PURPOSE

To establish standard operating procedures for the Peoria Fire-Medical Department's safe response to active violent incidents that will maximize the possibility for victim survival by minimizing patient "contact time" and definitive care delivery by Fire-Medical personnel, and to establish standardized procedures for agency coordination including defining the use of Fire/Law Enforcement Rescue Task Force Extraction Teams for active violent incidents while minimizing risk to personnel.

In order to save lives and minimize casualties from such a tragedy FD personnel must act as soon as the immediate threat is neutralized or contained. If viable casualties exist then Police, Fire-Medical, or joint Police/Fire-Medical Department extraction teams must be deployed, in a timely manner. This would be done after careful consideration of the situation, under a defined Incident Action Plan (IAP) after considering the Risk Management Profile.

BACKGROUND

Historically, Fire/EMS departments have been unable, due to policy, or unwilling to enter warm zones at active shooting scenes until Police resources have given the "all clear". Peoria Fire-Medical Department response actions to active shooting incidents have been to stage and wait for an all clear from the Police Department (PD). In active shooting or other violent incidents where great bodily harm to multiple casualties have occurred or continue to occur an "all clear" from PD may not be given for an extended period of time.

DEFINITIONS

- Active Threat – An ongoing attempt to actively engage in killing or attempting to kill people in a confined and populated area (i.e. a bombing, an active shooter, a terrorist attack with multiple casualties).
- Active Shooter – an armed person who has used deadly physical force on other persons and continues to do so while having unrestricted access to additional victims and ammunition.
- Barricaded/Hostage incident – a static situation involving an armed suspect, (with or without hostages), who has demonstrated or voiced violence, and has fortified a position of advantage in a room or building.
- Casualty Collection Point (CCP) – a specific, designated area where extraction teams hand casualties over to treatment personnel.
- Cold Zone – The area where no significant danger or threat can be reasonably anticipated. This could be achieved by distance, barrier,

geographic location, or inaccessible areas from the incident.

- Concealment – protects you from observation, not weapon fire.
- Cover – protects you from observation and weapon fire.
- Contact Team – a group of Law Enforcement Officers that have the intent to stop the suspect(s) deadly actions.
- Dynamic Situation – an incident that is fluid, evolving and changing with constant movement, numerous casualties, discovery of IED's and other tactical challenges.
- Hot Zone – the area where a direct and immediate threat exists.
- Neutralized or Contained – the shooter(s) are dead, in custody, fled the scene, reasonably contained or barricaded.
- Rescue Task Force (RTF) – a group of FD/PD personnel responsible for the rapid relocation or extraction of viable casualties from an incident "warm" zone to a casualty collection point or cold zone.
- Risk Management Profile – a preamble in which response personnel operate under that ensures the visibility, assessment and mitigation of risk and loss of life in an emergency situation.

  We may Risk our lives a lot to protect ***savable*** lives
  We may Risk our lives a little to protect ***savable*** property
  We will not Risk our lives at all to save what is already lost
  All of the above are under a structured plan
- Scene Safe to Enter – Law Enforcement has determined that there are no known threats in the immediate area or incident location and it safe to move about the perimeter (aka "Code-4").
- Warm Zone – an area of an incident that the Law Enforcement Contact Team has been through without engaging the subject(s) and communicated the location of all viable victims.
- Stage for Law Enforcement (PD) – units should stage far enough away as to not become part of the incident, out of line of sight, out of line of fire and behind cover and with two directions of egress without turning around. Companies should turn off warning lights and be aware of any crowds that may pose a hazard.
- Static Situation – the suspect(s) have stopped moving and appear to be contained. An uncontained static suspect(s) can become dynamic without notice.
- Tactical Benchmark – specific items, information or tasks that have been identified for consideration in as part of the progression in dealing with an incident.
- Transportation Sector – coordinates ambulance/rescue usage with Treatment

Sector and also, notifies and coordinates the number of patients sent to hospitals.

- Treatment Sector – set in the "Cold Zone" and allocates resources to treat casualties with an emphasis on rapid treatment and transportation.
- Triage Sector – receives casualties from extraction team and performs triage
- TLO – acronym for Terrorism Liaison Officer. PD or FD Officer assigned to assist the incident commander with confidential intelligence information related to the incident and to coordinate PD/FD activities and communications.
- Violent Incident – any event or occurrence in which personnel may be exposed to harm as a result of a violent or threatening act whether real or implied.
- Warm Zone – A well-defined area where a potential threat exists, but the threat is not direct or immediate – including hot zone areas cleared by law enforcement adjacent to active threat areas. Entry by fire personnel is limited to Rescue Task Force (RTF) teams as defined below.

POLICY

In order to save casualties of violent and active shooter incidents, the Peoria Fire-Medical Department has worked with the Peoria Police Department to develop a joint plan to access, extract, treat, and transport to definitive care viable casualties of active violent incidents in a coordinated and timely manner. To best ensure the safety of first responders, this plan as outlined below, defines the personal protective equipment (PPE), training, communications, and tactics necessary for this type of operation.

Due to the specialized training, agency coordination, and communications requirements during an active threat event which may differ from other CAD cities, the first arriving Peoria Fire-Medical unit will assume Command, including from any other automatic aid units. Command will remain with a PFMD unit until relieved by a PFMD Battalion Chief (other partner fire agencies without proper training should be directed by Command to support functions within established cold zone areas).

If used, Rescue Task Force (RTF) Extraction Teams will quickly move viable casualties from the warm zones to Casualty Collection Point (CCP) or designated Treatment areas in the cold zones of the incident. This expedites casualty relocation to a safer area where definitive EMS care can be performed at a reduced risk. Peoria Fire-Medical Department personnel will only enter warm zones when the defined tactical benchmarks (as listed below in Critical Tactical Benchmarks) have been

completed.

Fire-Medical personnel may also find themselves operating on non-active threat incidents that require a heightened sense of awareness and protection (i.e. routine shootings when the assailant has fled but not yet located, barricade situations, incidents that may be active nearby, etc.). Company Officers or Command may enact additional protection by declaring an “Active Threat Protocol” on any incident, which will mean:

- Units will stage according to violent incident procedures until cleared by Command.
- Only necessary personnel will operate in forward or vulnerable positions as assigned by Command.
- All personnel in forward positions will don & wear ballistic PPE.
- All companies and Command will monitor the active Police radio channel.
- Personnel will operate with a heightened sense of awareness and utilize a designated look-out when operating outside their vehicles.

PROCEDURES

Training:

All PFMD personnel assigned to the Operations Division will receive initial and annual training in active threat response operations. Initial training will be included as a part of the recruit fire-training program. This training includes the use of proper PPE, tactics, strategies, communications, RTF operations, and joint PD/FD operations. Only personnel that have received this training will be allowed to operate within warm zones.

Dispatch Considerations:

Incident Type:

PFMD units responding to any active violent incident with reported casualties should consider an early balance to an “Active Violent Incident” first-alarm medical assignment or larger, based on the PTI information. C1958 (TLO), MS194 (Medical Support), along with additional Command Officers, Ambulances/Rescues, ALS units, and Helicopters (Stand-by) should also be considered early.

ALL ACTIVE THREAT INCIDENTS WILL BE DISPATCHED AS A VIOLENT INCIDENT WITH “STAGE FOR PD”.

Operating on Police Radio Channels:

The most common PD Radio Channels are programmed into all PFMD vehicle and portable radios in the following positions:

- Fire C1 = PD A1 -- Dispatch / Routine tactical
- Fire C3 = PD A3 – Tactical
- Fire C4 = PD A4 -- Tactical
- Fire C6 = PD A6 – Tactical (outlying areas)

To better support on-scene agency coordination, the Peoria Police Dispatch Center will relay the police tactical radio channel to the Fire Alarmroom as soon as it is known – preferably during the initial 9-1-1 call. This information will be sent to all responding fire units via MCT. If not received, this information should be requested through our Alarmroom. Responding PFMD units should monitor for changes in the assigned PD Channel as the incident escalates.

All responding PFMD units will monitor the assigned police tactical radio channel throughout the duration of the incident. Fire-Medical personnel operating on PD channels should use the following etiquette when possible:

- Use plain English to contact PD dispatch and units.
- The PD term “Code-4” is understood to indicate a secure scene or area. However due to the dynamics of an active violent incident, Fire-Medical Personnel should monitor for updates and maintain visual vigilance.
- During extremely active incidents with high radio traffic, PD Dispatch may move into a “Holding the Station” mode which usually transmits an audible beep every few seconds. In this mode, PFMD personnel should monitor PD radio traffic but *only transmit vital safety information* to minimize radio interruption.
- If PD Radio traffic is not restricted, the FIRST DUE *Peoria* fire unit and Battalion Chief should:
    1. Acknowledge responding.
    2. Notify staging time and general location.
    3. Identify the Fire-Medical Command Post Location.
    4. Acknowledge a secure scene and moving into the scene when requested by PD.
    5. Identify the treatment sector location when established.
    6. Initiate or respond to any communications with PD, especially when a coordinated effort is indicated.
- Any pertinent information obtained on the PD channels should be relayed on the fire tactical channel for responding partner agency units without PPD radio capabilities.

Due to the dynamic nature of these type incidents, relaying information through the Fire Department Dispatch Alarmroom is vital, as responding units from partner fire departments may not be equipped with Peoria Police radio frequencies. Sensitive information (i.e. police unit locations, victim evacuation locations, treatment areas, etc.) may be forwarded strictly by MCT if necessary until all threats are neutralized.
PFD Dispatch should still continually share with all responding units timely updates which may include:

- Type of violence (stabbing, shooting-handgun, rifle, etc.)
- Status of weapons and suspects
- Number, location, and type of known casualties
- Location of law enforcement officers, PPD Incident Commander or Command Post (via MCT only when appropriate).
- Type of environment (Residence, School, Public area, Commercial building, etc.) including size, layout, access, hazards, approach direction, etc.

Initial On-Scene Actions:

The first arriving fire unit will assume command. Based on their experience, a quick scene size-up, and dispatch information, whenever possible they should:

- Stage out of sight of the incident, away from crowds, out of any line of fire and behind cover.
- Provide continuous scene size-up for dangerous activity or opportunities to move forward based on new information.
- Don Ballistic PPE early when situation warrants it.
- When possible establish and maintain police radio communications.
- Have a minimum of two directions of egress without backing up.
- Turn off warning lights while staged.
- Establish Level 2 staging early in a safe location.

When units are cleared to move into a secured scene, they shall:

- Maintain radio communication with PD for updated information.
- Proceed with caution while conducting a windshield survey.
- Turn off warning lights when approaching the scene if practical.
- Don additional PPE equipment, if available and indicated.
- Be aware that bystanders and/or crowds may be a hazard.
- Have someone specifically assigned to be a lookout. All personnel should have a heightened sense of awareness of their surroundings.
- *If treating casualties in a warm or cold zone ensure that casualties have been searched prior to Patient care and/or transport, including unconscious patients.*

If units find themselves in a potentially violent situation they should immediately retreat to a safe location as a group. Emergency traffic and/or RADIO-EMER buttons should be used if necessary to communicate information to other units.

Tactical Considerations:

It is up to Command or a responding BC to designate an incident as an “Active” violent incident based the available information and their experience.

Because other surrounding cities may not have Peoria PD radio capabilities, equivalent active violent incident response training & procedures, or appropriate PPE it is critical for the safety of personnel and the proper coordination with PPD that a unit with these capabilities assumes and maintains Command as early as possible. As such, *the first arriving PFMD unit will assume command of any active violent incident on arrival, including from another automatic aid city Company.* Command may be passed only to other PFMD units, ultimately to be assumed by a PFMD Battalion Chief. In addition for these same reasons, a PFMD Battalion Chief (BC) will relieve a partner agency BC, and a PFMD Deputy Chief or higher will assume the role of Senior Advisor upon arrival their arrival.

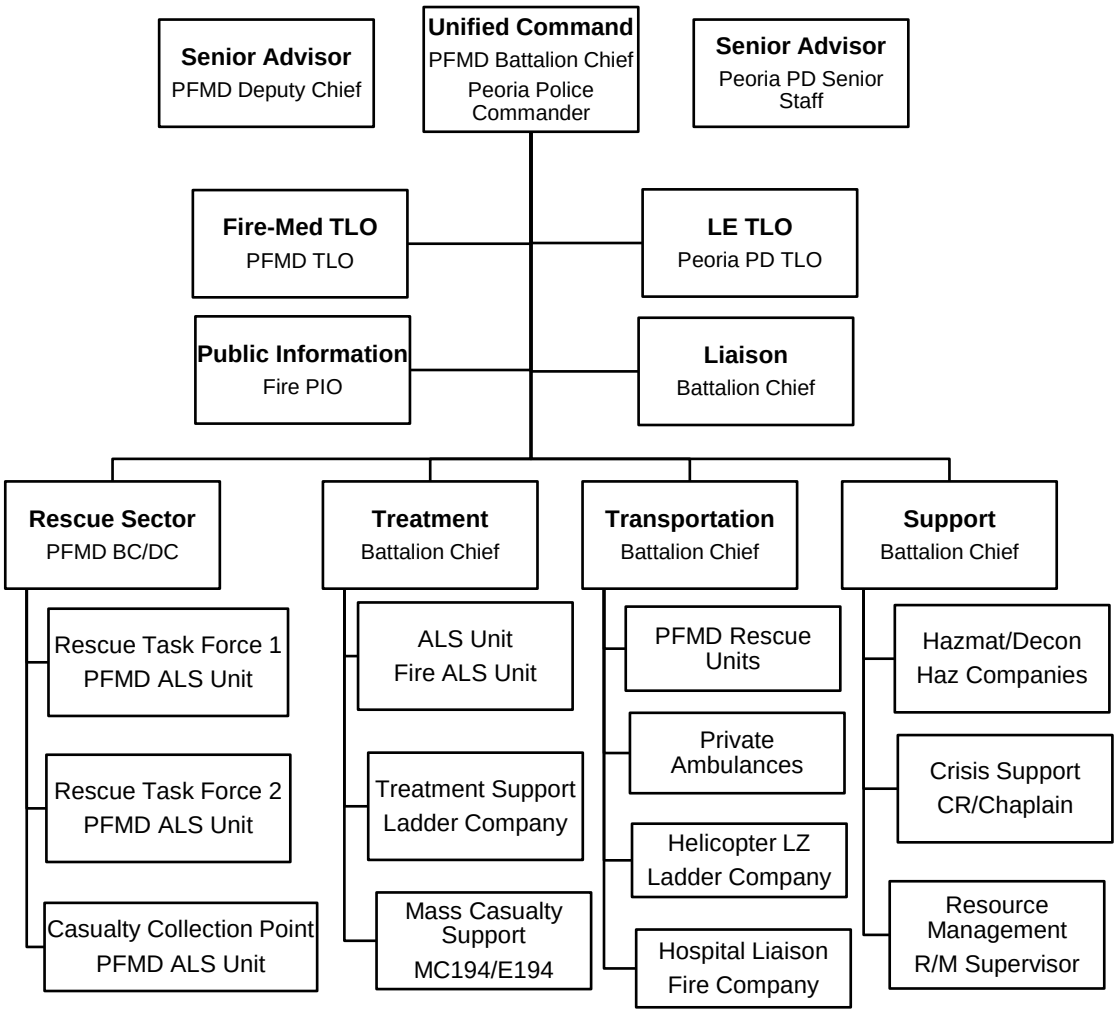
As such, the Fire Incident Commander should utilize PFMD ALS and Command units in forward positions, with PFMD BLS Ladder Companies and partner agencies providing traditional cold zone support functions such as treatment, transportation, and helicopter LZ sectors. All ambulances (including PFMD rescue units) should be reserved for medical transport purposes only.

It is imperative that communications be maintained by the Fire-Medical Incident Commander (IC) with all personnel operating within any warm zones. It is also imperative that clear and open communications be maintained at all times between the Police and the Fire-Medical ICs to ensure a coordinated approach to the incident. Initially this will likely occur by radio for the first arriving units. As the incident progresses, the use of dedicated liaison personnel as outlined below should be considered. Ultimately, a joint command post/location is ideal. If at any time communication between the PFMD IC and warm zone crews or the PPD ICs is lost or questioned, all Fire-Medical personnel will be recalled to a safe location until it is established.

To maximize safety and communications in the *initial* phase of an active threat incident, it is recommended that the Fire Incident Commander utilize the following command team until a joint PD/FD Command Post can be established:

- Incident Commander: PFMD Battalion Chief
- Support Officer: Battalion Support Officer (BSO)
- Senior Advisor: PFMD Deputy Chief
- Law Enforcement Liaison: PFMD TLO

As it grows, a standard active threat command structure could be:



Special Considerations:

Given the scope and uniqueness of these type incidents, Command and Fire-Medical personnel should give special consideration to:

- Crisis Support: Early crisis intervention for affected victims, witnesses, and their families using CR vans, chaplains, and other support tools.
- Hospital Disaster Notifications: Local Hospitals and Trauma Centers should be notified early and updated regularly to better prepare them to receive patients by ambulance and POVs, and to prompt enacting their internal disaster protocols.
- Hospital Support: Historically many patients are transported POV to local hospital ERs regardless of their ability to handle the injury level or number of patients. Fire-Medical personnel and rescue units may be dispatched to overwhelmed local hospitals to provide medical support and transportation to other facilities.
- Volunteer Management: Volunteers frequently self-deploy on high profile and large-scale incidents. Command should assign personnel jointly with Law Enforcement to effectively manage volunteers to support and not hinder operations.

After the initial mitigation, Command may need to manage transition to an extended operation. This could include a Liaison Branch (to coordinate with state and federal agencies, and other city departments, Logistical Support (including food, bathrooms, shelter, lighting, fuel, water, etc.), Finance & cost management. The command staff should consider transition to an all hazard incident management team (AHIMT) to support prolonged operations.

Rescue Task Force (RTF):

Certain active threat incidents may indicate the deployment of rapid RTF extraction teams to find, quickly stabilize, and remove victims to a safe & protected treatment area – even before the threat is completely secured. These extraction teams consist of adequate protection by PD and a four member ALS Company. (more or less fire/police personnel can be assigned based on the situation). All team members must be properly trained and equipped for the type of incident they are operating on (partner fire agencies without proper training, communications, or PPE should be directed by Command to the support functions within the confines of the cold zone areas).

RTF teams will only operate in "cold and warm zones" already cleared by PD, with the goal of the quickest possible removal of as many victims as possible to a designated CCP or Treatment Area.

The following are considered critical benchmarks and should be addressed prior to entry of fire department personnel into warm zones as part of a joint PD/FD RTF Team:

1. Initial Police and Fire Unified Command shall be in place with good communications and jointly located as soon as possible.
2. Initial Police and Fire Unified Command must agree that there are viable patients.
3. The immediate threat must be neutralized or contained under these or similar situations: suspect(s) are dead, in custody, fled the scene, reasonably contained or barricaded.
4. Initial Police and Fire Unified Command shall designate and agree to a specific ingress and egress path for PD Extraction Teams or joint PD/FD RTF Teams.
5. The boundaries of the specific warm zone area for entry shall be defined and communicated to the extraction team to ensure this area is a "warm zone" that is appropriate for RTF Team deployment and ensure personnel do not enter hot zones.
6. Initial Police and Fire Unified Command must jointly develop or at a minimum jointly approve an extraction plan based on available information and considering the Risk Management Plan.
7. The Fire IC has the final say as to deployment of fire resources into the warm zone based on the Risk Management Profile and all information available.
8. Designate a location for the Casualty Collection Point (CCP) if utilized.
9. Accountability shall be in place and tracked throughout incident.

<u>Communication</u>

- RTF team members shall be in constant communication with Fire IC or their designee.
- The use of radio ear buds or headsets (i.e. "Engineer's Headset") are recommended for all RTF team members utilizing an active radio to maintain concealment.
- RTF should communicate with Command their movement within the warm zone to allow for coordination of subsequent RTF teams, reducing redundant coverage and providing for back-up as needed (i.e. "Entering on Right Wall-Next RTF enter on Left…", "Need additional RTF in Classroom 5", etc.).

RTF Team Operations

Prior to entry, RTF Extraction team shall perform a brief face-to-face communication to coordinate the following:

- Route into the designated area.
- Team formations.
- When to turn off helmet lights for concealment.
- Identify security and EMS lead personnel.
- Communications / Signals.
- Cover / concealment.
- How to respond if an IED is located.
- Casualty care issues and CCP locations.
- Primary and secondary egress routes.
- Occupants to be extracted must be cleared of weapons by PD prior to treatment and extraction.
- Only immediate lifesaving EMS care should be delivered in the warm zone.
- Keep in mind it is important to minimize exposure time in the warm zone.
- Casualty collection areas will be identified in the IAP for the RTF teams to handoff casualties once extractions are made.
- RTF teams should only take appropriate equipment into the warm zone and keep in mind mobility is paramount.
- The RTF team shall enter as a team, leave as a team and shall not become separated. If the RTF splits within a room to treat multiple patients, they will stay close enough to remain covered & in visual contact by their PD counterparts.
- If the RTF team is threatened or comes under fire, follow the Law Enforcement leads direction.

Casualty Collection Point (CCP):

Depending on the situation, patients may be moved from the scene directly into a designated into a Casualty Collection Point (CCP) when movement directly to the Treatment Area is not practical due to distance, security, or other factors. A CCP is a specific, designated area where multiple RTF Extraction teams can move their patients to, providing for a centralized area for triage and rapid movement into the cold zone treatment area. This saves time in allowing the RTF members the ability to drop off patients to treatment personnel, and return quickly to the warm zone for more patients. A CCP may not be needed in all scenarios but some scenarios may require more than one CCP. Police and civilians may also utilize this area as an access point to the treatment area for victims.

The CCP is usually located at or near the cold/warm zone border, acting as a lobby sector between the two. Treatment personnel should be ready to accept multiple patients (with stretchers) and quickly move them into the treatment area (delayed patients) or directly to waiting ambulances (immediate patients) when available. Hemorrhage control supplies (combat gauze, tourniquets, etc.) can be stationed at the CCP for quick restock by the RTF personnel.

In some situations when access to the cold zone is not readily available (i.e. temporarily blocked by PD operations, an IED, a moving shooter, etc.) a CCP may be designated in rooms or areas that provide for cover, concealment, and police protection. Space should be selected based on security, size, and access to RTFs working in the warm zone. This is a temporary safe place to begin treatment until access to the cold zone treatment area is secure.

Command must coordinate the location of any CCPs, and clearly communicate the location with all police, fire, RTF, and treatment personnel. A CCP or Triage Sector Officer should be designated to coordinate patient movement, control entry into the warm zone area, and ensure all victims are checked for weapons prior to movement into the treatment area.

Treatment Area:

Uncontrolled transportation by law enforcement and civilians in past incidents has caused overloading of the closest hospitals, which also may not be the most appropriate level of care for the patient's injuries, causing a delay in definitive care. Early control and management of patients in mass casualty incidents is a key component in controlling patient flow from the scene to local hospitals.

Command should establish a robust treatment area early that is:

- In a safe cold zone location, with access to the warm zone areas & CCPs.
- In an area sheltered by barriers and cover, that can also be protected & controlled by law enforcement.
- Visible to victims / bystanders that may be moving without FD assistance.
- Easily accessible to transportation (ambulance, helicopters, etc.).
- Easily accessible to FD & EMS units.
- Expandable as needed.
- Well lit and sheltered from the elements if possible.

The Treatment Area should be well staffed early with ALS personnel, Command Officers (to coordinate treatment, transportation, and support), BLS Ladder Companies (for lighting, power, and manpower), CR Van/Chaplain services (emotional support), and Police security/crowd control as needed. Access, including entry and exit, must be controlled throughout the incident.

Medical Support Deployment:

The deployment of the 100 patient mass casualty module (MS194) should be considered early in the incident by Command due to its response and set up time. When possible E194 or other personnel familiar with set up should be assigned to the treatment sector early to prepare for victims. MS194 is equipped to manage up to 100 patients, provide support equipment (lighting, generators, large tents with A/C, etc.) and be utilized to support public safety personnel well into the investigation phase. An additional 100 patient module is available through EMS.

Demobilization:

Following the transport of all victims, all personnel should be cleared with a medical and PTSD evaluation prior to returning to duty. Active threat incidents can be horrific and chaotic, and can effect first responders for years. Command should begin to address a recovery plan on-scene with CISD debriefings and follow-up actions as needed in the coming months.

Fire-Medical personnel can be expected to remain on-scene for days or weeks to support law enforcement investigations (Haz-Mat sweeps/management, rehab centers, EMS stand-by, etc.). A long term IAP should be developed in coordination with Law Enforcement personnel to provide the necessary support.

Violent Incident Do's and Don'ts:

DO'S

1. Be aware of your surroundings and impending danger.
2. When approaching the scene and while on scene display a confident in control attitude (Command Presence).
3. Clear the scene of potentially violent materials.
4. Keep crew in sight at all times; never leave a crew member alone.
5. Use physical barriers between yourself and potentially violent people.
6. Separate disputants by taking them to an area where they can't see or hear one another (at least two crew members together) separating them will help calm the situation.
7. Use calm quiet voice to de-escalate the situation.

8. Keep a visual on people's hands.
9. Keep a visual on those involved with incident (don't let them go to another room without escort, etc.).

DON'TS

1. Don't get lulled into a false sense of complacency.
2. Don't ignore the potential for violence on any call we go to, to include to and from calls.
3. Don't ignore your gut feelings; when it doesn't feel right, it probably isn't.
4. Don't be confrontational; be confident, but not abusive to anyone or any group.
5. Don't be an easy target; be prepared to bail out when the need arises.
6. Don't stand between disputants.
7. Interview stance:
    - If you suspect violence, stand at a partial right angle out of arms reach.
    - Don't stand against a wall.
    - Don't fold your arms.

When in doubt, back out - be safe not sorry!

Approved: _____ 05/30/2018

Bobby Ruiz, Fire Chief — Date