Mitigating Community Risks of Active Shooter Incidents Through Best Practices

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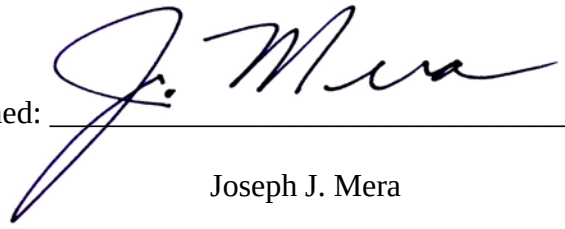
Certification Statement

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: 

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Abstract

The problem was that the Leesburg Fire Department did not have a response plan for active-shooter incidents which could have led to an uncoordinated response, inefficient use of department resources, as well as victim and responder safety concerns. The purpose of this research was to develop an active shooter response plan for the Leesburg Fire Department to ensure a coordinated response, efficient utilization of resources and to address victim and responder safety concerns. The procedures were an action research method that included a literature review, a questionnaire that was gathered from fire departments nationwide and personal interviews with the Medical Director and the SWAT Commander of the Leesburg Police Department. The action research method was used to answer the following questions for this applied research project: What are the current recommended standards for fire department/EMS active shooter response? What type of specialized equipment is required for an active shooter incident response? What type of specialized training is required for an active shooter incident response? What operational policies and safety procedures must be developed to support a response to an active shooter incident? The result of this research was the writing of a response SOG that is founded and based upon current recommendations for a fire departments/EMS department's response to an active shooter incident. Recommendations to the department include adoption of the ASI SOG and the further pursuit of training and specialized equipment to support the response to an ASI.

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Introduction

Fire departments train and equip their members for responses to a multitude of emergent and non-emergent incidents. Most frequently these responses are traditionally to fires, medical emergencies, motor vehicle collisions and a variety of technical rescue incidents to name a few. Despite this the fire service is now being required to respond to some of the most unthinkable acts of violence, sometimes involving the most innocent and defenseless victims. Although infrequently occurring, an active shooter incident can be the most physically, emotionally, and physiologically challenging incident that first responders might find themselves tasked to mitigate.

An active shooter incident (ASI) is defined by the Federal Bureau of Investigation (FBI) as "an individual actively engaged in killing or attempting to kill people in a confined and populated area" (Blair & Schweit, 2014, p. 4). The definition is expanded upon by Atwater in his thesis to include three distinct components.

> (1) Single or multiple assailants armed with multiple weapons and weapon types, are using ballistic protection, and are tactically disciplined (paramilitary). (2) The assailants present an ongoing, immediate threat to life (active). When law enforcement engages the assailants, they do not surrender or commit suicide– although they may expect to die in their confrontation with law enforcement. The attackers return fire and attempt to evade or relocate to continue the killing. (3) To extend the duration and scope of the killing, the assailants create a multi-hazard environment for responders (Atwater, 2012, p. 2).

The problem is that the Leesburg Fire Department does not have a response plan for active-shooter incidents; this could lead to an uncoordinated response, inefficient use of department resources, as well as, victim and responder safety concerns. The purpose of this research is to develop a draft active shooter response plan for the Leesburg Fire

Department to ensure a coordinated response, efficient utilization of resources and to address victim and responder safety concerns.

The action research method will be used to answer these questions for this applied research project:

1. What are the current recommended standards for fire department/EMS active shooter response?
2. What type of specialized equipment is required for an active shooter incident response?
3. What type of specialized training is required for an active shooter incident response?
4. What operational policies and safety procedures must be developed to support a response to an active shooter incident?

A literature review will be conducted to address the research questions. The literature review will consist of researching NFPA Standards that address active shooter incidents, FBI findings from past incidents, and any scholarly peer-reviewed works that examined active shooter incidents. A survey to fire departments nationwide will be conducted as well as an interview of the SWAT Team Commander and the Lake County, Florida's Emergency Medical Services (EMS) Medical Director to gather data on combat medicine and its relevance to my research topic.

Background and Significance

The Leesburg Fire Department is a small all-career department that is located in central Florida. The City of Leesburg is located in Lake County, Florida and the municipal boundaries encompass an area of approximately 24.5 square miles (City of Leesburg, 2014); with a population of approximately 21,142 (American Fact Finder, 2013). The community is a diverse make-up that consists agricultural areas, middle-

income housing, government housing projects, affluent residential housing areas, a local full service medical center (Leesburg Regional Medical Center), commercial areas, an international airport, a small local sport stadium, several State and Federal highways, and factory/manufacturing plants. The City of Leesburg is home to the annual Leesburg Bikefest, which consists of a three-day motorcycle rally that draws approximately 300,000 attendees to the City over the course of the event (Leesburg Bikefest website, n.d.).

The Leesburg Fire Department is staffed with professionally trained and certified firefighters according to National Fire Protection Association (NFPA) Standard 1001. All Leesburg firefighters are dual-trained as either, State of Florida Certified Emergency Medical Technicians (EMT), or Paramedics. All Lieutenants (Company Officers) are certified at a minimum to the level of Fire Officer I, in accordance with NFPA 1021. The Leesburg Fire Department operates four stations that are located throughout the municipal City limits; Station 61 is equipped with a staffed Advanced Life Support (ALS) Engine, a staffed Battalion Command Vehicle and an unstaffed 95' Tower/Ladder. Station 62 is equipped with a staffed ALS engine; Station 63 is equipped with a staffed 75' ladder and an Airport Rescue Fire Fighting (ARFF) vehicle. Station 64 is equipped with a staffed ALS engine and an unstaffed wild-land "brush" truck.

In 2014 the Leesburg Fire Department ran approximately 7,630 calls for service; of those numbers about 610 were fire or fire related calls, 5,112 were Emergency Medical Service (EMS) calls, and the remaining 1,908 were classified as "other." To date the Leesburg Fire Department has not responded an ASI in its 130-year history nor has the department taken any steps to prepare for an ASI. Organizationally the department is unaware of the problem, the threats it poses or how to mitigate the threats of an ASI. The

Leesburg Fire Department has undertaken no research into best practices by other fire/EMS departments.

The City of Leesburg has all of the location types identified by Blair and Schweit (2014) as location categories where the public was most at risk for an ASI. "These location categories include commercial areas (divided into malls, businesses open to pedestrian traffic, and businesses closed to pedestrian traffic), educational environments, open spaces, government properties (divided into military and other government properties), residences, houses of worship, and health care facilities" (Blair & Schweit, 2014, p. 12).

Table 1 City of Leesburg Active Shooter High Risk Areas by Type

High Risk Type with Percentage of Occurrences	High Risk Area
Commerce 45.6%	• Lake Square Mall • Numerous shopping areas • Grocery Stores • Retail sales • Warehouses
Education 24.4%	• Beverly Shores Elementary • Leesburg Elementary • Carver Middle School • Leesburg High School • Oak Park Middle School • Rimes Early Learning Center • Lake-Sumter State College • Beacon College
Government 10%	• City Hall • US Post office • National Guard Armory • Social Security Administration • Tax Collectors Office
Open Spaces 9.4%	• Saturday Morning Market • Leesburg Arts Festival • Leesburg Bikefest • Mardi-Gras Celebration • Christmas Parade • MLK Day Parade

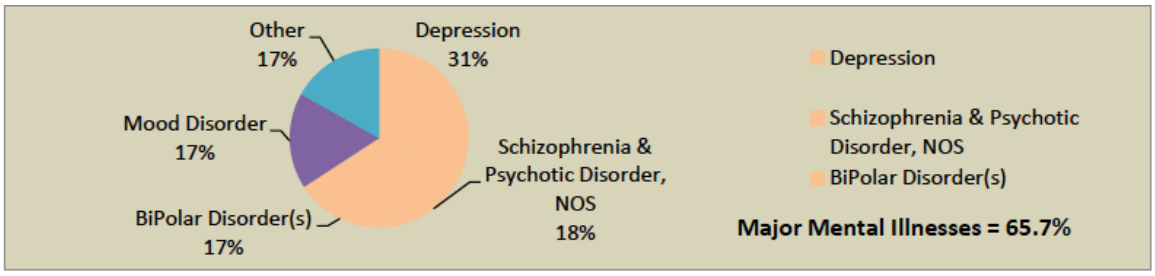
Note Table 1 lists the high-risk areas within the City of Leesburg by location type using the criteria identified by Blair & Schweit (2014). There are a large number of high-risk areas that could be the target for an ASI.

According to the FBI, ” mental illness is a common factor among many active shooters” ("Only 4 percent of active shooters were women," 2013, para. 3). This common factor seems to be, at least empirically, very prevalent in the City of Leesburg. Within the City limits of Leesburg is a very large behavioral health and social services organization that provides inpatient and outpatient treatment, residential, education, care management, and rehabilitation. According to Lifestream:

> While Lifestream serves all individuals needing acute psychiatric services in our hospital, statistics show that a vast majority of the consumers have severe and persistent mental illness. Information provided by the Florida Council for Community Mental Health (FCCMH) reveals that only a third of persons having serious and persistent mental illness currently receive services funded by the State of Florida and that Florida ranks 49th in per capita funding for such services (Lifestream Services, 2013, p. 9).

The collection of diagnoses rendered within the facility show the diagnostic trends of those served correspond to the three diagnoses regarded as major mental illness:

Table 2 Diagnostic Trends



This research topic relates to the National Fire Academy’s (NFA) Executive Fire Officer Program (EFOP) Executive Analysis of Community Risk Reduction R0274 by

mitigating community risk through emergency response (National Fire Academy, 2013). This research aligns itself with two of the five goals of the United States Fire Administration (United States Fire Administration, 2014, p. 9), which include:

- Goal 2: Promote Response, Local Planning and Preparedness for All Hazards.
- Goal 3: Enhance the Fire and Emergency Services' Capability for Response to and Recovery from All Hazards.

A direct linkage is established between the research problem (Leesburg Fire Department does not have a response plan for active shooter incidents) and the goals of the USFA by creating response protocols to an Active Shooter Incident.

Literature Review

The objective of the literature review process is to collect and evaluate literature on best practices in response to an ASI with the goal of reducing morbidity and mortality from the resulting injuries inflicted by an ASI. The literature review for this Applied Research Project started with a review of any Leesburg Fire Department guidelines or procedures that were applicable to active shooter incidents, the review revealed that the Leesburg Fire Department had no policies or procedures for response to ASI. Given this vacuum of information or guidance in responding to ASI. With the discovery that no such information or guidance for responding to an ASI existed within the departmental level; an extensive literature review was begun at the National Fire Academy's Learning Resource Center in Emmitsburg, Maryland. This research was conducted while attending *Executive Analysis of Community Risk Reduction* in January 2015. The literature reviewed for this applied research project included: peer-reviewed journals, EFOP Applied Research Projects (ARP), fire service publications, Internet websites, consensus statements and position papers. The literature review is organized around four specific research questions; which are:

1. What are the current recommended standards for fire department/EMS active shooter response?
2. What type of specialized equipment is required for an active shooter incident response?
3. What type of specialized training is required for an active shooter incident response?
4. What operational policies and safety procedures must be developed to support a response to an active shooter incident?

What are the current recommended standards for fire department/EMS active shooter response?

Although no specific standards exist that address how a fire department/EMS service should respond to an active shooter incident there has been several recommendations and guides published. During the writing of this ARP, the U.S. Department of Homeland Security published the most comprehensive guide for responding to active shooter incidents and improvised explosive devices, "*First responder guide for improving survivability in improvised explosive device and/or active shooter incidents."* This guide is tailored specifically for the fire department/EMS response side of an active shooter incident; law enforcements specific tactics are not addressed in this document. The primary way that this publication recommends that responders operate at an ASI is a departure from the normal "stand-by" mode. Historically the fire service has "stood-by" until law enforcement had neutralized the threat, whether by arresting the aggressor or through deadly force and after a search of the entire area that the shooting took place. This often resulted in an extensive delay in treatment of the injured. This specifically was a contributing factor at the ASI at Columbine High School, which resulted in additional deaths that might otherwise have

been saved with a different response model (Mell & Sztajnkrycer, 2005). The literature review pointed out that the Rescue Task Force (RTF) model was the ASI response procedure that is most likely to result in a higher chance of survival for victims. Both Atwater (2012) and United States Department of Homeland Security (2015) recommend a distinct deviation from past "stand-by" response models; both recommend that rescuers not stand by and wait for victims to be brought out to them or until the entire scene has been secured.

The following are common response recommendations that were discovered through the literature review:

1. Incident Command System (ICS) should be established early in the incident.
2. Use of the Rescue Task Force (RTF) concept. A RTF is a team deployed to provide point of wound care to victims where there is a ballistic threat. These teams treat, stabilize, and remove the injured in a rapid manner, while wearing Ballistic Protective Equipment (BPE) and under the protection of Law Enforcement. An RTF team should include at least one Advanced Life Support (ALS) provider.
3. Early hemorrhage control is essential to maximizing survival of injured victims.
4. Law Enforcement and Fire Departments should train together.
5. Use of common communications terminology. Fire department personnel must understand common law enforcement terms to such as Cleared, Secured, Cover, Concealment, and Hot Zone/Warm Zone/Cold Zone.

What type of specialized equipment is required for an active shooter incident response?

There are two specific operational equipment considerations when dealing with an ASI, the first is the safety of the responder and the second is the care for the wounded. There are also many other equipment considerations that must be followed at an ASI but many of those are considerations that are already observed at other events that fire departments routinely respond to on a daily basis. Both of these operational considerations do require specialized equipment, yet the level of specialization is not specialized to the fire service. All of the specialized equipment that is recommended to be used at an ASI is equipment which is currently being used, and has been used, in law enforcement and the military for, in many cases, decades.

Ballistic protection is a recommendation set forth by several entities, the Federal Bureau of Investigations (FBI), Federal Emergency Management Agency (FEMA), Committee for Tactical Emergency Casualty Care (C-TECC), National Fire Protection Association (NFPA), International Association of Fire Fighters (IAFF), International Association of Fire Chiefs (IAFC) and several others recommend that personnel operating in the warm zone of an ASI be provided and wear ballistic protection. The most recent publication from the U.S. Department of Homeland Security clearly spells out in its responder guidelines that in terms of protective equipment that:

> "First responders should develop inter-domain (EMS, fire, and law enforcement) TTPs (Tactics, Techniques, and Procedures) -including use of ballistic vests, better situational awareness, and application of concealment and cover concepts- and train first responders on proper use of the TTPs. The incorporation of ballistic vests and the concepts of concealment and cover into the EMS and fire professions, when active shooter threats and situations warrant, will better protect

> first responders. Additionally, the TTPs will facilitate improved interoperability between EMS and fire personnel and law enforcement during active shooter incidents" (United States Department of Homeland Security, 2015, p. 21).

The second equipment operational consideration for a response to an ASI is in the care of the wounded. An ASI is a specialized type of response that requires specialized treatment for patients that a fire department responder might not traditionally use at more traditional traumatic injury response. The very nature of the ASI requires that we reevaluate how we treat patients in combat type scenarios. When under fire, a responder does not have the time, environment or equipment to fully evaluate a patient.

"Military experience has shown that the number one cause of preventable death in victims of penetrating trauma is hemorrhage" (Jacobs et al., 2013, p. 1400). This concern is the driving force behind the treatment of victims of an ASI. The ability to control bleeding in a warm zone with the possibility of active shooting still in the area further complicates the ability to stop bleeding. The movement coming from experience and studies of combat has shown that commercially made tourniquets are the gold standard for the treatment of hemorrhaging secondary to a traumatic injury, "Regardless of tourniquet used, EMS professionals should use commercial tourniquets proven more effective than "homemade" devices and should use tourniquets obtained from reputable manufacturers and/or suppliers"(Oklahoma State Department of Health, 2013, p. 10H.3). Along with the use of tourniquets to control bleeding from the extremities the recommendations from TECC are for the use of a hemostatic agent in accordance with its directions for hemorrhage that is not feasible controlled due to the location of the wound (Committee for Tactical Emergency Casualty Care, 2014, p. 5).

The following list is the most commonly recommended medical equipment for an ASI response:

1. Commercially made tourniquets
2. Pressure Dressing
3. Hemostatic Agent
4. Oropharyngeal airway
5. Supraglottic Device (LMA, King-LT, Combitube, etc.)
6. Occlusive chest seal
7. Bag Valve Mask
8. Oxygen
9. Intravascular Access Catheters (IV)
10. Eye Shield
11. Extremity Splint
12. Spinal Immobilization Devices

What type of specialized training is required for an active shooter incident response?

The appropriate response to an ASI is an interdisciplinary response that blends elements from the military, law enforcement, and fire/EMS services. Because of this recommended integrated response, (United States Department of Homeland Security, 2015), the specialization that is required is only native to a particular discipline and not others. Despite this fact, those specialized skills are recommended to transcend historical/technical boundaries. Medical care has always historically been a function of EMS; law enforcement had not played a role in patient care. Despite this recommendations now exist that law enforcement provide immediate life saving medical treatments for victims as they are found. According to the National Tactical Officers Association:

> "The revised position statement recognizes the need for all police officers to have basic TEMS medical training. As law enforcement first responders to active

> violence incidents, patrol officers are now trained and equipped to intervene to end active killing using tactics that were once reserved for special operations teams. Where TEMS was conceived to support special operations teams, the time has come to provide patrol officers with basic TEMS training and equipment in order to potentially save the lives of victims, bystanders, police officers and suspects in the event they are wounded" (National Tactical Officers Association [NTOA], n.d., para. 3).

The skill of wearing ballistic protection is not a native skill set to the fire service, but in order to be best prepared for an ASI, firefighters/EMTs and paramedics are now learning those skills. Those skills are not new skills to the collective body of public safety but merely new specialized skills that the fire service must learn. The ability to operate using specialized skills such as cover and concealment are skills that non-traditional professions are being required to learn (United States Department of Homeland Security, 2015).

Many of the specialized skills that public safety will have to learn in order to best protect the public will be at the discretion of the local medical director. As a nation the skills that an EMT vs. a paramedic can perform vary by region, even the very classification of EMT means different levels of care based upon the state a practitioner is licensed to work. Any agency that will be responding to an ASI should work with its fellow response agencies and develop specialized protocols and have on-line medical direction's approval of skills to be performed (Committee for Tactical Emergency Casualty Care, 2014).

The following are skills that have been identified as potentially life saving in the event of an ASI by the Committee for Tactical Emergency Care, these will require specialized training based upon each responder's current level of training:

1. Hemorrhage Control:

    a. Apply Tourniquet

    b. Apply Direct Pressure

    c. Apply Pressure Dressing

    d. Apply Wound Packing

    e. Apply Hemostatic Agent

2. Airway:

    a. Apply Manual Maneuvers (chin lift, jaw thrust, recovery position)

    b. Insert Nasal pharyngeal airway

    c. Insert Supraglottic Device (LMA, King-LT, Combitube, etc.)

    d. Perform Tracheal Intubation

    e. Perform Surgical Cricothyrotomy

3. Breathing:

    a. Application of effective occlusive chest seal

    b. Assist Ventilations with Bag Valve Mask

    c. Apply Oxygen

    d. Apply Occlusive Dressing

    e. Perform Needle Chest Decompression

4. Circulation:

    a. Gain Intravascular Access

    b. Gain Intraosseous Access

    c. Apply saline lock

    d. Administer IV/IO medications and IV/IO fluids

    e. Administer blood products

5. Wound management:

a. Apply Eye Shield

b. Apply Dressing for evisceration

c. Apply Extremity Splint

d. Apply Pelvic Binder

e. Initiate Basic Burn Treatment

f. Initiate Treatment for Traumatic Brain Injury

6. Prepare Casualties for Evacuation:

a. Move Casualty (drags, carries, lifts)

b. Apply Spinal Immobilization Devices

c. Secure casualty to litter

d. Initiate Hypothermia Prevention

7. Other Skills:

a. Perform Hasty Decontamination

b. Initiate Casualty Monitoring

c. Establish Casualty Collection Point

d. Perform Triage (Committee for Tactical Emergency Casualty Care, 2014, p. 5)

What operational policies and safety procedures must be developed to support a response to an active shooter incident?

The fire service bases how it operates on scene of emergencies upon previously established policies and safety procedures that were established and written long before the emergent situation occurred. Through the establishment of response policies responders can respond in a uniform and consistent manner. This level of consistency allows for responders to know what needs to happen, who needs to do specific tasks, when it should happen and oftentimes why something is happening. A response to an ASI requires all of these elements to be in place in order to minimize the threat that

responders are facing. A specific response plan that has a detailed safety component is critical to the successful completion of the mission.

Throughout the literature review there are several components to an ASI response that were commonly observed. The majority of the information found in literatures that address ASI is based around operational policies and safety considerations. Oftentimes the primary component in an ASI is the emergency operational plan, "It is unlikely that any community can anticipate specific ASI/MCI scenarios they may experience, but it is possible to develop a generic plan that provides a model to apply in almost every situation that arises. Each community needs to have a detailed and comprehensive EOP" (U.S. Fire Administration, 2013, p. 10).

Research has demonstrated that the RTF response model is the most effective at saving the lives of victims of ASI. In order to ensure that the RTF deployment model is properly executed an operational policy with safety components built in should be in place to support the rescue effort. Atwater (2012) indicates that the following questions should be applied to an ASI operational policy to ensure its effectiveness:

> "Does the policy keep fire fighters safe? Is the policy consistent with fire service risk management principles? Does the policy maintain confidence in public safety officials? Is the policy effective in a multi-hazard environment, especially when fire is used as a weapon? Does the policy result in an expeditious response to immediate threats to life safety? Does the policy encourage collaboration between police and fire?"

To summarize, this literature review included peer-reviewed journals, EFOP Applied Research Projects (ARP), fire service publications, Internet websites, consensus statements and position papers in order to answer the four research questions. The literature revealed that there are some very new recommendations that have been brought

forward to address how fire departments should respond to an ASI. These recommendations include a deviation from the long-standing practice of "standing-by" until a violent scene is definitely secured. Along with the recommendations to operate in a warm zone patient care procedures have changed as a result of findings that have come from combat medicine from Vietnam to the current War on Terror. These findings were the basis of the proposed Leesburg Fire Department policy on responding to an ASI.

Procedures

This applied research paper utilized three tools to answer the problem statement that the Leesburg Fire Department does not have a response plan for active-shooter incidents. The action research method was used to answer the four research questions which were: what are the current recommended standards for fire department/EMS active shooter response, what type of specialized equipment is required for an active shooter incident response, what type of specialized training is required for an active shooter incident response, and what operational policies and safety procedures must be developed to support a response to an active shooter incident? The three tools that were used included (1) a literature review of pertinent information related to fire departments responses to ASI, (2) a questionnaire that was e-mailed to 97 fire departments, and (3) interviews with the Medical Director of the Leesburg Fire Department and an interview with the Leesburg Police Department SWAT Team Commander.

The first phase of the research was to conduct a literature review regarding fire departments response to an ASI. This initial research was conducted at the National Fire Academy's Learning Resource Center (LRC) in Emmitsburg, Maryland, in January 2015 and continued through March 2015. Literature for the applied research project was found in trade journals, Executive Fire Officer Program (EFOP) Applied Research Projects, scholarly reviewed journals, government publications, fire service publications, and

research databases (ABI/Inform Complete, Academic OneFile, Academic Search Complete, and GreenFile). Searches conducted on the various web based research databases were completed using key words such as: Active Shooter Incidents, Tactical Combat Casualty Care (TCCC), Rescue Task Force, ASI, Tactical Emergency Casualty Care (TECC).

The second phase of the research consisted of a questionnaire that was intended to gather information from fire departments on responses to ASI. The purpose of the questionnaire was to query fire departments and determine if there were any "best practices" that could be adopted by the Leesburg Fire Department for a response to an ASI. The questionnaire was developed, as well as distributed, using SurveyMonkey.com, a web based software-company. The decision to use SurveyMonkey.com was based upon: low cost, company reputation/familiarity, ease of software use, data collection, and processing abilities.

The questionnaire recipient list included 97 fire departments, all of which were accredited through Commission on Fire Accreditation International (CFAI). The list of recipients for the questionnaire came from CFAI's web site of accredited fire departments. This recipient list was chosen based upon availability; during this research the author was not able to find any other database of fire department e-mail addresses. The complete list of all the recipients of the questionnaire can be found in Appendix C. The questionnaire was distributed to the selected recipients using an e-mail invitation format to a web-link for collection; a blank sample survey can be found in Appendix A.

The questionnaire was sent out to 97 recipients. There were 88 responses collected and 9 responses that were unresponsive. Departments that did not respond by benchmark dates were re-sent the questionnaire to ensure that a valid sample size was obtained. The questionnaire was initially distributed on May 15, 2015, with subsequent

reminders sent out May 31st, June 8th, and June 13, 2015. The purpose of sending the reminder e-mails was to encourage responses from survey participants. The information gathered from the questionnaire can be found in the results section of this project.

Limitations

There are several limitations that were realized during the literature review and questionnaire phases of the research. There are approximately 26,482 registered fire departments in the United States (National Fire Department Census Quick Facts, 2012, para. 1); yet there is no database of e-mail addresses to which the questionnaires could have been e-mailed. This creates a limitation of available data for research and evaluation. Additionally a search of the National Fire Academy Learning Resource Center (LRC) revealed only 17 EFO ARP that examined ASI.

One of the biggest limitations during the questionnaire phase was that only accredited agencies were supplied the questionnaire. There currently is no database of departments that have an ASI response guideline or protocol in place. The limitation of the author's experience with Survey Monkey and creating questionnaires was also discovered; this was probably of little consequence. The contact list for the accredited agencies provided by CFAI also proved to be a limitation. Many of the departments did not list the specific person to whom questions regarding accreditation should be directed. In addition, many departments did not provide specific e-mail addresses for the department but rather provided only contact forms for the municipality or county government, these did not receive a questionnaire.

Definition of Terms

Active Shooter Incident- an individual actively engaged in killing or attempting to kill people in a confined and populated area; in most cases, active shooters use firearms(s) and there is no pattern or method to their selection of victims.

Ballistic Protection- an item of personal armor that helps absorb the impact from firearm-fired projectiles and shrapnel from explosions, and is worn on the torso.

Casualty Collection Point (CCP) –A location where casualties are kept and receive basic medical care until they can safely be moved to a medical treatment area. This location should be inside the cold zone whenever possible, however some situations may require it to be in the warm zone.

Cold Zone - Areas where there is little or no threat, either by geography or after area has been secured by law-enforcement. An area where a RTF will stage to triage, treat, and transport victims once removed from the warm zone.

Contact Team - A rapidly assembled team of LE members responsible for locating, engaging, and stopping an Active Shooter.

Hot Zone - Area where there is known hazard or life threat that is direct and immediate. An example of this would be any uncontrolled area where the active shooter could directly engage an RTF team.

Improvised Explosive Device (IED) - a bomb constructed and deployed in ways other than in conventional military action.

Rescue Task Force (RTF) - a set of teams deployed to provide point of wound care to victims where there is an on-going ballistic or explosive threat.

Tactical Combat Casualty Care (TCCC) – a set of pre-hospital trauma care guidelines for battlefield use that focus on the most common causes of treatable exsanguination deaths in combat.

Tactical Emergency Casualty Care (TECC) - a set of evidence based best practice recommendations for casualty management during high-threat civilian tactical and rescue operations that are based on military TCCC principles but account for differences in the civilian environment, resources allocation, patient population, and scope of practice.

Tactical Emergency Medical Support (TEMS) - an out-of-hospital system of care dedicated to the probability of special operations law enforcement mission success and promoting public safety.

THREAT (acronym)

Threat suppression,
Hemorrhage control,
Rapid ***E***xtrication to safety,
Assessment by medical providers, and
Transport to definitive care

Warm Zone - Areas that law-enforcement has either cleared or isolated the threat where there is minimal or mitigated risk. This area can be considered clear but not secure. This is where the RTF will deploy, with security, to treat victims.

Results

The basis of this research was to answer the four research questions, and this was completed using the action research method. The results of the research were obtained from a literature review, questionnaire and interviews. The questionnaire was responded to by 88 agencies (90.7%), the results of the literature are organized by research question.

Research Question 1: What are the current recommended standards for fire department/EMS active shooter response?

The literature reviews revealed that there are several documents relevant to how a fire department/EMS should respond to an ASI. These documents set forth best recommendations that are based upon scientific data derived from the Vietnam War and

the current War on Terror in the Middle East. Although the recommendations are based upon scientific data they are only recommendations and are not standardized or enforceable nationwide. Despite the movement by many agencies to adopt some or all of the recommendations many other agencies have failed to take any measures to implement the changes in response.

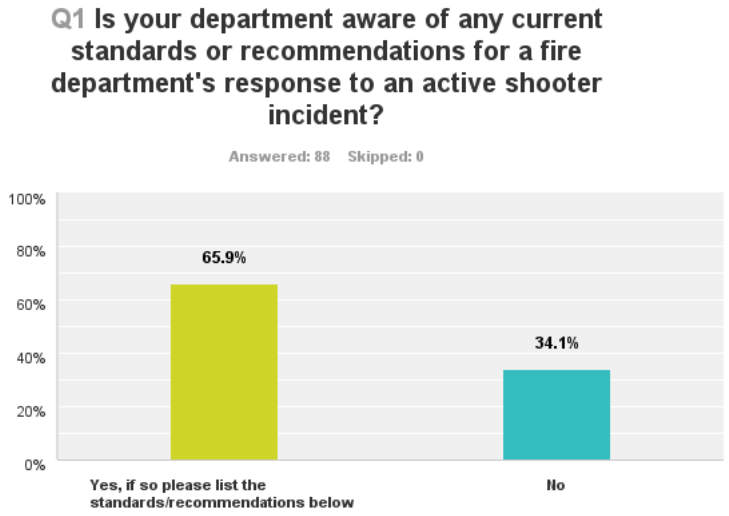
The questionnaire that was distributed to the list of fire department agencies revealed that although many are aware of some form of standard or recommendation for a response to an ASI, many are not. Of the 88 agencies that responded to the questionnaire, all 88 responded to the question regarding whether they were aware of any standard or recommendation for response to an ASI. The response to the questionnaire indicated that 65.9% were aware of a standard or recommendation in how to respond to an ASI. This left 34.1% of the respondents who are unaware of any standard or recommendation. Those that indicated what standards they were aware of or following answered:

- We have adopted the Rescue Task Force (RTF)/TECC concept.
- The SAVE program.
- FEMA, The Interagency Board, Tactical Emergency Casualty Care, IAFF and FBI.
- IAFC
- The IAFC/IAFF suggested policy.
- IAFF Local County recommendations.
- IAFC version.
- USFA Fire/EMS Department Operational Considerations and Guide for Active Shooter and Mass Casualty Incidents Local operating guidelines.

- Hartford consensus Position papers from IAFF, IAFC, IACP, Nat. Fire Administration.
- FEMA recommendations.
- First Responder Guide for Improving Survivability in Improvised Explosive Device and/or Active Shooter Incidents Homeland Security June 2015.
- IAFF Position Statement: Active Shooter Response Department of Homeland Security First Responder Guide for Improving Survivability in Improvised Explosive Device and/or Active Shooter Incidents June 2015 Department of Homeland Security/FEMA Fire/Emergency Medical Services Department Operational Considerations and Guide for Active Shooter and Mass Casualty Incidents September 2013.
- I believe the FFCA or FEMA has a model response to assist our departments in developing our guidelines.
- IAFF and IAFC have recommendations, as does Homeland Security.
- NFPA SAVE PEMS
- SAVE Program
- IAFF position paper
- Swift Assisted Victim Extraction
- US Fire Administration's 2013 active shooter guidelines
- We use the SAVE program.
- CSFD has created a planned resource response to an Active Shooter call. CAD for CSFD mirrors the CAD when CSPD gets a call. Initial resources are dispatched; SOPs outline expected use of resources in Unified Command with CSPD.
- FEMA, FBI as well as our internal policies.

- Police/Swat clear the incident as best as possible while paramedics with ballistic vests, helmets remove and treat victims.
- LAFD has a recommendation.
- IAFF and IAFC
- IAFC and Kansas City region plans.
- Refer to IAFF and IAFC recommendations.
- IAFC IAFF
- FEMA 2013 Fire/Emergency Medical Services Department Operational Considerations and Guide for Active Shooter and Mass Casualty Incidents (However, I did not know of this publication until Nov. 2014 when it was displayed in a PPT in the S.A.V.E. TTT course.) Initiative # 12 of the 16 Firefighter Life Safety Initiatives identified by the NFFF.
- IAFC and IAFF White Papers
- We are currently adopting the rescue task force or "warm zone EMS" model for reported active shooter incidents.
- IAFC guidance
- There are recommendations through the NFA and endorsed by the IAFF and IAFC that were generated, particularly in response to the Newtown school shooting. It offers best practice for FD response to these types of incidents and how to best establish and manage through UC.
- IAFC, NFA and IAFF Guidance

Table 3 Response Standards/Recommendations to an Active Shooter Incident



Research Question 2: What type of specialized equipment is required for an active shooter incident response?

Through the literature review and through a personal interview with the Medical Director of the Leesburg Fire Department it was discovered that there is not specific specialized equipment for an active shooter response. Much of the literature, specifically in the Tactical Combat Casualty Care (TCCC) and Tactical Emergency Casualty Care (TECC) calls for equipment and medical procedures that we already deploy on non-ASI on a routine basis. The single biggest piece of specialized equipment that we did not have access to is the commercially made combat-style tourniquet. The use of tourniquets in our routine medical protocols is the last resort to stop hemorrhaging. Recommendations through TCCC and TECC are to apply a tourniquet as a primary medical intervention to control bleeding. Most of the other recommendations were aimed at how current treatment modalities are implemented in non-combat type scenario, as we operate in on a daily basis, and combat-type scenario, as we would see in an ASI. This is most easily seen in penetrating chest injuries. Under our current protocols the caregiver

must go through numerous steps and assessments, one of which includes assessing lung sounds and an electrocardiogram (EKG), before performing needle decompression to a suspected tension pneumothorax. Under TECC guidelines the process of performing the life saving maneuver of needle decompression is simplified to any person with a penetrating chest injury exhibiting signs of dyspnea.

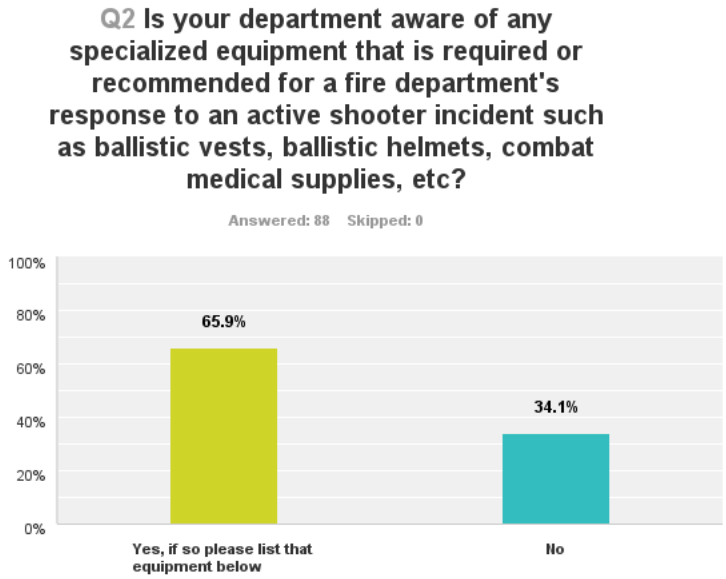
The questionnaire that was distributed to the list of fire department agencies revealed that although many are aware of any specialized equipment for a response to an ASI, many are not. Of the 88 agencies that responded to the questionnaire, all 88 responded to the question regarding whether they were aware of any specialized equipment for a response to an ASI. The response to the questionnaire indicated that 65.9% were aware of specialized equipment to respond to an ASI, this left 34.1% of the respondents who are unaware of any specialized equipment. Those that indicated that they were aware of specialized equipment indicated as follows:

- Short list of hemorrhage control equipment (TQs, Dressings, etc.), minimal invasive equipment (Airway adjuncts, chest decompression kits, cric kits, etc.).
- Our department requires the use of ballistic vests and helmets supplied by the department to on duty personnel.
- Not necessarily required. But, many departments are utilizing: Ballistic Vest, Helmets, Combat Medical supplies, and dragging devices.
- Tourniquets, pressure dressings, hemostatic gauze, chest seals, Level 3A ballistic vests and helmets.
- Ballistic vests, ballistic helmets, MCI/combat medical supplies.
- Ballistic equipment
- Ballistic vests, ballistic helmets, combat medical supplies.

- Ballistic vests and helmets Quick clot Tourniquets.
- We do not provide ballistic equipment.
- Ballistic protective equipment, trauma medical supplies, soft stretchers for rapid extraction.
- EMS has mass casualty protocol trailer with backboards, oxygen delivery devices, cots, etc.
- Ballistic Helmet, Vest TECC trauma bag.
- Swat emergency packs Swat vests Swat helmets slides to remove victims.
- Ballistic Vests, helmet, trauma kit with quick clot.
- Ballistic vests body armor.
- Drag Litters (Foxtrot, Rescue Lift, SORD). Drop Leg Medical Bags, Olaes Bandages, Blast Bandages, and tourniquets.
- As you stated, the model guideline suggests the use of helmets, vests, etc. for personnel responding within the hot zones with the law enforcement.
- Ballistic vests and helmets are recommended, as well as tourniquets.
- FD SWAT team has ballistic helmets and vests. Medical personnel will remain outside the hot zone and have patients brought to them (if possible).
- We have ballistic vests and helmets that are issued to each apparatus and to personnel that are working large-scale events.
- YES - All of the above is in our current budget - not yet purchased awaiting the completion of County-wide SAVE training.
- IAFF position paper
- Helmet, Vest, Foxtrot Stretcher Med Drop Kit

- We have had a local manufacturer of ballistic vest allow us to experiment and deploy vests for evaluation. Costs and deployment are limiting factors.
- Yes we have 10 ballistic vests and helmets and a dozen skeds.
- Police gear including ballistic helmets and vests.
- Ballistic vests and helmets.
- We just purchased helmets and vests.
- Helmets and vests have been ordered and will be implemented after department training on use and application.
- We carry ballistic vest on every rig.
- Body vests Ballistic headgear Specific combat medical supplies.
- We have both vest and helmets available. All response vehicles carry medical supplies including basic combat medical supplies such as rapid application tourniquets, blood stopping materials, and chest seals.
- Ballistic vests and helmets.
- Although aware of the recommendations for the ballistics equipment, the costs of properly fitted equipment and the mandated rotation of the equipment would require a more specialized group response. As the Active Shooter situations are fluid, our department is too small to limit the number of participants. Rescue Task Forces are recommended by FEMA to be equipped with ballistic PPE for ongoing ballistic or explosive threats. Thus, our department has chosen to limit TECC and extraction to warm zone entries only. Thus, we have chosen to utilize the leg bags, the SAVE bag and Mega Movers to outfit 3 SAVE teams. No ballistic PPE.
- Level IIIa MEDIC bulletproof vests with ballistic helmet.
- Recommendation of ballistic PPE for rescue teams.

Table 4 Specialized Equipment for an Active Shooter Incident



Research Question 3: What type of specialized training is required for an active shooter incident response?

Through the literature review and through a personal interview with the SWAT Team Commander for the Leesburg Police Department and the Medical Director of the Leesburg Fire Department it was discovered that there is some specialized training that responders must receive in order to best be prepared for an ASI. An ASI is a dynamic event that has elements from multiple public safety disciplines connected at its core. Although many of the required skills are very familiar to a specific discipline in public safety, i.e. patient care in the fire service/EMS, non-traditional skills must be learned by all of the public safety disciplines (Jacobs et al., 2013). Law enforcement must learn how to perform life saving medical care, firefighters must learn how to operate in the tactical environment, Incident Commanders working in a Unified Command System must learn to operate and develop an appreciation for the other stakeholders at an ASI (United States Department of Homeland Security, 2015).

The literature review process revealed one commonly appearing specialized training program, the Rescue Task Force (RTF) model. The RTF deployment model is a response plan where fire department EMTs/Paramedics are deployed along with a protection force of armed law enforcement officers with ballistic protection worn by all members. This RTF does not wait until the entire building or area is searched as was the process in the past. Historically the fire department/EMS would wait in the cold zone until the entire scene is secured, this often led to unnecessary deaths due to a delay in patients receiving life saving measures ("Columbine Teacher's Family Settles Lawsuit," 2002). The RTF will deploy after an initial law-enforcement contact team encounters the shooter and either neutralizes the threat or the shooter barricades him/herself. Upon the contact team indicating that the threat is secured the RTF will deploy into the warm zone to begin the process of triage, treatment and transport of the wounded. Much of the patient care occurs in a non-traditional environment to fire departments/EMS; therefore the combat medicine approach to patient care has been adopted (Committee for Tactical Emergency Casualty Care, 2014). Because of the level of sophistication that the RTF model requires, departments that are going to undertake the process of preparing for a response to ASI through the RTF model, must seek out the specialized training and, once successfully mastered, must exercise the skills, plan and procedures in order to remain proficient at coordinating the response (United States Department of Homeland Security, 2015).

The questionnaire that was distributed to the list of fire department agencies revealed that although many are aware of any specialized training for a response to an ASI, many are not. Of the 88 agencies that responded to the questionnaire, all 88 responded to the question regarding whether they were aware of any specialized training for a response to an ASI. The response to the questionnaire indicated that 63.6% were

aware of specialized training to respond to an ASI, this left 36.4% of the respondents who are unaware of any specialized training. Those that indicated that they were aware of specialized equipment indicated as follows:

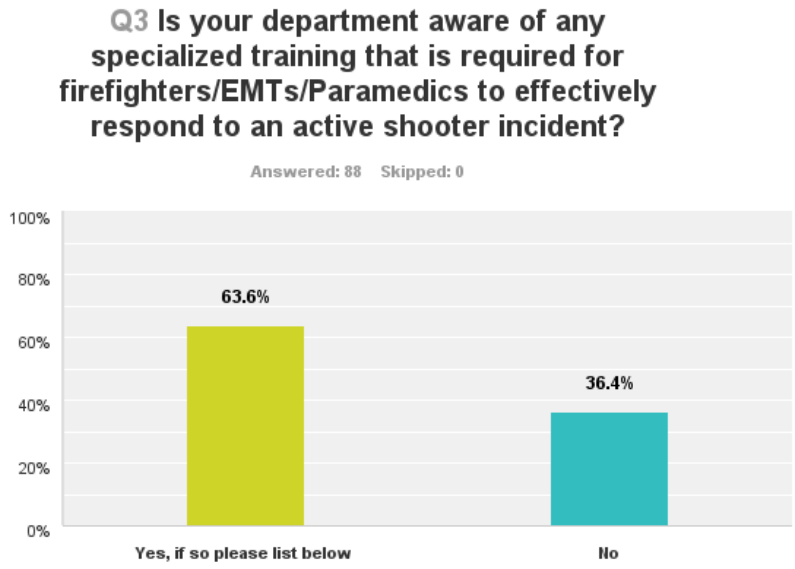
- Once again, we have developed policies around the RTF concept and trained accordingly.
- Not aware of requirement for training ...We did provide in house training to support our SOG and the proper donning doffing of the ballistic vest and helmets to our personnel including mock active shooter drills with PD.
- SAVE not required.
- TECC medical guidelines and Rescue Task Force Training. FEMA on-line Response to Active Shooter course.
- LEFR and TECC courses have been held, with most firefighters taking the LEFR course.
- Our EOC coordinated an active shooter that involved the school, hospital, police, sheriff's office, fire rescue, and road and bridge, and the Turner Center.
- Training as a responder with law enforcement while the scene is still active to access patients and get then out and treated.
- Combat Paramedic programs.
- Local classes offered from time to time.
- Training to operate effectively with law enforcement using rescue task forces and emphasizing a unified command structure.
- The training depends upon response model.
- Training with Sheriffs Office on an annual basis.
- (S.A.V.E.) COURSE

- Our public safety community uses the Swift Assisted Victim Extraction (S.A.V.E.) program.
- Palm Beach County Fire Rescue and Palm Beach Sheriffs Office have a combined training program for this event. We also have a combined Supervisor and Dispatcher training program.
- We have coordinated with sheriff's department for combined training.
- FEMA recommendations, Department SOG
- SWAT Medic program
- S.A.V.E. (Swift Assisted Victim Extraction) Survival Option Services LLC. P.E.M. (Protective Element Medical) Palm Beach County Public Safety Crisis Medical Response.
- I cannot recall specifics but I believe there are courses/classes being offered particularly through our local emergency management.
- Special Operations Training Services - www.sotint.com
- SAVE
- ICS Unified Command MCI protocols Rapid assessment by first entry team for extrication LEO via radio to Fire Command regarding number of casualties during MCI ops.
- SWAT team has trained with PD to coordinate rapid entry, room clearing and rapid extrication of patients.
- Florida TENS, Inc. Active shooter (LEFR and TCC).
- SAVE - In progress county-wide Seminole County (right next door) has launched a county-wide, multi-jurisdictional SAVE Training program for Active Shooter Incidents this month, June 2015.

- SAVE Program
- S.A.V.E. T.E.C.C.
- Yes, the SAVE program
- Specialized training would include familiarization with the history of these type of calls, current practice of LE to immediately address and contain the threat, and the intention of providing medical treatment and transport as soon as possible. Mass Casualty training is already a part of the department's training.
- We have conducted joint training with the police department for the past two years, and are working on response policies and protocols.
- TCCC classes as well as drills with local law enforcement based on industry best practices.
- Police department and fire department train together for such an incident. Police run the incident letting fire know when its clear or when coverage is provided to remove a victim to safety. We are in the infancy stages of this type of training. Our area SWAT team is in charge and has been conducting this type of training. Committee for Tactical Emergency Casualty Care (CTECC), TECC.
- Training with local police agencies.
- The only requirement I know of is that we are required to provide the best service possible to our citizenry.
- TEMS
- St. Petersburg College offers this as a seminar type of class.
- We engage in active shooter training with local law enforcement.
- Not familiar with required training, as this topic is a fairly new venture.

- We are aware of the recommended training in TECC and have begun a 3-session training program under the S.A.V.E. methodology.
- Great Lake Naval has a "SWAT" medic type training program they are working to tailor to a fire department response to an active shooter. Otherwise, we have been doing tabletop and practical drill training set up by local agencies.
- Functional and full scale exercises with law enforcement on the deployment of rescue teams.
- CCCT, in addition to trauma training specific to the equipment being carried - HALO, CAT, etc.

Table 5 Specialized Training for an Active Shooter Incident



Research Question 4: What operational policies and safety procedures must be developed to support a response to an active shooter incident?

Due to the very complex nature of ASI, and the potential for injury to responders, a sound operational policy with appropriate safety considerations in place must exist in order to properly support the rescue effort of victims. A sound operational

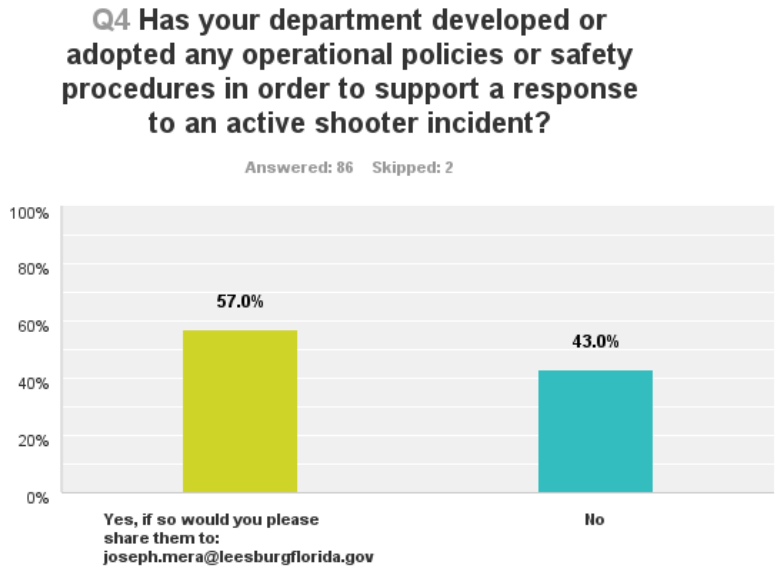
policy must have a risk-management component, according to Atwater (2012), “A policy for paramilitary-style active shooter incidents in a multi-hazard environment should provide firefighters with effective guidelines for risk management.

According to the U.S. Fire Administration (2013) the following key points should be addressed in an operational plan:

1. Command must be established.
2. Common terminology must be used.
3. A single ICP should be established.
4. Requirements for responders to wear appropriate PPE to include ballistic protection.
5. Cautious and deliberate approach to the scene.
6. Units that will stage must be at a safe distance.
7. If exposed to gunfire, rescuers must withdraw to a safe area.
8. Automatic/mutual aid arrangements should be in place well in advance of an incident.
9. Staging areas and rally points established.
10. Coordination with local hospitals.
11. The plan and policy must be exercised regularly.

The questionnaire that was distributed to the list of fire department agencies revealed that although many are aware of a need for a response to an ASI, many do not have a policy in place to support an ASI. Of the 88 agencies that responded to the questionnaire, all 88 responded to the question regarding whether they had an operational or safety policy in place for an ASI response. The response to the questionnaire indicated that 57% had operational/safety policies in place to respond to an ASI, this left 43% of the respondents who do not have policies regarding a response to an ASI. Those that

indicated that they had an operational policy in place were asked to forward a copy to the author for use as a template in developing the product of this applied research paper, 13 departments responded with SOG/SOPs.



Discussion

The ASI that have unfolded in the last decade have shown that no community is immune from the horrifying acts of a gunman intent on causing harm to innocent civilians. The only pattern that can be discerned from the study of where and when these have happened is that there is no pattern and no way to predict when the next ASI might take place. Through the research the FBI performed to evaluate the trends in ASI "the trend over the study period showed a steady rise in ASI. In the first half of the years studied, the average annual number of incidents was 6.4, but that average increased in the second half of the study to 16.4, an average of more than one incident per month (Blair & Schweit, 2014, p. 20). The FBI has classified some of the most frequent locations where a shooter might decide to shoot civilians; according to their research the most common incident type locations are not specific to any jurisdiction. ASIs occur in commerce

areas, educational institutions, government facilities, and open spaces (Blair & Schweit, 2014), the City of Leesburg has all of these types of incident locations.

The events that unfolded at the Columbine High School shooting have become defining moments in the paradigm shift from the way that law enforcement and fire departments have historically responded to ASI. With the recommendations that came from Mell and Sztajnkrycer (2005) the way an ASI response is handled has changed dramatically although painfully slow. Aside from the recommendations that came forth from the after action review of the Columbine shooting, litigation was also brought forward from the family of victims. "The daughter of slain Columbine teacher Dave Sanders has reached a $1.5 million settlement in her lawsuit against the Jefferson County Sheriff's Office, saying the department has finally been held accountable for failing to rescue her father" ("Columbine Teacher's Family Settles Lawsuit," 2002, para. 1). Only after Columbine were the recommendations that EMS be integrated along with law enforcement at events such as ASI (Mell & Sztajnkrycer, 2005). Along with that integration came the specialized training such as Tactical Emergency Medical Support (TEMS) which would improve the survivability of victims by having officers making entry into a building with medical training along with TEMS trained EMTs and Paramedics.

The current practice by Leesburg Fire Department on any violent event to wait until a perimeter has been established and the scene being secured by law enforcement is contrary to TCCC guidelines. The trauma victim can exsanguinate in a matter of five minutes or less; the leading cause of preventable death in the combat environment is isolated extremity trauma exsanguination. The "stand-by" response model for fire departments/EMS has proven to be ineffective in savings the lives of shooting victims (Atwater, 2012).

The change from the "stand-by" model has given way to the Rescue Task Force (RTF) model (Atwater, 2012). The RTF model is the response model of choice by many entities. Organizations such as the U.S Fire Administration, International Association of Police Chiefs, International Association of Fire Chiefs and the International Association of Firefighters have mutually agreed that the RTF response model is the most effective response to an ASI (Smith & Delany, 2013).

Aside from a shift away from standing by until the scene is secured, we must also change our way of treating patients at an ASI. When a gunman goes on a shooting spree there are more factors that cause the scene to resemble more of a battlefield and not a routine gunshot wound incident. The very nature of an ASI demands that we change our treatment modalities from the civilian non-combat arena to a battlefield modality. Rescuers on a RTF cannot carry all the equipment that they would carry and have at their disposal at a routine medical call. Because of this lack of access to equipment due to the impracticality of carrying it, we must use the lessons learned in combat. Medics in combat do not have access in the field to cardiac monitors, blood pressures cuffs, pulse oximetry, or other advanced diagnostic equipment. Trauma treatment modalities were modified from the lessons learned from recent battlefield data.

The Hartford Consensus has given several critical recommendations in how to increase victim survival. The paramount point brought out is the need to control hemorrhage early in the patient care process in order to improve survival. The Hartford Consensus' recommendations include the acronym **THREAT:**

1. ***T****hreat* suppression
2. ***H****emorrhage* control
3. ***R****apid* ***E****xtrication* to safety
4. ***A****ssessment* by medical providers

5. ***T****ransport* to definitive care (Jacobs et al., 2013, p. 1400)

The SOG that came as a result of this research has adopted the key point from the literature review, the questionnaire that was distributed to 97 fire departments and recommendations from the Leesburg Fire Department's medical director. That SOG will remain as a draft until final approval from the Leesburg Fire Chief.

Aside from the current information and data that exists and supports entry into the warm zone under a RTF type model to rescue victims the fire service must be ever vigilant to changing trends that violent perpetrators might adopt. An ASI shares traits of combat, and just as opponents in combat change tactics as they learn their adversary, those bent on committing violent acts might change their tactics in order to hurt or injure responders. Because of this, the research into this topic must continue and intelligence shared when injuries from responders are reported at an ASI.

Organizational Implications

There are several implications to the Leesburg Fire Department both on adopting an ASI policy and likewise for choosing to not adopt a policy. For a department that chooses to not realize that a threat from and ASI is real there will be two major implications. First, and most important, is the fact that should an ASI occur, there is a great risk to victims that they might not survive if the response is the typical "stand-by" mode, evidence has already been presented that a patient can "bleed-out" in a matter of minutes (Jacobs et al., 2013). Secondly, victim's families have successful brought forth litigation against first responders who responded to an ASI in the "stand-by" mode until the entire scene was secured. This litigation has cost response agencies in the millions of dollars in awards from the courts ("Columbine Teacher's Family Settles Lawsuit," 2002).

The implications for not adopting a proactive ASI response policy are potentially more impactful than if an agency does, despite this there are implications a department

will face for implementing a policy. The most obvious implication is the costs associated with medical supplies, ballistic protection, and training. These costs could vary greatly from one department to another and are based upon a multitude of factors. Another implication for adopting an ASI is the pushback that might come from the rank and file. Both the IAFF and the IAFC have written position papers supporting the RTF model for an ASI, despite this each department has its own culture that might not be as supporting as the international organizations.

Recommendations

The purpose of this Applied Research Project was to develop an active shooter response SOG for the Leesburg Fire Department. This ASI response SOG would provide for a safe and effective method of responding to an ASI. After conducting the research through a literature review, a questionnaire of fire/rescue agencies, and interviews with the Medical Director and the SWAT Commander it was determined there are some published standards on how a fire department/EMS agency should respond and operate at an ASI. The Rescue Task Force model gives rescuers and patients an effective means to mitigate the hazards and provide for the best medical care under the conditions to the injured. It is realized that there are some difficulties in developing and implementing an ASI response SOG such as costs of the specialized equipment and training, coordination with local law-enforcement agencies and obtaining employee “buy-in” to the response model, despite this the following recommendations were made:

1. A meeting should be set up between the Fire Chief and senior fire department staff to review the findings of this ARP. The purpose of this meeting would be to clarify, express and relay to the Fire Chief and the senior staff that adopting an ASI response SOG is a worthy and valuable

endeavor. The information discovered through this research project would be supplied as necessary.

2. The model ASI response SOG that is located in Appendix E be adopted.
3. A presentation should be made to the members of the department to explain what an ASI is, the process we are going through in developing a response SOG, the benefits that might be realized and indicating the commitment that has already been given to the process.
4. The funding for the equipment and training would be budgeted for in the next fiscal budget.
5. Neighboring agencies that are interested in pursuing a formal ASI response SOG would be contacted with the intent to pool resources, knowledge, skills and abilities. The intent of such a relationship is to have advocates for developing the ASI response model.
6. A training program should be developed to assist in the implementation of the Rescue Task Force approach to an ASI.

In conclusion the Leesburg Fire Department would see these benefits were clearly revealed through this research project. This particular threat to the public must be approached from a different perspective than as we have in the past. We must take a progressive and “outside the box” posture; what we have done in the past is not going to work for an ASI. The Leesburg Fire Department should adopt the Rescue Task Force model that has been endorsed by the International Association of Fire Chiefs, the United States Fire Administration and the International Association of Firefighters.

Appendix A- Fire Department Questionnaire

1. Is your department aware of any current standards or recommendations for a fire department's response to an active shooter incident?

Yes, if so please list the standards/recommendations below

No

Other (please specify)

2. Is your department aware of any specialized equipment that is required or recommended for a fire department's response to an active shooter incident such as ballistic vests, ballistic helmets, combat medical supplies, etc?

Yes, if so please list that equipment below

No

Other (please specify)

3. Is your department aware of any specialized training that is required for firefighters/EMTs/Paramedics to effectively respond to an active shooter incident?

Yes, if so please list below

No

Other (please specify)

4. Has your department developed or adopted any operational policies or safety procedures in order to support a response to an active shooter incident?

Yes, if so would you please share them to: joseph.mera@leesburgflorida.gov

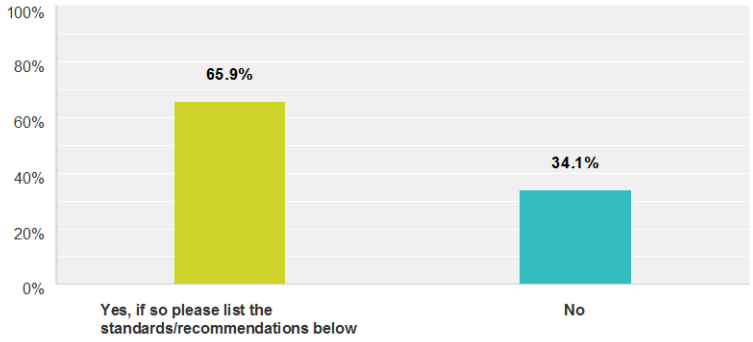
No

Done

Appendix B- Fire Department Questionnaire Results

Q1 Is your department aware of any current standards or recommendations for a fire department's response to an active shooter incident?

Answered: 88 Skipped: 0

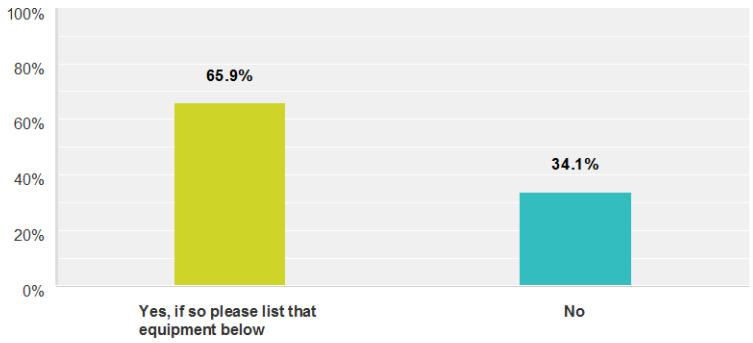


Answer Choices	Responses	
Yes, if so please list the standards/recommendations below	65.9%	58
No	34.1%	30
Total		88

Fire Department Response to Active Shooter Incidents SurveyMonkey

Q2 Is your department aware of any specialized equipment that is required or recommended for a fire department's response to an active shooter incident such as ballistic vests, ballistic helmets, combat medical supplies, etc?

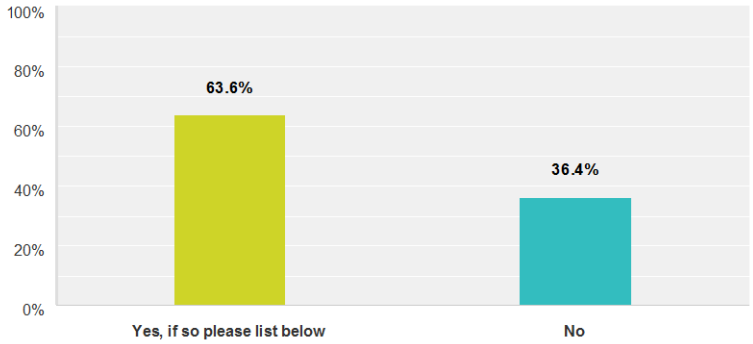
Answered: 88 Skipped: 0



Answer Choices	Responses	
Yes, if so please list that equipment below	65.9%	58
No	34.1%	30
Total		88

Q3 Is your department aware of any specialized training that is required for firefighters/EMTs/Paramedics to effectively respond to an active shooter incident?

Answered: 88 Skipped: 0

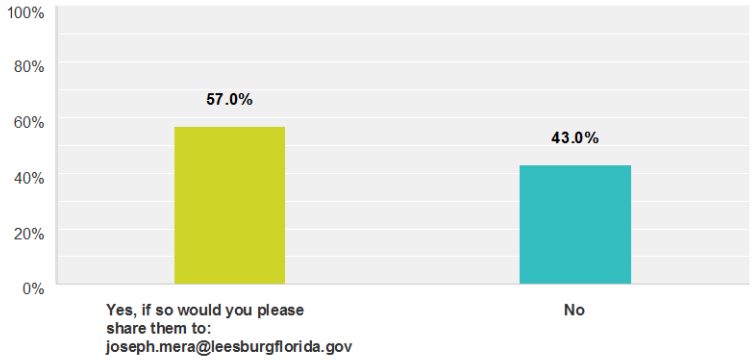


Answer Choices	Responses	
Yes, if so please list below	63.6%	56
No	36.4%	32
Total		88

Fire Department Response to Active Shooter Incidents SurveyMonkey

Q4 Has your department developed or adopted any operational policies or safety procedures in order to support a response to an active shooter incident?

Answered: 86 Skipped: 2



Answer Choices	Responses	
Yes, if so would you please share them to: joseph.mera@leesburgflorida.gov	57.0%	49
No	43.0%	37
Total		86

Appendix C- Sample Active Shooter Incident SOGs

Delray Beach Fire-Rescue Department
Standard Operating Guidelines

Volume:	
Chapter:	
Section:	**Active Shooter /Hostile Situation**
Date:	**Danielle Connor, Fire Chief**

1.01 PURPOSE:
The purpose of this document is to provide guidance for performance of scene control, victim treatment, and evidence preservation while maintaining the safety of all emergency personnel in the event of an Active Shooter/Hostile Situation. These incidents require close coordination between Delray Beach Fire-Rescue (DBFR) and Law Enforcement (LE) personnel due to the incident complexity. The primary goal is to minimize the risk to personnel and to provide a common framework when handling these types of incidents.

1.02 POLICY:
It is the policy of DBFR to follow these guidelines established during an Active Shooter/Hostile Situation. The prime consideration must be the SAFETY of all DBFR personnel by a constant assessment of RISK/BENEFIT factors in operations undertaken by all personnel.

1.03 AUTHORITY:
The authority vested in the Fire Chief by Florida Statute 166.021; Section 1.02 and 4.04 of the City of Delray Beach Charter; and Section 32.01, 32.21 and 33.20 of the City of Delray Beach Code of Ordinances.

1.04 RESPONSIBILITY:
It is the responsibility of the Assistant Chief of Operations to review and update this policy.

1.05 OPERATIONS:

1. When the Dispatch Center receives a call for a shooting and determines that shooting is ongoing (i.e., an active shooter incident) the following initial resources equivalent to a Level 2 MCI will be dispatched if the number of victims is unknown. Once the victim count is verified then the MCI level can be upgraded or downgraded as needed.

6 ALS Transport Units
5 Suppression Units
4 Command Staff

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2. The first arriving DBFR unit:
    - Establish command in accordance to DBFR Incident Command Standard Operating Guidelines -Volume II, Chapter 1, Section 1

3. To effectively handle a potential MCI, the Incident Commander (IC) should:

    - Establish organizational structure in accordance to DBFR Multiple Casualty Incidents Standard Operating Guidelines -Volume II, Charter 2, Section 18

4. The MCI functions of Triage and Treatment will take place in the Casualty Collection Point (CCP) unless the scene is determined to be safe, "a cold zone," then triage may be performed where the victims are and the victims moved to a treatment area when transport is available from the established staging area.

Tactical Considerations:

- Early reconnaissance and staging when Active Shooter incident conditions are recognized.
- Announce the Staging Area location and Incident Entry Point.
- Establish Unified Command with LE.
- Work with LE to identify Hot Zone and ensure no DBFR personnel enter area.
- Work with LE to identify Warm Zone for Rescue Task Force (RTF) deployment.
- Create Rescue Task Force (RTFs) from the initial responding resources and secure force protection.

5. Fire Operations should be defensive in nature and conducted in such a fashion that personnel safety is maximized. Consideration should be given by all deployed companies to providing a quick retreat should the conditions become untenable or ill advised.

    - Active fires will be allowed to burn until confirmation of a secure scene has occurred.
    - Additional fire resources should be pre-staged, with consideration of the worst-case scenario.

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1.06 RTF DEPLOYMENT

Once unified command has agreed to RTF deployment, teams will deploy to the warm zone to begin victim care.

1. Command will dispatch RTF teams by numbers, (i.e., RTF Team 1). RTF Teams are not to deploy unless they have LE personnel for security. DBFR shall not self-deploy into the warm zone.

2. Prior to deploying an RTF team, threat zones must be identified:

    - Hot Zone - Area where there is known hazard or life threat that is direct and immediate. An example of this would be any uncontrolled area where the active shooter could directly engage an RTF team. RTF teams will not be deployed into a Hot Zone.

    - Warm Zone - (also known as the area of indirect threat) Areas that LE has either cleared or isolated the threat where there is minimal or mitigated risk. This area can be considered clear but not secure. This is where the RTF will deploy, with security, to treat victims.

    - Cold Zone - Areas where there is little or no threat, either by geography to threat or after area has been secured by Police (i.e. Casualty Collection Points). An area where DBFR will stage to triage, treat, and transport victims once removed from the warm zone.

3. The first RTF team to make entry should notify the EMS branch through the Medical Group Supervisor of possible number of injured.

4. The first two RTF teams will enter the area and treat as many patients as possible until they run out of equipment to use or all accessible victims have been treated. Once this point has been reached, these RTF teams start the evacuation of injured. Additional RTF teams that enter the area should be primarily tasked with extrication of the victims treated by the initial two teams. If needed, additional RTF teams may be sent into areas unreached by the initial teams or to other areas with accessible victims.

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5. When the RTF is operating in the Warm Zone, no triage will be conducted. All patients encountered by the RTF teams will be treated as they are accessed. Any patient who can ambulate without assistance will be directed by the team to self-evacuate down the cleared corridor under LE direction, and any patient who is dead will be visibly marked to allow for easy identification and to avoid repeated evaluations by additional RTF teams.

6. To coordinate RTF teams inside a warm zone, a single DBFR Company/Chief Officer may deploy into the warm zone under LE security. This will help guide the RTF teams and allow ease of communications with the EMS branch.

7. RTF can be deployed for the following reasons.

    - Victim treatment
    - Victim removal from warm to cold zone
    - Movement of supplies from cold to warm zone
    - Any other duties deemed necessary to accomplish the mission

8. RTF personnel will work within their security team at all times.

1.07 RTF EQUIPMENT

The equipment needed for the individual RTF personnel are located on EMS111, BAT111, and DBFR MCI Trailer.

- EMS Supervisors carries three individual sets containing three helmets, three ballistic protective vest, three remote microphones w/ear pieces and two treatment bags.

- Battalion Chief carries two individual sets containing two helmets, two ballistic protective vest, two remote microphones w/ear pieces and one treatment bag.

- DBFR MCI Trailer carries fifteen individual sets containing fifteen helmets, fifteen ballistic protective vest, fifteen remote microphones w/ear pieces and six treatment bags, and MCI equipment.

- Each vest contains enough equipment to treat approximately eight victims, depending on injuries, and the extra equipment bags have enough equipment to treat an additional sixteen victims.

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- Each RTF member should equip themselves with a minimum of a Kevlar helmet, body armor, flashlight, radio, and exam gloves. Remote microphones w/ear pieces are required to ease communication with teams.

1.08 GENERAL:

A. Once an active shooter/hostile situation is identified, a primary objective should be establishing Command. Ideally a Unified Command with LE agency having jurisdiction is the first choice however, in the absence of LE, Command shall be established by the first arriving DBFR unit and transferred as rapidly as practical to the Company Officer/Chief Officer.

B. The primary responsibility for overall incident safety, security, and stabilization during an active shooter/hostile situation rests with the LE agency having jurisdiction. DBFR plays a supporting role in these types of events and must integrate into either an established Command or as a branch under Operations or a Unified Command structure with LE.

C. Because of the likelihood of multiple incidents occurring simultaneously or a rapidly expanding incident, DBFR personnel must take a proactive approach in activating the Emergency Operations Center (EOC) if warranted. The Incident Commander (IC) must determine the likelihood of disturbance escalation and request to implement this procedure as needed.

D. DBFR personnel should not enter the immediate area where a direct threat is believed to exist. However, if there is a basis to believe that the threat is no longer present, it may be appropriate for DBFR personnel to render aid or take other appropriate action, even prior to the arrival of LE. Extreme caution should be exercised when on scene of an incident involving a violent crime when no LE is present

F. Depending on the size of the incident and location, injured victims may need to be placed in a Causality Collection Point (CCP) before transition to the cold zone. This will be predetermined by initial units, secured by LE, and relayed to the RTF teams through Unified Command. As this area will be secure, it may be considered a Cold Zone and may be staffed with non-RTF personnel.

G. Response into a “Restricted Area or Warm Zone” will only occur with security force protection (LE) which must remain with FR units at all times until the mission is completed, then escorted out of the “Restricted Area”. The IC will be advised immediately of any exceptions. DBFR personnel **WILL NOT** respond into “Denied Areas or Hot (Red) Zones.”

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H. Units in staging will NOT be deployed into a known or suspected lockdown area until Unified Command confirms LE has the area secure and that they can maintain the security of areas for DBFR operations.

I. All DBFR or mutual-aid units assigned to the incidents, or in staging, are to be informed fully of situations, through the IC or designee, as they develop. The safety of mutual-aid units will receive the same priority as the primary DBFR units.

J. At no time shall the organizing or deployment of MCI functions delay the activation of the "THREAT" principles once an area of the incident has been granted access for a Rescue Task Force.

K. Emergency warning lights, sirens, and horns are **NOT** to be used while responding within lockdown areas and responses will be in a non-emergency mode unless directed.

L. DBFR resources will be committed to an incident in the lockdown area only if the IC determines that the benefits outweigh the risks.

1.09 DEFINITIONS

1. **Active Shooter:** One or more assailants participating in a random or systematic shooting spree, demonstrating their intent to continually harm others. Their overriding objective is to kill and injure as many people as possible. The assailants may also utilize other weapons (e.g. explosive devices, edged or blunt-force trauma weapons, weapons of mass destruction, etc.).

2. **Rescue Task Force (RTF):** is a set of teams deployed to provide point of wound care to victims where there is an on-going ballistic or explosive threat. These teams treat, stabilize, and remove the injured while wearing Ballistic Protective Equipment (BPE) in a rapid manner under the protection of LE. A RTF team must include at least one paramedic.

3. **Casualty Collection Point (CCP):** A location in the "Strong Hold" (warm zone) where DBFR can receive and treat victims brought by LE. This area should remain the primary treatment area for life threating injuries until transport is available or the scene is determined to be "cold" and the CCP will transition to the treatment area. Victims may be brought to the CCP by LE personnel or DBFR personnel, usually by being dragged or carried out of the hot zone.

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4. **Contact Team:** A rapidly assembled team of LE members responsible for locating and stopping an Active Shooter.

5. **Rescue Team:** A designated group of LE Officers that are not involved with the contact team, they will begin to assist with victim removal and coordinate with DBFR personnel for removal of critical patients.

6. **Risk vs. Benefit:** A critical decision making formula that states "Risk a lot to save a lot, Risk a little to save a little, Risk nothing to save nothing"

7. **"THREAT":** An acronym stands for **T**hreat Suppression, **H**emorrhage Control, **R**apid **E**xtrication to Safety, **A**ssessment by Medical Providers, **T**ransport to Definitive Care.

8. **Cover:** is a LE term that represents an object or location that provide protection from direct gunfire.

9. **Force Protection (FP):** Actions taken by LE to prevent or mitigate hostile actions against personnel, resources, facilities, and critical infrastructure.

10. **Strong Hold:** An area of the scene, typically inside a structure that serves a defensible area with relative security. Examples can be a portion of the interior of a structure that has doorways and access covered by armed protection.

1.10 RECOVERY

1. Records retention is crucial. Document all cases and information, in detail, for possible later investigation and shall be considered Public Safety Sensitive (PSS).

2. Photos by authorized personnel of any damage to our property or apparatus should be taken before repairs are made.

3. Consideration of a Critical Incident Stress Management Team (CISM)/Behavioral Health response for responders.

Active Shooter (Active Threat) Response - DRAFT

Purpose

To provide a standardized method for responding to and operating at a scene where an active threat exists and staging until the violence ceases will cause significant loss of lives. Response at these scenes will be executed in a manner than allows the highest possible level of security to personnel while allowing victims to be treated and removed to an area of safety.

Background

There have been increasing incidents of violence that involve persons injuring a large number of victims in a confined area. Most of these incidents involve 1 or 2 perpetrators attempting to injure or kill as many people as possible in a short amount of time. The typical means of inflicting injury is a firearm leading to the term Active Shooter (AS), although other weapons may be used.

Law enforcement (LE) has changed tactics in response to this threat. First arriving LE units will immediately begin to actively find, engage, and neutralize the perpetrator(s). As more LE units arrive, they will begin to either backup the first units or secure the area as much as possible. It is at this point that fire/EMS personnel may become involved.

Definitions

Active Shooter: An individual or individuals actively engaged in killing or attempting to kill people in a confined and populated area.

Hot (Red) Zone: The immediate incident location with a direct and immediate threat to personnel safety (not a secure area). Fire/EMS personnel will not enter this zone.

Warm (Yellow) Zone: An operational (geographic) area with a potential threat to personal safety. The Warm Zone typically exists between the Hot Zone and the Cold Zone. Fire/EMS personnel shall be escorted by a Law Enforcement security detail at all times while in this area. Only essential personnel will be given authority and clear direction to operate in the Warm (Yellow) Zone.

Cold (Green) Zone: An operational (geographic) area surrounding the Warm Zone where personnel can operate with minimal threat to personal safety.

Contact Team: A rapidly assembled team of LE members responsible for locating, engaging, and stopping an Active Shooter.

Rescue Team: A group of LE Officers that are not part of the Contact Team. They will begin to assist with victim removal and coordinate with fire/EMS personnel to form Rescue Task Force(s).

Rescue Task Force: Shall be comprised of a minimum of 2 LE officers and 2 fire/EMS personnel. The Rescue Task Force will be responsible for removing victims from within the Warm Zone to a Casualty Collection Point. The fire/EMS personnel shall be responsible for patient transport. LE Officers shall be responsible for the security of fire/EMS personnel.

Casualty Collection Point (CCP): A location at the edge of the Warm Zone where Rescue Teams and/or Rescue Task Forces will bring patients to. This area should remain the primary treatment area for life threatening injuries until transport to an MCI Treatment Area in the Cold Zone is available. Once the scene is determined to be "cold" the CCP may transition to the MCI Treatment Area.

Incident Command Post (ICP): Physical location of on-scene incident control.

Unified Command: Integration of command personnel from each responding agency.

Improvised Explosive Device (IED): An explosive device constructed and deployed in unconventional ways.

Policy

Identification of an Active Shooter Incident occurs when:

1. Dispatch notifies responding units that the incident is an Active Shooter Incident.
2. On scene LE notifies Dispatch that the incident is an Active Shooter incident.
3. Fire/EMS responding units recognize the incident as an Active Shooter incident.

Fire/EMS Response

When the incident is declared an Active Shooter Incident and there are an unknown number of patients a MCI Level II will be dispatched. This includes:

- 6 Rescues
- 3 Engines
- 2 Battalion Chiefs
- 2 EMS Operations Captains
- Special Ops or Truck
- Staff Page

First arriving Battalion Chief or Captain duties:

1. Determine the location of the LE Command Post
2. **NOT proceed into scene without establishing contact and clearance from on-scene LE.**
3. Establish Unified Command by physically proceeding to LE Command Post.

4. Determine a safe Staging Area in Cold (Green) Zone for all incoming units. Consider:
   a. Physical hard barriers that shield the units and personnel from the incident.
   b. Distance from the scene that reduces the chance of injury from firearms and IEDs.
   c. Allows adequate space for entry and exit of units.
5. Determine with LE the location of a CCP
6. Determine if Rescue Task Forces should deploy from the CCP or other location
7. Prepare to form Rescue Task Forces.
8. Determine if there is a need for special operations (i.e. haz-mat, high-angle, etc.)
9. Monitor potential patient numbers and increase response as indicated
10. Maintain contact and patient count with personnel at CCP
11. Adjust to operating as the appropriate MCI Level incident once the threat is neutralized and LE has declared the scene safe.

Units arriving at the Staging Area:

1. Units will stage at the identified Staging Area, and personnel will remain with their apparatus until an assignment is given from Command.
2. Rescue personnel shall put the rescue supply items in the MCI/AS Kit and bring it with them. This kit shall contain:

   a. Permanent items:
   - Left Pouch
     - 1 - Can Orange Marking Paint
     - 1 - FEMA Search Marking Instruction Card
     - 2 - Lumber Crayons
     - 2 - Grease Pencils
   - Bottom Pouch
     - 1 - Mega-mover
   - Right Pouch
     - 2 - Pairs Trauma Shears
     - 2 - White Light Sticks with lanyards
   - Center Pouch
   - 2 - START Triage Ribbon Pouches
   - 2 - “Triage” Vests

   b. Rescue Supply Items – to be placed in the center pouch:
   - All SWAT-T tourniquets
   - All multi-trauma pads
   - All ABD pads
   - All kerlix
   - All 3” tape
   - All OPAs and NPAs
   - All chest seals

- All 14 g angiocaths
- 1 - Box XL gloves
- 1 - Box L gloves

3. Engine personnel shall remove the oxygen tank from the Engine BLS Bag and bring this bag with them.
4. Await orders from Command to deploy to either the CCP or to a predetermined location to become part of a Rescue Task Force. **Do NOT proceed into scene without establishing contact and clearance from Command.**
5. Prepare to transition to the appropriate MCI level incident once the threat is neutralized

All personnel shall**:**

1. Not operate independent of direction from Command
2. Maintain a high level of situational awareness. Be aware of the following:
    a. Suspicious individuals and packages.
    b. Suspicious vehicles.
    c. Weapons/IEDs worn/found on the body of the shooter if the shooter is injured or killed
3. As possible, avoid civilian areas or predictable routes because of the potential of hidden IEDs.
4. When transporting patients, do not transport any objects that could contain hidden weapons or IEDs (e.g., backpacks, purses, briefcases, suitcases).
5. Be aware that the perpetrator(s) could be mixed in with the victims.

Rescue Task Force Operations:

1. Form Rescue Task Force of a minimum of 2 fire/EMS and 2 LE officers
2. Communicate identity of crew members and direction of deployment to Command
3. Rescue Task Force LE officers dictate speed and direction of Rescue Task Force movement
4. **Rescue Task Force members are to stay together**
5. Upon arrival at a potential patient, START Triage shall be used
6. Severe hemorrhage control and OPA/NPA insertion and tension pneumothorax decompression shall be the only treatment considered at that time
7. Place non-ambulatory patients in Mega-mover and prepare to transport to the CCP

Casualty Collection Point (CCP) Operations:

1. Treat any severe wounds, airway control, chest decompression issues as possible
2. Retriage patients as they arrive and prepare for movement to Treatment Area when advised to do so by Command
3. Update Command with patient count and severity when requested

Event Termination for Fire/EMS:

1. BC or EMS Operations Captain will coordinate a mandatory CISM response
2. BC or EMS Operations Captain will coordinate a mandatory IAP of the incident

OPERATIONS AT ACTIVE SHOOTER INCIDENTS

SCOPE

This ROG establishes recommended operating guidelines for safe fire department and EMS responses to active shooting incidents that will maximize the possibility for victim survival and to minimize the "arrival to patient contact time." In addition, this ROG establishes standardized procedures for implementing joint Fire/EMS/Law Enforcement patient extraction teams for active shooter incidents while minimizing risk to personnel.

Historically, fire and EMS departments (FD/EMS) have been unable, due to policy, or unwilling to enter warm zones at active shooting scenes until law enforcement (LE) resources have given the "all clear." FD/EMS response actions to active shooting incidents have been to stage and wait for an "all clear" from the involved LE agency. In active shooting incidents where great bodily harm to multiple casualties have occurred, or continue to occur, an "all clear" from LE may not be given for an extended period of time. In order to save lives and minimize casualties from such a tragedy, FD/EMS personnel must act as soon as the immediate threat is neutralized or contained. If viable casualties exist, then extraction teams must be deployed in a coordinated and timely manner. This would be done after careful consideration of the situation, under a defined Incident Action Plan (IAP) after considering the Risk Management Profile.

DEFINITIONS

- Active Shooter Incident – any event or occurrence where an armed person who has used deadly physical force on other persons and continues to do so while having unrestricted access to additional victims.
- Active Shooter – an armed person who has used deadly physical force on other persons and continues to do so while having unrestricted access to additional victims and ammunition.
- Barricaded/Hostage incident – a static situation involving an armed suspect, (with or without hostages), who has demonstrated or voiced violence, and has fortified a position of advantage in a room or building. No indication of immediate harm to any hostages.
- Casualty Collection Point (CCP) – a specific, designated area located in the cold zone where extraction teams hand casualties over to treatment personnel.
- Commander – The individual in charge of all resources within a given discipline (e.g. Fire Commander, EMS Commander, and Law Enforcement Commander). Under Unified Command, the Fire, EMS, and Law Enforcement commanders represent their respective disciplines within unified command and have individual authority limited to decisions concerning the use, non-use, or limitations on use of resources within the discipline represented.
- Concealment – protects you from observation, not weapon fire.
- Cover – protects you from observation and weapon fire.
- Contact Team – a group of Law Enforcement Officers that have the intent to stop the suspect(s) deadly actions.
- Dynamic Situation – an incident that is fluid, evolving and changing with constant movement, numerous casualties, discovery of IED's and other tactical challenges.

- Extraction Teams – a group of personnel responsible for the rapid relocation or extraction of viable casualties from an incident “warm” zone to a casualty collection point or cold zone.
- Neutralized or Contained – the shooter(s) are dead, in custody, fled the scene, reasonably contained or barricaded.
- Person with A Gun Incident – any event or occurrence where the reporting party states that a person does or did have a gun. This would include any handguns or long guns.
- Risk Management Profile – a preamble in which response personnel operate under that ensures the visibility, assessment and mitigation of risk and loss of life in an emergency situation.
    - We will assume a significant degree of manageable risk to protect savable lives
    - We will assume a minimal degree of manageable risk to save what is already lost
    - All of the above are under a structured plan
- Scene Safe to Enter – law enforcement has determined that there are no known threats in the immediate area or incident location and it safe to move about the perimeter.
- Warm Zone – an area of an incident that the Law Enforcement Contact Team has been through without engaging the subject(s) and communicated the location of all viable victims.
- Stage for Law Enforcement – units should stage far enough away as to not become part of the incident, out of line of sight, out of line of fire and behind cover and with two directions of egress without turning around. Companies should turn off warning lights and be aware of any crowds that may pose a hazard.
- Static Situation – the suspect(s) have stopped moving and appear to be contained. An uncontained static suspect(s) can become dynamic without notice.
- Tactical Benchmark – specific items, information or tasks that have been identified for mitigating an active shooting incident.
- Transportation Group – coordinates ambulance/rescue usage with Treatment Group and also, notifies and coordinates the number of patients sent to hospitals.
- Treatment Group – set in the “Cold Zone” and allocates resources to treat casualties with an emphasis on rapid treatment and transportation.
- Triage Group – receives casualties from extraction team and performs triage
- Violent Incident – any event or occurrence in which personnel may be exposed to harm as a result of a violent or threatening act whether real or implied.

POLICY

In order to save casualties of violent incidents, the FD/EMS agencies in Manatee County will work in
cooperation with LE agencies to facilitate the timely rescue of viable casualties of active shooting incidents. Under Unified Command, all involved FD/ EMS, and LE agencies will work collaboratively to develop a plan to extract, treat, and transport viable casualties of these incidents in a timely manner.

Once the immediate threat has been neutralized or contained, FD/EMS personnel, including the first arriving supervisor(s), will begin gathering information and make contact with arriving or on scene law enforcement personnel to identify the need to establish Extraction Teams.

These extraction teams will quickly move viable casualties from the warm to cold zones of the incident. This expedites casualty relocation to a safer area where definitive EMS procedures can be performed at a significantly reduced risk. FD/EMS personnel will only enter warm zones when the defined tactical benchmarks (as listed in Critical Tactical Benchmarks) have been completed.

PROCEDURES

The following considerations are provided to give responding personnel direction and benchmarks to assist Unified Command (UC) in making the decision whether or not viable casualties are in the warm zone and are in need of rescue. The initial FD Commander will gather information and, if appropriate, coordinate an extraction plan in conjunction with LE through direct communication, within the Risk Benefit Analysis. Extraction Teams will make entry into warm zones to rescue and relocate viable casualties from the warm zone to a predetermined location in the cold zone for further treatment and transportation to medical facilities.

Dispatch Considerations:

Dispatch should collect as much information as possible and rapidly communicate that information to responding units via radio and mobile dispatching terminals. Based upon the information provided by dispatch and the LE agency in charge of the incident, an initial decision must be made by the responding FD/EMS units to: 1) stage and continue to evaluate and size-up the situation, or 2) to proceed with caution, based on information gathered directly into a more forward position, allowing evaluation and emergency rescue within the risk-benefit profile while utilizing cover and concealment.

Dispatch and FD/EMS units will share updates during response which may include:

- Type of violence (stabbing, shooting-handgun, rifle, etc.)
- Status of weapons and suspects
- Number of known casualties
- Location of LE officers or command post
- Ideal direction of approach or best scene access
- Crews should monitor their 800 MHZ radio designated LE channels for additional information.

- What type of environment are you responding to? Residence, School, Public area, Commercial building, etc. If so, how large is the building or area?

Responding units based upon their experience and dispatch information should:

- Make an initial decision based upon the information provided by dispatch to either:
  - Stage and continue to evaluate and size-up the situation
  - Proceed with caution, based on information gathered directly into a more forward position, allowing evaluation and emergency rescue within risk-benefit profile while utilizing cover and concealment.
- Call additional resources as needed (i.e. additional ambulances, command staff, etc.)
- Request the location of the command post, if established; otherwise the law enforcement personnel in charge of the incident.

On-Scene:

When units are directed to stage or make the decision to stage they shall:

- Stage out of sight of the incident and away from crowds if possible
- Assume Fire Command
- Fire Command shall actively work to set-up Unified Command
- Provide continuous scene size-up for dangerous activity or opportunities to move forward based on new information
- Utilize 800 MHZ radio to communicate on designated LE channels for additional information
- Stage out of any line of fire and behind cover
- Have a minimum of two directions of egress without backing up
- Turn off warning lights while staged
- Contact dispatch for additional information, if applicable

Units called into a secured scene or moving forward from staging into a secured scene shall:

- Contact LE by radio for additional information, if applicable
- Proceed with caution while conducting a windshield survey
- Utilize 800 MHZ radio to monitor designated LE channels for additional information
- Turn off warning lights when approaching the scene, if practical
- Don additional PPE equipment, if available
- Be aware that bystanders and/or crowd may be a hazard
- Designate at least one person as a lookout. All personnel must have and maintain a heightened sense of awareness of their surroundings
- If treating casualties in cold zone, ensure that casualties have been searched prior to patient care and/or transport. This shall also include unconscious patients

If units find themselves in a potentially violent situation they should immediately retreat to a safe location. Emergency traffic and/or EMER buttons should be used if necessary.

Extraction Rescue Team Considerations

Once the decision has been made to deploy Extraction Rescue Teams consider the following:

Command and Control

- Unified Command shall be in place with good communications and jointly located
- Unified Command must agree that there are viable casualties
- The immediate threat must be neutralized or contained under these, or similar, situations: suspect(s) are dead, in custody, fled the scene, or reasonably contained or barricaded
- Unified Command **shall designate and agree** to a specific ingress and egress path for LE Extraction Teams or joint LE/FD/EMS Extraction Teams
- If a joint LE/FD/EMS extraction team is assembled, either the Fire or EMS Commander will be designated to direct and coordinate the joint extraction team operations
- The boundaries of the specific warm zone area for entry shall be defined and communicated to the extraction team to ensure this area is a "warm zone" and appropriate for Extraction Team deployment and ensure personnel do not enter hot zones
- Unified Command must jointly develop or, at a minimum, jointly approve an extraction plan based on available information and considering the Risk Management Plan
- The Fire Commander will consider the Risk Management Profile and all information available and has the final say as to deployment of fire resources into the warm zone
- The EMS Commander will consider the Risk Management Profile and all information available and has the final say as to deployment of EMS resources into the warm zone.
- Accountability shall be in place and tracked throughout incident

Communication

- Extraction team members shall be in constant communication with the designated Fire or EMS Commander, or their designee
- Members of joint LE/FD/EMS extraction teams shall do a face to face briefing with their Law Enforcement security detail to ensure all members are familiar with their assignment

Extraction Team Operations

- Extraction team briefings shall include brief face to face communication on the following:
    - Route into the designated area
    - Team formations
    - Identify security and EMS leads
    - Communications/Signals
    - Cover/concealment
    - How to respond if an IED is located
    - Casualty care issues
    - Primary and secondary egress routes
- Occupants to be extracted must be cleared by LE prior to treatment and extraction

- Only immediate lifesaving EMS care should be delivered in the warm zone, except when a casualty collection point is established and secured within the warm zone and treatment is being provided at that location
- Keep in mind it is important to minimize exposure time in the warm zone
- Casualty collection areas will be identified in the IAP for the extraction teams to handoff casualties once extractions are made
- Extraction teams should only take appropriate equipment into the warm zone and keep in mind mobility is paramount
- The extraction team shall enter as a team, leave as a team, and shall not become separated
- If the extraction team is threatened or comes under fire, follow the Law Enforcement leads direction

Critical Tactical Benchmarks

Specific items have been identified for consideration in this guideline as part of the progression in dealing with an active shooting incident. These considerations are important for the initial company officer acting as the initial Commander to consider in the development of an incident action plan.

Items listed below are considered critical benchmarks and shall be completed prior to entry of fire department or EMS personnel into warm zones as part of a joint LE/FD/EMS Extraction Team. These Critical Tactical Benchmarks are:

- Unified Command shall be in place with good communications and jointly located.
- Unified Command **must agree** that there are viable casualties.
- The immediate threat must be neutralized or contained
- Unified Command **shall designate and agree** to a specific ingress and egress path for LE Extraction Teams or joint LE/FD/EMS extraction teams
- If a joint LE/FD/EMS extraction team is assembled, either the Fire or EMS Commander will be designated to direct and coordinate the joint extraction team operations
- Unified Command will designate a location for the Casualty Collection Point (CCP)
- The boundaries of the specific warm zone area for entry shall be defined and communicated to the extraction team to assure this area is a “warm zone” and appropriate for extraction team deployment and assure personnel do not enter hot zones
- Unified Command must consider the Risk Management Plan and available information and jointly develop or, at a minimum, jointly approve an extraction plan
- Unified Command will consider the Risk Management Profile and all information available and has the final say as to deployment of fire resources into the warm zone
- Accountability shall be in place and tracked throughout the incident.
- Extraction team members shall be in constant communication with the designated Fire or EMS Commander, or their designee

ADDITIONAL SAFETY CONSIDERATIONS

DO’S

1. Be aware of your surroundings and impending danger. Circumstances can change quickly and devices intending to harm or impede responders may be present
2. When approaching the scene and while on scene display a confident in control attitude (Command Presence)
3. Clear the scene of potentially violent materials
4. Set up fire tape to help secure perimeter
5. Keep crew in sight at all times; never leave crew member alone
6. Use physical barriers between yourself and potentially violent person
7. Be subtle and non-aggressive in positioning yourself. Greet homeowner or casualties with a friendly demeanor
8. Separate disputants by taking them to an area where they can't see or hear one another (at least two crew members together) separating them will help calm the situation
9. Use calm quiet voice to de-escalate the situation
10. Keep a visual on people's hands
11. Keep a visual on those involved with incident (don't let them go to another room without escort, etc.)

DON'TS

1. Don't get lulled into a false sense of complacency
2. Don't ignore the potential for violence on any incident. This includes traveling to and from the incident location
3. Don't ignore your gut feelings; when it doesn't feel right, it probably isn't
4. Don't be confrontational; be confident, but not abusive to anyone or any group
5. Don't be an easy target; be prepared to bail out when the need arises
6. Don't stand between disputants
7. Interview stance:
    - If you suspect violence, stand at a partial right angle out of arms reach
    - Don't stand against a wall
    - Don't fold your arms (judgmental)
    - Don't put your hands in your pockets (appears unconcerned)

When in doubt, be safe not sorry!

Active Shooter Incident Field Operations Guide

Enroute

Responding units based upon their experience and dispatch information should:

- Make an initial decision based upon the information provided by dispatch to either:
  - Stage and continue to evaluate and size-up the situation
  - Proceed with caution, based on information gathered directly into a more forward position, allowing evaluation and emergency rescue within risk-benefit profile while utilizing cover and concealment
- Call additional resources as needed (i.e. additional ambulances, command staff, etc.)
- Request the location of the command post, if established; otherwise the law enforcement personnel in charge of the incident

Staging

When units are directed to stage or make the decision to stage they shall:

- Stage out of sight of the incident and away from crowds if possible
- Assume Fire Command and actively work to **set-up Unified Command as early as possible**
- Provide continuous scene size-up for dangerous activity or opportunities to move forward based on new information
- Utilize 800 MHZ radio to communicate on designated LE channels for additional information
- Stage out of any line of fire and behind cover
- Have a minimum of two directions of egress without backing up
- Turn off warning lights while staged
- Contact dispatch for additional information, if applicable

Units called into a secured scene or moving forward from staging into a secured scene shall:

- Contact LE by radio for additional information, if applicable
- Proceed with caution while conducting a windshield survey
- Utilize 800 MHZ radio to monitor designated LE channels for additional information
- Turn off warning lights when approaching the scene, if practical
- Don additional PPE equipment, if available
- Be aware that bystanders and/or crowd may be a hazard
- Designate at least one person as a lookout. All personnel must have and maintain a heightened sense of awareness of their surroundings
- If treating casualties in cold zone, ensure that casualties have been searched prior to patient care and/or transport. This shall also include unconscious patients

If units find themselves in a potentially violent situation they should immediately retreat to a safe location. Emergency traffic and/or EMER buttons should be used if necessary.

Deployment of Extraction Rescue Teams

Once the decision has been made to deploy Extraction Rescue Teams consider the following:

Command and Control

- Unified Command shall be in place with good communications and jointly located
- Unified Command must agree that there are viable casualties
- The immediate threat must be neutralized or contained under these, or similar, situations: suspect(s) are dead, in custody, fled the scene, or reasonably contained or barricaded
- Unified Command **shall designate and agree** to a specific ingress and egress path for LE Extraction Teams or joint LE/FD/EMS Extraction Teams
- If a joint LE/FD/EMS extraction team is assembled, either the Fire or EMS Commander will be designated to direct and coordinate the joint extraction team operations
- The boundaries of the specific warm zone area for entry shall be defined and communicated to the extraction team to ensure this area is a "warm zone" and appropriate for Extraction Team deployment and ensure personnel do not enter hot zones
- Unified Command must jointly develop or, at a minimum, jointly approve an extraction plan based on available information and considering the Risk Management Plan
- The Fire Commander will consider the Risk Management Profile and all information available and has the final say as to deployment of fire resources into the warm zone
- The EMS Commander will consider the Risk Management Profile and all information available and has the final say as to deployment of EMS resources into the warm zone.
- Accountability shall be in place and tracked throughout incident

Communication

- Extraction team members shall be in constant communication with the designated Fire or EMS Commander, or their designee
- Members of joint LE/FD/EMS extraction teams shall do a face to face briefing with their Law Enforcement security detail to ensure all members are familiar with their assignment

Extraction Team Operations

- Extraction team briefings shall include brief face to face communication on the following:
    - Route into the designated area
    - Team formations
    - Identify security and EMS leads
    - Communications/Signals
    - Cover/concealment
    - How to respond if an IED is located
    - Casualty care issues
    - Primary and secondary egress routes
- Occupants to be extracted must be cleared by LE prior to treatment and extraction

- Only immediate lifesaving EMS care should be delivered in the warm zone, except when a casualty collection point is established and secured within the warm zone and treatment is being provided at that location
- Keep in mind it is important to minimize exposure time in the warm zone
- Casualty collection areas will be identified in the IAP for the extraction teams to handoff casualties once extractions are made
- Extraction teams should only take appropriate equipment into the warm zone and keep in mind mobility is paramount
- The extraction team shall enter as a team, leave as a team, and shall not become separated
- If the extraction team is threatened or comes under fire, follow the Law Enforcement leads direction

Appendix D- IAFF/IAFC Positions on ASI Response

IAFF Position Statement: Active Shooter Events

The emerging threat of terrorism and asymmetric warfare, specifically small unit "active shooter" and improvised explosive device (IED) attacks, is a concern for the fire service. An attack by radicals armed with weapons in public areas, such as schools, shopping malls, churches or any other locations where people congregate is a real threat to a sense of security and daily lives.

An Active Shooter event is an event involving one or more suspects who participate in an ongoing, random, or systematic shooting spree, demonstrating an intent to harm others with the objective of mass murder.

Given the recent spate of what has become known as "active shooter" scenarios unfolding across the nation, fire and law enforcement departments, regardless of size or capacity, must find ways to marshal appropriate and effective responses to these events. Therefore, 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. Local fire and law enforcement departments should establish standard operating procedures to deal with these unusual, highly volatile, and extraordinarily dangerous scenarios. Standard operating procedures should include at minimum the following objectives.

1) Use of the National Incident Management System (NIMS) in particular the Incident Command System (ICS). In accordance with NIMS guidance, Fire and Law Enforcement Officers should establish a single Command Post (CP) and establish Unified Command (UC).

2) Use of nationally accepted standards and operational protocols including the number and type of response personnel, training level, personal protective equipment, operational environment, and scope of practice.

3) Use of the Rescue Task Force (RTF) concept for on scene response. An RTF is a set of teams deployed to provide point of wound care to victims where there is an on-going ballistic or explosive threat. These teams treat, stabilize, and remove the injured in a rapid manner, while wearing Ballistic Protective Equipment (BPE) and under the protection of a Law Enforcement (Police) Department (PD). An RTF team should include at least one ALS provider.

4) Provide appropriate protective gear to personnel exposed to risks. Firefighters will not carry weapons.

5) Law Enforcement and Fire Departments should train together. Initial and ongoing training and practice are imperative to successful operations.

6) Use of common communications terminology. Fire department personnel must understand common law enforcement terms to such as Cleared, Secured, Cover, Concealment, Hot Zone/Cold Zone and related terms (red, green etc.), and other.

POSITION STATEMENT

Active Shooter and Mass Casualty Terrorist Events

The emerging threat of terrorism and asymmetric warfare, specifically small unit active shooter and improvised explosive device (IED) attacks, is a concern for the fire and emergency service. An attack by radicals armed with weapons in public areas, such as schools, shopping malls, churches or any locations where people congregate, is a serious threat to maintaining a strong sense of security and the daily lives of the public.

An active shooter event is an event involving one or more suspects who participate in an ongoing, random, or systematic shooting spree, demonstrating the intent to harm others with the objective of mass murder.

Given the recent spate of what has become known as "active shooter" scenarios unfolding across the nation, fire and police departments, regardless of size or capacity, must find ways to marshal appropriate and effective responses to these events. Therefore, local jurisdictions should build sufficient public safety resources to deal with active shooter scenarios.

It is imperative that local fire and law enforcement agencies have common tactics, common communications capabilities and a common lexicon for seamless, effective operations. Local fire and law enforcement agencies should establish standard operating procedures to deal with these unusual, highly volatile, and extraordinarily dangerous scenarios. Standard operating procedures should include at minimum the following objectives.

1) Use of the National Incident Management System (NIMS) in particular the Incident Command System (ICS). In accordance with NIMS guidance, fire and law enforcement should establish a single Command Post (CP) and establish Unified Command (UC).

2) Fire and law enforcement agencies should train together. Initial and ongoing training and practice are imperative to successful operations.

3) Agencies involved should use common communications terminology. Fire department personnel must understand common law enforcement terms, such as Cleared, Secured, Cover, Concealment, Hot Zone/Warm Zone/Cold Zone and other related terms (red, green etc.).

4) Provide appropriate protective gear to personnel exposed to risks. Firefighters, EMT's and paramedics should be provided ballistic vests and helmets if they are to participate in a Rescue Task Force.

5) Consider secondary devices at the primary incident scene and secondary scenes in close proximity to the primary incident scene. Acts of terror using IEDs, as well as active shooters often prepare or actually begin their attacks at a location separate from the area designated as the primary incident scene.

6) For events including IEDs, consider fire hazards secondary to the initial blast. For example, in public areas such as restaurants, clubs, schools and churches, natural gas is used in food preparation and heating; therefore, responders should check to ensure that gas lines and valves have not been compromised.

A Rescue Task Force (RTF) is a set of teams deployed to provide point-of-wound care to victims where there is an on-going ballistic or explosive threat. These teams treat, stabilize, and remove the injured in a rapid manner, while wearing Ballistic Protective Equipment (BPE) and under the protection of law enforcement officers. An RTF should include at least one advanced life support (ALS) provider.

An RTF response may be deployed to work in an active shooter scenario in a school, business, shopping mall, church, conference, special event, or any other scene that has the potential of being an on-going ballistic or explosive threat.

Prior to deploying an RTF, the fire and law enforcement UC should consider IEDs or other secondary devices. Threat zones must also be identified by the UC. Threat zones include the following.

- Hot Zone - Area where there is a known hazard or direct and immediate life threat (i.e., any uncontrolled area where an active shooter/bomber could directly engage an RTF). RTFs should not be deployed into hot zones.
- Warm Zone - Area of indirect threat (i.e., an area where law enforcement has either cleared or isolated the threat to a level of minimal or mitigated risk). This area can be considered clear but not secure. The RTF will deploy in this area, with security, to treat and remove victims.
- Cold Zone - Area where there is little or no threat, due to geographic distance from the threat or the area has been secured by law enforcement (i.e., casualty collection points, the area where fire/EMS may stage to triage, treat, and transport victims once removed from the warm zone).

Each RTF member should be equipped at minimum with a Kevlar helmet, body armor, flash light, radio, and exam gloves. Remote microphones with earpieces are required for communications with UC.

An RTF should only be deployed upon agreement of the unified fire/ law enforcement command. RTFs of two firefighter/EMTs or paramedics should only be deployed with two law enforcement officers to provide security. The UC should establish an accountability

process for all incident responders using a check-in/check-out procedure. Firefighters should not self-deploy into the warm zone.

When teams make entry, they should treat the injured using Tactical Emergency Casualty Care (TECC) guidelines. Any victim who can ambulate without assistance should be directed by the team to self-evacuate via a cleared pathway under law enforcement direction. Any fatalities should be clearly marked to allow for easy identification and to avoid repeated evaluations by additional RTFs.

The RTF can be deployed for victim treatment, victim removal from warm to cold zone, movement of supplies from cold to warm zone, and any other duties deemed necessary to accomplish the overall mission. RTFs should work within law enforcement security at all times.

To sustain skills and readiness, RTF skills and operations should be taught annually and practiced regularly.

Rescue Task Force (RTF) initial and ongoing training for all EMS providers should include Tactical Emergency Casualty Care (TECC) guidelines and practical skills applications.

Tactical Emergency Casualty Care (TECC)

The Tactical Emergency Casualty Care (TECC) guidelines are the civilian counterpart to the U.S. military's Tactical Combat Casualty Care (TCCC) guidelines. The TCCC guidelines were developed for military personnel providing medical care for the wounded during combat operations. These guidelines have proven extraordinarily effective in saving lives on the battlefield, and thus provide the foundation for TECC. The TECC takes into account the specific nuances of civilian first responders.

The specifics of casualty care in the tactical setting will depend on the tactical situation, the injuries sustained, the knowledge and skills of the first responders, and the medical equipment at hand. TECC provides a framework to prioritize medical care while accounting for on-going high-risk operations, and focuses primarily on the intrinsic tactical variables of ballistic and penetrating trauma compounded by prolonged evacuation times. The principle mandate of TECC is the critical execution of the right interventions at the right time.

TECC is applied in three phases — direct threat, indirect threat, and evacuation care — as defined by the dynamic relationship between the provider and the threat. Indirect threat care is rendered once the casualty is no longer under a direct and immediate threat (i.e., warm zone). Medical equipment is limited to that carried into the field by RTF personnel and typically includes tourniquets, pressure dressings, hemostatic agents, occlusive chest seals and adjunct airways.

Tactical EMS (or Tactical Medic) Differs from the RTF Concept

Tactical EMS is *not* routine EMS. Tactical EMS — or Tactical Medic — refers to a select EMS provider assigned to a SWAT or similar specialized tactical law enforcement team. Tactical EMS requires the medic to be trained and equipped with the special skills necessary to support these law enforcement teams. Tactical medics should be members of agencies such as fire departments or EMS services who are specifically chosen and trained to be *part of* the tactical law enforcement team. In contrast, RTF responders come from the cadre of firefighter/EMTs and paramedics who respond daily to calls for help and should not be confused with tactical medics.

SUBMITTED BY: International Association of Fire Chiefs
ADOPTED BY THE IAFC BOARD OF DIRECTORS: 10 October 2013

Appendix E- Leesburg Fire Department Active Shooter Incident SOG

City of Leesburg Fire Department

General

100.000

Title: Active Shooter Response

Purpose

The purpose of this policy is to help save the lives of victims involved in an Active Shooter Incident. Accessing victims early will help save savable lives of those who may have otherwise died from their injuries. The purpose of this policy shall define roles, responsibilities, and operational procedures to support a Rescue Task Force (RTF) response.

Definition

The Rescue Task Force (RTF) is a set of teams deployed to provide point of wound care to victims where there is an on-going ballistic or explosive threat. These teams treat, stabilize, and remove the injured while wearing Ballistic Protective Equipment (BPE) in a rapid manner under the protection of the Leesburg Police Department (LPD). An RTF team must include at least one ALS provider. This response can be deployed to work in, but not limited to, the following:

- Active shooter in a school, business, mall, conference, special event, etc.
- Any other scene that is or has the possibility of an on-going ballistic or explosive threat.

General

1. The Leesburg Police Department (LPD) will be the lead agency and will establish a Unified Command with Leesburg Fire Department to rapidly deploy RTF teams into established zones.
2. Prior to deploying an RTF team, threat zones must be identified:
   - Hot Zone - Area where there is known hazard or life threat that is direct and immediate. An example of this would be any uncontrolled area where the active shooter could directly engage an RTF team. RTF teams will not be deployed into a Hot Zone.
   - Warm Zone - (also known as the area of indirect threat) Areas that ACPD has either cleared or isolated the threat where there is minimal or mitigated risk. This area can

be considered clear but not secure. This is where the RTF will deploy, with security, to treat victims.

• Cold Zone - Areas where there is little or no threat, either by geography to threat or after area has been secured by Police (i.e. Casualty Collection Points). An area where Leesburg Fire Department will stage to triage, treat, and transport victims once removed from the warm zone.

3. Depending on the size of the incident and location, injured victims may need to be placed in a Causality Collection Point (CCP) before transition to the cold zone. This will be predetermined by initial units, secured by LPD, and relayed to the RTF teams through Unified Command. As this area will be secure, it may be considered a Cold Zone and may be staffed with non-RTF Leesburg Fire Department Fire/EMS personnel.

Equipment

The equipment needed for the individual RTF members are located on Battalion 60. The equipment cache on Battalion 60 shall have three individual sets containing three helmets, three ballistic protective vest, and two extra treatment bags. Each vest contains enough equipment to treat approximately eight victims, depending on injuries, and the extra equipment bags have enough equipment to treat an additional sixteen victims.

1. Each RTF member should equip themselves with a minimum of a Kevlar helmet, body armor, flashlight, radio, and exam gloves.
2. Remote microphones are required to ease communication with teams. If possible, earpieces should be utilized.

RTF Deployment

Once unified command has agreed to RTF deployment, teams will deploy to the warm zone to begin victim care.

1. Command will dispatch RTF teams by numbers, i.e., RTF Team 1. RTF Teams are not to deploy unless they have two personnel from LPD as security. Do not self deploy into the warm zone.
2. The first RTF team to make entry should notify the EMS branch of possible number of injured.
3. When teams make entry, they will treat the injured using Tactical Emergency Casualty Care (TECC) guidelines.
4. The first two RTF teams will enter the area and treat as many patients as possible until they run out of equipment to use or all accessible victims have been treated. Once this point has been reached, these RTF teams start the evacuation of injured. Additional RTF teams that enter the area should be primarily tasked with extrication of the victims treated by the initial two teams. If needed, additional RTF teams may be sent into areas unreached by the initial teams or to other areas with accessible victims.
5. When the RTF is operation in the Warm Zone, no triage will be conducted. All patients encountered by the RTF teams will be treated as they are accessed. Any patient who can ambulate without assistance will be directed by the team to self-evacuate down the cleared corridor under Police direction, and any patient who is dead will be visibly marked to allow for easy identification and to avoid repeated evaluations by additional RTF teams.

6. To coordinate RTF teams inside a warm zone, a single ACFD officer may deploy into the warm zone under ACPD custody. This will help guide the RTF teams and allow ease of communications with the EMS branch.
7. RTF can be deployed for the following reasons.
    - Victim treatment
    - Victim removal from warm to cold zone
    - Movement of supplies from cold to warm zone

    - Any other duties deemed necessary to accomplish the mission

8. RTF teams will work within their security at all times.
9. Upon arrival at a potential patient, START Triage shall be used
10. Severe hemorrhage control and OPA/NPA insertion and tension pneumothorax decompression shall be the only treatment considered at that time

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Fire Chief

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