

EMS in a Bulletproof Vest: The integration of EMS into Active Shooter Scenarios

Evolution of EMS Response

Traditionally, EMS response in active-shooter situations differs greatly from that of any day-to-day 9-11 call, often delaying the time of critical lifesaving treatments. However, increased frequency in these types of events has called for updates in policies and protocols in both EMS and Law Enforcement. The following examines the current response operations designed to incorporate EMS into Law Enforcement operations in order to provide for a more effective and thorough response, in comparison to traditional EMS response to active shooter situations.

Recent increases in active-shooter type situations have called for updates and advancements in policies and operations throughout all public safety agencies in order to ensure a more effective response. According to Melissa Rivord in *Emergency Medical Services Policy and Practice*, law enforcement was quick to modify policies and procedures after “[identifying] weaknesses in the traditional active shooter response” however Emergency Medical Services (EMS) were not. One aspect of these updated operations is the incorporation of EMS into situations of this caliber in order to minimize the delay of on-scene medical interventions. Specifically, these advancements have called for the establishment of a level of care between the traditional tactical medic and external triage and treatment; this level is now commonly referred to as Rescue Task Force (RTF) (Bulloss, Blackburg Volunteer Rescue, Jems.com).

While EMS response to these situations has always been quick and abundant, the prior operational guidelines for these scenarios delayed patient contact due to scene safety precautions. Traditional operational guidelines for these scenarios focused greatly on scene safety. In order to

ensure the safety of emergency response personnel EMS operations are always external, or outside, and often far from the scene as explained by Vernon in his piece, *Mass Violence*:

Staging, command, triage and treatment areas may have to initially be located a half-mile or even a mile from the scene due to the distance a round fired from a weapon can travel if the incident is continuing to unfold (newslinegroup.org).

Additionally, Bulloss explains in *Active Shooter Response*, “only after law enforcement guarantees that the building is completely secure would EMS enter the building and begin treating injured people.” Due to this, law enforcement personnel had to transport patients from the triage area to the scene, but only after neutralizing the threat. As stated by Boston University Medical Center in *Active Shooter Training*, “it is not uncommon for a significant amount of time to pass before law enforcement has rendered the scene “safe.” [Unfortunately](#), this unintentionally prolongs the time before victims can receive life-saving care on the scene, as well as at a definitive care facility” (newslinegroup.org). For these reasons, “it became clear that to truly make a difference in patient outcome” a change in EMS protocols designed to decrease the delay to patient care was necessary.

Revisions and additions made to the operational guidelines and protocols for these events developed an extra level of care, RTF, for these scenarios in order to bridge the gap between law enforcement and traditional EMS operations. This aids in decreasing the time for patient contact (Bulloss, Blacksburg Volunteer Rescue, Jems.com). RTF was designed to “[integrate] EMS providers and law enforcement personnel to rapidly assess, treat, and remove casualties at an active shooter incident...[allowing] EMS providers to alter outcomes for casualties who would very likely succumb to their injuries without timely treatment” (Fletcher, *Responding to Active Shooter Incidents* 48).

In RTF operations, RTF teams enter the “warm zone” under law enforcement escort to provide an intermediate level of care between the scene and the traditional triage and treatment. RTF sets up a casualty collection point (CCP), where patients will be brought for critical lifesaving interventions, and then transferred to the exterior triage and treatment by law enforcement and RTF members (Bulloss, Blacksburg Volunteer Rescue, Jems.com). The majority of RTF operations take place in the CCP, however additional RTF teams may assist in evacuating patients to the CCP. Further explained by Vernon in *Disaster Response*, Fire and EMS personnel should remain in unsecured areas with law enforcement escorts only as long as necessary to perform their duties or extract victims to a casualty collection point (CCP). While RTF is an addition to historical response method, and not a complete restructuring of operations, there are three main components that set RTF apart from traditional response: warm zone operations, body armor, and critical treatment.

While historically, operations have been set far from the scene to ensure safety, RTF operated in what is known as the “warm zone.” Described by Fabbri in *FBI’s View* as “an active shooter scene, after elimination or isolation of the shooter threat, before completion of the laborious process of fully clearing the location of possible hidden threats” (FBI’s View, Jems.com). The warm zone is an area of potential hazard, as detailed by Bulloss “isn’t a hot zone because there are no active threats in the zone, but it is also not a “cold zone” because there could be sleeper shooters, IEDs or unidentified threats in the area” (Blacksburg Volunteer Rescue, Jems.com).

While a warm zone operation does not fall under the EMS motto of scene safety, this extra level of patient care is crucial in terms of patient outcome. As explained by Bulloss “Unfortunately, waiting for the scene to be completely secure means that patients lay there

suffering and dying. Studies of these events shows that the more rapidly critical interventions can be performed after onset, the more lives can be saved.” Nevertheless, while in the warm zone, EMS personnel are continuously under law enforcement guard and command to further ensure their safety and minimize any further threat. Fletcher explains that “The hierarchy of the LEO priorities is the safety and security of the EMS providers first; LEOs will put themselves, their body armor, and their weapon system between the EMS providers and any threat” (Responding to Active Shooter Incidents 50).

However, as a further precaution against any potential threat, RTF teams are also required to wear body armor, or bulletproof vests. Krebs explains in *Fire/EMS at Active-Shooter Incidents*, “Even though fire and EMS personnel will be operating in the warm zone with police security and away from the shooter, things can go wrong; a warm zone can become hot in an instant” (33). Krebs continues to discuss the different types of body armor, “standard body armor worn by police officers will stop a variety of handgun rounds” however, ballistic plates are necessary in protection against rifle rounds. Dave English, the Chief of Blacksburg Volunteer Rescue Squad explains:

We wear level IIIA vests, which are the highest level before you get to rifle plates, etc. This is a higher level [of protection] than a lot of the law enforcement has, and since they’re securing the area for us, it’s actually a very secure situation as compared to some of the other day-to-day rescue operations that we do. Higher-rated vests, helmets and other equipment are excessive and would limit mobility. (Bulloss, Blacksburg Volunteer Rescue, Jems.com)

While some agencies would like to provide body armor for all of their first responders, the more sensible option is to have several small caches of body armor available for response to active shooter situations (Krebs, *Fire/EMS*, 33). As is done by Blacksburg Volunteer Rescue Squad, “gear is kept in caches in EMS command vehicles deployed to any active shooter situation. Once

personnel arrive on scene they report to command and don their equipment.” (Bulloss, Blacksburg Volunteer Rescue, Jems.com).

While the vests provide extra protection for the EMS providers, they are also stocked with supplies for critical lifesaving interventions. Detailed by Bulloss, supplied are “two SWAT-T tourniquets, two Soft Tactical tourniquets for hemorrhage control, [and] four Z-Pak dressings and four Israeli bandages for hemorrhage control.” Additionally, supplies are “four Rusch 32 nasopharyngeal airways, four ARS 14-gauge needle decompression kits and four Bolin chest seals,” all for airway control. As hinted by the supplies, when it comes to RTF, lifesaving interventions focus on the two of the three basics of any EMS calls: airway and circulation. However, treatment provided by RTF is extremely minimal. First, patients are triaged using the START Triage model, then any immediately critical lifesaving interventions can be done before the patient is transferred to the external triage and treatment area. It is these minimal interventions that provide for the critical difference in patient outcome, as supported by Bulloss “Evidence has shown that the majority of victims in these types of incidents can be saved with quick and easy maneuvers such as hemorrhage control, tourniquet application, basic airway management and other rapid interventions” (Blacksburg Volunteer Rescue, Jems.com).

The necessity of developments to protocols and operations, with the support and cooperation of law enforcement for a more unified and complete response has made it possible for RTF type models to take the lead in EMS Active Shooter operations. Through the implementation of these warm zone operations, RTF has been able to effectively decrease the delay to patient care, and in doing so, provides a more favorable outcome for victims of these tragedies.

Sample Operational Protocol

1) Triage:

- Evaluate using START Triage
- Assign a color ribbon (according to START triage) and tie securely around their wrist.

2) Treatment:

- Patients with life-threatening injuries will be treated in accordance with WVEMS protocols, training, and Tactical Emergency Casualty Care (TECC) guidelines.
- Minor and non-life threatening injuries will be deferred to the exterior treatment area.

3) Patient Evacuation:

- Patients will be evacuated from the CCP to the exterior triage/treatment area in order of priority as directed by RTF Command or their designee
- When the CCP lies on the boarder of the warm zone and cold zone, non-RTF personnel can be utilized to move patients.
- If the CCP is deep inside the warm zone, RTF and Law Enforcement personnel will be utilized to move patients out to the cold zone. In this case, a secondary CCP may be established if needed.

It was late on a Sunday evening, as we piled into our vehicles and drove out to the local mall. Members of public service agencies across the county gathered outside as law enforcement prepared the scene for our active shooter drill. While most of our crew casually talked through the traditional external triage and treatment operations with members of the other agencies, I, as a member of our specialized Rescue Task Force team, prepared for a completely different experience. Separated from the rest of the crew, we slid into our bulletproof vests and began discussing the details of our warm zone operations. Finally, our radios went off and it was go time. Assigned to the first RTF team, three others and myself were the first EMS personnel to enter the building. Greeted by a law enforcement officer (LEO) as we walked through the door, we were instructed to stack up, or create a line behind him, and follow his lead. As we went through the building into the recently cleared warm zones, patients lay sprawled on the floor surrounded by bullet casings. Once deemed safe by our escorting officer we made patient contact and initiated primary triage, while continuously under the guard of the LEOs stationed in that area. Any patient who was able to walk on his or her own was escorted back to the casualty collection point (CCP) under the safety of an LEO. With the help of additional LEOs, our team under escort carried the rest of the patients back. At the CCP, the second RTF team provided critical medical interventions, before transporting the patients outside to the traditional triage and treatment area. As we completed our rounds and the remaining patients were brought to the CCP we assisted with critical treatment and transporting patients to the external triage. As the last patients were transported from the CCP we joined the rest of the crew in the traditional treatment area and the drill was a wrap.

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