ACTIVE SHOOTER

PLANNING AND RESPONSE

In today's ever changing environment, no business or organization is immune from violence. Whether it is a church, movie theater, mall, or healthcare setting the need to plan for an active shooter event is of paramount importance. The incident rate of violence against EMS and healthcare workers is a problem that is significantly under reported but effects thousands of workers across the country. From verbal and physical assaults on staff to hospital shootings, acts of violence are occurring at an alarming rate around the globe.

Situations involving an active shooter in the healthcare setting can have a devastating impact on victims and co-workers alike, as well as long term organizational effects. While many active shooter events are planned by the perpetrator(s) others may occur spontaneously. Employee situational awareness and vigilance is an absolute in the modern day workplace.

The Active Shooter Planning and Response Guide takes an in-depth look at the 4-phases of emergency management; mitigation, preparedness response and recovery and offers step by step guidance to assist healthcare facilities in active shooter planning and response. Designed with input from industry experts and incorporating the latest recommendations and techniques used in active shooter planning and response, this guide is a must read for all healthcare facilities.

The International Association of EMS Chiefs (IAEMSC) is pleased to support the *Active Shooter Planning and Response Guide.* IAEMSC is a staunch proponent and advocate of healthcare provider safety and training. IAEMSC works closely with many federal and state agencies in areas of emergency and disaster planning and response and is also an active participant in the International Committee of the Red Cross, Health Care in Danger (HCiD) project. This global initiative's intent is to reduce workplace violence across the pre-hospital and hospital setting.

To this end, IAEMSC believes it is imperative for all healthcare facilities to plan and train with their local EMS and public safety providers to review internal response plans, identify roles of outside agencies, develop best practices, and test specific response capabilities. With preplanning, training, and collaboration your actions can and will make a difference!

Paul Brennan, President
International Association of EMS Chiefs

International Association of Emergency Medical Services Chiefs (IAEMSC)
1900 L Street., NW, Suite 705
Washington, D.C. 20036
www.IAEMSC.org

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*A**ctive Shooter* events at a healthcare facility present unique challenges; healthcare professionals may be faced with decisions about leaving patients; visitors will be present; and patients or staff may not be able to evacuate due to age, injury, illness, or a medical procedure in progress.

"*Active shooter*" is defined as an individual or others are "actively engaged in killing or attempting to kill people in a confined and populated area[1]." *Active shooter* situations are unpredictable and evolve quickly. Because of this, individuals must be prepared to deal with an *active shooter* situation before law enforcement personnel arrive on the scene.

While this section addresses how healthcare facilities should plan for *active shooter* situations, healthcare facilities should also plan for other gun-related incidents (e.g., a single shot fired, possession of a weapon on campus).

Understandably, this is a sensitive topic. No single answer exists for what to do, but a survival mindset can increase the odds of saving a life. As appropriate for your healthcare facility or campus, it may be valuable to schedule a time for an open conversation regarding this topic. Though some healthcare staff may find the conversation uncomfortable, they also may find it reassuring to know, as a whole, their healthcare facility is thinking about how best to deal with this situation.

Ethical Considerations during a Healthcare Event

Healthcare professionals have a duty to care for the patients for which they are responsible. Since incidents such as an *active shooter* scenario are highly dynamic, some ethical decisions may need to be made to ensure the least loss of life possible. Every reasonable attempt to continue caring for patients must be made, but in the event this becomes impossible without putting others at risk for loss of life, certain decisions must be made. The following guidelines are meant to provide issues to consider when making difficult decisions, prompt meaningful discussions, and prepare those who might be involved in such an incident before it ever happens.

- Allocate resources fairly with special consideration given to those most vulnerable
- Limit harm to the extent possible. With limited resources, healthcare professionals may not be able to meet the needs of all involved
- Treat all patients with respect and dignity, regardless of the level of care that can continue to have provided them

[1] Other gun-related incidents that may occur in a healthcare facility are not defined as active shooter incidents because they do not meet this definition. Instead, they may involve a single shot fired, accidental discharge of a weapon, or incidents that are not ongoing.

This guide will use the general term "staff" which includes employees, licensed independent practitioners, dependent healthcare professionals, students, volunteers, vendors, contractors, and others who work in or are frequently in the facility.

Preventing an Situation

Warning Signs

No profile exists for an *active shooter*; however, research indicates there may be signs or indicators. Healthcare personnel should learn the signs which might be detectible of an individual who may turn thoughts or actions into potentially volatile *active shooter* situation and proactively seek ways to prevent an incident with internal resources, or additional external assistance.

By highlighting common pre-attack behaviors displayed by past offenders, federal researchers have sought to enhance the detection and prevention of tragic attacks of violence, including *active shooting* situations. Several agencies within the federal government continue to explore incidents of targeted violence in the effort to identify these potential "warning signs." These signs of changes in behavior may appear before a target is identified by the perpetrator(s).

These behaviors often include[2]

- Pathway warning behavior – any behavior that is part of research, planning, preparation, or implementation of an attack.
- Fixation warning behavior – any behavior that indicates an increasingly pathological preoccupation with a person. It is measured by:
    - Increasing perseveration (repetition)

- In 23% of shootings with the Emergency Department, the weapon was a security officer's gun that was taken by the perpetrator.

Preparing for an Situation

Planning

As with any threat or hazard included in a healthcare facility's Emergency Operations Plan (EOP), the planning team should establish goals, objectives, and courses of action for an *Active Shooter* Annex. These plans will be impacted by the assessments conducted at the outset of the planning process and updated as ongoing assessments occur. Create the plan with input from several stakeholders including executive leadership, legal, nursing, security, facility engineering, human resources, emergency management, risk managers, and local law enforcement. An effective plan includes:

- A preferred method for reporting *active shooter* incidents
- An evacuation policy and procedure
- Emergency escape procedures and route assignments (i.e., floor plans, safe areas)
- Lockdown procedures for individual units and locations and other campus buildings
- Integration with the facility Emergency Operations Plan and Incident Command System
- Information concerning local area emergency response agencies and hospitals (i.e., name, telephone number and distance from your location)

As courses of action are developed, the planning team should consider a number of issues, including, but not limited to

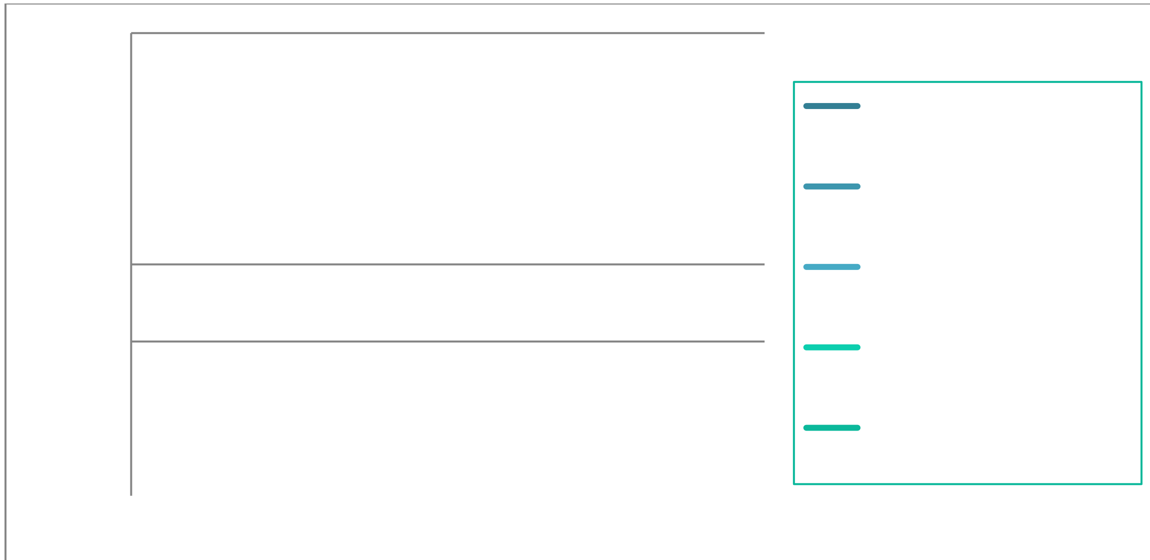
Additional considerations are included in the "Responding to an *Active Shooter*" and "After an *Active Shooter Situation*" sections below.

Every facility must have a security plan. Staff should be trained on their responsibilities in the plan. A facility security plan includes:

- All staff properly display an acceptable identification badge
- Create a culture of safety by empowering staff to report unusual or suspicious activity
- Ensure locked doors remain closed and locked
- Doors with keypad access should have their codes changed at specified intervals and codes are only given to employees with a need for access
- Foster a respectful workplace
- Be aware of indications of workplace violence and take remedial actions accordingly
- Empower employees who come in contact with individuals who seem lost or are obviously not familiar to their sur6(w)-6(n)-07[/T1_d1432ed

Plain Language Communication

While there is a sense in the popular culture that a clear warning may induce panic, research shows[5] people do not panic when given clear and informative warnings, and that they want to



analysis of changing and relevant behaviors. The TAT takes into consideration, as appropriate, information about behaviors, various kinds of communications, not-yet substantiated information, any threats made, security concerns, family issues, or relationship problems that might involve a troubled individual. The TAT may also identify any potential victims with whom the individual may interact. Once the TAT identifies an individual who may pose a threat, the team will identify a course of action for addressing the situation. The appropriate course of action— whether law enforcement intervention, counseling, or other actions—will depend on the specifics of the situation.

The TAT may also identify any potential victim(s) with whom the individual may interact. While TATs are not common in healthcare facilities, they have been pushed to the forefront of concern at institutes of higher education following the 2007 shooting at Virginia Polytechnic Institute and State University in Blacksburg, Va., where 32 individuals were killed.

Law enforcement can help assess reported threats or troubling behavior and reach out to available federal resources as part of the TAT process or separately. The FBI's behavioral experts in its National Center for the Analysis of Violent Crimes (NCAVC) at Quantico, Va., are available on a 24/7 basis to join in any threat assessment analysis and develop threat mitigation strategies for persons of concern. The law enforcement member of the healthcare facility TAT should contact the local FBI office for this behavioral analysis assistance.

Each FBI field office has a NCAVC representative available to work with healthcare facility TATs

Response Plans

The primary purpose of your response plan shall be to prevent, reduce or limit access to potential victims and to mitigate the loss of life. Options for consideration in developing your response plan are:

1. Run, [illegible]

4. ALICE *Active Shooter* Response

"ALICE" is an acronym for five steps the proponents say can be used to increase you/MCa(r)4(e)3(a)4(s)6(e)3(y

responsible for the care of patients or residents. However, if an individual suspects they may be in danger due to an active shooter situation, the following guidelines will assist the individual to make personal choices and take appropriate actions.

Responding to an Active Shooter Situation

Unified Command and the Active Shooter Event

Command and control at a healthcare active shooter event can be very complex; competing priorities of patient care, crime scene operations, and legal issues can create difficulties. First responders and healthcare providers are very familiar with incident command and the concept of unified command, but sometimes the management becomes more confrontational than cooperative or are working independently from law enforcement.

Active shooter events like other types of response related emergencies require comprehensive management systems. Many organizations state that they will use the Incident Command System[12] with the impression that this addresses command and control. Unfortunately, this is not the case.

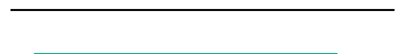
typical scene incident commander. A true unified command system has one incident commander. That person is supported by deputy incident commanders to accomplish the mission. The incident com [illegible]

fully informed decision about which option is best. While they should follow the plan and any instructions given during an incident, they will often have to rely on their own judgment to decide which option will best protect lives.

Improvised Explosive Devices

An Improvised Explosive Device can be defined as a device placed or fabricated in an improvised manner incorporating destructive, lethal, noxious, pyrotechnic, or incendiary chemicals and designed pyro

chemicals and designa 4finn7(2Dc( ) 0-1.0.Td (a (u)-0 1 14(,)1.0ra6(d)6(T)4(e)9-1.0.1)4(an)6(TdD(a i0.95a0 Tw (2a



- Check
- Control

Response is based upon the assumption that the device will explode at any moment. The cardinal rule is always – move people, do not move the suspicious device.

The Bureau of Counterrorism and Countering Violet Extremism has recommended that organizations, including hospitals, review and address the following questions so that they can be incorporated into your EOP and appropriate annex to better prepare your organization in response to an IED incident.

- Does hospital and departments have sufficient resources, especially work force, to carry out response procedures? If not, how will hospital provide resources to staff? Which direction should you tell everyone to evacuate?

the Virginia Tech shooting, individuals on campus responded to the shooting with varying degrees of urgency[18]. These studies highlight this delayed response or denial. For example,

Law Enforcement Active Shooter Tactics, Integrated Planning, and Crime Scene Management

As more follow-on responders arrive, a more formalized incident command structure should be established. There are several *active shooter* incident management models which dictate who should be the Incident Commander at an *active shooter* scene. One model suggests that the fifth arriving officer, regardless of rank, should assume command.[24] Regardless of the model used, law enforcement should quickly establish command to start organizing arriving resources. This will help alleviate the unorganized, over-convergence of law enforcement personnel that many past *active shooter* after action reports have identified.

The officer who assumes Incident Command (IC) from the first officer may remain outside of the facility directing incoming resources. In addition to assigning additional officers into the facility in search of the shooter, the IC also establishes a staging location for all additional responders including law enforcement, fire, and EMS. The Command Post should also be established in a safe location and this information relayed to all responders as well as the facility's emergency management team. The IC should make every effort to quickly establish communication, ideally in person, with a member of the facilities emergency management team.

Integration of Special Operations Teams

As the event continues to unfold, specialized police SWAT or tactical units will respond to assist with the follow up search and clearing of the facility. These units, working at the direction of the Incident Commander will be generally responsible for the room by room, floor by floor search of the facility or directly affected area. If the *active shooter* incident transitioned into a hostage or barricaded gunman situation within the facility, these tactical units will ultimately relieve the patrol officer first responders and take over the situation. These specialized units, working with and through the Incident Commander, will require direct access to members of the facilities incident command team for logistical and intelligence support regarding the facility. This support will include access to floor plans, to control systems, security camera systems, personnel rosters, and other pertinent information specific to the facility.

Facility Clearing Response

The clearing and ultimate evacuation of a healthcare facility in response to an *active shooter* event is a difficult decision with significant immediate and long-term consequences. Facility

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[24] Active Shooter Incident Management Checklist, C3 Pathways, Orlando, FL, 2014
http://www.c3pathways.com/asc/

evacuation is of tactical value only if it can be done in a coordinated manner, while not interfering or obstructing the ongoing law enforcement response to the active threat.

Depending upon the magintude of the event, law enforcement may need to search, clear and secure every part of the facility. The searching and clearing of the facility is to ensure there are no additional threats to include persons and possible devices such as bomb(s)/IED's. Although seaching and clearing the facility can be done without the removal of all persons, it could include the systematic evacuation of virtually all pesons from the facility as well.
The actual decision should be made by the senior Hospital Administrator or equivalent present, in consultation with the Incident Commander. Time is of the essence in such decisions, and such an activity will require significant preplanning.

Facility Evacuation – Definition

Healthcare facilities range in size, scope of service provided, and patient-caregiver mix. A small suburban single story ambulatory outpatient clinic will present profoundly different facility clearing challenges when compared to a large, multi-story, urban general hospital with a Level One Trauma Center; yet in both cases, the term facility clearing means the same thing – the rapid and coordinated physical movement of persons not involved in the *active shooter* event to safety beyond the physical confines of the healthcare facility and the simultaneous, methodical search of the facility for the individual(s) who are actively engaged in the intentional harm to others through violence. In practical terms, it may not be possible to move some patients due to the nature of their

Facility Clearing Teams

facilities have the staff, equipment, and expertise to rapidly treat victims. Facility staff may be well suited to assist Fire and EMS personnel within the CCP while law enforcement provides the

Pre-planning with Healthcare Security

Since hospital security personnel will be on scene at the inception of an *active shooter* incident, their knowledge of the facility and understanding of the present situation must be leveraged to the advantage of the law enforcement response. To ensure this is the case, there must be a formalized relationship attained through periodic face-to-face contact with the facility security team. This may be best achieved through a series of meetings as discussed previously and/or a series of periodic exercises ranging from table top exercises to full scale exercises. Regardless of the method of engagement, the relationship between on-site security and responding law enforcement must be memorialized and areas of responsibility assigned during incident response. Through pre-incident engagement activities, the following information and understanding should be gleaned from the security team:

- Maps and Floor Plans (Bird's Eye View maps and floor plans similar to "You Are Here" hallway evacuation diagrams)
    - Gas main shut off highlighted
    - Electrical shutoff highlighted
    - Water Shutoff highlighted
    - HVAC Controls highlighted
    - Building segmentation by department (e.g. Emergency Department, Pharmacy, Neonatal Unit, etc.) highlighted
    - Location of hazardous materials and MRI equipment
- Site Security Plan
    - Actions for an *Active Shooter* Response
    - Actions during a Hostage Situation
    - Actions during a reported Bomb/Improvised Explosive Device Situation
- Site Emergency Management Plan
    - Evacuation Plan to include routes and assembly areas
    - Tactical Medical Surge Capability (especially additional ICU beds) and Capabilities
- Identification of key hospital personnel and immediate contacts
- How hospital security personnel are identified
- Location and capabilities of facility Hospital Command Center
- Location of video control room (if applicable)
- Facility mass communication messagin

Pre-positioned Access Kits

It goes without saying that due to the nature of an *active shooter* incident, quick, efficient, and effective response by law enforcement is paramount to saving lives. However, upon making entry, what may stand between the responding law enforcement officer(s) and the *active shooter* could be a series of confusing hallways and/or secured doors. Once inside the facility, law enforcement will know generally where the *active shooter* is based on the facility security personnel, the sound of a gun discharging, the trail of victims, or statements from fleeing witnesses. To ensure law enforcement personnel can move to the *active shooter* as quickly and as efficiently as possible regardless of obstacles, select items associated with access control and a simple composite floor plan need to be made available. When working with facility security to build an access kit, consider the items needed to open every possible lockable door (e.g. card swipe, FOB, Master Keys, or code punch) within the facility and ensure that they are present in the kit. Also, a floor plan to navigate throu(s)6(s)6r(r t)-1(m)-10(s) -8

have limitations, in that, they may not be armed and therefore, should not be placed in harm's way where they may confront the shooter. There are however, valuable activities that security can perform leaving law enforcement to focus on the *active shooter* such as crowd control, evacuation control, control of assembly areas, hospital interface from the incident commander's location and even casualty notification. Facility support can aid in utility controls, lockdown, observation, and information.

Pre-planned Areas of Refuge

Pre-planned areas of refuge are a good concept if appropriately identified and disseminated among the employees of the healthcare facility, enabling them to bring that capability into their individual decision making cycle when responding to an *active shooter.* At the onset of an *active shooter* incident in a healthcare facility, tough decisions will need to be made by both attending medical staff and visiting family or friends. The medical staff may be caring for an immobile patient and feel a moral obligation to stay and protect that patient while family and friends simply feel that they can't leave a loved one that is incapable of defending them self. In either case, this will potentially result in more victims for the shooter and ultimately, more fatalities. If facility security informs law enforcement areas of refuge are designated throughout the facility, it is incumbent upon law enforcement to acknowledge the plan and seek out those areas for familiarity.

Immediate Required Employee Facility Return Point

In some instances, certain employees may be required to return to the interior of the facility based upon their specific responsibilities or perhaps unique medical skill. During the pre-planning phase of engagement it needs to be understood why someone may be ordered back inside and under whose authority. Additionally, protocols for the employee to follow covering physical actions, verbal communication, or evidence preservation should be developed and addressed to the returning employee prior to departing the control point. Recognizing and understanding the need to allow persons to re-enter the facility, law enforcement needs to be involved in the control of the movement from assembly area to Facility Return Point to keep wandering employees from becoming victims. To ensure this is the case, law enforcement should work closely with the facility security or administration team to identify a specific location to assemble returning employees. Selection of this location needs to take into account line of sight from the hospital, which if done incorrectly could compromise the employee's safety. The Facility Entry Point needs to feed into a secure and efficient passage way to the known critical sites. Since this could be incredibly difficult to communicate and execute via radio, during the pre-planning phase one entry point per side of facility should be analyzed for suitability.

Family (Employee, Patient, Visitor) Reunification Point(s)

With social media, word will travel fast across the community that an incident has or is occurring at the local medical facility. This will result in a large influx of family and friends of the facility's employees or patients, curiosity seekers and the local media. Anticipating this, consider in the pre-planning phase requesting that facility security or administration work with local public safety and emergency management to quickly establish a cordon area around the facility at a predetermined distance perhaps measured in blocks. This will establish an element of control while the *active shooter* threat continues to be pursued. However, if over time, no action is taken to reunite families and friends the cordon area will probably not hold. So, as pre-planning and time permits, plan for and establish secure corridors to move employees, patients, and friends from other identified assembly areas to known points on the edge of the cordon area to exit the area.

cleared. Having attained floor plans during the pre-planning engagement, it would be prudent to identify how the floors/departments can be secured once cleared without negatively impacting primary thoroughfares. Once cleared and mechanically secured, based on the availability of personnel, law enforcement personnel may be posted to ensure the integrity of the secured cleared area.

Pre-planned External Lockdown and Traffic Control

Prior to an *active shooter* incident, law enforcement and security should coordinate and develop a plan on the external lockdown of the healthcare facility. The plan should include:

There are three types of exercises, which will provide an opportunity for enhancing response capabilities: tabletop, functional, and full-scale. In addition, workshops are also beneficial to review established organizational and departmental procedures prior to conducting exercises.

Tabletop exercises are discussion-based sessions where all individuals who would be involved in an incid[illegible]

Preparation should be made for consistent use of interoperable communications (common radio frequencies) throughout the response efforts to ensure that incident command and on-scene responders situational awareness is maintained as strategies are implemented and priorities evolve. This includes proper equipment to support an incident command channel, necessary training, and plans to trigger the switch to a command channel. A second radio channel may be designated to facilitate command communio,68ininclud(e)(o)8is ammanE2(M)nd540.1( )]TJ 0

High Profile Patients

Healthcare facilities draw patients from all walks of life including high profile personalities who may have personal protection officers providing security. Although nearly impossible to pre-plan who these individuals are or where they may be at the time of an *active shooter* event, the incident commander working with the incident command team should plan to make attempts to identify and communicate with uniformed officers with any private or governmental protection detail providing security for a patient.

Behavioral Health Patient Areas

Behavioral health patients within a healthcare facility will be guarded by staff but law enforcement personnel should have a pre-plan on securing the area and the patients during an *active shooter* incident. For those patients that do not evacuate, a plan should be in place for the protection of the patients and staff while in lockdown.

Infectious Disease/Quarantine Areas

Law enforcement and security should coordinate before an *active shooter* incident to identify the infectious disease/quarantine areas of the healthcare facility. A plan should be developed for the security and protection of the patients and staff since evacuation may not be possible.

Coordination with the staff should include prior training of the proper protective equipment for the area, where PPE is located, and proper donning and doffing techniques, as well as basic information about the disease. Patients and/or staff who may exit the quarantine area should be handled per the policy of the healthcare facility, in coordination with its infection control team.

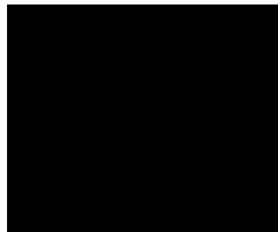
Medical Gases

Healthcare facilities utilize a magnitude of medical gases onsite and the responding law enforcement officers need to be aware of these and their dangers. These gases in large facilities are typically roughed-in during construction or remodeling and incased in the walls of the facility with large volume storage containers supplying the gases through piping. In smaller facilities these can be contained in standard cylinders. Law enforcement needs to identify the specific gases within their jurisdictional healthcare facilities and then identify the hazards associated with those gases. This can be accomplished by reviewing a current copy of

Typical commercial medical gas installation rough-in.

the piping may be a separate line from the sourc

.45 caliber semiautomatic pistol (Colt's Manufacturing, Hartford, CT). The officer notified the technologist that he was carrying a weapon before entering the MRI dressing room. The technologist told the officer to take the weapon with him. The



The law enforcement officer is in charge of the crime scene. The officer will make a determination regarding the status of the scene and make this information known to the responding police, fire, EMS, and the hospital incident command team. In the absence of being notified, the fire and medical units shall NOT assume the scene is secure, and they should take precautions to protect themselves from any potential danger. Law enforcement needs to emphasize if medical personnel rush into a crime scene and are injured or killed they become a victim themselves; take up valuable resources of fellow providers; increase additional risk to law enforcement and are no longer capable of being a trained care provider. Medical personnel shall follow the directions of law enforcement with respect to the crime scene management, but this direction shall not prevent nor detract from quality patient care. Although law enforcement is in charge of the crime scene, they should be mindful of the medical needs of the patients and victims.

Crime Scene Classifications

Crime scene classifications can include:

- **Hot Zone Crime Scene (Closed Access to Unsecured Crime Scene)**
  This is a crime scene in which a hazard still exists (hostage situation, shooter(s) are still on the scene, environmental hazards are present). Medical and fire personnel should not be allowed to enter the crime scene until directed to do so by law enforcement personnel or accompanied by a force protection team. By entering the crime scene, they would not only be putting themselves at risk for injury or death, they would be risking the lives of others. In addition, it would hamper the efforts of law enforcement trying to secure the situation, resulting in another person at risk who would also need police protection. This type of confusion will only prolong the time it takes to secure the crime scene and get medical help for the injured. Law enforcement, fire, EMS, and medical personnel each play a role in an emergency situation in accordance to their training and operational procedures. Stepping outside of these assigned roles can lead to disaster.

- **Warm Zone Crime Scene (Limited Access Crime Scene)**
  This is a crime scene in which critical evidence could be destroyed or compromised, or hazards may still be present.

  Lifesaving considerations will take precedence, but fire, EMS, and medical personnel will take direction from the law enforcement officer in charge who will direct entrance and arrange appropriate escort and/or force protection. Entry into a crime scene should be

made by the minimum number of law enforcement and other emergency response personnel necessary to access and provide care to the patient(s). When possible, entry and exit to the crime scene should be accomplished by the same route. When entering the crime scene, law enforcement and other emergency personnel should try to avoid obvious items of evidence, such as shell casings, blood smears, broken glass, weapons, or items that appear to have numerous quantities of blood or body fluids. Remain vigilant concerning unknown material, spills, damaged containers, and leaks. Personal protection equipment will protect caregivers from body fluid contamination, and it will also protect the scene by preventing responders from leaving their DNA in areas where investigators may have to perform timely elimination printing. It is also imperative that emergency responders not step directly into pools of blood or other fluids. These areas of importance should be discussed prior to an event and practiced during exercises.

If the situation permits, document the names of emergency response personnel entering the crime scene, time entered, and procedures performed as in any other crime scene situation. Alteration of the scene can include items left behind from medical personnel. Responders may find it difficult to manage trash created during pressing and urgent procedures. Caregivers need to be aware that it is possible to inadvertently remove trace evidence that may adhere to the supply packaging used during medic

Coordinated Medical Response
and Behavioral Health Support

Before the Incident

Police officers, firefighters, and emergency medical services (EMS) personnel (first responders) who come to a healthcare facility because of an emergency call involving gunfire face a daunting task. Though the objective remains the same – protect patients, visitors, and staff – the threat of an *active shooter* incident is different than responding to a nat(s)h.001 (o)-2(n)6.13m81(a-6)Tjr/T

Fire

If necessary, police will establish a Warm Zone within the Hot Zone so that a rescue team can

Hemorrhage control for extremities is often controlled by tourniquets. Public safety entities and healthcare facilities should ensure they have an adequate number of tourniquets to respond to an *active shooter* event.

Tactical Emergency Casualty Care Phases

The Tactical Emergency Casualty Care (TECC) Guidance provides a three-phased situational framework:

- Direct Threat Care (DT)/ Care Under Fire (CUF)
- Indirect Threat Care (ITC)/ Tactical Field Care (TFC)
- Evacuation (EVAC)/ Tactical Evacuation (TACEVAC)

This framework can be used by local communities in developing their response strategies.

Under the DT/CUF phase, the external, ongoing threat to life is as dangerous, or more dangerous, than the injury sustained. Casualty extraction may involve the use of Casualty Collection Points (CCP)

The ITC/TFC care priorities are relevant during high-risk operations when the casualty and the provider are in an area of higher security, such as a casualty collection point (CCP) with cover and/or concealment.

EVAC/TACEVAC describes actions taken to continue providing appropriate trauma care during transport to definitive medical care when there is generally reduced threat to the patient and medical provider. Applied to the hospital setting, this could involve the care provided by the hospital Code Team/Transportation Team; or EMS in route to the Emergency Department/Trauma Center within the hospital.

Establish Warm Zone (Safe Corridors/ Safe Areas) within Hot Zone if needed for rapid hemorrhage control

Defining a Warm Zone:

The US Fire Administration, Fire/ Emergency Medical Services Department Operational Considerations and Guide for Active Shooter and Mass Casualty Incidents (September 13) states:

"A few agencies are even exploring the use of LE (sic. Law Enforcement) for rapid patient removal. When possible, agencies should plan for warm zone, indirect threat-area medical

operations to provide TECC-driven point-of-wounding care according to their resources and capabilities." (Page 9)
http://www.usfa.fema.gov/downloads/pdf/publications/active_shooter_guide.pdf

Further:

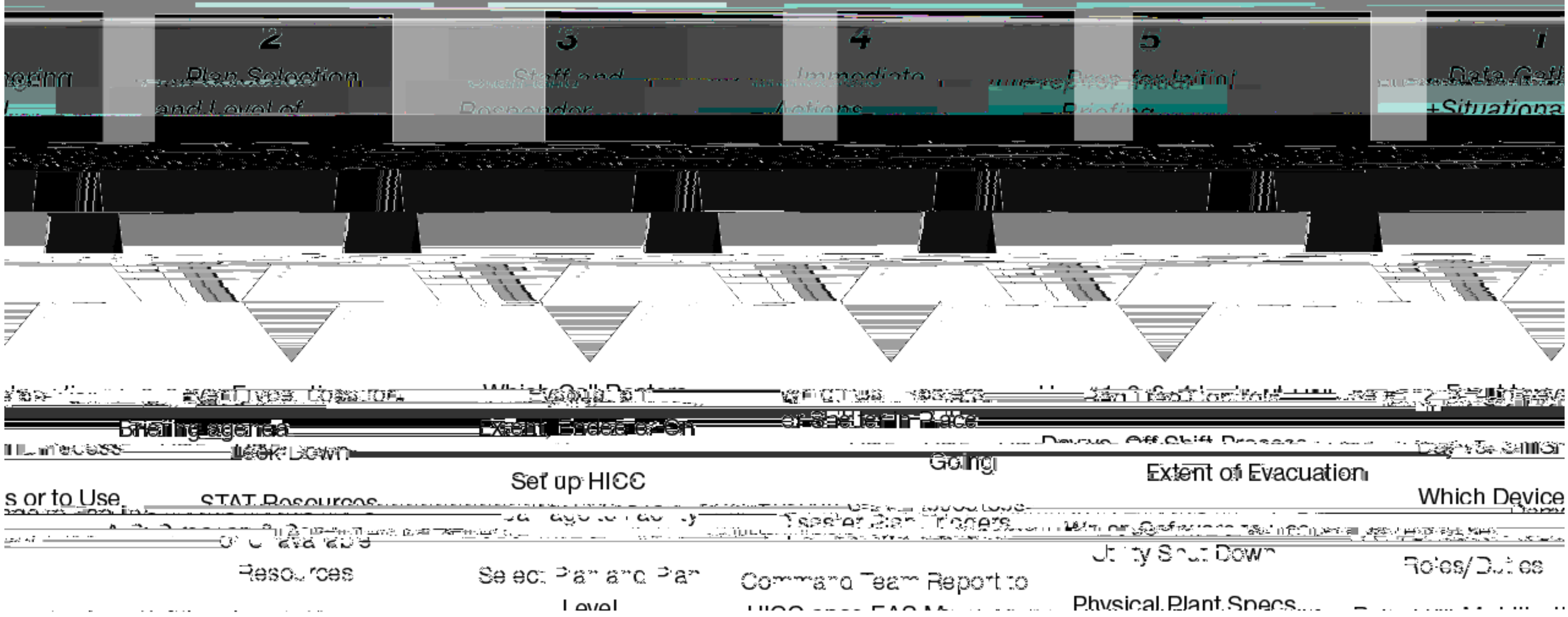
Personnel must understand common police terms to include:

- Cleared
- Secured
- Cover
- Hot zone/warm zone/cold zone and related terms (red, green, etc.)
- Concealment
- Rally points
- Casualty collection points (CCPs)

The following flow diagrams represent a set of response flow procedures that Johns Hopkins Hospital, in Baltimore, Maryland has developed when the designated emergency management staff member or administrator/supervisor on call is aware of an active shooter incident. The first flow diagram describes how the response is activated and the second one describes the response procedures dependent on the received situational awareness.

Components of Pre-Incident Response

then proceed with step #1



arriving officer(s) will be limited due to the nature of the incident and the dangers presents with an active shooter. The South Carolina Departments of Law Enforcement in association with the South Carolina National Emergency Number Association and South Carolina Chapter of the

- Loss of Work Force
- Loss of Technology
- Loss of critical supplies and equipment from vendors

Having an Institutional Plan (with supporting Departmental Plans) in place that addresses these three broad risks will generally cover approximately 80 percent of the risks that a hospital faces in terms of continuity planning. The Institutional Plan should include a broad statement from the hospital leadership addressing their intent to continue healthcare services despite potentially disastrous incidents; and the general strategies that they would use to continue providing healthcare. Many hospitals' continuity programs consist of a set of departmental plans – and do not address overall hospital strategies. Having an Institutional approach to continuity planning will result in better preparedness and provide coherent goals to the departmental continuity planners. HICS includes the Business Continuity Coordinator in the Operations Section of the Incident Command. The Business Continuity Coordinator shheord(a)4(5.9(t)10)]TJ66

(as well as other emergencies), and provide emergency intervention services and victim assistance beginning immediately after the incident and throughout the recovery efforts. This team will integrate with state and federal resources when an emergency occurs.

Behavioral Health Considerations before, during and after an Incident

Behavioral Health Support

Historically, most models of psychological support for healthcare workers and first responders in disasters focus on providing a "one size fits all" single encounter "recital of events of strong emotions" in the immediate post response phase of a disaster. This practice continues despite international consensus findings regarding the potential harm of such an approach (NIH, 2002). It seems clear based on the available literature, that a one size fits all approach, accomplished by "chasing tears," (Yin, 2012) is inadequate if not harmful to disaster responders (NIH, 2002, WHO, 2015). Similarly, other studies have shown that the needs of families of responders have also been largely ignored (Benedek, Fullerton, Ursano, 2007).

Given the above information, rapid psychological triage of all exposed to the incident should be performed. Those showing elevated levels of distress related to the event should be matched to the appropriate level of mental health intervention. This may include Psychological First Aid and stabilization for the least impacted, crisis intervention and evidence based acute traumatic stress Cognitive Behavioral Therapy (CBT) interventions for those a bit more impacted, and longer term evidence based CBT interventions for those at higher need that were severely impacted by the incident. There is also a need to focus on family members who may be vicariously impacted. They too should be psychologically triaged and those at risk should receive further screening by a trained provider. While offering general psychological and social support interventions, an assessment for level of risk for exacerbating an existing psychological condition, or a new onset psychological disorder should be completed. That assessment should be used to match level of risk to an appropriate level of care. For example, those who are the lowest level of risk, a version of Psychological First Aid may be sufficient. However, those who are at greater risk for psychological consequences should be matched to that level of care to mitigate psychological distress. This methodology applies to victims, bystanders, and staff.

Family Support Plan

Within an on-going and evolving emergency, where the **immediate reunification** of loved ones **is not possible**, providing family members with timely, accurate, and relevant information is paramount. Your local or regional mass fatality plan may call for the establishment of a Family

Assistance Center to help family members locate their loved ones and determine whether or not they are among the casualties. Having family members wait for long periods of time for information about their loved ones not only magnifies their stress and frustration, but can also escalate the emotions of the entire group and lead to duplication of efforts when family members don't receive timely information. When families are reunited, it is critical child release procedures are in place where minors might be involved (e.g., childcare or discharged patients) to assure a child is not released to an unauthorized person, even if the person is well meaning. A policy for unaccompanied minors is need as a component of this element.

Essential steps to help establito help1teps t(a)bl.IoC.d as a cD0u4normat(bl)4(i)4(ns)6(Tw T*[(me)-1(mb)-.001 T

1) Rapid mental health staff self-triage to determine the risk of the individual staff member is critical to offer the right level of support in a timely manner (for example the PsySTART Responder Triage System used in LA, Alameda and Bay Area Counties in California, North Central Texas, Washington, DC and the State of Tennessee.)
2) Rapid mental health triage information is aggregated to develop real-time situational awareness for leadership and the ICS responder health function based on summary risk surveillance for all involved staff to assist with development of a population level staff mental health incident action plan component to the overall response plan.
    a. In LA County, aggregated staff self-triage information is used in a modified employee health and wellbeing unit leader Job action sheet: http://file.lacounty.gov/SDSInter/dhs/217273_Attachment7.pdf
    b. Develop pre-event staff resilience strategy specifically for active shooter events targeting known traumatic features:
        i. For example, Anticipate, Plan, and Deter Staff Resilience System used with the Federal Ebola Team deployed to Africa available at http://file.lacounty.gov/SDSInter/dhs/220927_AnticipatePlanDeterInstructorPP-

Psychological First Aid is designed for delivery in diverse settings. Behavioral health providers, other hospital staff, family and community members and other disaster response workers may be called upon to provide Psychological First Aid using a model

The Family Reception Center

The Family Receptio

- Missing Persons/victim accounting
- Family Notifications of *identifications*
- Family Briefings
- Deoxyribonucleic acid (DNA) reference sample collection (with assistance of family)
- Final disposition
- Temporary Morgue Operations
- Support Functions (childcare/credentialing/behavioral health services/first aid/food
- Public Information

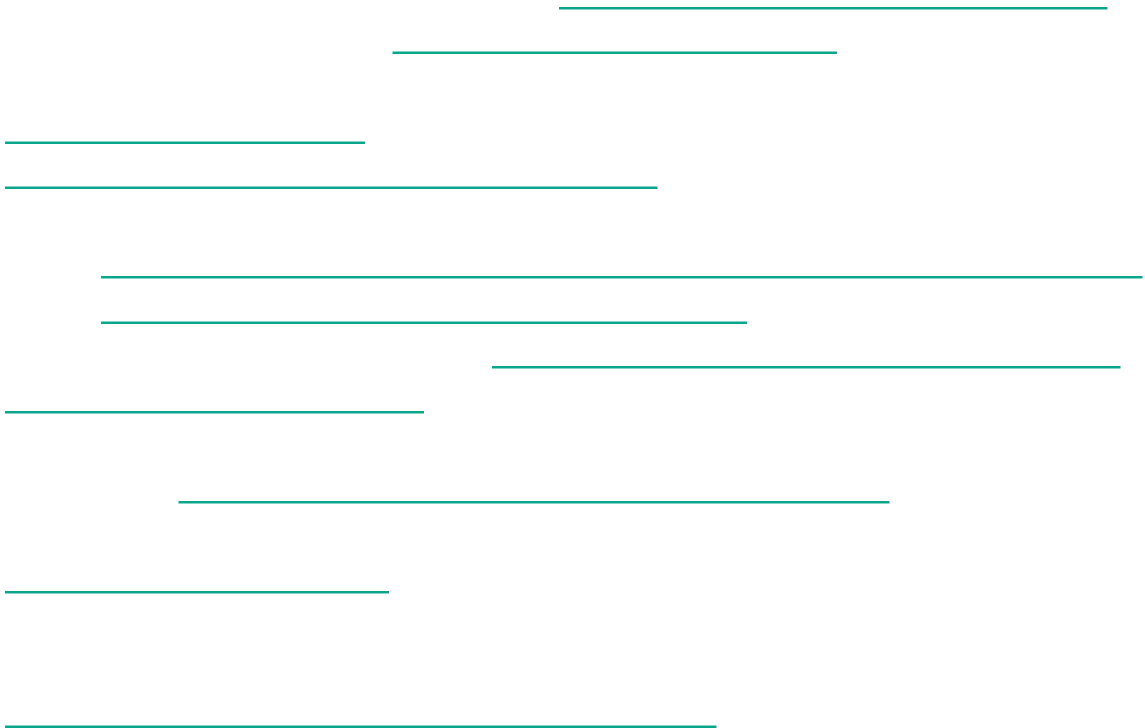
After Action Review – Considerations for Active Shooter Incidents

An After Action Review should be completed for all Active Shooter exercises and real incidents. Continuous Improvement of plans is the goal of any preparedness effort. The analysis undertaken in the After Action Review provides a framework for continuous improvement and quality control

The AAR should include a facilities security review and a review of existing policies related to Active Shooter incidents. If there is facility damage as a result of the incident, a post-incident accreditation survey may be needed.

Triage Systems

Hospital staff members that are accountable for planning the response to mass casualty incidents should remain current on recent trends in triage and be able to adapt the method of triage to the situation at hand. Be able to adapt to scenarios that might include a large number of pediatric patients. If the shooter uses explosives as part of the attack, consider that certain blast injuries may not be readily apparent, yet may still be life-



Appendices

These are sample policies from health systems to assist you in developing or reviewing your active shooter policies. Some of the information and wording contained in these sample policies may differ from the content of this guide.

Appendix A

Active Shooter

Appendix A

ACTIVE SHOOTER PROCEDURE:

1. In the event an individual or individuals come into the facility displaying a firearm or as an

Appendix A

Facility Incident Command System is established. The liaison role may remain with Security or be otherwise appointed by the Incident Commander upon arrival.

8. Staff outside the area of the incident will remain in their areas. They will secure their areas if they can be secured. Curtains will be closed calmly reassuring patients and visitors who may seem distressed. Department supervisors, charge nurses or clinical leaders for patient and non-patient areas should take a count of all individuals in their respective units or departments and be ready to report the following to Incident Commander:
   a. Number of staff members
   b. Number of patients
   c. Number of other individuals such as visitors, vendors, etc.
   d. Number of individuals who may be hurt or wounded.

9. The AOC or Incident Commander will activate the "call tree" to fellow Administrators in the event of a hostage situation or active shooter. Collectively they will meet in a predetermined area to assume roles designated by the Incident Commander. The AOC/Incident Commander will activate the emergency lockdown procedure for the facility and other buildings as required.

10. Patients and visitors wil

Appendix A

14.

Appendix B

3. As a last resort and, only as your last resort, prepare to defend yourself and your patients.

   ∉

Appendix B

- PIO: Ensure that HIMC approved internal messages (from Police HICC) are sent out at 15-minute intervals or sooner as deemed appropriate.
- PIO: Deploy additional PIOs to other areas (i.e. Police Dept. ICC) designated by Incident Commander or HIMC PIO
- Information Officers: Send out HIMC approved messages after receiving said messages
- Incident Commander or Operations Chief: Update the website or repository site with instructions and status reports on response to event
- Operations Chief: Inform which communication methods will be used to update respective branch directors
- Operations Chief: Activate the Hospital's "Hot Lines" for incoming external calls to hospital or to affected unit(s)
- Operations Chief: Activate the Family Assistance Center outside of the inner perimeter
- Incident Commander or Liaison Chief: Liaison with other affiliates, if applicable, on campus via unified command system
- Logistics Chief: Liaison with Facilities and other affiliates on campus to ensure all respective building entrance doors are locked
- Operations Chief: Coordinate evacuation response in conjunction with Medical Consultant or Vice President of Medical Affairs and with affected departments for injured victims once area(s) have been secured. Seek assistance from Fire Department when indicated.
- Logistics Chief: Open, if indicated, a loading dock outside of middle perimeter to receive essential supplies and equipment
- Liaison Of /Lian ⁄4/an a.005.0053CharSpan ⁄MCID 21 >>BDC /C2_0 1 Tf 0 Tc 0 T>>BDC /Cnc0(s1 T

Appendix B

- Request support from HIMC to respond to incoming telephone calls for affected unit(s) that need to evacuate (e.g. Family Assistance Center and/or Hot Line Team)
- Seek support and/or approval from HIMC prior to implementing a major decision in discontinuing patient care services
- Remind staff they are not to discuss event and victims with media and external parties

4. First Responders
    - Assistance from local and state law enforcement agencies will be provided under existing mutual aid agreements.
    - The Chief of Police or designee in consultation with Corporate Security or designee and other appropriate [illegible]

the safe location or assembly point until law enforcement authorities have instructed you to do so

7. How Employees Should Respond When Law Enforcement Arrives
    - Law enforcement's purpose is to stop the active shooter as soon as possible. Officers will proceed directly to areas in which the last shots were fired.
    - Officers usually arrive in teams of 4
    - Officers may wear regular patrol uniforms or external bulletproof vest, Kevlar helmets, and other tactical equipment

8. Crime Scene Requirements
    - The area or areas will be closed and off limits during crime scene processing
    - Those who evacuated, were relocated, or moved in the aftermath will be reunited with their personal property as soon as possible
    - Processing time will be determined by the complexity and scale of the event
    - Loss of use could last hours and easily extend into days

IV. <u>Subsequent Procedures/Information</u>

We cannot predict the origin of the next threat; assailants in incidents across the nation have been students, employees, and non-students alike. In many cases there were no obvious specific targets and the victims were unaware that they were a target until attacked. Being aware of your surroundings, taking common sense precautions, and heeding any warning information can help protect you and other members of the community. In addition, activation of the hospital's response will be based on when the incident has occurred and on how many perimeters have been established by the police

Appendix B

3. Options for Consideration Active Shooter Preparedness video. U.S. Department of Homeland Security, 1/16/13, http://www.dhs.gov/video/options-consideration-active-shooter-preparedness-video

4. Johns Hopkins Hospital Corporate and Administrative Policies & Procedures (October 2014). Security Disasters: Active Shooter & Hostage Incidents

5. Ready Houston (2012). Regional Disaster Preparedness - Run > Hide > Fight Surviving an Active Shooter. Retrieved from http://www.readyhoustontx.gov/videos.html

6. Kelen G., Catlett, C., Kubit, J., & Hsieh, Y. (2012). Hospital-based shootings in the United States: 2000 to 2011. American College of Emergency Physicians.doi: 10.1016/j.annemergmed.2012.08.012

7. Active Shooter Planning and Response in a Healthcare Setting, January 2014. Healthcare and Public Health Sector Coordinating Councils.

8. Incorporating Active Shooter Incident Planning into Healthcare Facility Emergency Operations Plans. March 2014 Draft. U.S. HHS, ASPR, DHS, FEMA, U.S. Dept. of Justice and FBI.

9. DHS Active Shooter Preparedness > www.dhs.gov/active-shooter-preparedness

10. FBI Active Shooter Resources > https://www.fbi.gov/about/partnerships/office-of-partner-engagement/active-shooter-resources

11. FEMA Active Shooter online training course -- IS-907: Active Shooter: What You Can Do > https://training.fema.gov/is/courseoverview.aspx?code=IS-907

Appendix C

- Compile aggressive behavior data compilation for review, analysis, and development of additional procedures
- Portable or hand held magnetometers in high risk areas (i.e. emergency departments, psychiatric areas, etc.)

Training: How to Select the Most Appropriate Option to Protect Yourself and Your Patients and Visitors

1. Active Shooter in Healthcare: What You Must Do

   - You must remain calm!
     - Take a deep breath and come to the understanding that you, your coworkers, and your patients are in danger.
   - You must quickly assess the situation.
     - How close is the shooter?
     - Is there time to get everyone out safely?
     - Can the area be secured?
     - Should we shelter in place?
     - Should I prepare to defend myself and protect my patients?
   - You must make decisions based on your assessment of the current situation and you must be prepared to act on those decisions.

2. Communication

   - Call Security at (telephone Number)
   - Let it ring until it is answered, do not hang up
   - Security will contact Police Department
   - Obtain updates by email and text from hospital and/or Department Incident Command Center
   - Security or Incident Commander or designee will notify adult trauma team attending or code team via (telephone #s) or request hospital operator to make/activate overhead announcement of Code Silver event and where victims are located
   - If trauma attending's or Code Team are not available, EMS/Fire Department will be responsible for the victims
   - Place signs in exterior windows indicating your location and location of injured
   - Department leaders will communicate with their respective staff, patients, and visitors

Appendix C

HIDE

- Are there any safe rooms?
- Does the unit lockdown?
- Do certain areas or rooms lockdown?
- How can the area be barricaded?

Appendix C

FIGHT

- What can be used as a weapon?
- What are options on your unit?
- Who will communicate with patients and visitors?
- Who will be the leaders on the unit?
- How will staff communicate?
- Who will contact: Corporate Security or Dept. Leaders or Dept. Command Management Center?

Appendix C

5. <u>Hospital Response Efficiency and Effectiveness</u>: To assist you in determining the quality of your response, please use the following questions to review the information gathered during the debriefing process and when you are ready to review/compare your lessons learned, improvement areas and established procedures. .r Tj 2 /T1_0 1nbl( )L7mfbl( )L7mfbl71(as)2(a

Appendix C