White Paper for the Integrated Public Safety Response to the
Active Shooter/Active Assailant

Prepared by:
The North Carolina Active Assailant and Mass Violence Work Group

In cooperation with:
The North Carolina Department of Justice
The North Carolina State Bureau of Investigations
The North Carolina State Highway Patrol
The North Carolina Division of Emergency Management
The North Carolina Office of Emergency Medical Services
The North Carolina Office of the State Fire Marshal
The North Carolina Chapter of the Association of Public Safety Communications
The North Carolina Chapter of the National Emergency Number Association
The Department of Homeland Security

January 20, 2017

Version 1.0
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Executive Summary

The threat of active shooters and active assailants continues to increase in the United States. Multiple agencies in North Carolina recognized the importance of planning and preparation for these types of incidents. Various agency leaders determined the need to define common response concepts to aid in operational continuity. The complexity of active assailant incidents demonstrates that mutual aid response is frequently required to mitigate these incidents with minimal loss of life. Optimal success at active assailant incidents requires a common response plan.

Recent active assailant attacks and numerous after-action-reports demonstrate that previous response models continue to result in unnecessary loss of life. Research from previous active shooter incidents demonstrates that half of the injured victims will have moderate to severe injuries\(^1\)-\(^2\). Additional data demonstrates that 67% of these injured victims will die if they do not receive basic medical care within 30 minutes of the injury\(^3\). Multiple research studies demonstrate that victims continue to die needlessly at active assailant incidents because of delays in point-of-wounding care, extraction, treatment, and transport\(^4\)-\(^5\).

North Carolina emergency responders have recognized that a new, aggressive response model is necessary to reduce death and serious injury at these incidents. This new model complements the North Carolina law enforcement rapid deployment model (REDS) and adds the rapid treatment and extraction of injured victims. The rescue task force (RTF) concept is a nationally recognized response model that integrates fire department and EMS providers with law enforcement officers to provide rapid care for active shooter victims. The RTF operates with law enforcement security to render care to victims in areas adjacent to potential hostile activity. The RTF model is scalable depending on the available resources, as well as the size and complexity of the incident.

An established, multi-disciplinary team consisting of numerous North Carolina public safety responders and subject matter experts spent more than three years to create this best practices document. Representatives from law enforcement, the fire service, emergency medical services, emergency management, 9-1-1 communications, military installations, airports, universities, intelligence analysts,

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the Department of Homeland Security, and the Committee for Tactical Emergency Casualty Care all provided input on this paper.

This document is based on best practice recommendations from professional and government organizations, including the International Association of Chiefs of Police, the International Association of Fire Chiefs, the International Association of Fire Fighters, and the Department of Homeland Security. Multiagency planning, preparation, and training are critical for successful response. This document provides a basic guideline for agencies to develop or modify their active assailant response protocols. This document does not replace or supersede individual agency policies or procedures. It is imperative for each agency, jurisdiction, and municipality to create a response plan that will maximize available resources to successfully mitigate these incidents.

There exists no “cookie-cutter” template for active assailant response, and each jurisdiction must develop a plan that fits the needs and abilities of the community. On behalf of the North Carolina Active Assailant/Mass Violence Work Group, we hope that you will find this document to be a useful adjunct in planning and preparing for an active assailant response in your community.

Sincerely,

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Work Group Chair

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Chair, Fire Service Subcommittee

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North Carolina State Emergency Response Commission

The North Carolina State Emergency Response Commission unanimously passed the resolution on April 21, 2017 recommending that North Carolina public safety agencies utilize this document to enhance agency response to active assailant events. The following are duly sworn members of the Commission:

Public Safety Secretary Erik Hooks, North Carolina Department of Public Safety

Director Mike Sprayberry, North Carolina Division of Emergency Management

Director Robert Schurmeier, North Carolina State Bureau of Investigations

Colonel Glenn McNeill, North Carolina State Highway Patrol

Major General Gregory Lusk, North Carolina National Guard

Chief Thomas Mitchell, North Carolina Office of Emergency Medical Services

State Fire Marshal Michael Causey, North Carolina Office of the State Fire Marshal

Chief Eddie Buffaloe, North Carolina Association of Police Chiefs

Director Jerry VeHaun, North Carolina Emergency Management Association

President Kevin Staley, North Carolina Association of EMS Administrators

Honorable William Schatzam, North Carolina Sheriff’s Association

Chief Cecil Martinette, North Carolina Association of Fire Chiefs

Secretary of Transportation James Trogden, North Carolina Department of Transportation

Branch Head Dr. Julie Casani, North Carolina Department of Public Health

Director Fleda Anderson, North Carolina Department of Labor

Coordinator Christopher Raynor, North Carolina Community College System

Chief Deputy Secretary John Nicholson, North Carolina Department of Environmental Quality

Director Maria Thompson, North Carolina Department of Information Technology

Mr. Larry Perkins, International Association of Venue Managers
RESOLUTION

NORTH CAROLINA EMERGENCY RESPONSE COMMISSION

We the North Carolina Emergency Response Commission (Hereinafter “Commission”), organized and existing under the laws of North Carolina and Executive Order of the Governor, hereby certify that the following is a true copy of a resolution adopted by the Commission at a meeting convened and held on April 21, 2017 at which a quorum was present and voting throughout and that such resolution is now in full force and effect and is in accordance with the provisions of the by-laws of the Commission.

BE IT RESOLVED:

That there was authored by the North Carolina Active Assailant and Mass Violence Work Group a White Paper for the Integrated Public Safety Response to the Active Shooter/Active Assailant dated January 20, 2017; and

BE IT RESOLVED:

The Commission recommends that state/local law enforcement, emergency management, and first response agencies use this document in a complementary manner as well as other guidance and suggested best practices to enhance prescribed training and protocols already in place by those agencies. The goal of using this document and other resources is to develop the appropriate response to potential active assailant and other incidents of mass violence in their communities.

Approved by the North Carolina Emergency Response Commission this 21st Day of April 2017.

Chair

Vice-Chair
North Carolina Agency Support

In addition to the State Emergency Response Commission, the following have endorsed this paper:

James Winslow
Tripp Winslow, MD; North Carolina State EMS Medical Director

Brent Myers
Chair Brent Myers, MD; North Carolina Chapter of National Association of EMS Physicians

Douglas Scot Brooks
President Scot Brooks, North Carolina Emergency Management Association

Jeryl Anderson
President Jeryl Anderson, North Carolina Chapter of the Association of Public Safety Communications

Lisa Reid
President Lisa Reid, North Carolina Chapter of National Emergency Number Association
Definitions

Active assailant: An active assailant is an armed person(s) who uses any type of weapon to inflict serious harm and/or deadly physical force on others in public and continues to do so while having access to additional victims. Examples of active assailant attacks include an active shooter incident, mass stabbings, explosives, vehicle-as-a-weapon, fire-as-a-weapon, and so forth. (These are also known as active shooter events, hostile incidents, mass violence attacks, rampage violence, spree killings, and so forth.)

Casualty collection point: A casualty collection point is a location where providers can assemble victims for basic treatment of life-threatening injuries while awaiting extraction from the crisis site.

Cleared: Cleared is an area in which law enforcement has conducted a rapid, protective sweep and no obvious threats are identified, or obvious threats have been neutralized. Victims may or may not be present in a cleared area.

Cold zone: The cold zone is an area surrounding an active assailant incident in which law enforcement has determined that there are no suspects or any other threats, including the presence of explosive devices.

Contact team: A contact team is a law enforcement officer or officers who proceed immediately into an incident with the goal of rapidly identifying, locating, isolating, containing, and neutralizing the perpetrator(s).

Crisis site: The crisis site is a geographical area at an active assailant incident where civilians and responders have a significantly increased risk of danger from violent actions committed by the perpetrator or perpetrators.

Direct-to-threat: Direct-to-threat is the action of law enforcement officers to quickly advance towards the perpetrator(s) with the immediate goal of stopping the perpetrator(s).

Direct threat care: Direct threat care is gross hemorrhage control provided to a victim when there is a direct threat of hostile activity. The goal of direct threat care is to immediately remove the victim from the hostile action.

Hot zone: The hot zone is an area surrounding a hostile incident where there is a clear and present danger from a perpetrator(s) or other deadly threats.

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Many definitions recognize an active shooter incident as one in which three or more people are shot in the absence of gang or drug activity, or in the commission of secondary crime (such as a bank robbery).
**Indirect threat care:** Indirect threat care is care provided to a victim when there is no direct threat, but there is a potential threat of engagement or reengagement by hostile forces.

**Medical director:** The medical director is a physician with oversight of an agency’s prehospital medical care as defined by North Carolina Administrative Code, 10A NACC 13, Sections .0101 and .0400.

**Point-of-wounding care:** Point-of-wounding care is the care for victims at their initial point of injury.

**Rescue task force:** The rescue task force (RTF) is an integrated group of medically trained responders and law enforcement officers who quickly enter into the warm zone to provide point-of-wounding care and rapid extraction of victims to safety.

**Tactical evacuation:** Tactical evacuation is the concept of providing rapid and secure extraction of a victim in a hostile environment to an appropriate level of care.

**Triage/Treatment/Transport location:** The triage/treatment/transport location is typically in the cold zone where triage, treatment, and transport of injured victims will occur. This is an area in which ambulances are available to transport victims.

**Secured:** A secured area is an area in which law enforcement has conducted a thorough search and threats are not found or have been neutralized. Law enforcement will maintain a continual security presence in a secured area.

**Unified command:** The unified command organization consists of a single incident commander with supervisory personnel from each responding agency. The unified command will allow the responding agencies to develop common objectives and strategies, share information, and maximize available resources.

**Warm zone:** The warm zone is an area where there are no direct or immediate threats, but a potential threat can exist or emerge.
Purpose and Scope

The threat of active assailants is a problem that faces communities large and small. North Carolina is not immune to the threat, as several towns and cities in the state have had active assailant incidents. The State of North Carolina recognizes that active assailant incidents are a real threat facing every community. Regardless of size and capacity, every public safety agency must plan and prepare to respond to these types of incidents. Active assailant incidents are not limited to large cities. Ninety-eight percent of active shooter incidents in the United States have occurred in jurisdictions served by a police department with 100 or fewer officers7.

Law enforcement officers focus on rapid response and immediate neutralization of the threat(s). However, the law enforcement response comprises only a part of the solution at active assailant incidents. The six highest active assailant victim incidents since 2000 happened despite law enforcement arriving on scene in less than three minutes8. Multiple research studies demonstrate that victims continue to die needlessly at active assailant incidents because of delays in point-of-wounding care, extraction, treatment, and transport9,10,11.

The Department of Homeland Security, the Federal Emergency Management Agency, the International Association of Chiefs of Police, the International Association of Fire Chiefs, the International Association of Fire Fighters, the National Fire Protection Agency, and the Hartford Consensus have all published best practice papers that state that law enforcement, fire personnel, and emergency medical services personnel must have an aggressive, integrated response plan to ensure optimal victim survivability at active assailant incidents. This document provides best practice guidance for the development and implementation of comprehensive, interagency strategies to reduce potentially preventable mortality during active violence incidents. Optimal survivability is dependent on integrated public safety response to these incidents.

The goal of this document is to provide guidance and share best practices to agency officials regarding planning, training, and response to active assailant incidents. This document provides recommendations on all phases of active assailant response, and includes responsibilities for all public safety disciplines. The recommendations in this document are scalable to allow variations for agencies, and to provide a

consistent recommendation across North Carolina. This document is not intended to replace, override, or limit any agency response procedure. The Work Group encourages agency officials to use this document to assist in creating, modifying, or maintaining current active assailant response procedures.

**Stakeholders**

The Work Group recommends that every community in North Carolina identify specific agencies and stakeholders responsible for community planning and response to active assailant incidents. At a minimum, the following stakeholders should create the community’s unified active assailant response plan:

- Local, state, and federal law enforcement
- Jurisdictional and county EMS agencies
- Local fire departments and rescue squads
- Local and state emergency management
- Local 9-1-1 dispatch and communications agencies
- Military installations
- Tribal jurisdictions

In addition, other community stakeholders should provide input and assist with guidance on the policy as needed. These stakeholders may include elected officials, educational institutions, healthcare facilities, malls, local businesses, airports, and any other high-risk facility or infrastructure that represents a potential for a high loss of life.
Unified Incident Command

As introduced above, optimal survivability during active assailant incidents is dependent upon integrated interagency response. While reviewing each of the public safety section reports below, consider that the utilization of unified command is essential to the success of any large-scale incident, including active assailant incidents. Incident command often is one of the most challenging aspects of any multi-agency response. Responders must use the appropriate National Incident Management System (NIMS) terminology and structure to ensure efficient communication between agencies and accomplishment of shared tasks.

Public safety leaders need to recognize and address challenges to implementing NIMS structure during active assailant incidents. There are three specific challenges that responders will face with the incident command system at active assailant incidents. Responders have faced these challenges at actual incidents and large-scale active assailant exercises.

First, the dynamic speed is an inherent and natural component of these incidents. Approximately 70% of active shooter incidents end in five minutes or less with approximately 25% of incidents over in two minutes. The average active shooter incident lasts three minutes and 70% of incidents are over before arrival of the first police officer. Therefore, the challenge is overlaying an incident command structure on top of a dynamic, ongoing incident. The incident command structure must be flexible to rapidly change tactical priorities as the incident unfolds.

Second, the major challenge to NIMS structure implementation may be establishing immediate interoperable communication both between and within responding agencies. Law enforcement (and possibly other agencies) may have personnel already responding inside a developing scene, as well as arriving concurrently. Establishing usual lines of communication within responding agencies may be chaotic, in addition to establishing communication across agencies.

Third, law enforcement, fire personnel, and EMS personnel all have critical responsibilities to perform at these incidents. The law enforcement agency having jurisdiction is ultimately responsible for the command and control of an active assailant incident. However, the law enforcement agency may not be the ideal lead agency to provide command and control during firefighting operations or victim extraction and care. A functional unified command system allows appropriate agencies to command the incident when their agency expertise is required. Figure 1 provides a description of a typical incident command model at an active assailant incident. The unified incident command is making decisions utilizing each public safety specialty.

13 Ibid.
Despite the challenges of a unified incident command, establishing unified command with all responding agencies is essential for scene organization, safety, and efficiency. Unified incident command functions best when the agency leaders are all physically present and standing next to each other at the command post. The first arriving supervisors from the respective response disciplines must develop and implement unified command as early as possible in the incident. For example, an initial challenge is the staging of incoming units. During the Aurora, Colorado incident, 55 police vehicles were on site within 16 minutes of the initial 911 call, not including other responding EMS or fire vehicles. According to the official after-action report, an initial lack of staging coordination caused delays in victim access and transport. Given the goal of minimizing delays, traditional staging of multiple units at some distance until the scene is “secured” is not effective in these incidents. Coordinating the initial response of multiple units across agencies in a dynamic fashion is paramount in developing a successful ingress and egress of all emergency vehicles and a primary early goal of the unified command team.

15 Ibid.
As law enforcement personnel develop and deploy contact teams, the unified command structure should ensure the safe and efficient integration of medical and law enforcement personnel into rescue task force (RTF) teams in parallel operations while the threat(s) is neutralized. Therefore, once an area is deemed “cleared” by law enforcement contact teams or is remote from the threat, the pre-established RTFs may immediately begin operations as directed by unified command. In many instances, the initial contact team(s) and other communication sources will provide the unified command with the location of known victims. It is essential that command immediately relay this information to the RTF(s) so that they may efficiently move to the location of the victims. Providing a specific section, hallway or floor to the RTF will also prevent the RTF from going to the wrong location and delaying access to the victims.
9-1-1 Communications

Introduction and Background
Emergency Communications Centers (e.g. 9-1-1/ECC) have an integral role in all public safety response. Emergency Communications Centers throughout North Carolina vary in size from large, integrated centers with numerous communicators to a call center with a single communicator. Some jurisdictions have a consolidated communication center that handles all 9-1-1 calls and dispatches law enforcement, fire, and EMS personnel from a single center. Other jurisdictions have a central 9-1-1 receiving public safety answering point (PSAP) and stand-alone ECCs for law enforcement, fire service, and EMS. Regardless of the size or type of 9-1-1 system, each jurisdiction must plan and prepare for the complexity of active assailant incidents.

Universally, almost every active assailant incident in the United States demonstrated that 9-1-1 communication centers could improve response operations to these incredibly overwhelming and complex incidents. Multiple after-action-reports address areas of improvement for 9-1-1 communications. These recommendations include call-taking procedures, call overload procedures, information sharing with responders, command staff notification, and the use of non-standard communication from victims, including social media, text messages, and other non-traditional forms of communication.

An active assailant incident will result in a massive influx of 9-1-1 calls into the PSAP and secondary/tertiary PSAPs. At the 2007 Virginia Tech shooting, the Virginia Tech Police Department 9-1-1 center received 2,027 9-1-1 calls into a center staffed by two communicators and supervisor\textsuperscript{16}. At the 2011 reported active shooter incident at Scott and White Hospital in Temple, Texas, 600 emergency calls were received by the hospital PBX system and several hundred 9-1-1 calls were received by Temple 9-1-1 in the first 60 minutes of the incident\textsuperscript{17}. At the 2013 Garden State Mall shooting in Paramus, New Jersey, 1,000 9-1-1 calls were received in the first 45 minutes requiring calls to be diverted to other New Jersey counties, the New York City Police Department, and call centers in Pennsylvania\textsuperscript{18}. At the 2014 Aurora Theater shooting, the Aurora 9-1-1 center received more than 6,000 9-1-1 calls into a center staffed with 13 call takers and communicators\textsuperscript{19}.

\textsuperscript{17} Mayes, T. (2015). Scott and White hospital shooting. ALERRT Active Shooter Conference, San Marcos, Texas.
Best Practice Considerations

Active assailant incidents provide several areas in which ECCs can implement best practice considerations. Each center should take time to address the following identified problem areas with active shooter incidents:

- The development of the definition between an active assailant incident versus shots fired or a person with a gun
- Coordination with jurisdiction response agencies to develop a standard initial dispatch recommendation for law enforcement, fire, and EMS resources to active assailant incidents
  - This initial response recommendation can ensure that adequate resources are responding, but yet prevent a massive influx of unnecessary resource response
- Discussion of when to utilize the standardized active assailant call taking procedure, including providing instructions to callers such as “Run, Hide, Fight”
- Modification of standard call taking questions to streamline call taking and increase capacity to handle numerous incoming 9-1-1 calls
- Coordination with responding agencies to ensure that the 9-1-1 center can communicate with all potential responding agencies (local, state, federal resources, mutual aid resources, and so forth)
- Identification of facilities that utilize PBX systems that would intercept internal emergency calls before the calls go to the 9-1-1 center
  - Information sharing from the PBX operator(s) to the 9-1-1 center
  - Training PBX operators on active assailant call taking
- Training of secondary and tertiary PSAPs on call taking during an active assailant incident
  - This is especially important if the secondary and tertiary PSAPs do not typically take law enforcement-related 9-1-1 calls
- Discussion of rolling calls when the 9-1-1 center is overwhelmed
  - All 9-1-1 centers should establish policies that address how these other 9-1-1 centers will relay information back to the primary PSAP when all communicators are busy
- Discussion of how communicators will handle the large number of potentially inconsistent, inaccurate, or delayed information from 9-1-1 callers
- Creation of a non-emergency telephone number that can handle the large influx of family members calling 9-1-1
- Monitoring social media sites to identify victim locations

This white paper is unable to provide blanket recommendations on how to handle the above best practice considerations because of the extreme variance in capabilities of ECCs throughout North Carolina. It is incumbent on each center to address these considerations and develop an action plan that will work given the number of resources in each jurisdiction.

Planning and Training

Every ECC should plan and train before an active assailant incident to ensure successful mitigation of the incident with minimal loss of life.
Some identified, but not all-inclusive, issues are:

- Development of active assailant/mass violence incident response procedures and protocols
- Checklist of ECC actions during active assailant incidents
- Use definitions established by the Work Group to aid in interoperability throughout the state
- Notification of command staff, additional staff, other agencies to include counties who participate in the Telecommunicator Emergency Response Team (T.E.R.T.) program and the public
- Debriefing / hot wash / after-action-reports / improvement planning
- Training – (active assailant, National Incident Management System (NIMS), stress management, critical decision-making, and so forth)
- Response to media, family members, and the “worried well”
- Use of non-standard communications from victims, including social media, text messages, and so forth

**Operations and Response**

The response to an active assailant incident involves multiple responses with multiple disciplines. Responders must have a reliable communication methodology that enables sharing of pertinent information. This information sharing allows for a developed, coordinated response that meets incident objectives. Inefficient communication can result in delaying the response effort, creating confusion about priorities and objectives, and generally waste valuable airtime and resources. Many land mobile radio systems (LMRS) throughout the nation have poor coverage, poor structural penetration, and poor capacity (not enough channels). In addition, the failure to properly train field responders on proper radio communications (radio discipline) exacerbates the existing LMRS infrastructure challenges. Poor LMRS infrastructure, the lack of radio discipline, and the lack of an incident communications plan has caused communication failures in previous active assailant incidents and has been identified as an area of weakness in after action reports. Considering the number of responding personnel to an active assailant incident as well as the number of participants scanning and/or monitoring the incident, the development and implementation of an incident communications plan is essential before an incident occurs.

There are multiple components vital to incident communication success. One important component is to assure channel assignment within and across agencies as part of the planning process to maximize successful transmission, minimize confusion, and avoid overloading the system. A component often overlooked, is ensuring all responders are trained on proper radio communications during a major incident. Responders must learn how to minimize transmissions, as this is often a major contributor to failure, and they must also be disciplined to remain on their assigned channels and utilize clear text. The planning process must account for the likelihood of occasional technical or system-based communication failures. Identifying non-repeated channels, commonly known as “talk around” or “line of sight” should be considered as a method of communication for the functions as assigned within the incident command system. Agencies must also consider the tried and true methods of communication by establishing “runners” and/or “message relayers” during an incident in case of technology failure.
All ECCs need to understand the unified incident command structure and methods that the ECC can support command operations. ECCs also need to understand what information needs to be distributed and to whom the information will be sent. Understanding the incident command structure and information distribution will help ECCs reduce communication confusion during active assailant events.

Communication failure is real and must be anticipated. Multiple strategies to mitigate the consequences of communication failure may be utilized; these must be developed and rehearsed in each community to ensure competency of responders. Every agency should implement pre-incident testing to identify infrastructure challenges, teach appropriate radio communications, assure understanding and use of the pre-assigned channels, and to practice an entire failure of the radio system infrastructure.

All ECCs should engage in the development and training of active assailant definitions, procedures, protocols and/or best practices. This can be accomplished by involving 9-1-1 professional organizations (Association of Public Safety Communications Officials, National Emergency Number Association, North Carolina Sheriffs’ Education Training and Standards Commission, North Carolina 9-1-1 Board, and others) to promote and support statewide standardization for the preparedness and response to active assailant incidents. The Work Group recommends that all ECCs have a pre-planned response to active assailant incidents, based on each ECCs available resources and capabilities. Assistance in planning and training for these responses should be made available to ECCs through direct technical assistance and grants. It is recommended that all ECCs maintain an updated list of stakeholders who are prepared to render logistical and technical assistance during an active assailant incident. Resources identified should include vendors and the private sector.

Summary and Conclusion
The development of a statewide standardization for preparedness and response to active assailant mass violence incidents will provide ECCs with guidance and tools to save lives, prevent further losses, and meet challenges these incidents will create.

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Law Enforcement

Introduction and Background
Active shooter/active assailant incidents are one of the most complex threats facing law enforcement today. Law enforcement officers face multiple challenges at these incidents. Law enforcement officers are responsible for locating and neutralizing the threat(s), establishing perimeter control, neutralization of potential/actual explosive devices, thorough searches for additional threats, witness interviews, and crime scene response.

The most important priority for law enforcement officers is to quickly neutralize the threat. Once an active shooter incident starts, there is an average death or serious injury every 15 seconds until the shooter stops or is neutralized. The six highest victim active shooter incidents since 2000 happened despite law enforcement arriving on scene in three minutes or less. Law enforcement must understand that simply neutralizing the perpetrator comprises only a part of the solution to active shooter incidents. Because of this, the Work Group recommends that North Carolina law enforcement agencies adopt the rescue task force model and incorporate medically-trained personnel into response procedures.

Best Practice Considerations
Numerous active shooter incidences and large-scale exercises have provided law enforcement with a myriad of lessons learned and best practice considerations. Many of these after-action-reports are available as open source. Law enforcement officials should take the time to carefully read and closely examine these reports. Examples of these reports include the following:


The rapid formation and utilization of a unified incident command with law enforcement, fire service, and emergency medical services is the most important best practice recommendation from this work group. Numerous active shooter incidents and large-scale exercises have demonstrated that victim treatment and extraction time doubles when law enforcement fails to form a unified command with other responding agencies. The creation of a unified command post is a federal requirement in the National Incident Management System. It is critical that law enforcement agencies conduct joint training with fire, EMS, and 9-1-1 personnel.

Law enforcement officials need to consider including the following best practices with active shooter response:

- Solo active assailant response
- Contact team movement in large structures (such as multi-story malls, large warehouses, manufacturing plants, and so forth)
- Open air contact team movement to the crisis site
- Individual issuance of air-purifying respirators (APRs) to combat CS gas deployment by perpetrators (firearms training should include personnel wearing their APR)
- Active assailant response that transitions to a hostage(s) incident or “doomed captive” incident
- Law enforcement response in fire/smoke conditions
- Law enforcement response to mobile or outdoor perpetrators
- Explosive device recognition and stand-off distance awareness for all officers
- Force protection for rescue task forces
- Creation of “secure corridors” for fire and EMS personnel
- Creation of “secure islands” for fire and EMS personnel
- Clear identification of responding plain clothes officers or off-duty officers
- Breaching of locked doors and windows, with emphasis on previous methods active assailant perpetrators have barricaded doors and windows

**Planning and Training**

Training for an active assailant incident must be an integrated, coordinated effort with law enforcement, 9-1-1 communications, area EMS providers, and local fire departments in various hostile environments. Regardless of rank, all law enforcement personnel should have training on the unified incident command system, with particular attention paid to the unified incident command system at active assailant incidents. All law enforcement agencies must plan, prepare, and train utilizing an integrated unified command system to manage active assailant incidents.

Law enforcement agencies regardless of size, must train and prepare for active assailant incidents. Law enforcement leaders must review previous active shooter incidents to determine training areas that their departments need. At a minimum, every law enforcement agency should train officers in solo active shooter response, contact team response, and the rapid treatment and extraction of injured victims.

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victims. Additional training should include interagency communications, incident command training, and tactical emergency casualty care.

This Work Group recognizes that the national model for active assailant response is an integrated law enforcement/fire department/EMS response model. Nearly every national, professional organization representing command staff from police, fire, and EMS recommends an integrated public safety response model. This model is the new standard of care and public expectation at active assailant incidents.

**Operations and Response**
To provide consistency, the Work Group has identified the following three law enforcement response teams:

**Contact Team(s)**
Contact teams involve law enforcement personnel locating, engaging, and suppressing the threat in the most expeditious manner possible. In this role, officers should not stop to render aid to victims but will inform rescue task force teams of the victim’s location and condition. In addition to training in teams, law enforcement officers must train and prepare for solo active shooter response. In 75% of active shooter incidents requiring law enforcement intervention, a solo officer response stopped the shooter.

**Rescue Task Force**
The rescue task force (RTF) involves law enforcement and medically-trained providers, to include but not be limited to fire, EMS, or other qualified medical personnel. These teams will consist of an adequate number of uniformed law enforcement to provide security for those providing life-saving measures. The RTF will not enter an area of direct threat of violence to the RTF. The role of the RTF is to conduct triage, mobile stabilization at the point of wounding, and provide for evacuation or sheltering-in-place. While lifesaving measures are underway, law enforcement personnel will focus solely on providing security for the medical personnel in the RTF.

**Rescue Team**
When resources are insufficient to provide RTF(s), law enforcement personnel will form rescue teams optimally comprised of four uniformed officers. These teams will treat, stabilize, and remove the injured in a rapid manner. This may occur when there are no fire/medical resources available, or when fire/EMS personnel refuse to enter the scene because of security concerns.

**Equipment:**
The equipment needed to respond and operate at an active assailant incident will depend on operational role, incident type, and available resources.

All law enforcement personnel should have the following:

- Appropriate weapon system(s)
- Agency-approved duty gear
- Clear law enforcement identification (outer wear and credentials)
- Radio
- Appropriate ballistic protection
- Basic medical equipment (hemorrhage control)

*For medical equipment recommendations, please see the EMS Section within this document.*

**Summary and Conclusions**

Law enforcement response to active assailant primarily focuses on engagement and neutralization of threats. However, neutralizing threats comprises only a part of the law enforcement response necessary to successfully mitigate these incidents with minimal loss of life. A critical component for the success at active assailant incidents is the rapid formation of a unified command post with law enforcement, fire service, and EMS command staff. Failure to rapidly form a unified command post has historically resulted in many needless lives lost at active assailant incidents.

Law enforcement officers must work to quickly integrate RTFs into the Warm Zone to provide care and extraction for victims. Law enforcement officers will provide force protection for the medical team members within the RTF. The RTF will follow the contact teams into the crisis site. Law enforcement can also create secure corridors within the crisis site, allowing fire and EMS personnel to move quickly with law enforcement escorts.

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Fire Service

Introduction and Background
The International Association of Fire Chiefs, the International Association of Fire Fighters, the National Fallen Firefighters Foundation, and the National Fire Protection Association have all published best practices papers that state that fire personnel will plan and prepare to conduct integrated operations at active assailant incidents, even when the scene is not secured (See Appendix A: Recommended Readings). The Work Group agrees that fire personnel must plan and prepare to conduct integrated operations at these incidents when the scene is not secured. Regardless of the size or capacities of the department, every North Carolina fire department must plan and prepare for response to active assailant incidents.

Fire department personnel may perform many functions at an active assailant incident. These functions may include any or all of the following: fire suppression, smoke or chemical munition removal, hazardous materials mitigation, victim treatment and extraction, and support of building systems to aid law enforcement (elevators, HVAC, utilities, and so forth). Fire department personnel may need to perform these functions in unsecured areas with law enforcement protection.

Best Practice Considerations
Multiple active shooter incidents demonstrate many lessons learned for fire department personnel. One of the most important lessons learned is the need for rapid formation of a unified incident command system. Failure to form a unified command system typically doubles the time it takes to provide point-of-wounding care and victim extraction\(^{26}\). Fire department personnel are very knowledgeable in incident command. At active assailant incidents, fire department personnel have frequently established command long before law enforcement creates a command post. It is incumbent upon fire personnel to quickly identify the law enforcement officer in charge and create a unified command post.

Fire department personnel must also actively plan for fire-as-a-weapon at active assailant incidents. Numerous active assailant perpetrators have utilized fire or smoke as a weapon to increase the number of victims. Fire personnel must train with law enforcement to mitigate scenes where there is both a fire and hostile threat(s). This response requires coordinated training and planning with both law enforcement and fire service personnel. This plan should also incorporate the mitigation of hazardous materials in conjunction with hostile threats. In some cases, mitigation of the hostile threat cannot occur until responders address the fire or hazardous materials threat.

Planning and Training
Fire department personnel need to plan and prepare for active assailant incidents. Training should occur in cooperation with 9-1-1, law enforcement and EMS. Fire personnel should plan and prepare to work with law enforcement during fire-as-a-weapon incident, or mitigation of hazardous materials with the

threat of potential hostile engagement. Fire department personnel must also train to provide care based on the Tactical Emergency Casualty Care (TECC) guidelines.

Operations and Response
To provide a framework, the Work Group identified three different levels of response for fire service personnel. Modeled after other fire service certifications, the three response levels are typed as (1) Awareness, (2) Operations, and (3) Technician. The fire chief will determine the level of rescue response capability for his or her department. The fire department’s medical director will determine the scope and level of medical care provided by the department. The Work Group recommends that all members of the department train to the same level to maintain operational consistency. In addition, the Work Group recommends that all departments in a county train to the same level to maintain operational consistency at active assailant incidents.

Awareness Level Response
This level of training and response will involve the fire department engaging the local enforcement agencies that have jurisdiction in their respective fire districts. With this response model, fire personnel will typically stage in a safe location and move forward when the scene is declared safe by the law enforcement agency in command. This level of response puts fire personnel at the lowest exposure to active assailants or other threats that may be present on the scene. However, this model also presents the most risk for victims who may die needlessly while waiting for medical care and evacuation.

Once the fire department resources move forward, personnel will engage in victim removal and life-saving treatment in accordance with their medical training and local protocols. The potential for victim decontamination may also be present if victims are exposed to hazardous materials or unknown substances. This level of response also needs to be commensurate with the level of hazardous materials training with which the department operates.

Training to this level of response includes familiarization of active assailant incidents, identifying resources necessary for incident mitigation, and the role of unified command. It is critical that fire departments train with local law enforcement and emergency medical services so that each agency understands the roles, responsibilities, and capabilities of each agency at active assailant incidents.

Operations Level Response
This level of training and response will involve the fire department engaging the local enforcement agencies that have jurisdiction in their respective fire districts. Fire service personnel will deploy to the outside of the crisis site utilizing law enforcement force protection. Once fire department personnel are in place outside of the crisis site, they will prepare to receive and treat victims that law enforcement brings to them. Fire personnel will then extract the victims to the triage/treatment/transport locations established by EMS. The potential for victim decontamination may also be present if victims are exposed to hazardous materials or unknown substances. This level of response puts fire personnel at higher exposure to the active assailants or other threats that may be present on the scene. However, this
model presents increased chances for survivability for victims who require emergent medical care and evacuation. Training to this level of response includes familiarization of active assailant incidents, identifying resources necessary for incident mitigation, the role of unified command, deploying to a crisis site, and tactical extraction of victims. It is critical that fire departments train with local law enforcement and emergency medical services so that each agency understands the roles, responsibilities, and capabilities of each agency at active assailant incidents.

**Technician Level Response**

This level of training and response will involve the fire department engaging the local enforcement agencies that have jurisdiction in their respective fire districts. Fire department personnel will integrate with law enforcement force protection to form rescue task forces (RTF) to deploy into the warm zone. This level of response puts fire personnel at the highest exposure to the active assailants or other threats that may be present on the scene. However, this model also presents victims with the highest degree of survivability with rapid medical care and evacuation.

These RTFs will provide point-of-wounding care and extraction of the victims to the Triage/Treatment/Transport location established by EMS. The potential for victim decontamination may also be present if victims are exposed to hazardous materials or unknown substances. Fire personnel should also train to integrate with force protection to provide firefighting operations or hazardous materials operations in the warm zone. Additional fire department responsibilities can include assisting law enforcement with control of building utilities, controlling elevators, and using building systems (HVAC) to assist law enforcement operations.

Training to this level of response includes familiarization of active assailant incidents, identifying resources necessary for incident mitigation, the role of unified command, deploying with law enforcement force protection as an RTF, deploying to a crisis site, and tactical extraction of victims. It is critical that fire departments train with local law enforcement and emergency medical services so that each agency understands the roles, responsibilities, and capabilities of each agency at active assailant incidents.

**Summary and Conclusions**

Fire department personnel will have multiple responsibilities at active assailant incidents. One of the most important responsibilities is to provide rapid treatment and extraction of victims. Using the rescue task force model, fire personnel would conduct these activities with law enforcement force protection. In addition to providing care for victims, fire personnel must be prepared to conduct fire suppression operations, hazardous materials mitigation, and assist law enforcement with other operational tasks.
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Emergency Medical Services

Introduction and Background
Since 2008, the Department of Homeland Security has recommended the integration of rescue teams comprised of medical personnel and law enforcement officers who will quickly enter active assailant incidents to provide care and remove victims. Numerous recent active shooter incidents demonstrate that victims continue to die needlessly while awaiting medical care. Utilizing traditional “stage and wait” models, the average time to access the first victim is 90 minutes, and the average time to evacuate all victims is 2.5 hours. Utilizing the rescue task force model, the time to access the first victim is less than 30 minutes, and all victims have an average extraction time of 30 minutes. The Emergency Medical Services (EMS) Subcommittee recognizes that optimal victim survival is dependent on rapid victim access, appropriate care, and emergent transportation to hospitals with surgical capabilities.

Best Practice Recommendations
Multiple scholastic publications have reviewed the priorities of EMS personnel at active assailant incidents. The overwhelming consensus from published literature recommends that EMS personnel train in the principles of Tactical Combat Casualty Care or Tactical Emergency Casualty Care. Responders should minimize treatment to focus primarily on hemorrhage control, and rapidly transport victims to a hospital with surgical capabilities. Numerous other publications also advocate for basic life support care for trauma victims, with little to no advanced life support care (with the exception of decompression of a tension pneumothorax). The Subcommittee agrees with these studies, and recommends that any advanced life support procedure conducted must have proven efficacy and result in minimal transport delays for the victim to the hospital. In addition, no victim should die on the scene while awaiting an ambulance. If transport ambulances are unavailable, personnel must consider the use of non-standard victim transport, using police cars, ancillary EMS vehicles, or fire apparatus. The most

29 Ibid.
important lifesaving decision made at the Aurora Theater shooting was the decision by police officers to transport victims to the hospital in police cars instead of waiting for ambulances.\(^{35}\)

There are four components to victim management in active assailant incidents: (1) access, (2) assessment, (3) stabilization; and, (4) evacuation. The threat, environment, and injuries determine the specific details of each response. However, the most effective response plans integrate operational and trauma care considerations to achieve these four medical objectives. The initial goal is for medically trained personnel to quickly access and assess victims. The rescue task force (RTF) model is a successful strategy to expedite victim access.

The RTF is an integration of law enforcement officers and medically trained personnel that shortens distance and time from the point-of-injury to stabilization and transport to definitive care. The RTF may operate either with direct, mobile law enforcement escort or in a secure, “warm zone” corridor secured by law enforcement officers that allows movement of medical personnel into a warm zone/indirect threat care area. After assessment, the RTF must determine whether to provide immediate lifesaving interventions consistent with the threat-based phases detailed in the TECC guidelines, to move the victim to a casualty collection point (CCP) or to evacuate directly to a transport vehicle. Factors including, but not limited to, level of threat, number of victims, injury patterns, number of RTF personnel, and evacuation capabilities factor into RTF decisions.\(^{36,37}\) The decision to create a casualty collection point should depend on the individual situation and not depend on predefined triggers (such as victim numbers, victim location, and so forth).

**Planning and Training**

EMS training for active threat incidents must involve all appropriate stakeholders and integrate law enforcement, 9-1-1 communications, fire, and any other local public safety resources that may respond. A primary training modality may be interagency drilling that highlights a team-based approach to active threat response. Training should focus on basic principles and goals of response (e.g. safety, speed, and victim care in parallel with dynamic scene operations), triage/sorting of victims, and rapid evacuation to definitive care.

Trauma care principles should be based upon the principles of TECC but may be adapted to the specific agency’s medical protocols. To gain and maintain competence in active threat response, agencies must participate in organized, integrated training on a regular basis. Appropriate community-based pre-

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planning for training incidents is necessary to determine which public safety resources will fulfill each role in the coordinated, integrated, team-based response to these incidents.

**Operations and Response**

Active assailant incidents have the potential to be very complex and require multiple EMS resources. After-action reports have described some of the common problems that EMS providers face at these incidents. These problems include evacuation of victims, limited number of transport ambulances, difficulty tracking victims on scene, limited communication with area hospitals, and coordination of victim transport to trauma centers.

**Victim Management and Evacuation**

The initial assessment and stabilization of any victim at an active threat incident is a medical responsibility. The Tactical Emergency Casualty Care (TECC) guidelines provide best practice guidance for the management of the most common potentially preventable causes of death in active threat incidents, including individual capability recommendations based upon the level of medical training (e.g. first responder, basic life support, or advanced life support). Rapid hemorrhage control is critical and emphasized by TECC, TCCC, and the Hartford Consensus. However, responders must also consider conditions such as tension pneumothoraces that may not present immediately, but may develop with intrinsic scene delays. For example, during the Aurora Century Theater shooting, it took 58 minutes to evacuate all victims. During the Washington, D.C. Navy Yard shooting, it took law enforcement officers 64 minutes to contain the shooter and allow for initial evacuation of victims. While these delays are not optimal, they must be anticipated as part of the response and the injuries and conditions that may require treatment. Multiple basic life support (BLS) and advanced life support (ALS) techniques address prevention and management of tension pneumothoraces. Medical directors should ensure a plan is in place based upon agency medical qualifications to address this condition and other preventable life threats.

The operational leaders, in conjunction with the system’s medical director should determine the medical composition of the RTF in each community. The medical director will determine the scope of treatments and ensure that the response plan has addressed all of the potentially preventable causes of mortality, within the providers’ certification level and scope of practice as set forth in system protocols and North Carolina Office of EMS Standards and Practice. The key is developing a plan that addresses these causes of mortality rather than mandating the specific composition (e.g. certification or agency) of the RTF medical component. In North Carolina, many EMS agencies may be the primary medical asset as part of the RTF. However, there are also many communities that do not possess the ALS resources or


39 A tension pneumothorax is a progressive build-up of air in the chest cavity, typically resulting from a laceration to the lungs. This buildup of pressure squeezes the heart until blood can no longer fill the heart, resulting in death.

capabilities to perform the function of the RTF. Leaders should examine their local capabilities to determine the appropriate integration of ALS and/or BLS providers into the RTF model.

The law enforcement composition of the RTF must be one that provides adequate security for the medical responders of the RTF. Many agencies have tactical EMS (TEMS) or tactical medical programs that frequently integrate with law enforcement in a pre-planned fashion. While agencies may have tactical EMS resources, the RTF is intended to be staffed by “regular” on-duty field providers, (i.e. first-arriving non-tactical medical resources). The law enforcement community has determined in an active threat scenario, they should not “wait for SWAT” and first arriving units should move directly towards the threat. Similarly, medical providers should not “wait for tactical EMS” to respond to form a RTF.

Upon deployment of a RTF, the medically trained personnel should move to provide immediate lifesaving interventions consistent with the threat-based phases of TECC41. Upon addressing the initial life threatening injuries, a casualty collection point (CCP) may be used to consolidate while additional resources are called for evacuation. However, another option may be to evacuate the victims from where they are found to an external treatment area. In either case, care must be taken not to cause a delay in immediate transport to an appropriate medical facility. In addition, the security of the CCP/treatment area must be taken into account. Communication with law enforcement is essential to ensure that law enforcement can provide adequate security regardless of the method used.

Once the initial evaluation of victims is complete, every effort to immediately transport victims should become the priority. In some instances, the immediate evacuation of victims may be necessary and appropriate. However, evacuation of some victims prior to the initial evaluation of others may delay lifesaving interventions such as controlling extremity hemorrhage. While immediate transport is the goal, there may be situations where immediate transport is not feasible. In those instances, it may be necessary to provide additional medical attention to additional injuries that was not provided in the initial assessment.

The evacuation component can be both physically demanding and manpower intensive. It may be necessary to augment the existing RTFs with additional responders to efficiently evacuate victims. Law enforcement should create a “safety corridor” in the warm zone to move victims from the CCP to the triage/treatment/transport location, to ensure a safe means of rapid evacuation.

**Equipment**

The equipment utilized for active assailant response should consist of supplies required to provide immediate, lifesaving interventions consistent with the threat-based phases detailed in the TECC guidelines to minimize potentially preventable mortality42. This equipment may be carried in smaller kits

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that enable the provider to move quickly and efficiently. Smaller kits with essential supplies also allow the medical providers to stay close to the law enforcement personnel providing protection as part of the RTF. An additional benefit to limiting the supplies carried by the RTF is the decreased chance of wasting time providing unnecessary medical treatments.

Equipment carried should be based on supplies necessary to treat particular injuries and medical situations likely encountered in an active assailant incident (e.g. hemorrhage control, airway management). Specifically, agencies should stock and deploy equipment essential to treat and manage victims encountered during the “Indirect Threat Care/Warm Zone” phase of TECC 43.

Based on the Indirect Threat Care Guidelines, example equipment may include (follow agency Medical Director recommendations):

**Hemorrhage control:** Multiple tourniquets, pressure dressings, hemostatic agents

**Airway:** Nasopharyngeal airways

**Breathing:** Chest seals, occlusive dressings, needles for chest decompression

**Hypothermia:** Minimize victims’ exposure to elements

**Victim Movement:** Collapsible litters, fabric litters, or drag straps may aid in movement of victims

**PPE:** Ballistic protection (Though not mandatory, if body armor is utilized, providers must have properly fitted PPE and be trained to ensure essential tasks can be rapidly completed while wearing PPE)

Responders should consult the recommendations made by the InterAgency Board regarding ballistic protection (see Appendix A: Recommended Readings).

**Victim Marking:** Self-contained, short-term chemical lighting devices, triage tags/tape

**Deceased Marking:** Body positioning, triage tags/tape

### Summary and Conclusions
Preparation for an active threat incident must be a priority for public safety agencies in communities across North Carolina. Topics covered in this document, such as command structure and communication, victim care and movement, necessary equipment and training, should be addressed in a team-based fashion by the public safety and medical leadership in North Carolina communities. While different communities may have varying approaches to planning for these incidents based on locally available resources and capabilities, this document highlights fundamental principles that should be incorporated in any response framework. Saving lives in an active threat incident requires a rapid, safe, interagency response that focuses on the threat-based victim care priorities of TECC.

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Introduction and Background
The purpose of this section is to provoke frank discussion and to present the Emergency Management Subcommittee’s suggestions that if implemented, will help build a robust planning and response capability across North Carolina applicable to any jurisdiction, regardless of the size or geographical location (rural, suburban, urban-like, or urban). A rapid, safe, and successful response to any active assailant incident requires planning and preparation.

Best Practice Considerations

Common Definitions
Common definitions should be developed that are uniformly accepted and understood by all communities. These common definitions are critical for operational coordination at incident sites. In addition, agency leaders can use common definitions to formulate policies, plans, procedures and protocols. Lastly, utilizing these definitions, emergency managers will immediately know that they must ramp up their multi-agency coordination system(s) and consequence management roles/support mechanisms.

Regional Mass Casualty Plan
Active assailant incidences can quickly overwhelm a community’s EMS and healthcare resources. Major efforts should be directed toward creating regional mass casualty incident (MCI) plans that include the use of all available resources capable of caring for and transporting victims of an active assailant incident. Agencies should review and integrate local, mutual aid, regional and statewide resources during the planning process. This includes 9-1-1, EMS, fire, rescue, law enforcement personnel, hospital/allied health, and public health partners.

Extensive planning and coordination should occur regarding ground/air ambulances, mass transit capabilities, ambulance buses, ambulance strike teams, morgue/mortuary and hospital capability/bed availability resources. Emergency managers in coordination with EMS leaders should ensure specific pre-planning of staging, triage, treatment, and transportation. Emergency managers should place additional emphasis on equipment caches of medical supplies, victim accountability systems, victim decontamination process, ICS, and triage training with a progressive exercise program to test the plans.

Hospitals can expand on their existing triage systems to develop victim acceptance availability for red (critical), yellow (non-critical), and green (walking wounded) victims. This would be the number of red, yellow, or green victims that they could accept, 24/7/365. With this in mind, for the first 30 minutes of the incident, the EMS Transportation Officer knows how many patients they can send, and to which hospital they can send victims. After the first 30 minutes, a more accurate bed count should be available. Emergency managers should also plan for the use of alternate facilities, such as burn centers and specialty care facilities that will help increase treatment capacity. The Emergency Management
Subcommittee recommends that the North Carolina Trauma Regional Advisory Committee (RACs) coordinate this effort regionally across the state and include representatives from 9-1-1, EMS, fire, law enforcement, and emergency management in the development process.

**Planning and Training**

**Statewide Planning Template**
The Federal Emergency Management Agency (FEMA) recommends that teams responsible for developing emergency operation plans (EOPs) use Comprehensive Preparedness Guide 101 (CPG-101) to guide their efforts. It provides a context for emergency planning in light of other existing plans and describes a universal planning process. The Comprehensive Preparedness Guide 101 establishes no immediate requirements, but suggests that the next iteration of all EOPs follow this guidance.

It would benefit many entities within North Carolina to use the same approach as CPG 101 in developing an active assailant planning framework. The framework could provide an outline of what the unified ICS structure might look like and what specifically should be addressed in the plan during an active assailant scenario. Some jurisdictions may not have the time or resources to develop their own ICS structure or plan for this type of incident. It is beneficial for emergency managers to create a well thought out guidance document that is operationally feasible across rural, semi-urban, and urban jurisdictions.

**Active Shooter 101 Training**
There are several different training programs occurring throughout the state. The Department of Justice has delivered the rapid deployment training for quite some time now. Texas State University offers the Advanced Law Enforcement Rapid Response Training (ALERRT) and many law enforcement officers throughout North Carolina are ALERRT certified instructors. The North Carolina Public School System is using the Critical Incident Response for School Faculty and Staff training delivered through the North Carolina Center for Safer Schools. FEMA offers IS-907 as an online active shooter course. Finally, several vendors in North Carolina deliver similar training.

It does not appear that there is coordination and integration of the active assailant training offered in North Carolina. For example, there are many notable lessons learned and best practices from recent active assailant incidents. However, these lessons learned and best practices have not made it into many of the training programs. Specifically, law enforcement rapid deployment training does not address the RTF concept, where fire and EMS respond under law enforcement cover before assailant neutralization. This is but one example of where this type of training must be effectively coordinated throughout the state. The same holds true for ICS training in relation to an active assailant incident. There is no coordination on what the ICS structure should look like and how to implement it on scene.

The Emergency Management Subcommittee recommends that an integrated, coordinated, and modularized approach be used to develop an Active Assailant 101 Training Course that can be delivered to members of the whole planning community (to include an ICS component). Educational institutions
(or businesses) may not need to know deployment tactics or methodologies, but they do need integration into response planning.

**Safer Schools and the Department of Public Safety**

The North Carolina Center for Safer Schools within the North Carolina Department of Public Safety serves as the primary point of contact on issues dealing with school safety. We have identified that while active assailant incidents are not solely school-based; the potential for a high consequence incident is prevalent in our schools. As emergency managers, we are concerned that the efforts within the Safer Schools initiative is taking place without full community involvement from police, fire, EMS, 9-1-1, and emergency management practitioners which has the potential to create conflicting plans and procedures for active assailant incidents. The Emergency Management Subcommittee therefore recommends that the North Carolina Center for Safer Schools involve additional local emergency responders in their planning initiative to ensure that best practices and local resources are considered.

**Emergency Management Performance Grant (EMPG) Funding**

The EMPG Program provides federal grants to states to assist state, local, territorial, and tribal governments in preparing for all hazards, as authorized by the Robert T. Stafford Disaster Relief and Emergency Assistance Act, as amended (42 U.S.C. §§ 5121 et seq.) and Section 662 of the Post Katrina Emergency Management Reform Act of 2006, as amended (6 U.S.C. § 762). The Emergency Management Subcommittee suggests that active assailant planning, training, and/or exercises be specifically authorized as a North Carolina “Optional” item to help counties meet their EMPG annual requirements. Subsequently, communities may utilize EMPG funds at the local level to support whole community active assailant planning, training, and exercises. Additionally, we request that the state seek authorization for active assailant funding in other local, state and federal grant opportunities such as COPS, ASPER, SHSGP, and so forth.

**Other Planning Considerations**

A standard set of planning documents should be developed, to include guidelines, checklists, best practices, and lessons learned in an effort to establish a statewide systematic approach to active assailant responses. Emergency managers must give substantial consideration to target and risk analysis beyond our educational institutions, to include other locations such as critical infrastructure, government facilities, high profile or controversial locations, and large crowds/venues. Additional consideration for public information, family support, security at hospitals, and public alert/warning coordination should be included in the planning process. Another important planning consideration is the identification and rapid deployment of crisis counselors for emergency response personnel, victims, survivors, survivor and victim family members, as well as local community members. All stakeholders should be involved from the beginning of the planning effort, with a major emphasis placed upon interagency and whole community coordination. Plans and policies should be developed in concert with solid educational practices and tested in a progressive series of multi-agency/multi-jurisdictional exercises.
Operations and Response

Use of External Evaluators for Exercises
One area of consideration is the use of external evaluators during active assailant exercises. In many cases, planners use personnel internal to their organizations to evaluate the plans and actions during active assailant exercises. This has led to a lack of objectivity in assessing exercises, and consequently, organizations do not make the needed improvements and corrections to their plans and procedures. This is an important point of discussion as communities are strongly encouraged to conduct active assailant exercises.

The Emergency Management Subcommittee encourages agencies to use external evaluators to the greatest extent possible. For example, for school exercises local emergency managers and school principals or administrators from other schools can serve as evaluators. Principals/administrators can use what they learn as an evaluator and take these lessons back to their own schools to improve on their own plans. If properly trained in crisis response, schools may also use the school resource officer (SRO) as an evaluator. To be successful, the SRO would need education on the roles and responsibilities of the evaluator. The SRO can obtain this education by taking an exercise development and exercise evaluation course. Taking this one-step further, the SRO could be trained in the four exercises that schools must complete each year (lockdown, tornado, fire, and earthquake). Following training in exercise design and evaluation and having a basic understanding of the four exercises, the SRO could become an even more valuable asset to the school.

Local Level Coordination Effort
An active assailant incident in any jurisdiction will overwhelm the community's resources for initial response and recovery. It is imperative that local emergency management organizations foster inter-agency communication and coordination of their partner agencies to ensure that plans are in place to respond to and recover from active assailant incidents. Most community-based emergency management plans are strategic in nature, leaving the tactics of incident management up to the lead agency for the threat in their jurisdiction. The complexity of an active assailant incident and the number of responding emergency response disciplines requires a more thorough planning effort to ensure an effective and efficient emergency response to this type of incident. Emergency managers should focus on conducting planning meetings and developing working relationships with all stakeholders to coordinate a whole community response to an active assailant incident.

Multi-Agency Coordination System
Emergency managers should develop capabilities to transition from the traditional Emergency Operations Center (EOC) structure to a Multi-Agency Coordination System (MACS) when the event escalates, or when a series of complex-coordinated attacks overwhelms their ability to provide support. State Emergency Management and the Federal Emergency Management agency could team up to provide technical assistance that includes planning, hands on training, and exercises to help develop this capability.
Media Considerations
Communities must plan on a large and immediate media response. Active assailant incidents will immediately attract a large media interest and focus. Incident commander can quickly address the media issue by designating a public information officer (PIO) and utilize the joint information system (JIS) as the situation grows. With the growing use of social media, it is critical to put a PIO forward as soon as possible. This will be an important tool to provide information to the media, the public and those in the impacted area. Coordinating the message between local, regional, state and federal partners as soon as possible will help develop the unified messaging that should go out. Social media is a very valuable tool that responders can use to disseminate quickly information and assist with the response and investigation. First responders should also be aware that many tactical details are often posted by civilians through social media.

Family Assistance Coordination
Emergency management plans should address family support efforts, to include the use of Family Reunification Centers (FRC) and Family Assistance Centers (FAC). A jurisdiction’s FAC is a secure facility that serves as a centralized location for the sharing of information and assistance about missing or unaccounted for persons and decedents to family members. The FAC also serves to collect information that will support the identification process for family members. Another key function of the FAC is to provide family members with behavioral health services and to link them with human service programs as needed. A Family Reunification Center (FRC) assists displaced survivors, especially children and helps to re-establish contact with family and friends after a period of separation. The primary focus of the FRC is to reunite children with their parents or legal guardians.

Summary and Conclusion
It is vital that emergency management personnel and administrators at all levels plan, train, and exercise together for these types of incidents. Discussions with all community partners serving the jurisdiction must take place before an incident occurs. Doing so will help establish common resource support expectations.

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Appendix A

Recommended Readings


Appendix B

Recommendations for Training and Exercises

Once agency leaders develop a response plan, the plan should be evaluated during drills and exercises to determine areas for improvement in the plan. Agencies should identify and measure important pre-determined response and victim care benchmarks to evaluate performance and track improvement. Training benchmarks may contain the following measures:

- Elapsed time until unified command is established
- Elapsed time until first contact team is deployed
- Elapsed time until the threat(s) is neutralized
- Elapsed time until the first RTF is assembled
- Elapsed time until the first and subsequent RTFs are deployed
- Receipt of appropriate deployment guidance for RTFs from unified command
- Elapsed time until contact with first victim for each RTF
- Elapsed time until last victim is contacted by RTF
- Performance of essential victim care procedures, such as tourniquet application
- Elapsed time until first victim is evacuated
- Elapsed time until last victim is evacuated
- Additional measures to evaluate the intended goals and functions of each element of response: command and control, contact team, and the RTF

Training exercises should contain realistic scenarios that test all aspects of the response. In addition, exercises should contain a realistic number of victims and should not be developed such that responders are incapable of successfully mitigating the incident.

Training programs should be developed and deployed in a step-wise fashion. First, individual disciplines (9-1-1, law enforcement, fire, EMS, and emergency management) should receive training to perform intended roles with the community’s agreed-upon active assailant response plan. A progressive exercise program should be implemented that utilizes tabletop, functional, and full-scale exercises following successful completion of other preparatory training. This step-wise approach ensures that responders
from various agencies have full understanding of their roles and expectations in order to maximize the success of time and personnel intensive full-scale interagency training incidents.

The development of guiding documents such as priorities of work, shared protocols, and operational checklists will be helpful to ensure all responders understand the entire team-based, interagency active threat response. Provision of these documents to supervisors and responders for both training and actual incident response will assist with understanding of priorities and task completion throughout the incident.
Appendix C
Common Acronyms in Active Assailant Response

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ALERRT</td>
<td>Advanced Law Enforcement Rapid Response Training</td>
</tr>
<tr>
<td>ALS</td>
<td>Advanced life support</td>
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<tr>
<td>APR</td>
<td>Air purifying respirator</td>
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<tr>
<td>BLS</td>
<td>Basic life support</td>
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<tr>
<td>BPE</td>
<td>Ballistic protective equipment</td>
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<tr>
<td>CCP</td>
<td>Casualty collection point</td>
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<tr>
<td>CISD</td>
<td>Critical incident stress debriefing</td>
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<tr>
<td>CISM</td>
<td>Critical incident stress management</td>
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<tr>
<td>CGI</td>
<td>Combustible gas indicator</td>
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<tr>
<td>CQB</td>
<td>Close quarters battle</td>
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<tr>
<td>C-TECC</td>
<td>Committee for Tactical Emergency Casualty Care</td>
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<tr>
<td>CS</td>
<td>Chlorobenzalmalononitrile</td>
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<tr>
<td>ECC</td>
<td>Emergency communications center</td>
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<tr>
<td>EM</td>
<td>Emergency management</td>
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<tr>
<td>EMPG</td>
<td>Emergency Management Performance Grant</td>
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<tr>
<td>EMS</td>
<td>Emergency medical services</td>
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<td>EOD</td>
<td>Explosive ordinance disposal</td>
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<td>EOP</td>
<td>Emergency operations plan</td>
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<tr>
<td>FACP</td>
<td>Fire alarm control panel</td>
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<tr>
<td>FEMA</td>
<td>Federal Emergency Management Agency</td>
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<tr>
<td>HVAC</td>
<td>Heating, ventilation, air conditioning</td>
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<tr>
<td>ICS</td>
<td>Incident command system</td>
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<tr>
<td>IC</td>
<td>Incident commander</td>
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<tr>
<td>IED</td>
<td>Improvised explosive device</td>
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<tr>
<td>LE</td>
<td>Law enforcement</td>
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<tr>
<td>LEO</td>
<td>Law enforcement officer</td>
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<tr>
<td>MCI</td>
<td>Mass casualty incident</td>
</tr>
<tr>
<td>Acronym</td>
<td>Definition</td>
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<td>---------</td>
<td>----------------------------------------------------------</td>
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<tr>
<td>NIMS</td>
<td>National Incident Management System</td>
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<tr>
<td>PACE</td>
<td>Primary, alternate, contingency, emergency</td>
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<tr>
<td>POV</td>
<td>Personally owned vehicle</td>
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<tr>
<td>PPE</td>
<td>Personal protective equipment</td>
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<tr>
<td>PPV</td>
<td>Positive pressure ventilation</td>
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<td>PSAP</td>
<td>Public safety answering point</td>
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<td>RAC</td>
<td>Regional Advisory Committee</td>
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<td>RTF</td>
<td>Rescue task force</td>
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<tr>
<td>SCBA</td>
<td>Self-contained breathing apparatus</td>
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<td>SRO</td>
<td>School resource officer</td>
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<tr>
<td>SWAT</td>
<td>Special weapons and tactics</td>
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<tr>
<td>TCCC</td>
<td>Tactical combat casualty care</td>
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<tr>
<td>TECC</td>
<td>Tactical emergency casualty care</td>
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<tr>
<td>TEMS</td>
<td>Tactical emergency medical services</td>
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<tr>
<td>T3</td>
<td>Triage, treatment, and transport</td>
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<tr>
<td>VBIED</td>
<td>Vehicle-borne improvised explosive device</td>
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</tbody>
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