

**The Bill Blackwood
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**The Use of Rescue Task Forces in Response to
Active Shooter/Hostile Events**

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ABSTRACT

While law enforcement's response to active shooter/hostile event incidents continues to evolve, fire and emergency medical services (EMS) response to the same type incidents have remained relatively unchanged. Typical fire/EMS response involves staging in a safe location and waiting for the scene to be rendered safe by law enforcement. This clearing can take a significant amount of time. The critically wounded victims often present at these scenes require rapid treatment and transport in order to give them the best chance available to survive. Law enforcement agencies should deploy integrated teams that include medically trained personnel in order to achieve the goal of saving as many lives as possible during these events.

Deploying integrated teams will allow for immediate, point of wounding treatment of the critically wounded by appropriately trained responders. Such deployment will also allow for the appropriate triage, extrication and transport of those patients that require advanced treatment off site. Finally, such integrations forces face to face communication in a commonly chaotic situation, increasing the effectiveness of the response.

In order to deploy such teams, law enforcement should work with their brother and sister responders in the fire/EMS realm in order to properly prepare, train, and equip themselves to respond to these types of events. Proper training should be ongoing, so that skills do not diminish. Preparation should include producing standard response protocols and operating procedures that mirror each other, so that each discipline is aware of the other's capabilities and responses. Equipment should be as standardized as possible

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INTRODUCTION

Blair, Nichols, Burns and Curnutt (2013) define the term “active shooter” as an event involving “one or more persons engaged in killing or attempting to kill multiple people in an area occupied by multiple unrelated victims” (p. 50). The National Fire Prevention Association [NFPA] (2018) uses the term Active Shooter/Hostile Event, defining it as “an incident where one or more individuals are or have been actively engaged in harming, killing, or attempting to kill people in a populated area...” (p. 3000-7). Of note, there is no requirement that the attempted killings involve the use of a firearm. The active shooter incident is by no means a new phenomenon. The first active shooter attack on a school in North America occurred in July 1764, when four Lenape Indians attacked a school in what is today Pennsylvania, killing eleven British settlers (Hand, 2016). As these events have continued throughout history, law enforcement response to them has evolved.

In 1966, when Charles Whitman began shooting from atop the University of Texas clock tower, killing 14 and wounding another 31, three law enforcement officers and an armed citizen stormed the tower in an uncoordinated assault that resulted in Whitman's death (Wallenfeldt, n.d.). Moving forward, the watershed moment for law enforcement that shifted the paradigm in response to active shooters came on April 20, 1999, when two students went on a killing rampage at Columbine High School in Littleton, Colorado, killing 12 students and a faculty member before committing suicide. During this attack, it took law enforcement teams over three hours to reach the faculty member, Dave Sanders. By the time they had arrived, Sanders had died from his wound (Olinger, 1999).

Law enforcement's use of life saving medical intervention has also changed. The advent of Tactical Emergency Casualty Care (TECC) is a civilianized model of the Military's Tactical Combat Casualty Care (TCCC). TCCC evolved in part from lessons learned in the Battle of Mogadishu in 1993. The goal of TCCC is to decrease preventable combat death at the point of wounding (Advanced Law Enforcement Rapid Response Training [ALERRT], 2015). The civilianized version, TECC, is focused in the civilian arena and has three stated goals: prevent further casualties, treat casualties, and complete the mission (Blair et al., 2013). In order to achieve these goals, TECC is divided into three phases of care.

The first phase of TECC is direct threat care (DTC). In this phase, operators and/or victims are exposed to an immediate threat. The focus of effort in DTC is on mitigating the threat, moving wounded from the threat area, stopping life threatening hemorrhage through the use of tourniquets, and assisting the patient's airway management through use of a recovery position. The second phase is indirect threat care (ITC). In ITC, the immediate threat has been mitigated or there are sufficient protective measures in place to protect responders. In this phase, operators address the most preventable causes of death and prepare the injured for the third phase, extrication. The third phase is evacuation care. This care is similar to normal emergency medical services (EMS) operations. The goal during this phase is monitoring and reassessment of the casualties and transportation of the critically injured to higher levels of care (Committee on Tactical Emergency Casualty Care [C-TECC], 2018).

While law enforcement's response continues to evolve, fire and EMS response has changed very little (Frazzano & Snyder, 2014). In most cases today, that response is to stage in a safe location and wait for the scene to be determined safe (TriData Division, 2014; Blair et al., 2013). This delay, in effect, leaves the wounded without advanced medical care for an unacceptable period of time. In an active attack/active shooter scenario, time costs lives (Smith & Delany, 2013).

On July 20, 2012, a gunman attacked the Century 16 movie theater in Aurora, Colorado, shooting 70 and killing 12 people. Responding police and fire /EMS units did not successfully integrate until after the wounded had been removed from the scene. This lack of coordination led to a disjointed and ad hoc evacuation of the injured, with little or no advanced treatment on the scene. While no one died from this lack of coordination, the after-action report refers to this as "luck" (TriData, 2013, p.56). In order to avoid relying on such luck in the future, law enforcement agencies should deploy integrated teams consisting of trained medical personnel and law enforcement officers in response to active shooter/hostile event incidents.

POSITION

The use and deployment of integrated teams which include medically trained personnel will save lives. The priority in any active shooter/hostile event situation is to stop the killing. Once that priority is accomplished, efforts must focus on the rapid treatment of the critically injured (ALERT, 2015; Williams, 2013; Jacobs et al., 2013). Rapid medical intervention will increase the survivability of the types of wounds that result from these events (Blair et al., 2013).

The traditional EMS response did not allow for such rapid intervention, and negatively affected the survivability of patients (Jacobs et al., 2013). Dave Sanders' death in Columbine is a direct example of such a response (Olinger, 1999). According to the Wound Data and Munitions Effectiveness Team study, stated in the Journal of Emergency Medical Services (Smith & Delaney, 2013) the longer a casualty goes without being treated, the more likely that casualty is to succumb to their wounds. However, in the same study, only 10% of victims injured in combat died after treatment was started (Smith & Delaney, 2013).

The use of TCCC by all members of the military, providing medical treatment at the point of wounding, has decreased the case fatality rate from 14% in Vietnam to 9.2% in the current Iraq and Afghanistan areas of engagement (Blair et al., 2013). The importance of integrating medical teams into this response revolves around the types of interventions that can be made by individuals with differing levels of training. Smith, Shapiro, and Sarani (2016) report that in 12 public mass shooting events, survivable injuries were most common in the thoracic area. Under TECC, law enforcement officers may only place a chest seal on injuries to the chest to prevent tension pneumothorax. Basic and advanced life support providers are able to use needle decompression to alleviate such issues (C-TECC, 2018).

In a shooting incident in Minneapolis, Minnesota in 2012, EMS, working in concert with law enforcement, evaluated, triaged and transported three gunshot victims to a level one trauma center. Of the three, one survived. His survival is credited to the emergency intervention of the EMS responders. The two fatalities were later determined to have sustained non-survivable injuries (Autry, Hick, Bramer, Berndt, & Bundt, 2014).

The goal of saving lives is clearly more easily accomplished by having medically trained personnel providing point of wounding care to the critically injured. In an uncleared, ITC environment, this is best accomplished by integrated teams of both armed law enforcement and trained medical personnel. This is best illustrated by the response to the Pulse Nightclub shooting in Orlando, Florida in 2016. In this incident, all non-hostage, critically injured victims were evacuated. Fifty-eight of the sixty-nine such victims survived (Straub et al., 2017).

In addition to providing point of wounding care to those in a non-cleared/ warm zone environment, integrating medical teams with law enforcement into a task force allows for the appropriate triage of injured patients. Triage is the act of assigning a priority to injured victims (ALERRT, 2016). The idea is to get the victims most in need of medical treatment to the appropriate treatment in the least amount of time. Armstrong and Frykberg (2007) state that accurately triaging injured victims is critical to survivability. There are two possible mistakes in the triage process. These are under-triage, or misidentifying more seriously wounded as less serious wounded; and over-triage, or overestimating the seriousness of a victim's wounds. In the Virginia Tech shooting, there was a documented 10% under-triage of victims and a 69% over-triage. The problem with over-triage is that it can rapidly deplete hospital based resources (Armstrong & Frykberg, 2007). These mistakes were made by trained medical providers. It is likely that a greater percentage of errors would occur if the triage process was completed by non-medically trained law enforcement officers.

The type of wounding present in an active shooter event is typically different than those studied under the TCCC model. There is a higher incident of wounds to the head

and chest, which require rapid transport to higher levels of care in order for the victims to survive (Smith et al., 2016; Blair et al., 2013). Rapid transport of gunshot victims to a higher level of care is a significant factor in their survival (Harmsen et al., 2015). While immediate treatment at the point of wounding is important, the rapid identification, classification, and extraction of the most critically wounded is also urgent in order to provide those most critically wounded patients the best chance of survival.

In the Aurora, Colorado shooting, triage was performed by a law enforcement officer that was also a certified paramedic. The after-action report points out that, “(m)ost public safety officials agree that using police officers to perform mass casualty incident triage is often avoided,” and that triage by trained emergency medical technicians and paramedics is more desirable than using a law enforcement officer (TriData, 2014 p. 52). Integrating medically trained personnel with law enforcement teams accomplishes this goal as well.

A final reason that the integration of medically-trained personnel, specifically fire and EMS units, into a rescue task force with law enforcement is that it forces the two disciplines to integrate their communications in order to operate effectively. The Aurora after-action report addresses the lack of direct communication between fire/EMS and law enforcement for the initial stages of the incident. Lack of integrated communications made essential tasks, such as designating a staging location, getting medical aid to the injured, and evacuating the injured difficult. The best solution to this lack of direct communications is establishing direct face to face contact among the different disciplines. This lack of integration also overwhelmed the dispatch center with both multiple and duplicate requests for EMS, which overwhelmed the dispatch center.

(TriData, 2014). Integrating the different disciplines into a rescue task force forces the integration of communications and effectively addresses this gap.

COUNTER ARGUMENTS

The first and most common argument against the use of these task forces is that it places fire/EMS into an unsafe situation. In order to minimize loss of life, fire/EMS personnel are trained on the scene security aspect of response early in their careers. In ordinary operations, fire/EMS response is to stage at a safe location and wait for the scene to be declared safe (Smith & Delaney, 2013; Autrey et al., 2014; Blair et al., 2013). Deploying into an unsafe area puts personnel at risk. That risk is too much for fire/EMS responders to assume and scene safety is the primary consideration before entering a location (Smith & Delaney, 2013).

While scene safety is important, the primary goal in this situation is to stop the killing. Once that is accomplished, the goal shifts to stopping the dying. The most effective way to accomplish that is through the deployment of integrated rescue task forces (ALERT, 2015). Fire/EMS responders will not be intentionally taken into a “hot zone” or area under active threat. They will be escorted by law enforcement into “warm zones” or “uncleared areas” where there remains a possibility of threat, with protective measures in place (NFPA, 2018; Smith & Delaney, 2013).

In order to provide a decision-making matrix for actions at a hostile event scene, the “priority of life” scale is advocated by the Advanced Law Enforcement Rapid Response Training (ALERT) Center. This scale, in order of importance is innocent victims, first responders, and then suspects (Blair et al., 2013). When taken in the context of deploying fire/EMS into a warm zone to address injured victims, the injured,

innocent victim's life is higher on this scale than the first responder, indicating that first responders (fire and EMS) should be deployed.

Another idea is the one of acceptable risk. Smith and Delaney (2013) point out that fire and EMS responders accept risk as part of their job. In the 30 years prior to their article, over 3,000 firefighters had died in the line of duty. Between 2005 and 2013, EMS on-duty injuries were in the thousands per month. These numbers clearly illustrate that fire/EMS responders do a dangerous job. They routinely accept risk as part of this job, and deployment into a warm zone environment is, while unfamiliar, an additional risk that must be taken in order to save the lives of the critically injured.

The Federal Bureau of Investigation's Study of Active Shooter Incidents in the United States Between 2000 and 2013, indicates that 65% of these incidents are over in five minutes or less, and 90 percent are over within 15 minutes of the first shot being fired. (Blair & Schweit, 2014). This indicates that, statistically speaking, these scenes become safer as they progress. ALERRT (2015) uses a hypothetical call handling, turn out, and "near optimal" response time by fire/EMS of eight minutes. By this point, over 65% of the time, the assailant is no longer a threat. Within seven minutes of this hypothetical arrival time, 90% of assailants have either been detained, killed, isolated, or have fled the scene. This indicates that, while the scene cannot be called completely secured, the risk to fire/EMS responders is not unacceptable.

Another argument against the integrated response model presented in this paper is the sole use of Tactical Emergency Medical Service (TEMS) trained paramedics or TECC trained law enforcement officers to provide point of wound care and triage without the additional risk to line fire/EMS responders (Williams, 2013). TEMS medics

are paramedics or doctors assigned to police special weapons and tactics (SWAT) teams. They are SWAT trained and are deployed into hot zones with a tactical or SWAT team. The primary responsibility of the TEMS medics is the SWAT operator. While able to provide treatment to other individuals, they are generally not properly equipped for treating multiple patients in a warm zone environment (Bobko et al., 2018). Due to the time required to stand up and deploy such units, TEMS trained medics are not a feasible solution when time is of the essence, as it is in these events (Autry et al., 2014).

While there are some benefits to the use of TECC guidelines by officers with no advanced medical training, the types of wounding and scope of care provided by trained medics provides a higher level of care (C-TECC, 2018). As addressed above, the types of wounds suffered by patients in these events require treatments beyond simply tourniquet application (Smith et al., 2016).

The higher level point that this argument misses is that the active shooter problem is not solely in the law enforcement realm (Williams, 2013). The active shooter/hostile event incident is complex. A successful, integrated, multi-disciplinary response is required in order to successfully mitigate such events (Frazzano & Snyder, 2014). Appropriate medical care provided at the appropriate time, across response disciplines, will save lives in these events (Pons et al., 2015).

RECOMMENDATION

The law enforcement response to active shooter/hostile events shifted dramatically following the attack at Columbine High School in 1999. This incident was a paradigm shift for law enforcement that has driven the move to the rapid deployment

model used today (Blair et al., 2013). This response continues to shift today with the recent moves to solo officer responses (ALERT, 2015). The fire service, and through them the emergency medical services, has not experienced such a precipitating event to push a paradigm change. Therefore, this change must be driven by law enforcement (Smith & Delaney, 2013). Law enforcement agencies should deploy integrated teams including both law enforcement officers and medically trained personnel in response to active shooter/hostile events.

Such an integrated response will have the direct result of saving lives. By training law enforcement officers in the tenants of TECC, point of wounding care to stop the most common forms of death to survivable wounds, exsanguination and airway obstruction, is accomplished. Training fire/EMS personnel in the same way, and integrating the two into a single response unit, will allow for the more highly trained medical personnel to use these skills to address the more seriously wounded.

Additionally, deploying trained medical personnel into the warm zone to assess patients provides for the more rapid transport of the critically injured who require advanced medical away from the scene. The pattern of wounding seen in these types of events indicates that some of the wounded will only be saved by rapid extrication and transport to higher levels of care. This requires an integrated response to provide for the appropriate triage of the wounded in order to determine which of the injured are most in need of such extrication and transport are.

Finally, such integration forces a concurrent integration of communications between fire and law enforcement which will reduce the inherent chaos at such events. Failed communications increase such chaos and results in a disjointed response seen

in the Aurora, Colorado theater shooting. While this response was ultimately successful, the success was more a factor of luck and outside the box thinking by responders than by relying on good tactics.

While there is understandably concern that such deployment will endanger fire and EMS responders, this must be looked at through the lens of manageable or acceptable risk. Fire fighters and medics engage in inherently dangerous work on a regular basis. This type of response is but another type of risk that, if properly managed, will allow for improved outcome for the injured. Firefighter and medics got into their professions to save lives, and most are willing to assume some risk in order to accomplish that goal. Finally, these scenes statistically become safer as they progress, with over 65% no longer being under active threat prior to a near optimal response time by fire/EMS.

Some argue for the use of tactically trained medics or medically trained officers as the sole response to such an event. Deployment of TEMS medics is time consuming. These medics are usually a dedicated piece of a SWAT team and primarily responsible for treating injured officers. They also do not carry sufficient equipment to perform the warm zone, ITC type treatment required. TECC trained officers are effective to a point, but using more advanced trained medical personal is more effective. Finally, the active shooter/hostile event problem is more appropriately resolved by a whole community response and is not "owned" by any one discipline.

In order to effectively prepare for such an event, law enforcement agencies, in whose arena response to this issue primarily resides, should reach out to their fellow responders in the fire and EMS disciplines in order to effectively prepare for such

events. There should be policies developed by each discipline that mirror each other. This will reduce confusion during an actual response. Training should be provided to familiarize each discipline with the capabilities and limitations of the others. Also, it is more desirable to identify flaws in the planned response to such events during a training scenario than during an actual event. Equipment should be researched acquired, and issued to both fire/EMS and law enforcement. The equipment should be compatible between disciplines. Training should include familiarization with each discipline's equipment by the other. Training must happen on an ongoing and regular basis to ensure that when (not if) such an event occurs, the entire community is trained, equipped, and ready to accomplish the primary task of saving lives.

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