Cedarville Township Volunteer Fire Department
Dayton MMRS Regional EMS Response to Active Shooter Incidents SOG
2016

PURPOSE:

Law enforcement agencies have dramatically changed the way they respond to "active shooter" incidents. Prehospital medical response must change from waiting for the area to be declared safe in these situations. Using this plan, EMS will enter "Warm Zones" of Active Shooter Incidents (ASIs) to provide care for the wounded while under the protection of armed law enforcement officers. A review of previous incidents shows that this approach will save lives.

The Dayton Metropolitan Medical Response System (MMRS) Active Shooter Rescue Task Force (RTF) program takes the best of numerous other protocols, uses grant funds to provide protective equipment sets, and collaborates with area law enforcement agencies to provide rapid treatment for casualties in an active shooter scenario. The Rescue Task Force (RTF) concept, pioneered in Arlington, VA, has been endorsed by the International Association of Firefighters, the International Association of Fire Chiefs, and the United States Fire Administration, among other agencies.

The RTF will mitigate provider risk using procedures, training, and protective equipment, while providing for rapid stabilization, treatment, and evacuation of the wounded despite hazardous conditions that would otherwise delay treatment. This plan delineates the standing medical and tactical orders for EMS functioning as members of a unified law enforcement/EMS response to an active shooter scenario.

This is a regional plan. This Standard Operating Procedure (SOP) is disseminated to participating departments and should be modified to meet the needs of each department. Operational sections, on the other hand, need to be consistent to provide for effective functioning of Rescue Task Forces involving personnel from multiple jurisdictions.

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DEFINITIONS:

Active Shooter(s): An armed person or persons who continue(s) to use deadly force while having unrestricted access to additional victims.

Area(s): Counties or sections of counties which are the primary response groupings.

- This enables personnel from different agencies to train and exercise together.
- Each county is an Area, except for Montgomery County.
- In Montgomery County, there are four areas, Montgomery Northwest, Montgomery Northeast, Montgomery Southwest, and Montgomery Southeast, defined by Interstate 75 and US Route 35.

Casualty Collection Points (CCPs): Depending on circumstances, and at the option of Unified Command (UC), there may be up to three echelons of CCPs:

- **Warm Zone or Tactical CCP**: If there are large numbers of patients/victims that cannot be evacuated immediately, RTF members may establish a CCP inside, where the RTF is operating.
- **Extraction CCP**: A CCP may be established near an entry/exit point. Since this will most likely also be in the warm zone, it will be operated by one or two RTFs, and may be collocated with a supply depot to allow for quick re-supply and turnaround for RTFs.
- **Cold Zone CCP**: Also known as the Treatment Area, this is the standard MCI Treatment Area. It must be located in a safe area (according to available information) and should be relatively close to the Transport Area.

Cold Zone: An area where Incident Command does not reasonably anticipate a significant danger or threat to the providers or patients. The Treatment Area, command assets, and staged non-tactical Fire/EMS personnel and apparatus will be located in the Cold Zone.

Contact Teams: Teams of up to four or five law enforcement officers (LEOs) who form on arrival at an active shooter scene. The initial Contact Team will immediately deploy into the building or site, moving rapidly with the goal of containing or eliminating the active shooter to prevent further injury or loss of life.

Depending on the size of the area to be searched, the number of perpetrators, and other factors, LE may use multiple Contact Teams prior to assigning personnel for one or more Rescue Task Forces.

DWJ: department with jurisdiction. The agency in whose area the incident occurred.

Hot Zone: Any area in which there is a direct and immediate threat to persons or providers. RTF plans and training are not intended for response into a Hot Zone where active aggression is likely.

Rescue Task Force (RTF): Two RTF-trained EMS personnel in tactical PPE with two law enforcement personnel, who may operate in the Warm Zone at ASIs.

- As with LE Contact Teams, there may need to be multiple RTFs.

RTF Cache: Each cache contains four sets of RTF gear, both medical and tactical Personal Protective Equipment (PPE). One set of equipment will outfit one EMS member, so each cache provides enough equipment for two Rescue Task Forces.

RTF Cache Agency: Selected EMS agencies throughout the eight counties of Ohio Homeland Security Region 3 have agreed to maintain and respond with equipment provided by Dayton MMRS. The RTF Cache is assigned to Ambulance / Medic 11 / 13 and available for immediate response.

RTF Personnel: EMS personnel who have been appropriately credentialed and trained for RTF activities.

- Personnel are referred to (and have IDs) as either RTF Members (RTFMs) or RTF Leaders (RTFLs).
- Note, however, that the roles specific to RTFLs are primarily in the Cold Zone. Once entering the Warm Zone, the RTF personnel function as partners, since their interior roles are rapid triage and life saving interventions. In fact, an RTF may be comprised of two RTFMs or two RTFLs; it doesn't change the tasks.

SWAT team: Special Weapons and Tactics team. Officers specially selected and trained to perform high-risk operations that fall outside the capabilities of regular patrol officers.

Warm Zone: An area where the potential for hostile threats exist, but the threat is not direct and immediate. This is the main zone of operations and staging for RTF personnel.

BACKGROUND:

Columbine in 1999, Virginia Tech in 2007, Mumbai in 2008, Fort Hood in 2009 are just a few of the ASIs that we have studied. In 2012, more were added: Aurora, CO, Oak Creek, WI, and Newtown, CT, and still more in 2013.

The number of incidents involving active shooters – defined for our purposes as an armed person who continues to use deadly force while having unrestricted access to additional victims – has increased dramatically. Since 1966, there have been over 200 active shooter events in the US with a total of 600 dead and 700 wounded. Over 200 deaths have been caused by active shooters in schools in the past 25 years. They occur in urban, suburban, and rural settings.

Following the shootings at Columbine and other incidents, police response to these situations underwent a paradigm shift. In many, if not most, agencies, law enforcement (LE) personnel are trained to respond aggressively to immediately pursue, establish contact with, and stop the shooter. Rapid response and takedown results in fewer casualties.

However, emergency medical services (EMS) response to active shooter situations in most areas has not followed suit. Often, the current fire/EMS response to the active shooter is to stage in a secure location until police mitigate the threat and secure the area. Unfortunately, securing such a complex scene can take hours. When EMS is waiting outside, casualties are not receiving care.

The often quoted statistic that ASIs are over within seven minutes is misleading. In the majority of those incidents (even including Newtown), uncertainty over who the shooter was, whether there were additional perpetrators, and whether IEDs or other hazardous devices existed, extended much longer than seven minutes, and those issues frequently delayed or impeded rescue and medical care.

Agencies in Colorado, Virginia, Kentucky, North Carolina, California, and other locations have developed protocols to provide a more rapid response. While entailing some new risk for EMS, this type of response fits within the typical fire and EMS risk management paradigm:

- Accept no significant risk when no lives or property can reasonably be saved at an emergency incident.

- Accept some limited level of risk, within normal operational procedures, when it is likely that lives or property can reasonably be saved.
- Accept a significant amount of risk, again within operational guidelines, when it is likely that a life can be saved.

TRAINING:

Personnel Selection:

- Participation in this optional RTF protocol requires the following five things:
  1. Formal agreement by the EMS agency to permit specifically identified personnel to participate. All personnel costs remain the responsibility of the participating EMS agency. Payment and reimbursement for training, exercises, and actual incidents are handled in accordance with the departments' normal procedures.
     - With input from line officers, the Fire Chief will select personnel and submit names, EMS certification level and number, and contact information to Dayton MMRS.
     - In the event of an RTF activation, individual RTF members will be notified by the Montgomery County Regional Dispatch Center (RDC).
     - When activated, RTF trained members will respond the station and staff Ambulance / Medic 11/ 13 for response. If only 1 driver available, the cache from both apparatus will be placed on the same unit.
     - Worker's compensation, injury policies, insurance, and related issues are covered by the CTVFD, as covered by the Greater Dayton Area Mutual Aid Agreement.
  2. Voluntary participation agreement on the part of EMS personnel. Both the agency and the individual must agree, or they may not be a member of the Rescue Task Force (RTF).
  3. Appropriate Ohio EMS certification, RTF members can be EMRs, EMTs, A-EMTs, and/or Paramedics with current status on Greater Miami Valley EMS Council Standing Orders.
  4. Completion of defined RTF training.
  5. Completion of biennial refresher training on RTF operations, procedures, and equipment.
- RTF personnel will each be issued either an RTF Member (RTFM) or RTF Leader (RTFL) ID.
  - RTFM personnel are those meeting the five criteria above who have been approved and entered into the Greater Miami Valley EMS Council's (GMVEMSC) Standing Orders Database as RTFs.
  - RTF Leaders (RTFLs) meet the standards above plus the following:
    - Completion of at least ICS-100, 200, and 300
    - Strong communications skills.
    - Command/leadership experience in fire/EMS agencies
    - Recommendation by their home agency.
    - Instructional experience (e.g., as an EMS Instructor) will be viewed positively when selecting RTFLs.
    - Approval by Dayton MMRS "Mumbai Committee" EMS Work Group.
    - Entered into the GMVEMSC Standing Orders Database as RTFLs.
- In addition, Rescue Task Force Instructors (RTF-Is) are individuals who have completed Dayton MMRS-sanctioned instructor training.

- RTF-Is must either hold EMS certification as an EMT, Advanced-EMT, or Paramedic or be physicians.
- RTF-Is must meet the standards above, and maintain either an RTFM or RTFL card.
- RTF-Is are authorized to conduct the required live RTF trainings, and notify Dayton MMRS of students' training completion and eligibility as an RTFM (provided all other requirements are met).

RTF Personnel Training Components:

- Eight online videos and tests
- Four hour live training
- Topics covered include:
  - Program Overview
  - LE procedures and expectations
  - Modified/abbreviated Tactical Emergency Casualty Care (TECC) training
  - Regional MCI Plan
  - RTF protocol
- Refresher training every two years
- Continuing Education credit will be provided for all RTF training and refresher training.

Drills and Exercises

- Exercises and drills will be organized and provided as often as possible.
- You are encouraged to participate in local drills (schools, hospitals, businesses, LE, etc.) at every opportunity.
- You are strongly encouraged to participate in multidisciplinary (LE, fire, and EMS) and multijurisdictional exercises and drills at every opportunity. ASIs will always involve mutual aid responses for both law enforcement and EMS.
- Whenever possible, involve Law Enforcement personnel in IC/UC.
- Whenever possible, improve interdisciplinary communications and relationships with LE.
- Some consumable supplies are available from Dayton MMRS for trainings, drills, and exercises.

Awareness Training: Fire and EMS Personnel

- A training video and Job Aid will be provided for Fire and EMS personnel other than those in the RTF.

Awareness Training: Law Enforcement Personnel

- A training video and handout materials will be provided for area law enforcement.
- Suggested additional language for LE SOPs discussing RTFs will be provided to agencies.
  - Emphasis will be placed on the expectations for LE personnel assigned to RTFs.
  - Emphasis will also be placed on the importance of maintaining an LE focus (ignoring victims) until there is absolute certainty that all perpetrators have been contained.

Awareness: Dispatch Personnel

- A Job Aid will be made available for public safety dispatchers

EQUIPMENT: Tactical Equipment:

- Level IIIA Tactical Vest
  - Large amount of overall chest and back coverage
    Adjustable in size to fit multiple medics
  - Identification with Dayton MMRS patch, and Rescue TF patch on front and back
- Level IIIA ballistic Helmet
  - Lightweight with high-cut back for greater range of motion
  - Four-point harness to prevent helmet from sliding over eyes during casualty care, maintains helmet securely in place on rescuer's head during casualty care.

Medical Equipment (MedKit Inventory):

- Each task force member carries a MedKit equipped with enough supplies to treat multiple casualties, depending on injuries, including:
  - Blackhawk Rapid Flex Medical Litter 1
  - Triage Ribbon Kit attached to Bail Out Bag 1
  - Nalgene Bottle 1
  - HeadLamp and 3-AAA batteries (Spare) 1
  - Duct Tape 15 Foot Folded Strips 2
  - Sharpie Pen 1
  - Grease Marker 1
  - CAT Tourniquets 4
  - Red Light Sticks 2
  - Blue Light Sticks 2
  - Green Light Sticks 2
  - LG Nitrile Gloves 10 pair
  - Alcohol Preps 30
  - Nasopharyngeal Airways 20FR 2
  - Nasopharyngeal Airways 36FR 2
  - 4X5 Elastic Wraps 6
  - 4.5" Sterile Kerlix Dressings 12
  - HyFin Vented Chest Seals 4
  - Abd Pads 8X10 4
  - ARS Decompression Needles 4
  - LA Police Gear Bail Out Bag w/shoulder strap held by two carabiners 1
  - Trauma Shears on Vest with Retractor 1
  - Pouch on Vest with 15' of 1" Tubular Webbing 1

PROCEDURES:

Notification and Response:

PSAPs and Dispatch Centers:

Each public safety dispatch center in Ohio Homeland Security Region 3 will be provided with a brief protocol for the RTF. In the event of an active shooter situation, the dispatch center (either on their own initiative or as directed by personnel on scene) will activate the RTF by calling the Montgomery County Regional Dispatch Center (RDC) at 937-333-USAR (8727).

- Dispatch centers are authorized to request mutual aid, including the RTF, as soon as possible, without prompting from the field.
- Command can also request the RTF at any time, including for other types of incidents. Because of equipment and training, the RTF may be considered for response to incidents including IED or other WMD incidents, civil disturbances, downed officer tactical responses and others.
- Jurisdictions can request that an RTF be pre-staged to stand by at large or high risk events. Such events should include communications with law enforcement and other EMS, so that the event also functions as an RTF exercise. Standbys should be coordinated directly with departments in your jurisdiction, or you can call Dayton MMRS for assistance.

Regional Dispatch Center has the following responsibilities:

- Maintain a list of RTF equipment cache locations and activation numbers.
- Maintain a list of active RTF personnel and activation numbers.
- On receipt of a request for RTF, RDC will take the following actions:
    - IMMEDIATELY notify (at a minimum) the nearest three equipment cache agencies to respond to the scene on an emergency basis as a mutual aid request from the department with jurisdiction (DWJ).
    - Notify RTF members in the RTF Area of the DWJ and at least one adjacent RTF Area (selected by RDC) to respond.
    - Activate additional equipment caches and RTF personnel as needed or requested.
    - When feasible, RDC will notify the command staffs of involved agencies (i.e., all agencies in the RTF Areas with personnel or caches activated).

Response:

- When activated, RTF trained members will respond the station and staff Ambulance / Medic 11/ 13 for response. If only 1 driver available, the cache from both apparatus will be placed on the same unit.
- Within those guidelines, an RTF activation will be considered a mutual aid request, and personnel will respond on that basis. Emergency response is not authorized unless the vehicle is equipped to Ohio Revised Code standards.
- Arriving RTF personnel and caches will report to Staging.
- First arriving RTFL will meet with Command:
    - All RTF personnel will report to Command directly or through the RTFL.
        - At no time will free-lancing of RTF personnel be permitted.

- RTFL will ensure that Command is aware of the presence of the RTF and its capabilities.
- RTFL will form RTFs as EMS and LE personnel and RTF equipment become available. If feasible, RTF composition should include an ALS provider.
- RTFL will establish a Communications Plan for the RTF.
    - Consider radio equipment, radio channels/talkgroups, who teams report to via radio, emergency procedures, etc. See onsite communications section, below.
    - Recognize that there is a sensory overload point when people simply stop hearing the messages. Repeat messages, ask for read-back, and consider deploying runners for critical information.
    - Determine what the evacuation signal is in the DWJ, and inform all RTF personnel.
- RTFL will discuss the location for staging area for RTF location and personnel.
    - RTFL will notify RDC to send an update page to all responding personnel and caches advising them of the staging location.
- RTFL will discuss with Command options:
    - Request additional RTF personnel or equipment caches through RDC, or
    - Advise RDC to send a cancel page, telling personnel that have not yet arrived that they are no longer needed.
    - If the RTFL is deployed as an RTF team member, a later arriving RTFL will report to UC team.
    - As additional RTFLs arrive, maintaining one in the IC/UC can be invaluable.
    - Among other things, an RTFL at the IC/UC should develop accountability for all RTF personnel on scene.
- Non-RTF EMS personnel should not generally enter warm or hot zones.

<u>On-site Communications:</u>

- Radio equipment will typically be brought by responding RTF personnel, but in the event those radios are not available or not compatible with the DWJ's radios, the RTF may need to borrow equipment at the site.
- RTF team communications may function on different radio channels with RTF LEOs communicating with one Branch, and RTF EMS personnel communicating with another Branch.
- Communications within a single RTF are typically face to face.
- In any case, it is important to relay information to IC/UC such as:
    - RTF location within the building
    - Number of casualties and injuries
    - Updates on location of the injured, the activities of LEO contact teams, and possible threats.

    - This allows for accountability and effective use of the teams as well as for planning and management of both the external casualty collection point and additional EMS resources.
- Nearly any incident of this type will require multiple RTFs. Assign each RTF a number as they are formed (e.g., RTF-1, RTF-2, etc.).
- RTF members must be aware that LE uses different nomenclature for building descriptions than Fire/EMS (Side 1 vs. A side).
- Given the number of different disciplines and agencies responding to such incidents, it is crucial that ALL communications be in plain language.
- Communications from an RTF to Command are typically via the LE personnel.

Law Enforcement Response to Active Shooter Incidents

- This plan is predicated on LE responding aggressively, with the initial responding officer(s) immediately making entry (ideally in three- or four-person Contact Teams).
- There may be multiple Contact Teams used, especially in large, complex settings.
- Contact Team officers move quickly through unsecured areas, bypassing the dead, wounded, and panicked citizens with the single goal of engaging and eliminating the active threat by "moving toward the sound of shooting."
- Work with other responders on scene, activate UC/IC, and develop unified objectives.
- Call for additional resources: law enforcement, EMS, and the RTF.
- Entry officers relay reconnaissance information, including data about victims, to UC/IC. This will help RTF quickly and easily locate casualties.
- Assign two armed and equipped law enforcement officers (LEOs) to accompany each RTF.
- LE personnel should not become engaged, in any degree, in care or movement of victims, until it is confirmed by UC that all perpetrators have been contained.

Supervision:

- ASIs necessitate close coordination of LE and EMS personnel in a high hazard environment.
- It is incumbent upon supervisors to form Unified Command as quickly as feasible, including LE, EMS, and other appropriate disciplines.
- Command or Unified Command will support RTF entry by assigning personnel and communications, working with RTFLs on scene.
- RTF supervision will function primarily within Incident Command/Unified Command (IC/UC), and provide liaison and communication for RTF entry teams.
- Any scenario that warrants RTF activation should have a Unified Command (UC) with law enforcement, EMS, and other disciplines as needed, as quickly as feasible.
- Any scenario that warrants RTF activation demands notification of the region's hospitals, whether you expect them to receive patients or not. Use the Regional Hospital Notification System by calling (or having dispatch call) 937-333-USAR to keep hospitals apprised of the situation.

- Request activation of the local Emergency Operations Center (EOC) through Command for long-term multiagency response, recovery, investigative, and support efforts.
- Recommend that Command establish a joint information center (JIC) involving all key agencies and players to manage media efforts.
- Recommend that Command consider family assistance centers (FACs) near the site and in other locations.

RTF Procedures

- Authorization for entry must be obtained from law enforcement (preferably via UC).
- Entry into Active Shooter scenes should not occur until RTF personnel have the appropriate protective equipment (PPE from an RTF Cache) and Law Enforcement escort.
- Subsequent RTFs, with the goal of evacuation and (possibly) initial treatment, will be established as additional personnel arrive.
- The RTF will typically deploy after law enforcement initiates entry with a contact team or teams. Risk is decreased, even though the scene is not completely secure.
- IC/UC must authorize entry of RTF.
- Each RTF is comprised of two RTF-trained EMS personnel equipped with RTF tactical PPE and medical gear, and two law enforcement officers (LEOs).
- LEOs provide security, while medics attend to casualties. The goal is to get medical resources to patients within minutes of being wounded while continuing to mitigate RTF risk.
- Our region has a number of physicians who are SWAT-trained and have ballistic equipment. Others will be trained as RTF personnel by taking the RTF online training. Roles for those physicians at ASIs may include entry with an RTF, or outside medical direction. Within an RTF, EMS personnel are not to defer to the physician. The same TECC procedures apply to all RTF personnel.

Procedures for LE Officers Assigned to an RTF

- The roles of a LEO assigned as a member of an RTF are security and coordination of team movement only.
- LEOs assigned to RTFs will not assist in lifting, carrying, or treatment of any patient until it is confirmed by UC that all perpetrators have been contained.
- Safety of the RTF is the primary concern for those officers, including searching for other secondary threats (e.g., IEDs, tripwires).
- One LEO will have 180 degree front security and the other 180 degree rear security.
- The front LEO will communicate with Police/Unified Command. All movement in the building should be directed by Police/Unified Command. This allows for accountability of each RTF team, and precludes accidental entry into hot zones.
- At no time will the RTF LEOs ‘freelance’ or move outside of their directed destination/area of operation.

- At no time will LEOs assigned to an RTF leave the EMS personnel further than close direct line of sight.
- LEOs must be able to provide effective defensive cover fire for RTF at all times.
- The RTF will move as a team, with the LEOs controlling the speed of movement.

Entry

- An RTF may approach the scene in a vehicle such as an ambulance or tactical vehicle, on foot, or by other means as directed by UC/IC.
- RTF ingress and egress corridors will be designated by UC, and RTFs will move in and out of the building only through entrances and corridors primarily cleared by LE Contact Teams.
- The first one or two RTFs that enter the building or site move deep inside to stabilize as many casualties as possible before any victim is evacuated.
- As victims are reached, the RTF LEOs provide security while the medics treat the casualties. RTFs stabilize only immediately life-threatening wounds on each casualty they encounter, but leave casualties where they are found and move on.
- Emphasis is on treatable immediate life threats. Casualties are treated in place, and the RTF moves on.
- Walking wounded and uninjured individuals are directed to exits away from the direction of shooting, if it is reasonably safe to do so. Communications with UC concerning this **are essential**.
- Additional RTFs are formed as personnel and equipment caches arrive on the scene, and enter the building as directed by UC.
- A supply depot will be set up near a secured entry point to allow for quick re-supply and turnaround for RTFs. This area may also serve as the Extraction CCP.
- RTF personnel must be aware of surroundings, potential threats such as IEDs, and open routes of rapid egress.

SCAB-E MEDICAL TREATMENT PROTOCOL

- RTFs when functioning in the WARM Zone will only provide stabilizing treatment, primarily following TECC and the SALT Triage Life-Saving Interventions (LSIs).
- Airway control is not first priority. Exsanguinating extremity wounds are more common in active shooter situations, and a person can bleed to death from a large arterial wound in just two to three minutes. Life-threatening bleeding is addressed first, followed by airway control. Open chest wounds and tension pneumothorax are addressed third, following the Circulation-Airway-Breathing sequence (CAB).
- Tourniquets are emphasized and prioritized as a quick and effective method to control extremity hemorrhage.
- For non-exsanguinating hemorrhage, mechanical pressure dressings with wound packing are used. Some wounds, including those in the femoral triangle or in the neck, are not amenable to tourniquets.

- All patients within a reasonable geographic area, not more than earshot of a quiet voice and direct line of sight from the RTF, will be rapidly triaged using SALT triage, applying triage ribbons to indicate their status (including ribbons for deceased victims to prevent teams from wasting time re-triaging them).
- Each RTF will place triage ribbons on patients they encounter. In general, if a patient warrants assessment, the patient warrants a ribbon (RTFs need not, for example, place ribbons on persons able to walk out). In particular, patients with significant medical issues should be ribboned. It is especially important to place ribbons on patients triaged to Black, to avoid having other RTFs waste time retriaging such patients. That said, when the situation demands immediate medical action, performing LSIs always has the highest priority.
- **S** – **Maintain Situational Awareness**:
  - Be aware of surroundings, potential threats such as IEDs, and always maintain open routes for rapid egress.
  - Be constantly mindful of the possibility of multiple attackers, or the potential for an attacker to circle around and turn your warm zone into a hot zone.
  - Ambulatory patients should be directed to evacuate the area down corridors used for RTF ingress.
  - Non-ambulatory patients should be medically stabilized and either evacuated or placed in proper position while awaiting evacuation.
  - Understand the difference between cover and concealment, and consider appropriate tactical positioning in case the team should come under fire.
  - Consider the need for forcible entry equipment.
  - Consider the possibility of a chemical or IED threat at the scene (and at other related scenes, e.g., the perpetrator's home).
- **C** – **Circulation** – Assess for and treat life threatening extremity bleeding
  - Direct pressure on the proximal brachial or femoral artery should be immediately applied by kneeling on the artery with body weight. This allows for both hands to be free to apply the intervention.
  - Tourniquets are to be placed immediately on extremity wounds including total or near-total amputations, large vessel arterial bleeding, massive vessel venous bleeding, and any wound with bleeding that cannot be adequately controlled with a pressure dressing
  - Mechanical pressure dressings may be applied for anatomically amenable extremity wounds.
  - Deep wounds should be packed with gauze to transmit pressure deep into the wound to site of bleeding.
- **A** – **Airway**
  - Any patient with an occluded airway or altered mental status will have a nasopharyngeal airway placed.
  - Place victim in any position that best protects the airway, including seated.

- **B** – **Breathing**
  - Assess for any open or sucking chest wounds, and place an occlusive chest seal to any trunk wound (anterior or posterior) from the umbilicus to the trapezius muscles.
  - Assess for and treat tension pneumothorax.
- **E** – **Evaluate and Evacuate**
  - Assess effectiveness of applied interventions and initiate evacuation.
  - Check tourniquets and pressure dressings for adequacy.
  - Assess for unrecognized hemorrhage.
  - Reassess for respiratory distress and proactively treat if present.
  - Roll patient and examine posterior for injury.
  - Place conscious patient in position of comfort and unconscious patient in recovery position while awaiting evacuation.
  - If adequate supplies remain and there are untreated patients further in the building, RTF should continue into the building toward those patients, remaining in the Warm Zone.
  - If no supplies remain or all patients are treated, initiate evacuation to a CCP according to triage categories, using appropriate patient movement technique. Evacuate to CCPs, and as feasible, communicate with the CCPs or Triage.
    - Within the same triage category, public safety personnel should receive priority assessment and evacuation since they may not fully comprehend the extent of their injuries.
  - The four members of the RTF, including LE members, remain together during egress.

Patient Evacuation

- Communicate with Unified Command, advising of team status and patient information.
- Once RTF medics are out of supplies, they begin to move out of the building, evacuating treated casualties.
- Additional RTFs can either be tasked with the primary mission of evacuating stabilized casualties, or with moving further into the building in a "stabilizing but not evacuating" mode to take over for the initial RTFs that have run out of supplies and begun evacuation.
- If needed, a Warm Zone CCP may be set up within the building, or an Extraction CCP set up near a secure exit point, where casualties can be grouped to allow for faster and more efficient evacuation. Both should be staffed by RTF-equipped and trained EMS personnel.
- Standard triage, treatment, and transport areas must be established far enough away from the scene to afford protection to casualties and medical personnel. Following the Dayton MMRS Regional MCI Plan, utilize a single Transport Supervisor if at all feasible to ensure appropriate hospital allocation.

- Patients will be moved from the scene to the triage location by ambulance or other means. Once triaged, patients should be moved to the treatment and transport areas as necessary and treated and transported as rapidly as resources allow.
- RTFs may consider establishing an internal, Warm Zone (tactical) CCP in a hardened area approved by LE Command.
- RTFs may also consider establishing an Extraction CCP to serve as a temporary way station at the location of the external RTF supply depot.
- Victims will be evacuated as quickly as feasible and safe to the Treatment or Transport Areas operated by non-RTF EMS personnel and located in the Cold Zone.

Emergency Evacuation Procedures

- If the Zone in which the RTF is operating changes from Warm to Hot due to a direct and immediate threat, immediate evacuation of the RTF will occur according to direction from the RTF LE element or UC.
  - This may include partial or complete evacuation of the RTF from the building.
- If any member of the RTF is injured during operations, immediate evacuation of the RTF will occur.

Secure Scene

- Once it is determined by UC that the scene is secure (i.e., all perpetrators are under control and there is no risk of secondary threats), RTF procedures will cease. The scene will revert to standard MCI procedures (in accordance with the Regional MCI Plan) using all available EMS personnel for treating and transporting patients regardless of location.
  - However, remember that RTF personnel have likely learned more about issues with ASIs than most personnel on the scene, and their advice and assistance will be invaluable even after the threat has been eliminated.

DISCUSSION:

This response must be clearly differentiated from typical violence calls. This plan is also not to replace Tactical EMS (TEMS) or SWAT Medics. These procedures are specifically designed for dynamic scenarios where violence and the risk to casualties are ongoing or for other high-risk situations where care would otherwise be substantially delayed.

Approved:

_____ Date: _____

Kyle E. Miller
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