ACTIVE SHOOTER

PLANNING AND RESPONSE

LEARN HOW TO **SURVIVE**
A SHOOTING EVENT IN
A HEALTHCARE SETTING

RUN HIDE FIGHT

2017

Healthcare & Public Health
Sector Coordinating Council

IAEMSC
International Association of Emergency Medical Services Chiefs

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!

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Introduction

Welcome to the third edition of Active Shooter Planning and Response in a Healthcare Setting. When our project began in 2013, we knew that while there were resources to address a public active shooter event, there was no guidance to address an active shooter event that occurs inside a healthcare facility. We gathered experts from the public and private sector, and discussed and debated the difficult questions of patient, visitor, and personal safety, duty to act, and abandonment. We also committed to regular updates of this guidance, to incorporate lessons learned, new tactics, and feedback.

This new edition brings additional information on warm zone operations (providing care in an area wherein a potential threat exists, but it is not direct or immediate, law enforcement tactics, unified command, and psychological support.

This guidance was produced and updated by the Healthcare and Public Health (HPH) Sector Coordinating Council (SCC). The HPH Sector Critical Infrastructure Protection (CIP) Partnership brings together leaders in business and government to prepare for and protect against all hazards facing the Sector. The CIP framework focuses on protecting HPH organizations *themselves* during a disaster, so that they may focus on their mission of saving lives. The partnership identifies and prioritizes the most critical elements of the Nation's HPH infrastructure, shares information on risks facing that infrastructure, and implements activities to protect the Sector. The HPH Sector partnership consists of a Government Coordinating Council (GCC) of government partners and the SCC of private sector partners. These two groups come together through two joint working groups and six subsectors to address issues of mutual concern. All public and private sector members of the HPH Sector with a role in the HPH Sector's homeland security mission are invited to take part in one or more of the joint working groups. More information is available at: http://www.dhs.gov/critical-infrastructure-sector-partnerships

Active shooter events in a healthcare setting present unique challenges: a potentially large vulnerable patient population, hazardous materials (including infectious disease), locked units, special challenges (such as weapons and Magnetic Resonance Imaging (MRI) machines (these machines contain large magnets which can cause issues with firearms, or remove it from the hands of law enforcement), as well as caregivers who can respond to treat victims.

There is no single method to respond to an incident, but prior planning will allow you and your staff to choose the best option during an *active shooter* situation, with the goal of maximizing lives saved. The best way to save lives is to remove potential targets from the shooter's vicinity. We address some difficult choices that will need to be made in this document.

We hope as you read, review, and implement your own plan, you will provide feedback to our team, so this continues to be a living document, providing the latest information and guidance to our healthcare community. Feedback may be sent to scott.cormier@medxcelfm.com. Thank you for all the work you do in keeping our patients, staff, and visitors safe.

We also encourage you to review the healthcare active shooter video produced by the MESH Coalition. MESH, Inc. is an innovative non-profit, public-private coalition located in Marion County, Indiana (Indianapolis) that enables healthcare providers to respond effectively to emergency events, and remain viable through recovery. For more information on the coalition, please use http://www.meshcoalition.org.

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Active 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 *Active Shooter* 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.

- Prepare to decide to discontinue care to those who may not be able to be brought to safety in consideration of those who can
- Realize some individuals who are able to avoid the incident will choose to remain in dangerous areas. Consider how to react to those situations
- To the extent possible, think about the needs of others as well as yourself. Consider the greater good as well as your own interests

During an *active shooter* situation, the natural human reaction is to be startled, feel fear and anxiety, and even experience initial disbelief. You can expect to hear noise from alarms, gunfire and explosions, and people shouting and screaming. Training provides the means to regain your composure, recall at least some of what you have learned, and commit to action. We know a trained individual will more likely respond according to the training received and will not descend into denial, while the untrained will more likely not respond appropriately, descend into denial and helplessness, and will usually become part of the problem. There are several sets of planning guidance that have been developed for *active shooter* incidents for organizations such as schools, government, and business office settings.

The key message of this document is that hospitals, academic health centers, and other healthcare settings represent a unique set of challenges for *active shooter* planning. The uniqueness of healthcare facilities and the limitations as a result of size, location, critical care versus acute care, rural versus urban versus suburban, the presence of students, whether you have security, law enforcement availability and response times are just a few of the many challenges when developing a response to an *active shooter*. For this reason, we recommend that as you develop your plan, you consider the planning guidance listed below and determine what works best in your particular circumstances. You will notice however that all of the guidance below shares a common set of principles. The first of these principles is that your plan should seek to maximize the protection of life. If possible, evacuation from the incident will reduce the number of people in harm's way, and facilitate the law enforcement response. Another principle is that in the end, individuals will have to make decisions based on their assessment of the situation in how best to maximize the protection of life and what tactics to employ. When all other options have been exhausted, an individual decision to engage or fight the shooter may be the only tactic available. Another important principle for healthcare is that individuals may have a duty of care for patients – in your planning, you should determine any specific requirements that your organization may have and include this in staff training so that they may include this aspect in determining the best course of action to take in maximizing the protection of life.

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 *Active Shooter* 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) on the person or cause
  - Increasingly strident opinion
  - Increasingly negative characterization of the object of fixation
  - Impact on the family or other associates of the object of fixation, if present and aware
  - Angry emotional undertone – typically accompanied by social or occupational deterioration

[2] Meloy, G.D., Hoffman, J, Guldimann, A, and James, D. The role of warning behaviors in threat assessment: An exploration and suggested typology. *Behavioral Sciences and the Law*, 2011 DOI: 10.1002/bsl.999. Available at: https://www.researchgate.net/profile/John_Meloy/publication/222104783_The_Role_of_Warning_Behaviors_in_Threat_Assessment_An_Exploration_and_Suggested_Typology/links/0a85e536be473606d4000000.pdf

- Identification warning behavior – any behavior that indicates a psychological desire to be a "pseudo-commando", have a "warrior mentality," closely associate with weapons or other military or law enforcement paraphernalia, identify with previous attackers or assassins, or identify oneself as an agent to advance a particular cause or belief system.
- Novel aggression warning behavior – an act of violence which appears unrelated to any targeted violence pathway warning behavior which is committed for the first time. Such behaviors may be utilized to test the ability of the subject to actually do a violent act, and may be a measure of response tendency, the motivation to act on the environment, or a behavioral tryout. When homicide occurs within this warning behavior, it may be "proof of kill."
- Energy burst warning behavior – an increase in the frequency or variety of any noted activities related to the target, even if the activities themselves are relatively innocuous, usually in the days or weeks before the attack.
- Leakage warning behavior – the communication to a third party of intent to do harm to a target through an attack.
- Last resort warning behavior – evidence of a violent "action imperative", increasing desperation or distress through declaration in word or deed, forcing the individual into a position of last resort. There is no alternative other than violence, and the consequences are justified. The subject feels trapped.
- Directly communicated threat warning behavior – the communication of a direct threat to the target or law enforcement beforehand. A threat is a written or oral communication that implicitly or explicitly states a wish or intent to damage, injure, or kill the target, or individuals symbolically or actually associated with the target.

Major Findings from the FBI's Active Shooter Incidents Study

The FBI document "A Study of Active Shooter Incidents in the United States Between 2000 and 2013[3]" contains a full list of the 160 incidents used in study, including those that occurred at Virginia Tech, Sandy Hook Elementary School, the U.S. Holocaust Memorial Museum, Fort Hood, the Aurora (Colorado) Cinemark Century 16 movie theater, the Sikh Temple of Wisconsin, and the Washington Navy Yard, as well as numerous other tragic shootings. A later study identified 40 active shooter incidents in 2014-2015. Here are some of the study's findings:

- Only 4 active shooter incidents occurred in healthcare settings between 2000-2013, and an additional 2 incidents occurred in 2014-2015.

[3] https://www.fbi.gov/file-repository/active-shooter-study-2000-2013-1.pdf

- Active shooter incidents are becoming more frequent—the first seven years of the study show an average of 6.4 incidents annually, while the last seven years show 16.4 incidents annually.
- These incidents resulted in a total of 1,043 casualties (486 killed, 557 wounded—excluding the shooters).
- All but six of the 160 incidents involved male shooters (and only two involved more than one shooter).
- More than half of the incidents—90 shootings—ended on the shooter's initiative (i.e., suicide, fleeing), while 21 incidents ended after unarmed citizens successfully restrained the shooter.
- In 21 of the 45 incidents where law enforcement had to engage the shooter to end the threat, nine officers were killed and 28 were wounded.
- The largest percentage of incidents—45.6 percent—took place in a commercial environment (73 incidents), followed by 24.3 percent that took place in an educational environment (39 incidents). The remaining incidents occurred at the other location types specified in the study—open spaces, military and other government properties, residential properties, houses of worship, and health care facilities.

According to a study in *Annals of Emergency Medicine*, in 2000-2011 the United States had 154 hospital-related shootings.[4]

- 91 (59%) inside the hospital and 63 (41%) outside on hospital grounds.
- 235 injured or dead victims.
- The Emergency Department environs were the most common site (29%), followed by the parking lot (23%), and patient rooms (19%).
- Most events involved a determined shooter with a strong motive defined by a grudge (27%), suicide (21%), "euthanizing" an ill relative (14%), and prisoner escape (11%).
- Ambient society violence (9%) and mentally unstable patients (4%) were comparatively infrequent.
- The most common victim was the perpetrator (45%).
- Hospital employees composed of 20% of victims.
    - Physicians (3%) and nurses (5%) victims were relatively infrequent.

[4] Kelen, G.D., Catlett, C.L., Kubit, J.G., and Hsieh, Y. (December 2012). Hospital-based shootings in the United States: 2000 to 2011. *Annals of Emergency Medicine, 60* (6), 790-798. http://dx.doi.org/10.1016/i.annemergmed.2012.08.012

- 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 *Active Shooter* 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

- How to evacuate or lock down patients, visitors, and staff. (Personnel involved in such planning should pay attention to access and functional needs when advising on shelter sites and evacuation routes.)
- How to evacuate when the primary evacuation routes are unusable.
- How to select effective shelter-in-place locations (optimal locations have thick walls, solid doors with locks, minimal interior windows, first-aid emergency kits, communication devices, and telephones or duress alarms).
- How the healthcare facility and/or campus will be notified when there is an *active shooter* on campus. This could be done through the use of familiar terms, sounds,

lights, and electronic communications, such as text messages or e-mails. Include in the courses of action how to communicate with those who have language barriers or need other accommodations, such as visual signals or alarms to advise deaf patients, staff, and visitors about what is occurring. Healthcare facility-wide "reverse 911-style" text messages sent to pre-determined group distribution lists can be very helpful in this regard. Planners should make sure this protocol is readily available and understood by those who may be responsible for sending out or broadcasting an all-healthcare facility or campus announcement. Rapid notification of a threat can save lives by keeping people out of harm's way. An important part of responding to an *active shooter* event is an emergency notification system. The emergency notification system can alert various parties of an emergency including:

- Individuals at remote locations within premises and other campus buildings
- Multi-lingual capability for staff or visitors with cultural or linguistic needs
- Local emergency responders
- Other local area hospitals
- How patients, visitors, and staff will know when buildings and campus grounds are safe.

The planning team may want to include functions in an *Active Shooter* annex that are also addressed in other functional annexes of the facility emergency operations plan. For example, evacuation will be different during *an active shooter situation* than it would be for a fire.

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 surroundings to be helpful and ask if they can be of assistance
- The plan should include information security processes, including compliance with the Health Insurance Portability and Accountability Act.

Modern health care settings can be the site for unusual and dangerous activities. Some facilities have opted to construct safe rooms. Such rooms are designated spaces where staff, patients and even visitors can retreat to in the event of an immediate threat of danger. A designated safe room should be equipped with a duress button, telephone, and reinforced doors.

Sharing Information with First Responders

The planning process is not complete until the healthcare facility EOP is shared with first responders. The planning process must include preparing and making available to first responders an up-to-date and well-documented site assessment, as well as any other information that would assist them. These materials should include building schematics and photos of both the inside and outside of the buildings, and include information about door and window locations, and locks and access controls. Emergency responders should also have advance information on where patients who may be unable to evacuate, such as the operating room, critical care units, nurseries, and pediatric units. Building strong partnerships with law enforcement, fire, and EMS officials includes ensuring they also know the location of available public-address systems, two-way communications systems, security cameras, and alarm controls. Equally important is information on access to utility controls, medical supplies, fire extinguishers, and how to access secured or locked areas of the facility.

Providing the detailed information listed above to first responders allows them to rapidly move through a healthcare facility during an emergency, to ensure areas are safe, and to tend to

people in need. It is critically important to share this information with law enforcement and other first responders before an emergency occurs. Law enforcement agencies have secure websites where this information is stored for many businesses, public venues, and other locations. All of these can be provided to first responders and viewed in drills, exercises, and walk-throughs.

Technology and tools with the same information (e.g., a portable USB drive that is compatible with computers used by first responders) should be maintained in secured locations in the facility from which healthcare facility officials can immediately provide it to responding officials or from which first responders can directly access it. The locations of these materials at the healthcare facility should be known by and accessible to a number of individuals to ensure ready access in an emergency. Every healthcare facility should have more than one individual charged with meeting first responders to provide them with the healthcare facility site assessment, the healthcare facility EOP, and any other details about healthcare facility safety and the facility. All parties should know who these key contacts are.

Exercises

Most healthcare facilities practice evacuation drills for fires and protective measures for natural disasters, but far fewer healthcare facilities practice for *active shooter situations*. To be prepared for an *active shooter* incident, healthcare facilities should train their staff, in what to expect and how to react.

Good planning involves conducting drills which involve first responders and facility security teams, and includes the role of sworn local law enforcement officers employed or stationed in the emergency department or other areas of the facility. Exercises with these valuable partners are one of the most effective and efficient ways to ensure everyone knows not only her or his role(s) but also the role(s) of others at the scene. These exercises should include walks through the healthcare facility and other campus buildings to allow law enforcement officials to provide input on shelter sites as well as familiarize first responders with the campus, including shelter locations, evacuation routes, and locations where patients who may be unable to evacuate, such as the operating room, critical care units, nurseries, and pediatric units.

Each person carries a three-fold responsibility.
First: Learn the signs of a potentially volatile situation and ways to prevent an incident.
Second: Learn the best steps for survival when faced with an *active shooter* situation.
Third: Be prepared to work with law enforcement during the response.

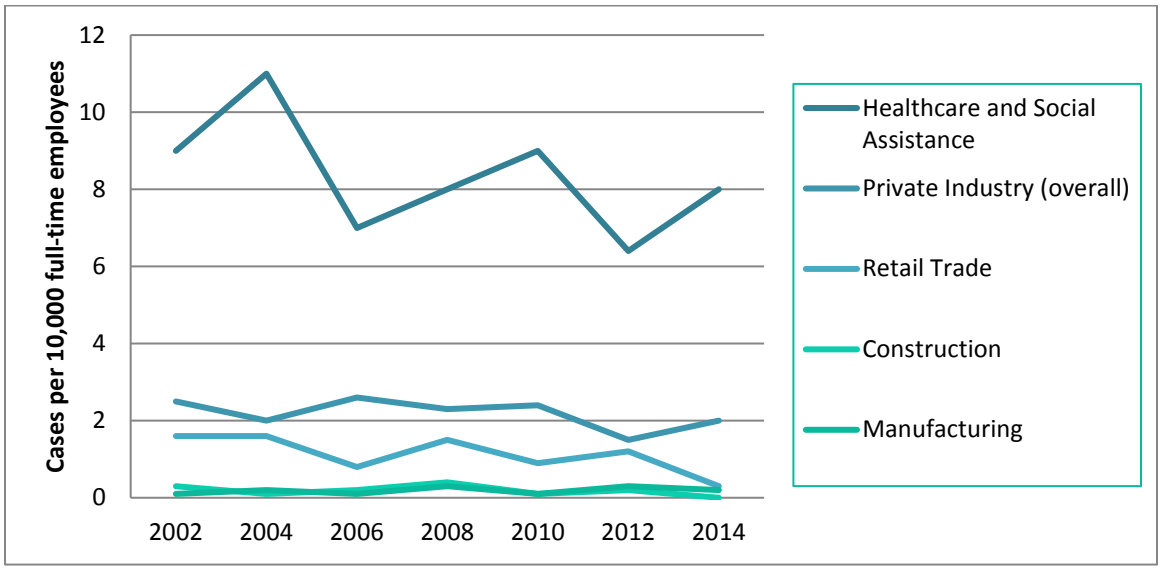
Plain Language Communication

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 have accurate information and clear instructions on how to protect themselves in the emergency[6]. Whether an academic health center, standalone hospital, long term care facility, clinic, or diagnostic center, not everyone (patients, visitors, vendors, students, or even staff) will understand a code system, and so plain language warnings and clear instructions should be given to make sure everyone in danger understands the need to act. As appropriate to the community, messaging should address those with cultural and linguistic needs.

Threat Assessment Teams

Violence in healthcare is well documented, and according to the Bureau of Labor Statistics, incidents of violence in healthcare are four times more likely than in other industries[7]

Violent Injuries Resulting in Days Away from Work, by Industry 2002 - 2013



**Data Source: Bureau of Labor Statistics data for intentional injuries caused by humans, excluding self-afflicted injuries.*

[5] Denis S. Mileti, *Public Response to Disaster Warning.* University of Colorado at Boulder. Available at: http://swfound.org/media/82620/PUBLIC%20RESPONSE%20TO%20DISASTER%20WARNINGS%20-%20Dennis%20S.%20Mileti.pdf

[6] For example, "Gunshots reported on 3-West. Evacuate if you are on 3-West. All other units perform lockdown."

[7] Workplace violence in healthcare: Understanding the challenge available at: https://www.osha.gov/Publications/OSHA3826.pdf

There are four broad categories of workplace violence:

- TYPE 1: Violent acts by criminals who have no other connection with the workplace, but enter to commit robbery or another crime.
- TYPE 2: Violence directed at employees by customers, clients, patients, students, inmates, or any others for whom an organization provides services.
- TYPE 3: Violence against coworkers, supervisors, or managers by a present or former employee.
- TYPE 4: Violence committed in the workplace by someone who doesn't work there, but has a personal relationship with an employee—an abusive spouse or domestic partner.

As described in the previous section, research shows perpetrators of targeted acts of violence engage in both covert and overt behaviors preceding their attacks. They consider, plan, - prepare, share, and, in some cases, move on to action[8]. One of the most useful tools academic and non-academic healthcare facilities can develop to identify, evaluate, and address these troubling signs is a multidisciplinary Threat Assessment Teams (TAT). A TAT with diverse representation often will operate more efficiently and effectively. TAT members should include healthcare facility administrators, counselors, current employees, medical and behavioral health professionals, residential life, public safety, and law enforcement personnel.

The TAT serves as a central convening body to ensure warning signs observed by multiple people are not considered isolated incidents and do not slip through the cracks, as they actually may represent escalating behavior that is a serious concern. Healthcare facilities should keep in mind, however, the importance of relying on factual information (including observed behavior) and avoid unfair labeling or stereotyping, and to remain in compliance with civil rights and other applicable federal and state laws.

For the purpose of consistency and efficiency, a TAT should be developed and implemented in coordination with healthcare facility policy and should address any annual training requirements, and how often to convene. In addition, staff already working to identify staff needs can be a critical source of information on troubling behavior for a TAT.

The TAT reviews troubling or threatening behavior of current patients and family members, visitors, staff, or other persons brought to the attention of the TAT. The TAT contemplates a holistic assessment and management strategy that considers the many aspects of the potentially threatening person's life—academic, residential, work, and social. More than focusing on warning signs or threats alone, the TAT assessment involves a unique overall

[7]See Threat Assessment Teams: Workplace and School Violence Prevention. http://www.fbi.gov/stats-services/publications/law-enforcement-bulletin/february-2010/threat-assessment-teams/

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 and coordinate access to the FBI's Behavioral Analysis Unit. It focuses not on how to respond tactically to an *active shooter* situation but rather on how to prevent one. Early intervention can prevent a situation from escalating by identifying, assessing, and managing the threat. The TAT should consult with its healthcare facility administration and develop a process to seek these additional resources.

Generally, *active shooter* situations are not motivated by other criminal-related concerns such as monetary gain or gang affiliation. Oftentimes situations may be prevented by identifying, assessing, and managing potential threats. Recognizing these pre-attack warning signs and indicators could help disrupt a potentially tragic event.

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, Hide, Fight *Active Shooter* Response

Run, **H**ide, **F**ight is a three step process to prevent or reduce loss of life in an *active shooter* event.

Run – is to immediately evacuate the area

Hide – seek a secure place where you can hide and/or deny the shooter access

Fight – where your life or the lives of others are at risk, you may make the personal decision to try to attack and incapacitate the shooter to survive[9]

2. Avoid-Deny-Defend

Avoid- This begins with situational awareness of one's environment prior to an active, hostile act occurring. It also includes having a plan ahead of time regarding what you would do in the event of an *active shooter* and knowing escape route. **Avoid Danger**

Deny- If avoidance is not possible, find ways to prevent the attacker from having access to you and other around you. (Close/lock doors, barricade doorways with furniture, etc.). **Deny Access**

Defend- Take action! As a last resort you have a right to defend yourself if you believe your life is in imminent danger. **Defend Yourself**[10]

3. The 4As *Active Shooter* Response

The 4As is a 4 step process to prevent or reduce loss of life in an *active shooter* event. They stand for:

- **A**ccept that an emergency is occurring.
- **A**ssess what to do next so that you can save as many lives as possible, which depends on your location.
- **A**ct: Lockdown (lock and barricade the doors, turn off the lights, have patients get on the floor and hide) or evacuate or fight back (last resort).
- **A**lert law enforcement and security

[9] http://www.phe.gov/preparedness/planning/Documents/active-shooter-planning-eop2014.pdf

[10] www.avoiddenydefend.org

4. ALICE *Active Shooter* Response

"ALICE" is an acronym for five steps the proponents say can be used to increase your chances of surviving a surprise attack by an *active shooter*. ALICE stands for:

Alert – Can be anything

Lockdown – This is a semi-secure starting point from which to make survival decisions. If you decide not to evacuate, secure the room.

Inform – Using any means necessary to pass on real time information

Counter – This is the use of simple, proactive techniques should you be confronted by the *active shooter.*

Evacuate – Remove yourself from the danger zone as quickly as possible [11]

5. Window of Life *Active Shooter* Response

Window of Life is an emergency response method authored by Safe Havens International. It says a person who is in a crisis has four responsibilities:

- A person's first responsibility is for his or her safety. You are an important asset in a crisis, not one to throw away lightly. If you are lost, that loss is felt in successive areas around you, much like the ripples in a pond.
- A second responsibility is to those in the immediate vicinity, those who are within line-of-sight or ear shot of where you are. Recognizing your importance as an asset involves using that asset to help others.
- A third responsibility is to those in your place. Having protected yourself and alerted those near you, it is important to alert those who will also be affected by the crisis but may have a bit more time to react.
- A fourth responsibility is to notify public safety.

Discussing and training for a possible *active shooter* situation allows each person to consider what he or she would do. As a situation develops, staff may be required to use more than one option. During an *active shooter* situation, staff will rarely have all of the information they need to make a fully informed decision about which option is best. While they should follow the plan and any instructions given during an incident, often he or she will have to rely on their own judgment to decide which option will best protect lives. Each individual must decide for himself or herself what actions are appropriate based on location and position during such an incident. The goal in all cases is to survive and protect. The safety of patients, visitors, and coworkers also must be considered when making decisions on how to respond. Many staff members are

[11] http://www.alicetraining.com/what-we-do/respond-active-shooter-event/

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. However, ICS should also be able to obtain situational awareness, as well as collaborate and coordinate internal and external (e.g., first responders, local and federal agencies, et al) response procedures when indicated. As you review this document it becomes clear that the complexity of the event requires a more comprehensive and integrated approach. As the incident progresses the situation evolves requiring changing priorities and goal development. Most active shooter events are short periods of time. The following aftermath of recovery, evidence collection, facility restoration and behavioral health take much longer.

The integrated response required is similar to Unified Command with some exceptions. First, the immediate priority of neutralizing the threat clearly rests with law enforcement. The healthcare facilities ability to maintain some level of service rests with executives. Having a Continuity of Operations plan that includes and active shooter scenario is imperative. The ever changing environment of required decisions requires flexibility in roles of participants. A decision requirement at hour one may be forgotten at hour two as a result of other priorities.

The solution is to develop a very flexible management tool commonly call Unified Command. Utilizing the incident command is adapting a system that was designed for direct scene command into a larger system. The challenge is that those larger scenes need higher level decision making and consideration of business and political issues. That is not the skill of a

[12] For free training on ICS, visit https://training.fema.gov/is/

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 commander may take breaks but never loses the mantle of responsibility of the situation. The example is the general does not give up being the general when they rest; they delegate responsibility to deputies who carry out specific missions as discussed. Their decision making ability is determined by the incident commander based on the experience and knowledge of the specific deputy given the command responsibility. The specific event of an active shooter is only one piece of a complex overall response to a disrupting event. This is why a unified integrated response is required.

Healthcare facility Emergency Operations Plan (EOPs) should include courses of action that will describe how staff can most effectively respond to an *active shooter* situation to minimize the loss of life, teach and train on these practices, and continue life-saving procedures and essential continuity of operations when indicated, as deemed appropriate by the healthcare facility.

Law enforcement officers may not be present when a shooting begins, hence it is critical for the hospital or healthcare organization to know the average time of arrival so procedures are in-place prior to the arrival of law enforcement officers. These procedures should be developed and selected dependent on when the incident occurs (e.g., day shift versus off shifts since there is less staff and inadequate staff mix dependent on the shift). Providing information on how staff can respond to the incident can help prevent and reduce the loss of life. Providing information on how staff can respond to the incident can help prevent and reduce the loss of life. No single response fits all *active shooter* situations; however, making sure each individual knows his or her options for response allows them to react decisively and save valuable time. Depicting scenarios and considering response options in advance will assist individuals and groups in quickly selecting their best course of action.

Remember, during an *active shooter* situation, the natural human reaction, even if you are highly trained, is to be startled, feel fear and anxiety, and even experience initial disbelief and denial. You can expect to hear noise from alarms, gunfire, and explosions, and people shouting and screaming. Training provides the means to regain your composure, recall at least some of what you have learned, and commit to action. There are three consistent basic options: run, hide, or fight. You can run away from the shooter, seek a secure place where you can hide and/or deny the shooter access, or incapacitate the shooter in order to survive and protect others from harm.

As the situation develops, it is possible you will need to use more than one option. During an *active shooter* situation, individuals will rarely have all of the information they need to make a

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 to destroy, incapacitate, harass, or distract. It may incorporate military stores, but is normally devised from nonmilitary component.

The term IED came into common usage in 2003 during the Iraq War and encompasses a wide range of improvised explosives, from a small pipe bomb to a significant device that can massive damage and loss of life. These devices share the common attributes of an initiator, switch, main charge, power source and a container. These devices can be enhanced with a variety of materials, e.g. glass, nails, metal fragments, that increases the number and severity of injuries inflicted during an explosion.

There have been numerous active shooter events in the past where the actors used or attempted to use improvised explosive devices or IED's. In December 2015, the attackers at the Inland Regional Center in San Bernardino, California attempted to use a remote detonated device that was intended for first and secondary emergency responders. The device failed to detonate most likely saving lives and further serious injury. Since 2000, explosive devices have been used in 8 different active shooter attacks as documented in a study by Texas State University and the FBI.[13] Other events such as the Boston Marathon bombing in 2013 and the series of bombings in New York City and New Jersey in September 2016 are a reminder that explosives are a serious concern and a weapon used by terrorists to create casualties, fear, and confusion.

The deployment and use of explosive devices coupled with the small-arms weapons magnifies the complexity of the event, the response and ultimately the recovery. In addition to different injury patterns caused by blast injuries, the presence of explosives can significantly alter the immediate response to an active shooter event. The visual identification of an unexploded device will most likely slow down the entire emergency response. If a device has actually detonated, there will likely be infrastructure damage and potential fire complicating the response. Healthcare facilities, especially emergency departments and locations where victims may be transported for treatment, should be on heightened awareness during and after any

[13] www.activeshooterdata.org (Texas State University)

active shooter attack for suspicious packages or items. This is also a consideration for a facility that was not directly attacked but is receiving casualties from another location.

Attributed to http://www.nam.ac.uk

Attributed to http://helmandblog.blogspot.co.uk

Improvised Explosive Devices

In the last few years more than 4,300 'improvised explosive device events' have resulted in an estimated 65,400 casualties – in 2014 alone, over three-quarters of casualties were civilian. IEDs now kill 10 times more civilians than landmines do in Afghanistan. Over the last decade, 367 humanitarian workers have been killed and injured by IEDs.

The presence of an Improvised Explosive Device makes the response by First Responders more challenging for it is now considered a special situation. For in an addition to an active shooter there is a bomb and the dangers attendant to an improvised explosive device. One of the critical factors in such situations is the identification of the device – for many IEDs by their design are extremely hard to detect.

Your strength is to be found in your suspicion – trust your instincts. If something seems wrong, do not ignore it; do not assume someone else has already reported it; call local authorities and most important **– Keep your distance from a suspicious package – do not approach or tamper with it.**

When you do report the suspected IED, be ready to provide your name, location, a description of what you think is suspicious and the time you saw it. Responding Officers will assess the situation and take appropriate measures.

The measures taken by those Responders will include the 5 c's

- Confirm
- Clear
- Cordon

- 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?

- Can the area you are requesting individuals to evacuate to be able to accommodate the evacuees and patients?
- Can any essential services or business continue?
- Who is in charge internally?
- Who will serve as the lead PIO?
- What responsibilities will internal security assume for BPD or Federal Government?
- Will the local police department takeover the response to the incident when they arrive on scene?
- What situation will allow the Federal Government to assume lead?
- How does hospital and security communicate with external agencies (local, region, state)?
- Where will external responders meet or stage while at hospital?
- How will hospital related information get included in messaging?
- How does hospital handle incoming family members physically coming to hospital?
- How does hospital handle all the incoming calls?

Compounding the IED threat is the common practice of bombing at multiple simultaneous locations; IEDs are planned and intentionally placed to hamper rescue efforts. Explosions in or near Healthcare Facilities can result in fire with possibility of toxic smoke, disruption of electric power, ruptured gas lines and water mains and debris.

Your strength is to be found in your suspicion. The presence of an IED will hamper and slow the response of first responders for it has compounded an active shooter situation with a bomb. Identify the suspicious device, mark the device, and then move away from the device as you notify proper authorities.

	Threat Description		Explosives Mass[14] (TNT equivalent)	Building Evacuation Distance[15]	Outdoor Evacuation Distance[16]
High Explosives (TNT Equivalent)		Pipe Bomb	5 lbs 2.3 kg	70 ft 21 m	850 ft 259 m
		Suicide Belt	10 lbs 4.5 kg	90 ft 27 m	1,080 ft 330 m
		Suicide Vest	20 lbs 9 kg	110 ft 34 m	1,360 ft 415 m
		Briefcase/ Suitcase Bomb	50 lbs 23 kg	150 ft 46 m	1,850 ft 564 m
		Compact Sedan	500 lbs 227 kg	320 ft 98 m	1,500 ft 457 m

[14] Based on the maximum amount of material that could reasonably fit into a container or vehicle. Variations possible.
[15] Governed by the ability of an unreinforced building to withstand severe damage or collapse.
[16] Governed by the greater of fragment throw distance or glass breakage/falling glass hazard distance. These distances can be reduced for personnel wearing ballistic protection. Note that the pipe bomb, suicide belt/vest, and briefcase/suitcase bomb are assumed to have a fragmentation characteristic that requires greater standoff distances than an equal amount of explosives in a vehicle.

		Sedan	1,000 lbs 454 kg	400 ft 122 m	1,750 ft 534 m
		Passenger/ Cargo Van	4,000 lbs 1,814 kg	640 ft 195 m	2,750 ft 838 m
		Small Moving Van/ Delivery Truck	10,000 lbs 4,536 kg	860 ft 263 m	3,750 ft 1,143 m

Sources

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The United Nations (2015) The United Nations Office for Disarmament Affairs, Improvised Explosive Devices (IEDs) Publication: https://www.un.org/disarmament/convarms/ieds2/

The United States Marine Corps (2014) Improvised Explosive Devices B3L4118 Student Handout: http://www.usmcofficer.com/wp-content/uploads/2014/02/Improvised-Explosive-Devices.pdf

Respond Immediately

It is common for people confronted with a threat to do nothing rather than respond. An investigation by the National Institute of Standards and Technology (2005) into the collapse of the World Trade Center towers on September 11, 2001, found people close to the floors impacted waited longer to start evacuating than those on unaffected floors[17]. Similarly, during

[17] Occupants of both towers delayed initiating their evacuation after World Trade Center 1 was hit. In World Trade Center 1, the median time to initiate evacuation was 3 minutes for occupants from the ground floor to floor 76,

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, some people report hearing firecrackers, when in fact they heard gunfire. Healthcare facilities should train staff to overcome denial and to respond immediately. Ensure that students and staff are able to recognize the sounds of danger, act, and forcefully communicate the danger and necessary action (e.g., "Gun! Get out!"). In addition, those closest to the public-address or other communications system, or otherwise able to alert others, should communicate the danger and necessary action. Repetition in training and preparedness shortens the time it takes to orient, observe, act, and decide.

Upon recognizing the danger, as soon as it is safe to do so, staff or others must alert responders by contacting 911 with as clear and accurate information as possible. Some of the information the dispatcher may request is:

- How many suspects are there?
- Where is/are the suspect(s)?
- Have they left the scene?
- What are they wearing (including body armor)?
- Where are they moving toward?
- What types of weapon(s) are involved?
- How many shots have been fired?
- When was the last time you heard gunfire?
- Where are you located?
- How many people are with you?
- How many people are injured?
- Are there hostages?

Run

If it is safe to do so, the first course of action is to run out of the building and move far away until you are in a safe location. Staff should be trained to:

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and 5 minutes for occupants near the impact region (floors 77 to 91). See National Institute of Standards and Technology, Federal Building and Fire Safety Investigation of the World Trade Center Disaster Occupant Behavior, Egress, and Emergency Communications. Washington, DC: Author, 2005. Available at http://www.mingerfoundation.org/downloads/mobility/nist%20world%20trade%20center.pdf

[18] Report of the Virginia Tech Review Team, available at http://www.governor.virginia.gov/tempContent/techPanelReport-docs/FullReport.pdf and http://www.governor.virginia.gov/tempContent/techPanelReport-docs/12%20CHAPTER%20VIII%20MASS%20MURDER%20AT%20NORRIS%20HALL.pdf

- Leave personal belongings behind;
- Visualize possible escape routes, including physically accessible routes for patients, visitors, or staff with access and functional needs;
- Avoid escalators and elevators;
- Take others with them but not to stay behind because others will not go; and
- Call 911 when safe to do so.

Hide

If running is not a safe option, hide in as safe a place as possible (and run when it becomes safe to do so). Staff should be trained to hide in a location where the walls might be thicker, have fewer windows, and contain the least amount of piping for medical gases and vacuums. In addition:

- Lock the doors if door locks are available;
- Barricade the doors with heavy furniture;
- If you are in a specialty care unit, secure the unit entrance(s) by locking the doors and/or securing the doors by any means available (furniture, cabinets, beds, equipment, etc.)
- Close and lock windows, and close blinds or cover windows;
- Turn off lights;
- Look for other possibilities of escape;
- Silence all electronic devices;
- Remain silent;
- Use strategies to silently communicate with first responders if possible, (e.g., in rooms with exterior windows make signs to silently signal law enforcement and emergency responders to indicate the status of the room's occupants.) Be careful not to expose yourself to the *active shooter* if they are located outside of the healthcare facility;
- Hide along the wall closest to the exit but out of the view from the hallway (allowing for an ambush of the shooter and for possible escape if the shooter enters or passes by the room); and
- Remain in place until given an all clear by identifiable law enforcement.

You may consider these additional actions should you choose:

- Barricade areas where patients are located;
- Transport patients in wheelchairs, on stretchers, or by carrying to a safe location;
- Identify a safe location in your unit before an event where staff or patients may safely barricade themselves during an event;

- If the shooter is not located in your unit, know how to lock down and barricade your unit in case of an attempt to enter the unit at a later time; and
- Provide emergency numbers at all available phone locations.

Fight

If neither running nor hiding is a safe option, as a last resort when confronted by the shooter, staff in immediate danger should consider trying to disrupt or incapacitate the shooter by using aggressive force and items in their environment, such as fire extinguishers, chairs, etc. In a study of 106 *active shooter* events that ended before law enforcement arrived, the potential victims stopped the attacker themselves in 35 instances. In 27 of those cases, they physically subdued the attacker[19].

While talking to staff about confronting a shooter may be daunting and upsetting for some staff, they should know they may be able to successfully take action to save lives. To be clear, confronting an *active shooter* should never be a requirement of any healthcare practitioner employee's job; how each individual chooses to respond if directly confronted by an *active shooter* is up to him or her. Further, the possibility of an *active shooter* situation is not justification for the presence of firearms on healthcare facilities or campus in the hands of any staff other than law enforcement.

Be prepared to implement your Mass Casualty or Trauma Care Plan as soon as it is safe to do so. Quick hemorrhage control is an important success factor in saving lives. Have medical supplies available and set the expectation for staff to assist victims as soon as it is safe to do so because the arrival of Emergency Medical Services may be delayed.

[19] www.activeshooterdata.org (Texas State University)

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

Law Enforcement Active Shooter Tactics

Attributed to http://www.ncbrt.lsu.edu

The tragic and violent attack at Columbine High school in 1999 significantly changed the law enforcement response to *active shooter* situations. This single event created a paradigm shift in the way law enforcement trains and responds to these violent, in-progress crimes. Prior to Columbine, an *active shooter* incident would have been considered an operation to be handled by a SWAT or tactical unit. Lessons learned from this tragedy included the need for all police officers to be properly trained, equipped and empowered to immediately intervene in an *active shooter* situation to stop the ongoing violence regardless of their assignment.

Modern day law enforcement training and tactics dictate that the primary objective of the first law enforcement officer(s) on the scene of an *active shooter* situation is to locate and stop the person or persons believed to be the shooter(s). As law enforcement *active shooter* training has evolved, there has been a move away from waiting for several officers to arrive and form a "team" prior to searching for the shooter. Today, many agencies and trainers recommend a solo officer entry into an *active shooter* situation if it is believed the officer on scene can locate, isolate, and/or stop the shooter prior to other arriving law enforcement officers. The solo officer entry can be a very dangerous response strategy. However, properly trained and equipped police officers acting alone without the benefit of backup have stopped ongoing *active shooter* situations, thereby saving lives.[20]

The first officers on the scene of an *active shooter* situation will move quickly to the location of the threat and take immediate action to stop the ongoing threat. This may include force up to and including deadly force by law enforcement if necessary. If the suspect has transitioned into a hostage situation or barricaded gunman where there are no longer shots being fired and victims being injured or killed, law enforcement first responders will isolate and contain the scene. Specialized units including Specialized Weapons and Tactics (SWAT) and hostage negotiators will be called to the scene to transition into a more traditional tactical operation.

[20] Blair, J. Pete, Martaindale, M. Hunter and Terry Nichols. "Active Shooter Events 2000-2012". FBI Law Enforcement Bulletin, January 2014. http://leb.fbi.gov/2014/january/active-shooter-events-from-2000-to-2012

In other cases, the suspect may have ceased the attack prior to law enforcement arrival or was otherwise neutralized before being located by police. In a study of *active shooter* events conducted by Texas State University and the FBI spanning a 15-year period examining 200 events, the attacks were over before law enforcement arrived on the scene in 106 cases (53%) of the time.[21] In these cases, law enforcement will locate and secure the known shooter while remaining vigilant and aware of the possibility of other unknown threats in the area.

Once a known threat has been stopped or located, or if the suspect cannot be immediately located, law enforcement will transition towards victim rescue and providing life-saving medical aid to wounded persons. In cases where the threat cannot be immediately located or identified and there is no specific and articulable information or intelligence about the location of the suspect, law enforcement will begin a systematic search of the healthcare facility while also providing medical aid to the wounded. This medical aid and evacuation of wounded may be conducted by only law enforcement or law enforcement working together with Fire and EMS services. The wounded may be moved to the facilities emergency department depending upon the location of the shooting and type of healthcare facility. It may become necessary to move and transport wounded victims to nearby hospitals or trauma centers due to the ongoing crisis and situation at the effected healthcare facility.

Depending upon the scope of the *active shooter* incident within the facility it may become necessary for law enforcement to search and clear the entire facility of any potential threats. This will likely be a very long and tedious process involving many different law enforcement agencies working in coordination with the incident command team. Even if it is determined that only the affected portion or area of the facility will be searched and cleared by law enforcement, this task can be daunting and time consuming. All stakeholders should be aware of these procedures well in advance. Law enforcement and the facilities incident command team should work together in advance to strike a balance between post-incident security and the continuity of operations for the facility.

Active Shooter Response in a Healthcare Setting

Healthcare facilities, particularly hospitals, can range in size from small rural facilities with less than ten beds to large complex building structures with 1,000 beds or more. In some cases, the facility may all be a single story structure, or it may be a series of capital improvement add-ons where no two buildings are alike resulting in the absence of uniformity throughout the structure as a whole, or a multi building campus spread over a wide area. Further, there are various secured and unsecured departments, multiple entryways, potentially confusing

[21] www.activeshooterdata.org (Texas State University)

hallways, and unique departments possibly containing radioactive materials, biological waste, or other hazardous materials. These features lend attractiveness to the facility as a soft target, and to the complexity or difficulty of maintaining within the facility a continuously safe and secure environment. Regardless of complexity, the greater the preparedness and familiarity with the facility and its security personnel and plan, the more effective and efficient a law enforcement response will be to an *active shooter* incident.

Initial Response

First Uniformed Officer Arrival

The first arriving uniformed law enforcement officer on the scene of an *active shooter* call at a healthcare facility faces a daunting task. Many facilities are large, sprawling buildings or complexes with many different ingress/egress points. Responding officers should attempt to obtain as much information as possible regarding the location of the shooter from police dispatch while enroute to the call. This will allow for a calculated and tactical approach to the building while arriving as near to the shooter's location as possible.

Upon arrival, the first officer should provide a "size up" of the scene for other responding officers, identify the danger zone, and establish command (mobile).[22] Depending upon training and local policies/procedures, the first officer may enter the facility in search of the shooter without waiting on backup. One important consideration to be taken into account when deciding whether or not to conduct a solo officer entry is that of actionable intelligence. Information such as the location of the shooter within the facility, number of shooters, the delay until backup arrives, and the first officer's ability to communicate with follow-on responders from within the facility are critical factors in determining whether or not to conduct a solo officer entry.[23] Therefore, facility personnel must provide all the information about the incident that they safely can.

Upon entry into the facility, either as a solo responder or with one or more fellow officers, the first officer should quickly move towards the sound of gunfire and/or use information from people within the facility to locate the shooter(s). The overarching goal is to stop the shooter and prevent additional injuries and deaths. Although the first officer should direct people to safety while quickly moving to isolate and stop the shooter, the officer should not stop and assist wounded victims at this point.

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

[23] Advanced Law Enforcement Rapid Response Training (ALERRT) Center, Texas State University. "Terrorism Response Tactics Active Shooter Level I" manual, v5.3, 2013.

The first officer may be able to link up with onsite facility security that will most likely have an increased knowledge of the facility as well as keys and access control capabilities. The first officer can coordinate with the security staff to meet and guide follow-on responders into the facility to the specific crisis spot and also provide redundant communications in the event the officer's radio does not work within the facility; radio "dead spots" are particularly common in healthcare facilities.

The first officer should be providing as much information to responding officers as possible. If the first officer can locate and stop the shooter, this information must be relayed to follow-on responders as soon as practical. If the first officer is unable to locate the shooter and no actionable intelligence is available indicating the location of the shooter, the officer should consider waiting for follow-on responders to develop a tactical plan to begin a systematic search for the shooter and evacuation of the wounded.

Secondary Uniformed Officer Arrivals

Attributed to http://www.ncbrt.lsu.edu

Follow-on responders or secondary uniformed officers who arrive on the scene should ensure they park their patrol vehicles so not to impede other emergency vehicles such as ambulances and tactical vehicles from entering and leaving the scene. These officers should be in direct communication with the first officer (Incident Commander) who can direct them to the specific crisis point within the facility or provide guidance as to actions that need to be taken. If there is an ongoing threat and shots are continuing to be fired upon arrival of follow-on responders, these officers should also move quickly towards the gunfire in an organized method to stop the ongoing violence. Officers should ultimately meet up with the first officer and develop action plans based upon the current state of the incident and status of the threat.

As soon as there is no longer an ongoing threat from the shooter, law enforcement officers should transition to providing life-saving medical aid to victims. This must be a coordinated effort among the responding officers to ensure there is sufficient security established at the crisis site before tending to wounded victims. Having a secure scene to provide medical aid does not necessarily imply the entire structure or even the immediate area has been cleared of all *possible* threats. It implies there is no active threat in the immediate area such as ongoing gunfire and some law enforcement officers are providing armed security in the area where others are caring for and consolidating the injured.

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

[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

Attributed to http://www.ncbrt.lsu.edu

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 medical conditions, so although those patients would not be moved, the facility clearing could still take place in those areas.

Facility Clearing Teams

The composition of the teams used to clear the facility will be dependent upon the situation encountered. Until the threat is controlled, teams must include armed police officers or security staff, enabling these teams to defend themselves as they clear the facility. Each situation is unique, but some fundamental principles apply. Those Facility Clearing Principles include:

- Perimeters must be monitored and controlled;
- Areas should be cleared once and then access should be limited until situation is resolved;
- Threats can present in several forms. Facility clearing teams must maintain situational awareness for improvised weapons to include explosives, pre-planned fire, ambushes, and secondary and tertiary attacks;
- Guides may be used in declared warm zones to speed the process of facility clearing. These pioneers can identify normal/abnormal activities throughout the healthcare facility to first responders; and
- Trained canine units can aid in the clearing process. Incident Commanders must declare intent, specifying if these teams are tasked with detection of explosives or tracking of the suspects.

Common Areas

To increase the effectiveness of the facility clearing or facility securing operations, it will be necessary to determine a common marking convention to be used by contact teams and force protection teams as they process common areas – such as cafeterias, waiting rooms, study areas, break rooms and locker rooms. This marking convention should be simple to apply and quickly communicated to all first responders.

Casualty Collection Points/ Force Protection Teams

Once there is no longer an ongoing threat to patients, visitors and staff, law enforcement officers or EMS personnel may establish a “casualty collection point” or CCP. A CCP may also be established in the event that the shooter has not been located and law enforcement is actively searching for the threat, though there is no current threat in the area of wounded victims. This designated location within the crisis site will be where injured victims are consolidated in one place in order to provide more efficient care and rapid extraction to higher levels of care. The movement of wounded victims may be done by law enforcement or law enforcement working in coordination with Fire and EMS providers. In the latter model, law enforcement provides security and force protection for the Fire/EMS providers as they assess, move, treat, triage and ultimately evacuate the wounded.

Heath care facilities provide unique challenges as well as unique opportunities as related to the treatment of wounded victims from an *active shooter* incident. Unlike other locations, many

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 security for this location. Depending upon the location of the *active shooter* within the facility, wounded victims may be best treated within the emergency department of the effected facility. If this is not feasible or the local emergency department was directly affected by the attack, fire and EMS providers will coordinate to evacuate and transport patients to other facilities.

Active Shooter Integrated Planning

Prior Coordination with Healthcare Security

http://www.abc.net.au/news/2010-11-04/nsw-opposition-calls-for-hospital-waitlist-inquiry/2322922

Depending on the size and complexity of any given healthcare facility, responsibility for the security of that facility could rest with a hospital staff member as a peripheral duty and no guard force, or be the responsibility of an experienced and trained security professional leading a team of armed security personnel. It is incumbent upon law enforcement to know what is available at the healthcare facilities within their area of responsibility, or surrounding communities. Once a relationship is established with the facility security team, periodic recurring meetings should be scheduled to maintain familiarity with the facility and update and review personnel or building structure changes. This also includes updating facility security personnel with law enforcement personnel changes or changes in tactics that may be employed at the facility. At a minimum, it is recommended that a facility walking tour be conducted at least annually. Consideration could be given to establishing a law enforcement liaison officer with the hospital for maintaining situational awareness and information sharing. This does not have to be a static post but rather an assignment for an officer to periodically stop by and engage with the facility security team. Healthcare security should proactively engage law enforcement personnel who patrol the healthcare facility within their district/beat/geographical area. This engagement strengthens the dialogue and understanding of not only the healthcare security interaction, but also the personnel and building structure changes.

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 messaging (i.e. what have the employees been told, what does the message say.) It is prudent for the facility to coordinate messaging with law enforcement so that containment and apprehension of the shooters are not compromised.

Pre-positioned Access Kits

http://www.411locksmithservice.com/residential-locksmith/

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 through the facility should be made available. This schematic or plan should closely resemble in simplicity the same "You Are Here" evacuation floor plans posted throughout the facility. Lastly, it may be beneficial to have access to a hospital radio to get immediate answers to team concerns from personnel that intimately know the building. Responsibility for maintenance and updating of the access kit rests with the facility and law enforcement personnel.

Video Control Room Access and Security Assistance

Attributed to http://www.ncbrt.lsu.edu

The video control room typically employed to cover the perimeter, critical locations or departments, key entryways, and sensitive areas, and therefore, can be a tremendous asset to responding law enforcement to locate the shooter during an *active shooter* incident. Since time is of the essence during an *active shooter* response, knowing where the video room is monitored and how to gain access to the control room is something that needs to be coordinated during the pre-planning with facility security. In the unlikely event that a trained video control room monitor operator is not present upon arrival of law enforcement, the responding officers will need to know how to operate the video control system.

To accomplish this, like any other train-to-proficiency task, select officers will need to receive a block of training on the video system and then receive periodic refresher training. During the course of their training, the assigned law enforcement officer should:

- Determine if their proficiency is sufficient to relieve any civilian or unarmed security personnel during an *active shooter* incident whose principal duty is to monitor/control the video control room.
- Become familiar with the capabilities and the limitations of the system (e.g. fixed versus movable cameras, zoom, wide-angle, etc.).
- Know what can and can't be observed by the system.
- Know which camera or series of cameras give the best likelihood of shooter detection based on last known sighting of shooter.
- Know what seasonal change does to the view of exterior cameras.
- Know whether the video control system is serviced by backup power, should the facility lose power.
- Know remote access capabilities.

Continual Site Surveys for Familiarization and Renovations

Site surveys are a good way to understand a facility's strengths and its weaknesses. There are at least two ways that law enforcement can benefit from a facility's site survey. First, by actively participating in the survey while it is being conducted, law enforcement personnel can engage in dialog associated with each respective finding, (positive or negative) developing a deeper understanding of the issue, or by reviewing a finished report and engaging with the security directors to address their take on the results. Through this type of engagement law enforcement may become aware of planned mitigation strategies not otherwise known that mandate altering existing tactical response plans. This could be due to the introduction of items such as secured doors, new walls or even bollards. Either way, the findings of a site survey can prove beneficial to law enforcement pre-planning.

Coordinated Healthcare Security and Facility Engineering Support

Coordinating Healthcare Security and Engineer Support should be done through a face-to-face meeting with facility security and a member of the senior administration team or designees (i.e., Facilities Design & Construction and Facilities Engineering.) Upon conclusion of the meeting, a Memorandum of Understanding (MOU) between the facility representatives and a representative of local law enforcement, including standard operating procedures, should be drawn up and signed. The purpose of the MOU is to outline expectations on the part of both parties so they can appropriately budget and plan to those requirements. In support of a collaborative response to an *active shooter*, healthcare security, if there is security at all, may

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.

Evacuation Assembly Points

Exterior Evacuation Assembly Points will be where the largest accumulation of persons that have fled the facility gathers and participates in accountability activity as prescribed in the facility's evacuation plan. If well disciplined, they will remain there until informed that they can return to work or depart the premises. This accumulation of personnel presents a lucrative soft target for the *active shooter* and must be addressed by law enforcement. Considerations for law enforcement personnel regarding Evacuation Assembly Points include:

- Employee assembly areas are typically tied to fire evacuation and NOT an *active shooter* resulting in the areas selected placing the evacuees in direct line of sight to the healthcare facility.
- Between law enforcement and facility security, or administration, a decision must be made on understanding who and how the evacuees are contained/controlled.
- Safe corridors must be established between assembly areas and Employee Facility Return Points or Family Reunification Points as additional manpower arrives.
- Identification of potential witnesses who require interviewing by law enforcement and process for conducting interviews/obtaining statements after the facility has been made safe.

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.

Media and Press Release Point

Once news of an incident is made public, it can be expected that local, national, and international media crews will arrive to cover the story and gather eyewitness statements. To maintain control of the area and ensure the safety of all persons, a location out of sight of the healthcare facility will need to be identified and secured to provide for a safe media area. Manpower to protect this area should be planned for based on priority of effort. Identification of the site, to include not only the media personnel but their associated equipment (satellite trucks, mobile stations, and initial broadcast locations) as well as a designated single location for news releases and updates could be left to the responsibility of the facility security leadership or facility Public Information Officer, but law enforcement should confirm its suitability during the pre-planning phase to ensure its ability to be effectively secured.

Pre-planned Floor/Department Lockdown after Clearing

http://www.dreamstime.com/stock-photo-hospital-maternity-ward-hallway-image56000

There are two considerations for pre-planned floor/department lockdown after clearing. As a working hospital, at the onset of the *active shooter* incident, there could have been persons on operating tables in the Operating Room, trauma patients in the Emergency Department, patients on dialysis machines or a room full of infants in the Neonatal unit that weren't able to run or hide. These areas (and possibly other areas, facility dependent) need to be positively identified and as additional law enforcement personnel arrive on scene and sufficient personnel are in pursuit of the shooter, the additional personnel need to search, lockdown, and/or defend these select areas. The second consideration deals more with confirming the absence of additional shooters, finding/aiding victims and preparing to secure the facility and declaring it clear once the shooter is secured.

Depending on the size of the facility and the availability of armed law enforcement personnel, a plan needs to be designed with the assistance of facility security and administration to secure portions of the facility as they are cleared. This is not intended to imply that facility security or administration enter the facility during the incident, but rather work with law enforcement during the pre-planning phase to address the ability to secure segments of the facility once

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:

- Lockdown and control access.
- Notification to EMS regarding the lockdown and patient diversion.
- Evacuation of non-impacted, non-medical areas such as waiting areas, cafeterias, chapels, etc. Movement of patients, staff, and visitors to safe locations.
- Providing supplies, equipment, pharmaceuticals, water, and food to lockdown areas.
- Facility census, updates and reporting in coordination with lockdown.
- Coordination and diversion of incoming traffic to other healthcare facilities.
- Communication with staff and law enforcement inside the healthcare facility.

Pre-planned Coordination of Crime Scene Activities and Patient/Equipment/Supplies Relocation

Prior to an *active shooter* incident, law enforcement and security should coordinate and develop a plan for crime scene activities. During an *active shooter* incident, one or more crime scene investigations may be required, and it is possible to have a large amount of evidence to be collected. It is important to maintain the healthcare facility operations to meet the medical needs of the community while preserving evidence. Those managing the facility and the investigators must try to balance three competing priorities:

- The forensic needs of the investigation,
- The need for the hospital or medical facility to continue to treat other patients, and
- The sensitivities of the family and their need to have contact it the deceased in the least distressing condition.[25]

[25] http://www.courts.qld.gov.au/__data/assets/pdf_file/0004/92875/m-osc-scene-preservation.pdf

The needs of the facility to have free access to operating room suites, etc. should be given priority. In most cases, the cause of death and the factors that contributed to it can be established from witness statement, medical records and notes etc. making the entire isolation of the scene unnecessary (do not have to secure the entire department, ward, floor or building).

The pre-plan should include the following:

- Identify the appropriate agency to take lead on crime scene investigations.
- Security and protection of crime scene(s) prior to processing.
- Crime Scene logs prior to processing.
- Control of all photographs of crime scenes by law enforcement, media, patients, staff, and visitors.
- Relocation of patients, staff, and visitors during crime scene activities.
- Providing medical needs for those individuals who cannot be moved or evacuated.
- Limiting personnel to crime scene areas while maintaining the medical needs of the patients.
- Coordinating witness information and collection of evidence while maintaining privacy of patient information.
- Relocation versus reserve supplies of durable medical goods and patient equipment.

Pre-planned Exercises (Tabletop, Functional, Full-Scale)

Exercises enhance knowledge of plans, allow management team members, individuals, and agencies to improve their own performance and identify opportunities to improve capabilities to respond to real events. This is a part of the Preparedness Cycle. Exercises are a great method to:

https://www.fema.gov/media-library/assets/images/114295

- Evaluate the preparedness program
- Identify planning and procedural deficiencies
- Test or validate recently changed procedures or plans
- Clarify roles and responsibilities
- Obtain participant feedback and recommendations for program improvement
- Measure improvement compared to performance objectives
- Improve coordination between internal and external teams, organizations, and entities
- Validate training and education
- Increase awareness and understanding of hazards and the potential impacts of hazards.
- Assess the capabilities of existing resources and identify needed resources[26]

[26] http://www.ready.gov/business/testing/exercises

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 incident would meet in an informal, classroom setting to discuss their roles during an emergency and their responses to a particular emergency situation. A facilitator guides participants through a discussion of one or more scenarios. The duration of a tabletop exercise depends on the audience, the topic being exercised and the exercise objectives. Many tabletop exercises can be conducted in a few hours, so they are cost-effective tools to validate plans and capabilities.

Functional exercises allow personnel to assess plans and readiness by performing their duties in a simulated operational environment. Activities for a functional exercise are scenario-driven for a specific event. Functional exercises are designed to exercise team members, procedures, and resources (e.g. communications, warning, notifications, response, and incident command).

A full-scale exercise is as close to the real thing as possible. It is a lengthy exercise which takes place on location using, as much as possible, the equipment and personnel that would be called upon in a real event.

Pre-planned Administrative/Media Coordination (Healthcare, Law Enforcement, Fire, EMS)

In preparing for an *active shooter* incident, healthcare facilities must develop goals, objectives and courses of action\decision making for the communication of emergency protocols and situational awareness. This involves integration with the local disaster response communication network, including law enforcement, fire, and EMS. Working together with law enforcement, hospitals should establish methods/protocols for reporting active shooting incidents and integrate the facility's emergency operations plan with the Incident Command System (ICS).

A pre-planned community contact list is essential to facilitate communication at the time of an incident. Community contacts include:

- Local law enforcement (police and sheriff's departments)
- State law enforcement agencies
- FBI field office
- Fire department/EMS
- City/county EOC
- Utilities (power company, water company)
- Other area hospitals

- Public/private ambulance services (in case patients need transfer)
- Nearby businesses

MOUs may be utilized to share information with first responders/receivers. These should include an up-to-date and well-documented site assessment. Site assessments may include building schematics, photographs of the interior and exterior of campus buildings, as well as information about door and window locations, locks and access controls, and locations where patients and staff with disabilities, access, and functional needs are likely to be sheltering or evacuating. These areas include operating rooms, critical care units, nurseries, and pediatrics units. MOUs may also contain information regarding locations of and access to public-address systems, two-way communication systems, security camera monitoring room, alarm controls, physical plant controls (electricity, water cut-offs, etc.,) and areas with inherent dangers, such as intensive care units, operation rooms, and radiology departments.

In addition to sharing a site assessment with first responders, healthcare facilities should also share evacuation policies and procedures, emergency escape procedures and route assignments (i.e. floor plans, safe areas), and lockdown procedures for individual units and other campus buildings. First responders should also be familiarized with the facility's EOP, including key contact information of those representatives of the healthcare facility authorized to serve as liaison and meet/provide first responders with site assessments, EOP and other details as may be necessary at the time of incident.

After law enforcement reviews response protocols with the appropriate healthcare facility representatives, this information, as well as any other information that would be of value in an *active shooter* scenario, should be placed on recorded media (e.g. USB drive) and maintained in secured locations from which it may be readily available to emergency responders. The location should be known by multiple individuals to ensure ready access in emergency situations.

Hospital security and emergency managers should further coordinate communication plans and develop pre-event risk communication in coordination with gap analysis and community threat assessment reviews, internal alert/notification (staff, patients and visitors), and external communication plans.

External communication plans include the establishment of a coordinated command and communications between law enforcement and the Hospital Command Center. Procedures should be devised to designate an agency representative from the facility to serve as liaison between arriving law enforcement and hospital officials (security, facility/building engineer or equivalent) who have facility knowledge critical for law enforcement's response.

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 communications, to include fire and EMS as well as law enforcement. Through the sharing of specific information regarding entry point locations, routes of travel within the structure, the use of stairwells, location of subjects/persons, suspicious devices, and other pertinent observations, the efficiency of the operation can be greatly enhanced. Law enforcement communication equipment should be tested in all areas of the hospital to ensure viability, such as basements, radiology (computed tomography (CT)/x-ray rooms, MRI), elevators, lab, etc.

In summary, when working with law enforcement, facilities should:

- Share site assessment and EOP.
- Describe emergency escape process and lockdown procedures.
- Review evacuation and lockdown procedures for individual units and other buildings on campus.
- Provide key contact information.
- Establish coordination of command and communications.

Preparations should also be made to assure appropriate process and procedure for required notifications and/or waivers to local authorities, state licensing agencies and/or federal agencies should temporary re-location or staging of patients occur.

Special Areas of Consideration for Response

Healthcare facilities create unique considerations for emergency response agencies. These unique considerations can be found in other types of facilities, but the totality of the number of considerations is not inherently taken into consideration when responding to incidents. During pre-planning actions with healthcare and supporting emergency response agencies, discussions and action steps need to be addressed with special consideration.

The pre-planning stages should include:

- A thorough review of surveillance camera capabilities on a regular basis. Incorporate surveillance video in exercises and use it to augment planning.

- Test law enforcement communication equipment in all areas of the hospital to ensure viability. Review protection of critical nodes in areas of the facility with power, gas, and communication partners.
- Stage critical access kits for law enforcement responders as previously described. Familiarize/brief law enforcement personnel in advance to facilitate knowledge of contents ahead of potential events.
- Lock-down and access control.
- Evacuation of non-impacted areas. Movement of patients, staff, and visitors to safe locations.
- Providing supplies, equipment, pharmaceuticals, water, and food to lockdown areas.
- Facility census, updates and reporting in coordination with lockdown.

Emergency Department

The emergency department (ED) of any facility is one of the most visible and heavily utilized areas of the facility. As a focal point for the public because of the services provided there, the ED of a facility is often a dynamic environment which requires a law enforcement presence on any given day. This is especially true in the event of an *active shooter* within the facility. If the ED is not directly affected by the *active shooter* incident, wounded victims, including suspects, may be evacuated to the ED for treatment. A significant law enforcement security element may be required to adequately secure the ED, allowing staff to feel secure and perform their duties. In preparing for an *active shooter* incident specialized training for law enforcement and security personnel, such as properly securing firearms, should be discussed before an *active shooter* incident occurs. Law enforcement and security personnel should also address additional ways weapons could get into the hospitals. Hospitals typically have multiple public entrances and large numbers of visitors each day. According *Annals of Emergency Medicine*[27], although metal detectors allowed security officers to confiscate more guns, the number of assaults did not decrease. Patients found other ways to elude metal detectors, such as slipping guns into hospitals through ambulances. Law enforcement and facility administration should develop a plan for diverting incoming traffic for the emergency department to other healthcare facilities, and notify local EMS agencies of this diversion.

Operating Room Suites

A well-planned response to an *active shooter* is vital for the operating room suites. Law enforcement and security should develop a pre-plan for securing the staff and patients within surgical suites. Staff and patients may be unable to avoid the threat because of ongoing or in-

[27] Rankins, R.C., and Hendey, G.W. (June 1999). Effect of security system on violent incidents and hidden weapons in the emergency department. *Annals of Emergency Medicine, 33*(6), 676-679. http://dx.doi.org/10.1016/S0196-0644(99)80006-7

progress procedures. Security and law enforcement personnel may need to establish security procedures so medical personnel can continue to care for surgical patients.

Neonatal Intensive Care Unit and Newborn Areas

The Neonatal Intensive Care Units (NICU) and newborn areas are extremely vulnerable to an *active shooter* threat due to the difficulty in evacuating the area. In addition, newborn areas pose additional concerns related to domestic situations, kidnappings, and custodial disputes. Law enforcement and facility security should develop a plan for the security of the area and working with the staff to continue to be able to provide medical care for the patients.

Intensive Care Unit

Patients in an Intensive Care Unit (ICU) who are unable to avoid the threats should be protected and the area locked down. Law enforcement and facility security should develop a pre-plan for the lock down and the security of the staff and patients. The plan should include:

- Lock-down and access control.
- Evacuation of non-impacted areas. Movement of patients, staff, and visitors to safe locations.
- Providing supplies, equipment, pharmaceuticals, water, and food to lockdown areas (as relevant to the scenario).
- Facility census, updates and reporting in coordination with lockdown.

Radiation Laboratories, Nuclear Medicine, and Other Radiation Areas

Many healthcare facilities have dangerous materials within the facility. Pre-planning and coordination between law enforcement and the facility is critical to the security of personnel and the hazardous materials that exist in the laboratory. Some of these materials, including radioactive sources, may be targeted for theft by suspects and the *active shooter*. Materials used for radiation therapy—such as in a high-dose-rate brachytherapy unit or a Gamma Knife—are secured within the unit itself and not easily removed. Nonetheless, securing the rooms where these units are housed should be a priority for law enforcement.

Prisoner Healthcare Forensics

An *active shooter* event could be an escape attempt or diversion needed to effect an escape. Prisoner patients within a facility will be guarded by law enforcement or correctional staff, but there should be a pre-plan on how to provide additional resources to secure these patients in an *active shooter* event. In, addition the custodial agency guarding the prisoner may not be the primary responding agency and therefore unaware of an attack within the facility. The law enforcement responders should attempt to quickly communicate with the custodial guarding agency to coordinate the continued safety and security of the prisoner.

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

Typical commercial medical gas installation rough-in.

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

the *Emergency Response Guidebook* or the Material Safety Data Sheets (MSDS), which the healthcare facility maintains. Gases would include but not be limited to:

- **Oxygen**
  Oxygen may be used for patients requiring supplemental oxygen via a mask. Usually accomplished by a large storage system of liquid oxygen at the hospital, which is evaporated into a concentrated oxygen supply, pressures are usually around 380 Pa (55 psi). In small medical centers with a low patient capacity, oxygen is usually supplied by multiple standard cylinders.
- **Nitrous Oxide**
  Nitrous Oxide is supplied to various surgical suites for its anesthetic functions during pre-operative procedures. It is delivered to the hospital in standard tanks and supplied through the medical gas system. System pressures are around 345 Pa (50 psi).
- **Nitrogen**
  Nitrogen is typically used to power surgical equipment during various procedures. Pressures range around 1.2 kPa (175 psi) to the various locations.
- **Carbon Dioxide**
  Typically used to inflate or suspend tissues during surgery, and also used in laser surgeries. System pressures are maintained at about 345 Pa (50 psi).
- **Medical Air**
  Medical air is supplied by a special air compressor to patient care areas using clean outside air. Pressures are maintained around 380 Pa (55 psi). Medical air can be used as surgical air when the pressures are raised to 7 Bars. Surgical air is majorly used in driving pneumatic tools like dental hand pieces. Oxygen can be used as medical air but medical air should never be used as oxygen.
- **Medical Test Gas Mixtures**
  There are many gas mixtures used for clinical and medical applications. They are often used for patient diagnostics such as lung function testing or blood gas analysis. Test gases are also used to calibrate and maintain medical devices used for the delivery of anesthetic gases.
- **Medical Culture Growth Mixtures**
  Culture growth applications include controlled aerobic or anaerobic incubator atmospheres for biological cell culture or tissue growth. Controlled aerobic conditions are created using mixtures rich in oxygen, and anaerobic conditions are created using mixtures rich in hydrogen or carbon dioxide.
- **Waste Anesthesia Gas Disposal**
  Waste Anesthesia Gas Disposal or WAGD is used in hospital anesthesia evacuation procedures. Although it uses the same vacuum pump as the medical vacuum system,

the piping may be a separate line from the source or can be combined with the medical vacuum. Continuous vacuum is maintained around 50-65 kPa (15-19 inches of mercury).

Biohazard Areas and Laboratories

Law enforcement is familiar with working in locations which contain biohazard areas and laboratories which are, either due to a result of personal injuries, prisoner issues, or mobile and stationary drug labs. Within a healthcare facility, these areas contain increased concerns for the responding officer due to the quantity of biohazard samples, tissues, fluids, and the testing associated with these hazards. Based on the degree of hazard posed by these agents, labs are divided into four biosafety levels, and mandated protective practices increase with each level. Biosafety Level 1 labs work with the least dangerous agents and require the fewest precautions; Biosafety Level 4 labs have the strictest methods for handling organisms because they deal with agents that are most dangerous to human health. Laboratories within a healthcare facility will typically not exceed a Biosafety Level 2 lab (BSL-2). Academic and Research healthcare facilities may include a Biosafety Level 3 lab (BSL-3).

During the pre-planning period, law enforcement needs to identify the locations of the laboratories, their biosafety level(s), and requirements for personal protective equipment.

Blood bank areas will most likely have a blood irradiator, which is utilized for the prevention of transfusion-associated graft versus host disease in immunosuppressed or otherwise at-risk patients. The majority of blood irradiators in operation are gamma-ray irradiators, with X-ray irradiators recently brought on the market.

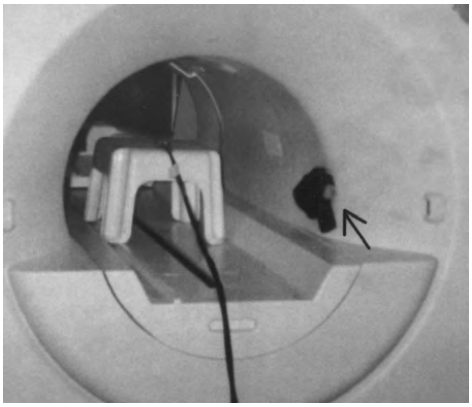
Magnetic Resonance Imaging Suites

This area of a healthcare facility is one which law enforcement and other emergency response personnel should be briefed on not only with respect to an *active shooter* situation, but any incident that could occur in a Magnetic Resonance Imaging (MRI) suite. The powerful magnetic field within this area has the potential of taking a firearm out of the hands of an officer, accidentally discharging a firearm, or pulling any metallic object into the magnet to include the officer himself. The MRI magnetic field is never turned off unless the unit is being installed, dismantled, or repaired. To turn the MRI magnetic field off takes several minutes and is only done by specially trained technicians.

Due to the powerful magnetic field used by the MRI Scanner, MRI facilities and hospitals restrict access to the MRI suite by establishing four conceptual zones around the MRI scanner. Each boundary zone in this four-zone safety system is defined by its purpose and distance from the MRI scanner. Since the magnetic field extends in three dimensions, some zones may extend into other areas or floors of the facility.

- **Zone One**
  Consists of all areas freely accessible to the general public. This zone includes the entrance to the MRI facility and the magnet poses no hazards in these areas
- **Zone Two**
  Acts as a buffer between Zone One and the more restrictive Zone Three. Here, patients are under the general supervision of MRI staff. Normally, these areas are also safe from the powerful magnet. Zone Two may include the reception area, dressing room and interview room.
- **Zone Three**
  Access to Zone Three should be restricted by a physical barrier. Only approved MRI personnel and patients that have undergone a medical questionnaire and interview are allowed inside Zone Three. The MRI control room and/or computer room are located within Zone Three.
- **Zone Four**
  Zone Four is the area within the walls of the MRI scanner room, sometimes called the magnet room. Access into the MRI scanner room should only be available by passing through Zone Three. Zone Four is sometimes considered to be inside of Zone Three because it does not have a direct entrance to unrestricted areas. Zone Three and Zone Four are sometimes collectively referred to as the MRI Suite.

Inside the MRI suite is an invisible boundary defined by the magnetic field's five Gauss line. The five Gauss line is the point at which the magnetic field begins to affect electromagnetic devices, such as pacemakers. Because the magnetic field extends in all directions, the five Gauss line can also extend to areas outside of the MRI Suite, including other floors, if the magnetic field is large enough. Magnetic fields cannot be seen or felt, so the five Gauss line is sometimes marked on floors or walls for safety. Marking the five Gauss line is particularly important when it extends beyond the walls of the MRI scanner room.



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Law enforcement and other emergency response personnel who may have to enter a zone within the MRI scanner must be aware of the powerful magnetic field and its associated hazards as documented in the following incidents:

- On December 31, 2015 a veteran was wounded at the Richard L. Roudebush Veterans Affairs Medical Center when a handgun he brought into the Indianapolis hospital accidently discharged in his pocket while he was in the MRI procedure room. The man's wound was not life threatening. Having a gun or other metal object in the vicinity of an MRI machine would be a violation of widely accepted medical and safety protocols, according to the American Journal of Roentgenology, and could have fatal consequences[28].

- On February 8, 2013 in Carol Springs, Illinois an officer was responding to a burglar alarm at a local doctor's office. During the search of the building, the officer entered the MRI suite room. The officer was conducting the search with his weapon drawn. The MRI machine's magnetism pulled away the officer's gun, which became stuck in the machine. Because there is no way to turn off the magnetism, the gun remained in place and no one was allowed inside the building. There were no injuries and the manufacturer had to be called to assist in the removal of the weapon[29].

- In July 2001, an officer from the Manheim Township (Lancaster County, Pennsylvania) Police Department had an incident where his issue firearm malfunctioned. The Smith & Wesson, Model 4013, .40 S&W caliber, semi-automatic pistol was found to have a magnetized firing pin, which stuck to the side of the channel within the slide. Upon inspection, it was determined that the entire pistol had become so magnetized that paper clips actually stuck to any metal surface. The department armorer was able to demagnetize the firearm with the use of a high-power, videotape-erasing unit after complete disassembly. When the malfunction was discovered, the officer had no idea of when or how his pistol had become magnetized. A review of the officer's activities revealed that he had investigated a burglar alarm call at a medical office that was equipped with a Magnetic Resonance (MRI) unit. During the investigation, the officer had walked into the MRI suite that magnetized the pistol. MRI medical personnel have detailed instructions on safety, which include keeping metal objects away from the unit. Upon further inspection, two additional officer's firearms were also found to have been magnetized[30].

- An off-duty police officer went to an outpatient imaging center in western New York State to have an MRI examination. The officer was carrying Model 1991 A-1 compact

[28] http://www.indystar.com/story/news/2015/12/31/gun-discharges-mri-va-hospital/78136982/
[29] http://www.nbcchicago.com/news/local/Cops-Gun-Stuck-In-MRI-Machine-In-Carol-Stream-190395261.html

[30] https://www.policeone.com/police-products/firearms/articles/62291-Officer-Safety-Alert-MRI-Unit-Causes-Malfunction-of-Officers-Issue-Firearm/

.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 technologist intended to meet the officer in the MRI patient waiting area before the examination and secure the weapon in that room, where he felt it would be safe. However, the officer apparently misunderstood and took the weapon into the MRI suite. The technologist was entering the officer's personal data into the computer and did not see him entering the MRI suite. Once the officer was inside the MRI suite, the weapon was pulled from the officer's hand as he attempted to place the gun on top of a cabinet 3 ft. away from the magnet bore, where it struck the left side and spontaneously discharged a round in to the wall of the room at the rear of the magnet. Fortunately, no one was injured.[31]

The importance of pre-planning and training for law enforcement and other emergency response personnel is greatly encouraged with respect to MRI Suites. The healthcare facility designated radiologist or the manufacturer can assist in providing this essential training.

Kitchen Areas

A location that is commonly not thought of during pre-planning or response is kitchen areas within the healthcare facility, especially those areas providing food service. Individuals who run from these areas do not consider the potential for food being ignited after they evacuate. They will immediately leave the area with items on burners, ovens, grills, toaster ovens, etc. which have the capability of both starting a fire and producing smoke which is not readily identified by law enforcement or emergency response personnel. They will initially identify this as a potential incendiary device used by the *active shooter*, when it most likely a result from cafeteria staff evacuating the area.

In 2006-2010, U.S. fire departments responded to an estimated average of 6,240 structure fires in or on healthcare properties per year. These fires caused an average of six civilian deaths, 171 civilian injuries and $52.1 million in direct property damage annually. Almost one-quarter (23%) were in hospitals or hospices. Cooking equipment was involved in three out of five (61%) fires. Only 4% of these fires spread beyond the room of origin[32].

[31] Case Report entitled *Spontaneous Discharge of a Firearm in an MR Imaging Environment*, *AJR* 2002; 178:1092–1094 0361–803X/02/1785–1092.
[32] **Report:** NFPA's "Fires in Health Care Facilities", **Author:** Marty Ahrens, **Issued:** November 2012

Pharmacies

The healthcare pharmacy may not be an area that law enforcement would look at as a special consideration, but the fact there are large quantities of medications (including narcotics) should make it a priority. Some of the medications in their inventories are available from a neighborhood pharmacy.

An *active shooter* may want to go to a pharmacy area for self-treatment of a wound, to self-medicate, to obtain a higher sense of invisibility, or to assist them with committing suicide. Law enforcement should provide a force protection team when all other areas of heightened concern have been addressed or when it appears the *active shooter* is moving towards this area. Non-affected areas of the healthcare facility will continue to need supplies from the pharmacy during and after the incident to support patient care.

Crime Scene Considerations

Crime scenes in a hospital or medical facility are especially challenging to not only the medical personnel but to law enforcement. It is clearly understood that the first duty of all personnel is to protect and preserve human life. Patient care should be given highest priority in all situations. To the extent possible, care should also be given with the consideration to the needs of law enforcement with respect to personnel safety, crime scene management, and the preservation of evidence. Every crime scene will come with various challenges for medical personnel and law enforcement. By working as a team, law enforcement can act to ensure the safety of the employees, patients, victims, and the public, and medical personnel (some which may be trained and equipped with ballistic protective gear), can accomplish the task of responding to the medical needs of the patients and victims, while still maintaining the integrity of the evidence needed by law enforcement.

Although law enforcement and the hospital incident command team will respond effectively to these events, it could be unavoidable that operations for some departments will be disrupted. Some parts of the hospital campus will be locked down and others will be evacuated. Patient care could be disrupted until the situation is under control by law enforcement. Law enforcement should work with hospital leadership and security to review and enhance their emergency operations procedures in place, so medical personnel will be able to respond swiftly and effectively without hindering law enforcement efforts.

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 medical procedures and caution should be taken. A good rule of thumb is to not remove medical waste except for sharps, which should be placed in a sharps container and left at the scene. Investigators may prefer most medical waste remain to determine where patients were treated and what treatment was performed. In some circumstances, wrappers and other disposable “trash” which accumulates as patient care is rendered can be placed in a single site away from the patient and/or potential crime scene evidence. Do not pick up on-scene trash items and discard because evidence may be destroyed. Law enforcement personnel may suggest a site to be used for trash that would be most ideal to maximize preservation of evidence. Regardless how unintentional, any widespread trampling at a crime scene can damage the efforts of the investigator(s), causing a loss of opportunity to gain the evidence needed to convict criminals. Contamination is a problem when valuable evidence is lost by accident or careless and hasty practices. Personnel at the crime scene inadvertently deposit material from clothing and equipment and this contamination is compounded as the number of rescuers, police and investigators increase. The majority of contamination at a crime scene is directly related to on scene personnel. Although preserving evidence never takes precedence over patient care, it is the responsibility of fire, medical and law enforcement to do everything reasonable not to complicate the investigation.

Deceased victims or other large objects should not be moved unless they impede patient care. If it becomes imperative to move an object, report its original position to investigators. Many of the referenced guidelines also recommend responders not approach patients who are obviously deceased or presumed dead by police. If examination is thought necessary to confirm death, confirmation should be done with minimal body movement.

- **Cold Zone Crime Scene (Open Access Crime Scene)**
  This crime scene still has evidence to be collected but appropriate law enforcement personnel have access to the entire area. Personnel should consult with law enforcement before entering or removing items. It is the responsibility of all responding fire, EMS, and medical personnel to be aware of the important evidence that can be damaged or destroyed upon entering a crime scene. All involved should take precautions to not disturb crime scene evidence such as weapons, bloodstains, shell casings, clothing or other evidence that can be vital to the investigators to reconstruct the crime.

- **None Crime Scene (Cold Crime Scene)**
  No evidential concerns or hazards are present.

In the event medical personnel discover a crime scene or are at a crime scene without law enforcement, an immediate request for law enforcement shall be made. Medical personnel shall ensure their own safety until such time as law enforcement arrives or until the scene is secured.

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 natural disaster or many other emergencies.

The better first responders and healthcare personnel are able to discern these threats and react swiftly, the more lives can be saved. This is particularly true in an *active shooter* situation where law enforcement responds to a 911 call of shots fired. Many innocent lives are at risk in concentrated areas. This is why it is critical healthcare facilities work with their community partners (e.g., first responders, emergency managers) to identify, prepare, prevent, and effectively respond to an *active shooter* situation in a coordinated fashion.

While an *active shooter* event presents challenges to responders, it does provide a valuable asset: healthcare providers, supplies, equipment, and medications may be available on-site to assist in the response. Depending on the scope and size of the incident, all patients may be cared for at the affected facility, some patients may be transported, or all patients may be transported. To ensure the most lives are saved, it is important for pre-hospital and hospital providers to pre-plan how they will respond to and care for patients from an *active shooter* incident. Coordination with responders that may already be on-scene (for example, an EMS unit at the emergency department) also needs to be part of a coordinated plan. Staging and treatment areas, issues of medical control, transportation decisions, and communication should be part of a written plan and exercised at least annually.

There are several agencies, in addition to law enforcement, that will be involved in an *active shooter* incident at a healthcare facility. These agencies will vary from jurisdiction to jurisdiction, but generally fall into one of the following categories: EMS, Fire, Emergency Management, and Public Works.

EMS- Multiple EMS agencies may respond depending on the size of the incident, and may include responders from public and private agencies. There may also be EMS units on-scene when the incident begins.

- Patient triage, treatment, and transport
- Responder medical support
- Rescue operations

Fire and Emergency Medical Services

- Fire suppression/standby
- Safety Inspections
- Hazardous Materials/Chemical, Biological, Radiological, Nuclear (CBRN) response
- Rescue Operations
- Patient triage, treatment, and transport
- Responder medical support

Emergency Management

- Logistical resource support
- Media management for large scale events
- Inter-agency coordination
- Mutual aid support

Public Works

- Long term traffic management
- Utility support (gas, water, electricity)
- Road clearance

Some jurisdictions may have additional response groups (e.g. health department, industrial partners, Red Cross, etc.). If these groups are active in your area, you should include these in your planning process.

Incident Command

As stated earlier, Law Enforcement will generally establish Incident Command, but in many jurisdictions this will eventually evolve into a Unified Command due to the complexity of the incident. This Unified Command centers should include the healthcare incident command team, and may be located inside the facility.

During the Incident

In this guidebook, the following Concept of Operations (CONOPS) will be used. You may need to adapt this to your particular jurisdiction and hospital. Developing a CONOPS for your jurisdiction is described in the planning section later in this guidebook.

Police will respond to the hot zone with armed law enforcement officer(s) or a tactical team(s) to neutralize the threat of the shooter(s).

If necessary, police will establish a Warm Zone within the Hot Zone so that a rescue team can provide medical care and hemorrhage control to victims as soon as possible. The Warm Zone is an area where victims are located and there is no longer an active threat. In the past, caregivers did not enter the scenes until law enforcement had completely cleared the area of any harm. With the Warm Zone concept, law enforcement initially establish there is not an active threat in the area, and provide security for caregivers, so they may provide life-saving treatment and evacuation to the Cold Zone.

The Rescue Team consists of law enforcement personnel and pre-hospital care providers, facility healthcare providers, facility security staff, or a combination of these assists. Information on Warm Zone operations as well as recommended protective gear is available at the Tactical Emergency Casualty Care website: http://c-tecc.org/

The Rescue Team will provide hemorrhage control in accordance with the recommendation included in the:

- Hartford Consensus http://www.naemt.org/Files/LEFRTCC/Hartford_Consensus.pdf
- The Hartford Consensus II http://bulletin.facs.org/2013/09/hartford-consensus-ii/
- Tactical Emergency Casualty Care (TECC): Guidelines for the Provision of Prehospital Trauma Care in High Threat Environments.[33]
- Stop the Bleed https://www.dhs.gov/stopthebleed

Victims will be transported to definitive care (e.g. the nearest hospital emergency department or designated alternate care site) as soon as possible. Transport may be carried out by police, emergency medical services, fire, or hospital staff (based on the incident and most expeditious means.)

Care provided during an *active shooter* event can be remembered by the acronym **THREAT:**

T-Threat Suppression
H-Hemorrhage Control
RE-Rapid Extrication to safety
A-Assessment by medical providers
T-Transport to definitive care

[33] Callaway, D.W., Smith, E.R., Cain, J., Sharpiro, G., Burnett, W.T., McKay, S.D, and Mabry, R. (Summer-Fall 2011). Tactical emergency casualty care (TECC): Guidelines for the provision of prehospital trauma care in high threat environments. *J Spec Oper Med, 11*(3) 104-122.

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

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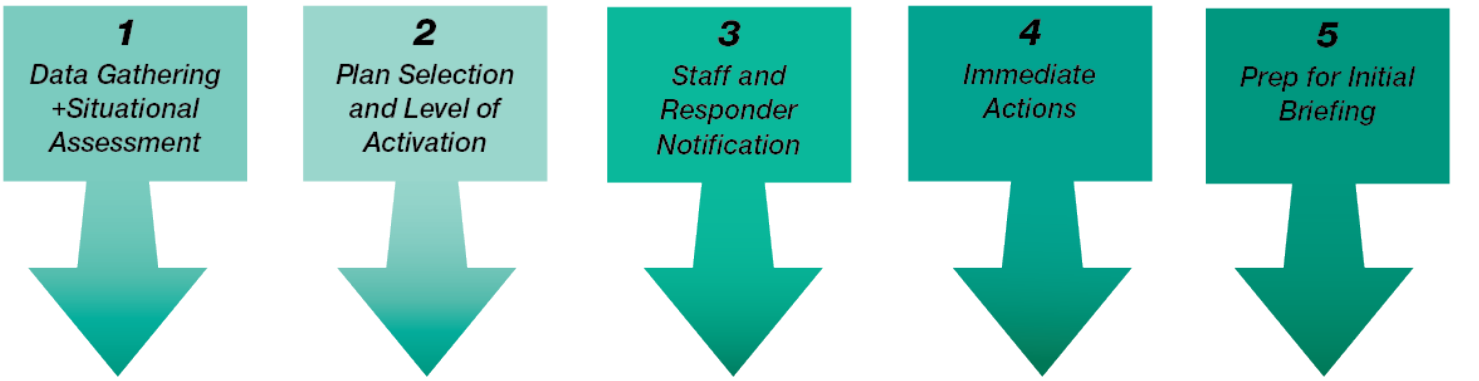
EAS if indicated (plus activate HICC as Enhancement)

then proceed with step #1



Event type, Location, Extent, Ended or On Going

Damage to Facility or Unavailable Resources

Evacuation or Shelter in Place

Extent of Evacuation

Disaster Plan Triggers

Select Plan and Plan Level

Unified Command System (if disaster impacts campus)

Which Call Rosters

Day vs. Off Shift Process

Which Devices or to Use Which Software to Use

Command Team Report to HICC once EAS Message Received

Tell DICCs Which Communication Methods To Be Used

Required Controls

Lock Down

STAT Resources

Utility Shut Down

Physical Plant Specs

Risk Assessment and Resolution

Job Reassignment

Decontamination

Use #1, 2, 3, 4 to develop Briefing agenda

Set up HICC

I A P: Direction & Dept. Roles/Duties

Resource Mobilization (What & Whom?)

Who's in Charge?

HICC Coordination of Response/Recovery Phases

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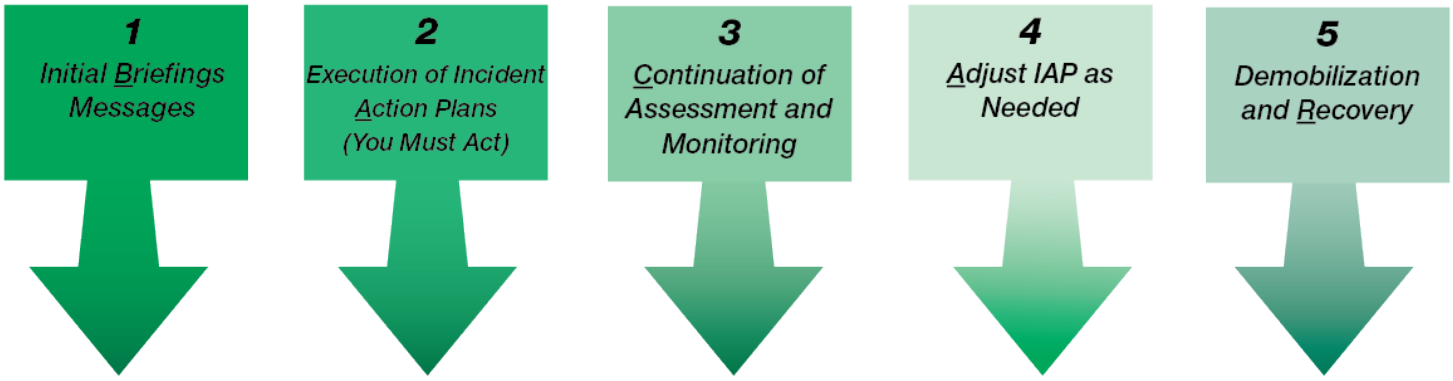

Briefings/IAP to ICC Staff

OPS Grp, Leaders, Community, etc.

Damage to Facility

Evacuate and/or Shelter In Place

IAP based on Initial Situational Assessment

Protective Measures

Mitigation Actions

Roles & Responsibilities Initial Problems

Q & A

Continue Critical Business

External Reports

Internal Reports

Escalate/Deescalate Response PRN (Checklists)

Sufficient Resources

Any Risk Mgt or Legal Issues

Mutual Aid

Results of Initial

IAP Actions

Other Problems

Escalate/Deescalate Response PRN (Checklists)

Job Reassignments Deployment

Network Partners

Termination

System Recovery

Return to Normal or "Almost" Normal

Honor Dead

Psychological Svcs Debrief & QI

Analyze Perf

Enhancements Root Cause Analysis Regulatory Agency Reviews

Unique Scene Management Issues:

- Possibility of multiple shooters
- Possibility of diversions (e.g. fire alarms, fires, improvised incendiary/explosive devices, etc.)
- Possibility of Chemical Biological Radiation, and Nuclear (CBRN) including explosives or threat of CBRN release
- Possibility of barricaded or hostage situation
- Safety (Medical Gases, MRI magnets, etc.)

Public safety agencies may need to deal with any or all of the complicating factors listed above. Incident Command System (ICS) provides a framework for managing escalating incidents. Planning and familiarization tours of the hospital may help to mitigate some of the unique safety issues that are present in a hospital.

Seven Critical Tasks for Public Safety Response

- Establish Communications and Control
- Identify Hot Zone
- Establish Inner Perimeter
- Establish Outer Perimeter
- Establish On-Scene Incident Command Post
- Establish Staging Areas (away from ICP)
- Request Resources as needed

Communications **(Police / Emergency Management/Hospital [internal & external])**

Communications will be the key to the success or failure of responding to an active shooter situation. An active shooter situation is unique as it relates to radio communications between officers on the scene and telecommunicators (dispatchers/PSAPs), as well as interoperable communications between responding public safety agencies (local and mutual aid), the healthcare facility command center and security teams, and law enforcement officers who may be at the facility at the time of the incident. In addition, the communication responsibility of the healthcare facility command center is essential in keeping executives, middle management and staff members updated of the response to the active shooter and the maintenance of life saving procedures and essential continuity of operations during the incident.

Telecommunicators should be trained on how to screen and prioritize calls, what calls can be released, what calls need to be maintained, and that communications with the on scene first

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 Association of Public Safety Communicators developed a course entitled "Active Shooter Dispatcher" which provides important telecommunicator training related to an active shooter incident. The course also integrates law enforcement and concealed weapon carry permit holders to have an increased understanding of these types of events and how dispatch/communication centers will relay information to the scene.

Accountability

Integrating multiple agencies (and potentially hospital staff) into a response increases the complexity of the response in a significant way. Active measures to account for responders need to be implemented – particularly if non-police responders are brought into a Warm Zone to transport victims to a Casualty Collection Point or to definitive care.

Public Safety Responses

Adapting the TECC recommendation for use inside the hospital

Transport to Trauma Center/Emergency Department/Operating Room

- Incidents within Hospital
  - Code/Patient Transportation Team
  - Emergency Medical Services
  - Other responding agencies (Police, Fire, and EMS)

- Incidents external to hospital
  - Emergency Medical Services
  - Other responding agencies (Police, Fire, and EMS)

Hemorrhage Control and Other Specialized Equipment

- Carried with officers
- Pre-staged in hospitals

Time as a Planning Consideration

According to *Toward the Sound of Shooting*, "The overriding principal in TCCC [Tactical Combat Casualty Care] is to perform the correct intervention at the correct time in order to stabilize and prevent death from the readily treatable injuries." (Smith, page 51) It usually takes 2 to 3 minutes for death to happen from life threatening bleeding, 4 to 5 minutes for death to happen from compromised airway, and 10 to 15 minutes for death to happen from open chest wound and tension pneumothorax. It is important to make life threatening bleeding the first priority followed by airway control.[34]

Media

- Coordinate beforehand with all departments and campus locations to provide unified and factual messages to staff, families, and the media using multiple modalities
- Develop pre-agreements with the media concerning debriefings and media holding areas during an emergency
- Designate a facility spokesperson
- If any media outlet calls to obtain information concerning the incident, ensure phone operators know how to respond and where to transfer the calls

Reducing the Crime Scene Footprint

The healthcare setting is not a location that can be shut down and secured for long periods of time due to a criminal act taking place within its boundaries. The facility may be the only healthcare facility available for specialized patient care, the regional area may not be able to accept all of the patients being cared for within the facility, and certain procedures cannot be interrupted during and/or after a criminal act has taken place (e.g. surgical suites, intensive care suites, newborn areas). As such, law enforcement with the input of the local prosecutor should discuss how to reduce a crime scene footprint in a healthcare facility in conjunction with the healthcare leadership. Some potential examples of reducing the footprint could be:

- Not closing off an entire floor and/or department but putting in place partitions or screens to cordon off the specific area required to accomplish a crime scene investigation and prosecution.

[34] Smith, E.R., Islin, B., and McKay, W.S. (December 2009). Toward the sound of shooting: Arlington county, VA, rescue task force represents a new medical response model to active shooter incidents. *JEMS, 34*(12), 48-55. doi:10.1016/S0197-2510(09)70321-3

- Engagement of prosecution staff immediately after a criminal incident to discuss how to best accomplish a reduced crime scene footprint, which would not hinder the prosecutorial process.
- Videotaping and/or photographing the larger crime scene footprint and then reducing the footprint for the actual processing of evidence.

Providing Limited Access for Medical Personnel

Due to the unique nature of a healthcare setting, every available space is being utilized to assist with patient care. With this in mind, law enforcement should be aware that patients in the area may have been there prior to the incident taking place and were not able to be moved by medical personnel as the event unfolded. After the scene is secured and/or the entrance of emergency response personnel with a force protection team, healthcare staff may need to start moving patients to another area within the healthcare facility or to another healthcare facility. Law enforcement needs to understand this complex issue for sustaining life. This needs to be addressed with the healthcare leadership team and security prior to an event, during revisions or development of emergency protocols, and while conducting exercises. This is especially important in special units within the healthcare facility.

Additionally, the crime scene area may encompass the location and/or storage of specialized medical equipment, medications, laboratories, or hazardous materials. Medical personnel may need to access these areas to sustain life of patients. These areas should be identified prior to an event, and processes should be put into place to allow for admittance by limited medical personnel as needed to sustain life. Law enforcement should plan on placing a security detail with support from the healthcare facility security team at these locations.

Patient Clothing and Wound Areas

Law enforcement should re-enforce to fire, EMS, and medical personnel that removal of patient's clothing should be kept to a minimum, if possible. The bullet/stab wound hole, powder particles or powder smudges around the hole can have considerable investigative value as evidence and should not be modified. Clothing removal should be done in a manner that will minimize the loss of physical evidence. If the clothing is bloody, do not allow blood and debris from one area or garment to contaminate another area or garment. Do not roll garments up in a ball. Never put wet or bloody garments in plastic bags. Carefully place garments in paper bags (one item per bag), seal, date and initial. Label the bags with the patient's tracking tag. Handle clothing as little and carefully as possible. Powder flakes from gunshot wounds may fall off clothing, decreasing the value of the powder-deposit examination. Pertinent items that could be considered evidence but need to stay with the patient, such as health aids, should be

documented by law enforcement. All of this is best accomplished in discussions of these issues prior to an event and during review and updating of emergency protocols.

Altering the Crime Scene

The emergency responder should make clear notation of what was done to alter the area of the scene. The purpose of the documentation by first responders in these situations is to create a visual record to assist criminal investigators in recreating an accurate picture of what occurred at the scene. This record will help preserve the location and relationship of physical evidence and condition at the scene. A follow-up interview by law enforcement is vital to understanding every aspect of the crime scene.

Considerations after an *Active Shooter* Incident

References and Checklists

The Hospital Incident Command System Guidebook (http://www.emsa.ca.gov/disaster_medical_services_division_hospital_incident_command_system) contains both a Planning Guide; and, a Response Guide for Active Shooter incidents (Excerpt below). Planning for the aftermath of an active shooter incident could begin by reviewing the sections of the Planning Guide and Incident Response Guide (IRG) that are relevant to Demobilization and Recovery. Your hospital could host a Tabletop discussion with the goal of adapting these documents specifically to your hospital and community. Some basic questions that you might address include:

- When does demobilization begin?
- When should the Hospital Command Center be deactivated?
- When should Recovery Operations begin?
- What marks Return to Normal Operations?

For other types of organizations, demobilization may begin once the threat of the shooter is removed and the facilities are rendered safe. But for the hospital, work will likely continue in treating victims of the incident.

Continuity Planning

Having a robust continuity plan in place prior to any Active Shooter incident will help in *Recovery* efforts. In general – the hospital Continuity Plan should address:

- Loss of Work Place

- 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 should participate in active shooter planning, exercise development, and any activation of the Hospital Command Center.

Considering that recent terrorist tactics include both active shooting and the use of IEDs. Be prepared for this scenario and augment your demobilization and recovery plans accordingly. Recovery may have to deal with blast damage.

System Support/Plans

If the hospital is part of a hospital or university system, system plans should be in place to assist the affected hospital in terms of *Recovery* and returning to normal operations. Support may be available for staff augmentation; risk management assistance (e.g. insurance policy claim support); assistance in repairs for facility damage; and if needed – use of alternate care space.

Public Information Officer – Demobilization and Recovery Operations

Incident Command training should regularly include the Public Information Officer (as part of the Hospital Command Center – Command Staff). PIO Planning should include the development of templates for various types of incidents including Active Shooter Incidents. A large body of professional literature has developed over the years since the Virginia Tech Active Shooter incident related to communications planning for Active Shooter incidents. In general, a key recommendation is that the PIO staff and leadership think in advance about what their key communications goals would be should a shooting incident occur. These could include for instance:

- Care and concern for the victims of the attack

- Concern for family members affected
- Restoring healthcare services as soon as possible
- Preparedness efforts that had been made and any improvements put in place to assure the community that the hospital is a safe place to seek care.
- (For Academic Health Centers) Assure that the hospital and campus is a safe place for students to continue their education.

Each hospital should consider these topics and if necessary adapt or add topics for their planning efforts. Having thought through topics like these in advance will help the PIO, Incident Commander, and Hospital Leadership focus on the communications goals that they have post incident. A general post incident communications plan should also include:

- Planned media staging areas (including parking for satellite equipment). Various staging areas could be designated in advance, but specific areas could be chosen based on the scenario of the incident
- General plans for:
  - Media Releases (generally used initially when not all information is available to the Hospital Command Center)
  - Press Conferences
  - Interviews
- Coordination with any jurisdictional Joint Information Centers that are established
- Automated Information lines and Website updates with general information
- Repurposing any telephone Call Centers to address inquiries
- Coordination with your Information Technology staff to minimize contention on telephone lines and the possibility of degraded service. (Consider use of the Government Emergency Telephone System and Wireless Priority Service (https://www.dhs.gov/government-emergency-telecommunications-service-gets)

Specific exercises should focus on post-incident communications plans and plan improvements.

Initial Support

Within an on-going and/or 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 adds to their stress and frustration, but can also escalate the emotions of the entire group. 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.

Essential steps to help establish trust and provide family members with a sense of control can be accomplished by:

- Identifying a safe location separate from distractions and/or media and the general public, but close enough to allow family members to feel connected in proximity to their children/loved ones;
- Scheduling periodic updates even if no additional information is available;
- Being prepared to speak with family members about what to expect when reunified with their child/loved ones; and
- Ensuring effective communication with those that have cultural or linguistic needs, such as sign language interpreters for deaf family members.
- Bereavement or traumatic grief, psychological and spiritual support to family members.

When reunification is not possible because an individual is missing, injured or killed**,** how and when this information is provided to families is critical. Before an emergency, the planning team must determine how, when, and by whom loved ones will be informed if their loved one is missing or has been injured or killed. Law enforcement typically takes the lead on death notifications, but all parties must understand their roles and responsibilities. This will ensure families and loved ones receive accurate and timely information in a compassionate way.

While law enforcement and medical examiner procedures must be followed, families should receive accurate information as soon as possible. Having trained personnel to talk to loved ones about death and injury on-hand or immediately available can ensure the notification is provided to family members with clarity and compassion. Counselors trained in disaster behavioral health techniques should be on hand to immediately assist family members and staff.

The healthcare facility EOP should include pre-identified points of contact to work with and support family members (e.g., counselors, police officers). These points of contact should be connected to families as early in the process as possible, including while an individual is still missing but before any victims have been positively identified. After an incident, it is critical to confirm each family is getting the support it needs, including over the long-term.

The healthcare facility EOP should consider printed and age-appropriate resources to help families recognize and seek help in regard to a variety of reactions they or their loved ones can

experience during and after an emergency. For example, a family that has lost a child may have other family members in the area or at the healthcare facility. It is critical the families and loved ones are supported as they both are grieving the loss and will be supporting their surviving family members.

The healthcare facility EOP also should explicitly address how impacted families will be supported if they prefer not to engage with the media. This includes strategies for keeping the media separate from families and staff while the emergency is ongoing and support for families who may experience unwanted media attention at their homes.

Employee Assistance Program

An Employee Assistance Program (EAP) can provide practical solutions, information, support, and referrals for a wide range of issues, including anxiety, depression, relationship challenges, alcohol and other substance abuse, grief, and loss, financial or legal concerns and work/life balance. An employee can talk about issues in confidence with a knowledgeable, caring professional to connect with resources and gain a new perspective, strategy, information, or solution.

Memorial Events

Memorial events in past *active shooter* occurrences have been an important part of the healing for the affected community. Law enforcement concentrates on the resolution of the event, reduction of casualties, safety of emergency responders, and investigation of criminal acts. These are high priorities, but memorial events have historically overwhelmed law enforcement in past incidents.

Site memorials will be seen shortly after an event has occurred from facility occupants, families, friends, and the local community. The same type of memorial may also be set up at the other healthcare facilities where the victims may have been taken for treatment. Pre-planning of these memorials are advantageous to assist with security of the site, traffic (vehicular and pedestrian) flow, media coverage, and assisting the psychological healing of individuals.

Law enforcement must understand that memorials will be conducted at various intervals after the actual event date. These have taken place one month, six months, one year and beyond to celebrate the lives of those lost and remember the emergency response personnel.

The healthcare facility EOP should identify trained personnel who will provide assistance to victims and their families. This should include establishing an incident response team (including first responders) who are trained to appropriately assess and triage an *active shooter situation*

(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 *Active Shooter* 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 establish trust and provide family members with a sense of control can be accomplished by:

- Identifying a safe location separate from distractions and/or media and the general public, but close enough to allow family members to feel connected in proximity to their children/loved ones;
- Scheduling periodic updates even if no additional information is available;
- Being prepared to speak with family members about what to expect when reunified with their child/loved ones; and
- Ensuring effective communication with those that have cultural or linguistic needs, such as sign language interpreters for deaf family members.

When reunification is not possible because an individual is missing, injured or killed**,** how and when this information is provided to families is critical. Before an emergency, the planning team must determine how, when, and by whom loved ones will be informed if their loved one is missing or has been injured or killed. Law enforcement may take the lead on death notifications, but all parties must understand their roles and responsibilities. This will ensure families and loved ones receive accurate and timely information in a compassionate way. For example, LA County Department of Health/ Emergency Medical Services Agency has developed a model family information center plan for healthcare facilities available at: http://dhs.lacounty.gov/wps/portal/dhs/ems/disastermedicalservices/fic

While law enforcement and medical examiner procedures must be followed, families should receive accurate information as soon as possible. Having staff trained in fatality notification to talk to love ones about death and injury immediately available can ensure the notification is provided to family members with clarity and compassion. Licensed mental health providers trained in evidence based acute trauma practices should be on hand to immediately assist patients, family members and staff.

The healthcare facility EOP should include pre-identified points of contact to work with and support family members (e.g., social services, mental health providers, certified chaplains/spiritual care, victims of crime programs, employee assistance program, and pre-identified partners in these areas). These points of contact should be connected to families as early in the process as possible, including while an individual is still missing but before any victims have been positively identified. After an incident, it is critical to confirm each family is getting the support it needs, including over the long-term.

The healthcare facility EOP should consider printed and age-appropriate resources to help families recognize and seek help in regard to a variety of reactions they or their loved ones can experience during and after an emergency. For example, a family that has lost a child may have other family members in the area or at the healthcare facility. It is critical the families and loved ones are supported as they both are grieving the loss and will be supporting their surviving family members.
Examples:
For children there are state of the art traumatic grief materials from the National Child Traumatic Stress Network:
http://www.nctsn.org/sites/default/files/assets/pdfs/childhood_traumatic_grief.pdf
http://www.nctsn.org/trauma-types/traumatic-grief/mental-health-professionals and
http://www.nctsn.org/trauma-types/community-violence

Also, Listen, Protect, and Connect Psychological First Aid, Family-to-Family Version:
https://www.ready.gov/sites/default/files/documents/files/LPC_Booklet.pdf and for children:
www.cdms.uci.edu/lpc can be provided to family members to support other support strategies.
And fact sheets from the Uniformed Services University of the Health Sciences:
https://www.cstsonline.org/resources/fact-sheet-search/

As part of the overall family support strategy, the healthcare facility EOP also should explicitly address how impacted families will be supported and protected if they prefer not to engage with the media. This includes strategies for keeping the media separate from families and staff while the emergency is ongoing and support for families who may experience unwanted media attention at their homes.

Staff/Employee Plan

Staff can be victims, engaged in patient care or both in the aftermath of an active shooter event. Based on their risk factors, a continuum of stepped care model is proposed (cite).

The elements include:

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-FINAL110414.pdf
        ii. Pre-identify resources for evidence based services for the subset of high risk staff needing services beyond crisis intervention.
    c. Engage an Employee Assistance Program (EAP) in pre-event planning for the "continuum of evidence based stepped care" for staff and their families
        i. An EAP can provide practical solutions, information, support, and referrals for a wide range of issues, including anxiety, depression, relationship challenges, alcohol and other substance abuse, grief, and loss, financial or legal concerns and work/life balance. An employee can talk about issues in confidence with a knowledgeable, caring professional to connect with resources and gain a new perspective, strategy, information, or solution.
        Provide employees with a range of options for behavioral health and/or spiritual care for acute crisis intervention and definitive care for those at higher risk and desiring care.

Memorial Events

Memorial events in past *active shooter* occurrences have been an important part of the healing for the affected community. Law enforcement concentrates on the resolution of the event, reduction of casualties, safety of emergency responders, and investigation of criminal acts. These are high priorities, but memorial events have historically overwhelmed law enforcement in past incidents. Site memorials will be seen shortly after an event has occurred from facility occupants, families, friends, and the local community. The same type of memorial may also be

set up at the other healthcare facilities where the victims may have been taken for treatment. Pre-planning of these memorials are advantageous to assist with security of the site, traffic (vehicular and pedestrian) flow, media coverage, and assisting the psychological healing of individuals.

Victim/Family Member Services

Similar to the strategy for staff, identification of patients at higher risk for psychological consequences using evidence based mental health triage is the first step in a continuum of triage to evidence based stepped care model.

PSYSTART

PsySTART is rapid, evidence based, emergency behavioral health triage system for use by non-behavioral health responders in hospitals, shelters, casualty collection points, schools, and other field settings in order to determine who needs secondary referral to a trained behavioral health provider. It does not require a mental health professional to use and identifies patients at risk, so they may be connected with limited acute phase mental health resources and to inform the need for additional in house or external resources using a "floating triage algorithm" and a patient behavioral health Incident Action Plan.

http://www.cdcradiationconference.com/presentation/PlanningPsychosocialBehavioralHealthRadiationEmergency-Yin.ppt

http://www.cdms.uci.edu/PDF/PsySTART-cdms02142012.pdf

Training is also available in cities and states using PsySTART including Los Angeles County, Seattle/King County, State of Minnesota, North Central Texas Trauma Regional Advisory Council (Dallas, Ft Worth), State of Tennessee and the District of Columbia. Both victim and emergency health worker self -triage systems have been developed.

Psychological First Aid

Psychological First Aid, originally conceived in 1954, is an evidence-informed modular approach used by behavioral health and disaster response workers, family members, neighbors, teachers, and co-workers to help individuals of all ages in the immediate aftermath of disaster and terrorism. Psychological First Aid is designed to reduce the initial distress caused by traumatic events and link them to appropriate next steps. Psychological First Aid is not a behavioral health response strategy on its own, it is one vital element of a continuum of evidence based of triage to stepped care.

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 appropriate to the provider. There are currently a number of different models aimed at different levels and include delivery by:

- Licensed behavioral health providers (e.g. NCTSN/NCPTSD)
- Non-behavioral health responders including emergency health workers (e.g. State of Minnesota Department of Health/University of Minnesota, and World Health Organization)
- Neighbors, family members, coworkers, teachers, parents (e.g. Listen, Protect, Connect Psychological First Aid)

Psychological First Aid Models

Available training on various models of Psychological First Aid

Psychological First Aid by Behavioral Health Professionals (e.g. NCTSN/NCTPTSD Field Operations Guide):

The online version (http://learn.nctsn.org/course/index.php?categoryid=11) is a ***6-hour*** interactive course that puts the participant in the role of a provider in a post-disaster scene. This professionally narrated course is for individuals new to disaster responses that want to learn the core goals of Psychological First Aid, as well as for seasoned practitioners who want a review.

Psychological First Aid by Disaster Responders (e.g. American Red Cross Psychological First Aid Program/ World Health Organization/World Vision International/War Trauma Foundation, 2010):

American Red Cross Psychological First Aid: Helping Others in Times of Crises is for non-behavioral health responders and is a 4 hour in person, interactive course using video based scenarios and participant interaction and includes learning the use of PsySTART Behavioral Health Triage and secondary referral for higher risk individuals to available behavioral health resources. Training in American Red Cross Psychological First Aid is available without cost at over 700 American Red Cross Chapters nationwide by contacting a local American Red Cross Chapter and accessing their training calendar or requesting a special training session for your organization.

World Health Organization:

The World Health Organization (WHO) Training Materials are available at:

http://www.who.int/mental_health/publications/guide_field_workers/en/

Family to Family, Neighbor to Neighbor (e.g. Listen, Protect. Connect Psychological First Aid)

Listen, Protect, and Connect Psychological First Aid: Neighbor to Neighbor, Family to Family is available without cost as a simple self-study course using the guidebooks available at: http://www.ready.gov/sites/default/files/documents/files/LPC_Booklet.pdf

Available for download on the US Department of Health and Human Services/SAMHSA Disaster Phone Application for Android and iPhone devices: from the app go to “on the ground resources”, then “online resources” then under Psychological First Aid, Listen Protect and Connect has three versions on the SAMHSA Disaster App: Neighbor to Neighbor, Parent, and Teacher (for children). This too is at no cost to the individual.

LPC for Parents Web/app version (beta)
www.cdms.uci.edu/lpc

The Family Reception Center

The Family Reception Center (FRC) is set up within or adjacent to the facility or another site. It is generally in place prior to the jurisdiction being able to set up a Family Assistance Center. Generally, it is for non-medico legal operations (i.e. those functions not conducted by the coroner or medical examiner). Their role is to provide information to family members of victims (or those thought to be potential victims). Behavioral health services are generally part of a FRC operation. The FRC can be staffed by behavioral health professionals, hospital pastoral care, preferably certified chaplains, hospital social workers, Employee Assistance staff, and volunteers. Ideally volunteers will have training including training in Psychological First Aid; crisis intervention, behavioral health triage and acute evidence based care for those at higher risk subset.

If a shooting incident occurs in the hospital, the Hospital Incident Management Team should expect that family members of known or suspected victims may begin to arrive at the hospital. For known victims, the family members will primarily be interested in information about the wellbeing of the patient. For suspected victims friends and family may arrive to inquire on whether the unaccounted for person is a known victim or admitted patient. Hospital staff members, patients, patient family members and visitors may be among those needing assistance even if they are not direct witnesses to the incident.

The Jurisdiction Family Assistance Center

The jurisdiction's Family Assistance Center (FAC) is a secure facility managed by the medico legal authority (coroner or medical examiner) that serves as a centralized location for the provision of information and assistance about missing or unaccounted for persons and decedents to family members, and for the collection of information in support of the identification process for family members. A key function of the FAC is to provide family members with behavioral health services and to link them with social service agencies as needed. A linkage between the hospital and the jurisdictional FAC/JIC is critical.

Functions of the Family Assistance Center

These functions are managed by the Medico legal authority (coroner, medical examiner) and may require interactions with family members. Families may need support and behavioral health services throughout this process.

- Family Management: Ante mortem data collection such as family interviews
- Decedent Identification

- 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. In each case, Improvement Activities should be identified as part of the review. Responsibility for completing the improvement activity should be assigned to a specific person and a deadline for completion should be set. If response plans are changed as a result of the improvement activity, the new response plan should be re-tested to assure that those activities do in fact improve the capability to respond. After Action Reviews should be reported to the hospital's Environment of Care Committee, or an appropriate committee overseeing safety and security. Ideally, active shooter preparedness should be included in the hospital's annual emergency preparedness program. Active shooter preparedness activities (based on risk assessments and analysis of the AARs) should be included in the proposed annual program and submitted to hospital leadership for approval.

If the hospital provided healthcare to the victims of a shooting, the AAR should address each of the Joint Commission Six Critical Emergency Management functions. The AAR should at a minimum, address the hospital response. Ideally an AAR of the community's integrated response should be completed. The hospital should update its Hazard Vulnerability Analysis based on the incident. If the topic of Active Shooter incidents is not currently on the hospital's Priority Risk list – it ought to be included. The implication of being listed on the Priority Risk list is that specific preparedness activities for Active Shooter incidents are included in the Annual Preparedness Program. This implies:

- An Incident Specific Plan for Active Shooters (beyond an All-Hazards approach)
- A program of training and exercises
- Emergency Supplies specific to Active Shooter incidents (like pre-staged hemorrhage control kits.) Internal first responders should be identified so they can be trained on how to use the tourniquets and other supplies in these kits.

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-threatening. Triage methods are also available for the behavioral health aspects of a shooting incident. Below is some basic information and references regarding various triage methods:

- START Simple Triage and Rapid Treatment http://chemm.nlm.nih.gov/startadult.htm
- JumpSTART (Pediatric Triage) http://www.jumpstarttriage.com/
- Tactical Combat Casualty Care, Board of Physicians
- http://www.health.mil/tccc
- http://www.naemt.org/education/TCCC/tccc.aspx
- Tactical Emergency Casualty Care
    - http://www.nfpa.org/~/media/Files/Research/Resource%20links/First%20responders/Urban%20Fire%20Forum/UFF%20TECC.pdf
- Model Uniform Core Criteria (MUCC) http://www.ems.gov/nemsac/dec2013/FICEMS-MUCC-Implementation-Plan.pdf
- PsySTART –Evidence base, Rapid Mental Health (See Part Two for additional information on PsySTART http://www.cdms.uci.edu/disaster_mental_health.asp
- LA County Emergency Medical Services Agency/ Alameda County EMS http://ems.dhs.lacounty.gov/
- North Central Texas Trauma Regional Advisory Council use of the “Anticipate, Plan, and Deter Responder Resilience System” http://www.cdms.uci.edu/disaster_mental_health.asp

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 Policy

SCOPE: All Company-affiliated clinical subsidiaries including, but not limited to hospitals, ambulatory surgery centers, outpatient imaging centers and physician practices (collectively, "Affiliated Employers" and individually, "Affiliated Employer").

PURPOSE: To provide all facility staff response information to address an active shooter or hostage situation within the facility.

POLICY: To provide a safe and secure environment for all employees, patients, and visitors. In the event of a person or persons taking a hostage during an incident on the property, or someone actively firing a weapon, facility staff will respond quickly and efficiently to secure the affected areas, protect life, and to clear the area for response by law enforcement.

In the event that a person or group of persons enter onto the property and take any person as a hostage or begin to fire weapons; there must be a controlled response to this situation. Patients, staff, and visitors must be removed from the affected areas. Movement by the hostage takers must be reduced as much as possible. Information must be clear so law enforcement can respond in a timely manner. The goal of this policy is to expedite the conclusion of the incident in the safest manner possible.

It is of the utmost importance that no employee risk injury to him/herself or others to try to end the situation. Employees are to cooperate as much as possible without putting themselves into further danger.

DEFINITIONS:

"Active Shooter" is an individual or persons 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. Active shooter situations are unpredictable and evolve quickly. Typically, the immediate deployment of law enforcement is required to stop the shooting and mitigate harm to victims. Because active shooter situations are often over within 10 to 15 minutes, before law enforcement arrives on the scene, individuals must be prepared both mentally and physically to deal with an active shooter situation.

"Hostage Situation" is defined as a person being held by force by one or more individuals in a conflict with security until specific terms are met.

Appendix A

ACTIVE SHOOTER PROCEDURE:

1. In the event an individual or individuals come into the facility displaying a firearm or as an "active shooter" as defined above, employees in the affected area should quickly determine the most reasonable way to protect their own life. Remember that visitors are likely to follow the lead of employees during an active shooter situation.

   A. Run

   If there is an accessible escape path, attempt to evacuate the premises. Be sure to:

   - Have an escape route and plan in mind
   - Evacuate regardless of whether others agree to follow
   - Leave your belongings behind
   - Help others escape, if possible
   - Prevent individuals from entering an area where the active shooter may be
   - Keep your hands visible
   - Follow the instructions of any police officers
   - Do not attempt to move wounded people
   - Call 911 when you are safe. If possible, employees should call "XXXX" stat to inform the PBX operators to activate Code XXX. The intent is for the employee to give as much information to the PBX operator as possible so they can dispatch security and call 911 to the scene immediately.

   B. Hide

   If evacuation is not possible, find a place to hide where the active shooter is less likely to find you. Your hiding place should:

   - Be out of the active shooter's view
   - Provide protection if shots are fired in your direction (i.e., an office with a closed and locked door)
   - Not trap you or restrict your options for movement

   To prevent an active shooter from entering your hiding place:

   - Lock the door
   - Blockade the door with heavy furniture

   If the active shooter is nearby:

   - Lock the door
   - Silence your cell phone and/or pager
   - Turn off any source of noise (i.e., radios, televisions)
   - Hide behind large items (i.e., cabinets, desks)
   - Remain quiet

   If evacuation and hiding out are not possible:

   - Remain calm
   - Dial 911, if possible, to alert police to the active shooter's location
   - If you cannot speak, leave the line open and allow the dispatcher to listen

D. Fight

As a last resort, and only when your life is in imminent danger, attempt to disrupt and/or incapacitate the active shooter by:

- Acting as aggressively as possible against him/her
- Throwing items and improvising weapons
- Yelling
- Committing to your actions

2. Departments outside of the affected area should lockdown their units. Curtains will be closed calmly reassuring patients and visitors who may seem distressed. Keep all visitors and patients as calm as possible during this time. Emergency Lockdown status should be ensured (stairwells and elevators) so staff can calmly continue patient care responsibilities. 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 the 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.

3. Upon arrival, law enforcement will assume accountability for the situation. The facility will provide assistance as needed, which may include providing access badges, floor plans of the area and any live feed cameras that the facility can provide.

IN THE EVENT AN ACTIVE SHOOTER EVENT BECOMES A HOSTAGE EVENT, THE FOLLOWING ADDITIONAL STEPS APPLY:

4. **<u>Hospital PBX Operator---phone 911</u>**.
Upon notification, give the appropriate plain language active shooter announcement with the location overhead six (6) times. Call 911 and give information that there is a hostage situation with the specific location, how many people are involved, any weapons involved. A Security Officer will meet the local Police at a location designated by the Incident Commander.

Appendix A

HOSTAGE PROCEDURE:

1. If the PBX operator receives a call that a hostage or hostages have been taken on the facility property and the caller is the hostage taker, the operator will try to keep the caller on the telephone as long as possible and attempt to obtain as much information as possible. If the caller is a staff member, the operator will obtain whatever information is available and a call-back phone number for the staff member.

2. The operator should listen to the background of the phone call to see if there are any identifying sounds or noises that may indicate the location, number of people involved or extent of danger.

3. The operator must write down all information obtained from the telephone call. This information is vital to law enforcement and all information must be kept secure.

4. Under no circumstances will the operator try to solve the situation or otherwise discuss the incident with the caller, other than to obtain the necessary information.

5. The PBX operator will page "Code XXX" or "Code XXX" overhead six (6) times as well as the location of the incident, then contact the police department by dialing 911 and informs them of the situation. Next, the operator will notify the security supervisor or acting supervisor by telephone. The PBX operator will then notify the Nursing Supervisor or supervisor on duty. Following the Nursing Supervisor or supervisor on duty, Administration or facility management will be notified during normal business hours. After business hours, the Administrator-on-Call (AOC) will be notified. Notifications will be made in that order. The operator will provide the information they have obtained at that time. This information will not be transmitted by radio. Additionally, if the Security Site Supervisor is not on duty, he/she will be notified immediately of the situation.

6. Do not call any codes to the affected area or areas of the "Active Shooter" scene until cleared by law enforcement officials. Codes to other areas of the facility should be sent via pager or phone. It is important to remember that certain persons responding may not be able to respond due to being compromised by the existing condition.

7. Security Officers will provide a safe perimeter for staff and visitors to the best of their ability and await the arrival of law enforcement. They should collect as much critical information about the situation/event regarding the perpetrator and victims. Security Officers will provide information to law enforcement upon their arrival. The security officers will then act as back-up to law enforcement while the security supervisor will act as the liaison to the AOC for information until

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 will be given limited information of the event/incident by department directors assuring them of the safety measures being taken on their behalf.

11. All traffic in and out of the facility will be limited. Any suspicious activity should be reported immediately to the Incident Commander, Security Supervisor, or the local Police (or agency in charge of the incident). A log will be kept of any persons allowed access to the facility by security or someone designated by the Incident Commander.

12. Upon arrival, law enforcement will assume accountability for the situation. The facility will provide assistance as needed, which may include providing access badges, floor plans of the area and any live feed cameras that the facility can provide.

13. **Security Department:**

    The Security Supervisor and one Security Officer will respond to the scene of the hostage situation in order to clear the area of patients, visitor, family, and nursing personnel. If possible, the Security Officers will contain the hostage taker to the immediate area. If the hostage taker has a weapon, the Security Officers will await the arrival of the local Police Department. In the event that there are Armed Security Officers in the facility, they should clear the area and contain the hostage taker/situation to the immediate area and wait for the arrival of the local Police Department. The Security Site Supervisor will be notified.

Appendix A

14. Security will ensure appropriate personnel only are at the scene of the incident to assist Police. This will include the Director and/or Manager of Safety and Security Services, Administrators, a Physician, Engineering Department Representative, and/or other key personnel upon request of the Incident Commander or local Police as needed.

15. Security Officers will not permit any family, loved ones, or relatives to negotiate with the hostage taker as they may exacerbate the problem, unintentionally or intentionally with their conversation. Police will screen friends and relatives to determine if they can be of any assistance in the negotiating process.

16. Public Relations and/or the local Police Department will designate an area away from the scene where information can be disseminated. It will serve to provide the release of information to the media. Remember, the hostage taker may have access to a radio and/or television and incorrect information can make the situation much worse. All inquiries will be given to a Public Relations Representative.

17. **Hospital Staff**:
    a. Hospital staff, regardless of department, will notify Security, through the PBX Operator, of the hostage situation. The PBX Operation will make all other notifications.

    b. The hospital staff shall give the PBX operator all information possible. This must include the location of the incident within the department, the number of hostage takers and hostages, a description of the hostage taker(s) and the nature of the incident at that time. This information must be written down for law enforcement's use later.

    c. Hospital staff shall institute either partial or lateral evacuations of patients. Patients and non-essential personnel must be moved from the "danger zone", identified as the immediate area of the hostage situation, to an area of safety and to continue necessary medical care.

    d. Under no circumstances shall any hospital staff play the "hero" and try to "take out" the hostage taker during a hostage situation. This can exacerbate the situation and may possibly harm the employees, a hostage, or another patient.

e. Under no circumstances will any drug be given to the hostage taker. If this becomes a demand, only management may authorize this after conferring with law enforcement.

f. A number of law enforcement agencies such as local and regional SWAT Teams may respond to this situation. Law enforcement officers from outside agencies will not recognize employees of the facility. It is imperative that all employees are wearing their identification badge at all times.

g. Hospital staff may be de-briefed by law enforcement. This information would include what was seen and heard while the employee was in the "danger zone". This information is vital to law enforcement as it may indicate the type of further response to the incident. Hospital staff is required to cooperate fully with law enforcement and relay any information they may possess.

18. **Administration**:
    a. In the event that an administrator or the administrative offices are taken hostage, the procedure outlined above for hospital staff shall be followed.

    b. In the event that the situation occurs in another part of the facility, Administration shall activate the facility command center. All personnel assigned to the facility command center shall respond and the situation may be controlled from there.

    c. Law enforcement may have its own command post for the incident. A member of the Administration should be at the command post to facilitate communication between law enforcement and the facility.

19. **Transportation**:
    a. Transporters shall assist hospital staff in moving patients during any type of evacuation. This shall be authorized by the management.

20. **All Other Ancillary Departments**:
    a. Hospital staff from any other ancillary department shall follow all procedures outlined in the Hospital Staff section of this policy.

21. No one will speak to the media except the Public Relations Representative.

Appendix A

22. The Media:

Regardless of an Active Shooter or Hostage Situation, the following steps will apply:

a. Public Information Officers will guide any media that is present and direct them to the command post for public relations.
b. Information provided will be at the Incident Commander's discretion.
c. If any media outlet calls to obtain information concerning the incident, all calls will be directed to the Marketing Department or Public Relations Department. The PBX Operators will neither confirm nor deny any information concerning the incident.
d. The PBX Operator must keep complete and accurate record of all actions taken during the incident, including any recordings. These recording may be subpoenaed at a later date and must be accurate.

23. Recovery Phase:

a. Facility Incident Command will gather all intelligence regarding the incident and process with the Command Chiefs. Recovery phase will be activated by the Incident Commander.
b. The Incident Commander will determine all-clear. Due to extreme circumstances, the Code may be cleared while leaving a partial lockdown intact.
c. Facility PBX Operator will announce the "all-clear" as directed by the Incident Commander only.

Appendix B

Security (Internal) Response: Subsequent Procedures/Information

DESCRIPTION OF PROCEDURES

These procedures will describe how individual staff, Corporate Security, Law Enforcement, and a hospital can respond to and recover from an active shooter event.

INTRODUCTION

The following internal security procedures have been adopted local and national accepted law enforcement response procedures to address such threats as quickly as possible. The following information is provided to guide you in protecting yourself, your patients, and visitors. Depending on the situation that you may be confronted with, use the following options – 'run, hide or fight.' As the situation develops or changes, it is possible you will need to use more than one option. To the extent possible, always consider the needs of others (i.e. patients, visitors, etc.) as well as yourself in protecting the most lives. Consider the greater good as well as your own interests.

DEFINITION

As defined by the United States Department of Homeland Security, an Active Shooter is "an individual actively engaged in killing or attempting to kill people in a confined and populated area; in most cases, active shooters use firearm(s) and there is no pattern or method to their selection of victims."

PROCEDURES

The following instructions are intended for incidents that are of an emergent nature (i.e. imminent or in progress). These instructions are categorized in the following manner:

I. **Immediate Actions for Staff**
II. **Security and Law Enforcement Response**
III. **Decision Maker(s)**
IV. **Subsequent Procedures/Information**
V. **References**

I. Immediate Actions for Staff

1. Assess the Situation
    - Try to remain calm, as your actions will influence others.
    - Try and identify where the event is taking place, how close is it to you and your

location, how many layers of protection are there between you and the shooter, do you have time to move yourself and people out safely, do you have time to secure you area, etc.

2. Evacuate, Shelter in Place and, if necessary, prepare to protect yourself and others (Run, Hide, Fight):
   - Dependent upon your patients' acuity and the unit's location in regards to the active shooter, remove all patients, staff, and visitors from the area to a secure location if safe to do so.
   - If patients, staff, and visitors cannot be moved or it is unsafe to do so, you must shelter in place. Lock or barricade all doors, block the door using heavy furniture – desks, tables, file cabinets, hospital bed, etc.
   - After securing the doors, turn off the lights and get away from the door and get behind any solid object.
     - Additional protective actions to reduce your vulnerability:
       - Relocate yourself to a pre-established safe room(s) within your department.
       - Close blinds.
       - Block or obscure interior windows.
       - Turn off sound to radios and computer monitors.
       - Silence cell phones and nurse call phones.
       - Place signs in exterior windows to identify your location and the location of injured persons.
       - Keep people calm and quiet.
       - After securing the room, people should be positioned out of sight and behind items that might offer additional protection – desks, file cabinets, bookshelves, etc.
       - Monitor and/or obtain updates in your e-mail box or via emergency text messages
   - Once you and your patients are safe notify 911 or your security office and provide as much detailed information as possible.
     - Your location, building, floor, room
     - How many people are with you
     - The location of the shooter
     - The number of shooters
     - Description of the shooter(s) and what they are wearing
     - The types and numbers of firearms if known
     - The number of victims if known

3. As a last resort and, only as your last resort, prepare to defend yourself and your patients.
   - You must commit to becoming the aggressor
   - Distract, disorient, and/or disable the shooter by using tactics such as throwing heavy or sharp objects; using a fire extinguisher to discharge fire retardant in shooter's face.
   - Once the shooter is distracted or disoriented, take action to disable him or her.

4. Issues to Consider:
   - The assailant(s) may not stop until their objectives have been met or until engaged and/or neutralized by law enforcement.
   - Attempts to rescue people only should be made if it can be done without further endangering the persons inside of a secured area.
   - Be aware that the assailant may bang on the door, yell for help, or otherwise attempt to entice you to open the door of a secured area. DO NOT open your area for anyone with the exception of Law Enforcement
   - Do not purposely confront the assailant or assailants unless they are in your immediate area and you and/or others are in danger.
   - Whenever possible work as a team if you must confront an assailant.

II. Security and Law Enforcement Response

Available Off-Duty and On-Duty Police, as well as Hospital Security Officers will immediately respond to the area, assisted by other local law enforcement agencies as they arrive on scene. Remember the first and foremost priority of Law Enforcement is to contain the assailant(s) from roaming the campus and then subduing the assailant(s). If these law enforcement or security officers are not in/at the hospital, wait for local police to arrive.

1. Initial Law Enforcement Response
   - Law enforcement will locate, contain, and stop the assailant.
   - The safest place for you to be is inside a secure room or safe haven. If safe havens are available, Security will direct staff, patients, and visitors to them when a lock down occurs
   - The assailant may not flee when law enforcement enters the building, but instead may target arriving officers or commit suicide.

2. Injured Persons: Initial responding police or security officers will not treat the injured or begin evacuation until the threat is neutralized and/or the area is secure.
   - You may need to explain this to others in order to calm them.

- Once the threat is neutralized, officers will begin treatment and evacuation.

3. Evacuation: Responding officers will establish safe corridors for persons to evacuate.
   - Remain in secure areas until instructed otherwise.
   - You will be instructed to keep your hands up and your fingers spread apart.
   - You may be searched.
   - You may be escorted out of the building by law enforcement personnel - follow their directions.
   - After evacuation you may be taken to a staging/holding area for medical care, interviewing, counseling, etc.
   - Once you have been evacuated you will not be permitted to return to the area to retrieve items until law enforcement releases the crime scene.
   - This may be time consuming.

III. <u>Decision Maker(s)</u>

1. Who's in charge
   - Highest ranking Corporate Security Supervisor on site
   - Then City Police Department
   - Then Organization's Incident Management Center in regards to the continuation of care and business continuity plans

2. Hospital Incident Management Center Response will support Corporate Security, Baltimore City Police Department, Baltimore Fire Department, and other agencies when indicated. Initial responses includes:
   - Incident Commander: Activate the primary Hospital Incident Management Center (HIMC) or alternate HIMC (outside of the inner perimeter if necessary). The Hospital Incident Management Team (HIMT) should report to the designated HIMC once they receive the Emergency Alert System (EAS) message.
   - Incident Commander: Request hospital operators or Security Communications Center to announce "Code Silver" occurring in (<u>*affected*</u>) building" over the overhead speaker system when directed by the HIMT or receipt of EAS message.
   - Incident Commander or Liaison Officer: Communicate with Corporate Security through the Security Officer assigned to the HIMT or through the Security HIMC
   - Incident Commander or Liaison Officer: Communicate with Police and Fire Departments directly or through Security HIMC
   - PIO (Public Information Officer): Activate the Media Center under the direction of the Office of Marketing and Communications or equivalent department

- 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 Officers: Activate designated internal and external safe havens for staff, patients, and visitors

3. Department Incident Command Centers (DICC)
    - Activate the primary Department Incident Command Center when HIMC is activated or when department staff receive the EAS message. Select an alternate DICC if the primary DICC is not in a safe location.
    - Deploy DICC positions to support units that will need to evacuate (e.g. affected area, adjacent areas, and 1-floor above and 1-floor below if a barricade situation occurs
    - Request assistance from HIMC to facilitate evacuation in collaboration with Medical Consultant and Bed Control

- 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 individuals in Senior Administration will make the decision to call in outside supporting agencies or to close all or a portion of the building and/or campus.
    - For areas with visitors (i.e. cafeteria, restaurants, waiting areas, etc.), Security Officers may direct them to another location that is deemed safer when indicated.
    - Request any locations of departmental safe rooms, if needed

5. Information will be released to the local community as quickly as circumstances permit. Campus Joint Information Center will assume responsibility and work with Police Department, Corporate Security, and Senior Administration to develop and release this information.

6. When Law Enforcement Arrives
    - Remain calm
    - Follow instructions and leadership of Corporate Security and Police Depts.
    - Keep your hands visible at all times
    - Avoid pointing or yelling
    - First responders are on scene to incapacitate the shooter
    - EMS and help for the injured will be on the way once area is secured
    - Avoid making quick movements toward officers such as attempting to hold on to them for safety
    - Avoid pointing, screaming, and/or yelling
    - Do not stop to ask officers for help or direction when evacuating, proceed in the direction from which officers are entering the premises
    - What to Expect from Police: Once you have reached a safe location or an assembly point, you will likely be held in that area by law enforcement until the situation is under control, and all witnesses have been identified and questioned. Do not leave

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. Subsequent Procedures/Information

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 department. However, containment/apprehension of the active shooter, hospital-wide communication and life-saving procedures will be paramount no matter when the active shooter incident occurs.

V. References

1. *Excerpt from University of Virginia Emergency Response Plan, Annex K, "Critical Incidents and Response Strategies – Active Shooter or Violent Incident"*

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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

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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

Preventive Measures

1. **Behavior Management Program & Team**

   - What: A program to provide:

     - Immediate support to staff when they observe or are involved in a situation with a patient, family and/or visitor behavior that has the potential to escalate beyond their control.
     - Training and skill development for all staff to pro-actively intervene to prevent escalation and skills to de-escalate potential volatile situations if they do occur.
   - Who:
     - Initially a select group of staff who have received special training to pro-actively intervene to de-escalate potential volatile situations when unit employees need assistance.
     - Long Term - all staff who interact with patients, families, and guests

2. **Behavior flag in electronic patient record**

   - The establishment of Behavior Alert Group (BAG) to review patients and/or family members who are overly aggressive
   - If aggressive patients and/or family members are found to be overly aggressive, they will be inserted in the patient's electronic record for review by clinicians and providers

3. **Education regarding recognizing and handling potentially aggressive behavior**

   - FBI Behavioral Analysis Unit: Familiarize employees with profiles of potential shooters
   - Environmental Threat Response Group assigning additional training needs for nursing administration, including aggressive patient training

4. **Other Strategies**

   - Patient Visitor Handbook revisions to address aggressive/threatening behavior
   - Visitor Guidelines Policy revisions to address behavior and ramifications
   - Install panic alarms on all inpatient nursing units and other clinical areas
   - Conduct annual risk management assessment

- 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

3. Review 'run, hide, fight' video(s) and develop content in slides, fast facts, and/or slides to accompany video.

4. Discuss the difference the role and responsibilities between non-clinical and clinical staff in implementing 'run, hide, fight.' Use the following questions to facilitate the difference …to best protect both employees and patients.

NOTE: The graphics in Appendix C were developed by Johns Hopkins Hospital in Baltimore, MD.

- **RUN**
  - What evacuation routes are available?
  - Will the entire unit decide together whether to run or hide? Will some be able to evacuate and others stay?

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

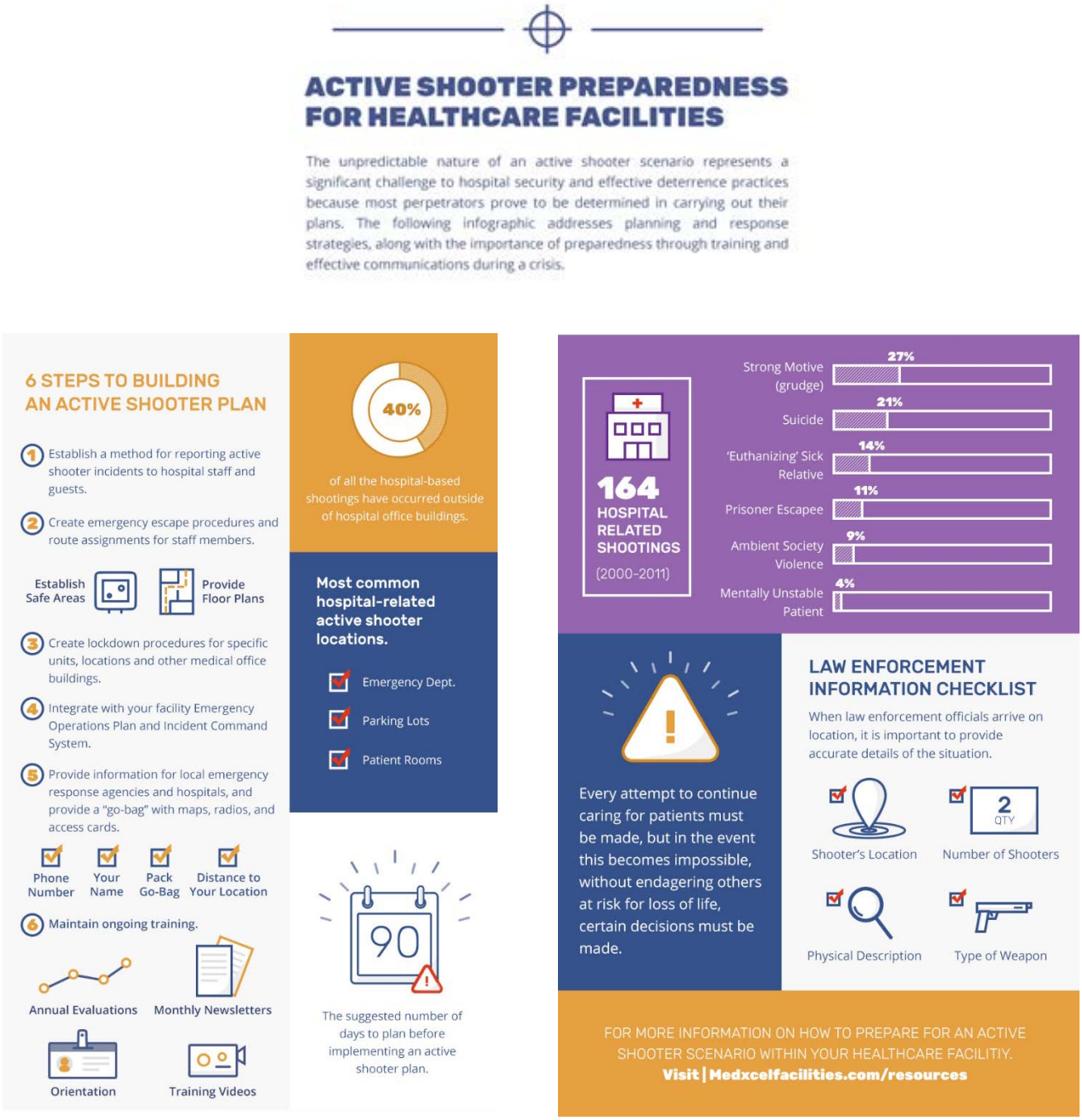
- **FIGHT**
  - What can be used as a weapon?
  - What are options on your unit?
  - Who will communicate with patients and visitors?
  - Who will be the leaders on the unit?
  - How will staff communicate?
  - Who will contact: Corporate Security or Dept. Leaders or Dept. Command Management Center?

Appendix C

5. Hospital Response Efficiency and Effectiveness: 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.

- Any patients killed or injured?
- Were employees notified of the incident? Were initial instructions communicated? Were subsequent internal communications timely, ongoing, and informative?
- Did the Hospital Incident Management Center (HIMC) provide adequate instructions, updates, and sufficient details after the initial alert?
- Was the HIMC set up in time?
- Was the Dept. Incident Management Centers (DIMCs), if developed
- Was the active shooter contained and apprehended in a reasonable period?
- Were all of the appropriate response procedures implemented?
- Was hospital leadership kept up-to-date?
- Were there any issues about who was actually in charge?
- Was the coordination between the UCS and the HIMC efficient and effective?
- Was essential business continuity preserved and maintained?

Appendix C



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