

U.S. Fire Administration

# Fire/Emergency Medical Services Department Operational Considerations and Guide for Active Shooter and Mass Casualty Incidents

September 2013



FEMA

# Message from the U.S. Fire Administrator

September 2013

This paper was developed as a fire and Emergency Medical Services (EMS) resource that can be used to support planning and preparation for active shooter and mass casualty incidents (AS/MCIs). These complex and demanding incidents may be well beyond the traditional training and experience of the majority of firefighters and emergency medical technicians. The U.S. Fire Administration (USFA) offers this report as one source of many available for the public safety community, but it takes into consideration the diverse local service levels available across America. In developing this paper, USFA consulted with individuals and groups engaged in fire and prehospital EMS, law enforcement, and hospital medical and trauma care. We also consulted with public safety organizations and numerous federal agencies.

If you have questions regarding this document, please contact the USFA at [www.usfa.fema.gov](http://www.usfa.fema.gov).

Sincerely,

A handwritten signature in black ink, appearing to read "Ernest Mitchell". The signature is fluid and cursive, with the first name "Ernest" being more prominent than the last name "Mitchell".

Ernest Mitchell  
U.S. Fire Administrator  
U.S. Fire Administration

## Executive Summary

### Background

More than 250 people have been killed in the United States during what has been classified as active shooter and mass casualty incidents (AS/MCIs) since the Columbine High School shootings in 1999. AS/MCIs involve one or more suspects who participate in an ongoing, random or systematic shooting spree, demonstrating the intent to harm others with the objective of mass murder.

It has become evident that these events may take place in any community impacting fire and police departments, regardless of their size or capacity. Local jurisdictions must build sufficient public safety resources to handle AS/MCI scenarios. Local fire/Emergency Medical Services (EMS) and law enforcement (LE) must have common tactics, communications capabilities and terminology to have seamless, effective operations. They should also establish standard operating procedures (SOPs) for these very volatile and dangerous situations. The goal is to plan, prepare and respond in a manner that will save the maximum number of lives possible.

### Maximizing Survival

Extraordinary efforts on the part of local fire/EMS agencies and direct pre-planned coordination with LE is required during response to these events in order to rapidly affect rescue, save lives, and enable operations with mitigated risk to personnel. It is essential that local policies be put in place before AS/MCIs happen to ensure coordinated and integrated planning, preparation, response, treatment and care.

The recognition of AS/MCIs as a reality in modern American life has led to the assembly of a number of public safety organizations representing various disciplines to share and develop strategies for combating the problem. One group, convened by the American College of Surgeons and the Federal Bureau of Investigation in Hartford, Connecticut, developed a concept document for the purpose of increasing survivability in mass casualty shootings. The paper, The Hartford Consensus, describes methods to minimize loss of life in these incidents.

The Hartford Consensus identifies the importance of initial actions to control hemorrhage as a core requirement in response to AS/MCIs. Experience has shown that the number one cause of preventable death in victims of penetrating trauma is hemorrhage. Well-documented clinical evidence supports the assertion.

The Hartford Consensus focuses on early hemorrhage control to improve survival. These very practical recommendations include the critical actions contained in the acronym **THREAT**:

- T** - Threat suppression
- H** - Hemorrhage control
- RE** - Rapid Extrication to safety
- A** - Assessment by medical providers
- T** - Transport to definitive care

The THREAT concepts are simple, basic and proven. The Hartford paper points out that life-threatening bleeding from extremity wounds are best controlled by use of tourniquets. Internal bleeding resulting from penetrating wounds to the chest and trunk are best addressed through expedited transportation to a hospital setting.

### **Coordinated/Integrated Planning and Response**

To increase survivability of victims, fire and EMS agencies must incorporate THREAT principles as SOPs. At a minimum, SOPs should include:

- Jointly developing local protocols for responding to AS/MCIs. Fire/EMS and LE should plan and train together.
- Planning for and practicing rapid treatment and evacuation, including who, what, when, where and how it will be carried out.
- Using the National Incident Management System (NIMS) and the Incident Command System (ICS). Accordingly, fire/EMS and LE should establish a single Incident Command Post (ICP) and establish Unified Command (UC).
- Fire/EMS, LE and all public safety partners planning and training together.
- Including AS/MCIs in tabletop and field exercises to improve familiarity with joint protocols. Regularly exercise the plan.
- Using common communications terminology. In addition to NIMS and ICS terminology, fire department personnel must learn common LE terms and vice versa. Share definition of terms to be used in AS/MCIs and establish a common language.
- Incorporating tactical emergency casualty care (TECC) into planning and training. Training must include hemorrhage control techniques, including use of tourniquets, pressure dressings, and hemostatic agents. Training must also include assessment, triage and transport of victims with lethal internal hemorrhage and torso trauma to definitive trauma care.
- Providing appropriate protective gear to personnel exposed to risks.
- Considering fire hazards secondary to the initial blast if improvised explosive devices (IEDs) are used.
- Considering secondary devices at main and secondary scenes.
- Determining how transportation to and communications with area hospitals/trauma centers will be accomplished.

AS/MCIs are volatile and complex. Research and history have indicated that the active risk at most incidents is over before first responders arrive on scene, or shortly thereafter, but they may also require extended operations. Extensive planning, recurrent training, and preplanned coordination are all required for optimal results. Coordinated involvement by the whole community is essential. The public, fire/EMS, law enforcement, medical transportation, and medical treatment facilities must be engaged cooperatively in order to maximize survivability and minimize deaths due to AS/MCIs.

<b>Active Shooter and Mass Casualty Incident Check List</b>			
<b>X</b>	<b>#</b>	<b>Responsible Party</b>	<b>Item</b>
			<b>Preincident</b>
	1	Local EMA/AHJ	Multiple victim incident EOP completed
			<b>Incident</b>
	2	LOG	CP established
	3	LOG	CP secured
	4	LOG	U/C and communications method established and communicated to all personnel and communications center
	5	U/C	UC/LE establishes goals and overall strategy; <b>Emphasize Rapid Triage, Treatment and Extrication</b>
	6	U/C	ICS established; command and general staff positions established
	7	OPS	Establish staging manager and staging areas
	8	U/C PIO	PIO staffed, JIS considered
	9	OPS	Fire, medical, and/or rescue branches or groups established in operations
	10	EMS	Establish casualty collection points, evacuation routes and LZs
	11	OPS	Size-up and determine resource requirement
	12	UC and LOG	Request required resources
	13	U/C	Notify hospitals to activate MCI plans
	14	OPS	Develop operational plan
	15	PLN	Start IAP process
	16	OPS	Aviation division established by air assets planned or airspace control required
	17	OPS	Safe, hard cover staging area established (multiples for discipline or geographically)
	18	LOG/ALL	Personnel have readily identifiable ID
	19	U/C	Duress code provided to all responders
	20	U/C	Plan approved by AHJ
	21	OPS	Accountability for victims and civilians involved — established
	22	EMS	Medical branch or group establishes rapid triage, treatment (include hemorrhage control), and transportation portals and sites
	23	EMS	Account for persons triaged, treated and/or transported (record and track locations)
	24	PLN	Provide for rotation and maintenance of on-scene personnel
	25	LOG	Provide refueling, battery charging, and replenishment of expendable materials
	26	PLN	Demobilization plan in place
	27	PLN	After action report process established
	28	PLN	ICS evaluation report plan in place
	29	PLN	Debriefing personnel planned
	30	LOG	Critical stress debrief action planned
	31	PLN	Personnel released
			<b>Post-incident</b>
	32	PLN	After action report prepared
	33	PLN	After action report completed
	34	U/C	After action report submitted to AHJ
	35	PLN	Improvement plan established
	36	PLN	Plan updates processed
	37	AHJ	Plan updates promulgated
	38	AHJ	Training and exercises based on plan updates

# Fire/Emergency Medical Services Department Operational Considerations and Guide for Active Shooter and Mass Casualty Incidents

**Background:** Active Shooter and Mass Casualty Incidents (AS/MCIs) require extraordinary efforts on the part of the local fire/rescue and EMS agencies. Although these attacks usually end within a few minutes from the time they begin, the incident and response actions may play out over an extended period of time. Also, they may include a “direct threat” or “hot zone” with an ongoing active shooter(s); multiple casualties requiring extensive triage, treatment and transportation efforts; and large numbers of response personnel, bystanders and spontaneous volunteers.

Research from prior AS/MCIs has shown that casualties sustaining only minor injuries in most cases will self-evacuate and may seek care from responding fire, EMS and LE assets on the periphery of the event. This creates a diversion and causes a delay in medical response to the area with people who are significantly wounded. Conversely, minor injured patients may directly self-transport to nearby local hospitals, thus arriving and creating emergency department crowding before the transportation of the more severely injured. If not prepared, this “reverse triage effect,” where the least injured enter the medical system first, can greatly impede response operations both on-scene and in the receiving hospitals. These incidents also require media engagement, demand organizing and managing large amounts of logistics, and require coordination among several disparate agencies, often from differing levels of government.

While the environment and circumstances will differ from incident to incident, there are an overarching series of actions that seem common to most, and awareness and planning will better position public safety agencies to effectively deploy when faced with an AS/MCI. The resultant monograph is intended to serve as a generic guideline in assisting fire/rescue and EMS agencies in preparing for and responding to AS/MCIs. While this document is intended to be comprehensive in scope, each agency will have to determine which parts of the information have value to their circumstances and those that will require additional development for local agency use. It is the intent of the USFA that this be a viable and dynamic document. As agencies engage in this work, we look forward to receiving comments, additional ideas, and suggestions for improvements in future editions.

**Active Shooter and Mass Casualty Incidents (AS/MCI):** This is a general term intended to cover active shooter incidents involving one or more subjects who participate in a random or systematic shooting spree, demonstrating their intent to continuously harm others. Since the purpose of this document is not focused on the LE operations, we will use AS/MCIs as the incident descriptor. AS/MCIs range from extensively planned terror-related events to unplanned, revenge-motivated or random events.

Successful command and control of AS/MCIs are based on multiple levels of planning and coordination including intra-agency among the fire/EMS response assets; interagency among all of the public safety and private sector responder agencies; externally with the facility personnel who provide expertise regarding facilities and technical matters; and regionally with the hospitals and receiving medical facilities. Using ICS provides a framework for managing the incident and should be utilized by the responders and incident infrastructure operators. Effective planning requires mutual goals, critical reviews, evaluation, revision and continued practice. Planning, coordination, communication and information sharing must be common if not daily practiced among all of the first responders to such an incident. Most often these agencies interact on routine calls on a daily basis providing for multiple, albeit less complex, interagency relationship building, communication and coordination. There must be a commitment to prepare and plan for such an incident before it occurs.

**General AS/MCI Operational Principles:** AS/MCIs are complex operations, and each requires the intricate coordination of people and other resources. They are extremely fast-evolving incidents. Each one is conducted real time under intense news and social media scrutiny and public interest. Several responding disciplines must work together to achieve the best possible outcome. Success in response to AS/MCIs requires prepared leadership, planning, communications, training and competent execution. Although overall operational priorities are unchanged from most routine incidents, for example, life safety, incident stabilization and property conservation, in AS/MCIs, the life safety and incident stabilization will be the nexus of the operation.

- 1. ICS:** NIMS advocates the use of ICS. USFA has been a longtime supporter of the National Wildland Coordinating Group ICS. Public works, LE, military, education, and health agencies and associations have joined in supporting the use of ICS for all emergency incidents as well as special planned events. It is used by federal, state, tribal, territorial and local governments and is now embedded in most first responders' operations. As such, this document supports ICS use. ICS should be the command and control system implemented for all AS/MCIs. The impact of well-deployed and practiced use of the ICS among providers who are likely to respond together cannot be overstated. The notion of a "unified" command must be well understood and practiced by all for successful command and control.
- 2. UC:** AS/MCIs are, at their most basic level, crime scenes that have injured people in need of treatment, rescue and expedient evacuation. Each incident is a primary LE event but requires coordination between the LE on-scene lead and the fire/rescue/EMS on-scene lead. UC provides the proper vehicle for command and control of AS/MCIs; therefore, responders should establish UC and a UC Post (UCP) as soon as possible. Fire and EMS command elements should recognize that the LE on-scene lead will be actively sending LE officers into the impacted area to directly engage the threat, secure the

perimeter to ensure the perpetrator doesn't evade, and to exclude inappropriate entry by additional perpetrators. Additionally, from almost the moment of arrival on-scene, the LE lead will be determining LE resource requirements, developing intelligence on the incidents, trying to identify the location and viability of the victim(s), and many other tasks. Thus, the fire and EMS commands should move to the LE Command Post (CP) and establish UC as planned.

Depending on local plans, there are several fire/rescue and EMS functions that can occur during the time frame that the LE lead will be making tactical decisions regarding operations prior to establishing threat zones for combined LE/EMS casualty rescue operations. These functions include establishment of fire/rescue and/or EMS branches or groups. Assist the LE on-scene lead by supporting the ICS functions that may not have been addressed yet. It is essential that UC protocols be pre-established, planned and practiced. Operational command and control of large-scale, multidiscipline/multijurisdictional responses requires practice and exercise to become effective. The selection of the Operations Section Chief (OSC) position is usually assigned to the agency having the highest priority for achieving the UCP incident action plan objectives. Hence the initial selection of a LE officer for the OSC position with assistance from fire/EMS, as the deputy OSC, in accordance with a UC system.

- 3. Plan for Treatment of Casualties:** It is the perpetrator's intended purpose to kill or injure people. Plan for casualties, when and where they will be treated, and how they will be evacuated from the point of wounding. **THREAT** principles (hemorrhage control, rapid extrication, assessment by medical, transport to definitive care), to improve survivability, should be an integral part of planning. Determine which agency or personnel will locate casualties, triage them, provide point of wounding medical stabilization, and/or remove them to a safe location. There should be preplanning discussions with medical directors, medical control and with the primary receiving medical centers regarding the principles of TECC. As the civilian equivalent of the military combat medical guidelines, the TECC guidelines account for the unique operational considerations and limitations of medical operations in high-risk conditions and prioritize and focus medical efforts to only what must be done to affect survival. Considerations should be made for all potential first responders, including LE patrol officers, to be trained to the basic tenets of TECC. Training, equipment and protocols around use of TECC for medical first responders should be explored, considered and implemented when feasible. The survival benefit of TECC is based on rapid application of point-of-wounding care, thus the equipment must be forward deployed for care to be immediately implemented. This requires that TECC equipment and supplies be carried with all other medical aid and equipment. In short, TECC equipment could become a valuable part of the standardized equipment for fire/EMS response assets.



Usually police resources in the initial moments of AS/MCIs are focused on locating, containing and eliminating the threat, thus the local fire/EMS resources should emphasize planning for rapid triage, treatment and extrication of the wounded. Tactical EMS support personnel are not a typical resource because they are usually very limited in number, not immediately available, and committed to their tactical team's assignment. This will preclude them from casualty care activities until the tactical team's objective is met. Considerations, planning and interagency training should occur around the concept of properly trained, armored medical personnel who are escorted into areas of mitigated risk, which are clear but not secure areas, to execute triage, medical stabilization at the point of wounding, and provide for evacuation or sheltering-in-place. Some jurisdictions accomplish this through the deployment of Rescue Task Forces (RTFs). Were this an ongoing ballistic or explosive threat, under the protection of LE officers these teams treat, stabilize and remove the injured rapidly while wearing ballistic protective equipment. An RTF team should include at least one advanced life support (ALS) provider. A few agencies are even exploring the use of LE 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. Consider secondary devices at the main scene and secondary scenes in close proximity to the main scene. Such threats, if identified, would necessitate upgrading the area to one of direct threat requiring rapid evacuation of all medical personnel and surviving patients.

- 4. News Media/Public Information Officer:** The community-specific Emergency Operations Plan (EOP) should have predetermined media connections, and the Public Information Officer (PIO) should be activated. Large extended events may necessitate the use of a joint information system. Media may appear quickly and may aggressively attempt to enter the CP, the exclusion zone, or other places to obtain direct surveillance and communications with survivors, family members and/or responders. They may also have aviation assets that may be co-opted for use in scene surveys but which should be controlled to ensure safety of the operation. If aviation units become problematic, the Incident Commander (IC) can request the Federal Aviation Administration to issue a restriction for the incident area air space.

Strong consideration should be given for the use of a Joint Information System (JIS) that consolidates all agency and incident information flow from the multitude of agencies involved. A JIS further establishes a well-controlled information-sharing plan. Utilization of the Joint Information Center (JIC) may be considered to house the JIS efforts. Experience at previous AS/MCIs demonstrates the advantages of locating the JIC at a different location than the CP. **DO NOT CO-LOCATE THE JIC AND THE ICP.** The PIO must have a plan for media announcements regarding a staging area for parents and relatives of victims. In school shootings, the scene is quickly inundated with parents and bystanders. Considerations should be given to assigning PIOs or liaison officers to support families of casualties in handling media requests.

5. **EOP:** It is unlikely that any community can anticipate specific AS/MCI scenarios they may experience, but it is possible to develop a generic plan that provides a model to apply in almost every situation that arises. Each community needs to have a detailed and comprehensive EOP. Federal Emergency Management Agency (FEMA) Publication CPG 101, available at [http://www.fema.gov/pdf/about/divisions/npd/CPG\\_101\\_V2.pdf](http://www.fema.gov/pdf/about/divisions/npd/CPG_101_V2.pdf), can be used to develop planning documents. The EOP may provide the framework for command and control at AS/MCIs in the general section, or more often, in an annex specific to AS/MCIs. In the absence of existing plans, the fire/rescue and EMS agency leadership should develop a plan for AS/MCI operations. The EOP must provide the framework for coordinating the activities of police, fire, rescue and other supporting agencies. Here are some things that should be considered in the development or revision of the AS/MCI annex to an EOP:
- a. The EOP is a written document.
  - b. The EOP should reflect the multiagency, multidisciplinary nature of the incident.
  - c. The EOP establishes command, control and communications procedures.
    - Use of common communications terminology is imperative.
    - 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).
      - Other
  - d. In accordance with NIMS guidance, the EOP provides for the establishment of a single ICP.
  - e. The EOP plans for UC.
  - f. All emergency responders need to be apprised of LE plans and procedures, strategy, and tactics:
    - LE personnel may bypass injured victims to subdue the perpetrators.
    - LE protective gear will not protect them from all threats.
    - LE personnel may attempt to enter an AS/MCI area without waiting for additional units in order to contain or neutralize an active threat.
    - Most LE agencies will not wait for SWAT to engage active shooters.
    - LE may request fire/rescue/EMS equipment to breach or force structural elements or to access roofs or other areas, or other needs. LE may request fire/rescue/EMS personnel to assist with operating specialized equipment.
    - LE may request fire/rescue/EMS personnel to assist with victim triage, treatment and/or removal from the danger zone. LE should train to accompany personnel into areas of higher risk to perform these duties.

- LE should be aware of fire/rescue/EMS capacities, tactics and procedures.
- g. The EOP establishes the preincident requirement for discipline and integrated training in use of the plan.
- h. The EOP directs a coordinated public messaging process through the PIO and/or JIC.
- i. The EOP should address aviation considerations including establishing helispots, landing zones, control of aircraft in the incident area, and excluding unauthorized aircraft. The EOP should include communications plans between aviation assets and incident operations and consider establishment of an Air Ops Branch.
- j. The EOP must consider the use of additional community resources. Agreements for automatic and mutual aid should be formalized.
- k. To the extent possible, in advance, designate staging areas, rally points, CCPs, and the CP. Consider designating primary, secondary and alternate positions in the event that one of your designated positions is in the “hot zone” and unusable. If possible, avoid obvious locations such as police or fire stations that may already be targets.
- l. The EOP should consider specific target hazards and relocation and support areas in the preincident planning process. The incident may require facilities where outside persons will need to contact or interact with the “surviving victim population” (for example, schools, day care centers, hospitals, entertainment venues, hotels, and other public assembly areas) and identify and staff a family assistance center. The assistance center should be readily identifiable, large enough to hold and administratively process survivors as they are released to families, provide basic amenities, make referrals to post-incident counseling services, and have adequate traffic flow (buses may be used in large incidents) and parking. The family assistance plan includes custodial care, reunification, guardianship, accountability, mortuary service planning, and victim tracking.
- m. The EOP should address the process for obtaining additional support and resources from external resources. Supporting agencies and resources should be integrated into the UC.
  - Liaison officers and systems should be planned, empowered and understood by the UC and supporting agency.
  - Management of planned and spontaneous volunteers must be addressed by UC and supporting agencies.
- n. The EOP should be reviewed, endorsed and supported by the community policymakers, including medical and educational communities.
- o. The EOP should be reviewed, exercised and updated regularly. After the AS/MCI, wherever located, consider the timeliness, completeness and efficacy of the EOP. EOPs are only effective when they are exercised, updated and regularly used. Where possible, jurisdictions should follow the Department of Homeland Security’s Homeland

Security Exercise and Evaluation Program. The improvement model used in this program will help the jurisdiction to enhance response readiness.

**Interagency On-scene Practices:** Many of the standard operating practices an agency uses in its day-to-day operations may be unchanged for AS/MCIs. Some will require reconsideration and perhaps modification. AS/MCIs usually involve a perpetrator trying to maximize casualties, so responders need to exercise due caution en route to the incident as well as after arrival. A single ICP is crucial. LE should always maintain a presence at the UCP to coordinate operations and ensure the safety of all personnel operating on the incident, even if the OSC assignment shifts from LE to fire/rescue/EMS.

- a. Use a deliberate and cautious approach to the scene.
- b. While the community-accepted practice has been staging assets at a safe distance (usually out of line-of-sight) until a perimeter is established and all threats are neutralized, considerations should be made for more aggressive EMS operations in areas of higher but mitigated risk to ensure casualties can be rapidly retrieved, triaged, treated and evacuated. Rapid triage and treatment are critical to survival.
- c. Consider turning off emergency lights and warning devices before arrival. Remember many frightened citizens may be fleeing the event and are likely to act in an unsafe manner, so use extreme caution. Clarify this procedure with LE authorities since there have been reports wherein the perpetrator ends the threat when they hear or see public safety personnel or units arrive on-scene.
- d. If exposed to gunfire, explosions or threats, withdraw to a safe area.
- e. Consider/Investigate the use of apparatus' solid parts such as motor, pump, water tank and wheels as cover in the hot zone. Understand the difference between cover (protection from direct fire) and concealment (protection from observation).
- f. Remove victims from the danger zone in a manner consistent with predetermined agency training and standards of practice. LE officers may bypass casualties in order to eliminate the threat.
- g. Use internal CCPs for large area facilities with multiple casualties where evacuation distances are long. Point-of-wounding medical stabilization should occur prior to evacuation to the CCP, which should provide cover to the injured and responders and be secured by LE officers. Identify people at CCP for accountability and protection of staff.
- h. For larger geographic incidents or incidents with travel barriers, consider the use of multiple staging, triage and other supporting setup areas.
- i. Establish the single UC ICP in safe location. Secure the CP. Remember the CP may become a target.
- j. Events with mobile perpetrators or sequenced attacks may necessitate CP relocation and additional protection or security.
- k. Establish PIO and a JIS.
- l. Establish UC with LE as lead operational component.

- m. Establish ICS structure necessary to manage the incident. Consider fire and EMS branches in operations.
- n. The UC/LE lead determines the type of operation and direct strategy.
- o. LE “on-scene” radio report should not be construed to imply that the scene is secure or safe. A scene is not considered secure until a detailed deliberate search of the entire area is concluded.
- p. Stage fire/EMS resources, identify and prepare personnel for operations in areas of higher risk, if appropriate, and await instruction. The first unit/responder in staging capable of managing staging until the appointment/arrival of a designated staging officer should assume that responsibility.
- q. The staging area should provide hard cover and concealment from perpetrators.
- r. Minimize people exposed to unnecessary risk. Provide appropriate protective gear to personnel operating in indirect threat areas.
- s. If bystanders become hostile, extricate yourself. Advise UC.
- t. Have a “duress code” known to all responder personnel.
- u. UC should have the communications center alert area hospitals. UC may ask for activation of their Multiple Casualty Incident Plan. Some casualties may “self-present,” and emergency rooms need to be aware of the situation.
- v. Consider early ordering for additional triage, treatment and transportation resources. This should be detailed in a preplan established order by predetermined resource needs based on the extent, scope and anticipated duration of the event.
- w. Use identification that is discernible from a distance. Police snipers at Columbine were unable to identify a fire officer and treated him as a suspect. Be aware that responders may be wearing uniforms and civilian attire, so exercise caution in identifying individuals.
- x. Work as teams or in pairs as a minimum. If possible, assign an extra responder to serve as a team spotter. Their role is to observe, identify and avoid threats while the balance of the team executes their tactical assignment. This is similar to some of the safety precautions used in wildland/interface firefighting.
- y. Have medics and personnel who might be in situations requiring indirect threat-area operations for point-of-wounding care train to the tenets of TECC for guidance on prioritization and familiarization with the management of ballistic and explosive wounds. Departments should train and equip fire/rescue/EMS personnel to work with LE within areas that are clear but not secure, representing an indirect threat risk, for immediate lifesaving interventions. The RTF concept is designed for this purpose.
- z. Mental and physical health for responders remains a tactical consideration throughout the incident. It is possible that some of the responders know the aggressors and/or victims. The UC should determine how to utilize or relieve these responders.

- aa. Assign extra communications personnel for the CP to monitor inbound intelligence from responders. These types of incidents provide a tremendous amount of radio traffic with real time updates coming from fleeing civilians and responders. Due to the critical time factors involved in getting intelligence back to the entry team personnel, extra communications personnel should be allocated to receive, analyze and rebroadcast (per the UC) the many data transmissions received.

**Operational Practices En Route and On-scene:** As a part of the initial assignment or for a senior officer en route to AS/MCIs, there are several additional considerations. These may include:

- a. Obtaining the maximum information/intelligence en route. If closed circuit camera systems allow visual monitoring of the area or specific elements, they should be utilized.
- b. On-scene, verifying what you can as a part of the size-up.
- c. Determining threats to response personnel as well as additional civilians.
- d. Obtaining as much information as possible from persons who have fled the event. This is usually done by LE personnel, but may also be done by fire/EMS, if in certain situations. Fire/EMS personnel must provide LE with any intelligence/information obtained during patient/casualty contact or treatment. Medical facilities should also be trained to provide any non-Health Insurance Portability and Accountability Act information to LE.
- e. Considering IED possibility or other secondary devices. This speaks to the consideration of a second level of staging for the balance of responding resources until they are needed and can be advanced in safely.
- f. If first on-scene, ensuring LE and other necessary resources are en route.
- g. Expanding alarm as required, but using smallest response appropriate. Ideally, to the extent possible, this should be preplanned by the number of anticipated victims.
- h. Identifying a safe staging area for inbound resources.
- i. Establishing command (done by initial officer).
- j. Establishing CP as soon as possible.
- k. Using single CP to establish UC.
- l. Using PIO/JIS function for release of information. Exercise caution regarding releases to avoid compromise of operations.
- m. Accounting for victims on the scene, those who may be relocated to safer or reunion areas, and those transported to medical or other facilities. (Accounting by name, if practicable, or by gross numbers should be protected information). Most agencies will have explicit policies in that regard and have noted the tracking location of children to be essential.

- n. Accounting for response personnel. Establish an accountability process for all incident responders to the incident. Use a check-in/-out procedure.
- o. Communicating all movement on the incident, especially if the threat has not yet been contained, to the ICP and units in the operations section.
- p. Calling for resources trained in AS/MCIs necessary to staff ICS to the appropriate level. This speaks to having an adequate number of ICS-trained and capable personnel to expand to the incident size. Reassess every 30 minutes or during periods of low activity.
- q. Basing the assignment of staff on qualifications, available resources, and the need for extended operations periods.
- r. Considering the possibility of spontaneous volunteers attempting to participate in the incident. Determine how/if they may be used, informed, controlled and dismissed. In AS/MCIs it is possible some volunteers will be armed. Consider this in planning.

**Post-incident/Demobilization:** While stand down is an appropriate time to decompress and refresh, it also is the best time to capture staff recollections of specific events that may not have been well documented. Obtain responder listings and tasks performed. This is also the time to account for equipment, pack supplies, complete records, and release staff to duty or home. A demobilization plan will include member information regarding post-incident briefings, stress management briefings, and family support information.

- a. Establish and manage a formal unit-release process.
- b. Collect incident management records and unit logs.
- c. Determine and announce an incident debriefing strategy (UC).
- d. Assign a debrief team to prepare a report of the incident.
- e. Determine and announce a stress debrief plan.
- f. The PIO position may stand down, returning that responsibility to the IC. Based on the size of the incident, there may be a need for ongoing support of this function.
- g. Set up an EOP AS/MCI plan review and evaluation team (UC).
- h. Prepare evaluations by position (UC).
- i. Close down the CP.
- j. Prepare and review the EOP AS/MCI report and evaluation (UC or command group, the community policymakers, and others as determined by policy). The report may be sensitive and involve ongoing investigation. It should be reviewed by appropriate legal authorities prior to release based on agency policy.
- k. Assure appropriate stress debriefing and management resources for all personnel.



## Media/Information Resources

There is much more valuable information to be learned from past incidents and the best practices created by those who have experienced them. You are encouraged to go to the following locations for more information.

Note: We are providing the following information and links to third-party sites for your reference. USFA does not endorse any nongovernment publication, website, company or application.

- U.S. Department of Homeland Security website: Active Shooter Preparedness, <http://www.dhs.gov/active-shooter-preparedness>.
- Hamilton, Steve C., September 2012, Fire Engineering, pp. 26-35.
- Vernon, August, June 2012, Fire Engineering.
- Video article, Fire Ground Commentary — Mass Shootings, October 18, FireRescue1News Chief Rob Wylie.
- Krebs, Dennis R., When Violence Erupts: A Survival Guide for Emergency Responders, Jones & Bartlett, 2003.
- Renaud, Cynthia E., (2010), Making Sense in the Edge of Chaos: A Framework for Effective Initial Response Efforts to Large-Scale Incidents, thesis, Naval Postgraduate School, San Diego, CA.
- U.S. Fire Administration, (2012), Fire Service Operations for the Southeastern Tornadoes: April 2011, Emmitsburg, MD.
- U.S. Fire Administration and TriData Corporation, 1999, [Wanton violence at Columbine High School, April 20, 1999: special report](#), (Emmitsburg, MD), Federal Emergency Management Agency, U.S. Fire Administration.
- Baldanza, Mauro V., 2005, [Fire department response to “active shooter” incidents](#), Fire Engineering.
- Ludwig, Gary G., 2012, [The active shooter: a special challenge — plan and practice your fire-EMS response to mass-casualty shootings](#), FIREHOUSE.
- National Fire Academy – 2012 Field Operations Guide.
- FIRESCOPE’s Field OPS manual, MCI section.
- National IMS Consortium Model Procedures Guide, 2008 Book 1, Multi-Casualty section with appendix
- Firefighter Life Safety Initiative 12, [www.lifesafetyinitiatives.com/12/FLSI12\\_FinalReport.pdf](http://www.lifesafetyinitiatives.com/12/FLSI12_FinalReport.pdf).
- Jones, Jeff, NIMS Field Guide, Informed, 2006.
- Swanson, Eric, Law Enforcement Field Guide, Informed, 2004.
- Glarum, Jan and Swanson, Eric, Homeland Security Field Guide, Informed, 2004.
- Federal Emergency Management Agency — Incident Management Handbook: FEMA B-761/Interim, 2009.
- FIRESCOPE California, Fire Service Field Operations Guide, ICS 420-1, Incident Command Systems Publication, 2001.
- Website for the Committee for Tactical Emergency Casualty Care [www.C-TECC.org](http://www.C-TECC.org).



- Callaway, David W., Smith, E. Reed, Cain, Jeffrey, et al, Tactical Emergency Casualty Care (TECC): Guidelines for the Provision of Pre-hospital Trauma Care in High Threat Environments, Journal of Special Operations Medicine, summer 2011, Volume 11(3): p. 1-20.
- Smith, E. Reed, Iselin, Blake, McKay, W. Scott, Towards the Sound of Shooting: The Arlington County Fire Department Rescue Task Force, Journal of Emergency Medical Services, December 2009.
- Joint Committee to Create a National Policy to Enhance Survivability From a Mass Casualty Shooting Event, Hartford Consensus, April 2, 2013.
- Joint Committee to Create a National Policy to Enhance Survivability From Mass Casualty Shooting Events, Hartford Consensus II, July 11, 2013.
- Committee for Tactical Emergency Casualty Care, <http://c-tecc.org/c-tecc-announcement-iaff-position-statements-hartford-consensus-document>.
- IAFF Position Statement, [http://www.iaff.org/Comm/PDFs/IAFF\\_Active\\_Shooter\\_Position\\_Statement.pdf](http://www.iaff.org/Comm/PDFs/IAFF_Active_Shooter_Position_Statement.pdf).
- DHS Active Shooter: How to Respond, [http://www.dhs.gov/xlibrary/assets/active\\_shooter\\_booklet.pdf](http://www.dhs.gov/xlibrary/assets/active_shooter_booklet.pdf).
- The FBI, <http://www.fbi.gov/about-us/cirg/active-shooter-and-mass-casualty-incidents>.
- Urban Fire Forum/Metropolitan Fire Chiefs Association Active Shooter Position Paper.

If you have questions regarding this white paper, please contact the  
U.S. Fire Administration.

[www.usfa.fema.gov](http://www.usfa.fema.gov)

16825 South Seton Ave.  
Emmitsburg, MD 21727