Improving Survival: Responding to the Active Shooter

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EAST Traumacast: Supplementary Materials
2015
Boston 2013
“We were lucky, not good. Don’t ever confuse lucky for prepared.”

-Ed Davis
Commissioner (ret.)
Boston Police Department
Active Shooter

160 incidents occurred between 2000 and 2013

An average of 11.4 incidents occurred annually, with an increasing trend from 2000 to 2013.

1,043 casualties, including killed and wounded (shooters were not included in this total)

486 were killed in 160 incidents

557 were wounded in 160 incidents.
Should We Prepare?

A Study of 160 Active Shooter Incidents in the United States Between 2000 - 2013: Annual Totals of 1,043 Casualties

Source: Federal Bureau of Investigation, 2014

According to the 2007 National Crime Victimization Survey, 53.4% of the time, law enforcement was able to respond to a reported violent crime in less than 10 minutes. Bureau of Justice, National Crime Victimization Survey, Criminal Victimization in the United States, 2007 Statistical Tables, February 2010.

A Study of 160 Active Shooter Incidents in the United States Between 2000 - 2013: Location Categories

- **EDUCATION**
  - Schools (Pre-K to 12), 16.9% (27)
  - Institutions of Higher Education, 7.5% (12)

- **GOVERNMENT**
  - Other Government Properties, 6.9% (11)
  - Military, 3.1% (5)

- **OPEN SPACE**, 9.4% (15)

- **RESIDENCES**, 4.4% (7)

- **HEALTH CARE FACILITIES**, 2.5% (4)

- **HOUSES OF WORSHIP**, 3.8% (6)

- **COMMERCE**
  - Businesses, Open to pedestrian traffic, 27.5% (44)
  - Malls, 3.8% (6)
  - Businesses, Closed to pedestrian traffic, 14.4% (23)

Source: Federal Bureau of Investigation, 2014
ASE Characteristics

![Diagram showing the ASE Characteristics process with various stages and outcomes.](image-url)
Historical Response

- Surround, Contain, Call SWAT
- Fire/Rescue/EMS an afterthought

- April 20, 1999
  - 49 minutes
  - 15 killed, 29 wounded
  - Paradigm shift
Modern LE Response

• Rapid deployment
  – ALERRT

• Transition from teams to individual response from any LEO

• Aurora, CO (2013)
  – Public Information Officer
Aurora, CO
PreHospital Trauma Care

- Nonpermissive or semi-permissive environment

- Current Response
  - Essentially unchanged despite previous lessons

- Who’s responsible?
  - LEOs
  - Fire – Rescue
  - EMS
TCCC Overview

Coalition forces at this point in time have the best definitive care and evacuation system in history.
What were the Causes of Preventable Death?

Hemorrhage: 91% (n=888)
- Extremity [119/888] = 13.5%
- Junctional [171/888] = 19.2%
- Truncal [598/888] = 67.3%

Airway Obstruction: 7.9% (n=77)

Tension Pneumothorax: 1.1% (n=11)

Hemorrhage Control
Q: Who owns civilian prehospital trauma care?

A: Potential decision makers:
- Competing professional groups (ACS/ACEP/NAEMT)
- Federal law enforcement agencies
- Local and state law enforcement agencies
- Local EMS systems
- Local HMOs
- Local fire departments
Translating TCCC

- Problems with translation to civilian world
  - C-TECC
  - NTIC
  - IACP, NAEMSP, NSC, White House
Dr. Peter Rhee, at a memorial service Wednesday, has been an unofficial spokesman for Tucson.
First-aid kits credited with saving lives in Tucson shooting

By Sandhya Somashekhar and Sari Horwitz
Washington Post Staff Writers
Friday, January 21, 2011; 9:57 PM

TUCSON - Some of the first deputies to arrive at the scene of the Jan. 8 shooting rampage here described a scene of "silent chaos" on Friday, and they added that the carnage probably would have been much worse without the help of a $99 first-aid kit that recently became standard-issue.
Dallas SWAT
Standard Officer Medical Kit

- Tourniquet
- 14ga Needle
- Modular Bandage
- Nasal airway
- Trauma Shears
- Latex gloves (nonpowdered)
TCCC – Dallas, TX
C-TECC

- Translation of TCCC Concepts
- Attempts to recreate CoTCCC Structure
- Heavy focus on hemorrhage control
- Rescue Task Forces
The Hartford Consensus

- American College of Surgeons (Jacobs)
- ACS-COT (Rotondo)
- FBI (Wade and Fabbri)
- PHTLS (McSwain)
- CoTCCC (Butler)
- Major Cities Chiefs Association (Eastman)
- International Assn of Fire Chiefs (Sinclair)
THREAT

- Threat suppression
- Hemorrhage control
- Rapid Extrication to safety
- Assessment by medical providers
- Transport to definitive care
LE/EMS/Trauma Integration

- Maximize Survival

- CTECC / Arlington, VA Model

- LE-Based Model
  - Nontraditional providers

- DHS Stakeholder Meetings
  - February 2014
  - June 2014
# USFA Guidance

## Active Shooter and Mass Casualty Incident Check List

<table>
<thead>
<tr>
<th>X</th>
<th>#</th>
<th>Responsible Party</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Preincident</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Local EMA/AHJ</td>
<td>Multiple victim incident EOP completed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Incident</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>LOG</td>
<td></td>
<td>CP established</td>
</tr>
<tr>
<td>3</td>
<td>LOG</td>
<td></td>
<td>CP secured</td>
</tr>
<tr>
<td>4</td>
<td>LOG</td>
<td></td>
<td>U/C and communications method established and communicated to all personnel and communications center</td>
</tr>
<tr>
<td>5</td>
<td>U/C</td>
<td></td>
<td>UC/LE establishes goals and overall strategy; <strong>Emphasize Rapid Triage, Treatment and Extrication</strong></td>
</tr>
<tr>
<td>6</td>
<td>U/C</td>
<td></td>
<td>ICS established; command and general staff positions established</td>
</tr>
<tr>
<td>7</td>
<td>OPS</td>
<td></td>
<td>Establish staging manager and staging areas</td>
</tr>
<tr>
<td>8</td>
<td>U/C PIO</td>
<td></td>
<td>PIO staffed, JIS considered</td>
</tr>
<tr>
<td>9</td>
<td>OPS</td>
<td></td>
<td>Fire, medical, and/or rescue branches or groups established in operations</td>
</tr>
<tr>
<td>10</td>
<td>EMS</td>
<td></td>
<td>Establish casualty collection points, evacuation routes and LZs</td>
</tr>
<tr>
<td>11</td>
<td>OPS</td>
<td></td>
<td>Size-up and determine resource requirement</td>
</tr>
<tr>
<td>12</td>
<td>UC and LOG</td>
<td></td>
<td>Request required resources</td>
</tr>
<tr>
<td>13</td>
<td>U/C</td>
<td></td>
<td>Notify hospitals to activate MCI plans</td>
</tr>
<tr>
<td>14</td>
<td>OPS</td>
<td></td>
<td>Develop operational plan</td>
</tr>
<tr>
<td>15</td>
<td>PLN</td>
<td></td>
<td>Start IAP process</td>
</tr>
<tr>
<td>16</td>
<td>OPS</td>
<td></td>
<td>Aviation division established by air assets planned or airspace control required</td>
</tr>
<tr>
<td>17</td>
<td>OPS</td>
<td></td>
<td>Safe, hard cover staging area established (multiples for discipline or geographically)</td>
</tr>
<tr>
<td>18</td>
<td>LOG/AHJ</td>
<td></td>
<td>Resume normal activities if No ID</td>
</tr>
</tbody>
</table>

USFA/FEMA 2013
Rescue Task Force Concept

AOR Rear Guard  AOR Pointman

Direction of Travel
Rescue Task Force

Rescue Task Force Concept

AOR Rear Guard

AOR Pointman

Direction of Travel
RTF Limitations

• Wont survive first contact

• Limited Equipment
  – Protective equipment
  – Hemorrhage Control Equipment

• Perfect deployment still too slow
Novel Training Paradigm

• Integrated
  – ALERRT

• Realistic
  – Time
  – Expense

• Change in traditional EMS training
Public Access

• FROST
  – ACEP, NAEMT, ACS, MCCA

• Run, Hide, Fight

• Public access hemorrhage control
Response to Active Shooter

• RUN
  – preferably exit the area completely

• HIDE
  – if unable to exit
  – barricade entrances & prepare to defend

• FIGHT
  – last resort, but do not hesitate
  – improvised weaponry
Public Access Hem Control
Six Steps to AS Preparedness

1) LE Hemorrhage Control Program (NTPs)

2) ICS and AS/IMCE

3) Integrated public safety comms

4) Quarterly Integrated Meetings
   - LE, FR/EMS, Trauma – Appropriate Levels

5) Unified public safety special ops

6) Outreach & Preplan
   - EMS plays critical role
Confronting Emerging Threats
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