Support
ARP – Applied Research Project
ASHE – Active Shooter / Hostile Event
ASHER – Active Shooter / Hostile Event Response
ASI – Active Shooter Incident

BLS – Basic Life Support

CAT – Combat Application Tourniquet
CCP – Casualty Collection Point
CCTA – Complex Coordinated Terror Attack

EMS – Emergency Medical Service

FBI – Federal Bureau of Investigation

IACP – International Association of Chiefs of Police
IAFC – International Association of Fire Chiefs
IC – Incident Command/er
ICP – Incident Command Post

NFA – National Fire Academy
NFFF – National Firefighter Foundation
NFPA – National Fire Protection Association

PAC – Policy Advisory Committee
PCSD – Pima County Sheriff's Department

RET – Rapid Extraction Team
RTF – Rescue Task Force

SOG – Standard Operating Guideline
SOP – Standard Operating Policy

TCCC – Tactical Combat Casualty Care
TECC – Tactical Emergency Casualty Care
TTTT – Treatment, Triage, Transfer, and Transport

UC – Unified Command/ers
UFA – Unified Fire Authority
UFF – Urban Fire Forum
USFA – US Fire Administration

Abstract

The continued harsh realities of Active Shooter or Active Killer Incidents have become all too frequent. Over the last several years, the incidents that have occurred in Orlando, Florida at the Pulse Nightclub—where 49 died and 53 were injured; Las Vegas, NV where 58 died and over 850 were wounded; and Parkland, Florida, at Marjory Stoneman Douglas High School where 17 died and 17 were wounded are just to name a few. The FBI statistics show that in 2017, there were 30 active shooter incidents within the U.S.—claiming the lives of over 138 individuals—the highest number of incidents and deaths since the FBI started tracking them in 2000. The increasing frequency of these events have led fire agencies across the nation to address their response to these events. The problem was that Unified Fire Authority (UFA) did not have a standard operating guideline (SOG) or policy for an Active Shooter / Hostile Event Response (ASHER). The purpose of this applied research project is to identify what belongs in an ASHER SOG and/or policy, and to outline best practices of various components that belong in a successful rescue task force (RTF) program and response. The action research method was utilized to identify what has been outlined in the current knowledge base within current accepted guidelines and incorporate those into the UFA SOG and policy. Additionally, the following research questions were answered with this research: What guiding documents are currently being used and are in place across the nation, statewide, and locally? What are the current best practices for integration into law enforcement operations regarding RTF and hostile act responses? What are the current strategies and tactics utilized by other agencies during a hostile act response? What are the current best practices regarding patient care during a hostile act response? These questions all helped to form what became the UFA SOG and policy.

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Introduction

Active shooter and active killer events have occurred within the history of the Salt Lake Valley multiple times. The most infamous of the incidents occurred February 12, 2007, when a lone gunman entered the Trolley Square Mall in Salt Lake City—killing five individuals and wounding four others prior to being engaged and killed by local law enforcement. This alarming active killer event is just one of many across the United States that are occurring with alarming frequency. Unfortunately, there has been little interest in changing the culture of Unified Fire Authority (UFA) in responding to these events without spending a significant amount of time staging on an event. This is not far different from the slow cultural changes that have occurred nationwide regarding the implementation and integration of Rescue Task Force response in coordination with law enforcement personnel (Smith, 2014). Due to the extent and frequency of these hostile acts, it has forced fire and rescue agencies to reconsider their current positions on responding into these incidents. The problem was that UFA did not have a current Hostile Act Response Guideline or an Active Shooter Response Plan, potentially allowing preventable deaths to occur; lack of coordinated response with fire and law enforcement integration; lack of effective use of responding resources; and creating a danger to the personnel of UFA responding to such an incident.

The purpose of this project was to identify steps, policies, trainings, and exercises that UFA can pursue and implement to better prepare fire personnel, as well as to create a standard operating guideline (SOG) and policy for UFA responses into an active shooter / hostile event response (ASHER). The action research method was used for this applied research project and sought to answer the following research questions: What guiding documents are currently being used and are in place across the nation, statewide, and locally? What are the current best

practices for integration into law enforcement operations regarding RTF and hostile act responses? What are the current strategies and tactics utilized by other agencies during a hostile act response? What are the current best practices regarding patient care during a hostile act response?

Background and Significance

Salt Lake County, Utah, is Utah's most populous county with 1,029,655 people (U.S. Census Bureau, 2014). Salt Lake County is located in the north-central region of Utah and has the state capitol and seat of Salt Lake City within its borders. The Oquirrh Mountains run the length of the valley on the West, the Wasatch Mountains run the length of the valley on the East and is bordered by the Great Salt Lake in the northwest section. Within the Salt Lake Valley, there are currently 8 fire agencies: Bluffdale, Draper, Murray City, Salt Lake City, South Jordan City, West Jordan, West Valley, and Unified Fire Authority of Greater Salt Lake (Unified Fire Authority, 2018).

UFA is a Special Service Taxing District within Salt Lake County, Utah. It was formerly the Salt Lake County Fire Department and it remains the county-level fire department even though it has moved to a Special Service District. It is governed by a 17-member Board of Directors, one elected official from each municipality within the service area, and three from the Salt Lake County Council. Of the nearly 1.1 million citizens within Salt Lake County, 403,314 are covered by UFA (Utah State Tax Commission, 2017). UFA currently has 420 sworn personnel, over 200 part-time personnel, and 52 civilian personnel. It is an all-hazards fire agency that currently provides fire suppression; emergency medical services—both with basic life support (BLS), and advanced life support (ALS); heavy and technical rescue; wildland response; urban search & rescue; hazardous materials response; emergency management; fire

prevention; bomb/arson response and fire investigation responses—all of this is accomplished with an annual budget of nearly $67 million. The 420 sworn firefighters deploy from 23 operational fire stations located throughout the 607 square miles of its response area, with 556 (out of 808 square miles) within Salt Lake County and the other 51 square miles in neighboring Utah County. UFA responded to 28,388 calls in 2014; 29,429 in 2015; 30,281 in 2016, with 22,167 of those being Emergency Medical Services (EMS) calls (73%); 28,774 in 2017, with 20,989 of those being EMS calls (73%) (Unified Fire Authority).

The FBI defines an active shooter as "one or more individuals actively engaged in killing or attempting to kill people in a populated area", which excludes apparent gang- and drug-related shootings, as well as gun-related incidents that appear incidental ("Active Shooter Incidents in the United States 2016-2017", 2018). Within the Salt Lake Valley there have been multiple active shooter events. Beginning in 1991, the following have been deemed active shooter incidents (ASI) in the Salt Lake Valley: Alta View Hospital Hostage Incident (1991, 1 dead); Triad Center Shooting (1999, 1 dead, 2 wounded); LDS Church History Shooting (1999, 2 dead, 5 wounded); Chevy's Restaurant shooting (2000, 2 dead, 3 wounded); Trolley Square Shooting (2007, 6 dead, 4 wounded), ("Active Shooter Incidents in the United States", 2018).

The underlying factor and goal of these individuals perpetrating these events is "to kill and injure as many victims as possible before being stopped by authorities" (Blair et al., 2013, p. 23). This dramatically increases the overall complexity and difficulty of response both for law enforcement, and for fire/EMS. From the initial recognized active shooter incident in Texas, 1966, to the primary event most discussed and referred to in Columbine High School in 1999, to modern active shooter/killer events—which are the deadliest that we have seen in the nation—law enforcement has consistently changed their culture and response protocols to meet new and

emerging threats. When Columbine occurred, the primary response was for law enforcement to wait for specialized teams to respond to an incident of that nature. Following Columbine, law enforcement changed their culture in immediate interdiction by forming teams and making immediate entry into an area where the killing was taking place (Blair, et al., 2013, p. 13).

Following the Virginia Tech Shooting in 2007, law enforcement started integrating basic life support (BLS) training and application (Drysdale et al., 2010), as well as the movement of the injured to the exterior of an incident into their training and response into ASIs (Blair, et al., 2013, p. 29). This was due to the lack of a paradigm shift in fire/EMS response to go interior of a scene that hadn't been termed 'safe', and remaining in staging for the all clear. Law enforcement continued to change their response, but following the incident at Virginia Tech, Arlington County Fire and Rescue (ACFR) recognized the need for a better approach to the problem as the understanding is there that "[w]hile waiting for a secure scene, those injured inside the building aren't receiving care and are dying from their injuries" (Iselin, 2009, p. 2) and "…recognized this weakness in…EMS response during after-action briefings…in which EMS assets were staged for more than an hour before the police declared the scene safe for medical operations." (Iselin, 2009, p. 3). From this, the concept and idea of Rescue Task Force (RTF) and the application of Tactical Combat Casualty Care (TCCC) guidelines within the civilian EMS population was borne (Mueck, 2017).

As the paradigm shift continues to evolve nationally, it has been recognized that this issue needs to be addressed within all fire/rescue agencies. The International Association of Firefighters (IAFF) published a position statement in October, 2013, which was supported by both a position statement of the International Association of Chiefs of Police (IACP) and the active shooter response guidance by the United States Fire Administration (USFA). Due to the

various changes, recommendations, and requirements from across the nation, UFA has recently fully embraced the need for integrated operations of RTF and Unified Command during an ASHER incident, and has done training with most of the fire and police agencies within the Salt Lake Valley. Due to the increasing number of events in the U.S., and the number of events that have occurred locally within the Salt Lake Valley, it was imperative that UFA develop and implement a standard operating guideline (SOG) and/or policy in order to keep its personnel safer and under the same understanding of response into an ASHER event.

The research topic of this Applied Research Project (ARP) directly relates to the curriculum of the National Fire Academy's (NFA) Executive Analysis of Community Risk Reduction (EACRR) course, R0274, by "mitigating community risk through emergency response" (EACRR Student Manual, 2017). This project also correlates directly to four of the five goals of the USFA, as it "reduces fire and life safety risk through preparedness, prevention, and mitigation," it "promotes response, local planning and preparedness for all hazards," which then "enhance[s] the fire and emergency services' capability for response to and recovery from all hazards". Upon completion of this project, it will also "advance the professional development of fire service personnel and of other people engaged in…control activities" (U.S. Fire Administration, 2013, p. 1). This topic also meets the Executive Fire Officer Program goal in order to "transform fire and emergency services organizations from being reactive to proactive, with an emphasis on leadership development, prevention, and risk reduction (U.S. Fire Administration, 2013, p. I-4).

Literature Review

A literature review was conducted in the Learning Resource Center found at the National Fire Academy, as well as the review of numerous books, periodicals, and articles found on the

Internet, to determine the various resources this author could utilize in the creation of an SOG and to utilize the various methodologies that will fall directly in line with the overall protection of the citizens within the communities that UFA covers. The literature review was also utilized to address the following four research questions.

The first research question was addressed by performing a review of available resources on current trends within the fire/EMS service, by a review of National Fire Protection Association (NFPA) 3000 (PS), *Standard for an Active Shooter/Hostile Event Response (ASHER) Program*, and by utilizing a SurveyMonkey survey that was distributed to all fire agencies within the Salt Lake Valley. The second research question was addressed by both reaching out to various national and regional level individuals that have been a part of the development and integration of RTF strategies and tactics, including those agencies that put them in place following a local incident—including law enforcement, fire/rescue and EMS, and military guidelines. The third question was addressed by reviewing the strategies and tactics utilized by other agencies with the integration into law enforcement operations during an ASHER incident. The fourth question was likewise answered with the review of those same strategies and tactics, and drew from those findings.

It has been recognized from the early 1970's that the sooner medical interventions can be applied to those soldiers wounded in the battlefield, the greater their chances of survival. In a report from 1970, Maughon outlined that of a cohort of 2,600 deaths that he had reviewed, 193 of those deaths were from preventable injuries—showing that 7.9% of the cases reviewed those individuals could have survived with point-of-wounding care being provided (pp. 8-11).

From these original findings, and subsequent research done in the field of preventable deaths, the concept of Tactical Combat Casualty Care (TCCC) was implemented in the mid-

1990's due to "improving combat trauma outcomes through optimization of the care rendered in the tactical prehospital environment" (Butler & Blackbourne, 395). This care has shown that "TCCC is saving lives on the battlefield and is improving the tactical flow of missions during which casualties have occurred" (Butler & Carmona, 2015, p. 87). This care is directly relatable to the same types and injuries that many in the civilian population face, which Butler & Carmona (2015) contend that "[s]ome aspects of TCCC (the use of tourniquets to control extremity hemorrhage, the use of hemostatic agents to control external, non-extremity bleeding) have clear application in civilian trauma care" (p. 88). Butler and Carmona (2015) go on to state that:

> One of the best examples of how TCCC applies to TEMS was the mass casualty shooting incident at Fort Hood in 2009. Officer Kim Munley's life was saved by a 68W Army medic. She was wounded in both thighs, and was showing signs of shock despite the attempts of bystanders (including physicians) to control the hemorrhage with direct pressure and improvised tourniquets. The medic had a Combat Application Tourniquet (CAT) with him and applied it to Officer Munley's leg, successfully controlling the hemorrhage" (p. 88).

One of the greatest lessons learned from that day in Fort Hood was the fact that a class of army medics and nurses was just down the hall from the shooting, rushing into the 'hot' zone, rendering care to those injured, saving numerous lives (Keyes, 2010).

Another lesson learned within the civilian population was during the mass shooting that occurred in Tucson, Arizona, killing six, and wounding 13 individuals—including Congresswoman Gabrielle Giffords. Responding to the incident, Pima County Sheriff's Department (PCSD) personnel utilized individual first aid kits (IFAKs) that were put together for response into an ASHER incident, typically for the individual responding. An attending

physician at the University of Arizona Medical Center stated that the "use of IFAK chest seals had saved the lives of at least three people that day" (Paros, 2012). The correlation of integrating TCCC and Tactical Emergency Casualty Care (TECC) into any response into an ASHER incident has been successfully illustrated. When the IAFF came out with a position statement in April of 2013, it was in response that "[g]iven the recent spate of what has become known as "active shooter" scenarios unfolding across the nation, fire and police departments, regardless of size or capacity, must find ways to marshal appropriate and effective responses to these events" ("IAFF Position Statement", 2013). Additional support to this concept is provided by the IACP, where they state that "[t]his EMS support is crucial to the law enforcement community and provides a critical service that continues to save lives" (McArdle, p.1).

The New York Police Department (NYPD) in 2016 compiled an exhaustive report showing a drastic increase in active shooter events in the U.S. From 2001-2005, the average number of ASHER events was nine. From 2006-2010, the average rose to sixteen, and from 2011-2015 the average 17, reflecting a total of over 350 incidents overall (NYPD, 2016). During this time, 707 innocents were killed and 1272 injured (DOJ, 2014, 2016), although the number of those killed and injured have increased drastically. From 2000-2013, the average number of those killed was 38, and those injured was 42. Just in the last two years, that average has increased exponentially to an average of 111 killed and 361 injured each year. This is an astounding increase and drastically demonstrates the need for fire/EMS and law enforcement to be better integrated into a coordinated response. In the executive summary written by the InterAgency Board on improving active shooter / hostile event response (2015), the board outlined 10 best-practices. The first recommendation is to "[e]nsure leadership prioritizes and

supports the development and implementation of proactive ASHE-relevant joint policies, procedures, training, exercises, and equipment" (p. 5).

During a summit and focus group session in March, 2012, leaders from across the fire service revisited one of the firefighter life safety initiatives that they had created in 2004. The National Firefighter Foundation (NFFF) expanded Firefighter Life Safety Initiative 12, which states "[n]ational protocols for response to violent incidents should be developed and championed" (NFFF, 2013). This lack of protocols and guidelines in general the ASHER situations are recognized as a national issue and problem, particularly due to the increase of the incidents, and the need to get fire/EMS personnel into a scene before it is fully secured.

Critical life-safety interventions utilizing TCCC and TECC have been shown to save lives—although without the guiding documents, policies, and guidelines—it places those responders going into a scene, and the force protection provided by law enforcement, into a greater arena of danger. Within the IAFF position paper (2013), they also outline that responders should "[u]se…nationally accepted standards and operational protocols including the number and type of response personnel, training level, personal protective equipment, operational environment, and scope of practice."

The recently released NFPA 3000 was published in 2018 as "only the second provisional standard in the NFPA's history." The request for a new project was submitted on behalf of the International Association of Fire Chiefs (IAFC), as there was no "consensus standard for the components of a multidisciplinary program for preparedness, response, and recovery to active shooter and/or hostile events" (p.2). In fact, in November of 2017 it outlines that:

> The committee petitioned the Standards Council to expedite the development and release of NFPA 3000. They cited the increased frequency and severity of active shooter/hostile

> events since 1999 and the lack of a standard program. At the time there was an abundance of guidance material but no accredited consensus standard (p. 2).

This lack of overall guiding documents and standard program has been identified as a primary focus of all agencies and entities involved in ASHER events. This has been reflected in the needs to create SOPs/SOGs or policies. Within NFPA 3000, that is addressed under section 6.4 'SOP Planning Components'. Under 6.4.1 SOPs it outlines "SOPs shall be developed as part of the ASHER program to enhance personal safety, provide response consistency, serve as a guide for response action, enhance decisions process, allow for better coordination and interoperability with other agencies and organizations, and ensure unified incident management." 6.4.2 outlines "SOPs shall be built around relevant core capabilities as identified by the National Preparedness Goals" (p. 20).

Yearly, a collection of fire chiefs from around the world meet at the NFPA headquarters to discuss and support various documents that are of high importance to the fire profession. This group of fire chiefs meet in what has been named the Urban Fire Forum (UFF). In 2013, the UFF first addressed the need for responses to ASHE events. In the 2017, the UFF came out with an additional statement on preparedness and unified response to hostile events. In that statement, they outlined that the standard will "not dictate local tactics, but will provide necessary elements of a successful response to such an event." They additionally agreed that the "Metro/Urban Fire Forum Chiefs support the work of the NFPA 3000 technical committee and endorse the development of this standard." ("UFF Position Statement", 2017)

Following a Joint Counterterrorism Awareness Workshop (JCTAWS) held in November of 2017 with over 225 individuals from Salt Lake County, including participants from law enforcement, fire/EMS, emergency management, private businesses, and hospitals—it was

identified that there was a "significant lack of awareness of other agencies' and stakeholders' emergency response plans and Standard Operating Procedures (SOPs). … [It was also] reported that law enforcement and fire are not familiar with discipline-specific roles and responsibilities" ("JCTAWS Summary Report", 2018, p. 11). It has been noted that UFA and valley fire agencies already train together regularly, and have a generalized response into ASHER incidents, but the lack of knowledge of the various SOGs/SOPs and/or guiding documents is a critical issue that all agencies are struggling with to one extent or another (p. 11).

In all of the literature review that this author conducted, there were several overarching themes regarding ASHE Responses. The need for full collaboration between law enforcement, fire, and EMS is required for successful operations. The utilization of the Incident Command System (ICS) and the National Incident Management System (NIMS) are necessary for any response into such an event. The need for establishment of unified command (UC) and common terminology are all necessary components of response, and also need to be a part of the guiding documents, trainings and exercises—before an incident occurs. It is the general lack of clear-guiding policies and procedures—and the overall lack of training and exercises—that generally are cited as major findings after any incident occurs.

Written in 2015, following the violent killings in Sandy Hook Elementary, in Newtown Connecticut that occurred in 2012, an extensive after-action report (AAR) was released. In that report, it was written that "[i]t is essential to have disaster response protocols in place that can quickly bring order to chaos and begin the long process of recovery" (198). This is a critical component of the incident command system (ICS) writ-large, and one where multiple findings in major events is a factor.

Following the Aurora Theater shooting in Aurora, Colorado, the AAR revealed that "[i]ncident command was disorganized, primarily because no unified command or organized single command structure was established early on, which made it difficult to coordinate EMS with police operations...[leading] to: Inability to delineate specific safe zones" as well general overall lack of organized and effective communications on scene (TriData Division, p. 78). Another finding from that same report identified that:

> Prior to the theater incident, there was no joint police, fire, and EMS active shooter policy. This affected many aspects of the incident from ICS, communications, safety and patient care. Since July 2012, the APD, AFD and PSCD have been forming a High Risk Extraction Protocol (HREP) that includes policies, tactics, and ICS strategies (p. 79).

One additional finding was that agencies need to "[e]nsure that the new active shooter protocol remains a "living document" with leaders from AFD, APD, and the EMS provider monitoring and evaluating the SOG's success and continued relevance" (p. 82).

The San Bernardino shooting and response AAR, from the incident that occurred in December, 2015, identified that their response was successful, due in large part to "[l]aw enforcement leaders emphasized the need to engage fire and EMS agencies in the planning, training, and exercise process", both with creation of policies, as well as operational response Brazier, et al., p. 52).

In the review of SOGs that were obtained during the literature review, other AAR's reviewed by this author included: multiple reports regarding the Columbine Shooting in Littleton (CO) in 1999; the Trolley Square Shooting in Salt Lake City (UT) in 2007; the University of Texas Active Shooter Event in 2010; the Boston Marathon Bombings in 2013; the Las Vegas Metro Police Department's Ambush Incident in June, 2014; the Pulse Nightclub shooting in

Orlando (FL) in 2016; the Fort Lauderdale-Hollywood International Airport ASE in Broward County, Florida, in January, 2017; and the Las Vegas Shooting in October, 2017. Within all of the AARs reviewed, the same findings regarding policies, trainings and exercises are universal throughout these documents—either as identifications of failures, or things having gone well during an incident.

Another review of applicable SOGs that were obtained through personal communications also occurred. The review of policies and/or SOG/SOPs from Arlington County Fire & Rescue (VA), Rancho Cucamonga Fire Protection District (CA), whose response area includes San Bernardino, Ventura County Fire Department (CA), Salt Lake City Fire and Police Departments (UT), and Unified Police Department (UT), were also completed as part of the literature review of this author, utilizing current best practices found.

Review of the recommendations of the Hartford Consensus, a committee formed following the Sandy Hook Elementary School shooting, formed by the American College of Surgeons (ACS) and including members of: the medical community; the Federal Government; the National Security Council; the U.S. Military; the Federal Bureau of Investigation; governmental and non-governmental emergency medical response organizations (amongst others). Additional in-depth review of the newly released NFPA 3000 was completed. With the significant findings and recommendations from the literature review, policies, guiding documents, and SOG/SOPs, they greatly influenced the overall SOG and Policy created as a result of this project and attached as Appendices A & B.

Although the Unified Fire Authority has followed guidelines and recommendations regarding the Rescue Task Force (RTF) concept regarding the carry and use of ballistic protection, as well as medical equipment and gear that should be utilized during an ASHER

event, this author felt that it was outside of the scope and intent of this applied research paper and project, as the intent of this project was to create an SOG and policy for UFA responses into ASHER incidents. Therefore, the inclusion of this information has been omitted within this project.

Procedures

A six-step process was used to conduct this action research project. First, a thorough review of available literature on ASHER incidents was conducted. An analysis and review of incidents, including the backgrounds, histories, behaviors, injuries, deaths, methodologies, life-saving measures utilized, and other relevant information was completed. This included agencies' responses, challenges encountered, and best practices identified.

Second, a survey was created utilizing the SurveyMonkey platform and was sent out to the other seven fire/EMS agencies, as well as to the private ambulance entity (Gold Cross) within the Salt Lake Valley asking about their in-house policies and procedures. That survey was open for four weeks and had four respondents of the eight agencies emailed. The results of that survey are included in Appendix C.

Third, an in-depth and analytical review of various, national-level organizations and professional groups (i.e. IAFF, IACP, UFF, etc.) position statements and responses to cultural-change recommendations. This allowed overall guidance for the needs and requirements of both operational response and guiding literature to be created or refined.

Fourth, the outreach to obtain policies and guidelines, both locally and nationally, occurred for available policies, SOGs, and SOPs occurred. This identified local agencies that had current guiding documents, and those that were willing to share them, in addition to various

agencies that have dealt with ASHER incidents, and the utilization of their documents for common factors and best practices.

Fifth, several meetings occurred between various fire and law enforcement entities within the Salt Lake Valley, to discuss the need and outline for creation of various guiding documents. Subsequent meetings occurred between UFA and the Unified Police Department (UPD), as that is the primary law enforcement agency that UFA responds and works with regularly.

Sixth, the creation of a draft SOG and a draft policy were created for UFA integrating best practices, policies, and lessons learned. The draft SOG and draft Policy were the results of several meetings between: Local 1696 (UFA's Union); UFA's Policy Advisory Committee (PAC); UFA's Battalion Chief (BC) over Training, who is also the BC over RTF; UFA's Assistant Chief over Administration and Planning; and this author. These documents were subsequently submitted to UFA's Command Staff, and accepted as a new policy and SOG (Appendices B & C).

The action research that was utilized in this applied research project had several limitations. The request for information from the local fire agencies was limited by the number of respondents (50%), as well as the fact that it was limited to the Salt Lake Valley. The request to various agencies in regards to their current SOPs, SOGs, and policies was limited by the fact that it was narrow in scope to those agencies that responded to personal requests, or the requests made by others at this author's behest. There is a large limitation regarding the literature review, as there is not a practical way to scrutinize or review all present and current practices for dealing with an ASHER incident. Another limitation is that ASHER events are continually evolving, which then changes the responses needed by law enforcement and fire/EMS. Due to the nature of any given event, even though lessons learned from events years ago are still valid and may be

recognized as best practices, they may be outdated by the time that the next ASHER incident occurs. New, progressive approaches need to be considered and taken regarding SOPs, SOGs, and guiding documents. Additional limitations are due to the slight differences and nuances from agency to agency across the nation.

Results

The purpose of this applied research paper was to create an SOG and policy for UFA in response to ASHER events. This occurred through assessing the four questions, literature review, review of various SOGs, SOPs, and policies, a survey of local fire agencies, various meetings, and discussion on how best to create an SOG and policy based on best-practices and recommendations.

The first research question asked—what guiding documents are currently being used and are in place across the nation, statewide, and locally? In response to the guiding documents used nationwide, those were found through the literature review. The review of NFPA 3000, as well as the documents guiding TCCC and TECC providing trauma care in an ASHER event were reviewed. The review of military publications and battlefield medicine was conducted to understand the historical and current methodologies and current guiding documents that are in place nationally.

In all the research conducted, there was agreement across all experts of the aspect that the sooner that interventions are placed by first responders, the greater the chance of their survival. This is why the integration of medical personnel into military units has occurred regularly, and has exponentially increased the survivability of the soldiers (Kotwal, et al., 1350-1358).

Regarding the documents that are in place locally within the Salt Lake Valley, of the survey that was sent out to the eight fire/EMS agencies in the Salt Lake Valley, five responded.

Of the five respondents, four indicated that they had an internal SOG or policy regarding RTF. Of those four, two indicated they had an SOG, and two indicated they had a policy. Three of those indicated that they believed that their SOG/policy provided enough guidance for an ASHE Response. Two of the agencies stated that they feel like their agencies were prepared for an ASHER incident, while two replied that they were unsure, and one did not feel prepared for an ASHE Response. Four of the five responded that they train regularly with their local police agency, and three of the four respondents stated they train regularly with all agencies in the Salt Lake Valley (i.e. large, valley-wide drills and exercises).

The second research question asked—what are the current best practices for integration into law enforcement operations regarding RTF and hostile act responses? An online search specific to current best practices, as well as the review of available literature was conducted. In addition, the review and application of pertinent SOGs/SOPs and policies all occurred. The review of current Tactical Emergency Casualty Care (TECC) guidelines as well as those priorities outlined in the Hartford Consensus was considered. The review of NFPA 3000 also occurred to ensure that the recommendations there were added into any SOP/SOG or policy that was created.

The third research question asked—what are the current strategies and tactics utilized by other agencies during a hostile act response? This researcher reached out to several different agencies that were recognized through research and the literature review as having in-place, vetted plans in regards to either SOPs/SOGs, or policies. Through personal communications, SOPs/SOGs or policies were obtained from Arlington County Fire & Rescue (VA), Rancho Cucamonga Fire Protection District (CA), Ventura County Fire Department (CA), Salt Lake City Fire and Police Departments (UT), and Unified Police Department (UT). Through the review of

these documents, this author was able to review what the common strategies and tactics utilized across all plans, guidelines and policies, incorporating those items into an SOG. This includes the incorporation of Unified Command, common terminology, common movements, the implementation of TCCC/TECC guidelines, and a common command structure are all necessary in the overall SOG—as well as within trainings and exercises.

The fourth research question asked—what are the current best practices regarding patient care during a hostile act response? Again, this researcher utilized the SOGs/SOPs, policies and literature review in order to answer this research question, in addition to the review and adoption of current TCCC/TECC patient care guidelines and the review of current trauma care. This included the addition of multiple tourniquets, chest seals, wound-packing materials, 14-gauge needles for chest decompressions, components to carry/lift victims—all providing for treating as many patients as possible at the point of wounding, which was identified as a critical component during any hostile act response—and which subsequently was outlined in the overall plan that was created for Unified Fire Authority.

One of the primary findings that this researcher identified was common terminology and common definitions are necessary as a baseline level of understanding across all agencies. The following are definitions and terminology that is critical during an ASHER incident for the understanding of all response elements that has been included in the SOG:

Active Shooter / Active Killer: Any armed person who uses or has used deadly physical force on a person or persons and continues to do so while having unrestricted access to additional potential casualties. Note that the term “shooter” and “killer” are now synonymous and interchangeable, as it is understood that deadly weapons other than firearms can be used for these violent, mass casualty assaults. Active Killer is a more apt term.

Complex Coordinated Attack (CCA): Killing or threatening to kill multiple unrelated individuals where there are [a] two or more attackers, or [b] simultaneous attack of two or more sites, or [c] an act of terrorism which overwhelms the local jurisdiction and initiates a regional/statewide response.

Casualty Collection Point (CCP): A specific designated location within the Cold Zone and outside of the Inner Perimeter where casualties are assembled to be triaged, treated, and transported to a medical treatment facility. This is a safe location where Fire/EMS personnel can interface with LE operations and receive casualties without the threat of injury or violence. Transfer of medical care from the LE Rescue Teams and Rescue Task Forces to Fire/EMS personnel happens here.

Clear: An area that during an initial sweep revealed no immediate or direct life threat.
(it is critical to differentiate the difference between clear of threats vs victims)

Concealment: Objects, structural elements, and/or locations that hides an individual from view but does not provide protection from incoming hostile fire.

Contact Team(s): The initial team(s) of LE officers who form at the scene of an active killer incident and deploy to the killer's location with the goal of initiating contact to contain or eliminate the active killer to prevent further injury, loss of life, or escape.

Contact Team Group Supervisor (CGS): Law enforcement person who assumes overhead position early into the incident to direct and coordinate the operations of the contact teams. The CGS position will likely be filled by one of the responding law enforcement sergeants or senior officers and will serve as the communication point between law enforcement dispatch / UCP and the Contact Teams. The CGS will help gather information from the Contact Teams and relay intelligence: suspect/shooter location; estimated number of casualties; Hot/Warm Zone(s);

Rescue (RTF) access route(s) etc., to the UCP and or Rescue Group Supervisor (RGS). The Contact Group Supervisor plays a critical role in initiating the "Go" for the joint rescue mission of the Rescue Task Forces (RTFs).

Cover: Objects, structural elements, and/or locations that stops, turns, or impedes incoming hostile fire.

Dynamic Risk Assessment: A continuous process of gathering and evaluating information throughout the entire incident in an effort to properly determine risk. Considerations: A strong Unified Command; number/location of shooters; determine whether shooter is engaged/ barricaded or eliminated; known rescue; known IED's; availability of security element; properly trained fire personnel; identified access points/travel routes; proper PPE, etc. It is important to remember that when determining threat zones, do not get fixated on concentric circles surrounding the scene; zones might be discontinuous/dynamic depending on the threat locations.

Extraction Team(s): A combination of Fire/EMS and LE Force Protection personnel who deploy after the Rescue Task Forces with the goal of extracting/directing viable casualties to the Casualty Collection Point. These casualties may include the "walking wounded" and/or those already treated by the Rescue Task Forces. Extraction Teams may don ballistic PPE if available and deploy into the Warm Zone with LE Force Protection. If PPE is not available, these teams will only deploy into the Cold Zone or down established Security Corridors under the direction of law enforcement.

Force Protection: A team of law enforcement officers specifically designated to escort and provide armed security to the medical Rescue Task Force. The ideal configuration is four LE officers, with the minimum being two per medical Rescue Task Force. It is understood that the dynamics of the situation will dictate the size of the Force Protection team and their deployment

configuration. Force Protection LE officers may also provide security at the Casualty Collection Point and throughout the Security Corridor.

Immediate Action Rapid Deployment (IARD): The swift and immediate deployment of law enforcement resources to ongoing, life threatening situations where delayed deployment could otherwise result in death or serious bodily injury to innocent persons.

Improvised Explosive Device (IED): A device placed or fabricated in an improvised manner incorporating destructive, lethal, noxious, pyrotechnic, incendiary or chemicals designed to destroy incapacitate, harass or distract.

Inner Perimeter: A geographically defined area in which subjects are contained. Entrance and egress is controlled by law enforcement. Typically, this is the outer wall of the structure/building or the property boundaries in which the incident occurred.

MACTAC: MACTAC is the acronym for Multi-Assault, Counter Terrorism Action Capabilities. MACTAC is an expansion of Immediate Action Rapid Deployment (IARD) tactics. MACTAC concepts provide officers options based on tactical knowledge, skills and abilities to respond to such an event.

MACTAC Event: MACTAC Event is an extraordinary incident involving extreme violence which exceeds conventional law enforcement tactics and resources and requires immediate police intervention. These events are likely to occur in multiple locations simultaneously or consecutively. Examples include active killers, a terrorist attack involving improvised explosive devices (IED), high-powered weapons, or a hostage siege where the armed subjects have used deadly force or are preparing to use deadly force on other persons; and is an on-going dynamic incident.

Medical Rally Point (MRP): An area within the Inner Perimeter Warm Zone where injured casualties are brought directly from the Hot Zone by LE Rescue Teams. This is considered a clear but unsecured internal location where casualties are collected temporarily *only if they cannot be immediately transported directly to the Casualty Collection Point*. Rescue Task Force personnel rendezvous with Hot Zone casualties here and takeover/begin medical care and evacuation. MRPs can be:

- A pre-designated location within the Inner Perimeter developed from preplanning for a specific event or location or;
- An area where multiple casualties will take time to assess and do the initial rapid treatment, effectively ending progress of the RTF. Such an MRP can be designated using an orange glowstick and the location should be communicated out to the RGS, or;
- A spontaneously selected location based on the dynamics of the situation and/or environment where the Rescue Task Force and casualties meet. It should be noted that during an extended, ongoing event, RTF personnel could be staged/held in these areas to await casualties being brought out of the Hot Zone by LE Rescue Teams.

Operational Zones: Geographic locations or areas established based on the severity of the threat or hazard.

- Hot Zone: A snapshot of the geographic location within the Inner Perimeter in immediate proximity to a known threat (i.e. any uncontrolled area where an active killer could directly engage others or within the radius of the active killer's

affective projectile). Individuals within this zone are capable of taking affective incoming hostile fire or in other ways being injured.

- Warm Zone: The geographic location either inside or outside of the Inner Perimeter but may still be in the general proximity of a known or potential threat (i.e. an area where LE has either cleared or isolated the threat to a level of minimal or mitigated risk). Individuals within this zone are less likely of taking effective incoming hostile fire through the use of LE perimeter protection, hard cover, structure layout, and/or distance. This area can be considered "clear" but not "secure."
- Cold Zone: The geographic location outside of the Inner Perimeter and well away from any known or potential threat. Individuals within this zone are no longer capable of taking any incoming hostile fire through the use of hard cover and distance.

Outer Perimeter: A larger area encompassing the Inner Perimeter, which is controlled by law enforcement and from which the public is excluded. Typically the city block in which the incident occurred.

Rescue Group Supervisor (RGS): A firefighter will be assigned to the RGS. The RGS will coordinate with the UCP on security element and resources for the formation of the RTF's. The RGS will direct / coordinate RTF(s) and the rescue operation for rapid treatment and extraction of victims. The RGS will monitor conditions and confirm Warm/Hot Zones; determine RTF staging, entry points, and the CCP(s). The RGS will be the point of contact between the UCP and the RTF's. The RGS will communicate/coordinate with the incident Medical Group Supervisor for the relocation of victims from the CCP to MCI Treatment Areas.

RGS Assistant: A firefighter assigned to the RGS that will assist with: accountability/PAR, movement of patients between the CCP and Cold zone/treatment areas, communications, etc.

Rescue Team: Team(s) of LE officers who form at the scene of an active killer and deploy behind the Contact Teams into the Hot Zone with the goal of extracting viable casualties to a Medical Rally Point or Casualty Collection Point.

Rescue Task Force (RTF): A combination of Fire/EMS and LE Force Protection personnel deployed to identify, quickly stabilize, and extract the critically injured from the Warm Zone to the Casualty Collection Point where they can receive definitive care and/or transport to the hospital.

Rescue Task Force Staging Area (RTF Staging): An area "On Deck", that has been determined by the RGS to have both cover and concealment and will function as the staging area of the RTF(s). This will be the area where fire personnel in tactical PPE and law enforcement assigned to the RTF report for deployment into the Warm Zone.

RTF Tactical Gear: Tactical Medical and evacuation gear carried on RTF teams. See Appendices section.

Safe Refuge area: An area identified within the Warm zone where RTF's or individuals can seek temporary refuge. These areas may be identified by the RTF's as they progress through the warm zone.

Secure: An area that has been actively maintained free of any immediate or direct life threats by Law Enforcement.

Security Corridor: The geographic travel path secured by Force Protection and other LE officers used by non-injured persons and ambulatory casualties evacuating the Hot and Warms Zones as well as Rescue Task Forces to access and egress the Warm Zone.

Security Element/Detail: Law enforcement component of a RTF that provides protection for the Fire Rescue personnel. The security element for RCFD, will only be done by qualified LE personnel.

Stop Point: This is a term used to describe anytime a RTF has changed its objective, or has a change of condition from a go/no-go position for any reason. This could be from running out of supplies, encountering an IED, Loss of communication, Lack of "LACES" or no more patients. *** When using this term it should be immediately communicated to the UCP with "Why Stop"

Tactical Combat Casualty Care: A military's approach to best-practices found in the battlefield on how to operate in a high-risk environment on treating casualties and how to best affect survival. Currently taught by NAEMT.

Tactical Command: Commands and coordinates the tactical law enforcement response within the inner perimeter of an incident.

Tactical Operations Center (TOC): The location where law enforcement tactical operations are coordinated through the incident's LE Tactical Commander. The TOC may or may not be co-located with the Unified Command Post.

Tactical Emergency Casualty Care (TECC) Guidelines: The civilian equivalent of the military's combat medical guidelines (i.e. TCCC). TECC guidelines account for the unique operational considerations and limitations of medical operations in high-risk conditions and prioritize and focus medical efforts to only what must be done to affect survival.

Tactical Medics (TMs): Specially trained and equipped FIRE/EMS personnel currently assigned to the SLCPD, UPD or other SWAT teams within the region. They are sworn SFOs/LEOs and trained in the principles of TECC/TCCC and LE tactical operations.

Unified Command (UC): A unified team effort which allows all agencies with responsibility for the incident, either geographical or functional, to manage an incident by establishing a common set of incident objectives and strategies.

One of the elements that is a new thought and an item that needs to be considered moving forward in the creation of any and all SOPs/SOGs and policy is the planning for, testing of, and exercising to a complex coordinated terror attack (CCTA) event. This is a new and emerging threat that is seen on the international stage at an increasing and alarming rate. Thus, any SOP/SOG and Policy also needs to address the possibility that an ASHER event isn't a single, isolated event, but that it is also tied into a larger, more complex event of multiple attacks in multiple areas.

Discussion

From the beginning of recognized active shooter/active killer events, with the first major recognized event occurring in Texas with the Texas Tower Shooting in 1966; to the primary active shooter event most often referred to in Columbine; to the primary active shooter event that has occurred within the Salt Lake Valley during the Trolley Square shooting in 2007 (the same year as Virginia Tech); to the Sandy Hook school shooting; to current events such as the Vegas Shooting in 2017—there has been a continual shift from both the law enforcement communities, as well as the fire and EMS communities.

With the beginning of the paradigm shifts, the law enforcement community has been much quicker to find and embrace change. With Columbine, there was a history and culture of having specialty teams (i.e. SWAT) respond to any specialized, complex situation that had barricaded subjects. Following Columbine, the law enforcement community took note and changed their approach to the contact team approach to end killing (Smith & Delaney, 2014).

Following the Virginia Tech massacre, again the law enforcement community had a paradigm shift with initializing basic life support (BLS) care and extricating victims to the outside so fire/EMS could start care (Drysdale, et al., 2010). During this time, and in the eight years between the two events, there was almost no change within the approach to these events with fire/EMS—stage and wait.

The Fort Hood response, due to the graduating class of Army Medics that occurred within the perimeter of the incident, was the first glimpse of how getting personnel into a hot or warm zone and providing point of care at the point of wounding, saves lives. This was the single biggest change to occur within the medical and EMS community since the initial Texas Tower Shooting in 1966. This concept was later solidified in the Rescue Task Force (RTF) approach, which allows fire/EMS personnel into an active scene to work in the warm zone, integrated with force protection (Atwater, 2012).

This concept of point of wounding, point of care is a concept that has been around since the 1970's. In the 1970's, it showed that in nearly 8% of those cases reviewed, preventable deaths occurred (Maughon, 1970). From the 1970's, the military created the Tactical Combat Casualty Care (TCCC) guidelines that greatly increased the survivability rates of those injured in a "tactical prehospital environment" (Butler & Blackbourne, 2012, 395), as well as "saving lives on the battlefield and is improving the tactical flow of missions during which casualties have occurred" (Butler & Carmona, 2015, p. 85).

This knowledge has been pushed into the civilian world due to the ever-increasing incidents, as well as having been embraced and incorporated by the USFA, the IACP, the IAFF, and the IAFC have all come out with support position statements regarding active shooter

response (Smith & Delaney, 2014). Additional guidance and recommendations have come out from NFPA with the publication of the NFPA 3000.

Multiple fire departments have taken the various concepts and theories from this response framework and have incorporated it into their SOPs/SOGs and policies. The initial fire department and organization that created the concept for RTF and the response model is Arlington County Fire Department (VA). During the creation of the RTF SOG for Unified Fire Department and collaboration of its sister police agency—Unified Police Department—various other agencies SOGs or policies were reviewed as a starting point. Those agencies were Arlington County Fire and Rescue (VA), Rancho Cucamonga Fire Protection District (CA), Ventura County Fire Department (CA), Salt Lake City Fire and Police Departments (UT), and Unified Police Department (UT). Looking at these various agencies and reviewing different best practices from national-level leaders was a beginning point for this action research project and led to the initial creation of both the policy and SOG for UFA.

In reviewing NFPA 3000 as well as the statements from the IAFF and the IACP—which fully support the need for a collaborative approach—as well as being better prepared and better trained as first responders with both fire and law enforcement personnel. This is a drastic paradigm shift in the response models for both fire and law enforcement. The previous approach to such events was to have fire personnel stage well down the road until law enforcement had deemed the area 'safe' for personnel to enter. This new approach is also supported by the Salt Lake County Firefighters Local 1696 and they were participants in the creation of the UFA SOG and policy.

This new approach, supported by the aforementioned organizations, puts personnel that have ballistic protection into as relatively as safe a location as possible to work on those victims

that are wounded, typically designated as a ‘warm zone’ (Atwater, 2012). Indeed, the entire concept that drives RTF is point of wounding—point of care. RTF elements are not to work in the ‘hot zone’, which is a defined area where the active gunfight or known suspect(s) are located. Law enforcement personnel work in the hot zone, and that work is primarily meant to end the threat, or to bring the active incident to a resolution (USFA, 2013).

A cold zone is the area in which there is no element of danger and personnel can safely work without any ballistic protection. Casualty collection points (CCPs), the incident command post / unified command (ICP/UC), and treatment, triage, transport and transfer (TTTT) areas are all located in the cold zone. RTF elements are to work in the warm and cold zones and the primary purpose of RTF is to provide life-saving interventions—such as tourniquets and chest seals—as quickly as possible and moving on to the next victim(s). There are two times when an RTF will transition into a rapid extraction team (RET). Those times are when they run out of victims, or run out of medical gear.

UPD has also fully embraced the RTF concept and both agencies have established a baseline understanding of the concept in both theory and practice. Common terminology; the RTF approach; law enforcement movement with fire department personnel that have been integrated; incident / unified command; and command and control are all concepts that have been agreed and trained to over the last several years within both agencies. NFPA 3000 that outlines the response to ASHER events identify all components that should be included in a common response model and both UFA and UPD have worked to incorporate all elements of that provisional standard. These meetings and trainings have occurred the last several years, although there has been an overall lack of SOGs/SOPs and/or policies.

One of the approaches that has been implemented in conjunction with the RTF concept is the adoption of the new medical approach that has been created that is based off of the lessons learned and military approach to combat trauma care is the newly accepted policies/practices of Tactical Emergency Casualty Care (TECC). TECC has taken the military approach and lessons learned and transitioned those into a civilian approach dealing primarily with the warm zone work, placement of tourniquets, chest seals and dealing with tension pneumothoraxes (C-TECC, 2018).

There have been several joint trainings that have occurred between multiple law and fire personnel. One of the biggest challenges has been to get all valley agencies on board. All fire agencies within the Salt Lake Valley have agreed to the concept and theory of RTF. There are some minor differences and variations to those agreements, with some law enforcement agencies within the valley having differing opinions as to the approach and integration of RTF. Some, such as UPD, fully accept and push forward with this approach. Not all agencies are the same.

Ballistic protection and the push for fire personnel to be protected during warm zone work is also a challenge that has occurred within the UFA. IAFF and IACP have both recommended utilizing ballistic gear for work in the RTF capacity ("IAFF Position Statement", 2013; IACP, 2018). Through grant funding, UFA has been able to secure 58 sets of ballistic protection for their fire personnel, consisting of Type IV rifle plates (front and back), a Type IIIA Kevlar helmet, and enough medical gear attached to the vests to treat up to eight victims at a time. The medical gear consists of tourniquets, chest seals, 14 gauge 3.25" needles for needle decompressions, Israeli bandages, Kerlix, hemostatic agents, and carry litters. These meet the intent of the recommendations made by the Committee for Tactical Emergency Casualty Care (C-TECC) (Callaway et al., 2011).

Recommendations

With this action research project, the purpose was to develop a Standard Operating Guideline and Policy for Unified Fire Authority of Greater Salt Lake. This SOG and policy are to allow the flexibility for UFA and UPD to respond to an Active Shooter / Hostile Event with common understanding, common terminology, unified command, and clearly defined areas of work. These recommendations are based off of national-level best practices, in addition to meeting the current applicable standards of NFPA 3000, as well as the recommendations made by both the IAFF and IACP. Additional recommendations were taken from lessons learned and after-action reviews (AARs) from multiple large-scale active killer events that have occurred from Columbine in 1999 to the Las Vegas Shooting in 2017.

On September 29, 2018, following several collaborative meetings between the UFA RTF Committee, the UFA Policy Advisory Committee (PAC), UPD, several Salt Lake Valley fire agencies, as well as Salt Lake County Local 1696, a policy (Appendix A), as well as a Standard Operating Guideline (SOG) (Appendix B) were formally presented to UFA's Command Staff and approved as to form. The policy and subsequent SOG were formally distributed on October 3, 2018.

Additional recommendations are (1) to continue the trainings and exercises that have been agreed to by both UFA's training cadre and UFA's Command Staff. (2) To fully implement and integrate command and control trainings and exercises during the remainder of 2018. (3) To continue the implementation of roles and responsibilities within an ASHER event, primarily that of Incident Commander, Rescue Group Supervisor — which handles the Rescue Task Forces and Rapid Extraction Teams (RETs), the Medical Group Supervisor — which handles the Casualty Collection Points and the treatment, triage, transfer, and transport areas,

respectively. (4) Continue valley-wide trainings and exercises, not only among the various fire agencies, but also with all the police agencies within the area. The current outline is to provide annual training at a minimum with UFA and UPD personnel, and working other agencies into that mix is critical for the success of the program. (5) Better prepare the civilian population to respond to an active shooter / hostile event. This is done through implementation the applicable components of Tactical Emergency Casualty Care. Additional components of TECC also needs to be trained to within UFA. The last recommendation (6) is to continue the purchase and outfitting of UFA personnel with RTF gear and ballistic protection. UFA currently has 58 RTF kits, and the overall goal is to provide 99 kits, outfitting all operations positions within UFA outside of Battalion Chiefs.

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Appendix A: Unified Fire Authority Hostile Act / RTF Policy

UNIFIED FIRE AUTHORITY Rules, Policies and Procedures		
Volume II *UFA Operational Policies and Procedures*	Chapter 4 *Field Operations Responses*	Section 10 *Rescue Task Force*

REFERENCE:
UFA Policy and Procedure - Volume III Chapter 1 Section 35 – Rescue Task Force

PURPOSE:
Given the increasing occurrences of active shooter and mass shooting events in modern society, the purpose of this policy is to outline the expectations, training requirements, and response within Rescue Task Force operations. The primary purpose of the response is to get trained Fire/EMS personnel and resources to the casualties of an active shooter/active killer event within a reasonable amount of time and provide the ability to initiate point of wound care to victims that otherwise may die from preventable death injuries.

POLICY:
1. Rescue Task Force within the Salt Lake Valley and surrounding areas is recognized as a regular duty and requirement of an operational response within Unified Fire Authority.

2. Participation in the Rescue Task Force program, including all required training, is mandatory and necessary to keep operational responses coordinated among all agencies for the greatest amount of safety.

3. Training sessions will require a safety search of all fire and law enforcement personnel participating within the training venue. No live weapon or live ammunition, as determined by the training venue and/or cadre, shall be permitted within the training venue(s). Failure to abide by these requirements may result in employee discipline.

4. All automatic/mutual aid requests through VECC will be granted on a routine basis as per the CAD recommendations.

5. Refer to the Rescue Task Force Field Operations Guideline (FOG) and Standard Operating Guideline (SOG) for background, response, and operating procedures.

New policy dated Sep 29, 2018

Approved by Fire Chief Dan Petersen: Sep 29, 2018 Policy distributed: Oct 3, 2018	Page 1 of 1

Appendix B: Unified Fire Authority Hostile Act / RTF Response SOG

UNIFIED FIRE AUTHORITY Rules, Policies and Procedure		
Volume III *Related Information*	Chapter 1 *Salt Lake Valley Fire Alliance Field Operations Guide (F.O.G.)*	Section 35 *Rescue Task Force (SOG)*

REFERENCE:
UFA Policy and Procedure – Volume II Chapter 4 Section 10 – Rescue Task Force

PURPOSE:
To establish a uniform response and tasking of responsibilities for an operational response when the lives of multiple people are at stake, such as during an active shooter event, barricaded suspect, hostage situation, terrorist attack or complex coordinated attack. The primary purpose of the response is to get trained Fire/EMS personnel and resources to the casualties of an active shooter event within a reasonable amount of time of being wounded and providing the ability to provide point of wound care to victims that otherwise may have died from preventable death injuries.

While the general practice of 'staging' assets at a safe distance until all threats are neutralized may be appropriate for many potentially violent situations, during active shooter events or complex coordinated attacks (CCA's), considerations should be made for more aggressive EMS operations in areas of higher but mitigated risk to ensure casualties can be rapidly evacuated, triaged, treated, and transported.

Care of these casualties is a shared responsibility between the Fire and Law Enforcement (LE). Optimal outcomes depend on communication between both agencies before and during the event. The response to an active shooter incident is a continuum that requires close coordination between LE officers and Fire/EMS responders. Consequently, it is important that Fire/EMS personnel have a general understanding of active shooter law enforcement tactics when responding to this type of incident.

Training on RTF will occur regularly—and yearly, multi-jurisdictional and multi-functional trainings will occur (fire/EMS and law enforcement).

DEFINITIONS & ACRONYMS:
1. Acronyms
   CCA–Complex Coordinated Attack
   CCP–Casualty Collection Point
   CGS–Contact Group Supervisor
   IARD–Immediate Action Rapid Deployment
   IC–Incident Command
   IED–Improvised Explosive Device
   LE–Law Enforcement
   MACTAC–Multi-Assault, Counter Terrorism Action Capabilities
   MRP–Medical Rally Point
   RGS–Rescue Group Supervisor
   RTF–Rescue Task Force
   TOC–Tactical Operations Center
   TECC–Tactical Emergency Casualty Care

TCCC–Tactical Combat Casualty Care
TM–Tactical Medic (also known as SWAT Medics)
UC–Unified Command

2. Definitions

Active Shooter: Any armed person who uses or has used deadly physical force on a person or persons and continues to do so while having unrestricted access to additional potential casualties. Note that the term "shooter" is used throughout this Policy but it is understood that deadly weapons other than firearms can be used for these violent, mass casualty assaults. Active Killer is a more apt term.

Complex Coordinated Attack (CCA): Killing or threatening to kill multiple unrelated individuals where there are [a] two or more attackers, or [b] simultaneous attack of two or more sites, or [c] an act of terrorism which overwhelms the local jurisdiction and initiates a regional/statewide response.

Casualty Collection Point (CCP): A specific designated location within the Cold Zone and outside of the Inner Perimeter where casualties are assembled to be triaged, treated, and transported to a medical treatment facility. This is a safe location where Fire/EMS personnel can interface with LE operations and receive casualties without the threat of injury or violence. Transfer of medical care from the LE Rescue Teams and Rescue Task Forces to Fire/EMS personnel happens here.

Clear: An area that during an initial sweep revealed no immediate or direct life threat. (it is critical to differentiate the difference between clear of threats vs victims)

Concealment: Objects, structural elements, and/or locations that hides an individual from view but does not provide protection from incoming hostile fire.

Contact Team(s): The initial team(s) of LE officers who form at the scene of an active shooter incident and deploy to the shooter's location with the goal of initiating contact to contain or eliminate the active shooter to prevent further injury, loss of life, or escape.

Contact Team Group Supervisor (CGS): Law enforcement person who assumes overhead position early into the incident to direct and coordinate the operations of the contact teams. The CGS position will likely be filled by one of the responding law enforcement sergeants or senior officers and will serve as the communication point between law enforcement dispatch / UCP and the Contact Teams. The CGS will help gather information from the Contact Teams and relay intelligence: suspect/shooter location; estimated number of casualties; Hot/Warm Zone(s); Rescue (RTF) access route(s) etc., to the UCP and or Rescue Group Supervisor (RGS). The Contact Group Supervisor plays a critical role in initiating the "Go" for the joint rescue mission of the Rescue Task Forces (RTFs).

Cover: Objects, structural elements, and/or locations that stops, turns, or impedes incoming hostile fire.

Dynamic Risk Assessment: A continues process of gathering and evaluating information throughout the entire incident in an effort to properly determine risk. Considerations: A strong Unified Command, Number/location of shooters, determine whether shooter is engaged/ barricaded or eliminated, known rescue, known IED's, availability of security element, Properly trained Fire personnel, identified access points/travel routes, proper PPE, etc. It is important to remember that when determining threat zones, do not get fixated on concentric circles surrounding the scene; zones might be discontinues/dynamic depending on the threat locations.

Extraction Team(s): A combination of Fire/EMS and LE Force Protection personnel who deploy after the Rescue Task Forces with the goal of extracting/directing viable casualties to the Casualty Collection Point. These casualties may include the "walking wounded" and/or those already treated by the Rescue Task Forces. Extraction Teams may don ballistic PPE if available and deploy into the Warm Zone with LE Force Protection. If PPE is not available, these teams will only deploy into the Cold Zone or down established Security Corridors under the direction of law enforcement.

Force Protection: A team of law enforcement officers specifically designated to escort and provide armed security to the medical Rescue Task Force. The ideal configuration is four LE officers, with the minimum being two per medical Rescue Task Force. It is understood that the dynamics of the situation will dictate the size of the Force Protection team and their deployment configuration. Force Protection LE officers may also provide security at the Casualty Collection Point and throughout the Security Corridor.

Immediate Action Rapid Deployment (IARD): The swift and immediate deployment of law enforcement resources to ongoing, life threatening situations where delayed deployment could otherwise result in death or serious bodily injury to innocent persons.

Improvised Explosive Device (IED): A device placed or fabricated in an improvised manner incorporating destructive, lethal, noxious, pyrotechnic, incendiary or chemicals designed to destroy incapacitate, harass or distract.

Inner Perimeter: A geographically defined area in which subjects are contained. Entrance and egress is controlled by law enforcement. Typically, this is the outer wall of the structure/building or the property boundaries in which the incident occurred.

MACTAC: MACTAC is the acronym for Multi-Assault, Counter Terrorism Action Capabilities. MACTAC is an expansion of Immediate Action Rapid Deployment (IARD) tactics. MACTAC concepts provide officers options based on tactical knowledge, skills and abilities to respond to such an event.

MACTAC Event: MACTAC Event is an extraordinary incident involving extreme violence which exceeds conventional law enforcement tactics and resources and requires immediate police intervention. These events are likely to occur in multiple locations simultaneously or consecutively. Examples include active shooters, a terrorist attack involving improvised explosive devices (IED), high-powered weapons, or a hostage siege where the armed subjects have used deadly force or are preparing to use deadly force on other persons; and is an on-going dynamic incident.

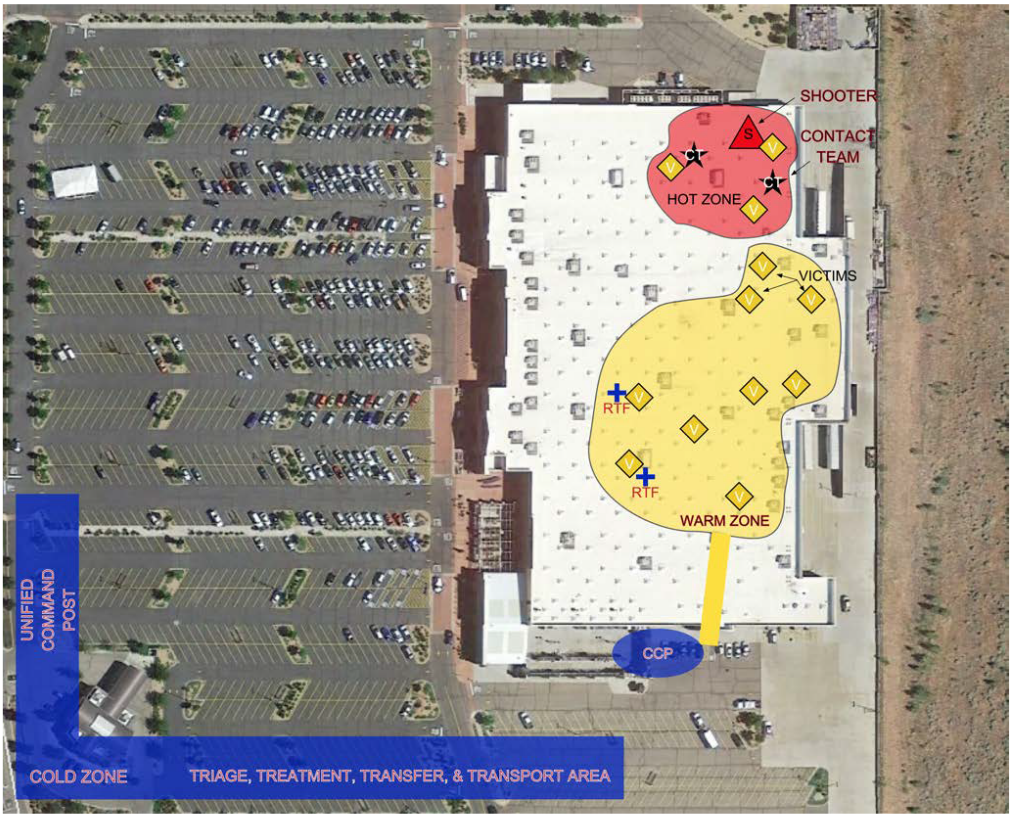
Medical Rally Point (MRP): An area within the Inner Perimeter Warm Zone where injured casualties are brought directly from the Hot Zone by LE Rescue Teams. This is considered a clear but unsecured internal location where casualties are collected temporarily *only if they cannot be immediately transported directly to the Casualty Collection Point.* Rescue Task Force personnel rendezvous with Hot Zone casualties here and takeover/begin medical care and evacuation. MRPs can be:

- A pre-designated location within the Inner Perimeter developed from preplanning for a specific event or location or;
- An area where multiple casualties will take time to assess and do the initial rapid treatment, effectively ending progress of the RTF. Such an MRP can be designated using an orange glowstick and the location should be communicated out to the RGS, or;
- A spontaneously selected location based on the dynamics of the situation and/or environment where the Rescue Task Force and casualties meet. It should be noted that during an extended, ongoing event, RTF personnel could be staged/held in these areas to await casualties being brought out of the Hot Zone by LE Rescue Teams.

Operational Zones: Geographic locations or areas established based on the severity of the threat or hazard.

- Hot Zone: A snapshot of the geographic location within the Inner Perimeter in immediate proximity to a known threat (i.e. any uncontrolled area where an active shooter could directly engage others or within the radius of the active shooter's affective projectile). Individuals within this zone are capable of taking affective incoming hostile fire or in other ways being injured.
- Warm Zone: The geographic location either inside or outside of the Inner Perimeter but may still be in the general proximity of a known or potential threat (i.e. an area where LE has either cleared or isolated the threat to a level of minimal or mitigated risk). Individuals within this zone are less likely of taking effective incoming hostile fire through the use of LE perimeter protection, hard cover, structure layout, and/or distance. This area can be considered "clear" but not "secure."
- Cold Zone: The geographic location outside of the Inner Perimeter and well away from any known or potential threat. Individuals within this zone are no longer capable of taking any incoming hostile fire through the use of hard cover and distance.

UNIFIED FIRE AUTHORITY Rules, Policies and Procedure		
Volume III *Related Information*	Chapter 1 *Salt Lake Valley Fire Alliance Field Operations Guide (F.O.G.)*	Section 35 *Rescue Task Force (SOG)*



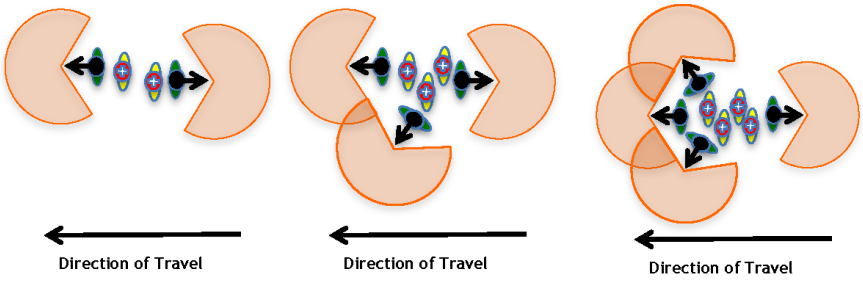
Outer Perimeter: A larger area encompassing the Inner Perimeter, which is controlled by law enforcement and from which the public is excluded. Typically the city block in which the incident occurred.

Rescue Group Supervisor (RGS): A firefighter will be assigned to the RGS. The RGS will coordinate with the UCP on security element and resources for the formation of the RTF's. The RGS will direct / coordinate RTF(s) and the rescue operation for rapid treatment and extraction of victims. The RGS will monitor conditions and confirm Warm/Hot Zones; determine RTF staging, entry points, and the CCP(s). The RGS will be the point of contact between the UCP and the RTF's. The RGS will communicate/coordinate with the incident Medical Group Supervisor for the relocation of victims from the CCP to MCI Treatment Areas.

RGS Assistant: A firefighter assigned to the RGS that will assist with: accountability/PAR, movement of patients between the CCP and Cold zone/treatment areas, communications, etc.

Rescue Team: Team(s) of LE officers who form at the scene of an active shooter and deploy behind the Contact Teams into the Hot Zone with the goal of extracting viable casualties to a Medical Rally Point or Casualty Collection Point.

Rescue Task Force (RTF): A combination of Fire/EMS and LE Force Protection personnel deployed to identify, quickly stabilize, and extract the critically injured from the Warm Zone to the Casualty Collection Point where they can receive definitive care and/or transport to the hospital.



Rescue Task Force Staging Area (RTF Staging): An area "On Deck", that has been determined by the RGS to have both cover and concealment and will function as the staging area of the RTF(s). This will be the area where fire personnel in tactical PPE and law enforcement assigned to the RTF report for deployment into the Warm Zone.

RTF Tactical Gear: Tactical Medical and evacuation gear carried on RTF teams. See Appendices section.

Safe Refuge area: An area identified within the Warm zone where RTF's or individuals can seek temporary refuge. These areas may be identified by the RTF's as they progress through the warm zone.

Secure: An area that has been actively maintained free of any immediate or direct life threats by Law Enforcement.

Security Corridor: The geographic travel path secured by Force Protection and other LE officers used by non-injured persons and ambulatory casualties evacuating the Hot and Warms Zones as well as Rescue Task Forces to access and egress the Warm Zone.

Security Element/Detail: Law enforcement component of a RTF that provides protection for the Fire Rescue personnel. The security element for RCFD, will only be done by qualified LE personnel.

Stop Point: This is a term used to describe anytime a RTF has changed its objective, or has a change of condition from a go/no-go position for any reason. This could be from running out of supplies, encountering an IED, Loss of communication, Lack of "LACES" or no more patients. *** When using this term it should be immediately communicated to the UCP with "Why Stop"

Tactical Combat Casualty Care: A military's approach to best-practices found in the battlefield on how to operate in a high-risk environment on treating casualties and how to best affect survival. Currently taught by NAEMT.

Tactical Command: Commands and coordinates the tactical law enforcement response within the inner perimeter of an incident.

Tactical Operations Center (TOC): The location where law enforcement tactical operations are coordinated through the incident's LE Tactical Commander. The TOC may or may not be co-located with the Unified Command Post.

Tactical Emergency Casualty Care (TECC) Guidelines: The civilian equivalent of the military's combat medical guidelines (i.e. TCCC). TECC guidelines account for the unique operational considerations and limitations of medical operations in high-risk conditions and prioritize and focus medical efforts to only what must be done to affect survival.

Tactical Medics (TMs): Specially trained and equipped FIRE/EMS personnel currently assigned to the SLCPD, UPD or other SWAT teams within the region. They are sworn SFOs/LEOs and trained in the principles of TECC/TCCC and LE tactical operations.

Unified Command (UC): A unified team effort which allows all agencies with responsibility for the incident, either geographical or functional, to manage an incident by establishing a common set of incident objectives and strategies.

PROCEDURE

1. An active shooter incident shall initially be under the command of LE. As FIRE/EMS units arrive to the incident, every effort shall be made to establish a Unified Command with law enforcement at a common Command Post. Active shooter events require close coordination with law enforcement at all levels, utilizing the Incident Command System. Based on the dynamics of the incident, FIRE/EMS assets shall either work under a Unified Command organization or as an EMS, Rescue, or Fire division.

2. Within a CCA, the response greatly resembles that of an Active Shooter Event, save the fact that it is generally spread out over a greater area, may require multiple Incident Command Posts and may ultimately fall under an Area Command.

3. In general, the overall response of the FIRE/EMS to an Active Shooter Event/CCA will follow these basic steps:
    - All units initially respond to staging where the first arriving unit establishes command and begins to make assignments. Subsequent arriving units begin to fill assignments as outlined.
    - Parking both at the beginning and throughout the event is critical to the response. Traffic corridors shall be established early providing for both access to the scene and egress.
    - Keys shall be left in all response vehicles as the need to shift or move vehicles is critical, should the need arise.
    - Rescue Task Forces and Extraction Teams are formed from incoming units.
    - Rescue Task Forces and Extraction Teams join with LE Force Protection.
    - Rescue Task Forces enter the Warm Zone and immediately begin to treat and stabilize casualties as they encounter them. They may begin extraction as needed based on the situation.
    - Extraction Teams enter when and where appropriate behind the RTFs and extract patients to designated exits to Casualty Collection Point(s) as established by on-scene response or Unified Command.
    - FIRE/EMS EMS units establish Casualty Collection Point(s) and further triage, treat, transfer, and transport casualties to hospitals or landing zones.

    A. When the Dispatch Center receives a call for a violent incident that is dynamic/ongoing and involves the potential for multiple casualties (i.e. active assailant/shooter or CCA), the following FIRE/EMS resources shall be dispatched and respond 10-39:
        - 2 Combat Battalion Chiefs
        - 4 ALS Heavy Apparatus
        - 6 ALS/BLS Ambulances (a minimum of 3 RTF response units)
        - Other Specialty Units/Personnel

    B. If a CCA is determined to be happening, a "MACTAC Event" will need to be declared through dispatch. If a CCA Response is requested, or if dispatch determines that a CCA has or is occurring, each of the following items may occur in different locations within an area.

    C. The first arriving FIRE/EMS unit on scene of an active shooter incident shall:
        i. Confirm the nature of the incident (i.e. simple shooting or barricade vs. active shooter/MCI vs. CCA).
        ii. Dispatch will notify all fire entities which PD Radio Channel the law enforcement response is occurring.

iii. If it is determined or initially assumed that this is a single active shooter event, the first arriving Heavy Apparatus will go directly to the scene, with close coordination with Law Enforcement.

iv. One member of the responding Heavy Apparatus crew will switch over to the PD Radio Channel and try to ascertain where the ICP is being established with PD.

v. If there is no ICP established upon arrival, the first arriving Heavy Apparatus will establish initial Incident Command.

vi. When a law enforcement supervisor arrives on scene either before or after fire, he/she shall coordinate with fire to form Unified Command.

vii. Upon arrival, provide a scene size-up to the Dispatch Center and other responding units. Consider designating a specific approach route for other responding units

viii. Establish initial command for FIRE/EMS resources and amend the response as needed.

ix. Designate a staging area for other responding units. Consider an area that is not in direct line of sight or in immediate proximity to the scene. This may be a predetermined area developed from preplanning for a specific event or location.

x. The first arriving Officer shall begin to gather intelligence and information about what is occurring (number and location of suspects, hot zone/warm zone/cold zone locations, number and location of victims, Bomb/EOD information, etc.) and determine if it is a go/no-go situation.

xi. The rest of the fire crew shall start setting up the Medical Group—Triage, Treatment, Transport, and Transfer—in a safe location within the cold zone. Consider elevated attack areas, proximity to warm/hot zones, bomb/EOD concerns, etc.

NOTE: If casualties are encountered immediately upon arrival, and the Warm Zone and Casualty Collection Point have not yet been established, an attempt to access and remove these obvious casualties in plain view should ONLY be made if there is no imminent or potential threat in that area AND it has already been secured by responding LE officers. First arriving FIRE/EMS units may have to designate a temporary Triage Unit Leader who will have the responsibility of coordinating the immediate triage and movement of casualties to impromptu treatment areas.

D. The first arriving FIRE/EMS battalion chief shall:

i. Assume command of the FIRE/EMS resources. Co-locate with the on scene, in-charge law enforcement agency IC and establish a Unified Command or EMS, Rescue, or Fire division. Establish a Command Post if not otherwise established.

- NOTE: Based on the dynamics of the situation and the geographic area of involvement, it may be necessary for the responding operations battalion chiefs to link up with staged fire units to drop off the RTF PPE kits before moving to the command post and assuming command.

ii. Create Rescue Task Forces and Extraction Teams from the initial responding resources and secure the necessary PPE and Force Protection officers for them. (See Section G of this guideline.)
iii. Work with the law enforcement IC to identify the Hot Zone, possibly by making use of a map or drawing, and ensure that FIRE/EMS or other non-law enforcement personnel do not enter that area.
iv. Work with the law enforcement IC to identify the Warm Zone, an entry/access location, and clear travel/Security Corridor for Rescue Task Force deployment. There should be an LE officer assigned to each entry point to direct RTF's and Extraction teams.
v. Once Unified Command has declared the boundaries of the Operational Zones, provide a quick briefing to the Rescue Group Supervisor and/or Rescue Task Forces and Extraction Teams.
vi. Determine the location of the Casualty Collection Point(s) and notify responding EMS resources of that location.
vii. Request additional resources for casualty treatment and transport, fire suppression, hazardous materials, and explosives hazards as needed.
viii. Consider working off of a common radio channel for communications. Those established channels are designated as SL Ops (Zone 2, Ch's 6-15), Event Channels (Zone 4, Ch's 1-16), SL Regional (Zone 9, Ch's 11-16)

E. The second arriving FIRE/EMS company officer should normally be assigned as the Rescue Group Supervisor. This may also be the first arriving company officer if a transfer of Command to the battalion chief has taken place. The Rescue Group is configured to extract viable casualties from the Warm Zone and/or Medical Rally Points and move them to the Casualty Collection Point. Based on the dynamics of the situation and the available personnel, the Rescue Group Supervisor may co-locate with the law enforcement Tactical Command Officer who is coordinating tactical operations and Force Protection or may serve as a Rescue Task Force member and coordinate rescue efforts from inside the Warm Zone. The Rescue Group Supervisor shall:
   i. Assume command of the initial Rescue Task Forces and Extraction Teams (both deployed and in staging).
   ii. Create additional Rescue Task Forces and Extraction Teams. Secure the necessary PPE and Force Protection officers for them as needed.
   iii. Designate a Rescue Task Force medical cache location in close proximity to the entry point, at the Rescue Task Force staging area, or at the Casualty Collection Point and ensure the stocking of that cache.

iv. Consider the use and designation of Warm Zone Medical Rally Points based on the size of the incident, the number of casualties, and the transport distance to the Casualty Collection Point.
v. Serve as the primary point of communication between the Rescue Task Forces, Extraction Teams, the Medical Group Supervisor, and Command. Consider utilizing a Common Radio Channel for RTF and Extraction Teams operations.
vi. Consider making a special call through command for the FIRE/EMS Tactical Medics and sworn investigators that are on duty and have them respond to the Rescue Task Force staging area.
vii. Maintain accountability for all FIRE/EMS personnel assigned to RTFs.

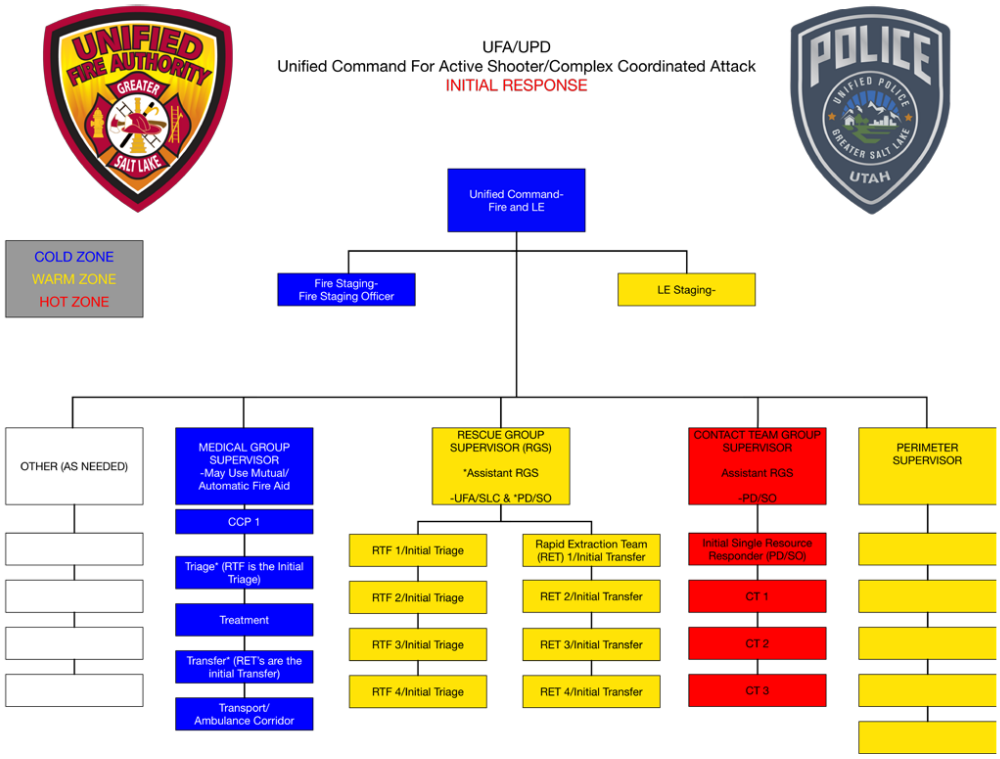
F. The second arriving FIRE/EMS captain or battalion chief should normally be assigned Medical Group Supervisor. The Medical Group is configured to receive the casualties from LE Rescue Teams and/or Rescue Task Forces, and manage the triage, treatment, transfer and transportation of casualties from the Casualty Collection Point to the local hospitals. As the incident develops, if large numbers of casualties are encountered at multiple locations around the incident or when casualties are separated by a distance that makes it impractical to have a single Casualty Collection Point, a Medical Branch may need to be established. If this occurs, multiple Medical Groups and Casualty Collection Points at different geographic locations will need to be configured under one Medical Branch Director. The Medical Group Supervisor / Director shall:
   i. Request/secure Force Protection officers for the Casualty Collection Point as needed.
   ii. Before or as part of the initial triage, ensure that a body search for weapons is performed on all persons entering the Casualty Collection Point from the incident sight.
   iii. Implement the FIRE/EMS Mass Casualty policy, as well as the District 2B Protocol (Mass Casualty Incident Plan) and the Triage and Treatment Protocol.
   iv. Assign Triage, Treatment, Transfer, and Transport officers.
   v. Confirm that open travel routes exist for responding EMS vehicles to access the Casualty Collection Point and that the path away from the incident area is clear for ambulances when transporting to the hospital.
   vi. Direct the Dispatch Center to advise local hospitals to prepare to receive casualties of an active shooter MCI or a CCA, as deemed appropriate.

NOTE: If the battalion chiefs are unavailable or delayed, the first arriving FIRE/EMS company officers shall assume the above tasks.

F. If a legitimate threat of explosion or signs of an active fire exist, Command shall establish a Fire Group. The Fire Group is configured to suppress fires and coordinate any other FIRE/EMS non-EMS operational needs of the incident. Additional groups (e.g. HRT, HazMat, etc.) may need to

be created or developed as well, based upon the needs of the incident. The Fire Group Supervisor shall:

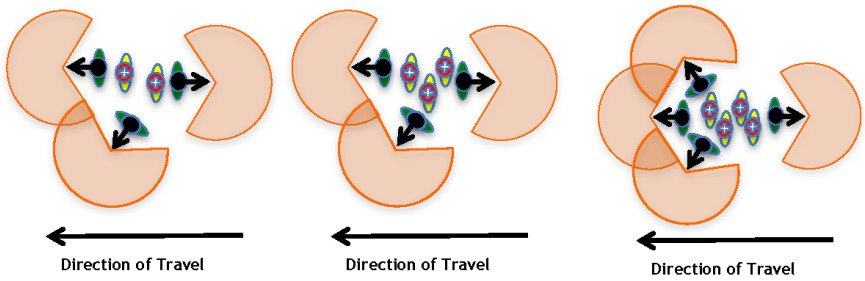
i. Determine the type and number of FIRE/EMS resources needed and request that they respond to a designated safe staging area.
ii. Request/secure Force Protection as needed.
iii. Designate and operate on a separate radio channel from the rest of the event.
iv. Confirm that open travel routes exist for responding fire apparatus and establish a safe staging area.
v. Communicate the boundaries of the incident's Operational Zones to all companies and ensure that FIRE/EMS personnel stay out of those areas that hold a threat of violence. Under no circumstances should FIRE/EMS firefighters enter or move through the Hot Zone to deploy ladders, hose lines, or other equipment.
vi. Consider allowing active fire to burn until the security and safety of FIRE/EMS suppression personnel can be confirmed by law enforcement.
vii. Be aware that fire as a weapon has been used to deny LE into an active scene, and the active scene has prohibited Fire Responders to put out fires, putting additional lives at risk. If possible, utilize Fire-trained responders to move into an active scene as part of a modified RTF to extinguish fire.



G. Rescue Task Force Operations: As noted in definition, the RTF is a medical treatment team accompanied by LE Force Protection deployed within the Warm Zone to areas that are clear but not necessarily secure to provide point of wound care to casualties. These teams treat, stabilize, and prepare casualties for removal by the Extraction Teams from the Warm Zone to the Casualty Collection Point where they can then be triaged and receive definitive care and/or transportation to the hospital. RTFs wear ballistic protective equipment and move with LE Force Protection. The Rescue Group Supervisor coordinates and oversees the activities of the RTFs and the Extraction Teams.

4. At a minimum, an RTF shall have two FIRE/EMS medical personnel and three armed Force Protection officers (based upon the discretion of UC). Law enforcement personnel are there to provide security for the team and should not become involved in or asked to assist with medical care or casualty extrication. FIRE/EMS medical personnel assigned to an RTF shall work within Force

Protection security at all times. When possible, RTFs should incorporate at least one paramedic. The circumstances and available personnel will dictate the number, size, and configuration of the RTFs. Possible RTF configurations are below:



A. If FIRE/EMS Tactical Medics and/or sworn FIRE/EMS SFO/LEO Investigators are on scene and are not engaged in SWAT or other duties, they should be assigned to the RTFs. They can act either as a medical provider or as a Force Protection officer but not as both.

B. If an RTF is configured with three or more FIRE/EMS personnel, one should be a Company Officer and shall serve as the Communications Officer. The Company Officer shall relay information to Command or the Rescue Group Supervisor regarding the number of casualties, situation status, and pertinent information including the need for additional RTFs and Extraction Teams (i.e.: multi-level structure, multiple theaters, large interior/exterior areas, etc.). They shall also be responsible for overall accountability of FD personnel within their RTF.

C. RTF, Extraction Team, and Force Protection communications shall be in plain language (i.e.: *Moving forward, Moving left/right, Moving back*, etc.). In the unlikely event that shooter contact is made by the RTF, commands shall be: *Contact front, Contact left/right, or Contact rear*. During any hostile contact, RTF and Extraction Team medical personnel shall immediately take a position of cover, crouching (vs prone) or move to cover if directed so Force Protection officers can engage the hostile threat, hold ground, or retreat to a safe area. Force Protection officers shall NEVER leave RTF or Extraction Team medical personnel behind.

5. RTFs must be able to move and react quickly. RTFs may carry modified/lightweight configurations of medical equipment to provide increased mobility as well as enhanced hemorrhage control and quick airway management. Extraction Teams may carry rapidly deployable casualty movement adjuncts such as SKEDS, rescue straps, tarps, backboards, etc. Prior to executing any missions or deployments, it is highly recommended to have the RTF and Extraction Team personnel assemble at a

staging area for a mission briefing and updated intelligence. RTFs and Extraction Teams shall only be deployed upon agreement of the Unified Command.

6. It is important to emphasize that if RTFs and Extraction Teams are being configured and deployed, lives may be at extreme risk. Discipline must be maintained and members must be prepared to move quickly and deliberately while maintaining a high level of alertness and situational awareness. As RTFs and Extraction Teams move through areas in search of casualties, it is advisable to maintain LACES (Lookout, Accountability, Communications, Escape Routes, and a Safe Refuge). The Force Protection component of each RTF and Extraction Team shall have tactical control of the movement of the team at all times while operating within the Warm Zone.

7. An integrated active shooter response utilizing law enforcement and FIRE/EMS personnel should include the critical actions contained within the THREAT, or WEMARCH (if the situation stays a warm-zone operation) or WEBAD (if the situation de-escalates) acronyms.
    a. THREAT stands for (to be used in a warm-zone operation):
        a) **T** = Threat suppression (LE Contact Teams)
        b) **H** = Hemorrhage control (RTFs)
        c) **RE** = Rapid Extraction to safety (RTFs)
        d) **A** = Assessment by medical providers (RTFs and FIRE/EMS Medical Group)
        e) **T** = Transport to definitive care (FIRE/EMS Medical Group)

    b. WEMARCH stands for (to be used in a warm-zone operation):
        a) **W** = Weapons (LE Contact Teams)
        b) **E** = Extraction (RTFs)
        c) **M** = Massive Hemorrhage Control (RTFs)
        d) **A** = Airway Opened and Secured (RTFs and FIRE/EMS Medical Group)
        e) **R** = Respirations Secured (RTFs and FIRE/EMS Medical Group)
        f) **C** = Circulation Contained (RTFs and FIRE/EMS Medical Group)
        g) **H** = Head Injury and Head to the CCP (RTFs and FIRE/EMS Medical Group)

    c. WEBAD stands for (typically used if the situation de-escalates):
        - **W** = Weapons (LE Contact Teams)
        - **E** = Extraction (RTFs)
        - **B** = Bleeding (RTFs)
        - **A** = Airway/Assessment by medical providers (RTFs and FIRE/EMS Medical Group)
        - **D** = Disability (FIRE/EMS Medical Group)

A. When RTFs are operating within the Warm Zone, no detailed triage is conducted. The first RTFs will enter the area and treat casualties as they find them. If there are multiple casualties

found in close proximity to each other (i.e.: inside a single room), RTFs shall use three simple criteria to rapidly sort them visually and/or verbally:

- Still/Obvious Life Threat – Assess 1st
- Wave/Purposeful Movement – Assess 2nd
- Walking/Standing – No assessment; order the individuals to evacuate or shelter in place.

B. After assessing any casualty, RTFs shall apply one of two colors of tags/tape to either the casualty's wrist or ankle:
   - Black Tag/Tape – Expiring (dying) or Deceased. Casualties with respirations and/or injuries not compatible with life. Another option is placing a **white** glowstick in the mouth, or near the head of those dying or dead, as this will provide a quick visual indicator.
   - Orange Tag/Tape – Immediate. Viable casualties who cannot evacuate on their own and/or lifesaving interventions may need to be performed immediately to extend the casualty's viability before removal to the CCP.
   - No Tag/Tape is needed for the walking wounded or walking with assistance.

C. RTF treatment is limited to rapid, TECC/TCCC-based lifesaving interventions only (e.g. tourniquets, rapid wound dressing/bleeding control, NPAs, recovery position, etc.) with the goal of stabilizing as many casualties as possible. Any person (injured or otherwise) who can walk without assistance will be instructed to place their hands on their head and either:
   i. Ordered to shelter in place, or;
   ii. Be directed to self-evacuate down cleared Security Corridors under LE direction or;
   iii. Be escorted to safe areas by the Extraction Teams.

D. Deceased casualties are left in place and tagged black for easy identification and to avoid repeated evaluations by additional RTFs. Another option is placing a **white** glowstick in the mouth, or near the head of those dying or dead, as this will provide a quick visual indicator.

8. RTFs treat as many casualties as possible until they run out of equipment or until all accessible casualties have been assessed and treated. Once this point has been reached, RTFs start the extraction/transfer of the viable (orange tagged) casualties to the CCP. It is recommended that if time and the situation allow during the removal phase, RTFs mark the location of the casualty prior to moving them. A corresponding mark should be placed on the casualty to assist in tracking, documentation, and post incident investigation. Once the RTF has removed the casualties, they should continue to restock and re-enter until all survivable casualties have been moved to the CCP. Additional RTFs that enter the area should be primarily tasked with the movement of the orange tagged casualties treated by the initial RTFs, or if needed, sent into areas previously unreached by the initial RTFs. Additionally, as part of the marking system, all casualties should also marked (at a

minimum) as to the address or location where they came from (i.e. South Towne, State Capitol, etc.), as tracking these individuals during and after a CCA is critical.

A. Other general FIRE/EMS considerations:
   1. Do NOT Self-Dispatch. Safety and accountability issues are only some of the problems caused by this. If not formally requested by the Dispatch Center, FIRE/EMS apparatus and personnel shall not respond to the scene.
   2. Use extreme caution when approaching the scene and minimize personnel exposed to unnecessary risk throughout the operation.
   3. Consider turning off emergency lights and warning devices before arrival. Many frightened citizens may be fleeing the event and are likely to act in an unsafe manner.
   4. If bystanders become hostile, extricate yourself and advise Command.
   5. For larger geographic incidents or incidents with travel barriers, consider the use of multiple staging areas and Casualty Collection Points.
   6. Work as teams or in pairs as a minimum.
   7. When deploying FIRE/EMS personnel on special assignments, if possible assign a team spotter. Their role is to observe, identify, and avoid threats while the balance of the team executes their tactical assignment. This is similar to some of the safety precautions used in wildland/urban interface firefighting.
   8. Consider the possibility of IEDs or other secondary devices. If this is a real possibility, designate a second level of staging for the balance of responding resources until they are needed and can be advanced in safely.
   9. While the saving of life is the primary role of FIRE/EMS responders, all personnel on scene should remain cognizant of the need for crime scene preservation. Do not touch or move items unnecessarily or in other ways alter the scene. Report any suspicious activity or persons to LE immediately.
   10. Any and all clothing or items transported with the victim(s) needs to be kept and collected at the hospital using best practices in preserving any items of evidentiary value. The hospital(s) need to be told of the importance of keeping clothing and/or items that are or could be of use for Law Enforcement purposes.

B. Tactical LE Incidents and active shooter events can take many hours to completely resolve. Although the scene may appear to be static, until the suspect is in custody and all potential threats neutralized, these incidents present the potential to turn hostile without notice. It is essential that FIRE/EMS personnel remain alert to their surroundings and situations at all times, and closely monitor all developments.

C. Recovery begins the minute that the scene or scenes are stabilized and deemed safe. Recovery will take days to months to years and will take many personnel from LE, Fire/EMS, the

Government (local, state and Federal), and the community as a whole. All parties will need to take part in different roles and with different responsibilities than they are used to or normally trained for.

New procedure dated Sep 29, 2018

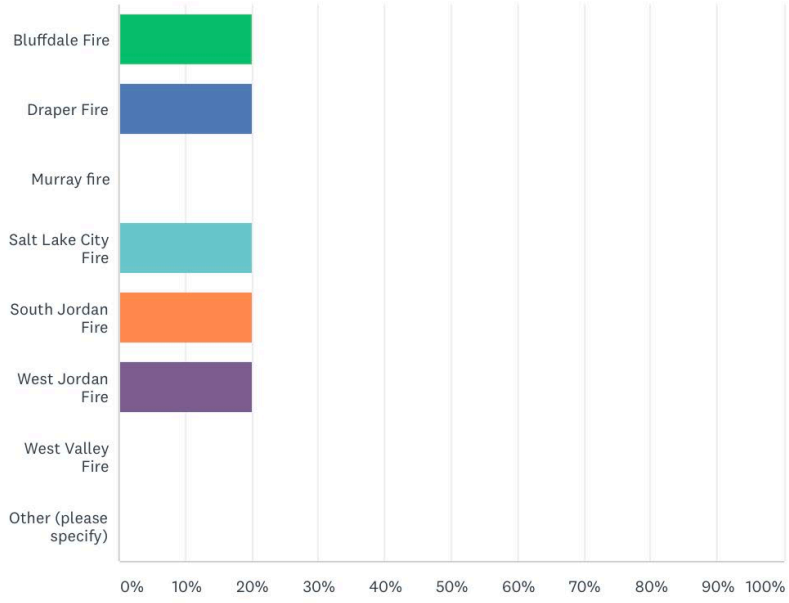
Appendix C: Salt Lake Valley Fire Agency Survey

Q1

Customize Export

Which agency do you belong to?

Answered: 5 Skipped: 0



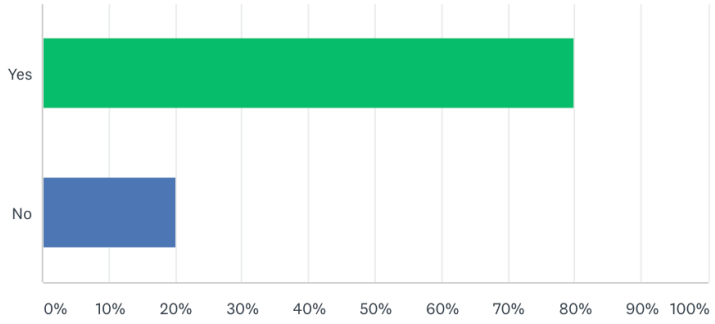
ANSWER CHOICES		RESPONSES	
Bluffdale Fire		20.00%	1
Draper Fire		20.00%	1
Murray fire		0.00%	0
Salt Lake City Fire		20.00%	1
South Jordan Fire		20.00%	1
West Jordan Fire		20.00%	1
West Valley Fire		0.00%	0
Other (please specify)	Responses	0.00%	0
TOTAL			5

Q2

Customize Export

Do you currently have an internal SOG or Policy regarding Rescue Task Force, or a Hostile Act Response Plan?

Answered: 5 Skipped: 0



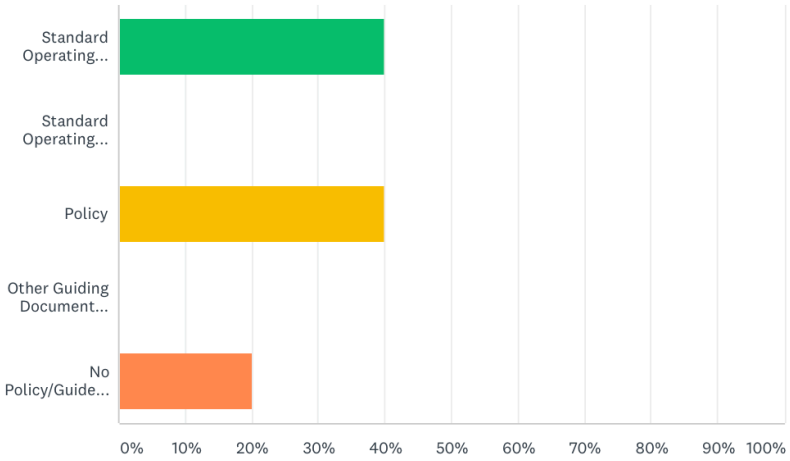
ANSWER CHOICES	RESPONSES	
Yes	80.00%	4
No	20.00%	1
TOTAL		5

Q3

Customize Export

If you answered 'Yes' to the previous question, what do you currently have in place? (Check all that apply)

Answered: 5 Skipped: 0



ANSWER CHOICES	RESPONSES	
Standard Operating Guideline	40.00%	2
Standard Operating Procedure	0.00%	0
Policy	40.00%	2
Other Guiding Document (please specify)	0.00%	0
No Policy/Guidelines	20.00%	1
Total Respondents: 5		

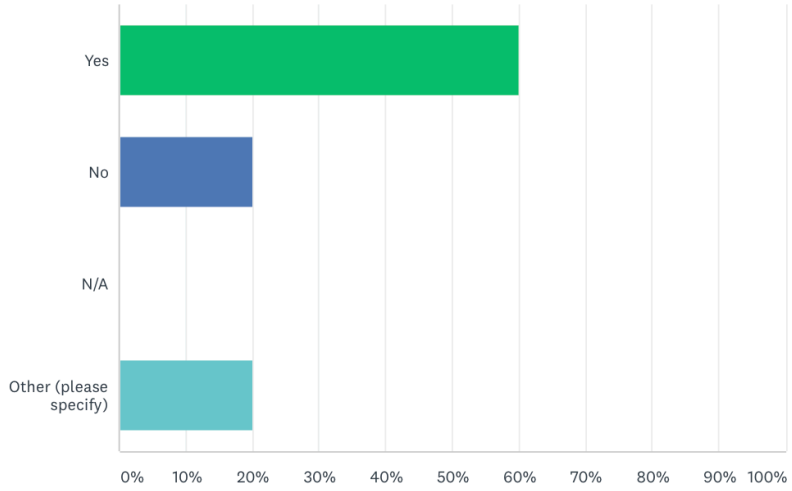
Comments (0)

Q4

Customize Export

Do you feel that your guiding documents regarding a Hostile Act Response, or RTF response provides enough guidance, as well as allows enough flexibility for a response.

Answered: 5 Skipped: 0



ANSWER CHOICES		RESPONSES	
Yes		60.00%	3
No		20.00%	1
N/A		0.00%	0
Other (please specify)	Responses	20.00%	1
TOTAL			5

Q5

Export

If you answered 'No' to the previous question, how would you change your agency's guiding documents?

Answered: 1 Skipped: 4

RESPONSES (1) TEXT ANALYSIS TAGS

Add Tags Filter by Tag Search responses

Showing **1** response

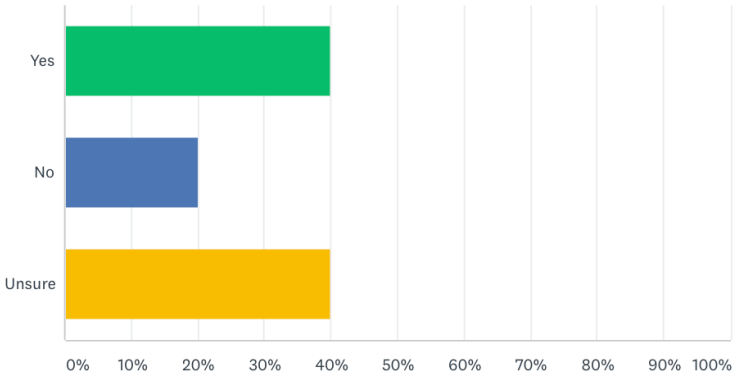
A little more in-depth on response

Q6

Customize Export

Do you feel that your agency is prepared enough for a response into an active shooter/active killer incident?

Answered: 5 Skipped: 0



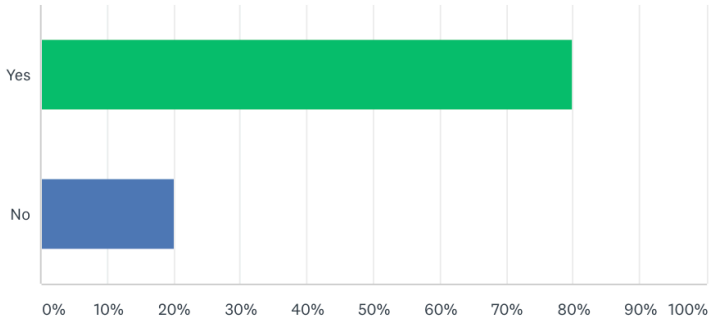
ANSWER CHOICES	RESPONSES	
Yes	40.00%	2
No	20.00%	1
Unsure	40.00%	2
TOTAL		5

Q7

Customize Export

Do you regularly train with your local police agency regarding RTF?

Answered: 5 Skipped: 0



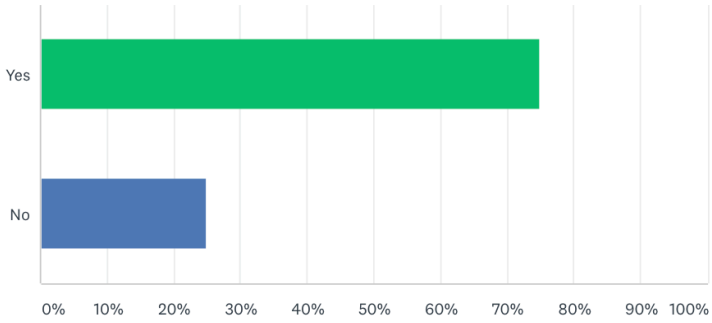
ANSWER CHOICES	RESPONSES	
Yes	80.00%	4
No	20.00%	1
TOTAL		5

Q8

Customize Export

Do you regularly train (at least annually) with agencies in the valley, both fire and law enforcement with RTF response?

Answered: 4 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes	75.00%	3
No	25.00%	1
TOTAL		4

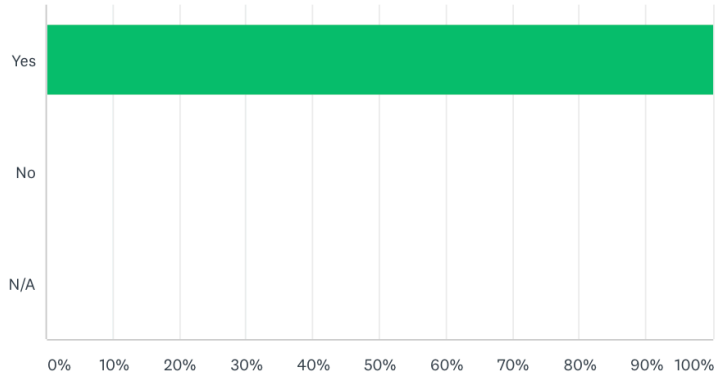
Comments (1)

Q9

Customize Export

Are you willing to share your guiding documents with other agencies in the valley?

Answered: 4 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes	100.00%	4
No	0.00%	0
N/A	0.00%	0
TOTAL		4