

Implementing the Hartford Consensus and the USFA's Active Shooter Response Guidelines:

Oak Creek (WI) Fire Department's Response to Tactical, Mass Casualty Incidents

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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: _____

Abstract

In 2013, the Oak Creek Fire Department (OCFD) drafted a response procedure for active shooter incidents and worked with the Oak Creek Police Department (OCPD) to insure that efforts were collaborative and response was coordinated. The problem was that OCFD had not practiced or implemented the recently approved response procedure for tactical mass casualty/active shooter incidents. The purpose of this research was for OCFD to practice and implement the new tactical mass casualty response procedures.

Using descriptive methods, this research challenged procedures and programs created to address OCFD's response to active shooter, mass casualty incidents. Through procedural and program implementation, this applied research addressed the following questions: a) How does OCFD address the response continuum (bystander first aid, OCFD response, mutual aid response, transport to definitive care)? b) How effective is the response continuum? c) What difficulties were encountered during roll-out? d) How is response to active shooter incidents accepted within OCFD's culture?

To implement the *Hartford Consensus* and the *USFA's Active Shooter Response Guidelines*, this research needed to consider various levels of the continuum of care. Community Tactical Emergency Casualty Care (TECC), the Fire/EMS response, law enforcement activities, and mutual aid support were assessed. This research used feedback instruments, time-to-task analysis, and observations to answer research questions.

Results for this research confirmed that progress has been made in OCFD's implementation of an active shooter response. Research supported OCFD's bystander and emergency responder initiative. Feedback received and data collected confirmed that OCFD's

active shooter continuum of care is effective and accepted. Further, difficulties encountered were addressed and improvements to response have been made.

Moving forward, collaborative planning, implementing, and training were recommended. It was also suggested that fire departments develop internal experts so that training is continual. Further, local policy and procedure must resemble the regional/ mutual aid effort.

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Implementing the Hartford Consensus and the USFA's Active Shooter Response Guidelines:**Oak Creek (WI) Fire Department's Response to Tactical, Mass Casualty Incidents**

Regardless of training, policy, equipment, or experience, fire and emergency medical services (EMS) will be called to access, treat, evacuate, and transport victims injured during active shooter incidents. The population of the municipality will have no bearing on the probability of occurrence and the size of the fire department will provide little-to-no excuse for a limited response. Bystander observation and public opinion will influence the perception of firefighter and emergency medical provider integrity- especially in incidents where responders wait for the scene to be safe. Preparation, policy, and training will have the largest impact on responder readiness and victim survivability during an active shooter incident. For the purposes of this research, an active shooter incident will include any activity (stabbing, bombing, aggressive act) that threatens the lives of multiple victims.

Firefighters and medical providers must be prepared to provide medical care sooner in a less-than-safe environment. To address this need, in 2013, the Oak Creek Fire Department (OCFD) drafted a response procedure for active shooter incidents and worked with the Oak Creek Police Department (OCPD) to ensure that efforts were collaborative and response was coordinated. The problem is that the OCFD had not practiced or implemented the recently approved response procedure for tactical mass casualty/ active shooter incidents. The purpose of this research is for the OCFD to practice and implement the new tactical mass casualty response procedures.

Using descriptive methods, this research will challenge procedures and programs created to address OCFD's response to active shooter, mass casualty incidents. Through procedural and program implementation, this applied research will address the following questions: a) How does OCFD address the response continuum (bystander first aid, OCFD response, mutual aid

response, transport to definitive care)? b) How effective is the response continuum? c) What difficulties were encountered during roll-out? d) How is response to active shooter incidents accepted within OCFD's culture?

Background and Significance

Located in southeastern Wisconsin, Oak Creek is a suburb of the City of Milwaukee in Milwaukee County. According to the 2010 U.S. Census, the City of Oak Creek is an urban/rural community. With an estimated population of 35,008 and a population density of 1,211 per square mile, much of Oak Creek is classified as urban (U.S. Census, 2013). However, according to the City of Oak Creek Director of Community Development and the Southeastern Wisconsin Regional Plan Commission, 60% of Oak Creek's 28.45 square miles is considered suburban residential. The remaining 40% of Oak Creek's land use would be comprised of commercial, industrial, and open space (D. Seymour, personal communication, June 26, 2014).

Pulvermacher (2013) reported that the City of Oak Creek is home to many critical infrastructure and key resources (CIKR). Power generation, water treatment, and liquid natural gas (LNG) peak shaving facilities are all examples of CIKR sites in Oak Creek. Additionally, six elementary schools, two middle schools, one high school, three private/parochial schools (K-8), and one technical college campus are located in the City. Oak Creek is also the home community for 16 formal places of worship. Through emergency preparedness, Oak Creek recognizes that an active shooter incident in a CIKR facility could significantly impact the community and the region.

Protective services in the City of Oak Creek consist of a local fire department and police department. The OCFD is made up of 51 sworn members- staffing three fire stations with three, 24 hour shifts. Minimum staffing for a shift is 13 firefighters; four at each station and one

command staff officer. OCFD also provides emergency medical services for Oak Creek- all firefighters are trained as emergency medical providers.

OCFD is a member of the Mutual Aid Box Alarm System (MABAS). MABAS Division 107 consists of 13 suburban Milwaukee County fire departments. In the event local resources are overwhelmed by the demands of the incident, OCFD would request mutual aid off of a pre-determined response card. Asset types (engines, trucks, ambulances, special equipment) are influenced by the type of emergency. During a mass casualty incident, it is likely that OCFD would require mutual aid assistance.

The OCPD has one, centrally located police station. With 58 sworn police officers, OCPD staffs three, eight hour shifts with a minimum of seven officers per shift. OCPD also has a part-time emergency response unit (ERU; also known as special weapons and tactics [SWAT]) who have other law enforcement functions during their normal duty day. To address the medical threats of a tactical environment, five firefighters are assigned to the ERU as tactical emergency medical support (TEMS).

In the spring of 2004, the OCFD sent a firefighter/paramedic to a week-long TEMS program to evaluate the training commitment of an operational vision (to provide emergency medicine in a tactical environment). Planning turned into operational necessity at the end of that same year. In November 2004, The City of Oak Creek experienced its first active shooter incident with multiple casualties. The shooter killed two and injured two others on the third floor of the Oak Creek Comfort Suites Hotel. The active shooting event became a hostage situation and a standoff as the shooter ran out of ammunition and forced another hotel guest into a third floor hotel room- the shooter intended on negotiating with the OCPD.

While the shooter was barricaded in the room, two victims required immediate treatment. One of the victims was located in a nearby room and the other victim was lying in the third floor hallway. With no trained TEMS unit (at the time), OCFD committed firefighters to what was assumed to be a safe environment. OCFD operated under the assumption that the shooter was in custody or was no longer a threat. Fire department emergency medical personnel practiced traditional emergency medicine until they were informed that the shooter was not in custody and the shooter was still armed (lack of ammunition was discovered after the response phase- during the criminal investigation). As soon as responder safety was in doubt, patients were quickly moved out of the tactical environment. Without training or situational awareness, firefighters could not adequately determine if OCPD provided appropriate security to emergency medical providers during the incident. Some of the responding firefighters expressed concern that they were ordered into an environment where they didn't belong.

Although the Comfort Suites shooting manifested trust issues between the police and fire departments, it did provide a sense of urgency to equip and train firefighters as TEMS operators. Over the following six months, five firefighter/paramedics were trained to respond with and support the Police Department ERU- an attempt to reduce the confusion associated with a tactical incident. By the end of October 2005, OCFD TEMS operators were functional and available to respond with the OCPD ERU on high risk warrants, drug busts, standoff/barricaded subject incidents, hostage situations, and active shooter incidents.

In the spring of 2012, the OCPD and OCFD began a reassessment of their response to active shooter incidents. After years of joint police and fire training, it was identified that an active shooter incident is not as much an ERU incident as it is a patrol officer incident. So, an active shooter incident is less-likely to be handled by TEMS as it is to be handled by line

firefighters/paramedics/EMTs. A typical ERU response requires unit members to report to the police station, assemble gear, receive the initial briefing and respond out. The OCPD ERU's goal is to provide a quick turn-out and to establish an emergency response within 20 – 30 minutes. The concern of OCFD and OCPD was the survivability of hemorrhaging patients in an active shooter situation. Even if the ERU's response goal is met, victims suffering from traumatic injuries (especially those with significant blood loss) would not survive long enough for medical care.

This assessment prompted a discussion between OCFD and OCPD about active shooter preparedness in the Oak Creek Franklin Joint School District (OCFJSD). The discussion involved response provisions to expedite the response of medical personnel. Additionally, the OCFJSD's superintendent was consulted about allowing faculty and staff to be interviewed by police and fire department representatives. Questions and feedback would provide information about the school district's preparedness and the readiness of educators. Ultimately, the OCPD and OCFD wanted to make tools, training, and procedures available sooner in the incident and address the needs of an active shooter response - even if care was initiated by a bystander.

In August 2012, the OCFD and the OCPD were preparing for the school year to start. A feedback instrument had been drafted to solicit the input of Oak Creek faculty and staff- as it pertained to the preparedness in tactical/crisis incidents in schools. Then, on August 5, a lone shooter entered the Sikh Temple of Wisconsin and shot members of the Sikh community as they gathered to worship. The gunman killed six and injured four before being shot by a patrol officer and then turning his handgun on himself.

Of the injured, two victims were outside and two remained inside the Temple. The two victims outside of the Temple consisted of a worshiper that fled and ran to a neighboring

residential area and an Oak Creek police lieutenant that was lying in the parking lot- shot 17 times. Per OCPD protocol, the ERU was paged to respond to the incident- TEMS is part of that page. Initial arriving OCFD units were requested from their staged location to the Temple parking lot to provide emergency medical treatment to the fallen police lieutenant. An ambulance from a neighboring municipality was dispatched to the other victim. Within a matter of six minutes of the injured lieutenant's arrival on scene, his transport to a trauma facility was initiated. Quick decision proved beneficial and emergency medical treatment began very quickly. The lieutenant survived the event and was eventually discharged from the hospital. If responders would have waited for TEMS, care would not have been initiated until 20 minutes into the incident. If emergency care would have been delayed, the lieutenant would not have survived his injuries (B. Murphy, personal communication, April 25,2014).

In the Sikh Temple incident, it was uncertain whether a second shooter was still at large. So, while paramedics provided care to the injured lieutenant, OCPD officers provided scene protection. Given the fact that firefighters were committed to the incident soon after their arrival, they were not certain if the scene was controlled- especially since police activity was observed first hand. It was readily apparent that the scene was not yet safe.

An after-action debrief of the Sikh Temple shooting provided firefighters an opportunity to voice their concerns. The most significant issues affecting police and fire cooperation involved communication, scene safety, staging, and organization/preparation. It was evident that firefighters were not comfortable in the tactical environment and that police officers and firefighters needed to develop policy and procedure to address the tactical response. This would be especially important during a mass casualty situation.

In November 2012, an applied research project was authored to address Oak Creek's risk during tactical, mass casualty incidents in K-12 schools. Through the eyes of school staff, research provided perspective on the public's expectations of an emergency response during tactical incidents. Research also expressed the viewpoints and concerns of police and firefighters. Results indicated that school district employees expect a quick response and they know first aid needs to happen quickly; yet, very few had the requisite skills to initiate care. It was further noted that police officers and firefighters had contrasting views on emergency care and the role of firefighters during tactical incidents. The recommendation from this research was to have OCFD, OCPD, and OCFJSD develop a collaborative incident action plan. School district employees also needed to be trained for first aid and combat care (Pulvermacher, 2012).

Shortly following the completion of Pulvermacher's applied research in K-12 schools, on December 14, 2012, in Newtown, Connecticut, Sandy Hook Elementary experienced an active shooter incident that claimed the lives of students, faculty, and staff (Sedensky III, 2013). Based on this incident, the OCFJSD solidified their commitment to making sure Oak Creek Schools were prepared to address active shooter prevention, recognition, and action. Plans were made to have police and fire department representatives deliver active shooter instruction prior to the start of the 2013-2014 school year.

In January 2013, Captain Mike Bolender of the OCPD and Battalion Chief Joe Pulvermacher of the OCFD met to discuss response priorities. Policy and procedure were not written until each department understood the other department's role in an active shooter situation. Since an active shooter incident typically falls under the command of law enforcement, OCFD needed to know what was required to support the priorities of incident control. OCFD also needed to communicate the vulnerabilities and limitations of fire department responses in a

tactical environment. The fire department was aware of its responsibility to access, treat, and evacuate patients. The fire department was also aware of its commitment to the well-being of the responder. The OCFD needed to address patient care while mitigating risk to responders in a less-than-safe environment (Pulvermacher, 2013).

In 2013, Pulvermacher authored an applied research project that instituted policy and procedure for the OCFD to address tactical mass casualty incidents. OCFD policy and procedure outlined definitions, response hierarchy, incident parameters (thresholds), incident actions, equipment, and Rescue Task Force (RTF) roles. A checklist was also developed to insure that incident objectives were being met. OCFD and OCPD representatives continually met to insure that terminology and procedure in the OCFD policy closely resembled the terminology and procedure outlined in the OCPD directive.

In July 2013, the Joint Committee to Create a National Policy to Enhance Survivability from Mass Casualty Shooting Events met to issue a call-to-action document known as *The Hartford Consensus*. At about the same time, the USFA authored a document known as the *Fire/Emergency Medical Services Department Operational Consideration and Guide for Active shooter and Mass Casualty Incidents*. Both documents were published in September 2013 and would provide further direction for OCFD/OCPD's active shooter response.

The National Fire Academy's (NFA) Executive Fire Officer (EFO) Executive Leadership (EL) program addresses effectiveness in adaptive leadership situations. Heifetz and Linsky (2009) state that adaptive leadership issues challenge familiar reality- threatening the end user as major changes are made. Providing emergency medical care inside of a tactical environment with less-than-safe conditions will require a major cultural shift within the fire service. Beliefs will have to be challenged, minds will have to be changed, and values will need to be modified.

NFA's EL program distinguishes the value of taking leadership risks using influence and persuasion (National Fire Academy, 2012).

Through strategic initiatives, the USFA provides leadership on issues that foster prevention, preparedness, and response. By implementing an active shooter protocol, the OCFD plans to address two of the USFA's operational objectives: "Improve local planning and preparedness, and improve the fire and emergency services' capability for response to and recovery from all hazards" (United States Fire Administration, 2010, p.13).

Literature Review

Despite the awareness of school shooting indicators and prevention efforts to limit school violence, there has not been any appreciable reduction in the number of annual school shootings reported since the Sandy Hook (Newtown, Connecticut) shooting in 2012 (Hefling, 2014). Many schools districts have tightened security programs and many have strengthened safety plans and security infrastructure. Yet, school violence and active shooter incidents continue to happen. In 2014, Mayors Against Illegal Guns reported that 44 school shootings occurred between December 15, 2012 and February 10, 2014. Further, active shooter incidents outside of educational institutions have continued to trend upward (Blair, Martaindale, & Nichols, 2014).

In 2013, Blair, Nichols, Burns, and Curnutt evaluated active shooter events from 2000 to 2010. Their research indicated that active shooter events never topped eight annually from 2000 to 2008. In 2009, 16 active shooter events were reported. Continuing on an upward trend, 21 active shooter events were recorded in 2010. The intent of this evaluation was to determine incident dynamics that would influence the response to and mitigation of these events. Although the research was conducted from a law enforcement perspective, the authors outlined the need for scene security and rapid trauma care. Law enforcement's role is contingent on how quickly

the shooter is contained. Police officers may not be able to render medical care to the injured- especially if the shooter has not yet been stopped. One of law enforcement incident priorities is to “stop the dying” (p.168). However, emergency medical care comes secondary to law enforcement’s resolve to “stop the killing” (pp. 66-67). When the shooter is stopped, less people are injured, and fewer people die.

The New York City Police Department (NYPD) (2012) analyzed 281 incidents from 1996 to 2010. They were able to determine that 98% of shooters in that time frame acted alone. 41% of the attacks involved professional relationships. 29% of all active shooter incidents happened in schools. 36% of shooters carried more than one weapon. 46% of all incidents were resolved through applied force and 40% were resolved by suicide/attempted suicide. Of the data analyzed, the United States had the most active shooter incidents (237). Canada was the second country on the list with 8 incidents.

Active shooter incidents are often called active killer incidents due to the potential of the aggressor inflicting mass-casualties without using a firearm. An example of such activity happened in the suburban Pittsburgh municipality of Murrysville, Pennsylvania where a high school sophomore stabbed and cut 22 people with two, eight-inch knives. This incident was brought to resolution when a school administrator tackled the suspect. Multiple people were needed to contain the suspect and control the weapons. This incident happened prior to the start of the school day; so school lock-down procedures were difficult to activate. Additional confusion happened when one student attempted to help evacuate the school by pulling the fire alarm- which caused more students to occupy the halls (Silver, 2014).

When dispatched to an active shooter situation, first responders can expect confusion and multiple injuries. Although some active shooter incidents have involved over 25 victims, the

median numbers reflect four injured and two dead. Statistically, most active shooter incidents are carried out by a lone shooter; however, many law enforcement incident commanders are unable to rule out accomplices until later in the incident (Blair, Maraindale, & Nichols, 2014).

Therefore, due to reports of a second shooter, law enforcement must maintain scene security to insure the incident does not escalate. As a result, many law enforcement agencies may not be able to assist with patient care without abandoning another assignment that reduces risk by providing protection to unarmed emergency responders.

Pulvermacher (2012) recommended that OCFD develop response procedures that addressed the incident priorities of tactical, mass casualty incidents in K-12 settings. This would challenge OCFD's traditional approach to tactical incidents. In order to improve victim survival, treatment needed to begin sooner. It was further recommended that OCFD initiate a collaborative effort with OCPD and the Oak Creek Franklin Joint School District (OCFJSD). This effort would consider terminology, medical equipment, communication, scene protection, protective equipment, and command functions. Oak Creek's response to active shooter incidents would directly involve school district faculty and staff- using them as a force multiplier to control bleeding earlier in the incident.

In 2013, OCFD established a new response procedure for tactical mass casualty incidents. Following an active shooter incident in the City of Oak Creek, the adapted response identified the role of OCFD in all active shooter, mass casualty incidents- not just responses in an educational setting. Policies and procedures were written to closely resemble the response of law enforcement. Command functions were recognized and the need for unified command was reinforced. The injury rescue team (later to be identified as the rescue task force- RTF) was the main concept that was introduced. The goal of accessing patients quickly, treating patients soon

after arrival, and evacuating the injured rapidly was the primary focus of a coordinated effort. Firefighters would enter cleared- but not secured- areas and treat patients under police protection- allowing officers to provide protection to unarmed firefighters in less-than-safe environments. Realistic, joint training was recommended and mutual aid participation was considered. Familiarization, training, equipping and funding were needed for full procedural implementation (Pulvermacher, 2013)

The Joint Committee to Create a National Policy to Enhance Survivability from Mass Casualty Shooting Events (2013) met to discuss patient care strategies. A consensus statement, known as the *Hartford Consensus*, was written to provide guidance for the continuum of care during intentional mass-casualty/active shooter incidents and to increase survivability of victims. In the statement's call to action, the committee stated that "no one should die from uncontrolled bleeding" (para. 5). To achieve this goal, the role of the public, law enforcement, EMS/fire/rescue, and definitive trauma care was outlined.

According to the *Hartford Consensus*, Bystander application of trauma care, the pre-positioning of necessary first aid equipment, and active shooter recognition (i.e. run, hide, fight) was acknowledged as part of the public's actions during an active shooter event. Law enforcement needed to identify and apply appropriate hemorrhage control with the right equipment. Additionally, law enforcement would evaluate for internal hemorrhage and assist EMS/fire/rescue in the evacuation of the injured. Fire service/EMS needed to be integrated into the response- limitations needed to be revised. Firefighters and emergency medical providers must, "increase their awareness and operational knowledge about the initial response" (Joint Committee to Create a National Policy to Enhance Survivability from Mass Casualty Shooting Events, 2013, para. 8). Fire department responsibilities should include common terminology for

responders, appropriate trauma care- using TECC techniques, immediate involvement (no more staging and waiting). After the victim is evacuated and transported, definitive care facilities must insure that the patient is addressed surgically and that hospital surge capacity is managed.

The International Association of Fire Chiefs (IAFC) (2013) and the International Association of Fire Fighters (IAFF) (2013) wrote position statements in an effort to establish operational necessity for active shooter responses. Both position statements started out nearly identically by stating, “Local jurisdictions should build sufficient public safety resources to deal with active shooter scenarios. It is imperative that local fire and law enforcement departments have common tactics, common communications capabilities and a common lexicon for seamless, effective operations” (IAFF & IAFC, 2013, para. 3). In addition, both stressed the need for incident command by using the National Incident Management System (NIMS) and Incident Command System (ICS). The importance of a single command post (CP) and the establishment of unified command (UC) were also delineated. The statements further recognized the need for nationally accepted standards, RTF concepts, ballistic protective equipment (BPE), and joint police/fire training. The IAFC document went on to address improvised explosive devices (IED), tactical emergency casualty care (TECC), and threat phases (direct, indirect, and evacuation); while the IAFF’s document stipulated that, “firefighters will not carry weapons” (IAFF, 2013, para. 8). All told, the position statements of labor and management were written in concert and opposing views were not conveyed.

The United States Fire Administration (2013) stated that, “Extraordinary efforts on the part of local fire/EMS agencies and direct pre-planned coordination with law enforcement is required during response to these events in order to rapidly affect rescue, save lives, and enable operations with mitigated risk to personnel” (p. 3). Following the direction of the Hartford

Consensus, early hemorrhage control was stressed and critical actions were outlined in the THREAT acronym: Threat suppression, Hemorrhage control, Rapid Extrication, Assessment by medical providers, and Transport to definitive care. The USFA also recommended that fire/EMS and law enforcement collaboratively develop SOPs. Concepts should be jointly trained and common terminology must be used. NIMS and ICS should be established during the incident. To improve patient care in the tactical environment, TECC concepts and supplies applied by an RTF are recommended. Mitigated risk is not the absence of risk; so, medical responders are encouraged to don the same ballistic protection as their law enforcement counterparts. While a deliberate and cautious approach is observed on scene, consideration should be made for more aggressive EMS operations.

With over 30 years of response experience to terrorism incidents, the Israeli paramedic organization Magen David Adom (MDA) endorsed the USFA's active shooter guidelines. As with MDA's response to active terror incidents, warm zone medicine concepts have proven beneficial in less-than-safe environments. During mass-casualty active shooter incidents, the MDA attests that victims will bleed to death unless they are treated quickly (Ludwig, 2014).

The National Tactical Officers Association (as cited in Roberts, 2010), listed a basic plan for care under fire. The following items can be considered for RTF/ warm zone medicine: Take cover and direct the casualty to move to cover and apply self-aid (if able). Keep the casualty from sustaining additional traumatic injury. Defer elaborate airway maneuvers- address positional airways with nasal pharyngeal adjuncts (at most). Stop life threatening bleeding by instructing the injured to apply self-aid (if possible). If intervention is required, the tourniquet should be applied by the rescuer. Upon treating life threatening injuries, the injured should be moved to cover.

Sztanjnkrycer (2010) evaluated data from police officer line of duty deaths. Information summarized Law Enforcement Officers Killed and Assaulted (LEOKA) data from 1998 - 2007. Of the 341 officer deaths evaluated, the most common cause of death was head trauma (198 officers) and 90 officers died from chest trauma. One of the most notable statistics, however, categorized 123 deaths as “being potentially preventable” (p.54). The right tools, training, and timing must be instituted to provide the victim with the best possible chance of survival. LEOKA data supports the use of Tactical Casualty Combat Care (TCCC- tourniquets, chest seals, and needle decompression). LEOKA data also supports airway management secondary to the control of life-threatening extremity bleeding.

TECC is similar to Tactical Combat Casualty Care (TCCC) in the sense that similar first aid supplies and equipment are used to treat similar traumatic injuries. The variables that distinguish TECC from TCCC include: scope of practice and liability, patient populations, casualty evacuation, baseline health, wounding patterns, history of chronic medication use, and special populations. Whereas the military offers TCCC to a select population that is in relatively good physical condition, the civilian population has several variables that may influence care. Those variables need to be considered when providing care- it is likely that emergency care providers may have to treat medical emergencies (such as cardiac and respiratory conditions) along with the presenting trauma. Although evacuation to definitive care is not as much of a concern in the civilian environment, initial patient movement from the warm zone may be difficult due to patient disability or body size. For these reasons and more, military combat care must be modified for civilian settings (Callaway, Smith, Cain, Shapiro, Burnett, McKay, & Mabry, 2011).

While addressing the American Ambulance Association on November 18, 2013, former U.S. Surgeon General Dr. Richard Carmona remarked on the need for EMS personnel in the warm zone. Regardless of local philosophy or policy, police, fire, and EMS were encouraged to train and equip emergency responders with, “tourniquets, chest seals, hemostatic agents, and pressure dressings so they can attend to the critically injured” (Heightman, 2013, November 19, para. 14).

Croom III (2013) asked whether it was appropriate for emergency medical services to enter active shooter incidents (go or no-go?). Evidence proves that active shooter events are not safe incidents- so using scene safety as the sole indicator of fire service/EMS participation is problematic. The challenge for emergency responders should be the reduction of risk in a very dynamic environment. The establishment of hot, warm, and cold zones is a critical component. Insuring that law enforcement focused on scene security and threat elimination is equally critical. The fire service needs to work collaboratively with law enforcement to move rescue teams into the warm area and treat victims sooner. “At what point is it no longer acceptable to say that victims are going to die because we don’t feel safe entering the scene?” (para.17). The risks are high and response will be dependent on personnel and agency resources; however firefighters and police officers should understand capabilities and limitations prior to an actual incident.

CBS/Associated Press (2013) reported that lessons were learned through the Los Angeles Airport shooting on November 1, 2013 and offered criticism about the response to the shooting. Although it is not known how much uncontrolled hemorrhage contributed to the death of TSA officer Gerardo Hernandez, incident reports indicate that 33 minutes passed before Hernandez was placed into a wheelchair and removed from the area. The shooter was actively shooting people for approximately 5 minutes. After that, the shooter had been shot and placed in custody.

While law enforcement worked to clear the area and make it safe, Hernandez was left untreated. One report stated that medical attention was delayed because law enforcement's initial incident assessment communicated that Hernandez was deceased. Without entry, concern about appropriate care was voiced through the American Federation of Government Employees, "... there will always be confusion, but 33 minutes is absolutely unacceptable. If someone had gotten to [Officer Hernandez] earlier, this could have been a survival story" (para. 17).

Rivalries, turf wars, budget competition, and response disciplines have affected the way that the fire service and law enforcement cooperate during incidents. Many communities have experienced one or more variables that have complimented or diminished operational readiness. Traditionally, police, fire, and EMS have viewed their roles as independent. However, in order to achieve maximum force, responders must be prepared to exhibit their strengths and do it cooperatively with other response entities. Case studies prove that active shooter events happen quickly. Emergency responders are going to be faced with the dead and injured upon their arrival. It is imperative that response variables are considered prior to an actual incident and that police and fire prepare by training together (Frazzano & Snyder, 2013).

Some fire departments have indicated that they will enter with police as an RTF when they have confirmation that the shooter is neutralized or in custody. Sedensky III (2013) provided a report of the Sandy Hook shootings. The report stated that from the moment the first 9-1-1 call was received by the Newtown Police Department, to the time that an officer entered the school, 9 minutes and 52 seconds passed. Although law enforcement was quickly able to identify one shooter in the school committed suicide, they were unable to rule out a second shooter. An initial police encounter with (an) unknown subject(s) outside of Sandy Hook Elementary, the reports of someone running around outside, the location of two black zip-up

sweat jackets outside the shooter's car, an additional weapon and ammunition inside the shooter's car, shell casings found outside of the school, and the sound of apparent gunfire coming from outside the school all contributed to the concern about a second shooter.

Lightfoot (2013) states that law enforcements response to active shooters is evolving. When police officers arrive on scene during an active shooter incident, they must decide how quickly to commit themselves to contact the shooter. Depending on how many officers are on duty and responding, the first arriving officer must decide whether they are going to wait for a multiple-person contact team or go in with fewer officers (possibly alone). Law enforcement is also taking into consideration what other functions they will have to fulfill- to include rescue task force operations. The OCPD has recently changed their response to active shooter incidents. In an email addressed to the training officer of the OCFD, M. Bolender (personal communications, February 3, 2014) advised that the police department would no longer wait outside of an active shooter incident if gunshots were not heard. Recent active shooter training proved that gunshots on one side of the building may not be heard on the other side of the building. Police officers would enter with three, two, or even one officer if the response warranted.

Schmidt (2013) reported that medics were rushing in to help the injured in active shooter, IED, mass-casualty events. It was further reported that in one situation a medic went into the building to join up with police officers scouring the building to look for the gunman and the injured. The focus is to move faster to treat victims earlier. Case studies suggest that in many situations, the general public remains on scene to assist the injured until emergency responders arrive. New advice suggests that emergency responders should commit sooner than traditionally accepted.

Sanders and Klaene (2013) state that firefighters and police officers will benefit from an integrated approach. When firefighters, EMTs, and paramedics provide patient care, law enforcement is able to concentrate on risk reduction and threat isolation. With firefighters and police officers working together as a RTF, the importance of unified command/ incident command, plain text communication, and shared policy and procedure with common terminology was stressed. To further address risk reduction, the authors stated that those assigned to the RTF (police and fire) should be outfitted with ballistic protection.

In 2013, medical directors from EMS services around the United States met and conferred about active shooter responses. Understanding that an emergency medical response is needed during an active shooter, mass-casualty incident, communication was identified as a major concern. Responders need to know when to link-up, move, treat, and evacuate/transport. Clear-cut radio communication must be established and practiced prior to an active shooter incident. Police and fire representatives must work together through incident command and rescue task force deployment. Without a communication plan, radio transmissions will confuse and complicate the incident (Heightman, 2013, February 21).

On February 5 and 6, 2014, the Department of Homeland Security Office of Health Affairs hosted a stakeholder engagement to improve survivability in IED and active shooter events. Presentations and panel discussions provided background to work that has already been accomplished on active shooter response. On the second day, breakout sessions facilitated active discussion about the path forward. State, local, and non-governmental entities were involved in the sessions. Focused discussion was framed around best practices, opportunities/innovations, and challenges/obstacles. The event summary outlined that hemorrhage control training and supplies should be available to law enforcement, emergency medical responders, and the general

public. The event also considered the appropriateness of ballistic protection for medical responders- stating that more research is needed to recommend the appropriate level protection and that decision makers need protective equipment training so that an educated decision can be made about ballistic acquisition. Finally, interoperability was covered by the breakout sessions. Interoperability must consist of common protocols, procedures, planning, training, and must be scalable to insure that department size does not rule out response (United States Department of Homeland Security Office of Health Affairs, 2014).

For the fire service, working in a tactical environment upsets the status quo. The absence of regularity creates an environment of conflict and tension- or disequilibrium. Heifetz, Grashow, and Linsky state that adaptive leadership issues challenge familiar reality- threatening the end user as major changes are made. Adaptive work places personnel in a sustained period of disequilibrium (2009). When addressing cultural changes and traditional mindsets in the fire service, the National Fire Academy's Executive Leadership program considers the use of influence and persuasion (National Fire Academy, 2012). Heath and Heath accept that change is hard and have evaluated conventional psychological wisdom to make change happen. In order to effect change, one must consider the emotional (instinctive) side and the rational (logical) side to every decision. If change addresses logic without considering emotion, change will be influenced by direction- not motivation. Knowledge alone does not change behavior. Logic, emotion, and clarity persuade behavioral changes (2010).

Hiatt (2006) outlined a model for change in business, government, and community. The ADKAR model is an acronym for: awareness, desire, knowledge, ability, and reinforcement. The process involves getting those who are susceptible to change to understand the nature of change (awareness), be willing to engage in and support change (desire), become educated about

behaviors and techniques needed to change (knowledge), turn knowledge into action (ability), and identify internal and external factors needed to maintain change (reinforcement). Awareness for change must be built by answering the following questions: “What is the nature of the change?” “Why is the change being made?” “How will the change impact our organization?” “What’s in it for me?” (p. 9).

During emergencies, firefighters are called to respond- regardless of response specialty. Haz mat, swift water, emergency medical, technical rescue, weapons of mass destruction, fire prevention, fire investigation, documentation/legal concerns, rapid intervention, firefighting, and now tactical medicine all require training and repetition. Additionally, firefighters are responsible for maintaining a base knowledge of labor standards (discrimination, harassment, etc). These expanding roles make it more difficult for training officers to keep up with requisite knowledge and training. It is important to come up with creative ways to address response needs with operational capacity (Stone, 2014).

In low-frequency operations, it is essential to conduct regular training sessions. Repetition will inspire predictable performance. The company officer can ensure success by conducting periodic procedure reviews and practical walk-throughs. It is equally important to participate in inter-departmental (police and fire) and regional (mutual aid) training sessions. If a community is going to rely on mutual aid resources during the actual event, that community must develop standardized policy and procedure consistent with national directive. Further, mutual aid partners should train with each other for proficiency. It is important to conduct realistic and performance oriented sessions. Planning appropriate training sessions will inspire competence and confidence through a challenging, realistic work environment (Hyderkhan, 2014).

Law enforcements focus during active shooter incidents is on the shooter. EMS has not typically entered the incident until the scene has been determined safe. Delays in the treatment of the injured may impact the survivability of victims. The kill-to-injury ratio is increased when expeditious assessment and treatment do not occur. Active shooter environments require responders to consider care under fire and tactical rescue. Positive victim outcomes will be enhanced if EMS, firefighters, and law enforcement adopt policies and procedures that address triage, treatment, and transport in the tactical environment (Jacobs, Burns, McSwain, & Carver, 2013).

Active shooter incidents have trended upward over the last decade. Until recently, traditional EMS has not provided appropriate and timely patient care in the tactical environment. Historical perspectives have provided insight on the issues of a stage-and-wait approach- especially when shooting victims require immediate care. Considering the role of EMS, citing the position labor and management organizations, and understanding the need for hemorrhage control in a less-than-safe environment, the fire service can better appreciate when it is most appropriate to dedicate emergency medical resources to an active shooter event.

The response to active shooter events will change with every incident. Modifications to law enforcement directives will likely drive amendments to the fire department's response procedures. Adaptation is essential to remaining current. Police and fire departments must work with each other and the general public to prepare for emergency response. Change management models will provide guidance for the emotional and logical aspects of adaptive issues. Although change will not come easy, the effectiveness of medical care in a tactical environment will be dependent on the fire service's ability to work through a significant cultural shift.

Procedures

This research is the continuation of previous applied research projects. Pulvermacher (2012) addressed the need for an emergency medical response to tactical mass-casualty incidents (specifically in K-12 schools). Pulvermacher (2013) established collaborative response guidelines to all active shooter incidents that required cooperation between OCPD and OCFD. Procedures for this (2014) research evaluated the implementation of OCFD's response guidelines. Research would examine Oak Creek's continuum of care, response effectiveness, difficulties encountered, and responder acceptance.

Continuum of Care

Although a national standard has not been developed for the delivery of EMS during an active shooter incident, the *Hartford Consensus* and the USFA's ...*Guide for Active Shooter and Mass Casualty Incidents* were consulted for direction and consistency. Further, *TECC: Guidelines for the Provision of Prehospital Trauma Care in High Threat Environments* was referenced to guide emergency medical practices in tactical (active shooter) environments.

OCFD initially addressed the response continuum in 2012 when this researcher authored an applied research project that addressed risk reduction in tactical, mass casualty incidents- specifically in K-12 schools. In order to address patient care during a tactical/ active shooter incident, OCFD's continuum of care and the efficacy of its components were evaluated. Pulvermacher (2012) made the following recommendations for tactical mass casualty incidents in educational K-12 environments: a) OCFD must challenge traditional response methodologies in active, tactical incidents- medical professionals must enter sooner to impact victim survivability. b) OCFJSD should host tactical emergency casualty care (TECC) classes facilitated by the fire department. c) OCFJSD must develop procedures to communicate victim

location and condition to emergency responders. d) OCFD and OCPD should establish an incident action plan and standard operating guidelines that integrate a collaborative response. e) Training must be conducted jointly and regularly in the most realistic setting and, ultimately, culminate with a full-scale exercise.

In 2013, this researcher addressed OCFD's operations inside a tactical, mass casualty environment. Research assessed the seriousness of the situation, the urgency of response, the potential for situational growth, recommendations for training frequency, the need for personal protective equipment, and the protection of fire/EMS personnel during an active shooter incident. Pulvermacher's (2013) action based applied research project resulted in the development of response procedures for tactical, mass casualty incidents. The results and recommendations of Pulvermacher's 2012 and 2013 research were reviewed and referred to during the implementation of OCFD's active shooter response.

During and after an active shooter event, some vital components of the continuum of patient care are not within OCFD's immediate control. Bystanders, OCFJSD faculty/staff, OCPD officers, and mutual aid companies all impact patient survivability- the longer a victim suffers from uncontrolled bleeding, the more likely they are to die. Regardless of OCFD's legitimate authority (or lack of legitimate authority) to regulate these entities, OCFD does have significant influence by sharing information learned through practical experience.

In the *Hartford Consensus'* call to action, definitive trauma care is listed as a category and the optimization of existing trauma systems is advised. Typical triage, treatment, transport, and hospital care were not evaluated through this research. Traditional evaluation and patient care methods have already been vetted through the Milwaukee County Emergency Medical System. Care received outside of the tactical/austere environment would be handled similarly to

other mass casualty events. It is not the intent of this research to recommend procedural changes to mass casualty incident management (outside of the tactical environment).

To influence community level trauma care, OCPD and OCFD personnel presented at an OCFJSD faculty and staff in August 2013. Over 800 administrators, faculty, and staff participated in the presentation. The intent of the meeting was to share active shooter dynamics- from prevention to consequence management. In this forum, results of the initial feedback instrument conducted by Pulvermacher (2012) were shared. The presentation also conveyed OCPD, OCFD, and OCFJSD's plan to address concerns that OCFJSC faculty and staff expressed through the inquiry.

First, OCPD reviewed shooter prevention and awareness. Concepts like "Hear Something, Say Something" (OCPD's equivalent of Homeland Security's See Something, Say Something) and "Run, Hide, Fight" were discussed. Then, OCPD demonstrated the initial law enforcement response to active shooter incidents. This demonstration was designed to provide faculty and staff an overview of the typical police department response. Participants were able to observe the quickness of the police department's effort to stop the shooter and the absence of first aid for the injured. Finally, OCPD had one officer play the role of an active shooter and fire blank rounds in the hallways of the school- allowing faculty and staff to experience the sound of gun fire in a school environment.

OCFD's portion of the school district presentation focused on the care of the injured. Results of the 2012 feedback instrument indicated that faculty and staff wanted to know what they could do in the event of an active shooter incident. Most employees of the school district did not have any formal first aid training- they were concerned that there would be no patient care prior to the fire department's arrival. Faculty and Staff were introduced to military first aid

concepts through the demonstration of TECC supplies and techniques. Using science and statistics, the efficacy of treatment was communicated. Case studies were used to pass along the necessity of treatment and to encourage faculty/staff buy-in. OCFD introduced a trauma kit that could be placed in every classroom- so that medical supplies could be available at the point of wounding. The placement of trauma kits in each classroom is especially important when faculty, staff, and students are locked down and unable to retrieve equipment.

Within a week of the initial school district presentation, a fundraising effort was initiated. The OCFJSD, OCPD, and OCFD drafted a mutual donation letter and distributed the request to local businesses and organizations (Appendix A). In order to completely equip this initiative, OCFJSD would require 400 kits. Since each kit costs approximately \$110, the fundraising effort would total \$44,000. In September 2013, OCPD and OCFD representatives presented at the OCFJSD School Board meeting. The presentation provided school board members an opportunity to ask questions and stay informed about school safety initiatives and the intended response to active shooter incidents.

During two OCFJSD faculty in-services in November 2013, an OCPD and OCFD representative conducted on-site visits of every school in the school district. While the police department conducted law enforcement-centered training at one school, the fire department covered TECC at another school. All faculty and staff had the opportunity to see the TECC equipment that is being placed in every classroom. First aid equipment was available on-site so that school district employees could also practice application. By the end of November, over 90% of school district employees were trained in TECC techniques. In addition, through OCPD's presentation, those in attendance were able to apply the "run, hide, fight" model and were able to identify the sound of gunfire in their own school.

While developing and delivering the community trauma care initiative, OCFD continued to implement the fire department's active shooter response. Having had two active shooter incidents in the past decade and with an active shooter response drafted/approved, OCFD was asked to present its new procedures at a Professional Fire Fighters of Wisconsin (PFFW) Wisconsin Affiliate Leadership Training Seminar (WALTS). Interest stemmed from a September 2013 IAFF position statement that endorsed RTF concepts. Oak Creek's active shooter response procedures resembled incident priorities outline by the IAFF, IAFC, the Hartford Consensus, and USFA active shooter response guidelines. OCFD's presentation was intended to initiate conversation throughout the State of Wisconsin and encourage fire departments to begin a dialog with the law enforcement agency in their respective districts.

Medical direction played a significant role in OCFD's active shooter response. Since OCFD has medical direction through Milwaukee County EMS (MCEMS), it was imperative to advise the medical director about advancements in RTF concepts. Policies, procedures, and medical equipment/supplies needed to be approved by the medical director before training could begin. A meeting with the MCEMS medical director was scheduled to discuss the future of a RTF response in Milwaukee County. The medical director wanted more information about RTF implementation and requested a pilot proposal (Appendix B).

In October 2013, OCFD was invited to present at a State of Wisconsin EMS Board meeting. EMS board members requested information about patient treatment in an active shooter environment. Background information included lessons learned through OCFD's active shooter events and best practices of RTF response. Board members were provided information about OCFD and OCPD's collaborative planning process and shared response plan. Incident scalability, EMS response modifications, and risk mitigation were discussed in detail.

In November 2013, The Milwaukee County Association of Fire Chiefs (MCAFC) met at their monthly meeting and wanted to ensure that the direction of RTF was a shared concept. The chiefs knew that a mass-casualty, active shooter event would likely involve a mutual aid response. The direction of the MCAFC was that RTF response plans must be similar, if not the same, for all departments in Milwaukee County. OCFD's progress with RTF implementation was temporarily halted while terminology and standardization were discussed. However, OCFD continued training its firefighters by conducting formal TECC training. Training was conducted with the assistance of a military/tactical medicine expert. It was important to communicate TECC concepts through the experience of an outside expert- especially since OCFD was one of the first in the State of Wisconsin to advance an RTF model.

In December 2013, Milwaukee County Area Fire Departments sent representatives to Milwaukee County EMS to discuss the development of RTF responses and its impact on mutual aid. The initial session was designed to provide information and direction. RTF response guidelines were compared and best practices were developed. Based on the direction of the MCAFC, Milwaukee County area fire departments needed a procedural foundation prior to meeting with law enforcement. Consequently, the fire department group met again in January and developed an active shooter response model that was shared with departments in attendance (Appendix C).

At the end of January 2014, the MCAFC was invited to speak at the Milwaukee County Law Enforcement Executives Association (MCLEEA) meeting. Given the fact that active shooter incidents are generally under the command of law enforcement, it was imperative to involve area police departments early in the process. Further, an RTF response requires a law enforcement (protection) element. In order to address the incident priorities in an active shooter

environment, an Ad Hoc committee was formed to insure that the fire service perspective and the law enforcement perspective were considered when policy was drafted- especially since standardization was stressed by the MCAFC.

In February 2014, an Ad Hoc committee of fire service and law enforcement representatives was assembled. The committee was comprised of five police officers and five firefighters from Milwaukee County police and fire departments. With more than a year into planning a response, OCFD and OCPD's procedures were used as a starting point for discussion. Additionally, another major metropolitan municipality had a plan that had been developed by its fire department. Although the metropolitan procedure was written for a larger fire department, their procedure was reviewed for operational similarities. The Ad Hoc committee met regularly through May 2014. At the end of May, the Ad Hoc committee presented their recommendations to a joint MCAFC and MCLEEA meeting. The meeting provided an opportunity for police and fire chiefs to ask questions, express concerns, and influence the final Milwaukee County Rescue Task Force Guideline.

While local and regional response guidelines were being developed, OCFD continued efforts to develop its community/bystander/OCFJSD TECC program. Throughout the year, donations for the trauma kits were received and supplies were ordered. Kits were assembled, inventoried, and security sealed with the assistance of two high school student groups. In May 2014, OCFD delivered the first 114 trauma kits to the school district. OCFD and OCPD walked through select schools with the OCFJSD facilities manager to determine kit placement. A kit inventory and tutorial sheet was distributed electronically to all school district employees (Appendix D). The tutorial included video links that offered a visual element to self-paced/ self-instructed refresher training.

Procedures and initiatives intended to improve Oak Creek's continuum of care during active shooter incidents were developed to provide care at various levels. General public/bystander, law enforcement, fire/EMS, and mutual aid responses were considered. All aspects of the initial response were instituted with the intent of treating victims quickly and evacuating them to traditional triage, treatment, and transport (also known as the medical group). Once victims arrived at the medical group, MCEMS standards of care and medical direction would resume as expected for any other mass casualty event.

Response Effectiveness

In order to determine the effectiveness of the response continuum, this researcher evaluated various response components. The assessment of bystander response to active shooter incidents was accomplished by soliciting the input of OCFJSD faculty and staff. Using the same feedback instrument that was initially used in OCFD's 2012 applied research (Appendix E), responses were compared to determine if readiness improved or if delivery and implementation required changes. Krejcie and Morgan (1970) established that a population size of 800 (OCFJSD faculty and staff) require a sample size of 260 in order to achieve a 95% confidence level. This researcher was not able to influence faculty/staff participation and could not insure a 95% confidence level. Further, the responses were anonymous; so, there is no way to determine if the 2012 participants participated in the 2014 feedback instrument.

The effectiveness of the police and fire response was evaluated through a time-to-task analysis. Using OCFD's 2013 90% fractile response time (dispatch to arrival) and information collected on a time-to-task worksheet (Appendix F), patient treatment and evacuation times were estimated. During this evaluation, firefighters and police officers implemented concepts prescribed in OCFD's response procedures. To realistically simulate the number of casualties

during an active shooter incident, the median number of dead and injured in actual active shooter incidents from 2000 – 2010 was used in this analysis (Blair, Maraindale, & Nichols, 2014).

Further, TECC techniques needed to be appropriately applied in order for the task time to register on the worksheet. A lesson plan (Appendix H) was written to ensure that the analysis was conducted consistently.

Firefighters selected to participate in this activity were the same firefighters that responded to the Sikh Temple active shooter incident on August 5, 2012. The intent of this approach was to compare real-life data to the task analysis. Although this research could not recreate all incident variables, it did address the importance of procedure and practice. Further, not everyone who responded to the Sikh Temple was available during this analysis. However, information shared during the task analysis reflected the viewpoints of those who were not able to attend.

Time-to-task analysis did not incorporate the mutual aid/ regional response procedures/guidelines. Effectiveness of the regional response was not evaluated through this research. However, this researcher was involved in the Milwaukee County police and fire Ad Hoc committee. The committee was established to provide direction to departments considering a joint police/fire active shooter response. A Rescue Task Force Guideline (Appendix C) was authored by the committee to outline definitions, incident thresholds, response hierarchy, law enforcement responsibilities, fire/EMS responsibilities, RTF responsibilities, incident command functions, accountability, and emergency communication/duress.

Difficulties Encountered

The difficulties encountered during roll-out were primarily based on observations made by the researcher. Observations were noted about a) implementation of community TECC in the

school district, b) immediate treatment versus immediate evacuation, c) RTF equipment selection and placement, d) on-scene communication, e) incident command versus unified command, and f) ballistic protection. Observations about difficulties at the regional response/ mutual aid level were also recorded. Variables in police and fire department relationships impeded uniform policy development. Limitations to OCFD's local procedural implementation were noted. Debates and demands expressed from well-intended neighboring fire chiefs delayed OCFD's progress. Continued requests for technical and operational detail limited a prompt and full implementation of OCFD's plan at the local level. While concern was expressed about the impact of OCFD's policy and procedure on a regional response, the neighboring major metropolitan fire department continued to press its policy into practice- regardless of outside input.

Response Acceptance

As the fire service establishes its role in active shooter responses, a major cultural shift is occurring. A similar shift is being experienced in the community through TECC application and the recognition of its need. Acceptance of an active shooter response had to be considered due to the emotional impact of adaptive change. To evaluate acceptance from a community perspective, this researcher compared data in the 2012/2014 feedback instruments (Appendix E). OCFD acceptance was monitored through a pre and post-training feedback instrument (Appendix G and H). Once again, limitations in sample size were noted and the 95% confidence level was not achieved. However, as it pertains to OCFD's acceptance, those who were the most verbal (and sometimes critical) of an active shooter response- due to a negative active shooter response experience- were selected to participate in the response analysis.

Results

Results for this research addressed the continuum of care, response effectiveness, difficulties encountered, and response acceptance. Research procedures accounted for involvement at the community (bystander) level, local emergency responder level (OCFD and OCPD), and the regional level (mutual aid). Results provide insight to OCFD's systematic approach to the implementation of Hartford Consensus and USFA Active Shooter Guidelines.

Continuum of Care

By the end of the first quarter of the 2013-2014 school year, approximately 95% of the school district's administration, faculty, and staff received active shooter training. Prior to the collaborative initiative of the OCPD, OCFD, and OCFJSD, the active shooter policy in the OCFJSD was limited to locking down the classroom and sheltering in-place. The revised concepts presented by OCFD and OCPD in August of 2013 provided a more realistic expectation. Faculty and staff were provided with more information about active shooter prevention through OCPD's "hear something, say something" program. Further, school district employees were given more options when responding and reacting to an active shooter- lock down is no longer the only option. Faculty and staff were educated on the principles of "run, hide, fight." If it is realistic to leave the building, OCPD cited better outcomes when potential victims get further away from the area of conflict. Educators were also given information about protecting themselves and their students. They were instructed on methods used to defeat the shooter- especially when the shooter forces his/her way into a room that has been "locked down."

OCFD presented school district employees with information about providing care in an active shooter environment. The primary focus was on hemorrhage control. Tourniquets,

emergency bandages, hemostatic agents, and chest seals were introduced at the bystander level. The intent was to use school district staff as a force multiplier (the use of existing on-site personnel and equipment to enhance the typical emergency response). One teacher summarized it by stating, “[During an active shooter situation in the schools, teachers] are the real first responders if you really think about it.” To address the response of educators and to improve survival potential, OCFD introduced TECC supplies and procedures into OCFJSD’s environment.

Through a local fund raising effort, 80 trauma kits were funded by the end of the 2013 calendar year. Throughout the school year, other fund raising efforts took place and private/parochial schools requested kits. By the end of the 2013-2014 school year, 150 kits were purchased and assembled. Nearly 30% of the needed kits have been delivered and installed in Oak Creek schools. Private corporations/organizations and parent/teacher organizations continue to raise funds in an effort to equip all classrooms in OCFJSD with a trauma kit. If there is a need to provide emergency care, trauma supplies should be close- those providing care should not have to search for a trauma kit.

Community-based TECC is expanding to Oak Creek’s civic buildings. Oak Creek’s City Hall is equipped with similar TECC trauma bags. At present, temporary placement of the bags has been established in locations in the building that have been designated as shelter-in-place areas. Since Oak Creek’s City Hall is in the process of relocating, permanent placement is a topic of on-going discussion. Consequently, Oak Creek’s civic TECC program is currently concentrating on familiarization and education. Kit placement will be discussed further when the layout of the new building can be evaluated.

To implement active shooter response guidelines, as outlined by the Hartford Consensus, law enforcement must actively train in hemorrhage control. Since 2011, OCPD has equipped its squad cars with tourniquets and emergency bandages. Through instruction and training evolutions, OCPD has instituted TECC training for all officers. Since the inception of this initiative, OCFD TEMS operators have functioned as TECC trainers. Since 2012, 100% of all OCPD officers have been trained in TECC and all have been equipped with their own tourniquet. Within the last year, all OCPD squad cars have been equipped with chest seals and hemostatic agents. During an active shooter situation, police officers will grab a “go bag.” The bag is equipped with additional ammunition, disposable handcuffs, drag strap, and TECC supplies. The bag’s purpose is to provide responding officers with supplies needed to address the shooter and first aid equipment needed for self-care/ buddy-care. TECC supplies in the “go bag” can be used to treat victims; however, officers will not stop to render care until the shooter (threat) has been stopped.

This research also resulted in a more aggressive approach from firefighters. OCFD firefighters were instructed on scene dynamics and advised of the direction of OCFD’s active shooter response. Introductory TECC application, terminology, and RTF concepts were shared with 100% of all sworn OCFD members. Firefighters were advised that waiting for the scene to be determined safe was not realistic. During an active shooter incident, OCFD will provide patient care in areas of mitigated risk. Joint police and fire active shooter training was instituted by early 2014 and all police officers and firefighters in the City of Oak Creek have received introductory training. RTF positions and movements were reinforced through repetitive training. Further, OCFD’s and OCPD’s policies, procedures, and directives were aligned with the

THREAT acronym established by the Hartford Consensus and reinforced through the USFA's Active Shooter Guideline.

T- Threat Suppression	<ul style="list-style-type: none"> • Contact team • Entry protection • Rescue element protection
H- Hemorrhage Control	<ul style="list-style-type: none"> • TECC supplies • Bystander TECC application • Responder TECC application • Rapid deployment of emergency personnel
RE- Rapid Extrication	<ul style="list-style-type: none"> • Extrication happens secondary to hemorrhage control • RTFs will assemble to evacuate patients • All RTFs will be equipped with evacuation supplies (soft stretcher/ webbing)
A- Assessment	<ul style="list-style-type: none"> • Fire/EMS introduces sooner through mitigated risk • Warm zone medicine applied • Attempt to address as many victims as possible prior to evacuation
T- Transport	<ul style="list-style-type: none"> • Medical group established through incident command • Once victims have been evacuated from the warm zone, traditional triage, treatment, and transport will take place in the cold zone. • Priority status will be determined and hospital transport initiated.

Figure 1. OCFD and OCPD's application of the THREAT acronym. As adapted from "Active shooter and intentional mass-casualty events: The Hartford consensus II" by the Joint Committee to Create a National Policy to Enhance Survivability from Mass Casualty Shooting Events, 2013, para. 1, Copyright 2013 by the American College of Surgeons.

Understanding the importance of a regional response, procedures were evaluated for mutual aid compatibility. A police and fire Ad Hoc committee was established to address response uniformity. The purpose of this research was not to evaluate the response of mutual aid departments during an active shooter event. However, OCFD's ability to move forward with an active shooter response was contingent on the direction of the Milwaukee County Association of Fire Chiefs (MCAFC). Since a suburban response is likely to involve participation from mutual aid agencies, this step insured that when other fire and police departments develop response guidelines, response procedures are similar. The guideline was written and presented to

Milwaukee County area police and fire chiefs at the end of May 2014. Police and fire chiefs approved the information as presented; therefore, a police and fire train-the-trainer program was developed to improve the probability of uniform procedures- regardless of department.

Response Effectiveness

The effectiveness of response was evaluated on two different levels. Bystander response and the fire/EMS response were evaluated separately. At the end of May 2014, a feedback instrument was distributed to all school district employees through the superintendent’s office. The instrument contained the same questions that were used in a 2012 feedback instrument that evaluated a tactical, mass casualty response in a K-12 environment. Through this medium, school district employees could comment anonymously. Of the over 800 school district employees, 170 responded to the instrument. The number of respondents fell short of the statistical 95% confidence level. However, as compared to the 2012 instrument, 10 more school district employees provided input. A report of the responses was produced so that 2012 and 2014 data could be compared (Appendix I). The following responses allowed this researcher to determine the effectiveness of bystander applied TECC (Figure 2-4).

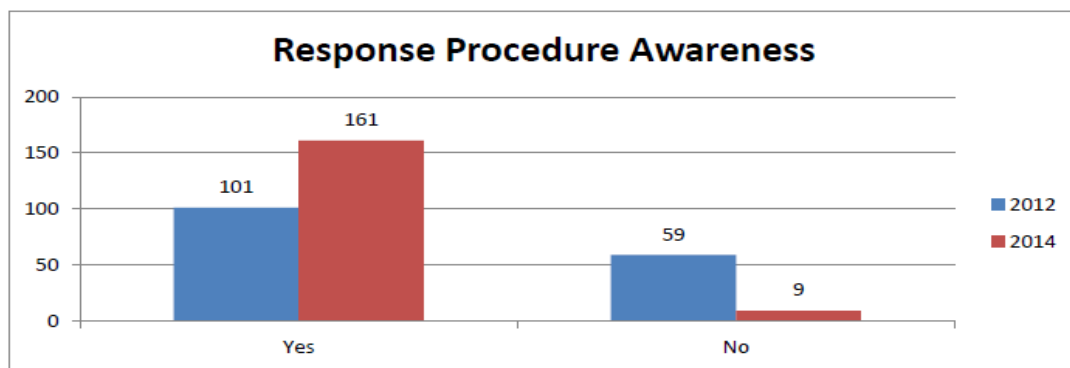


Figure 2. OCFJSD active shooter response awareness. In 2012, 63% of all school district respondents indicated that they were aware of OCFJSD’s response procedures to active shooter incidents. In 2014, 95% indicated that they were aware of the districts response procedures. The increase in procedural awareness reinforces that active shooter education positively impacted readiness.

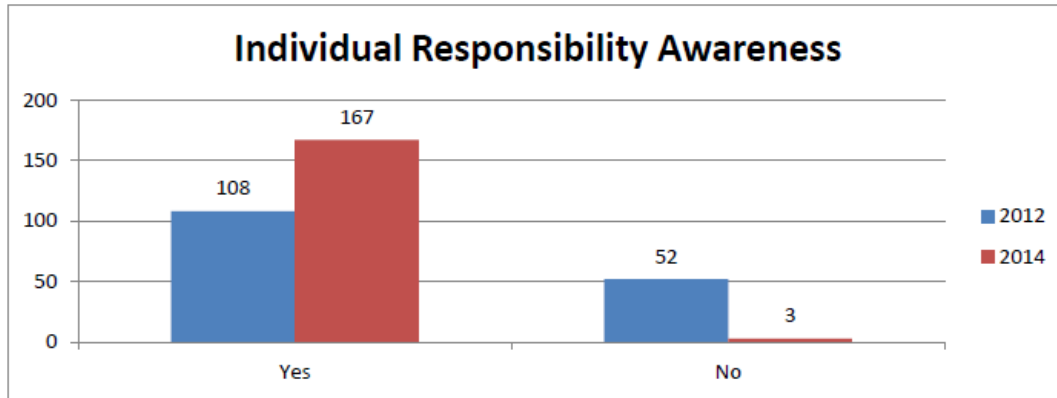


Figure 3. OCFJSD individual responsibility awareness. In 2012, 68% of all school district respondents indicated that they were aware of their individual responsibilities during an active shooter incident. In 2014, 98% indicated that they were aware of their individual role during active shooter incidents. Once again, improvements noted after active shooter training.

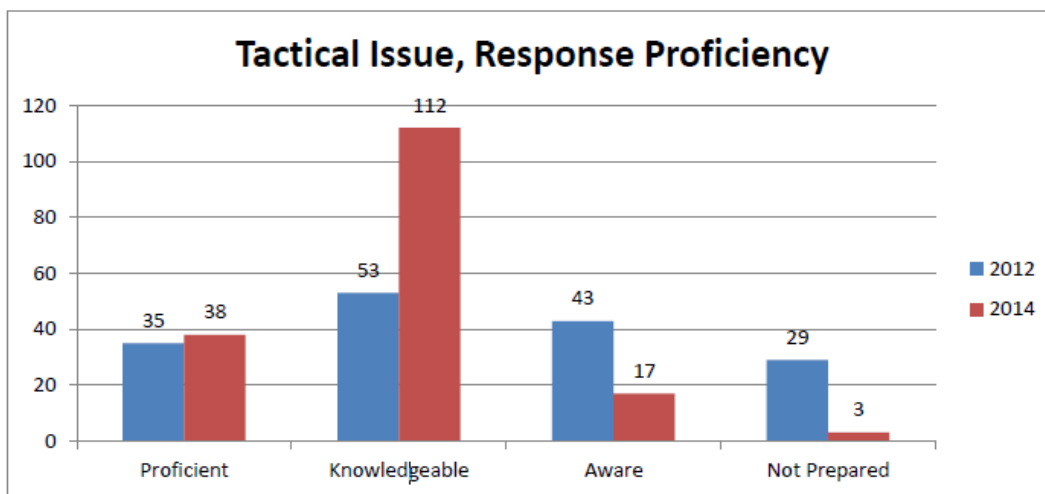


Figure 4. OCFJSD response proficiency. In 2012, 55% of all school district respondents indicated that they were proficient or knowledgeable in the application of an active shooter response. In 2014, 88% of all respondents indicated that they were knowledgeable or proficient. Similarly, in 2012, 18% felt that they were not prepared for an active shooter incident. In 2014, less than 1% felt unprepared.

Two questions in the feedback instrument provided questionable results. Follow-up questions would have to be solicited to better understand the findings. In one question, respondents were asked about practicing their role in a simulated incident. In 2014, a greater percentage (66%) replied that they had not practiced their role versus the respondents of 2012

(61%). So, even though all school district employees had greater access to training scenarios, more felt that they had not practiced their response in a simulated incident.

Likewise, in the 2013-2014 school year, all educators were provided an opportunity to learn TECC methods. A lecture and hands-on component were provided at two separate in-services. Regardless of increased instruction in TECC and emergency medical care, 58% of all respondents felt that they had not participated in formal first aid training. In 2012, 51% replied that they had no first aid instruction. In future training sessions, OCFD instructors will have to stress that traditional first aid techniques are not always appropriate for TECC. But, TECC can be used for emergency first aid.

To evaluate the effectiveness of the fire/EMS response, a time-to-task analysis was conducted. Times collected provided information about RTF assembly, patient contact/treatment, and patient evacuation. Response times (dispatch to arrival) were simulated using OCFD's 2013 response data. In 2013, OCFD's 90% fractile response time was 7:04 minutes (Oak Creek Fire Department, 2014). Adding the simulated response time to the times collected during OCFD's active shooter exercise provide a projection for RTF effectiveness. OCPD and OCFD have established a 10 minute benchmark to make initial patient contact with the RTF and a 60 minute benchmark to have all patients evacuated. In this time-to-task analysis, the entry benchmark and the total victim treatment benchmark were prioritized. All rotations were timed and benchmark times were used to insure that incident priorities were being achieved (Appendix J).

Three exercises were recorded (Table 1). In all instances, response benchmarks were achieved. Patient contact was made within 10 minutes (longest = 09:51) and all patients were extricated within 60 minutes (longest = 15:07). Simulated deceased victim assessment times

were not recorded. It is important to note that responders spent very little time with deceased victims. Non-breathing patients and those with injuries incompatible with life were bypassed.

During OCFD's real life active shooter experience, initial patient contact was accomplished early in the incident. However, police protection was not made available (or at least communicated) to the emergency medical responders. This research reinforced the need for mitigated risk and the effectiveness of policy and procedure in a less-than-safe environment.

Table 1

RTF Time-To-Task Analysis: Response Benchmarks

Benchmark	Benchmark Times		
	Exercise 1	Exercise 2	Exercise 3
RTF1 Donn BPE Grab Kit	00:47	00:42	00:30
RTF1 @ Link-Up Point	01:32	01:24	01:13
RTF1 Linked-Up with Police	02:31	02:20	02:03
RTF2 Donn BPE Grab Kit	00:50	00:42	00:30
RTF2 at Link-Up Point	01:32	01:24	01:13
RTF2 Linked-Up with Police	05:06	04:51	04:30
Patient #1 Contact	02:47	02:41	02:30
Add Response Time (90% Fractile Constant)	07:04	07:04	07:04
Total Response Time to First Patient Contact	09:51	09:45	09:34
Patient #1 Evac	03:36	03:33	03:35
Patient #2 Contact	04:32	04:07	03:50
Patient #2 Evac	06:59	06:50	06:45
Patient #3 Contact	05:47	05:30	05:12
Patient #3 Evac	06:59	06:50	06:45
Patient #4 Contact	05:47	05:42	05:12
Patient #4 Evac	07:47	06:50	06:45
All Patients at Medical Group	08:03	07:32	07:29
Add Response Time (90% Fractile Constant)	07:04	07:04	07:04
Total Time	15:07	14:36	14:33

Difficulties Encountered

Community based continuum of care (using TECC) resulted from the need for hemorrhage control immediately following a traumatic event. Active shooter incidents can happen at any time and often surprise those in the immediate area of the event. Hopefully those who witness an active shooter event and can provide assistance quickly and involve themselves in patient care. With that, it is important to train as many people as possible in the life saving practices of TECC. Unfortunately, some school district staff members did not receive the active shooter training. It was noted that front office and custodial staff should be able to participate in training.

Initially OCFD's active shooter response provided care and extricated patients as casualties presented. Mirroring Israeli mass casualty care, an "assess, treat life threats, grab, and go" approach was considered. Initially, a "grab and go" approach seemed appropriate- especially when victims did not outnumber responders. However, when the numbers of victims are greater than the number of responders, treatment must be prioritized. Difficulties were encountered in providing quick hemorrhage control during mass-casualty incidents- priority patients were being missed as other patients were being evacuated. The longer a patient was left to bleed, the greater the possibility of irreversible blood loss. OCFD's policy was updated so that responders could provide hemorrhage control to as many people as possible.

OCFD worked with various TECC kit configurations. Large kits provided more equipment, but hampered movement. If a kit was too small, supplies were limited. Pouches were sampled; however, digging through a pouch was difficult in a high stress environment and kit contents kept falling out as rescuers attempted to grab their intended equipment. The kit needed to be small enough to be carried on-person, large enough to carry multiple supplies, functional

enough to work out of when fine motor skills are compromised, and affordable enough so that all medical responders could have one attached to their personal protective equipment. OCFD found a kit that could open completely, had enough room to carry multiple supplies, and was able to attach to the responder. Working in pairs, fire/EMS providers have enough supplies to treat multiple injuries/ injured. However, during a mass-casualty situation, when supplies are used in larger quantity, RTFs will also carry a drop bag (resupply bag) that can be carried into the warm zone and dropped in the casualty collection point.

Additional consideration was given to evacuation equipment. Initially, evacuation supplies (soft stretcher/ webbing) were carried as needed and by assignment. Training evolutions reinforced that evacuation supplies need to be carried by all RTFs- regardless of primary function (treatment or evacuation). Two examples provide background for this decision. Unlike schools, large manufacturing buildings, warehouse complexes, and cubical-partitioned office space may not have room numbers. Victim movement may need to occur to expedite evacuation- victim location was hard to communicate when landmarks were not easily explained over the radio. Additionally, when patient care has been completed, it is important to optimally utilize personnel and equipment. When RTFs have the ability to treat and evacuate, they can adapt to the needs of the situation and make decisions based on the variables of the incident.

When OCFD's command-level officer (Battalion Chief) arrives on scene of an active shooter incident, vital information is requested and received from the incident commander (police). Experience gained from the Sikh Temple incident identified that communicating with command through dispatch will be difficult. Dispatch will be overwhelmed by police activity and other telephone calls being placed into the dispatch center. OCFD's active shooter procedure provides the battalion chief the ability to communicate with the incident commander over the

police frequency. Training identified difficulties when multiple radio channels are used. OCFD's battalion chief (Fire Ops) is responsible for monitoring OCFD's primary dispatch, the interagency fire emergency radio network (IFERN- mutual aid channel), MABAS Red (tactical channel), and OCPD's primary dispatch channel. During training, while the RTF was operating inside the warm zone, OCFD's battalion chief was monitoring transmissions on the police and fire frequencies. When police officers and firefighters transmitted similar information at the same time, radio transmissions were confusing. In order to address this concern, once the RTF is formed and firefighters are linked up with police officers, the battalion chief can discontinue monitoring the police frequency. The RTF will provide a natural communication bridge as firefighters will remain on the assigned tactical channel and police officers on their primary frequency.

Considerable discussion took place about incident command and unified command. Some fire departments have indicated that they will not initiate an RTF response without unified command. Although OCFD appreciates the value of unified command and a coordinated command structure, experience has proved that Oak Creek's unified command structure will not be instituted immediately. In the suburbs, during an active shooter incident, front-line police supervisors will likely be involved in operational elements of the incident. Unified command may not happen until off-duty command staff personnel have been called to the scene. Waiting for a formal unified command structure to form will likely stifle the rescue effort. Time waiting is equivalent to time bleeding. OCFD has prioritized RTF functions over unified command- with the understanding that command staff functions are important and unified command positions must be filled quickly (Appendix K).

Ballistic protection is necessary in the active shooter environment. Although the risk in a warm zone environment is mitigated, active shooter incidents are not without risk. Emergency responders must continually evaluate their work environment. If law enforcement is entering the scene with ballistic protection, emergency medical providers need to consider similar ensembles (vest and helmet). Until recently, the fire service has not typically been involved in active, tactical incidents. As a result, ballistic protection has not typically been funded through the local budget, state funding, or federal funding. Furthermore, it is difficult to find grants that allow ballistic protection for firefighters. OCFD has a few sets of ballistic protective equipment; however, more ensembles are needed to equip all first-line fire and EMS equipment. OCFD will continue to investigate funding options.

Difficulties were observed in the implementation of local policy. As OCFD's active shooter response procedures were being instituted, a neighboring, major metropolitan fire department was establishing their own response. Other neighboring fire chiefs expressed concern about mutual aid support and the standardization of an active shooter response. A few chiefs suggested adopting and implementing procedures put in place by the larger metropolitan department. As with many emergency operations, variables exist at the local level. OCFD's active shooter response procedures closely resembled the active shooter response of the OCPD. Implementing another fire department's policy would not resemble the collaborative effort that took place between OCFD and OCPD. At the conclusion of this debate, it was unlikely that one, uniform policy would exist. However, through the fire and police Ad Hoc committee, guidelines were established so that terminology and methods were shared (Appendix B).

Response Acceptance

In the response continuum, school district employees and firefighters experienced the most significant cultural change. Acceptance drives emotion and emotion influences initiative and procedural application. The results of this research evaluated the acceptance of the bystander’s role during an active shooter incident and the firefighters’ pre and post training impressions.

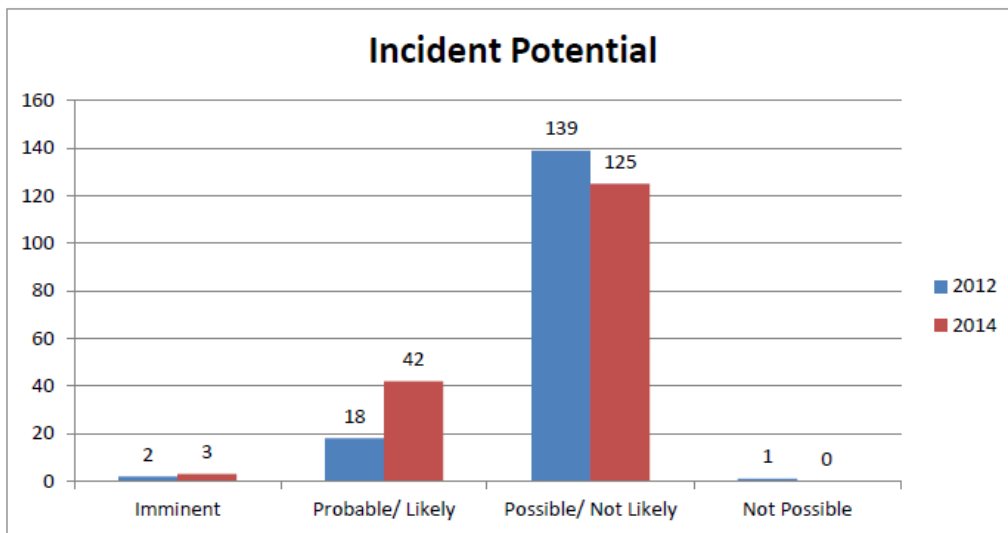


Figure 5, OCFJSD perception about active shooter incident potential. In 2012, 11% of all school district respondents indicated that it was probable/likely that an active shooter incident would happen in the school district. In 2014, 25% of all respondents indicated that an active shooter incident was probable/likely.

In the OCFD/ OCPD active shooter program, readiness and the predictability of response was stressed. Readiness is often accomplished through visualization and incident anticipation. Those who feel that an active shooter incident is not likely to develop will be the most surprised and least prepared when an active shooter situation occurs. OCPD and OCFD emphasize that training should be conducted with the expectation that skills learned could be used at any time. In 2014, more school district employees have indicated that an active shooter incident is probable (Figure 5).

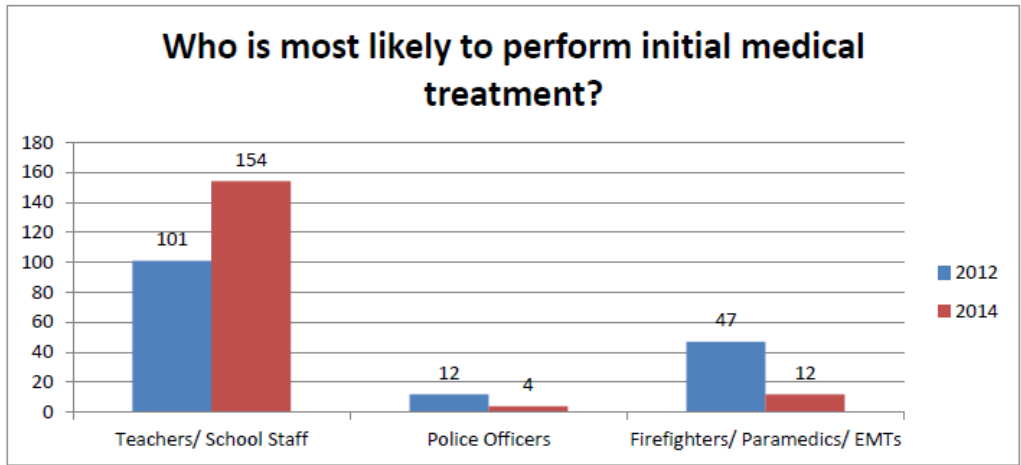


Figure 6. OCFJSD initial medical treatment during active shooter incidents. In 2012, 63% of all school district respondents indicated that teachers and school staff would be performing initial medical treatment. In 2014, 91% of all respondents indicated that teachers and staff would most likely perform medical treatment.

Faculty and staff were asked, “Who is most likely to perform initial medical treatment?” Comparative data from 2012 and 2014 indicate that more faculty and staff accept the fact that the emergency response will begin with them (Figure 6). The results of this inquiry reinforce the need for community TECC training and bystander awareness.

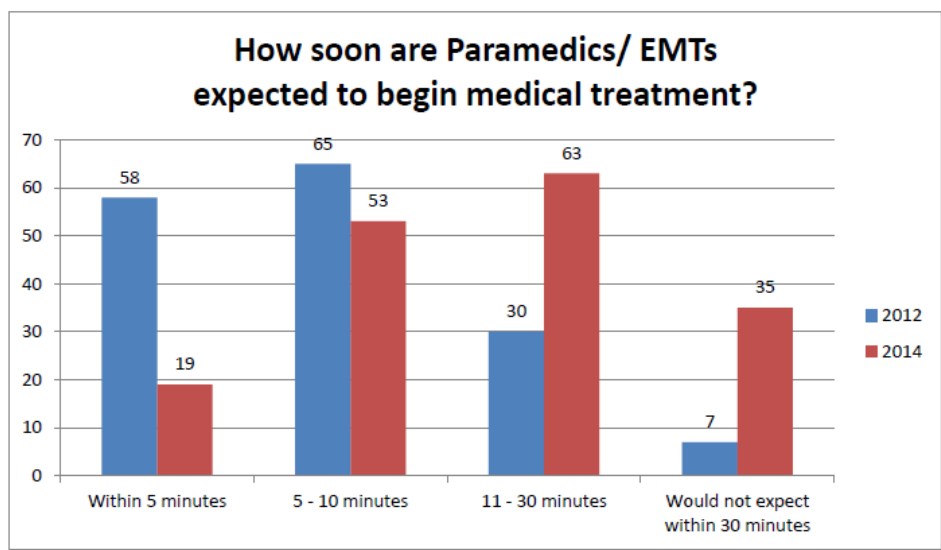


Figure 7. OCFJSD expectations of professional emergency medical response. In 2012, 77% of all school district respondents indicated that a professional EMS response would happen within the first 10 minutes of the incident. In 2014, the expectation shifted to longer response times.

In 2012, the need for bystander first aid/trauma care was not prioritized. The expectation and perception of an emergency medical response suggested that firefighters/ EMTs would arrive quickly and take care of the injured. The OCFD and OCPD active shooter program provided insight to an actual active shooter response. Although firefighters have made significant progress in the delivery of emergency medical treatment in a tactical environment, realistic expectations have been shared about the response timeline. The 2014 data reflects a shift in expectation- more school district personnel indicated that it will take time for a professional EMS response (Figure 7). Longer response times strengthen the acceptance of community/bystander TECC.

Firefighters were also given the opportunity to comment on OCFD’s active shooter response. Results provide insight to acceptance and readiness. Pre and post training feedback instruments were circulated and data was recorded (Appendix L and M).

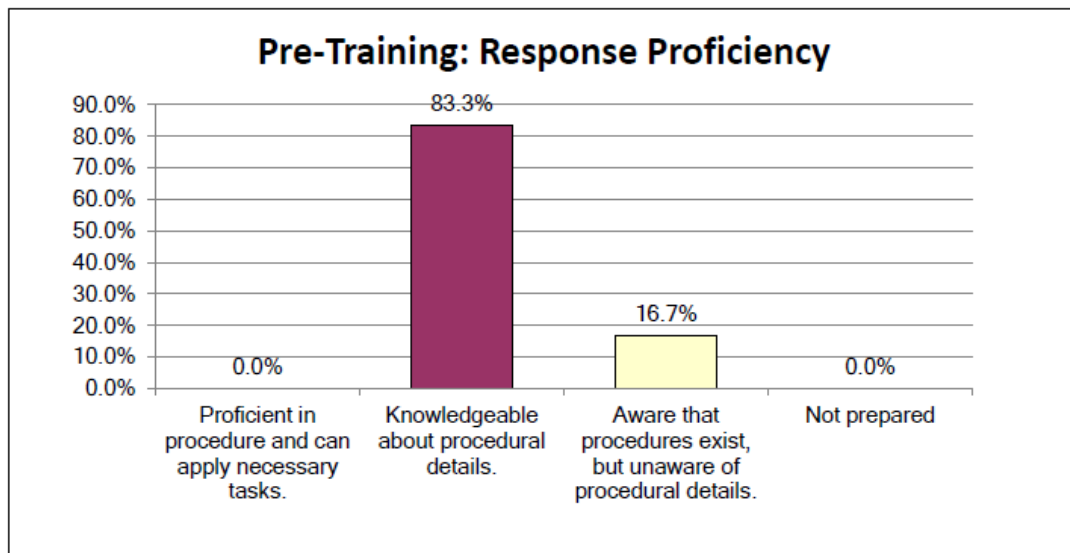


Figure 8. OCFD pre-training response proficiency.

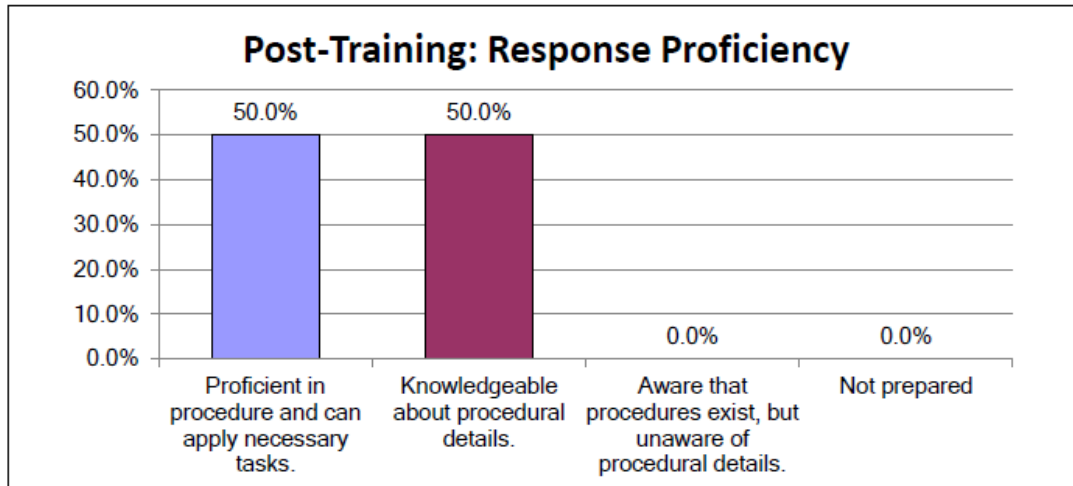


Figure 9. OCFD post-training response proficiency.

Improvements were noted in response proficiency. Respondents expressed a better appreciation of active shooter initiatives after participating in joint police/fire training (Figure 8 and 9). In order for firefighters to accept an active shooter response, they have to understand their role in the continuum of care and convey knowledge in policy and procedures.

Prior to training, firefighters were asked if they had any concerns about an active shooter response. Respondents wanted to ensure that scene safety was considered and that protection was provided to emergency medical providers. In the post-training feedback instrument, with the exception of one firefighter, those who attended indicated that the training addressed their concern (Figure 10). The firefighter who continued to express concern about an active shooter response stated that the training “somewhat” addressed response concerns. In the narrative provided, the firefighter mentioned that the effectiveness of communication was questionable.

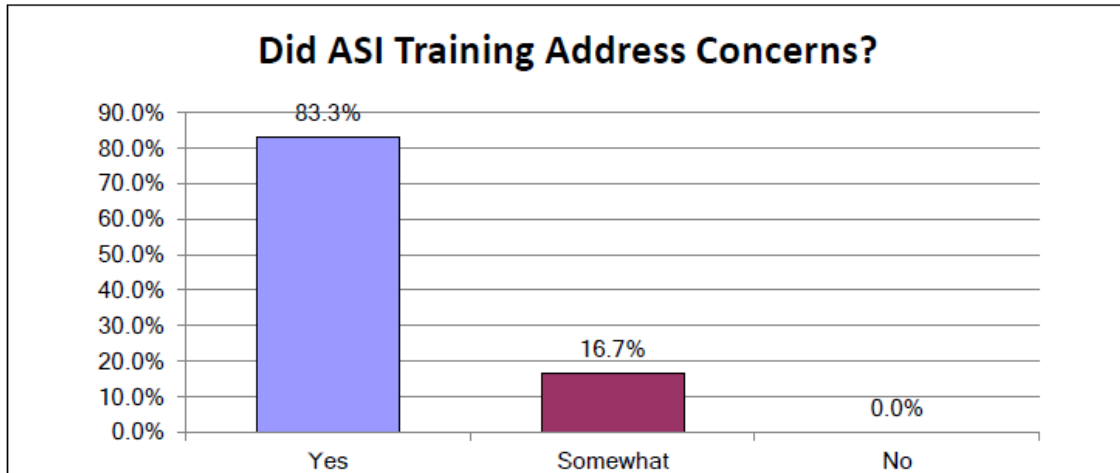


Figure 10. OCFD post-training concerns about active shooter response.

Finally, in order to determine OCFD’s acceptance of an active shooter response, research questioned the perception of a shared response. Respondents were asked if OCPD and OCFD had shared priorities. Prior to training, most firefighters indicated that police and fire priorities were not shared (Figure 11).

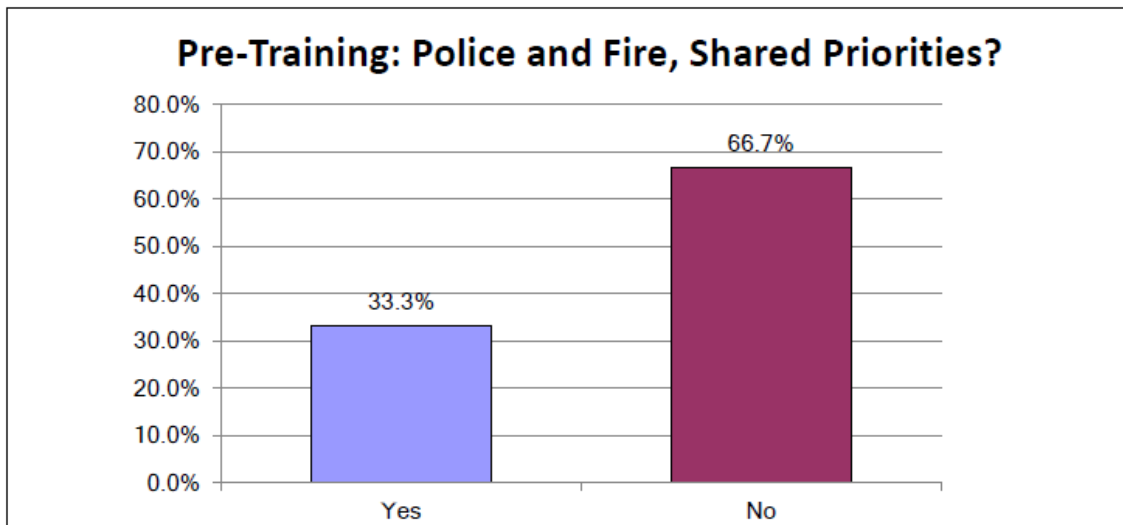


Figure 11. OCFD pre-training perceptions on shared police and fire incident priorities.

Following joint police and fire active shooter training, with the exception of one firefighter, all feedback respondents indicated that police and fire incident priorities are shared in an active shooter incident (Figure 12). The firefighter that had concerns about the active shooter

response expressed concern about firefighter and police officer roles. Further, mutual aid compatibility was questioned.

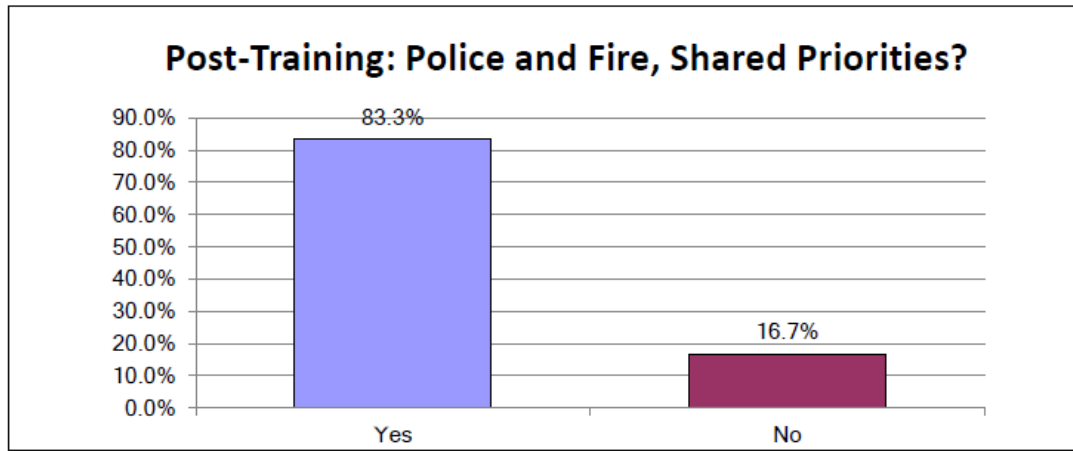


Figure 12. OCFD pre-training perceptions on shared police and fire incident priorities.

Results for this research confirm that progress has been made in OCFD's implementation of an active shooter response. Research supports OCFD's bystander and emergency responder initiative. Feedback received and data collected confirm that OCFD's active shooter continuum of care is effective and accepted. Further, difficulties encountered are continually being addressed and improvements to response are made.

Discussion

Active shooter incidents and incidents of domestic violence are the new normal. Mass casualties resulting from violent acts are happening more frequently and are trending upward (Blair, Martaindale, & Nichols, 2014). From an observer's perspective, fire departments and emergency medical service providers are no longer afforded the security of waiting until the scene is safe before rendering emergency medical care. Active shooter incidents are not safe incidents and they will not likely be considered safe for hours after the initial insult (Croom III, 2013). However, society will no longer accept a stage-and-wait mentality (CBS/Associated Press, 2013). The longer a victim is left bleeding, the more likely they are to die (Callaway,

Smith, Cain, Shapiro, Burnett, McKay, & Mabry, 2011) and, “no one should die from uncontrolled bleeding” (Joint Committee to Create a National Policy to Enhance Survivability from Mass Casualty Shooting Events, 2013, para. 5).

Active shooter incidents are stressful, unpredictable incidents. Firefighters, police officers, and emergency medical personnel are all action-oriented. When life threatening problems are presented, emergency responders feel compelled to improve the situation through a quick and effective response. However, without policy and procedure, emergency response personnel will initiate a response based on instinct and emotion. Police departments and fire departments must collaboratively develop response procedures that reflect a joint response with common goals and objectives (USFA, 2013).

Prior to developing policy, OCFD met with OCPD to discuss response variables. With the understanding that active shooter incidents are law enforcement incidents, OCFD needed to comprehend law enforcement response directives that were already in practice. Similarly, OCPD needed to understand the requirements of an effective fire department response. Firefighters and police officers will benefit from an integrated approach (Sanders and Klaene, 2013). In an active shooter incident, “it is imperative that local fire and law enforcement departments have common tactics, common communications capabilities and common lexicon for seamless, effective operations” (IAFF & IAFC, 2013, para.3).

The OCPD has been training for active shooter incidents for over a decade. Over that time, the OCFD has supported active shooter responses in varying capacities. After the City of Oak Creek’s first active shooter (with multiple casualties) in 2004, tactical EMS (TEMS) was implemented. During the Sikh Temple incident of 2012, OCFD realized it needed a more immediate response for the critically injured. Pulvermacher (2013) developed a RTF policy and

procedure that addressed OCFD's role in a less-than-safe active shooter environment. Through the RTF approach, Oak Creek firefighters and police officers could provide emergency medical care to those that have been injured in an active, tactical incident. "Pre-planned coordination with [law enforcement would]... rapidly effect rescue, save lives, and enable operations with mitigated risk to personnel" (USFA, 2013, p.3).

Through trial and error, policy submissions and revisions, responder input and explanation; OCFD and OCPD were able to develop a scalable response strategy that addressed the fluctuating staffing levels of a suburban police and fire department. Scalability must exist in the response procedure so that department size does not preclude participation of emergency medical providers in an active shooter incident (United States Department of Homeland Security Office of Health Affairs, 2014).

Introducing an active shooter response procedure into the OCFD was an adaptive challenge- creating tension and disequilibrium (Heifetz, Grashow, & Linsky, 2009). To effect change, OCFD looked beyond logic. If change was addressed by logic without considering emotion, change would have been influenced by direction- not motivation (Heath & Heath, 2010). A cultural change in emergency response needed to consider the concerns of the firefighters (end user). Awareness, desire, knowledge, ability, and reinforcement were used by OCFD to help firefighters become educated about techniques, understand the change, support the change, and act on the change (Hiatt, 2006).

By listening to the suggestions of the end users, OCFD was able to make changes that positively affected the outcome of training exercises. Firefighters found that it was difficult to carry emergency medical supplies when providing tactical emergency casualty care. As a result, firefighters were provided with a kit that made TECC supplies available on their person- keeping

their hands free and giving both rescuers of an RTF the ability to work independently. Firefighters stated that they could treat more people if they didn't have to evacuate every patient after treatment. As a result, rescuers were instructed to treat a patient, call for another RTF to evacuate, move and treat another patient, and the process continued. However, there were situations where the RTF completed their treatment and could assist with patient evacuation; or, the patient was in a spot that required movement because their location was not easily communicated. Based on those experiences, RTF members were outfitted with the same equipment regardless of assignment (treatment or evacuation).

OCFD was also sensitive to the fact that active shooter incidents are low frequency events. Retention of specialized response procedures would be difficult if not practiced regularly. Specialized responses require firefighters and training officers to keep up with requisite knowledge and training. It is important to come up with creative ways to address operational capacity when firefighters are already stretched thin (Stone, 2014). OCFD attempted to establish an active shooter response that used as much "everyday" procedures and terminology as possible. First Aid/ TECC concepts were selected to resemble the Milwaukee County EMS standard of care. Existing MABAS box cards were used to establish local and mutual aid resource allocation. On-scene tactical communications were designed to follow the existing communications template. Using as many pre-existing, standardized policies as possible will offer the most predictable outcomes (Hyderkhan, 2014).

Even if all of OCFD's response policies are followed flawlessly, OCFD still has a 7:04 90% fractile response time (Oak Creek Fire Department, 2014). Victims with critical traumatic injury will suffer significant blood loss if hemorrhage control is not applied immediately. The Department of Homeland Security Office of Health Affairs (2014) indicated that hemorrhage

control/ TECC should not only be made available to firefighters and law enforcement, but it should also be available to the general public through community TECC. OCFD and OCPD's introduction of emergency casualty care in the school district makes life-saving supplies and techniques available prior to the arrival of police officers and firefighters. If a school shooting does happen, faculty and staff will not have a choice, they will already be involved. Case studies have found that in many school shootings, faculty and staff jumped in to protect students and render medical care. The active shooter presentation that was provided to OCFJSD by OCFD and OCPD, empowered the faculty and staff to make educated decisions and provided them with supplies and equipment to improve their effectiveness during an active shooter incident.

Progress has been made. Firefighters have learned the logic associated with the need for an active shooter response and demonstrated the emotion needed to effect change. Feedback and analysis support the effectiveness and acceptance of OCFD's continuum of care. As with any change process, difficulties are anticipated. Much like funding and equipping firefighters with ballistic protection, OCFD will address those difficulties with a solution in mind. The fire service is a dynamic occupation and firefighters are susceptible to change. Those who institute change (fire chiefs) should involve those who are susceptible to change (firefighters) so that all can eventually support the change (Hiatt, 2006).

Recommendations

Those looking to institute an active shooter response should evaluate all levels of the response- bystander/community TECC, law enforcement self-care/buddy-care, fire/EMS rescue tack force operations, and mutual aid support. All aspects of the continuum of care impact patient survivability at different levels of the response. No policy or procedure is "the" policy or procedure. Instituting this initiative is a collaborative process between various agencies. Involve

the school district in community TECC, the police department in the local RTF response, and neighboring municipal departments in mutual aid support. Work toward uniformity and standardization but realize that variables exist in every agency and response procedures will need to be written to address the initial, local response.

RTF and active shooter procedures are relatively new to the fire service. Difficulties should be anticipated and adjustments should be carefully considered. While implementing an active shooter response, make sure the message is well-defined. Set some clear expectations about RTF techniques and the active shooter environment. Decisions may be influenced by logic, but motivation and ownership is inspired through emotion (Hiatt, 2006). Get assistance from those within the organization that are passionate about the project. Training will be continual; the department is going to want to establish some in-house experts. It will be equally important to institute an external network; so that lessons can be learned through other's experiences.

Through applied research, OCFD was able to implement its active shooter/ tactical mass casualty response procedures. Further, OCFD was able to make changes to its existing policy and procedures that reflect a regional rescue effort (Appendix O and P). Moving forward, OCFD must consider how to best utilize mutual aid companies responding into the City of Oak Creek. Further, OCFD must determine how it will support active shooter incidents when responding to neighboring communities. Joint training between police, fire, and mutual aid departments will help establish incident predictability through repetition. Training will make this response more effective and repetition will insure that the response initiatives are accepted. New police officers never question the role of the patrol officer during active shooter incidents. 15 years ago (following the Columbine school shooting) that wasn't the case as law enforcement was going

through its own paradigm shift. Given time, the fire service may look back at this transitional period and wonder why an EMS response into active shooter incidents was ever questioned.

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Appendix A



**Oak Creek Franklin
Joint School District**

Sara J. Burmeister, Ph.D.
Superintendent of Schools
s.burmeister@ocfsd.org

7630 South 10th Street
 Oak Creek, Wisconsin 53154
 (414) 768-5886
 Fax: (414) 768-6172

[Date]

[Name]
 [Address 1]
 [Address 2]

Dear [Name]:

The safety of our community and, in particular, the safety of our children is important for all of us. This became an even greater priority after the tragic Sikh Temple shooting in our own community last year and the Sandy Hook Elementary shooting last December.

The Oak Creek Police Department and Oak Creek Fire Department have been teaming with the schools in our community to help us prevent these types of tragedies from occurring in our schools and help prepare us to deal quickly and efficiently if there ever were to be a situation we can't prevent. They have prepared and delivered inservice training to all of our staff on the topic of Reducing the Community's Risk to Tactical, Mass Casualty Incidents in Oak Creek.

As the Police and Fire Departments have pointed out, the first 10 minutes are the most crucial for dealing with shooting victims, which is why it is so important for our staff to be prepared for administering necessary aid immediately if there were an active shooter in our schools. The Oak Creek Fire Department will be training staff in our schools on skills such as applying tourniquets and quick clot gauze to stop bleeding.

We will be purchasing Mass Casualty First Aid Kits for our schools, and we are hoping to purchase as many as possible. Our ultimate goal would be to have the fund to purchase 400 kits to ensure one in every classroom and office in our schools. The kits are \$188.45 each.

If your business or organization is willing and able to purchase a number of kits to help us reach the goal of 400, we would greatly appreciate any donation you could provide.

We know what a wonderful community we have in Oak Creek-Franklin. It's a great place to live, work, and attend school, and we will continue to work together and do all we can to ensure this continues. As always, we appreciate your help in accomplishing this.

Sincerely,

Dr. Sara Burmeister Oak Creek-Franklin Schools	Chief John Edwards Oak Creek Police Department	Chief Tom Rosandich Oak Creek Fire Department
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It all starts here.

Appendix B

OAK CREEK FIRE DEPARTMENT EMERGENCY MEDICAL SERVICES TACTICAL MASS CASUALTY- RESCUE TASK FORCE

Introduction

For the sake of this research, a tactical incident is defined as any malicious activity that threatens the safety of the general public. Tactical incidents will most likely require the deployment of police, fire, and emergency medical resources. Many in the fire service continue to dispute the role of firefighters during tactical incidents. When should firefighters commit to a tactical incident? What is a firefighter's responsibility while the scene is still active?

In many communities, the fire department is also responsible for emergency medical care. One of the leading questions in many emergency medical incidents is: "Is the scene safe?" Yet, regularly, firefighters and emergency medical technicians (EMTs) render care at incidents where the scene is less-than-safe. For example, firefighters treat patients at motor vehicle crashes when passing, high-speed traffic is a significant safety factor. Fire departments continue to provide life and property saving skills at structure fires knowing that the scene is not safe. And firefighters continue to provide technical rescue and hazardous material mitigation during high risk, low frequency events. Still, in tactical incidents, one of the main reasons firefighters do not commit to the scene is based on the perception that it is not safe.

Based on the observation of tactical incidents, most fire departments currently stage emergency medical personnel and equipment until given an "all clear" from the police department. The concern with staging emergency medical resources during a tactical mass casualty incident is that life-saving skills are not delivered in a timely manner. Thus, lives may be lost while victims wait for medical attention. Working with law enforcement to identify an incident action plan during tactical incidents has been difficult in the past due to varying incident management philosophies and priorities. Yet, the intended outcome for police and fire departments are the same: Stabilize the incident and provide care to the injured as quickly as possible.

The use of existing fire service terminology is important when defining the changing role of the fire service in tactical incidents. Further, terminology between firefighters and law enforcement should be standardized to reduce confusion. Training must be implemented and equipment modified to reduce firefighter risk. Incident participation and scene access should be determined by training and equipment. Current hazardous materials mitigation processes illustrate this point: Only the right people, with the right equipment, and the right training are allowed in the hot zone. However, the hazardous materials incident is supported by personnel (that may not be trained to the same level) through the warm zone. The hazardous materials incident would not run efficiently without warm zone support. In the tactical environment, the warm zone is defined as an area controlled and protected by law enforcement. Police officers will be responsible for supporting emergency medical responders by reducing their response risk.

**OAK CREEK FIRE DEPARTMENT
EMERGENCY MEDICAL SERVICES
TACTICAL MASS CASUALTY – RESCUE TASK FORCE**

Development of Response Policies and Procedures

The Oak Creek Fire Department (OCFD) has developed procedures that relate fire and EMS activities in the warm zone during active, tactical incidents. The intent of response procedures is to improve OCFD's performance during tactical incidents. Emergency operations are more predictable when fire and police activities are coordinated. OCFD's policy and procedure address the following:

1. Considerations and modifications needed during active, tactical operations.
2. Rescuer qualifications in active, tactical environments.
3. Emergency medical equipment and supplies needed during tactical operations.
4. EMS responder protection in a warm zone.
5. Emergency care/treatment given in a warm zone.

Pilot Program Proposal

Training

All Oak Creek Fire Department emergency responders will undergo a standardized training program that will cover the following:

- PPE overview (medical PPE, Ballistic PPE)
- Tactical Emergency Casualty Care (TECC) Techniques
- TECC medical equipment/ supplies- efficacy and use.
- Rescue team overview- terminology and incident parameters
- Rescue Team join drills- Team movement and cohesiveness
- Table Top Exercise for OCFD/ OCPD command staff/ supervisors.
- Functional Exercises for all OCFD/ OCPD personnel.
- Full Scale exercise to involve neighboring/ mutual aid departments.
- After Action will be conducted to determine policy/ procedure improvements.
 - Response Time/ At Patient Time
 - Application of patient care concepts
 - Evaluate equipment provided/ equipment needs.
 - Suggest procedural/ policy changes.

Location

The pilot program will include all employees of the Oak Creek Fire and Police Departments and be implemented on all tactical incidents within the geographical boundaries of the City of Oak Creek.

Duration

One year beginning November 1, 2013 and ending November 1, 2014.

OAK CREEK FIRE DEPARTMENT
EMERGENCY MEDICAL SERVICES
TACTICAL MASS CASUALTY – RESCUE TASK FORCE

Logistics

Minimum equipment to be stocked on each unit designated as part of the pilot program:

- (2) BPE ensembles (Vest/ Helmet/ IFAK)
 - Individual First Aid Kit (IFAK)
 - (2) Tourniquets
 - (2) Israeli Bandages
 - (2) Occlusive Bandages
 - (1) 14 gauge needle for decompression
 - Combat Gauze
 - (2) 28 Fr. Nasal Pharyngeal (NP) Airway
 - Sharpie Marker
 - Tape
 - Mult. Gloves
- (1) Resupply Kit
 - Extra Tourniquets
 - Extra Israeli Bandages
 - Extra Occlusives
 - Extra Combat Gauze
 - Extra NP Airways
- Typical BSI
 - Gloves
 - Goggles/ Safety Glasses

These are low frequency incidents. If equipment is used, remaining equipment would have to be equally distributed between units and replacement equipment would have to be ordered. We will not stock replacement equipment in the station.

Inclusion Criteria

The Rescue Task Force concept will be implemented and used by all OCFD emergency responders.

Typical inclusion criteria for trauma patients would be followed

Treatment would begin at point of wounding.

Exclusion Criteria

Treatment would not be administered for:

- Patients that are typically black or grey tagged (SALT triage)
- Green tagged patients would be encouraged to self-extricate with instruction.

**OAK CREEK FIRE DEPARTMENT
EMERGENCY MEDICAL SERVICES
TACTICAL MASS CASUALTY – RESCUE TASK FORCE**

Procedure

The full OCFD policy and procedure for injury rescue teams (operating in a warm zone-tactical environment) is attached to this proposal.

Police Department responsibilities:

1. Cautiously proceed to incident location.
2. Attempt to identify the cause of mass-casualty.
3. Identify safe route for Fire Department/ EMS.
4. Visually identify possible location for entry corridor.
5. If gun fire is heard, assemble contact team and make entry.
6. Communicate entry location.
7. Walk past victims to address threat.

Police Department Supervisor responsibilities:

1. Establish Incident Command
2. Establish perimeter
3. Identify mobile command post/ Unified Command
4. Initiate response priorities:
 - a. Contact Team(s)
 - b. Perimeter
 - c. Evacuation of the uninjured
 - d. Rescue Task Force cover/ Escort Team (Protection Element)

Fire Department Supervisor responsibilities:

1. Identify active shooter response
2. Determine mutual aid response
3. Make contact with PD Supervisor (may have to use Police radio freq.)
4. Safe response route identified.
5. Assist with cold zone/ staging.
6. Evaluate rescue team response/ police support.
7. Assign Medical Group Supervisor
8. Assemble with PD/ Unified Command
9. Consider EOC

First-In Fire/ EMS response:

1. Assemble BPE
2. Work with PD Command to identify:
 - a. If injuries are reported
 - b. Entry corridor/ perimeter established
 - c. Warm Zone identified
 - d. Protection element for Rescue Team in place.
3. Work with protection element and always work within security
4. Communicate with Medical Group Supervisor
5. Use TECC techniques for injuries
6. Grab and Go triage would be implemented -vs- SALT/ START.
7. Establish casualty collection point (CCP) if needed

**OAK CREEK FIRE DEPARTMENT
EMERGENCY MEDICAL SERVICES
TACTICAL MASS CASUALTY – RESCUE TASK FORCE**

Documentation

Documentation would not be required in the tactical environment. If time and security allowed, SALT triage would be implemented- patients would be triage tagged and removed from the tactical environment to the medical group. Traditional triage, treatment, and transport would take place in the "cold zone."

Quality Assurance

Milwaukee County EMS instructors/ evaluators will be invited to participate in all functional/ full scale training exercises. At the completion of any exercise, an after action will be conducted to collect response and patient care information. As compared to procedural direction, participants will be evaluated to determine if care was effective. Procedural modifications will be suggested through this review process.

In an actual emergency, those emergency medical providers that responded (using injury rescue team techniques) will participate in an after action review. Information will be collected from those who had an opportunity to apply the skills of a rescue team. Based on experience and input, appropriate modifications to the policy and procedure will be made.

Data Reporting / Review

Any information requested from the State of Wisconsin EMS Office and the State of Wisconsin EMS Board's Training and Education Committee will be provided.

A final report will be made available to both bodies prior to January 1, 2015 to determine if more widespread implementation should be recommended to the State of Wisconsin EMS Office.

Appendix C

RESCUE TASK FORCE GUIDELINE

PURPOSE

Mass casualties and other life threatening injuries during a violent event, such as an active shooter event, presents difficult situation for law enforcement and EMS/Fire to both address the threat and quickly respond to the victim(s) in order to render aid and save lives.

The purpose of this policy is to identify guidelines, procedures and tactics that will assist law enforcement and EMS/Fire in working as a team in order to respond to these situations and optimally provide *victim contact* within ten (10) minutes and *victim transport* within sixty (60) minutes in order to maximize victim survival.

GUIDELINE

This guideline recognizes the need for the integration of law enforcement and EMS/Fire resources in order to provide life saving measures during an ongoing active shooter incident or similar type of violent event; whereby law enforcement provides a protection element for EMS/Fire personnel in order to get them directly to the injured person(s) for treatment and/or evacuation. This integration of law enforcement and EMS/Fire resources is recognized as a Rescue Task Force.

DEFINITIONS

- A. **Active Shooter / Mass Casualty Incident:** A crime scene that has injured people in need of treatment, rescue, and expedient evacuation.
- B. **Ballistic Protection Equipment (BPE):** A Level IIIA (minimum) ballistic vest with a "RESCUE" patch on the front and back, and a Level III ballistic helmet.
- C. **Casualty Collection Point:** A location designated for the holding, further assessment and treatment of casualties. A secure area within the warm zone. An ideal CCP has **cover** and **concealment**.
- D. **Clear, but not secure (primary):** Clear means an area is clear of the suspect **only**. Clear does **not** mean an area is clear of victims. It is an area currently absent of a known threat. Law enforcement has passed through; however, a deliberate search has not been conducted to guarantee life safety.
- E. **Cold Zone:** A **secure** area.

RESCUE TASK FORCE GUIDELINE

- F. **Concealment:** Protection from observation.
- G. **Contact Team:** Law enforcement strike team responsible for stopping the suspect. Shall locate and mark secondary devices. Shall callout the number of victims.
- H. **Cover:** Protection from direct fire or an explosion.
- I. **Distant Staging:** Staging that will keep the bulk fire personnel and equipment at a safe distance from the theater of operations, thus minimizing the potential dangers that exist in the hot and warm zones. Members will exit Distant Staging and progress to Link-Up Location in anticipation of becoming a member of a Rescue Task Force (RTF) where they then can be moved to Forward Staging.
- J. **Duress Signal:** Duress signal of "**Broken Arrow**" is the preface call to alert others of a duress situation, **immediately followed by common language to specifically identify the imminent danger**. Response to duress signal will be detailed in a later section.
- K. **Entry Corridor:** Path from the **Cold Zone** to the **Warm Zone**. An established path to a location that has security measures in place. An Entry Corridor is generally utilized to move to an affected site or to leave a site and/or evacuate injured from the site.
- L. **Forward Staging:** An aggressive staging position for Rescue Task Force operations (once the Rescue Element and Protection Element have been linked up).
- M. **Hot Zone:** An area that contains an immediate threat to life safety. A **Warm Zone** could quickly become a **Hot Zone** and vice versa.
- N. **IFAK** (Individual First Aid Kit) **Minimum:**
- 2 Combat Application Tourniquets (CAT),
 - 2, 28-Fr/9.3 mm Nasopharyngeal Airways (NPA),
 - 2 Israeli bandages,
 - 2, 14-gauge decompression needle,
 - 2 – Chest Seals
 - 2 - Combat gauze,
 - Sharpie marker,
 - Triage tags,
 - Tape,
 - Multiple gloves

RESCUE TASK FORCE GUIDELINE

- O. **Leapfrog:** To move ahead of each other in turn; to advance by keeping one **RTF** in action while moving the other **RTF** past it to a position farther in front. Also referred to as bounding overwatch.
- P. **Level 1 Staging:** A *clear* staging position for EMS operations usually out of the line-of-sight of the threat.
- Q. **Level 2 Staging:** A *secure* staging position for Fire/EMS operations. Normally some distance from the event and large enough to accommodate a significant number of apparatus.
- R. **Link Up Location:** A location where the Rescue Element and the Protection Element meet up and form a Rescue Task Force.
- S. **Protective Element:** Minimum of two law enforcement officers. One of which may be the **RTF Team Leader**.
- T. **Rescue Element:** A minimum of two EMS personnel with **BPE/IFAK**. Takes direction from and provides information to the **Team Leader**.
- U. **Rescue Task Force (RTF):** A team with three elements (**Team Leader** – Law Enforcement, **Protective Element** – Law Enforcement, and **Rescue Element** – EMS). The **RTF** enters the **Warm Zone** to execute **TECC** techniques and to rapidly extricate the wounded. Although operating as one unit, the RTF may simultaneously communicate on two radio channels.
- V. **Secure (secondary):** A detailed and deliberate search of an entire area is concluded and it is safe from the suspect and from secondary devices. Law enforcement remains in the area.
- W. **Security Measures** – Any means utilized to reduce the amount of dangers or hazards to 1st responders and victims in a specific area or location. This can include, but is not limited to, cover, concealment, ballistic shields, law enforcement officers with lethal weapons, vehicles, armored vehicles, positioning, teams utilizing Protection Element, movement, etc.
- X. **Team Leader:** Directs the **RTF** maneuvers. Law enforcement individual. Team Leader receives direction from the Rescue Element with regards to medical actions necessary.
- Y. **TECC:** Tactical Emergency Casualty Care.
- Z. **Treatment Bags/Drop Bags:** Contain additional equipment and supplies capable of treating additional victims and can either be used in conjunction with or in replace of IFAK kits.

RESCUE TASK FORCE GUIDELINE

- AA. **Triage:** Standard victim sort in the *Cold Zone*. Under the direction from the Medical Group Supervisor.
- BB. **Warm Zone:** An area that is *clear, but not secure*. A *Warm Zone* could quickly become a *Hot Zone* and vice versa.

PROCEDURES

Rescue Task Force Thresholds

Prior to the deployment of a Rescue Task Force, specific thresholds must be met. These thresholds include:

- A. Injuries are being reported.
- B. An entry corridor or perimeter has been established.
- C. A warm zone has been identified.
- D. The RTF Team Leader, Protection Element and Rescue Element personnel have been identified and equipped, and have been assigned by Unified Command. All elements must be in contact with their respective command structure via radio.

Hierarchy of Response Responsibilities and Responsible Party

- A. **Stop the Shooter or Threat (Contact Teams):** Law Enforcement
- B. **Establish a Perimeter:** Law Enforcement
- C. **Protection Element:** Law Enforcement
- D. **Rescue Injured:** Based upon the circumstances and numbers of injured persons this could be either a Law Enforcement response Fire Personnel assigned to a Rescue Task Force
- E. **Staging:** Fire Personnel (Primary); Law Enforcement (Secondary)

Law Enforcement Responsibilities

Prior to the deployment of a Rescue Task Force, specific thresholds must be met. These thresholds include:

RESCUE TASK FORCE GUIDELINE

- A. **Unified Command must be established prior to deploying the RTF.** U/C may be established initially via radio but ultimately face-to-face. A shared command post should be established as soon as possible.
- B. Establish and deploy **Contact Teams** to stop the threat.
- C. Report on number of wounded
- D. Establish a **Protective Element**.
- E. Identify and establish **Entry Corridor, Warm Zone** and **Casualty Collection Point**.

Fire / EMS Responsibilities

- A. **Unified Command must be established prior to deploying the RTF.** U/C may be established initially via radio but ultimately face-to-face. A shared command post should be established as soon as possible.
- B. Establish tactical communications channel.
- C. Establish **Staging and Linkup Location**, as necessary.
- D. Verify that **Entry Corridor, Warm Zone** and **Casualty Collection Point** have been identified and established.
- E. Establish a **Rescue Element**.

Rescue Task Force (RTF) Responsibilities

- A. Conduct RTF tactical brief with the Unified Commander.
- B. Approach the **Warm Zone** through the **Entry Corridor**.
- C. Continually call out number of victims.
- D. Treat the wounded with TECC techniques and move to next victim. Repeat as necessary and evacuate when appropriate.
- E. Additional RTF's may leapfrog with RTF's already treating victim(s).

RESCUE TASK FORCE GUIDELINE

- F. Consider using the Casualty Collection Point as IFAK re-supply and as staging for evacuation equipment.
- G. Evacuate victims (this can be accomplished by the RTF or a separate EVAC Team depending on individual department procedure).
- H. The Rescue Element maintains contact with the Medical Group Supervisor or Fire Department Command/Ops.

FD Command (or Ops) Medical Group Supervisor Responsibility

- A. Brief incoming *Rescue Elements* with *Linkup Location*, *Entry Corridor* and *Warm Zone* locations.
- B. Track the *Casualty Collection Point*, if established.
- C. Receive updates from the *RTF's* in the *Warm Zone* and those waiting in the *Cold Zone*.
- D. Update the Milwaukee County EMS Communications.
- E. Prepare for re-supply of *RTF's* that may return to the Cold Zone.
- F. Prepare to send an additional *Rescue Elements* to the Linkup Location to form additional *RTF's* into the *Warm Zone* for re-supply or for *evacuation*.
- G. Establish triage, treatment and transport branches.
- H. Coordinate victim(s) removal and transport to *Cold Zone*.

Accountability/Emergency Actions

Broken Arrow Duress Signal – The term “Broken Arrow/Broken Arrow” will be announced over the radio in the event of a life threatening event such as shots fired or an IED is discovered in the immediate area of an RTF. The RTF team leader will take immediate action to protect the rescue element. This may include sheltering in place, finding additional cover/concealment, or a hasty evacuation depending on the situation.

The duress signal shall be followed with a clear text radio communication describing the situation. U/C shall perform a Personnel Accountability Report (PAR) check with each RTF. Once the situation is deemed under control, the U/C will give the command to “Resume Rescue Operations” via radio. **Accountability** – Team accountability will be managed by the respective fire or LE branches. If there is a loss of radio communication with the RTF, a LE rescue team will be sent to the last known location.

Appendix D



OAK CREEK FRANKLIN JOINT SCHOOL DISTRICT

"Treat and Go" Kits

Each "Treat and Go" Kit is contained in a sealed red pouch:



Each Kit is numbered to assist in keeping track of kit placement and expiration dates:





OAK CREEK FRANKLIN JOINT SCHOOL DISTRICT

"Treat and Go" Kits

Each Kit will include the following supplies (tutorial video links provided):

Trauma Shears

CAT Tourniquet (2)

Upper Extremity Buddy Care:

<http://www.youtube.com/watch?v=3-WnRUi5UZI>

Lower Extremity Buddy Care:

<http://www.youtube.com/watch?v=v0OeZCsyB>

One-handed Arm Application- Self Aid:

<http://www.youtube.com/watch?v=tzXNsfesUb0>

Lower Extremity- Self Aid:

<http://www.youtube.com/watch?v=LDN03FgUhxU>

HALO Chest Seal:

http://www.youtube.com/watch?v=ZcKpOI_3KR0

Quick Clot:

<http://www.youtube.com/watch?v=VxfG58lpTUg>

Israeli/ Emergency Bandage (2):

http://www.youtube.com/watch?v=S2_EU1T-o-g

Gloves and Inventory Card

Please refer questions to:

Battalion Chief Joe Pulvermacher


Oak Creek Fire Department

414-570-5629 (office)

414-349-4199 (cell)



Appendix E



Tactical Incident- Emergency Medical Response to Oak Creek K-12 Schools

Page 1 of 3

***1. In the event of a tactical emergency (school crisis), which option best describes your role?**

- Oak Creek/ Franklin School District (Administration)
- Oak Creek/ Franklin School District (Staff)
- Oak Creek/ Franklin School District (Teacher)
- Oak Creek Police Officer
- Oak Creek Firefighter
- Other (please specify)

***2. In our local school system, do you feel that a tactical incident is:**

- Imminent
- Probable/ Likely
- Possible, but not likely
- Not possible

***3. Are you aware of your organization's response procedure to tactical (crisis) incidents in a K-12 school?**

- Yes
- No

***4. If you attended the police and fire department in-service, do you have a better appreciation of your (individual) responsibilities during a tactical incident?**

- Yes
- No
- Did not attend the in-service

***5. Have you ever practiced performing your role in a simulated tactical incident using equipment/ supplies identified in your response plan?**

- Yes
- No

***6. As it pertains to your role in a tactical emergency response, do you feel:**

- Proficient in procedure and can apply necessary tasks.
- Knowledgeable about procedural details, but application is questionable.
- Aware that procedures exist, but unaware of procedural details.
- Not prepared

***7. Have you participated in a first aid program in the last two years? If not, do you know a colleague who has?**

- Yes, I have taken a first aid class.
- No, I have not. But, I know a colleague who has.
- No, I have not and I am unaware of a colleague who has.

***8. Based on your expectation, during a tactical incident, who do you believe is most likely to perform initial emergency medical treatment?**

- Bystanders/ General Population
- Police Officers
- Firefighters/ Paramedics/ EMTs

***9. In an ongoing tactical incident, if injuries were life-threatening, how soon would you expect paramedics/ EMTs to begin medical treatment?**

- Within 5 minutes
- 5 - 10 minutes
- 11 - 30 minutes
- Would not expect them within 30 minutes

10. In a brief narrative, please explain how you would expect police officers and firefighters/ paramedics to be notified of the number and location of injured victims inside the school (during an ongoing tactical incident).**11. What is the perceived response of firefighters/ paramedics in tactical (crisis) incidents?**

- They come in right away.
- They come in right after the first police officers.
- They don't come in until the police officers have confirmed scene safety.
- They don't come in at all.

***12. Who brings injured patients out of the school to be transported?**

- Police officers
- Firefighters/ paramedics
- Other (please specify)

13. In an attempt to identify best practices, provide any information you have that may improve an emergency response to a tactical (crisis) incident in a K-12 school- especially information that pertains to the rapid removal of injured patients.

Done

Appendix F



OAK CREEK FIRE DEPARTMENT
RTF Active Shooter: Time-to-Task Data Collection

Time Starts when Fire Ops arrives on scene and contacts Police IC (stopwatch starts @ 00:00)

Battalion 18 Radio Traffic on OCPD 1:

- "Police Command from Fire Ops," wait for reply...
- "We are staged on 13th & Drexel... We are assembling a Rescue Element for the Rescue Task Force... Our link-up point for the RTF will be at 13th & Willow."
- "Command, What is the status of the situation?.. Injuries?... Warm Zone?... Entry Corridor?"

Injuries Reported?	Warm Zone Established?	Entry Corridor?

Battalion 18 Radio Traffic on MABAS Red:

- "Oak Creek (Engine 1, Med 181, etc), your crew will assemble for the RTF"
- "Donn ballistic protection and meet OCPD at the link-up point on 13th & Willow"
- "Your will be designated RTF #____"

TASK	RTF #1	RTF #2	RTF #3
FD Donned BPE/ Grabbed Kit			
@ Link-up Point			
RTF Formed: Rescue/Protection			

ACCOUNTABILITY	RTF #1	RTF #2	RTF #3
Police Officers			
Firefighters			

Battalion 18 Radio Traffic on OCPD 1:

- "Command from Fire Ops"... wait for reply...
- "RTF#____ is assembled. I will have a another rescue element available shortly."

TASK	RTF #1	RTF #2	RTF #3
Patient #1 Contact/ Treatment (Outside)			
Evac Patient #1 VAN / CCP			
Patient #1 @ Medical Group			

Enter Building/ Warm Zone			
---------------------------	--	--	--

Patient #2 Contact/ Treatment (Inside)			
Evac Patient #2 VAN / CCP			
Patient #2 @ Medical Group			

Patient #3 Contact/ Treatment (Inside)			
Evac Patient #3 VAN / CCP			
Patient #3 @ Medical Group			

Patient #4 Contact/ Treatment (Inside)			
Evac Patient #4 VAN / CCP			
Patient #4 @ Medical Group			

Notes:

When all RTF are accounted for with PAR... Time Ends.

Ending Time: _____

Appendix G



OAK CREEK FIRE DEPARTMENT

RTF Active Shooter: Pre-Training Feedback Instrument

You have been asked to participate in this training evolution- based on your experience in active shooter incidents/ tactical environments. Please answer the following questions to give insight to your observations/ impressions.

1) As it pertains to your role in a tactical emergency response, do you feel:

<input type="checkbox"/> Proficient in procedure and can apply necessary tasks
<input type="checkbox"/> Knowledgeable about procedural details
<input type="checkbox"/> Aware that procedures exist, but unaware of procedural details
<input type="checkbox"/> Not prepared

2) What is your greatest concern about responding to an active shooter incident?

3) Based on your real-life observations, did police officers and firefighters have shared priorities/ direction during the incident?

<input type="checkbox"/> Yes
<input type="checkbox"/> No
If "No", explain:

Please feel free to provide more information on the back of this form.

Appendix H



OAK CREEK FIRE DEPARTMENT

RTF Active Shooter: Post-Training Feedback Instrument

Now that you have participated in joint Police/Fire training. Please answer the following questions to give insight to your observations/ impressions.

1) As it pertains to your role in a tactical emergency response, do you feel:

<input type="checkbox"/> Proficient in procedure and can apply necessary tasks
<input type="checkbox"/> Knowledgeable about procedural details
<input type="checkbox"/> Aware that procedures exist, but unaware of procedural details
<input type="checkbox"/> Not prepared

2) Did today's training address your concerns about responding to an active shooter incident?

<input type="checkbox"/> Yes
<input type="checkbox"/> No
If "No", what can OCFD do to address this?:

3) Based on today's training, do police officers and firefighters have shared priorities/ direction during an active shooter incident?

<input type="checkbox"/> Yes
<input type="checkbox"/> No
If "No", explain:

Feel free to provide more information on the back of this form.

Appendix I



OAK CREEK FIRE DEPARTMENT
Lesson Plan

Active Shooter: Rescue Task Force
Page 1 of 5

Rescue Task Force: Joint (Police & Fire) Training

Session Reference: 1

Topic: Active Shooter- Rescue Task Force **FireHouse Category #:** ### ###

Level of Instruction: Intermediate **Time Required:** 3 - 4 Hours

Materials:

- Full BPE (Vest/ Helmet)
- IFAK- With training Supplies (TQ, Israeli, Combat Gauze)
- Webbing, Soft Stretches
- Drop Kit
- Fire Department Portable Radio(s)
- Police Department Portable Radios(s)
- Manikins, Treatment Training Adjuncts
- Role Players (if available)
- Police Officers (with training weapons)

Training Environment:

- Acquired Structure (School, Commercial, Industrial, Assembly)
- Police Station and Fire Station (for initial and follow-up training)

References:

- Hartford Consensus II
- USFA Active Shooter Guidelines
- IAFF, IAFC Position Statement
- OCFD Policy 303.902 Tactical Incident Response Hierarchy
- OCFD Procedure 303.903 Tactical Mass Casualty Response
- OCFD Checklist 303.903.01

PREPARATION:

Motivation: Emergency medical care in the tactical environment is going to be contingent on the skills and ability of Firefighters and Police Officers. Law enforcement and firefighters must work together under a collaborative action plan. Incident priorities (for both departments) must be considered during the response. Firefighters must understand that they will be working in an environment that is less-than-safe and Police officers must do whatever is possible to reduce the risk for unnamed emergency responders.

Everyone will benefit when duties are performed based on the strengths of responders. OCFD is best at providing emergency medical care; while OCPD is best at providing scene protection and de-escalation.



Objective: This training evolution will reinforce the benefits of a rescue task force during an active shooter incident. Using information learned through active shooter incidents in the City of Oak Creek and evaluating data through published case studies, OCFD and OCPD have authored policy and procedure that reflect common incident priorities. The objective of this training is to provide an opportunity to apply those concepts.

At the end of this training, firefighters will have accomplished the following:

1. Practiced incident command with police department
2. Established communication with OCPD incident command
3. Established staging and link-up locations
4. Assembled as an RTF
 - a. Verified the report of injuries
 - b. Verified an entry corridor
 - c. Verified a warm zone
 - d. Linked up with a protection element
5. Moved into the warm zone as an RTF
6. Determined the location and importance of the Casualty Collection Point (CCP)
7. Assessed the injured
8. Treated the injured
9. Evacuated the injured

Overview:

Given statistics from 2000 – 2012, the median number of injured: dead in an active shooter incident is 4:2. Training will reflect those statistics.

Given the high probability that injured will meet emergency responders outside of the warm zone (i.e. Columbine, Aurora, Sikh), ballistic protection will be maintained on fire apparatus (engines and trucks), medical apparatus (ambulances), and command vehicles (Battalion Chief's car, Command Post). That will allow the fire department to provide a rescue element to the rescue task force- even if the ambulance is dedicated to patient care upon their arrival.

This exercise will involve three RTFs (RTF1, RTF2, RTF3). All three RTFs will have the capability to treat or evac patients. It is preferred that the first RTF treat- move- treat.

1. Incident Command/ Communication

- A. Battalion 18
 1. Will be placed en-route over OCFD-1 (primary fire dispatch)
 2. Will contact OCPD incident command on OCPD -1 (primary police dispatch)
 - a. Attempt to get response information.
 - b. Establish the initial staging location.
 - c. Communicate rescue capabilities (rescue element for RTF).
 - d. Provide/ Get information about link-up point
 3. Monitor OCPD-1 for further information/ incident details.
 4. Initially communicate on OCFD-1 to fire department personnel
 5. Switch to a tactical channel (MABAS RED) for on-scene communication.



- B. OCFD Fire and EMS- Company level communications
 - 1. Initially communicate on OCFD-1 (while enroute, and initial scene communications).
 - 2. Once all OCFD personnel have arrived on scene, communications will be switched to the tactical channel.

- C. Mutual Aid Companies
 - 1. Respond in on IFERN.
 - 2. Staged on IFERN
 - 3. Once assigned to an incident task, communications will be conducted on tactical channel.
 - * Mutual Aid Companies/ Command Staff will likely function in the Medical Group Roles
 - a. Medical Group Supervisor
 - b. Triage
 - c. Treatment
 - d. Transport

- D. RTF Communications
 - 1. OCFD/ Rescue Element = MABAS Tactical Channel
 - a. Communicate with Fire Ops
 - 2. OCPD/ Protection Element = OCPD1 primary dispatch
 - a. Communicate with Incident Command
 - 3. Information will always be available to the RTF- regardless of the transmission.

- E. Incident Benchmarking
 - 1. RTF Accountability (Firefighters/ OCFD Unit/ Police Officers)
 - a. "Oak Creek Engine 1 will be RTF1 with Officer Smith and Officer Jones"
 - b. OCPD does not have passport tags, so identification is helpful for accountability.
 - 2. RTF Movement
 - 3. RTF Entry
 - a. Number of RTF members Minimum report
 - b. Side of Building
"Command, Oak Creek Engine 1 will be RTF1- entering with two firefighters and two officers on the Alpha side."
 - c. Task Additional information may include
 - d. Incident Info
"We have been assigned to patient treatment- patient reported in room 102"
 - 4. Patient Contact- CAN Report
 - a. **Conditions**- "RTF1 Found one patient in room 102..."
 - b. **Actions** "Treating with a tourniquet- bleeding controlled. Patient has been moved close to the door in room 102..."
 - c. **Needs** "Send in another RTF for evac."



5. Patient Treatment
 - a. Treat patient according to injury
 - i. Major bleeding/ arterial = Tourniquet
 - ii. Moderate bleeding/ venous = Israeli Bandage
 - iii. Minor bleeding/ controlled = may not require any management.
 6. Patient Evac
 - a. "RTF2 has made contact with the patient in room 102"
 - b. "RTF2 will evac patient to the CCP (Van)"
 - c. Provide a heads-up for the Medical Group when patients are being evacuated to the cold zone. "Patient(s) are being moved from the CCP to the medical group/ triage"
- 2. Staging and Link-Up Locations**
- B. OCFD Battalion Chief will assist with the identification/ location of staging
 1. ODFD Staging
 - a. Crews remain together
 - b. Apparatus is available for assignment
 2. OCPD Staging
 - a. Fire Ops will assist with the identification/ location
 - b. Officers will likely NOT stay with the vehicle
 - c. Vehicles are parked and not easily moved
 - d. Police Department Incident Command should assign a law enforcement supervisor to coordinate police staging once a location has been identified.
 3. Fire Department and Police Department Staging should not be co-located.
 - C. Link-Up Location
 1. Provides a location for the rescue element to link-up with the protection element and form a RTF.
 2. Should be done close to the "Cold Zone" out of the line-of-site of the warm zone.
 3. Fire Ops and Incident Command should be advised about the RTF's status/ movement.
- 3. Incident Threshold Verification-** Fire Ops should verify the following:
- A. Injuries Reported
 - B. Warm Zone Established
 - C. Entry Corridor Identified (Perimeter)
 - D. Protection Element available for Rescue Task Force
 - E. CCP location (if available)

**4. Casualty Collection Point**

- A. Used to collect patients when transport is not immediately available
 1. Additional RTFs can be sent to this location to assist with patient care.
 2. An RTF supervisor (Chief) should be sent to this location if span of control is questionable (multiple RTFs operating).
- B. Safe Haven/ Place of Refuge
 1. This area will be cleared and secured.
 2. Will act as an immediate collection point for unarmed responders who may need to be sheltered in-place
 3. Will be one of the last areas vacated during a controlled disengagement.
- C. Resupply point.
 1. Drop bags/ additional supplies will be brought to the CCP.
 - a. Used to treat patients in the CCP
 - b. Used to resupply RTFs working in the "warm zone"
 2. Drop bags must be marked with "RESCUE" or other fire department identifier to prevent the bag from being mistaken as an IED.

Review:

This training should provide Oak Creek Firefighters with the following training opportunities:

- ICS/ NIMS
- Communications
- Staging
- RTF Thresholds
- Warm Zone
- Team Movement
- Assessment/ Treatment/ Evacuation
- Casualty Collection Point (CCP)

Instructors Comments:

EVALUATION:

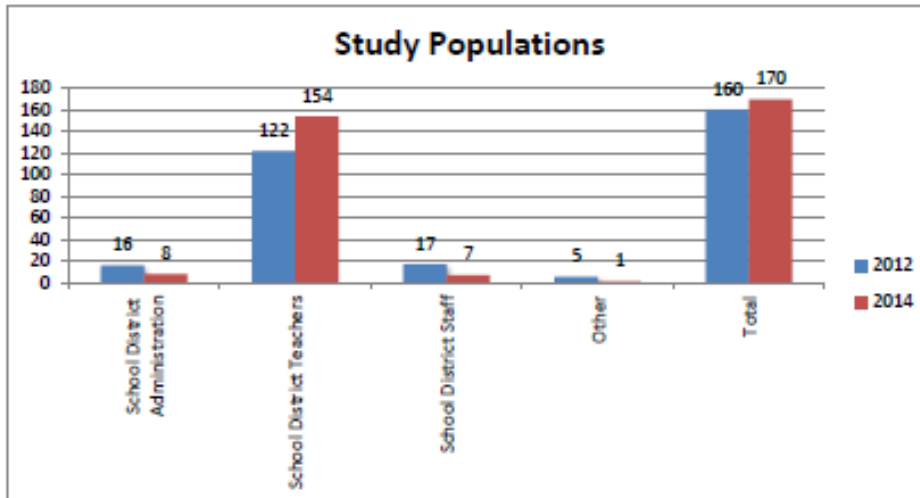
- This exercise will reinforce RTF Operations in a tactical environment.
- Forward comments and suggestions to the Training BC.

Appendix J

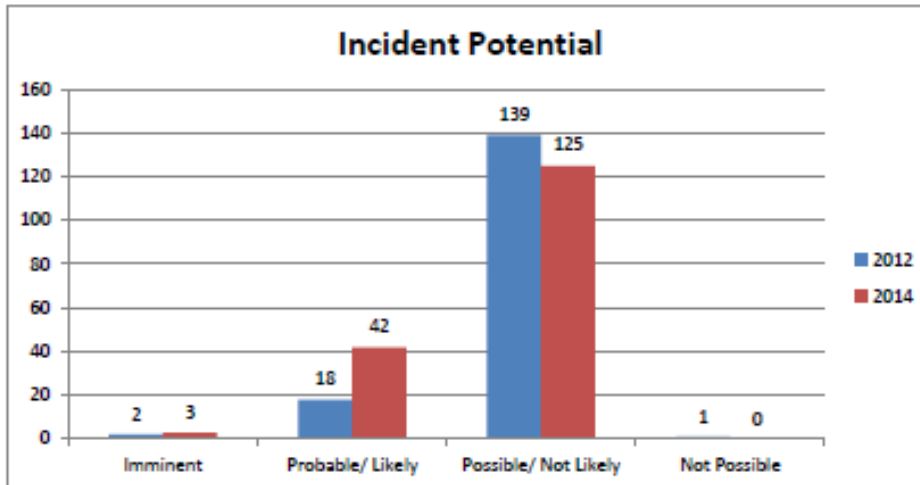


OAK CREEK FIRE DEPARTMENT
K-12 School Tactical Mass Casualty Feedback Instrument Results

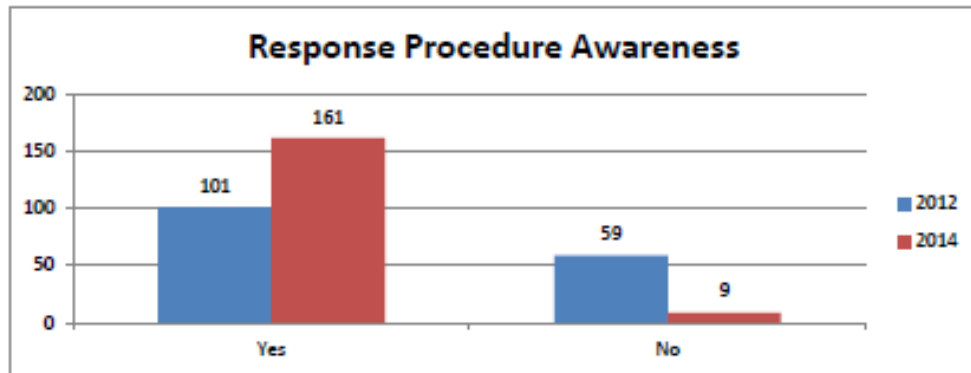
1) In the event of a tactical emergency (school crisis), which option best describes your role?



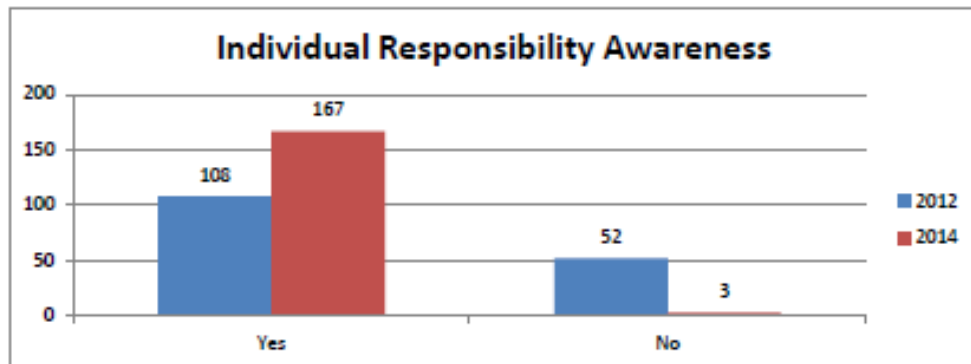
2) In our local school system, do you feel that a tactical incident is:



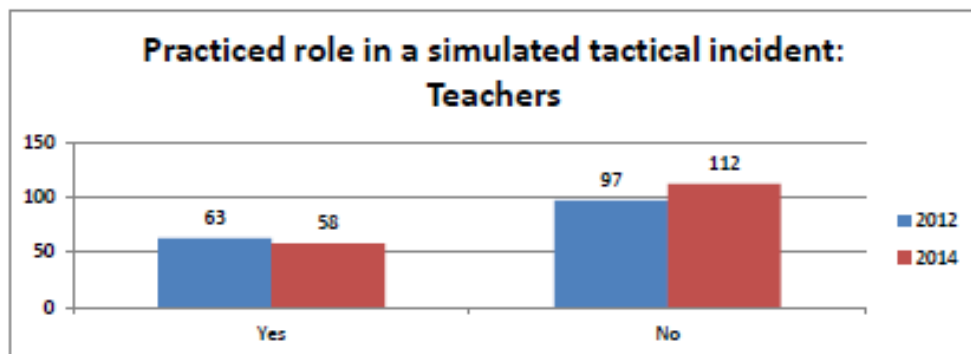
3) Are you aware of your organizations response procedure?



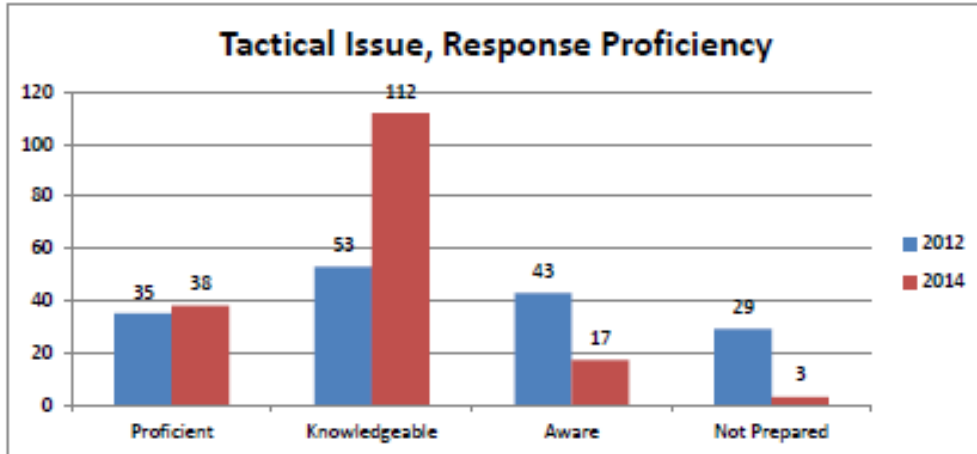
4) Do you know what your (individual) responsibilities are in a tactical incident ?



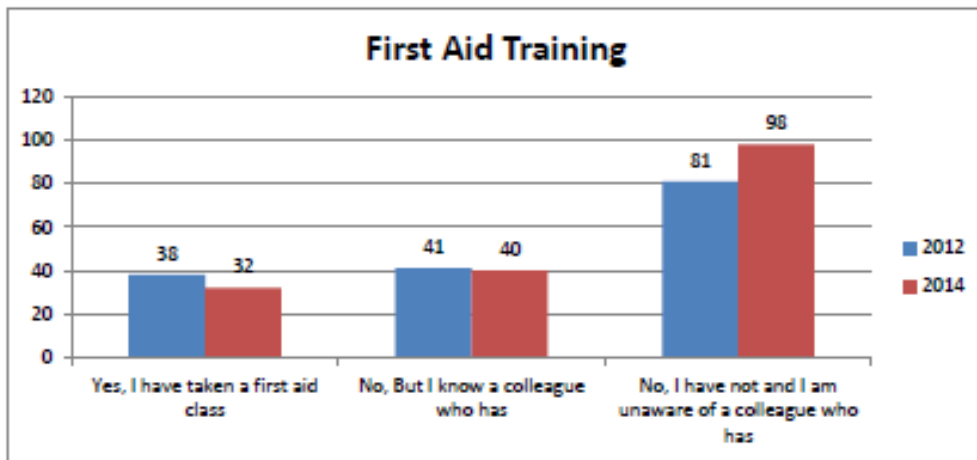
5) Have you ever practiced performing your role in a simulated tactical incident using equipment/ supplies identified in your response plan?



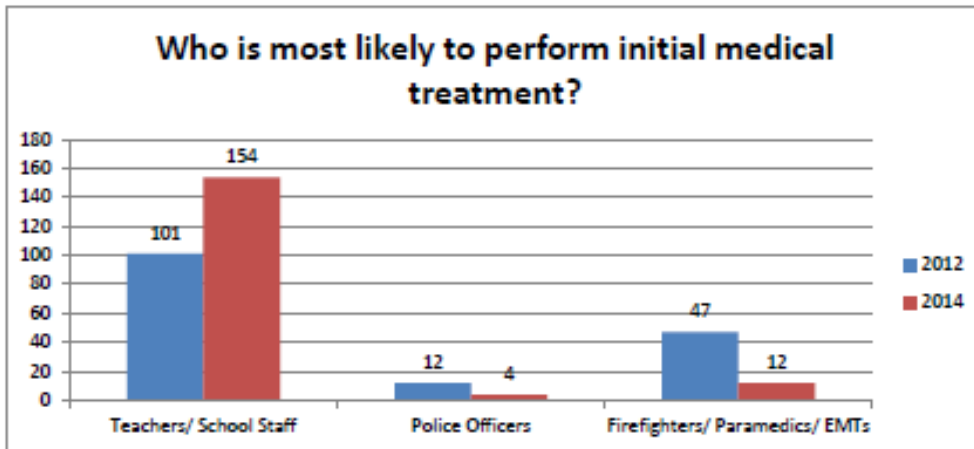
6) As it pertains to your role in a tactical emergency response, do you feel:



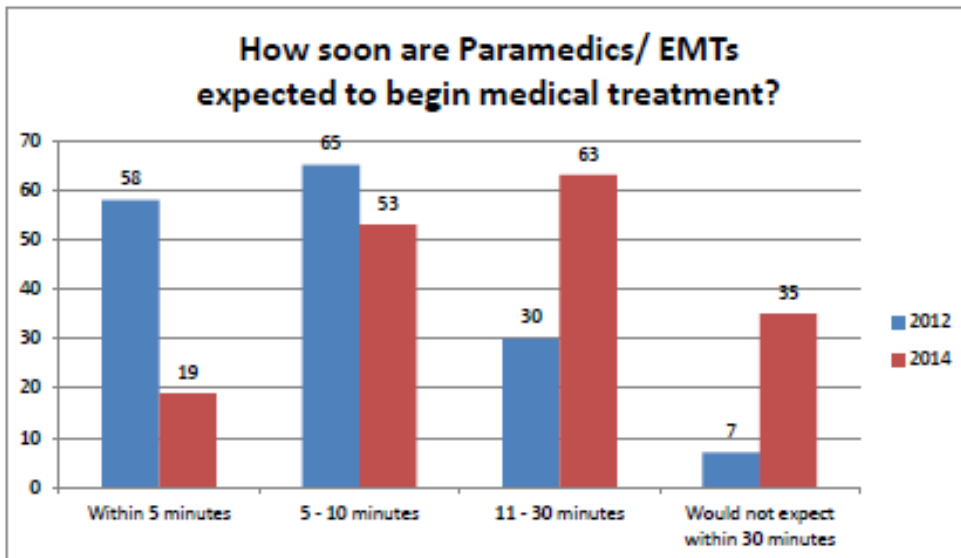
7) Have you participated in a formal first aid program in the last two years? If not, do you know a colleague who has?



8) Based on your expectation, during a tactical incident, who do you believe is most likely to perform initial emergency medical treatment?



9) In an ongoing tactical incident, if injuries were life-threatening, how soon would you expect paramedics/ EMSs to begin medical treatment?

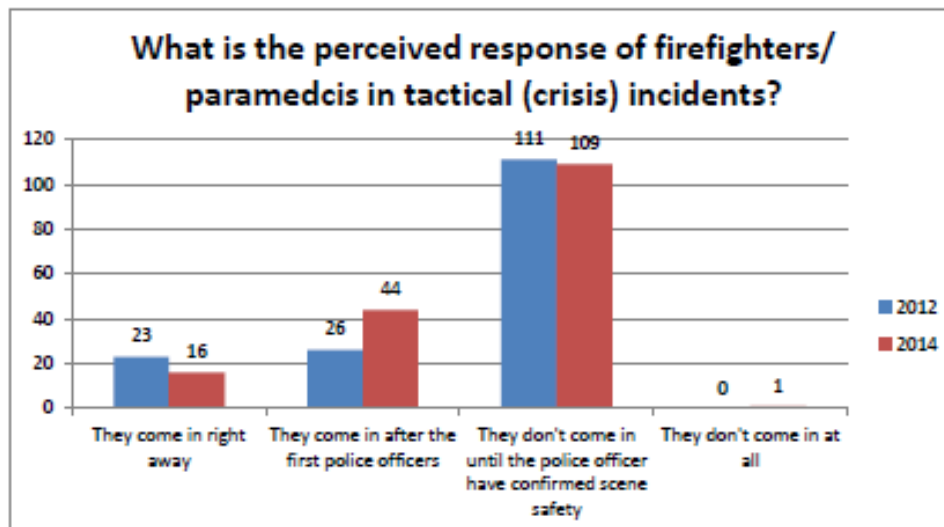


10) In a brief narrative, please explain how you would expect police officer and firefighters/ paramedics to be notified of the number and location of injured victims inside the school (during an ongoing tactical incident).

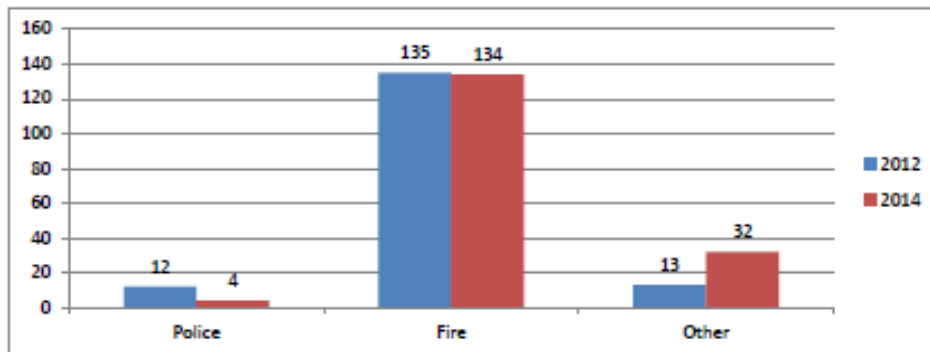
	OCFJSD
People in building/ Exiting building	41
Phone/ 911	86
Walkie Talkies	5
Text Message	2
Responders/ SWAT/ Fire	13
Not Sure	16
Misc	16

Responses were summarized. Total number of responses to question #10 outnumber the total number of feedback instruments received (some respondents provided more than one answer to this question).

11) What is the perceived response of firefighters/ paramedics in tactical (crisis) incidents?



12) Who brings injured patients out of the school to be transported?



Whoever can safely get them out first.
ANyone who can with directive from law enforcement/paramedics
Firefighters/paramedics or other in the building, once the situation is safe
firefighters/ paramedics, staff
Firefighters/paramedics, unless it's a light injury.
If the person is moveable, anyone capable of doing so.
Anyone. If during the crisis we can get out, we will. We should not wait.
Anyone who is able to help, once the scene is safe, unless it is a severe injury, then I would assume that trained personnel would
general population able to find safe exit from the building
Initially those who are in care of the students at the time and then the police, firefighter, etc.
firefighters and paramedics are the best, however whomever is able may have to aid and is situation specific
If victim is unable to walk I would wait for paramedics, but if victim can walk, I would escort out
Could be a combination.
anyone who is able
In a tactical incident I believe it would be police, fire and even staff members whomever can help if a tragedy.
whomever is in a position to do so, could be bystanders, EMT, firefighters, concerted effort together
Anyone willing.
whoever is able!
police officers, firefighters, paramedics, and anyone else who is told to do so
Anyone available to help once location is secured
Could be both, depending on the situation.
Anyone who is capable of transporting injured patients away from the crisis, not just police and fire.
Other victims/ bystanders and/or firefighters/paramedics and police after scene is safe.
If the person is able to walk I would guess anyone could help transport them to the ambulances
Its possible it could be anyone able to get them to safety.
Once the scene is secure, firefighters and paramedics. If it can be done sooner then a bystander may be able to assist getting the injured out of the building.
Anyone able to help
Anyone who is uninjured would bring patients out of school.
any trained responder
whoever can safely get them out first
Anybody, once the threat has been neutralized or they have a safe mode of egress.
Anyone who is in a position to get victims out

13) In an attempt to identify best practices, provide any information you have that may improve an emergency response to a tactical (crisis) incident in a K-12 school- especial information that pertains to the rapid removal of injured patients.

There needs to be training offered for teachers that goes above and beyond any control the administration controls.
Review/training of procedures at each building at start or each school year. We have many new staff/admin who will not have been trained.
The main thing would be that everyone involved is in the safest environment possible. Also, try your best to remain as calm as possible so that others may not panic as much.
First aid training
I think the most confusing part is knowing when it is "safe" to open your door to allow in emergency personnel that might be outside. How do we know it's not a trick by the suspect? This could certainly slow down the removal of the injured.
Remove all non-injured students and staff as quickly as possible to get rid of the overcrowding. The high school is over capacity, which will make responding to an incident more difficult and make the teacher's role as first responder more difficult. Providing some sort of communication between the classrooms and the tactical team to help us know when to release uninjured students would be helpful.
Talk with kids about this and what to do. There will be more of them than us (adults). They need to be mentally prepared for what to do.
A school wide communication plan such as walkie-talkies, that police/paramedics can easily be brought into in the case of an emergency. They would allow us to communicate the location of an intruder, and also the location of injured. Our current speaker system would not be beneficial in the event of an intruder. it takes a few moments for messages to be sent out, and there are only a few people in the school that know how to operate it. The way our school is setup, some classrooms would not know anything was going on until it was outside their door.
It might be feasible to have a specified medical person traveling with the Swat-like team whose role is to assess the medical needs and coordinate medical treatment/removal from the inside. That leave the assessment of safety and removal of shooter/criminal to the Swat people.
We need a better way to communicate throughout the school. Other than if someone who is in the office could communicate between classrooms, the only other way to communicate would be for the teachers to email each other or call/text using our personal cell phones (again if we are able cell phone service in the building).
My classroom has a door to the outside and is also adjacent to the basement storage area which has an elevator. Particulars such as these should be noted on layout maps police/fire have of each school building.
It would be helpful to be able to work with the SRO's to put together specific classroom action plans. This has been requested several times; however, the SRO's were not allowed by the building principal to do this. The teacher was asked by the building principal to put their own plan together and then a discussion would be had. The teacher put the plan with questions together and was not provided with SRO support. When SRO's were asked, the teacher was told that the building principal had to give permission.
CPR and First Aid trained staff. Having 1 or more designated meeting places outside of the building if leaving the building is a necessity. Communication between staff that does not involve paging the front office.
Not expecting police to provide care to the injured, but attempting to do it while we wait for emergency personnel.
To get as far away of the intruders as quickly as possible.
They don't go until scene is secure, if we have kits by then we must use them to help injured people
Involve support staff (secretaries, instructional aides, custodians) in future training. Our support staff was not invited to that meeting. We greatly appreciate the training we've gotten but, if we have a question, I don't understand why it can't be asked and answered.
I would like assistance determining the best "escape" route in my area of the school.
Continued practice.
I truly feel doing a simulation of a tragic event would be beneficial so all staff could see the process in practice and then discuss it with each other.

I think it would be good to practice the part about injured people and the treatment in a mock situation. We have practiced lockdowns in different times of day and locations but the treatment of injured and movement is something that is not as clear as what should be done and how to notify of injured
Evening the "playing field" for teachers. (I feel like a sitting duck)
Not sure. I assume you've been through the schools many times to get a feel for the layout???On another note: I would like repeat in-services on the treat and go kits that you gave earlier in the year. Time erases a lot in an overloaded brain!
Please continue to train us. One in-service is not enough. We need more practice!
The training that we received this year, was helpful. We have staff turnover every year, so I would suggest having the training on-going and repeated every year. Hearing the gun shots within our school buildings was unvarying, but SHOULD CONTINUE every year. It was eye opening to hear how "normal" it could sound within a loud hallway or busy school. The more we are exposed to those situations as a staff, the better we will be to handle ourselves in a real situation. Thank you for your willingness to work with us to prepare our schools.
Consider removal through class windows.
Specific spots in the surrounding areas should be identified as go to zones. Armory, Edgewood, Community Center, etc. Also, teachers don't know the door numbers--we never needed to--this should be common knowledge, so we can identify our position and the position of the known assailants. I think more individuals in our building need to "what if" their classrooms so they don't freeze or have students as sitting ducks in the corner. Thank you for moving this forward and please continue to push training in our building. Please feel free to contact me for in school support.
I would encourage/remind staff to regularly evaluate the different settings that they are in throughout the day and think about how they would respond if a crisis occurred while they were in that setting.
Having first aid and CPR, etc. training would help. Yearly review of the training with dummies to put on/use the emergency kits would be helpful.
We need to practice "Lock Down" drills in every area of the school day - lunch, recess, passing time, class time, dismissal, etc. Thanks so much for the training!! We really learned a lot!
Having officers/paramedics/firefighters become very familiar with the layout of each school building (knowing where all the exits, hallways, rooms, etc. are located) as well as multiple ways of escape from each location.
Practice! Additional trainings in our own buildings.
When and How will we know the area is secure and okay to be moving around and helping others if needed? What kind of communication type will be used to notify us of the actual attack and/or the okay signal after things are secure?
As a teacher, I do not feel any more prepared in the use of the kits or in any type of first aid training. Also, I am still very unclear about what procedures should really be followed in an emergency tactical situation because the new training seemed to conflict with prior training and procedures we were told. More final communication and clarification between school administration and authorities on classroom procedures in a crisis situation.
If individuals have specific questions about how to leave from their area (office,etc), could we ask questions and get specific answers?
You Tube Israeli Tactical training in schools. Their counter-terrorism is a daily threat and high occurrence. Good ideas.
hands in the air
If something dangerous were to happen in the school, and then it was resolved (i.e. there was no longer a threat in the building), it would be beneficial to make an announcement so that everyone would know. They could be asked to have a student stand by the door to wait for a paramedic if there is someone injured inside that particular room.
Could each school designate a couple areas that would be good locations to go with injured patients?
Hands on practice with "injured" patients
Possible camera placement in buildings
The sooner we get the "all clear", the sooner we can remove the injured -- so clear communication is important.

Appendix K



OAK CREEK FIRE DEPARTMENT
RTF Active Shooter: Time-to-Task Data Collection

05:03

Time Starts when Fire Ops arrives on scene and contacts Police IC (stopwatch starts @ 00:00)

Battalion 18 Radio Traffic on OCPD 1:

- "Police Command from Fire Ops," wait for reply...
- "We are staged on 13th & Drexel... We are assembling a Rescue Element for the Rescue Task Force... Our link-up point for the RTF will be at 13th & Willow."
- "Command, What is the status of the situation?.. Injuries?... Warm Zone?... Entry Corridor?"

Injuries Reported?	Warm Zone Established?	Entry Corridor?
✓	✓	✓

Battalion 18 Radio Traffic on MABAS Red:

- "Oak Creek (Engine 1, Med 181, etc), your crew will assemble for the RTF"
- "Donn ballistic protection and meet OCPD at the link-up point on 13th & Willow"
- "Your will be designated RTF # ____...."

TASK	RTF #1	RTF #2	RTF #3
FD Donned BPE/ Grabbed Kit	00:47	00:50	
@ Link-up Point	01:32	01:32	NO ENTRY
RTF Formed: Rescue/Protection	02:31	05:06	1

ACCOUNTABILITY	RTF #1	RTF #2	RTF #3
Police Officers	2	2	
Firefighters	ENG 3 ⁽²⁾	ENG 2 ⁽²⁾	ENG 1 ⁽²⁾

Battalion 18 Radio Traffic on OCPD 1:

- "Command from Fire Ops"... wait for reply...
- "RTF# ____ is assembled. I will have a another rescue element available shortly."

TASK	RTF #1	RTF #2	RTF #3
Patient #1 Contact/ Treatment (Outside)	02:47		
Evac Patient #1 <i>(VAN)</i> / CCP	03:36		
Patient #1 @ Medical Group	04:26		

Enter Building/ Warm Zone	03:57		
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Patient #2 Contact/ Treatment (Inside)	04:32		
Evac Patient #2 <i>(VAN)</i> / CCP	06:59		
Patient #2 @ Medical Group	08:03		

Patient #3 Contact/ Treatment (Inside)	05:47		
Evac Patient #3 <i>(VAN)</i> / CCP	06:59		
Patient #3 @ Medical Group	08:03		

Patient #4 Contact/ Treatment (Inside)	05:47		
Evac Patient #4 <i>(VAN)</i> / CCP		07:47	
Patient #4 @ Medical Group		08:03	

Notes:

When all RTF are accounted for with PAR... Time Ends.

Ending Time: 08:03



OAK CREEK FIRE DEPARTMENT
RTF Active Shooter: Time-to-Task Data Collection

2
07:32

Time Starts when Fire Ops arrives on scene and contacts Police IC (stopwatch starts @ 00:00)

Battalion 18 Radio Traffic on OCPD 1:

- "Police Command from Fire Ops," wait for reply...
- "We are staged on 13th & Drexel... We are assembling a Rescue Element for the Rescue Task Force... Our link-up point for the RTF will be at 13th & Willow."
- "Command, What is the status of the situation?... Injuries?... Warm Zone?... Entry Corridor?"

Injuries Reported?	Warm Zone Established?	Entry Corridor?
✓	✓	✓

Battalion 18 Radio Traffic on MABAS Red:

- "Oak Creek (Engine 1, Med 181, etc), your crew will assemble for the RTF"
- "Donn ballistic protection and meet OCPD at the link-up point on 13th & Willow"
- "Your will be designated RTF #____..."

TASK	RTF #1	RTF #2	RTF #3
FD Donned BPE/ Grabbed Kit	00:42	00:42	
@ Link-up Point	01:24	01:24	NO ENTRY ✓
RTF Formed: Rescue/Protection	02:20	04:51	

ACCOUNTABILITY	RTF #1	RTF #2	RTF #3
Police Officers	2	2	
Firefighters	ENG 2 ^②	ENG 1 ^②	ENG 3 ^②

Battalion 18 Radio Traffic on OCPD 1:

- "Command from Fire Ops"... wait for reply...
- "RTF#____ is assembled. I will have a another rescue element available shortly."

TASK	RTF #1	RTF #2	RTF #3
Patient #1 Contact/ Treatment (Outside)	02:41		
Evac Patient #1 <u>VAN</u> / CCP	03:33		
Patient #1 @ Medical Group	04:12		

Enter Building/ Warm Zone	03:52		
---------------------------	-------	--	--

Patient #2 Contact/ Treatment (Inside)	04:07		
Evac Patient #2 <u>VAN</u> / CCP		06:50	
Patient #2 @ Medical Group		07:32	

Patient #3 Contact/ Treatment (Inside)	05:30		
Evac Patient #3 <u>VAN</u> / CCP	06:50		
Patient #3 @ Medical Group	07:32		

Patient #4 Contact/ Treatment (Inside)		05:42	
Evac Patient #4 <u>VAN</u> / CCP		06:50	
Patient #4 @ Medical Group		07:32	

Notes:

When all RTF are accounted for with PAR... Time Ends.

Ending Time: 07:32



OAK CREEK FIRE DEPARTMENT
RTF Active Shooter: Time-to-Task Data Collection

3
07/29

Time Starts when Fire Ops arrives on scene and contacts Police IC (stopwatch starts @ 00:00)

Battalion 18 Radio Traffic on OCPD 1:

- "Police Command from Fire Ops," wait for reply...
- "We are staged on 13th & Drexel... We are assembling a Rescue Element for the Rescue Task Force... Our link-up point for the RTF will be at 13th & Willow."
- "Command, What is the status of the situation?.. Injuries?... Warm Zone?... Entry Corridor?"

Injuries Reported?	Warm Zone Established?	Entry Corridor?
✓	✓	✓

Battalion 18 Radio Traffic on MABAS Red:

- "Oak Creek (Engine 1, Med 181, etc), your crew will assemble for the RTF"
- "Donn ballistic protection and meet OCPD at the link-up point on 13th & Willow"
- "Your will be designated RTF #____"

TASK	RTF #1	RTF #2	RTF #3
FD Donned BPE/ Grabbed Kit	00:30	00:50	
@ Link-up Point	01:13	01:13	NO ENTRY
RTF Formed: Rescue/Protection	02:03	04:30	/

ACCOUNTABILITY	RTF #1	RTF #2	RTF #3
Police Officers	2	2	
Firefighters	ENG 1 ^②	ENG 3 ^②	ENG 2 ^②

Battalion 18 Radio Traffic on OCPD 1:

- "Command from Fire Ops"... wait for reply...
- "RTF#___ is assembled. I will have a another rescue element available shortly."

TASK	RTF #1	RTF #2	RTF #3
Patient #1 Contact/ Treatment (Outside)	02:30		
Evac Patient #1 (VAN) / CCP	03:24		
Patient #1 @ Medical Group	04:04		

Enter Building/ Warm Zone	03:35		
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Patient #2 Contact/ Treatment (Inside)	03:50		
Evac Patient #2 (VAN) / CCP		06:45	
Patient #2 @ Medical Group		07:14	

Patient #3 Contact/ Treatment (Inside)		05:12	
Evac Patient #3 (VAN) / CCP		06:45	
Patient #3 @ Medical Group		07:14	

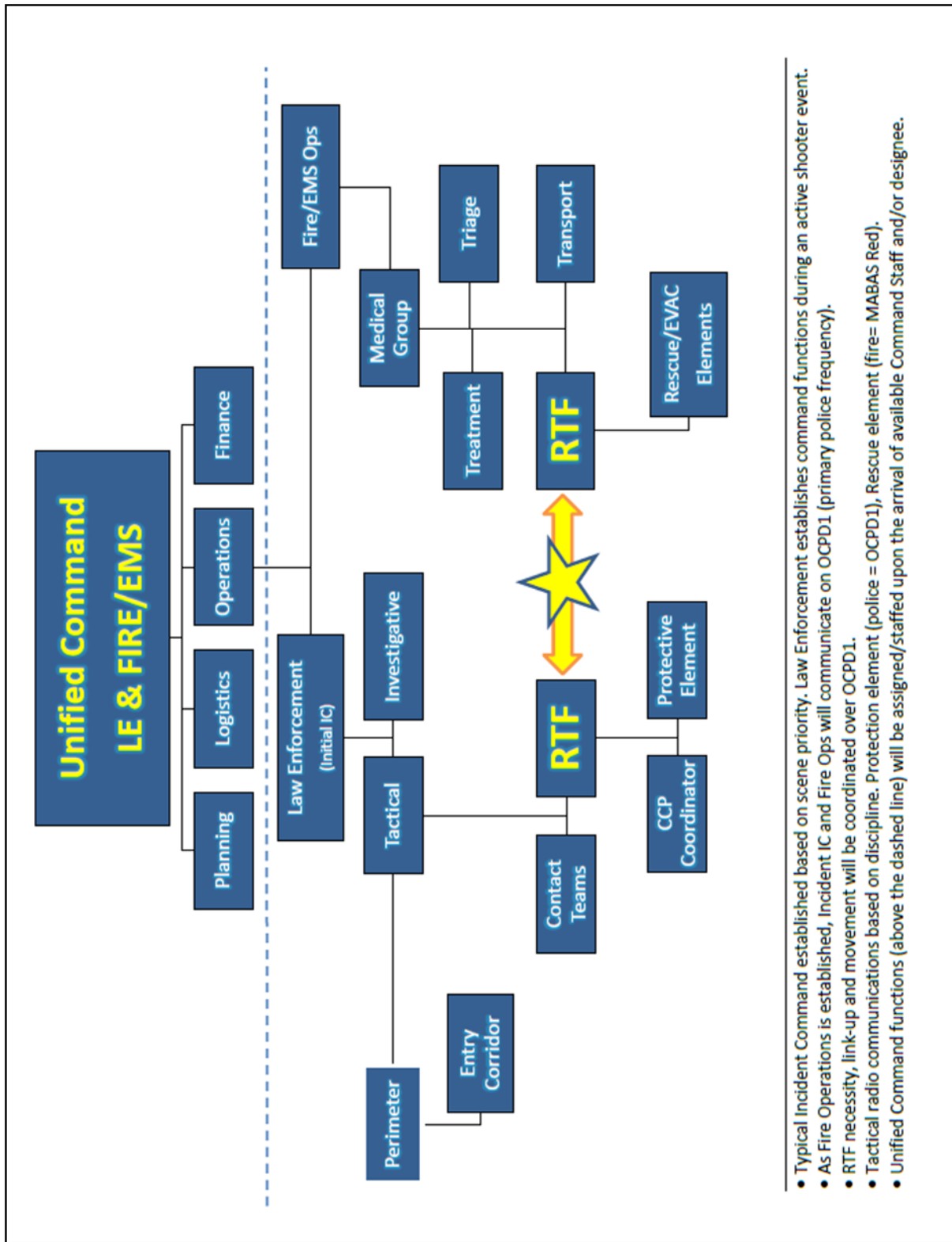
Patient #4 Contact/ Treatment (Inside)		05:12	
Evac Patient #4 (VAN) / CCP	06:45		
Patient #4 @ Medical Group	07:14		

Notes:

When all RTF are accounted for with PAR... Time Ends.

Ending Time: 07:29

Appendix L



- Typical Incident Command established based on scene priority. Law Enforcement establishes command functions during an active shooter event.
- As Fire Operations is established, Incident IC and Fire Ops will communicate on OCPD1 (primary police frequency).
- RTF necessity, link-up and movement will be coordinated over OCPD1.
- Tactical radio communications based on discipline. Protection element (police = OCPD1), Rescue element (fire= MABAS Red).
- Unified Command functions (above the dashed line) will be assigned/staffed upon the arrival of available Command Staff and/or designee.

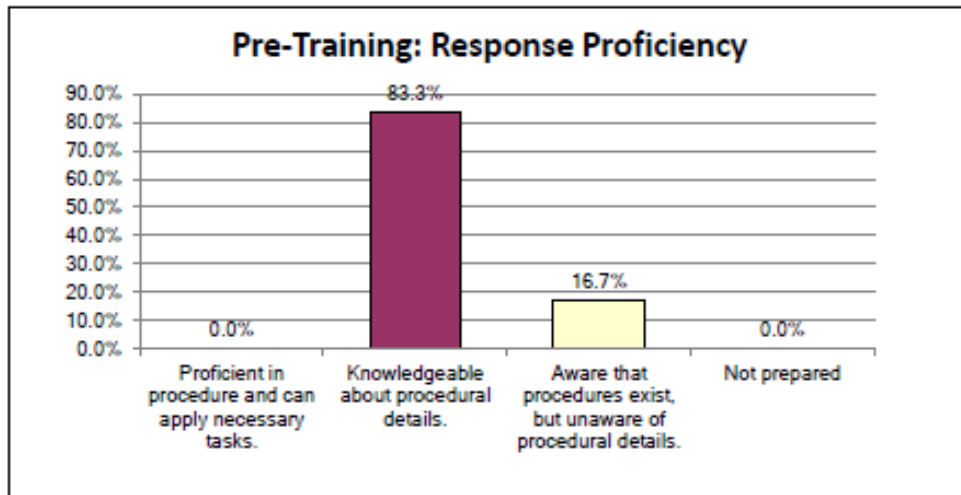
Appendix M



OAK CREEK FIRE DEPARTMENT
RTF Active Shooter: Pre-Training Feedback Results

You have been asked to participate in this training evolution- based on your experience in active shooter incidents/ tactical environments. Please answer the following questions to give insight to your observations/ impressions.

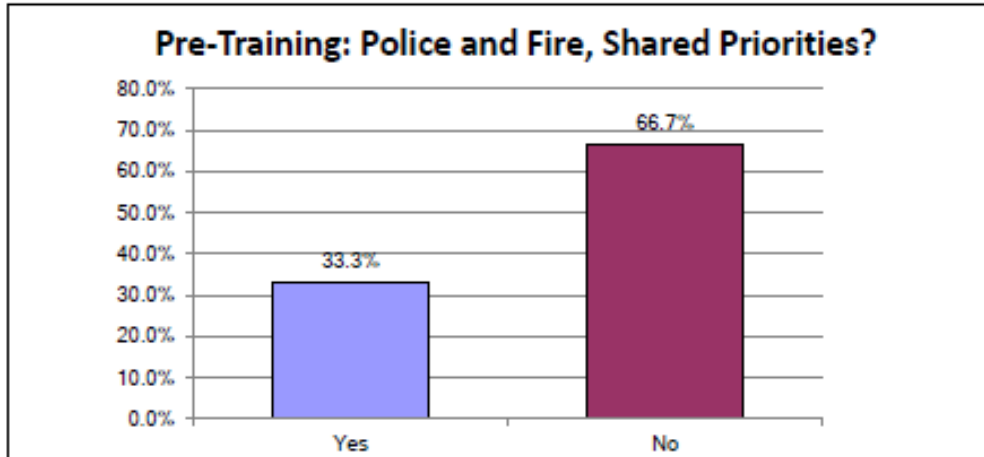
1) As it pertains to your role in a tactical emergency response, do you feel:



2) What is your greatest concern about responding to an active shooter incident?

Being brought into and or left in an area where we are left exposed or unprotected. Put differently, being led into an area we shouldn't be in with the possibility of being left without protection.
Safety of the public and 1st responders.
Not having enough police officers to adequately protect EMS if we enter warm zone. OCPD will have many tasks to perform with limited personnel. May not have enough for escort team or protective element.
Scene safety
Safety. Personnel has the knowledge of the procedures.
Safety of EMS persons

3) Based on your real-life observations, did police officers and firefighters have shared priorities/ direction during the incident?



- Our job is pt. care while their job is to minimize the threat.
- However, unorganized in communications and carrying out objectives.
- There was not a game plan in place. So, it was chaotic. With a possible 2nd shooter, scene wasn't secure.
- FD did not have knowledge of the operations of PD. No communication.
- Fire is more concerned with EMS. Police with the shooter and potential vics.

Appendix N

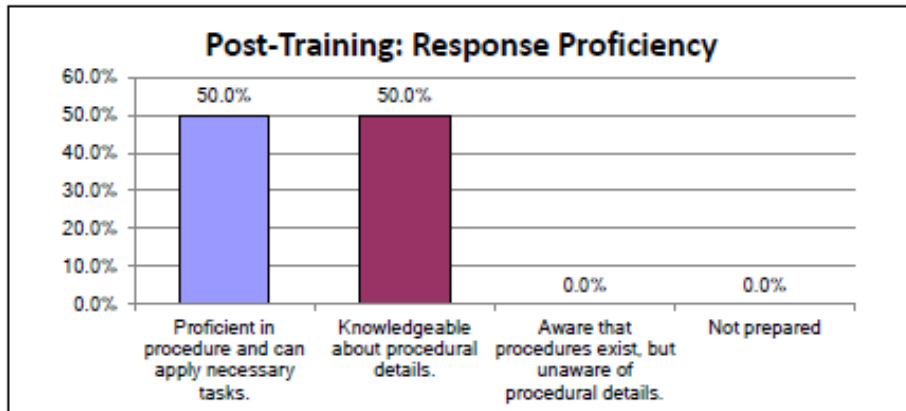


OAK CREEK FIRE DEPARTMENT

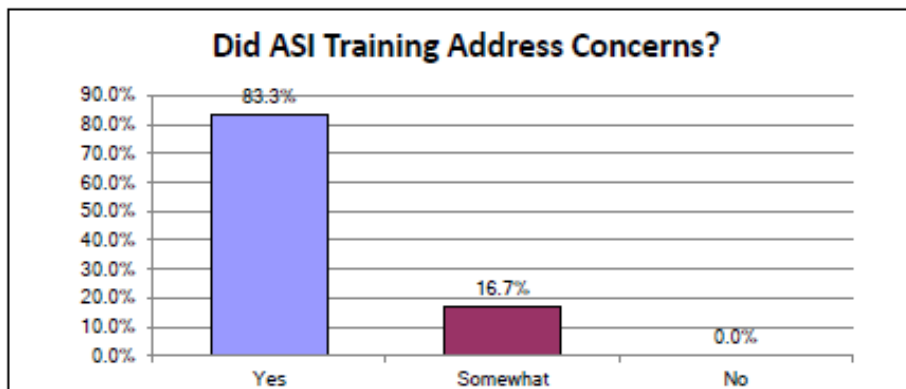
RTF Active Shooter: Post-Training Feedback Results

Now that you have participated in joint Police/Fire training. Please answer the following questions to give insight to your observations/ impressions.

1) As it pertains to your role in a tactical emergency response, do you feel:



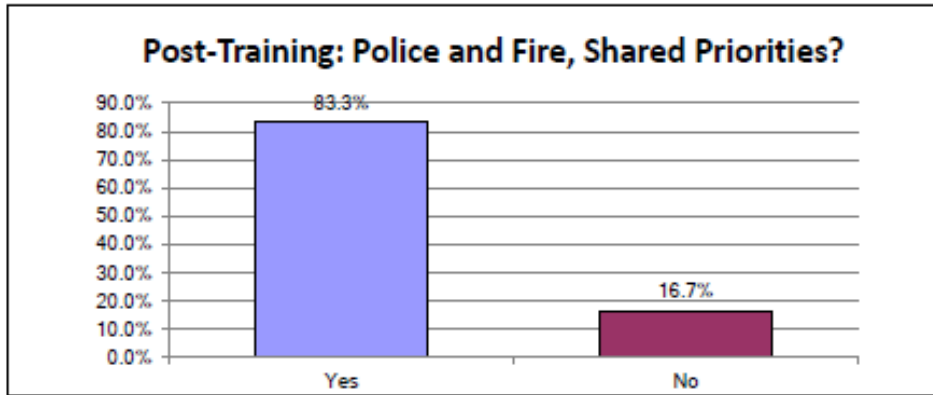
2) Did today's training address your concerns about responding to an active shooter incident?



Somewhat. I think the main concern I have is the communication concerns. It's one thing for OCPD to call out tactics and OCFD pt. conditions, but until all other local PDs are calling out differently, I could see the radio getting confusing.

Went well. Still unsure whether there will be enough OCPD.


3) Based on today's training, do police officers and firefighters have shared priorities/ direction during an active shooter incident?



We're patient care and they're tactics. I think radio talk should reflect the group's top priority. My concern is that PD from Franklin gets paired with us and we all aren't talking about our designated priority. All PD & all fire must know their role.

More training will make us proficient.

Appendix O

	OAK CREEK FIRE DEPARTMENT <i>Policy</i>	Tactical Incident Response Hierarchy 303.902
Section:	300 Emergency Operations	
Accreditation Category:	5 – Programs, 10 – External Agency Relationships	
Path/filename:	K/Training/ OCFD SOG/303.902 Tactical, Mass-Casualty Response Policy	
Issue Date:	June 1, 2013, Draft	
Last Revision:	June 30, 2014	
Supersedes:	N/A	
PURPOSE:		
<p>The purpose of this policy is to outline the hierarchy of response priorities in active shooter incidents or similar types of occurrences. This policy has been created in conjunction with the Police Department’s Active Shooter/ Mass Casualty Response Directive. The primary focus is to provide medical treatment as soon as possible in a less-than-safe (tactical) environment while reducing risk to responders. Definitions listed in this policy have been approved by the Milwaukee County Fire Chief’s Association (MCFCA) and the Milwaukee County Law Enforcement Executives Association (MCLEEA) to insure that uniformity and standardization exist during multi-discipline mutual aid situations.</p>		
SCOPE:		
<p>All Oak Creek Fire Department personnel will be responsible for applying this policy at active shooter, mass casualty incidents. The availability of Tactical Emergency Medical Support (TEMS) is not realistic within the first 30 minutes of the incident. So, on-duty medical providers must be familiar with the expectations of the Fire Department response.</p>		
ACCOUNTABILITY:		
<p>Policies shall be followed by all personnel without deviation. Procedures give definition and a uniform process for how the policy is administered. Policies and procedures have a legal, ethical, operational, contractual and safety reasons for their existence. No deviation exists in policies or procedures for any member of the Department except as authorized by the Fire Chief.</p>		
DEFINITIONS:		
<p><u>Active Shooter</u> – One or more subjects who participate in a random or systematic attack to continuously harm others. The overriding objective appears to be that of mass murder, rather than other criminal conduct. For the purpose of this Directive, the term active shooter also includes anyone using any other deadly weapon (knife, bow & arrow, explosives, etc.) to systematically or randomly inflict death or great bodily harm.</p>		
<p><u>Ballistic Protective Equipment (BPE)</u>- A Level IIIA (minimum) ballistic vest and a Level III ballistic helmet. Emergency medical providers/ RTF will have a “RESCUE” patch on the front and back of the vest. TEMS will have a “MEDIC” patch on the front and back of the vest.</p>		
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OAK CREEK FIRE DEPARTMENT
Policy

Tactical Incident Response Hierarchy

303.902

Casualty Collection Point (CCP)- A location designated for the holding, further assessment and treatment of casualties. The CCP is a secure area within the warm zone. An ideal CCP has cover and concealment.

Clear, but not secure (primary)- an area that is clear of the *suspect only*. Clear does *not* mean an area that is clear of victims. It is an area currently absent of a known threat. Law Enforcement has passed through; however, a deliberate search has not been conducted to guarantee life safety.

Cold Zone – A designated area that has been identified to contain a low degree of danger or hazards for 1st responders. Cold zones should be out of the line of sight of hot and warm zones. Secure area.

Concealment- Protection from observation. Minimal protection from direct fire and/or explosion.

Contact Team – Law enforcement strike team responsible for stopping the suspect. Shall locate and mark secondary devices. Shall callout approximate victim numbers/ location.

Cover – Protection from direct fire and/or explosion.

Distant Staging – Staging that will keep the bulk fire personnel and equipment at a safe distance from the theater of operations, thus minimizing the potential dangers that exist in the hot and warm zones. Members will exit distant staging and progress to the link-up location in anticipation of becoming a member of a Rescue Task Force (RTF). Once the RTF has been formed (police and fire), the RTF can move to forward staging.

Duress Signal – Duress signal of “Broken Arrow” is the preface call to alert others of a duress situation. The duress signal will be **immediately followed by common language to specifically identify the imminent danger.**

Entry Corridor- Path from the Cold Zone to the Warm Zone. An established path to a location that has security measures in place. An entry corridor is generally utilized to move to an affected site or to leave a site and/or evacuate injured from the site.

Forward Staging – An aggressive staging position for RTF operations (once the rescue element and the protection element have been formed up).

Hot Zone – An area that contains an immediate threat to life safety. A Warm Zone could quickly become a Hot Zone and vice versa.

IFAK – Individual First Aid Kit. In the RTF, the IFAK is primarily used for victim care.



Leapfrog - To move ahead of each other in turn; to advance by keeping one RTF in action while moving the other RTF past it to a position farther in front. Also known as **bounding overwatch**.

Level I Staging - A clear staging position for EMS operations; usually out of the line-of-sight of the threat.

Level II Staging- A secure staging position for fire/EMS operations. Normally some distance from the event and large enough to accommodate a significant number of apparatus.

Link-Up Location - A location where the rescue element and the protection element meet up to form an RTF.

Mass Casualty- Any incident that may potentially overwhelm the initial emergency medical response.

Protective Element - Minimum of two law enforcement officers. One of which will be designated as the RTF Team Leader.

Rescue Element - A minimum of two EMS personnel with BPE/IFAK. Takes direction from and provides information to the RTF Team Leader.

Rescue Task Force (RTF) - At least two Oak Creek Firefighters (rescue element) who team up with at least two Oak Creek Police Officers (protection element) to assess, treat, and evacuate victims in the warm zone. TECC concepts will be used in the warm zone.

RTF Team Leader - Law enforcement officer responsible for coordinating RTF movement. All movement in and around the warm zone must be communicated through the RTF Team Leader.

Secure (secondary) - A detailed and deliberate search of an entire area. This area is safe from the suspect and from secondary devices. Law enforcement will remain in a secure area to insure it remains protected.

Security Measures - Any means utilized to reduce the amount of dangers or hazards to first responders and victims in a specific area or location. This can include, but is not limited to, cover, concealment, ballistic shields, law enforcement officers with lethal weapons, vehicles, armored vehicles, positioning, teams utilizing protection element, movement, etc.

Tactical Incident- Any malicious activity that threatens the safety of multiple bystanders. Tactical incidents require the response of police, fire, and emergency medical resources.



Tactical Emergency Medical Support (TEMS) - Oak Creek Fire Department members who regularly train with the Police Department Emergency Response Unit (ERU). TEMS Unit members are not sworn police officers and are not armed; but they are familiar with tactical operations and have been trained in the operation and safe handling of ERU weapons. With an appropriate protection element, TEMS members are permitted to work in the Hot Zone.

TECC – Tactical Emergency Casualty Care.

Treatment Bags/ Drop Bags – Contain additional equipment and supplies capable of treating addition victims. Bags may be used to resupply IFAKs, supply CCP with TECC equipment, or in conjunction with IFAK for direct patient care.

Triage/Treatment/Transport (TTT) – Typical mass casualty level care. TTT is under the supervision of the Medical Group Supervisor. Activities for TTT are typically coordinated in the Cold Zone.

Warm Zone – A designated area that has been identified and has security measures in place to reduce the amount of dangers or hazards to 1st responders and victims. The Warm Zone is cleared but not secured.

POLICY:

I Hierarchy of Response Priorities

- A. **Stop the Shooter**- If incident is an active shooter situation.
 1. Law Enforcement is responsible for this activity.
- B. **Establish an Entry Corridor/ Perimeter**- Contain the threat and reduce the threat to nearby innocents and first responders. Control access points (ingress and egress).
 1. Law Enforcement is responsible for this activity
- C. **Provide protection for RTF/ Protection Element**- Provide protection for those removing injured.
 1. Law Enforcement is responsible for this activity
- D. **Rescue Injured**-
 1. Law Enforcement initiate when practical (if officers are not needed for Contact Team, Perimeter Assignment, or Injury Rescue Protection/ Escort Team)- *Realistically, Law Enforcement will not have enough officers to fulfill a rescue assignment.*



2. If Law Enforcement is assigned to other incident priorities, and Tactical Emergency Medical Support (TEMS) personnel are on scene, TEMS may initiate the treatment and retrieval of the injured.

TEMS will arrive with the Emergency Response Unit (ERU) and may not be available for the first 30 minutes of the incident.

TEMS may be attached with the ERU in the "Hot Zone." The first priority of TEMS is to support OCPD ERU operations.
 3. If Law Enforcement is assigned to other incident priorities, and TEMS is not available, first-in fire/EMS personnel will assist with the treatment and movement of injured in the "Warm Zone".
- E. **Staging-** Establish staging/ parking in the identified cold zone (police, fire, & victims/ witnesses)
1. Fire Department will initially establish the cold zone and staging area.
 - a) Fire Department staging
 - b) Police Department parking
 - c) Victim/ Witness collection/ staging.
 2. Law Enforcement will assign an officer to assist with the staging/ parking of law enforcement resources ASAP- an off duty OCPD supervisor may be called in to assist or a mutual aid officer may be used.


II Fire Department- Incident Parameters

- A. All of these questions should be answered "yes" in order for the fire department to proceed with a Rescue Task Force deployment
1. Are injuries reported?
 2. Has an entry corridor/ perimeter been established?
 3. Has a Warm Zone been identified?
 4. Is a protection element assigned to protect firefighters in the RTF?

CONCLUSION:

This policy was written to provide guidance during tactical incidents that require fire department intervention (due to mass casualty and the need for injury assessment/ treatment). Definitions have been provided to ensure uniform/standardized communication between police, fire, and mutual aid resources. An active, tactical incident must be approached in a way that provides risk reduction and a coordinated response with law enforcement. Responders must always assume that the scene is not safe. THESE SCENES ARE NOT SAFE.

Appendix P

 OAK CREEK FIRE DEPARTMENT <i>Procedure</i>	Tactical Mass Casualty Response 303.903
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Section:	300 Emergency Operations
Accreditation Category:	5 – Programs, 10 – External Agency Relationships
Path/filename:	K/Training/ OCFD SOG/303.903 Tactical, Mass Casualty Response Procedure
Issue Date:	June 1, 2013, Draft
Last Revision:	June 30, 2014
Supersedes:	N/A

PURPOSE:
 The purpose of this procedure is to outline the Fire Department’s role in active shooter incidents or similar types of occurrences. This policy has been created in conjunction with the Police Department’s Active Shooter/ Mass Casualty Response Directive. The primary focus is to provide medical treatment as soon as possible in a less-than-safe (tactical) environment while reducing risk to responders.

SCOPE:
 All Oak Creek Fire Department personnel will be responsible for applying this procedure at active shooter, mass casualty incidents. The availability of Tactical Emergency Medical Support (TEMS) is not realistic within the first 30 minutes of the incident. So, on-duty medical providers must be familiar with the expectations of the Fire Department response.

ACCOUNTABILITY:
 Policies shall be followed by all personnel without deviation. Procedures give definition and a uniform process for how the policy is administered. Policies and procedures have a legal, ethical, operational, contractual and safety reasons for their existence. No deviation exists in policies or procedures for any member of the Department except as authorized by the Fire Chief.

DEFINITIONS:
 Refer to OCFD Policy # 303.902, Tactical Incident Response Hierarchy for Definitions.

PROCEDURE:

I Initial Response


- A. When Dispatch receives a report(s) of a shooting/ mass casualty incident at a specific location, the dispatcher will utilize the Active Shooter/ Mass Casualty call card.
- B. When the fire department is notified, Dispatch will relay as much information (as possible) to all responding units.
 - 1. The on-duty BC will determine the Box Alarm Type (Life Safety/ EMS18-23 or Disaster 18-09).
 - 2. The on-duty BC will also determine if off-duty personnel are needed for staffing.

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**OAK CREEK FIRE DEPARTMENT**
*Procedure***Tactical Mass Casualty Response**

303.903

- C. TEMS will be notified with the ERU activation- At least one TEMS member will advise the on-duty BC of TEMS staffing.
- D. Dispatch shall advise responding fire personnel of safe routes into the incident location.
- E. In the event numerous victims (more than 2) are reported:
 - 1. Fire and EMS will begin to stage at a designated location that provides cover and quick response (cold zone).
 - 2. Based on the number of reported injuries, the need for mutual aid (MABAS) support will be determined by the on-duty BC
 - a) A Medical Group will be established and will report to Fire Ops.
 - (1) Rescue Task Force (RTF) will be considered. The RTF will initially report to Fire Ops. Once the medical group is established, RTF will report to Medical Group Supervisor.
 - (2) Medical Group
 - (a) Medical Group Supervisor
 - (b) Triage
 - (c) Treatment (green, yellow, red)
 - (d) Transport
 - b) Milwaukee County EMS Communications will be updated.
- F. First arriving OCPD personnel will:
 - 1. Cautiously proceed toward the reported location looking for signs of ambush, booby traps, or I.E.D.s.
 - 2. Attempt to identify cause of the mass casualty.
 - 3. Identify safest route in/ staging location for Fire/ EMS.
 - 4. Visually identify location of possible entry corridor.
 - 5. Officers will assemble a contact team and make entry.
 - 6. Initial entry team(s) will broadcast their entry point and the number of officers entering.
 - 7. Initial entry team(s) will continue past victims and move toward gunfire.
- G. Initial Police Supervisor arriving on scene will:
 - 1. Establish Incident Command
 - 2. Establish an entry corridor/ perimeter.
 - 3. Identify location of Mobile Command Post (to be moved to the cold zone ASAP).

	OAK CREEK FIRE DEPARTMENT <i>Procedure</i>	Tactical Mass Casualty Response 303.903
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4. Identify Hot Zone, Warm Zone, and Cold Zone (Fire Department BC may assist with Cold Zone designation).
5. Determine a safe route into the incident/ staging.
6. Initiate response priorities (hierarchy).
 - a) Contact Teams
 - b) Entry Corridor/ Perimeter
 - c) Evacuation of the uninjured
 - d) Rescue Task Force Protection Element.

II Initial Fire/ EMS Actions:

- A. Battalion 18 (OCFD) will contact the OCPD incident commander over OCPD primary dispatch (OCPD1).
 1. Determine safe route in
 2. Situation status report from OCPD
 3. Assist with "Cold Zone" designation.
 4. Assist with staging location.
 5. Determine medical need for RTF formation.
 6. Verify PD/FD link-up location for RTF
- B. Oak Creek Police Department (OCPD) will be the lead agency and will work toward developing Unified Command with OCFD. Until Unified Command is activated, Battalion 18 will be known as "Fire Ops."
- C. If medical treatment is indicated, Battalion 18 (Fire Ops) will have ambulance crews assemble a rescue element (with appropriate BPE and medical equipment) and report to the link-up location for RTF assembly.
- D. Prior to deploying a Rescue Task Force, threat zones must be identified:
 1. Hot Zone – Area where there is known hazard or life threat that is direct and immediate. Only the right people with the right training and the right equipment shall enter (i.e. Law Enforcement, ERU, TEMS).
 2. Warm Zone – Area of indirect threat- areas that have been cleared by OCPD or the threat has been isolated. These are areas of minimal or reduced risk. This area can be considered clear- but not secure. OCFD will provide a Rescue Task Force(s) in this area, with ballistic PPE (Section III) and law enforcement security, to treat victims.
 3. Cold Zone – Areas where there is little or no threat. This area may have been secured by police or may be protected by geography. In this area OCFD will stage to triage, treat, and transport victims (once removed from the warm zone). Police protection should still be considered in the Cold Zone- especially if the total number of shooters is not known.



- E. Once the warm zone has been identified and secured, the Rescue Task Force will be advised of their response parameters and assigned a protection element at the **link-up location**.
- F. Once OCFD personnel have been assigned to the Rescue Task Force(s), mutual aid ambulances may be needed for transport.
- G. Depending on the size and location of the incident, injured victims may need to be placed in a Casualty Collection Point (CCP) before transition to the cold zone. The CCP will be determined by the initial arriving police units, secured by OCPD, and relayed to the Rescue Task Force(s) through Incident Command

III Rescue Task Force Equipment

The equipment needed for Rescue Task Force members:

- A. Ballistic Vests
- B. Kevlar Helmets
- C. IFAK (attached to vests)
 - (2) CAT Tourniquets
 - (2) Israeli/Emergency Bandages
 - (2) Occlusive Dressings (Chest Seal)
 - (2) Combat Gauze (Hemostatic Agent)
 - (1) 14ga Chest Decompression Needle
 - (2) 28 Fr. Nasal Pharyngeal Airways
 - (1) Black Marker
 - (1) Roll Bandage Tape
 - (10) Triage Tags
 - Latex Free Exam Gloves
- D. Treatment Bag/ Drop Bag (extra equipment designed restock IFAKs or treat additional victims)
- E. Flashlights for each member
- F. Radios (with mic)

IV Deployment

Once Command and Fire Ops (or Unified Command) has agreed to Rescue Task Force deployment, teams will deploy to the warm zone to begin victim care.

- A. Each Rescue Task Force will deploy with at least two OCPD officers (security element) and two OCFD firefighters (rescue element)- (See Appendix A for examples).
- B. The first Rescue Task Force to enter should advise the Medical Group Supervisor (or Fire Ops if Medical Group is not yet assembled) of the approximate victim count.
- C. When the Rescue Task Force makes entry, they will treat the injured using Tactical Emergency Casualty Care (TECC) guidelines.



- D. The first two Rescue Task Forces will enter the area and treat as many patients as possible (until they run out of equipment- or until all accessible victims have been treated). Once this point has been reached, these Rescue Task Forces start the evacuation of injured. Additional Rescue Teams that enter the area should be primarily tasked with extrication of the victims treated by the initial two RTFs. If needed, additional Rescue Task Forces may be sent into areas unreached by the initial teams or to other areas with accessible victims.
- E. When the Rescue Task Force is operating in the Warm Zone, SALT triage will be conducted (when appropriate). All patients encountered by the Rescue Task Forces will be treated as they are accessed. Any patient that can ambulate without assistance will be directed to self-evacuate down the cleared corridor under police direction. Any patient who is dead will be visibly marked (by maker or triage tag) to allow for easy identification and to avoid repeated evaluations by additional Rescue teams.
- F. To coordinate Rescue Task Forces in the Warm Zone, a single OCFD officer may deploy into the Warm Zone under OCPD protection (RTF Group Supervisor). This will be provided to ease communication between Rescue Teams and the Medical Group Supervisor.
- G. Rescue Task Forces can be deployed for the following reasons:
1. Victim treatment
 2. Victim removal from the Warm Zone to the Cold Zone, Warm Zone to CCP, or CCP to Cold Zone.
 3. Movement of supplies from the Cold Zone to the Warm Zone or Cold Zone to CCP.
 4. Any other duties deemed necessary to accomplish the mission.
- H. **RESCUE TASK FORCES WILL ALWAYS WORK WITH A LAW ENFORCEMENT SECURITY ELEMENT. AND WILL WORK WITHIN THEIR SECURITY AT ALL TIMES.**
- V Victim Removal/ Transport to Cold Zone**
- A. Once victims have been rapidly assessed, treated, and evacuated from point of injury, RTFs will move the victim to the casualty collection point (CCP) or to a waiting vehicle that will move the victim to the medical group (Cold Zone) for more definitive treatment/ transport. Patients/ victims will be transported in the following vehicles:
1. Bearcat- or other armored vehicle
 2. Squad car or other passenger vehicle (preferably van-type)
 3. Ambulance (least advisable, ambulances may be needed for hospital transport. If used, consider removal of pressurized oxygen vessels).
- B. Vehicles used for warm zone transport should, if available, have an armed police officer for a protection element.

**VI Emergency Actions/ Duress**

- A. "Broken Arrow, Broken Arrow" will be announced over the radio in the event of a life threatening event (shots fired, IED, gas release) is discovered in the immediate area of the RTF.
- B. The duress signal shall be immediately followed with a clear text radio communication describing the situation.
 1. RTF Team leader will take immediate action to protect the rescue element
 - a) Additional cover/concealment
 - b) Hasty evacuation
 2. Personnel Accountability Report (PAR) will be conducted with each RTF.

CONCLUSION:

This procedure was written to provide guidance during tactical incidents that require fire department intervention (due to mass casualty and the need for injury assessment/ treatment). The response environment during tactical incidents must be approached in a way that provides risk reduction and a coordinated response with law enforcement. THESE SCENES ARE NOT SAFE. Emergency medical responders must always assume that the scene is not safe and work within a security element.

During a tactical, mass-casualty response, the following questions must be asked by firefighters to determine the status of the incident- and prior to committing an RTF to the "Warm Zone" (See Appendix B):

1. Are injuries reported?
2. Has an entry corridor/ perimeter been established?
3. Has a Warm Zone been identified?
4. Is a protection element assigned to protect firefighters in the RTF?

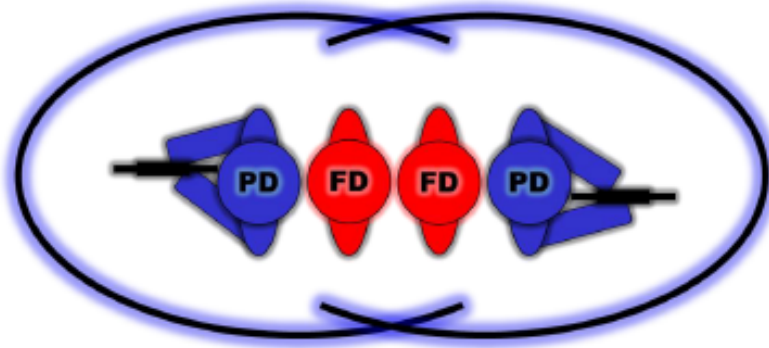
All of these questions should be answered "yes" in order for the fire department to proceed with a Rescue Task Force deployment.



Appendix A

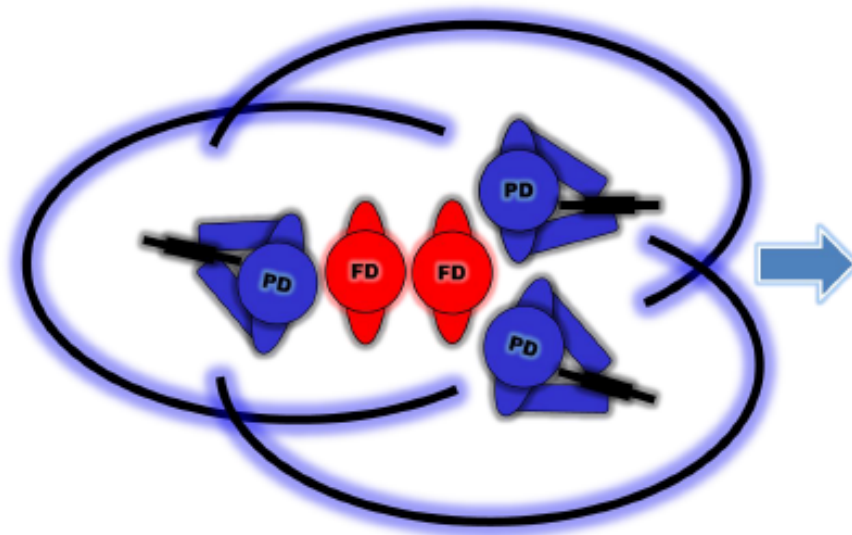
RTF 2 x 2:

2 Officer Protection Element, 2 Firefighter Rescue Element



RTF 3 x 2:

3 Officer Protection Element, 2 Firefighter Rescue Element





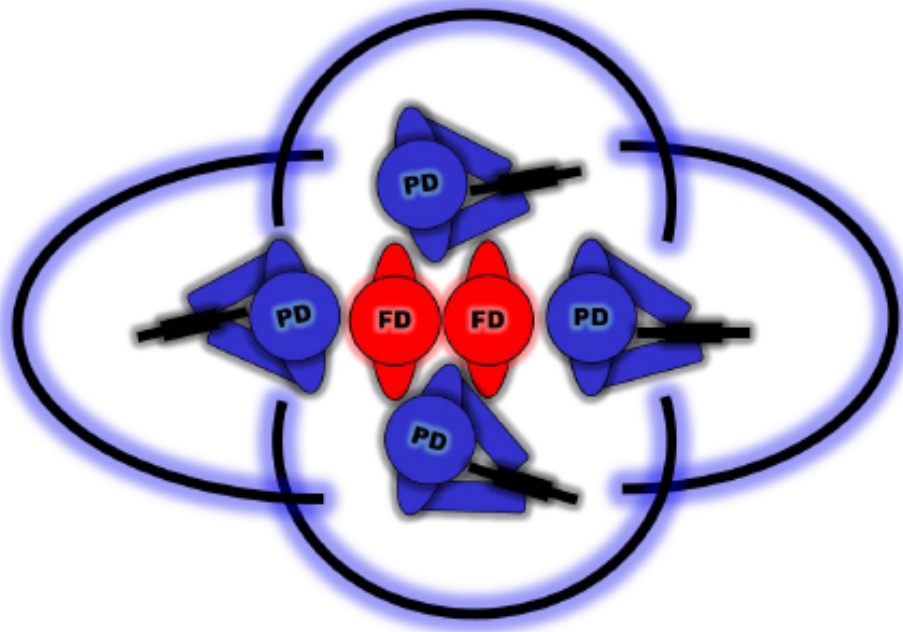
OAK CREEK FIRE DEPARTMENT
Procedure

Tactical Mass Casualty Response

303.903

RTF 4 x 2

4 Officer Protection Element, 2 Firefighter Rescue Element



Appendix B



Example of incident elements needed for fire department participation in tactical incidents