International Public Safety Association

Rescue Task Force Best Practices Guide Version II

2019

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Executive Summary

History illustrates that active shooter, hostile events and mass casualty incidents (hereinafter ASHE, MCI or ASHE/MCI) can occur in any venue, in both hard and soft targets, in any municipality at any time of day on any day of the week. Secure locations like law enforcement agencies, military bases, airports, court buildings and other government structures are all types of venues in which an ASHE/MCI has occurred. Further, ASHE/MCIs have occurred at places of worship, hospitals, schools, casinos, movie theaters, shopping centers and nightclubs.

ASHE/MCIs occur in small, medium and large municipalities. New Zealand, Las Vegas, Parkland, Sutherland Springs, Thousand Oaks, Washington D.C., Newtown, Orlando, San Bernardino, Fort Lauderdale, Clackamas County, Aurora and Seattle are just some of the jurisdictions in which an ASHE/MCI has occurred.

Vehicles, explosives, fire, knives, assault rifles and handguns are some of the weaponry involved in dynamic, ASHEs/MCIs. First responders must train for multiple weapon types and dynamic scenarios. Given the complexity and wide range of possible scenarios, first responders need new resources, tools, education and training that emphasizes an integrated response to any ASHE/MCI.

For any jurisdiction to be fully prepared for an ASHE/MCI means that they must have a comprehensive, integrated response and recovery plan with allied emergency responders. A truly integrated response means that law enforcement, fire, EMS and 911 telecommunications must increase their opportunities to cross-train and debrief with allied emergency responders. These opportunities are not currently widely available.

The key points to remember throughout this document include:

1. Assailants pose a threat to all hard and soft targets.
2. While population density is often a consideration among assailants, this does not always drive their motive.
3. The events evolve rapidly, and an assailant can have one or multiple types of weapons on his or her person.
4. Multiple assailants may be involved in a complex, coordinated attack.
5. While there are several existing, valuable and recent studies that address unique components of ASHEs/MCIs, there is a lack of research and readily available information about how agencies can create an effective integrated, cross-disciplinary response to dynamic ASHEs/MCIs.

The International Public Safety Association's Rescue Task Force Committee, comprised of practitioner, subject matter experts who convene regularly to discuss ASHEs/MCIs, debriefings, response strategies and best practices, came together to share their lessons learned and expertise to create the ***International Public Safety Association's Rescue Task Force Best Practices Guide***. Since the document was released in October 2017, tragically, several additional ASHE/MCIs have occurred.

Acknowledgements

The IPSA would like to recognize the following members of the IPSA RTF Committee for sharing their expertise, lessons learned and their commitment to developing this resource for the global public safety community. This publication was directed by IPSA Executive Director Heather R. Cotter, RTF Committee Chair (and IPSA Board Member) Lieutenant George Steiner with Elgin (IL) Fire Department and RTF Committee Vice-Chair Lieutenant Daniel Murphy with Arlington County (VA) Police Department. The IPSA is charged with reviewing this document on a continual basis and will release updated versions as tactics and operations evolve.

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Rescue Task Force Justification

Acts of mass violence in the United States, and globally, have prompted several jurisdictions to evaluate their level of preparedness. Tragically, there have been several ASHE/MCIs that have made national headlines, including New Zealand, Thousand Oaks, Las Vegas, Parkland, Sutherland Springs, Café Blue, Ft. Lauderdale Airport, Aurora Movie Theater, Virginia Tech, Columbine, Sandy Hook, San Bernardino and Pulse Nightclub. These events occurred in different locations, different times of day, different days of the week and some lasted several hours. While the underlying motivation or ideology of each assailant is varied and complex, the objective is often consistent: to attack and attempt to rapidly injure or kill as many people as possible.

Communities have been devastated and they are looking to first responders to improve their response to minimize causalities. Since Columbine, first responders continue to revamp the way they train for and respond to these events. However, just as the threat continues to evolve, first responder strategies and tactics must also evolve with this threat. Integrated, coordinated response in early phases of an ASHE/MCI is crucial to ensure life safety is address in a timely manner.

Many jurisdictions rely solely on law enforcement to handle every aspect of an ASHE/MCI while leaving out the critical role of training for fire, EMS and 911 telecommunicators. When jurisdictions leave out these allied first responders, they are setting themselves up for ASHE/MCI response failure.

Law enforcement, fire, EMS and 911 telecommunicators all recognize the need to definitively address rapid medical care at the point of wounding or where casualties are found in a less-than-safe incident environment. After reviewing capabilities, many first responders recognize they are not equipped to handle an effective, integrated response to violence.

Survivability

What we've learned after myriad exercise debriefings, actual operations and after-action reports is that members of law enforcement, fire and EMS recognized the delay in getting trained fire and/or EMS to the injured. Many victims of survivable blasts injuries and/or gunshot wounds have died at the point of wounding without rapid emergency care and extrication to a medical care center.

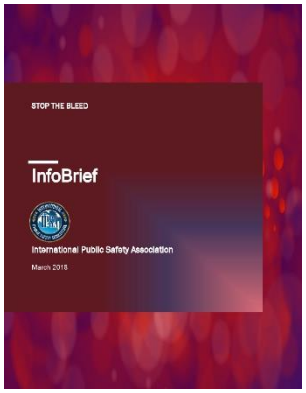
Linear, department-centric response models are not always effective in the current ASHE/MCI environment and the traditional development of incident objectives. Eliminating the threat at an ASHE/MCI is always priority number one but getting care to the injured should occur before making a structure or scene secure. Time equates to victim survivability.

Depending on the jurisdiction's plans, training, equipment and other capabilities, the time frame from incident initiation, point of injury, call receipt, dispatch, stage, Unified Command to deploy an RTF may be 15 minutes or more.

FIGURE 1: BEST CASE SCENARIO RTF RESPONSE TIME IS 15 PLUS MINUTES

Providing immediate medical aid to victims immediately after an ASHE/MCI threat is eliminated or removed is essential for their survivability. Often, it will be law enforcement personnel in the most advantageous position near the victims immediately after threat removal.

Uncontrolled hemorrhage can lead to death within minutes. Therefore, the best chance of survival for victims during an ASHE incident is when immediate responders (bystanders, citizens) at the scene can initiate care followed by law enforcement providing emergency medical treatment. The ***IPSA's Stop the Bleed InfoBrief*** provides additional lessons learned and strategies for organizations to adopt specific to this issue.



If RTF entry into an ASHE does not occur until 15 plus minutes after the time of injury, there is an increased possibility that a survivable injury will turn fatal without immediate and proper medical intervention. Jurisdictions must explore adding immediate emergency casualty care equipment to law enforcement 'go-bags' to provide the best chances of survival for the most critically injured.

At the same time, law enforcement has numerous other tasks that must be accomplished, including establishing and maintaining inner and outer perimeters, securing witnesses, protecting traffic flow for emergency vehicles, providing security for other sites including family assistance centers and hospitals, searching for additional perpetrators and other threats such as improvised explosive devices, interviewing and protecting victims and witnesses, initiating the investigation and many other roles. RTF can serve as a force multiplier for law enforcement in terms of providing victim care.

However, just as jurisdictions must recognize the benefits of law enforcement providing immediate lifesaving medical care, they must also recognize the benefits of fire and EMS operating in environments traditionally avoided (e.g. entering a building to provide medical care after an ASHE threat has been eliminated, even though the building may not yet be secured).

The effective care of victims is a shared responsibility of the first responder agencies and maximizing survivability depends heavily upon effective responder interoperability. The response to these events is a continuum that requires a high degree of coordination at all levels of incident command across the involved agencies. This coordination includes:

- Shared definitions of terms (common operating language) used in ASHE/MCIs.
- Unified Command.
- Jointly developed local protocols, training standards and lesson plans.
- Inclusion of ASHE/MCIs into table top and field exercises in order to improve familiarity and test the coordinated response.

First responders must recognize and communicate that the threat of mass violence isn't going away; it's picking up steam. It is reckless to not have an exercised plan in place before the tragedy of an ASHE/MCI occurs. A plan not exercised is just a theory. Further, that exercised plan must include law enforcement, fire, EMS and 911 telecommunicators operating cooperatively and in unison, realizing the synergism and force multiplication that can result.

Rescue Task Force Program Support

Due to the inherent, cross-disciplinary nature of an RTF, obtaining and sustaining support is a key component to a successful RTF program. Agencies must have both internal and external support. Internal support comes from leadership and line personnel. External support may include unions and Medical Directors. Support from community members, local businesses and schools, may provide financial and critical asset support.

Agencies must educate their personnel about the need for an RTF program, the vision of the program (including tactics and strategic goals) and the anticipated support for the program (both philosophically and fiscally). An effective delivery that addresses these issues can help lay the groundwork for acceptance of the RTF concept. Including key personnel early in the development of the policies, procedures and training curriculum will help garner further support and ownership of the RTF program.

Leadership Support

A key factor to having an effective RTF program is support from the executive level to line personnel. Simply having each executive from law enforcement, fire, EMS and 911 telecommunications sign a document that approves some funding and the notional development of an RTF will not suffice.

> *"The collaboration between first responders prior to a major incident is the linchpin of being prepared. The tactics of the suspects who commit random acts of violence has evolved into more complex scenarios. Subsequently the law enforcement response was pressured to evolve. But that alone is not enough. These incidents are usually over in 15-20 minutes. The shooting stops, but the bleeding continues. A rapid multi-disciplined response is required to save lives. RTF training prepares law enforcement, fire and EMS together prior to an AVI. We know from recent incidents, that law enforcement treating in the warm zone is paramount to a successful response. We have too many 'lessons learned' and it's time to evolve and apply these lessons." Daniel J. Murphy Jr., RTF Committee Vice-Chair, Lieutenant/Special Operations, Arlington County Police (VA).*

Leadership from each agency must make it a priority to participate in annual trainings, drills, workshops and full-scale exercises to understand first-hand how the RTF is functioning and to provide suggestions for improvement. They must be part of the solution and able to provide strategic guidance. Further, when line personnel observe leadership participating at RTF trainings, they feel supported, understand its value and realize being on an RTF is not just another job responsibility.

Leadership in all disciplines must recognize that when establishing an RTF program, it is going to take time and there is no standard about how an RTF program should be developed or implemented. While agencies can look to other similar agencies for guidance and best practices, each agency and response community is unique.

Union Support

Law enforcement, fire and EMS unions are often involved with agency policies, procedures and safety. When establishing an RTF, law enforcement, fire and EMS unions should be brought in at the inception of the RTF training to give their support and have equal input in the process. Agencies might see some apprehension from the unions, but they must be willing to do the necessary due diligence and be prepared to address any issues or concerns.

> *"ASHE/MCI incidents are overwhelming events for all agencies and first responders – law enforcement, fire, EMS and 911 telecommunicators. Simply put, these events are incredibly resource intensive. It is imperative that agencies partner with one another on a local and regional level. We have repeatedly seen many of the same shortcomings at each incident: (1) a break-down of Unified Command; (2) communications and interoperability problems; (3) a lack of accountability; and (4) response and training issues. Developing and nurturing partnerships with local/regional agencies will lead to successful planning, preparedness, unified training opportunities and the ability to have an effective multi-agency coordinated response plan. This collaboration will ultimately help save lives." George Steiner, Lieutenant, Elgin (IL) Fire Department, IPSA RTF Committee Chair and IPSA Board Member.*

Medical Director/EMS System Manager Support

Medical Directors often regulate means by which fire and EMS first responders to give medical care and, typically, changes cannot be made unless they approve. Since most law enforcement officers are not certified as paramedics or EMTs, they typically do not fall under the same guidelines, or scope of practice, as fire and EMS needing approval of a Medical Director for medical care. Therefore, Medical Directors must be allowed to review an RTF's standard operating procedures to make sure it is in line with medical procedures for law enforcement, fire and EMS. Further, Medical Directors must be invited to attend planning meetings and be part of the RTF approval process.

Several jurisdictions that developed successful RTF program engaged their Medical Directors early in the process. They found that the Medical Directors' support of the RTF is extremely important and must occur at the beginning of an RTF program. They are champions for getting treatment to the injured safely and quickly – one of the founding principles of an RTF.

It is important for Medical Directors to receive a presentation of the RTF concept and the science behind the clinical aspects of the program. Give them time to review literature discussing medical interventions in an ASHE environment, both recommended and not recommended.

When approaching the Medical Director about specialized medical supplies or equipment, agencies must do some research to demonstrate the value and benefits of any specialized products (e.g. tourniquets, wound packing, hemostatic blood clotting agents and vented chest seals).

While an agency may get the approval to make initial procurements of specialized equipment such as tourniquets and chest seals, there may be issues with resupply. Some agencies use the hospital or transport provider to resupply. This means that during the initial stages of an RTF program resupply may have to be done by the individual agency. However, after setting precedent, the equipment may transition as part of an agency's inventory throughout the region and the hospital may resupply the equipment.

A challenge that some agencies have encountered is creating the right terminology. Agencies looked at it as normal actions during an MCI, and simple triage and rapid treatment (e.g. SALT triage or other method) says that during triage they should stop major hemorrhage and open airways. While this is basically what RTF's are doing, the difference is that they are forgoing full triage because they are in a potentially hazardous area that has not been rendered safe.

EMS system managers are a crucial link between the Medical Director and the tactical level operations personnel. In systems that have a TEMS program there is a logical and intuitive link between that program and a RTF program. EMS system managers can reach out to the EMS providers in their areas and facilitate training and coordination between law enforcement agencies and EMS providers.

Along with facilitating information and logistical flow, EMS system managers can act as translators between fire, EMS, law enforcement and the medical facilities where these casualties will eventually arrive.

Accountability Officers

Just as it is critical for departments to maintain complete accountability in all operations, it is equally imperative to establish the Accountability Officer role at an ASHE/MCI. This position must be deliberately planned and implemented. It is generally maintained where fire, EMS and law enforcement are being blended and formed into RTFs.

Depending on the size and scope of the ASHE/MCI, this position will often start by working from the Unified Command post. However, depending on the geography and size of the event, there may be multiple Accountability Officers outside the Unified Command post.

Effectively tracking an RTF also includes tracking the law enforcement officers attached to each team. Accountability Officers must track the responders at an ASHE/MCI, and the Incident Commander may also task them with the added responsibility of maintaining situational awareness related to changes in operational/geographical designations (e.g. an area switching from a hot zone to a warm zone or vice versa).

The Accountability Officer tracks resources and RTF teams by geographical zones – hot zone and warm zone differential. The Accountability Officer must make sure they have all personnel

accounted for in the hazard area. This function must be maintained where the RTF teams are being blended and formed and where law enforcement, fire and EMS personnel are being teamed together. This is to ensure tracking of individuals and RTF teams. This is generally best accomplished from the Unified Command post.

Training with other Jurisdictions

Whether a jurisdiction is large, small or in a rural area, there must be training with neighboring agencies. Small and resource-light jurisdictions will rely heavily on automatic or mutual aid to fully fill the resource needs of an ASHE/MCI. It is imperative that all responding resources of all disciplines are working on the same page as the impacted jurisdiction.

Even larger or resource-heavy jurisdictions must train with surrounding agencies to ensure all resources can operate together. An ASHE/MCI that occurs on the boundary of a large jurisdiction can often elicit an automatic aid response that blends neighboring resources with the primary jurisdiction. Taking a regional approach to planning, training and exercising greatly facilities coordination and response.

Citizen Responders

Citizens are often the true first responders – the immediate responders. They are often caught in the middle of an ASHE/MCI, they are also in the best position to make an immediate impact on the survivability of victims as seen during the Boston Marathon and Las Vegas events.

We must train these immediate responders in basic trauma skills such as those outlined in the Stop the Bleed Campaign. RTF proponents need to advocate for immediate responder training and for establishing trauma kits in the public space like the now omnipresent AEDs.

ASHE/MCI preparedness must include a whole community approach. Just as full-scale exercises that involve multiple jurisdictions are critical for ASHE/MCI preparedness, training that includes citizens as responders is equally critical. Training citizens will enhance community resiliency.

Emergency planners must also highlight the importance of citizen responders in jurisdictions where they anticipate delayed public safety response times to the scene of an ASHE/MCI. This may be a volunteer fire department, a town that relies on the county sheriff, state police for law enforcement protection or even urban areas with limited development. Simply training emergency responders to work together is not enough.

A program, like Stop the Bleed, to train citizens in these skills is imperative to a community's ability to respond to these types of events. No matter how effective an RTF and integrated response program is, the time it takes to react and respond to an ASHE/MCI will always remain a critical factor.

As discussed in the Survivability section above, time remains statistically significantly as it relates to survivability. Training citizens how to avoid becoming injured lowers the number of casualties, and training citizens in basic trauma care provides the best chance of survival.

Additional information about the concept of citizen training and community resiliency is discussed in the Awareness Training section of this document.

Rescue Task Force Program Challenges

With any program, especially an integrated response program like an RTF, there are bound to be some challenges – at the executive level, line level and in-between. There is often one discipline driving the need to create an RTF program. In some jurisdictions, it may be the law enforcement agency championing the RTF concept and in other areas it may be fire and EMS leading the discussion. This is not uncommon.

> *"Agencies have come a long way toward a truly integrated response, but there is still a long way to go. Agencies can't give up. Gone are the days of each emergency response discipline working in a silo. It's expected by the citizens we serve and political leaders that we will all come together and solve the complex problems ASHEs/MCIs present. Plan together. Train together. Save together." J. Scott Quirarte, Battalion Chief, IPSA Board Member Ventura County Fire Department (CA).*

It is important to identify and utilize the right people when establishing and sorting through the infancy of a RTF program. Personalities are just as important as competency. The architects of an RTF program must have the knowledge of what each department's roles and responsibilities should entail and the end-state objective of saving lives must take center stage. Building cross-disciplinary relationships between law enforcement, fire, EMS and 911 telecommunications is critical to the RTF program's growth and success.

Funding

While common with many programs, funding to fully support an RTF program is a challenge most jurisdictions encounter. From equipment needs to staffing positions, the lack of a programmatic budget can derail even the best RTF programs. Funding for RTF equipment can be daunting in the start-up phase of the program. Creativity, strategic planning and department buy-in yields huge dividends in this area.

A department may be able to reallocate existing funds, may find local, state or federal grants or may even be able to designate a new budget line-item. Agencies may want to look to private sector donors willing to financially support the RTF program. However, be wary of one-time, start-up funds because the goal is program sustainability.

Law enforcement agencies will incur costs, but they are not as extensive as fire and EMS. Body armor is generally already supplied by law enforcement agencies to their sworn members. However, law enforcement officers will generally need a suitable go-bag and supplies such as tourniquets, hemostatic agents and combat dressings.

Costs for fire and EMS protective equipment (e.g. body armor, ballistic helmets) can be extensive. Fire and EMS will also need response supplies and equipment which may be

supported through the normal budgeting process. However, many agencies have found this is often not the case.

A jurisdiction's financial support for a RTF program is a direct indicator of their commitment to an effective, integrated ASHE/MCI response and public safety operations.

Perceived Fire and EMS Risks

There have been debates about fire and EMS entering a scene that is not cold, and it is important to educate fire and EMS about the level of risks of being on an RTF team. However, after explaining and showing these first responders the truth about where they will be working in the warm zone, as relative as it was to what they do in fires and on US&R and HAZ-MAT calls, it should reduce any fears or concerns.

While maintaining situational awareness is essential, first responders are likely safer operating as part of a RTF in a post-ASHE environment than many other emergency scenes, including freeway operations, driving emergency vehicles and structure fires.

Consistent Communications

All RTF team members need to hear what each department is being told, what is expected of them and that the message is uniform. Ideally, instructors from each discipline (law enforcement, fire, EMS and 911 telecommunicators) deliver the RTF training to a blended and unified student audience.

Having law enforcement, fire, EMS and 911 telecommunicators together in the same training environment helps clarify terminology, outline the roles of each department, promote mutual respect for differing missions, stress the importance of the unified concept and emphasize the need for cross-disciplinary education. Jurisdictions must give strong preference toward this cross-disciplinary training concept and recognize that the delivery may take weeks, months and even a year.

Scheduling RTF Training

Scheduling training is a challenge that all agencies will encounter. Sometimes it comes down to logistics and schedules. Other times, scheduling training at an in-service level proves difficult. Some agencies struggle in getting the right people to the training (e.g. training patrol officers instead of tactical teams). Depending on the size of the agency, scheduling the initial training could take so long that yearly refreshers are not possible.

Most agencies have training programs to meet annual training requirements. Each discipline (law enforcement, fire, EMS and 911 telecommunications) schedules and conducts training differently. For example, fire and EMS may conduct most of their training during their work shift whereas law enforcement conducts it when they are off shift or at shift change. These differences in training schedules must be reviewed strategically and seek ways to leverage the difference in training schedules as an advantage and not a hinderance.

Regardless of the climate in each jurisdiction, a focused and forecasted training plan is essential. Recognize that it may take many years to achieve the level of RTF proficiency that your agency desires.

Joint Training

The most effective way of ensuring buy-in from all disciplines is joint training. Most of the resistance to RTF programs is caused by a lack of understanding. This is common when training is conducted without representatives from all disciplines. Therefore, the makeup of the instructor cadre is critical for training success and buy-in from field personnel.

First and foremost, the fire and EMS instructors must be well versed in Unified Command, tactical operations and medical care that will occur during an ASHE/MCI. They must be a group respected by their peers.

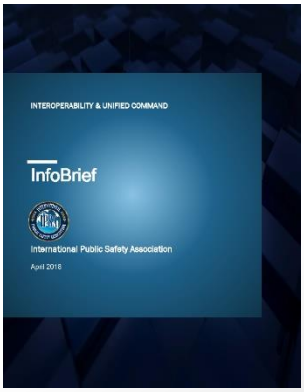
Equally important, the law enforcement instructors must be well versed in tactical operations, have a thorough understanding of RTF concepts and respected by their peers. One method to ensure this is to use SWAT officers as the law enforcement component of the instructor cadre. SWAT officers are well-versed in tactical operations and highly regarded by their peers. This will increase buy-in from other law enforcement officers. Involving SWAT will also be beneficial when conducting hands on scenarios because they will be able to clearly explain force protection tactics and address any questions from the RTF team members.

Cross-disciplinary training reduces resistance among the responders. Using fire and EMS to train law enforcement on medical tasks while using law enforcement to teach movement and conceal/cover techniques to fire and EMS gives the responders an opportunity to train and learn from one another.

Through this and regular RTF team training, the responders will become familiar with each other on a personal level and establish trust between each other. When an ASHE/MCI occurs, trust will be a critical component in an RTF team deployment.

Unified Command

All jurisdictions seem to struggle with effectively implementing Unified Command. While establishing and operating within an Incident Command System structure is second nature for most fire and EMS departments, this is not often the case for law enforcement. The IPSA's RTF Committee published a companion document, ***Interoperability and Unified Command InfoBrief***, that provides additional detail, strategies, lessons learned and best practices specific to Unified Command and interoperability.



Fire and EMS is usually trained to take command and then take control, whereas law enforcement takes control and then

establishes command. It is a different road map to get to the same objective, but the contrast is exacerbated when each department must intermingle as closely as required in a RTF within an ASHE/MCI response. While the command of an ASHE/MCI is driven by law enforcement, educating frontline supervisors in establishing and operating within Unified Command is critical to the success of an RTF program.

When agencies integrate the Unified command Concept as a matter of consistent practice, Unified Command efficiency during an ASHE/MCI event will be greatly enhanced and reflexive. Every jurisdiction must start working toward achieving implementation of Unified Command on every multi-agency response call-type (whether an incident of violence, industrial accident, hazardous material or other). Adopting this as a best practice will result in the ability of that same frontline personnel to effectively establish Unified Command when an ASHE/MCI occurs.

Overcoming RTF Support Challenges

RTF programs are a far departure from the standard way that law enforcement, fire, EMS and 911 telecommunicators operate. However, once these first responders are educated about the vision of the RTF program, why the RTF is needed and understand how it will be financially supported, they should begin supporting the concept. By involving these personnel early-on with the development of the policies, procedures and training curriculum, you will gain further support and ownership of the RTF program.

With every challenge, there is a solution. Most RTF programs have experienced challenges along the way, and they all concede that executive level support, education and training are the keys to overcoming these obstacles.

Whether your executive leadership must go to its respective union president and spell out the entire RTF program to get their support or you must place law enforcement, fire, EMS and 911 telecommunicators in the same room to work together to solve problems and create responses or you must run multiple drills over and over– there are myriad ways to overcome challenges.

All first responders need to hear what each department is being told and what is expected of them. The goal is to introduce them to the training instructors from each of the disciplines (law enforcement, fire, EMS and 911 telecommunications), so that everyone could receive cross-disciplinary education and help them grasp the unified concept. Therefore, it is strongly advised to bring together all fire and EMS operations personnel, all law enforcement patrol personnel and all 911 telecommunicators together, in the same classroom. This will likely be over a period of a few months.

It is important to reason with each agency individually and as a group. Once these groups begin to train together, clarification of terminology is established to create an understanding of everyone's individual mission. From this experience, a mutual respect is established.

When RTF Support is Refused

While many progressive jurisdictions have rolled out RTF programs, several jurisdictions have not bought into the concept, despite compelling case studies, supporting research and support for RTFs from authoritative sources like the IPSA.

If law enforcement, fire, EMS and 911 telecommunications fail to commit to the RTF concept, the resolution of the ASHE/MCI will revert to traditional and linear operational responsibilities that will only decrease the impact of on scene resources and serve to lengthen the time between time of injury and care/evacuation.

When refusal to support the RTF occurs, it is important not to give up on the concept. Below are five things you can do to help reverse the decision:

1. Explain the need by discussing specific examples and ASHEs/MCIs in which an RTF helped (e.g. Virginia Tech, Las Vegas) and when an RTF wasn't used (e.g. LAX shooting).
2. Offer to meet with the decision-makers and walk them through some RTF SOPs.
3. Continue to invite decision-makers to participate in training and exercises to observe the RTF in practice.
4. Give them contact information to the law enforcement, fire and EMS training cadre who have adopted the RTF concept.
5. The IPSA has a long list of RTF subject matter experts that can assist.

Rescue Task Force Program Implementation

When any new program is developed, there are risks of failure. Failure can occur due to lack of leadership buy-in, lack of funding, lack of mission or purpose, lack of line-level buy-in and for many other reasons.

RTF programs have a high risk of failure because there are no standards when it comes to developing a successful RTF program. Like this publication, the NFPA 3000 standard will help guide agencies, however, the NFPA 3000 standard does not describe how-to develop an RTF program. How an RTF program is developed is still driven by individual agencies and jurisdictions. Learning from other agencies about what went right and what went wrong is a way to mitigate the risk of program failure. Before teams are formed and training curriculum is created, there must be agreed upon conversations, buy-in and signed support from front line personnel and each agency executive (e.g. Chief, Sheriff, Director). A signed memorandum of agreement between agencies to include a joint set of SOPs to address ASHE incidents is also necessary, and it may come into play when there is a change in administration.

Once the memorandum of agreement is signed, then a core team of representatives from law enforcement, fire, EMS and 911 telecommunications must be established. It is not practical to have a representative from each agency, just one representative from each discipline for the core team. RTF programs require significant culture changes within each one of the disciplines and support is essential. This core team will govern the development of the unified doctrine, the training curriculum and schedule the coordination of training.

While the core team will oversee the development of the training curriculum, multiple representatives from different agencies must be involved with the development of the RTF program including Medical Directors, unions, city and county government representatives, transport providers and emergency management.

Once the RTF SOP is created, make sure to apply it in the emergency action plan at the city and county level.

Rescue Task Force Core Team

Every RTF program must have representatives from each public safety discipline on the core team: law enforcement, fire, EMS and 911 telecommunications. This core team of individuals will be accountable for planning, training, exercising, response, after-action report policies and procedures.

The core team is essentially providing programmatic oversight of the RTF program to ensure it is functioning to its greatest potential. They are responsible for identifying, developing and overseeing the division of labor. They will identify who is responsible for what and what other organizations and individuals should be involved (e.g. Medical Directors, unions, hospital personnel).

The core team must come with solutions to any problems and relay them to the RTF teams and first responders. As the RTF program is developed and training gaps are identified, the core team will be able to establish baseline training objectives and adjust as needed. Combining training objectives with information from after-action reports results in realistic and challenging training exercises that may be developed in the future.

The core team will also be responsible for developing an internal communications strategy about how to inform team members and local agencies about upcoming training, policy or meetings. They will debrief on command, control and accountability of all first responders operating on the crisis site.

Further, the core team should roll out training in small groups to work out the response plan and ensure any issues are corrected before introducing the training to all agencies. If training is confusing or hard to grasp, then it will be hard for leadership to stand behind the concept. The more time the core team works together, the more respect they will have for one another. They will have a deeper understanding and appreciation for the roles of each first responder – whether it's a law enforcement officer, fire service professional, EMS professional or 911 telecommunicators.

Everyone assigned to the core team has similar responsibilities:

1. To represent their respective discipline.
2. To identify a point of contact for each discipline specific agency they represent that does not have a member on the core team.
3. To update on progress and obtain feedback from their contacts.

4. To provide discipline specific insight to the core team when developing RTF plans, training, processes and procedures.
5. To communicate (or translate) their discipline specific language into a common response language for all to understand.
6. To build and maintain trust in the process within the discipline they represent.
7. To identify training methods that will work for their respective discipline.
8. To identify a core group of instructors experienced in teaching a multi-discipline approach.
9. To provide oversight, guidance and ensure the core group of instructors have the necessary support to advance the RTF program's development.
10. To periodically review training, SOPs and AARs of any deployment to continuously learn, adapt and improve.

Law Enforcement

Law enforcement has two primary initial objectives neutralize the threat and manage the casualties. Once the threat is neutralized, responding officers may be tasked to use RTF's to conduct medical care and/or they may begin providing emergency medical treatment. At a minimum all law enforcement officers should be trained in major hemorrhage control (pressure bandages and tourniquets), airway protection (recovery position), exposure protections (protecting victims from hypothermia) and evacuations (lifts, drags, carries and alternative methods for moving patients).

"While a fire-based RTF will have a tactical role during an ASHE/MCI in the warm zone, caution must be emphasized when using it as your only treatment platform. Agencies must recognize that the greatest chance of survival for victims inside the hot zone will be immediate treatment (hemorrhage control) by responding law enforcement officers. As the number of responding law enforcement officers increase during the first 5-10 minutes of an ASHE/MCI, the ability to treat, extract and maintain tactical superiority will be available. Responding officers must train and recognize the need for immediate patient care to occur while maintaining a tactical objective. If there is a shooter – eliminate the threat. If there is no shooter, no active stimulus, or no live intelligence, then preservation of life takes precedent." Justin Parrinello, Captain, Assistant Team Leader SWAT-MED unit Coral Springs-Parkland Fire Department (FL).

Fire and EMS

The goal for fire and EMS is to get patients from the incident to definitive care. It is their priority to provide rapid lifesaving medical care and patient evacuation. Operations occurring in the warm zone are those that focus on keeping patients alive until they can be safely evacuated. At no time should incident operations delay this objective. There will be times when patient evacuation is not immediately possible. In this case, the objective then becomes to treat as many patients as possible at the point of wounding with the goal of delaying death until evacuation. If patients are in the cold zone, then fire and/or EMS should perform normal operating procedures.

Ambulance Providers

Some RTF programs include ambulance providers in training and full-scale exercises. This helps the ambulance providers understand how the responding agencies will run an incident and what to expect regarding any casualties coming from the warm zone.

911 Telecommunications

The 911 telecommunicators are the linchpins of the response. In the past, the focus has been on the information they gather. Although critical, it is only one part of the response. An overlooked function of 911 telecommunicators is the vital role they play as the connection point between the different disciplines.

For a safe and effective response to occur the different disciplines (law enforcement, fire and EMS) must come together into an integrated response. In most jurisdictions this connection is made by different dispatch centers. The RTF program must provide operational training to 911 telecommunicators about the importance of this connection and how it should occur. Training 911 telecommunicators in violent incident response provides them the tools needed to predict responder and incident needs and problem solve during the event.

All 911 telecommunicators must have the opportunity to participate in RTF operational training to understand what the responders in the field are doing and what it is they need to save lives. Law enforcement, fire, EMS and 911 telecommunicators need to develop relationships working together for the RTF concept to work. While it is common for line level and response personnel to work well together because they respond to some of the same daily incidents, they need to substantially improve and work on their communications in the RTF environment.

Rescue Task Force Team Qualifications

Not every first responder is a good fit for an RTF team. Experience of individuals should be the number one priority, and an individual's ability to communicate with the team – and the public – should also be a deciding factor. There is a cultural paradigm shift with RTF programs. It is imperative that RTF members fully understand the changes in procedures. Below is a list of five preferred qualities each team member should have.

Law Enforcement Qualities

1. **Cardiovascular fitness.** The environment is incredibly dynamic, and officers must have the cardiovascular capacity to handle a high stress environment.
2. **Mental fitness.** The scene will be loud, chaotic and disorienting. An officer will have to shoot one or more assailants. The officer must be able to confidently work in a very difficult environment. All responding officers should receive some type of clinical therapy (e.g. stress inoculation therapy) following an ASHE/MCI. This will allow for better coping during and after the incident.
3. **Experienced professional.** A more experienced officer will be able to draw on his or her knowledge and past events.

4. **Advanced firearms skills.** The law enforcement RTF members will be required to move quickly and be able to neutralize the threat in any position or location.
5. **Ability to work with limited supervision within an Incident Command System structure.** Officers must be able to think quickly and act decisively in a Unified Command situation. They will not be able to rely on direction from supervisors. As members of the RTF, they will be required to accurately assess a complex, rapidly unfolding and dynamic situation and make critical decisions.
6. **Self-discipline.** Officers must have the self-discipline to avoid freelancing. They must maintain 360° situational awareness, search for tripwires and other hazards and always provide force protection for the fire and EMS members of the RTF.

Fire and EMS Qualities

1. **Physically fit.** Every fire and EMS RTF member must be physically up to the task because it is strenuous work. RTF members are required to move rapidly from patient to patient. Patients may be spread out over a large area. Care will be done at a rapid pace with little time to stop, and they may be required to move multiple patients alone.
2. **Mentally prepared.** The scene will be loud, chaotic and disorienting. Injuries will be severe and traumatic. Fire and EMS RTF members must be able to confidently work in a very difficult environment. All responders should receive some type of clinical therapy (e.g. stress inoculation therapy) following an ASHE/MCI. This will allow for better coping during and after the incident.
3. **Experienced professional.** This will be one of the most difficult incidents that fire and EMS personnel will ever respond to. A more experienced member will be able to draw on his/her knowledge and past events.
4. **Strong EMS skills.** The fire and EMS RTF members will be required to quickly and efficiently treat severe injuries. Strong EMS skills will help them provide effective and rapid treatment.
5. **Ability to work with limited supervision.** Fire and EMS RTF members must be able to think quickly and act decisively. They will not be able to rely on direction from supervisors outside the warm zone. As members of the RTF they will be required to make critical decision related to patient care and movement.

Rescue Task Force Training

Since there are no standards for RTF programs, training widely varies. Generally, RTF training includes classroom, practical training, full-scale exercise and online training modules. It's a dangerous misperception to believe that RTF training will not be needed and is only for the large incident. Any call for service has the potential to turn violent. Law enforcement officers and fire and EMS must to be trained to work together on all violent incidents.

RTF training must address all training or performance issues as soon as they are discovered. If the task isn't up to the performance standard, safety issue or questionable practice, then the RTF team must immediately stop the drill, address the issue with corrective measures and reset the scenario where it was left off and then continue. The number of training hours should be

based on the student – operators/frontline, technicians, supervisors and incident command – and the type of training – operational or awareness.

There are several components to a solid RTF training program. This guide breaks it up into two areas: operational training and awareness training. Operational training is for anyone that will operate in the warm and hot zones (law enforcement). Awareness training is for anyone that will operate in the cold zone or anyone that would support the response.

An RTF program needs to tailor its training to focus on the threats and the operational environment of a specific community. Rural locations will have different tactical considerations as well as manpower needs and availability.

Operational Training

RTF operational training will improve on the basic scene safety skills needed to operate on any violent incident regardless of size and complexity. There are several RTF operational training models that agencies can choose from. Law enforcement, fire and EMS are the front lines of emergency response. These individuals must work in a synchronized manner to ensure coordination and rapid medical treatment of casualties, which could include their own personnel.

Given this, individuals that must receive operational training include: local law enforcement officers, federal law enforcement officers, fire, EMS, 911 telecommunications and ambulance providers.

At a minimum, operational training should include the following eight concepts.

1. **History and background about ASHEs/MCIs**: Prior to the response, the RTF team must receive training about past ASHEs/MCIs. It is important for each team member from each discipline (law enforcement, fire, EMS and 911 telecommunications) to understand past violent incents, have knowledge about current trends in violent incidents, be educated on domestic terrorism and have general knowledge about mass shooting incidents (e.g. locations of mass shootings, duration of shooting phase of incidents, use of IEDs and common traits of mass shooters).

2. **Scene survey/pre-arrival assessment**: There must be a pre-arrival assessment component to the operational training that includes the type of incident (e.g. domestic assaults, fights, large crowds, drug or alcohol related incidents, psychiatric/behavioral emergencies and gunshots or stabbings). It is also important to include incidents with limited information or no information. Further, operational training must run scenarios for different incident locations and identify whether the location has a history of violence, is a location of significance or critical infrastructure/key resources (CIKR). Finally, there must be an arrival assessment that includes anything out of the ordinary, large crowds or lack of people, drug or alcohol paraphernalia and any signs that violence has occurred.

3. **On scene safety assessment:** Operational training must include instruction about how to assess scene safety. This must include how the RTF team can make a safe approach, how to identify escape routes, safety zones and areas of concealment and cover. Discussions about

methods of determining scene safety and methods for maintaining safety while on scene are paramount to ensuring each RTF team member's safety.

4. **Establishing scene control:** There are several items that need to be discussed during operational training about how to establish scene control. This includes, but is not limited to the following:

    a. Concepts of safe staging.
    b. Concepts of perimeters.
    c. Access and egress routes.
    d. Scene security.
    e. Concepts of zones – hot, warm and cold.
    f. Concepts of contact and cover for patient care.
    g. Skills used to provide responder safety while conducting medical care.
    h. Skills used to create a safe work environment to conduct patient care.
    i. Conventional and non-conventional weapons.
    j. Emergency escape plans.

5. **Implementing an integrated response:** Establishing an effective integrated response is an integral component of operational training. During training, there must be discussions about discipline specific objectives as related to violent incident response. This includes, but is not limited to the following:
    a. Law enforcement objectives.
        i. Hot, warm and cold zone operations.
        ii. Mitigating the threat.
        iii. Contact team and rapid deployment.
        iv. Hot zone medical care.
    b. Fire and EMS objectives.
        i. Cold and warm zone operations.
        ii. Medical care and evacuation.
        iii. Hazard control.
        iv. Patient evacuation and transportation.
    c. Rescue Task Force operations.
        i. RTF staffing.
        ii. RTF command and control.
        iii. RTF communications.
        iv. RTF functions and objectives.
        v. RTF movement.
        vi. Safety considerations.
        vii. Emergency procedures.
        viii. Casualty collection points.
        ix. RTF patient evacuation methods.

6. **Coordination, command and control:** Operational training must include discussion about team coordination, command and control. This must include ICS and NIMS as it relates to integrated response to violence, Unified Command as it relates to integrated response to violence, communication methods as it relates to integrate response to violence and force

protection concepts. Co-locating command posts should occur if Unified Command is not utilized.

7. **Warm zone medical care:** It is critical to include these items in operational training. Discussion will include care by RTFs and care by individual law enforcement officers. Further, there must be discussion around lifesaving medical care that includes care needed to delay death until patient can be evacuated from hazard area. This will consist of rapid lifesaving medical care applied to as many patients as possible and in the shortest time possible. Operational training must include:
    a. Major hemorrhage control.
        i. Tourniquets.
        ii. Direct pressure.
        iii. Pressure dressings.
        iv. Hemostatic agents where approved.
    b. Airway management.
        i. Position of comfort.
        ii. Recovery position.
        iii. Airway adjuncts such as NPA or OPA.
        iv. Chest seals.
        v. Chest needle decompression.
    c. Exposure protection (e.g. protect patients from hypothermia).

8. **Patient evacuation:** Further, there must be operational training on patient evacuation. This must include short moves, such as lifts, drags, carries. It must also include long moves and how to use devices and any available resources to assist with moving patients' long distances (e.g. office or wheeled chairs, motorized golf carts, vehicles and improvised carry devices). Finally, operational training must include how to transition to standard ASHE/MCI care in cold zone.

Local Law Enforcement

It is important to remember than an ASHE/MCI is a law enforcement incident. It will require an overwhelming large law enforcement response. Because of the complexity of ASHEs/MCIs, law enforcement officers must fill be able to fill multiple roles. They must be able to perform multiple tasks including patient care, patient movement and force protection as members of an RTF.

All local law enforcement officers (any law enforcement officer that carries a gun – university police, transit, court marshals, SROs, deputy sheriffs, airport police, hospital police) must receive an RTF program's operational training. Whereas the other disciplines on the core team (fire, EMS and 911 telecommunications) will maintain their primary role in the response, law enforcement officers must be able to fill all roles that could be needed in the hot and warm zones.

Federal Law Enforcement

Federal law enforcement officers (e.g. ICE, FBI, State Parks, NCIS, MP's) need to participate in RTF operational training because this will be a true cross-disciplinary, multiagency response. An ASHE/MCI can occur anywhere at any time. Recent history shows us that these events will even occur in secure areas (e.g. Navy Yard, Fort Hood). Every armed law enforcement officer will be needed. All law enforcement officers must be trained to respond as members of contact teams and RTFs. It must be expected that RTFs will be staffed with law enforcement officers from other jurisdictions and agencies.

Fire and EMS

Fire and EMS personnel are constantly responding to potentially violent incidents. The skills necessary to respond to an ASHE/MCI are the same as those needed for responding to any violent incident. Fire and EMS personnel need the skills to safely work alongside law enforcement while conducting rapid lifesaving medical care and evacuation on all violent incidents. Regardless of whether fire and EMS is expected to operate in the warm zone, they need to be trained to work safely on violent incidents.

911 Telecommunicators

Critical information is disseminated in the first few minutes through 911 telecommunicators. Early RTF program did not include 911 telecommunicators, but in today's climate it is necessary to include and cross-train them on ASHE/MCI response protocols. For example, fire 911 telecommunicators should go through scenarios answering law enforcement 911 calls and asking questions. All 911 telecommunicators must be trained to not add to the confusion or pass on bad information, but to ask questions relevant to the scenario.

The first two questions below are critical because they can help stop the violence:

1. What is the assailant's current or last known location?
2. How many assailants are there?
3. What are the physical descriptors? (e.g. height, weight, gender, clothing, race)
4. Does the assailant have a gun or weapon?
5. What kind of gun or weapon?
6. Does the assailant have a badge on his or her belt?
7. Is the assailant pointing the gun at people?
8. How many injured people do you see?

It is important for 911 telecommunicators to understand that ASHE/MCI response is not like any other call they receive. There is no value in clearing the queue of 911 calls. What is imperative, is finding a witness who is on scene and can calmly provide real-time intelligence. By keeping this caller on the line, they can direct law enforcement to the correct location to intervene and stop the attack.

Further, there must be separate classes for 911 telecommunicators that includes the following:

1. The differences between violent incidents and ASHE/MCIs.
2. How law enforcement operates during ASHE/MCIs.
3. How fire and EMS operates during ASHE/MCIs.
4. How to correctly make the connection between law enforcement, fire and EMS during an ASHE/MCI.
5. How to facilitate a Unified Command between law enforcement, fire and EMS personnel.
6. Understanding common communications issues and solutions to those issues.

Also, all 911 telecommunicators must attend the training sessions and full-scale exercises so they can see what the RTF is doing as it relates to real-time communications. They must have a script to use for all the in-service training and do it over the air/hand held radios during training.

Joint on-scene operations between law enforcement, fire and EMS cannot occur until the disciplines are brought together. It will be critical for the disciplines to unify command as rapidly as possible. This can only occur with face-to-face communications.

For this to happen on-scene resources will need to connect. Since most law enforcement officers, fire and EMS operate on separate frequencies, this connection occurs through dispatch centers. The 911 telecommunicators will be the key factor and possibly the driving force in this connection. The 911 telecommunicators need to know what field personnel need and are doing to understand how they can help.

At the onset of the incident it is likely that fire and EMS resources will be staged. To make the initial connection and start Unified Command law enforcement and fire and EMS resources need to meet face-to- face. For this to occur safely, the staged fire and EMS resources will need the following information:

- Identifying the law enforcement officer(s) they are supposed to connect with.
- The location they are to meet.
- Safe access to this meeting location.

The 911 telecommunicators must be able to relay for this information. By knowing what each discipline needs, they can enhance incident safety and speed up this connection.

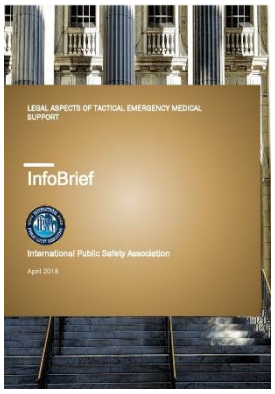
Ambulance Providers

It is important to allow ambulance providers RTF operational trainings so they know how the RTF team will run an incident and what to expect regarding the casualties coming from the warm zone. Regardless of whether a transport provider is expected to operate in the warm zone or not, they must be trained to work safely on ASHE/MCI incidents.

Tactical Medical Training

All law enforcement on the RTF team need basic tactical medical training to be truly ready for an effective, integrated ASHE/MCI response. All fire and EMS members on the RTF team need more advanced training.

There are no standards or mandates about the type of tactical medical training RTF programs must use. Some RTF programs participate in tactical medical trainings by other non-profit associations and others use tactical combat casualty care principles derived from the military. While the IPSA recognizes the need for there to be tactical medical training standards for RTF programs, there are unique policy and legislative barriers to consider and overcome.



The IPSA's TEMS Committee developed the ***International Public Safety Association InfoBrief: Legal Aspects of TEMS.*** This document will shed light on some of the legal and training considerations agencies need to be aware of when implementing a tactical medical program.

Until standards exist, RTF programs must continue to learn from other jurisdictions, participate in tactical medical training programs offered by authoritative sources, and make sure that the medical protocols used are approved by the local Medical Director.

Patient/Victim Transport

It is critical for RTF teams to think outside the box when it comes to patient or victim transport. While it is ideal for RTF teams to use medical equipment that is specifically designed for patient transport, this may not be realistic during an ASHE/MCI.

RTF programs must have a training component that teaches drags and carries for short moves and how team members can improvise and identify what is available to them in any given environment that will assist with longer moves (e.g. rolling office chairs).

Several RTF programs have discovered that drags and carries work best for short moves. And theoretically, the collapsible soft-webbed litters would work best for longer moves, but many teams have found them to be cumbersome. The bottom line is to test before you invest and learn how to use the resources available in any given environment. RTF team members will have to be able to make decisions based on the scale of the crisis site as well as the number of members on the RTF team capable of providing transportation.

Continued Education/Training

Agencies with RTF programs must address the need for continuing education and refresher training on RTF operations after the initial training. There are myriad ways to incorporate continued education. For example, some agencies address it in in-service annual training every other year and other agencies provide continuing education credit hours annually.

Continued education includes full-scale, integrated ASHE/MCI exercises, tabletop, academy recruit curriculum, video and on-line training. Ultimately, the practice of the RTF program comes down to interagency cooperation.

Refresher training does not have to be a large-scale exercises or schedule classroom. It also does not have to be large groups of responders. Refresher training will always be a challenge but being creative with training will yield success. Taking advantage of small drills and training session is usually easier.

As example, when fire and EMS is conducting a quick drill on RTF, invite the local on-duty law enforcement officers to attend. Also, most law enforcement agencies conduct some type of active shooter, rapid deployment refresher training. Adding RTF concepts to this training has proven to be a successful way of training law enforcement in RTF operations. During these training sessions invite local fire, EMS and 911 telecommunicators to participate. This gives everyone the opportunity to train together in RTF operations.

The goal is to train all responders – together – in RTF operations. Review each disciplines' annual training program and find opportunities to insert joint RTF training.

Awareness Training

The goal of awareness training is to create community preparedness and resiliency. Awareness training is for anyone, responder or citizen, that may find themselves first on scene of an act of violence. It is also for anyone that will operate in the cold zone or support the response, this includes county, state and federal law enforcement agencies that are not involved with the RTF program's operations training. The focus of training should be self-survival skills and basic lifesaving medical interventions.

Below is a list of stakeholders that the IPSA recommends receive RTF awareness training:

1. Area hospital administrators.
2. Hospital emergency room personnel (doctors, nurses).
3. Hospital coalition representatives.
4. Local airports.
5. Local politicians and government officials.
6. Congressional members.
7. Emergency management.
8. Critical infrastructure partners.
9. School/university teachers.
10. Municipal employees in the bleeding control (B-Con).
11. Transport providers (ambulances, medical helicopters, air ambulances).
12. Security officers.
13. Local businesses.
14. Places of worship.

Awareness Training Programs

There are many programs currently available to meet the needs of ASHE/MCI awareness training. All awareness training efforts should be consistent with the national campaigns. More specifically, the following should be presented and discussed during every awareness training course:

- Disaster response.
- Human behavior and psychology.
- Stress reaction to disasters.
- Defining stress inoculation.
- Knowing stress inculcation tools and methods.
- Understanding types of violent events.
    - Localized small-scale events (domestic violence, fights, workplace violence).
    - Larger mass casualty events (types, recent events, commonalities).
    - Active shooter events.
    - Terrorism events.
- Learning basic response of emergency personnel to these events.
- Describing the key concepts.
    - Run.
        - Do not delay, leave the hazard area if safe to do so.
        - Know exits and exit paths, have an escape plan.
        - Difference between cover and concealment.
    - Hide.
        - Methods for denying the attacker from gaining access to your location.
        - Methods for barricading and securing doors or whatever location you are hiding in.
        - Methods for maintaining stealth.
    - Fight.
        - Understanding when fight is an option.
        - Methods of defend yourself and others.
- Understand methods for providing lifesaving medical care.
    - Know when providing care is appropriate and when it is not.
    - Level of medical care to provide.
    - Minimum level of care.
        - Major hemorrhage control.
            - Pressure bandages.
            - Tourniquets.
    - Airway protection.
        - Recovery position.
    - Exposure protection.
        - Protecting victims from cold.
    - Evacuation.
        - Lifts, drags, carries.
        - Alternative methods for moving victims.

Awareness training can be accomplished on-line, by video, in person or any combination of those methods. However, the IPSA recommends that a portion of training must include hands on skills practice. Hands on training is critical for the medical skills portion of training. Students must be given the opportunity to practice hands-on training for hemorrhage control and airway control with a qualified instructor.

Continued Education/Training

Once the initial awareness training is completed, a method of continuing education must be addressed. Continuing education can include development of training programs for awareness training continuing education, or the training can be incorporated into current related programs. As example, incorporating hemorrhage control and recovery position into side walk CPR training is one way of addressing awareness level continuing education needs.

Rescue Task Force Training Assessments

There are several areas that RTF programs need to continually assess, prepare for and train on to have an effective response when an ASHE/MCI occurs. This includes target assessments, threat assessments, capabilities assessments and critical task training.

Target Assessment

In every jurisdiction, there is a list of targets. These are those locations where the community is the most vulnerable. Examining the probability and level of severity planners must identify those locations that are the most important and the most vulnerable. Once those have been identified, first responders must begin working with those locations and organizations to build comprehensive Emergency Operations Plans.

Once targets are identified, training must be conducted on-site to gain familiarity and discover the challenges presented by individual venues. Working with stakeholders in the community who occupy the targets presents information sharing that enhances pre-incident planning. First responders learn the locations of critical infrastructure like security monitors, emergency stairwells and roof access points. Primary and secondary locations for staging areas, casualty collection points and command posts can be pre-identified.

Threat Assessment

What is the threat? Planning for the unexpected is one of the most challenging steps. Preparing for what can occur in any location, whether it's a school, a shopping center, a place of worship or another setting is the only way to prepare sufficiently. Networking with larger organizations or state/federal level agencies can provide detailed threat information. Even small and rural jurisdictions have threats to manage. An ASHE/MCI can occur anywhere at any time. There are no geographical boundaries.

Envision, plan for and execute realistic training that challenges the capabilities of everyone involved.

Capabilities Assessment

Capabilities are often overstated, and it does not have to take a complex scenario to challenge a jurisdiction's capabilities. When done correctly, simple scenarios are often very challenging, when conducted in a realistic manner. Understanding the strengths and weaknesses of your jurisdiction's capabilities (first responders' and citizens' capabilities) will decide your training needs. Getting a holistic understanding of existing capabilities will allow agencies to identify where they are strong and where improvements must be made.

Below are key questions that agencies can use to establish a baseline capabilities assessment:

- **Safe response to potential acts of violence.** Can an agency respond safely to calls for service that may involve acts of violence/ASHE/MCIs?
- **Integrated response to all calls for service.** Do all local agencies work together on any incident type? Are there automatic aid or mutual aid agreements in place?
- **MCI response.** Can the community operate in integrated response on MCI's that are not caused by violence?
- **Initial connection and Unified Command.** Can law enforcement, fire and EMS safely make a face-to-face connection on scene of an ASHE/MCI? Can law enforcement, fire and EMS safety and effectively operate in Unified Command during an ASHE/MCI?
- **Hot zone medical care.** Does law enforcement have the capabilities to provide patient care and evacuation in areas that are not safe for fire and EMS to operate?
- **Warm zone medical care.** Can law enforcement, fire and EMS operate together as members of an RTF?
- **Patient evacuation.** Can law enforcement effectively move patients from the hot zone to the warm and or cold zone? Can law enforcement, fire and EMS move patients from the warm zone to the cold zone?

Separately testing and assessing capabilities may be a more effective strategy than attempting large-scale exercises that tests everything at once. Mastery of the basics is what saves lives.

Every organization will quickly reach the limit of their capabilities in an ASHE/MCI. This is precisely what makes joint training so critical. The planning of joint full-scale exercises is very challenging, but when done well, is extremely valuable.

While, RTF teams need to know how to perform more complicated tasks, appropriate time must be spent on the critical tasks they perform daily. Once the RTF program reaches the desired level of performance, they can begin to increase the difficulty of the training. If an agency can operate an RTF but is unable to effectively manage an ASHE/MCI, then the entire operation will fail.

Make sure to consider testing capabilities like mass notification, employee accountability, crowd control and crisis communication. After realistic training, everyone will better understand the need for continuity of operations planning.

Critical Task Training

Past incidents or training sessions may have identified shortcomings. Include training on these tasks in your short and long-term training plans. Based on the previous capabilities' assessment, create a short list identifying the five or six areas that need improvement. Based on assignment within the unit, these areas will vary. One squad may perform one task very well, while another may not. The leaders of the RTF team are best able to assess their capabilities.

Rescue Task Force Team Ratios

Jurisdictions that have RTF programs have explored and tested several options when it comes to the ratio of law enforcement to fire and EMS. While it is important for RTF programs to have a policy in place regarding ratios, it is more important to remain flexible.

Ratios must be completely dependent on the circumstances of the incident, task to be performed by the RTF team and resource allocation to each event. Considerations to the geography, terrain, layout of the incident location, the demographics of the victims, the number of victims, the status of the suspect(s) and the tactics used (e.g. IEDs).

Promoting critical thinking skills, rather than a solid number by policy, is a better approach. Given this, the below questions must be discussed and addressed:

1. How many law enforcement officers are available?
2. How many fire and EMS personnel are available?
3. How close in proximity are the wounded to the threat?
4. What type of force protection will be required to protect the RTF team members?
5. Is the threat isolated or locked down?
6. How many wounded are there?
7. How critical are the patients?
8. How difficult will patient evacuation be?
9. What is the terrain?
10. What is the distance patients needing to be evacuated from their location in the warm zone to the cold zone?
11. What types of patient transport options are available to responders? Golf carts, trucks, rolling office chairs, nothing?

The best way to determine the correct ratio is to base ratios on the task the RTF will accomplish, the environment they will operate and the risks they will encounter. Below are some scenarios.

Scenario one: Law enforcement creates a warm route by securing key terrain. In this example, no law enforcement officers are specifically escorting medical personnel, but law enforcement is posted throughout the route.

Scenario two: Patients scattered thought a large business office complex or multiple school classrooms. In this scenario, it would be difficult to move a large RTF. Using three to four law enforcement officers and two fire and EMS members may make it easier and faster to move through the tight and winding hallways. The faster the RTF moves the more patients they can

treat. In this same scenario when transitioning to evacuation an increase in the number of fire and EMS members may assist in a faster patient evacuation. Another solution for this scenario is to use multiple smaller RTF teams during the patient care phase and then combine them for patient evacuation.

Scenario three: Treating patients in large open areas. The ratios in this case are dependent on what the RTF will do. If they will treat the patients where they lay you may need a higher number of law enforcement officers to provide open area force protection for the RTF. If the objective will be to move the patient to safe area and then provide care, the number of fire and EMS members needs to be higher.

Scenario four: The RTF is completing patient care and has gathered patients in a CCP in the warm zone. The RTF needs assistance evacuating the patients and requests additional fire and EMS members. Law enforcement does not have additional resources to bring in the requested fire and EMS and/or establish another RTF. In this scenario, if safe to do so, one of the law enforcement officers will leave the RTF and exit the warm zone back, to the cold zone and the location of the additional fire and EMS members. This single officer will lead the fire and EMS members into the warm zone, where they will form up with the original RTF. They will now have a larger fire and EMS contingent to help with patient evacuations.

Scenario five: Large number of patients located in a single area. If law enforcement can lock down the area, in this scenario it may be beneficial to have more fire and EMS members than law enforcement officers. The more fire and EMS members on the RTF the faster they can provide care to this larger number of victims.

Scenario six: Large areas that can be made safe by law enforcement can handle larger RTF's.

Scenario seven: Tight areas such as buildings with multiple hallways or multiple small office spaces will require smaller RTF's. For these scenarios, it would be better to have multiple smaller RTF's than one large RTF.

Scenario eight: RTF operations using armored vehicles. In this scenario, ratios will be limited by available space in the armored vehicle. It is ideal to have two fire and EMS members available to conduct patients care in the back of the armored vehicle. The number of law enforcement officers will be dependent on expected threat, combined with where and how they will ride in the vehicle.

RTF programs need to be fluid and policies must ultimately base their ratios on the number of injuries, casualties and current staffing. It's important to adapt to each event. Ultimately, the situation will dictate the ratio.

Casualty Collection Points

Casualty collection points are area used for the assembly, triage, stabilization and evacuation of casualties by the RTF teams. Depending on the scale of the threat and the locations of the

injured, there may be one or more CCPs per event. Having multiple CCP options available allow for the critical thinkers on-scene to adapt to a dynamic situation. It is important to keep critical patients closest to the evacuation point for immediate transport.

Transporting victims must be driven by the dynamics of the scene, and every RTF team member must have the ability to move victims as needed. There is no reason for victim transport to be a function of one group over another.

In a traditional RTF program and environment, fire and EMS member are moving the victims, with law enforcement officers providing force protection. However, rarely an ASHE/MCI is ever traditional. Several recent ASHE/MCIs revealed that law enforcement officers are moving and evacuating patients.

There are caveats to every ASHE/MCI that may present alternative situations. An ambulatory casualty self-evacuating and directed to CCP, casualties in a defined hot zone (e.g. barricaded suspect) where law enforcement officers takes casualties to the warm zone line or a disproportion of resources (law enforcement inside a structure and very few casualties inside).

It is critical for RTF programs to allow for flexibility, and for the role of transporting victims in the warm zone primarily fall on fire and EMS. The point is not to lock into a one way of doing it. Be fluid and dynamic.

Moving Patients

There are several ways an RTF team can transport patients from tactical drag devices to collapsible soft-webbed litters. For patient and responder safety, many agencies are no longer using physical hands-on carries.

While it is ideal for RTF teams to use medical equipment that is specifically designed for patient transport, during an ASHE/MCI this may not be realistic. Therefore, it is imperative for members of the RTF team to be ready to use resources in the local environment to transport patients – this could be a rolling chairs or table with wheels or pieces of carpet as drags.

RTF teams need to have the flexibility to improvise and identify the best and most effective way to extract a patient whether it's using rolling office chairs, shopping carts or some other mechanism.

Ultimately, decisions are going to be dependent on the size of the crisis site as well as the number of members on the RTF team capable of providing transportation.

Rescue Task Force Program Budget

Adding a new initiative in your agency's operating budget is no easy task. However, one of the biggest lessons learned for an RTF program to be successful is to make sure it is fully funded and an agency priority. Saying it's a priority is one thing but allocating time and money to the RTF program is how it succeeds.

Establishing line-item budget allocations for equipment and realistic training are important to ensure survival of the RTF program. Therefore, when developing the RTF budget, make sure it includes:

1. Personnel.
2. TECC equipment.
3. Ballistic gear.
4. Medical supplies.
5. Radio batteries.
6. Snacks and water.
7. Operations training.
8. Full-scale exercise training.
9. Awareness training.
10. Continued education training.
11. MCI management equipment.
12. Long guns.
13. Extra magazines.
14. Casualty cards.
15. IFAKs.

From a budgetary perspective, RTF teams are like SWAT or TEMS team. There is a lot of funding needed initially for training and equipment, then constant funding for on-going training. RTF programs are a high acuity, low utilization due to their fundamental mission and purpose.

Reducing Costs

There are several ways an agency can off-set RTF program costs that will not necessarily compromise its mission.

Cost reduction strategy one: Schedule mini drills while on duty. Theses drills will accomplish four things. First, they will allow more of a real-life response. Two, they will keep the training cost down. Three, running mini drills will create a better team concept. And finally, mini-drills while on duty resolves concerns about overtime.

Cost reduction strategy two: Apply for federal grants, state grants and private funding from foundations. Generally, the U.S. Department of Homeland Security and the U.S. Department of Justice have grants available every year – sometimes more often. Not only does a federal grant award help your RTF program financially, but it will also help showcase your agency's work for other jurisdictions to model. There are also several funding opportunities available from private foundations. Seek out the foundations that have a history of giving to the public safety community.

Cost reduction strategy thee: Request donations. For large-scale exercises, reach out to your community partners and ask them to donate their facility. Take it a step further and ask them if they can help solicit volunteers. One agency even partnered with a medical school that then gave a class credit for students that volunteered to participate in the exercise. You can also ask community partners to donate food and beverages. In-kind donations will help the RTF program budget's bottom line.

Cost reduction strategy four: Re-use supplies when possible. Make improvised bandages and tourniquets to use on victims. Instead of using moulage on victims during an exercise, use pre-printed casualty cards with injury description and pictures.

Rescue Task Force Equipment and Supplies

RTF programs require substantial equipment and supplies. It is unrealistic to assume that an RTF team can efficiently treat multiple victims with traditional EMS equipment or limited gear. Accessibility to equipment and supplies must be addressed from law enforcement, fire and EMS leaders.

Although expensive, law enforcement, fire and EMS responders must be provided the correct tools for an RTF to fully work. This includes ballistic PPE for fire and EMS, specific mass violence kits with only the supplies needed to stop bleeding, seal an open chest or abdominal wound, or support an airway in an unconscious party and access to ASHE/MCI management equipment Further, law enforcement officers need to have long guns (with slings), war bags with extra magazines, radio batteries, snacks, water and IFAKs.

To save overhead costs, agencies are encouraged to seek grants from state, federal and private sources. Some agencies have received financing via their state and others from federal government entities. Another jurisdiction partnered with its resource hospital to use their grant money to fund a stocked active shooter bag for every fire engine, ambulance, ladder truck and battalion chiefs' vehicle in their region.

Ballistic Protection

Policies about fire and EMS use of ballistic protection equipment on calls that aren't initially qualified as ASHEs/MCIs vary across jurisdictions. Some agencies simply do not allow it, some assess it on a case-by-case basis and others have SOPs that stipulate that BPE may be worn on other incidents where an individual feels ballistic protection is prudent or necessary (e.g. domestic disputes, stabbing, shooting).

Just like BPE policies, the types of body armor that RTF programs are using varies by jurisdiction. Here is a breakdown of what some of the RTF programs use that developed this document:

- From one SOP: "Ballistic protective equipment (ballistic vest, ballistic helmet, and eye protection) should be worn if firefighters are aware, they are responding to or about to operate at an active threat incident, but it is not mandatory. It is acceptable to either delay life-saving actions to don BPE or to delay donning BPE to engage in life-saving actions."
- Level lllA panels in an external carrier that fits most sizes.
- Most of the agencies require their employees to wear body armor. External vest with a threat protection Level II.

- Fire and EMS use Level III soft armor with a front and rear ballistic plate and a ballistic rated helmet. The equipment is stored on the law enforcement agency's armored vehicle.
- Level IV external armor.
- Plate carriers with Level IIIA plates and IIA side panels. Since the PPE was funded by each individual agency, uniformity in equipment has become a challenge.
- Level III hard plate carrier.
- Some department have ballistic vests and helmets located in the supervisors' vehicles.
- Level IIIA vests and helmets.

EMS Supplies

RTF teams need a combination of traditional and advanced EMS supplies to effectively respond and treat multiple patients during an ASHE/MCI. While there are no standards or mandates about the types of EMS supplies RTF teams should have, there is a minimum expectation that each RTF team member will be equipped with the following:

- Multiple tourniquets.
- Multiple vented and non-vented chest seals.
- Multiple compression bandages.
- Multiple decompression needles.
- Hemostatic agents.

The ideal situation would be for each RTF team member to have access to all the supplies above, plus:

- Advanced airway equipment.
- Nasal pharyngeal airways.
- Hemostatic agents.
- EMS or trauma shears.
- Extra gloves.
- Safety glasses.
- Lumber crayon and permanent markers.
- Triage markings (e.g. black to identify deceased in warm zone).
- Assorted gauzes.
- Medical tape and/or duct tape.
- Grease pens/pencils.
- Glow sticks.
- Hypothermia blankets.
- Patient tracking cards (optional).

Jurisdictions that rely solely on traditional equipment are disserving the response teams.

Unified Command

Failing to plan is planning to fail. Jurisdictions must be prepared to provide qualified leadership at one command post to make critical decisions using a Unified Command model. The expectation of the public is that emergency responders will work in a coordinated fashion and exercise together to prepare for serious incidents and disasters.

Effective incident management of an ASHE/MCI includes the assumption that managing a complex incident can simply not be done without cooperation and coordination between agencies. The objective of Unified Command training is to provide opportunity for agencies to practice incident management and incident command together. Interoperability is already occurring daily between agencies at frontline levels, but when incidents expand beyond daily spans of control and standard operating procedures; interoperability at the incident commander levels has been less rehearsed but is vital to effective incident management.

Unified Command is a part of the Incident Command System. The National Wildfire Coordinating Group defines it as a unified team that allows all agencies with jurisdictional responsibility for the incident, either geographical or functional, to manage an incident by establishing a common set of incident objectives and strategies. This is accomplished without losing or abdicating authority, responsibility, or accountability.

A Unified Command is a mechanism to define and achieve a set of objectives in situations where two or more political or functional entities have authorities and/or assets. In the Unified Command model, representatives of the entities meet to set goals and decide how each can contribute to the achievement of those goals.

Jurisdictions have a few options when deciding the degree of formalization for Unified Command. Option one, they can elect a formal Unified Command and control relationship between all entities like the military Unified Command. Option two, entities can create an informal Unified Command that is based on structured arrangements that recognize federal responsibilities and the legal sovereignty of state and local governments under our federalist form of government. Option three, entities can create a hybrid approach.

In a disaster response involving elected and appointed officials, consensus building and a collaborative approach to problem solving are important aspects of Unified Command. The most important factor is to assess how well the Unified Command model is working and adjust as needed.

The reality is that most agencies do not operate in a Unified Command model often enough to be comfortable and competent with it when it counts the most. The day of an ASHE/MCI occurs is the wrong time for commanders to meet for the first time. Planning and training must be done in advance of these dynamic, complex events.

The RTF response at the Incident Commander level will only be successful to the degree that the Incident Commanders from each agency have both trained together and routinely use Unified Command concepts. Developing a Unified Command training model is the key to a successful response.

It needs to be understood that Unified Command does not mean any agency is abdicating authority or autonomy but ensures that the incident commanders from the responding agencies work together to develop clear and common event objectives. The resources for each agency always remain under the administrative and policy control of their respective agency.

Desired outcomes

There are several critical learning outcomes that should be considered in a Unified Command training program. These include the demonstrated ability to:

1. Articulate common terminology (to reduce the potential points of confusion, conflict and communication barriers).
2. Define Unified Command and explain how to achieve Unified Command functionality.
3. Develop resource accountability systems and integrate those within a multiple-agency response.
4. Conduct a PPOST assessment (Identify incident Priorities, Problems, Objectives, Strategies and Tactics).
5. Demonstrate effective management by objectives.
6. Organize agency resources into modular organizational structure and demonstrate proper deployment of those resources in an effective span of control.
7. Understand the various factors of incident complexity.
8. Identify the risks, hazards and vulnerabilities within the unique context of the incident.
9. Demonstrate joint situational awareness and information sharing.
10. Maintain composure and flexibility.

Drills

Unified Command must be implemented at the Incident Command Post during all incidents where RTF teams are going to be deployed to warm zones. Plans and training must also be prepared to create a Unified Command between law enforcement, fire and EMS in the warm zone to manage the interior operations. All Unified Command must be addressed in a plan and practiced during drills until it become a part of muscle memory. Having strong, Unified Command at the ICP and in the warm zone is key to keeping responders safe and achieving the best possible outcome for all victims.

An effective Unified Command training program must involve classroom, table-top and live exercise training to ensure the vital learning objectives have been cemented in the incident commanders decision-making processes.

Staffing

Determining how Unified Command will be addressed should occur at the executive level of each agency. Unified Command must be part of all RTF training. Line supervisors, such as law enforcement sergeants and battalion chiefs, must be brought together for Unified Command training specific to this type of incident. This will give all a chance to work together prior to the

incident. More importantly it will be a time to build relationships between the disciplines. This training should include tabletops and drills.

Everyone selected must undergo extensive command training to grasp the concepts of working in a unified model of command. All RTF programs must train on and practice the rarely utilized Unified Command model, regardless of the size of the agency, until all command-level personnel are familiar with its unique concepts.

Initial RTF command and control will likely be the first arriving law enforcement supervisor and the first fire company officer. These two will need to be inseparable in the early stages of the incident. It is doubtful that a functioning Unified Command will be established and operating when the first RTFs are ready to enter the crisis site. Therefore, fire command should remain on their operational channel while the responsible law enforcement agency remains on their channel until a Unified Command can be established and command and control of the incident can be passed off to that entity.

In the initial stage of the ASHE/MCI, the fire and/or EMS supervisor and law enforcement supervisor will be responsible for the isolation and elimination of the threat and the accountability of the contact team and any deployed RTFs. This will place considerable stress on that initial command and control element.

The 911 telecommunications centers should establish dedicated channels for the ASHE/MCI for fire, EMS and law enforcement. The 911 telecommunicators become vital lifelines between disciplines, RTFs and contact teams. There should be at least one channel dedicated to fire and EMS and a separate channel for law enforcement. The integration of communications and supervision must be rehearsed from the initial on-scene command through the full Unified Command.

Different types of training can be used including chalk talks, brief backs, table tops and culminate in a full-scale exercise. These training events must include 911 telecommunications personnel to ensure as seem less transition as possible. It is important for 911 telecommunications to be the information conduit for passing information from the crisis site to area hospitals as well as on-scene responders.

In nearly all ASHE/MCIs, people will self-evacuate to medical treatment facilities. Often the hospitals have little or no forewarning that a sizeable number of casualties are going to impact their facility both delivered by fire, EMS, law enforcement and private vehicles. It is critical to keep hospitals and emergency departments informed. Further, the fact of such self-evacuations makes the role of EMS allocating patients appropriately even more important.

Staging Units: Law Enforcement and Fire and EMS

Several After-Action Reports from previous ASHEs/MCIS reveal that law enforcement officers need to stage away from the event. During recent events, responding officers often drive as close as possible to the scene. Lessons from these AARs are revealing that these self-deploying officers often create a gridlock. Therefore, the establishment of a transportation corridor early in the ASHE/MCI is crucial for requested resources to get where they are needed.

Rescue Task Force Interoperability and Communications

A common theme running throughout this document is to plan early, review the plans often, adjust when necessary and train until it is muscle memory.

Interoperability takes in everything from ballistic gear and radios to patient care equipment and communications centers' staffing needs during an ASHE/MCI. The RTF program must establish, at the forefront, common terminology and concepts of operations. These items must be continually reviewed and updated as the RTF program evolves.

While radios and radio systems have improved vastly in the last ten years, agencies still struggle during drills to maintain effective communications. Given this, the RTF core team members must make sure to have discussions and plans for communications and interoperability – and then run different scenarios that include unique communications interoperability scenarios.

It is important for these discussions to be detailed. In other words, make sure to address details about mutual aid, automatic aid, ASHE/MCI response and whether the RTF team should stay on their own channel or switch to another jurisdiction's channel.

Regarding communications centers, RTF programs need to have a plan for how to aid small or thinly staffed communications centers so that the 911 telecommunicator can focus on accounting for and tracking their initial responding law enforcement officers, fire and EMS member. Examine ways that routine emergency calls can be routed to another communications center or how to get additional qualified staff quickly added to the telephones and radios. And remember to ensure that radio systems are integrated.

Further, RTF programs must work collaboratively with neighboring agencies to agree on what equipment to carry. This way when an emergency responder shares a mass violence care kit, the other responder knows what to expect is in it and is familiar with how the equipment works.

Assessment of Soft Targets

Assessing soft targets and working with the community for better education and resource allocation. The inherent value of identifying potential targets is being able to then plan for incidents occurring at these locations. Emergency plans can become more detailed by locating/designating off-site evacuation sites, staging areas, assembly areas, landing zones and ingress/egress routes.

Step One: Identify and prioritize potential soft targets
When examining soft targets within your community consider two characteristics: probability and severity. First, how likely would it to be for an incident to occur at this location (the probability). The second item to consider is how devastating would it be for the community, if it did happen (the severity).

Examples of soft targets include:

- Government buildings.
- Schools/colleges.
- Sporting venues.
- Business headquarters.
- Hospitals/health-care facilities.
- Shopping centers.
- Theatres.
- Crowded gatherings.
- Faith-based organizations.
- Fire departments and law enforcement agencies.
- Airports (unsecured areas).

Working with the stakeholders at each target, emergency personnel can assist them by helping them prepare their plans by asking key questions, such as:

- What are the planned actions of the occupants?
- Where are you going to evacuate to?
- Is this location able to shelter employees in the event of inclement weather?
- Is parent-student reunification possible at this location?

Step Two: Conduct cross-disciplinary training with all first responders
Basic classes (Fire 101, EMS 101, Law Enforcement 101 and 911 telecommunications 101) that explain basic roles and methods help foster understanding and respect between the disciplines. Understanding what each discipline is trying to accomplish and their methods helps the other support the overall mission.

Too often they are portrayed as different or competing missions, when this is rarely the case. There are two primary concepts that should be a priority for the joint training: Team Structure/Movement and Unified Command. Team Structure/Movement can be taught and refined at the drill level, while Unified Command can be done initially with tabletop exercises and later with full-scale exercises.

Step Three: Identify and collaborate with community leaders
Meeting with community leaders at the soft target locations and discussing vulnerabilities with the occupants can provide unique insight. Often these individuals include:

- Security directors at soft target locations.
- Human resources managers.
- Business and government leaders.
- Facilities managers.

Asking a security director, “what keeps you awake at night,” will provide valuable information with your assessment. Reviewing their incident response plans with them can potentially predict employee behavior during an incident. For example, each year before the beginning of the school year an information-sharing meeting with the School Resource Officers and the local fire and EMS personnel should be conducted.

Step Four: conduct training on location at key soft target locations
While this step is costly and time consuming, it is the most effective way to identify gaps in capability. Taking the time to develop and execute challenging and realistic training pays dividends in lessons learned that saves lives.

For example, it was during a full-scale exercise at a small university where Arlington, Virginia first discovered the gap that RTF addresses. They realized that rapid point of care treatment was the best way to increase survivability at these incidents and made the changes necessary in their response.

The less simulation and assumptions, the better. If a participant begins by saying, "Well, in this circumstance I would ____ ." When at all possible, make them do it. The task is always easier said than done and usually takes considerably more amount of additional time than was anticipated.

Training on-site exposes the participants to the actual target location. A walk around the facility is also beneficial and gives the members an estimate on the number of users. However, a walk around is not the same perspective as operating in the environment. Drills and exercises conducted on-site can be done during off-peak hours and do not have to take up a full shift.

Step Five: Community engagement and education

The initial video on Run, Hide, Fight is excellent to begin a discussion, but it is only a video and not a plan. Individual municipalities must engage their community and assist them in developing individual response plans related to active violence.

Schools and major business entities are a great place to begin because they typically have the resources and infrastructure to support educational campaigns. In business communities, human resource managers and security directors must gain support from business leadership to attain any success in implementing successful pre-incident preparation.

The value in community engagement is learning what the members are planning on doing during an incident. Expectations can be clarified, and recommendations made to Emergency Operations Plans prepared by schools, businesses and organizations. Correct terminology can be shared so that during a crisis there is less confusion. For example, explaining the differences between an assembly area versus a staging area makes a difference.

The Stop the Bleed campaign is just one excellent source of information for managers and directors to improve their own level of preparation. Commercially available trauma kits are now being purchased by the private sector. Train the immediate responders.

Many local jurisdictions through their Offices of Emergency Management have training and education programs that cover Response to Active Shooter and Stop the Bleed Programs. Many others use their Community Emergency Response Teams (CERTs) as volunteers during large-scale exercises as volunteer role players during ASHE/MCI training.

Recommendations

This document includes a substantial amount of information for new and existing RTF programs to consider. Given this, the IPSA identified several key themes and offers the following recommendations.

1. *Recommendation: The International Public Safety Association recommends that every jurisdiction has a Rescue Task Force.*

2. *Recommendation: The International Public Safety Association recommends inviting cross-agency leadership to participate in annual RTF trainings.*

3. *Recommendation: The International Public Safety Association recommends engaging your unions and Medical Directors early in the development of an RTF.*

4. *Recommendation: The International Public Safety Association recommends that every first responder receives an RTF briefing even if they are not on the RTF team.*

5. *Recommendation: The International Public Safety Association recommends that all RTF trainings are cross-disciplinary and always include representatives from law enforcement, fire, EMS and 911 telecommunications.*

6. *Recommendation: The International Public Safety Association recommends that all fire, EMS agencies should have an SOP that allows individuals to wear ballistic protection equipment when he or she feels ballistic protection is prudent or necessary.*

7. *Recommendation: The International Public Safety Association recommends that all law enforcement officers receive training in the medical aspect of tourniquets and hemostatic agents.*

8. *Recommendation: The International Public Safety Association recommends that 911 telecommunicators be on the RTF Core Team and actively participate in training sessions, full-scale exercises and attend specialized ASHE/MCI courses.*

9. *Recommendation: The International Public Safety Association recommends that continued education be discussed and addressed in the signed memorandum of agreement.*

10. *Recommendation: The International Public Safety Association recommends that since air support is often limited, agencies should develop a Mass Casualty Transport protocol in coordination with their receiving facilities. The plan makes provision for the local hospitals to receive patients outside of the acuity level they would normally receive (i.e. trauma patients to non-trauma receiving facilities) for stabilization purposes.*

11. *Recommendation: The International Public Safety Association recommends that all policies allow for all RTF team members to have the authority to transport victims to CCPs and the decision-makers on scene must have the flexibility to allocate its RTF team accordingly.*

Definitions

Abbreviation/Word/Phrase	Definition
Accountability	A system that allows for an accurate tracking of first responders operating on an incident scene.
Airway Adjuncts	Tools designed and used to keep the tongue from blocking the air passage. There are two types of airway adjuncts: (1) Oropharyngeal (oral) airways (OPAs) and (2) nasopharyngeal (nasal) airways (NPAs).
Active Shooter/ Hostile Event (ASHE)	An event where the assailant(s) seek to cause mass injury and death. ASHEs require initial patient treatment at the point of wounding. ASHEs can include, but are not limited to, active shooter, knife assaults, riots and use of a vehicle as a weapon.
Active Violent Incident (AV)	Assailant(s) are actively engaged in harming, killing or attempting to kill people in a populated or confined location.
Bleeding Control (B-Con)	Methods to mitigate or stop the loss of blood in an individual affected by intentional or unintentional physical harm.
Ballistic Protection Equipment (BPE)	Types of equipment that law enforcement, fire and EMS may use to help protect them against bullets and other shrapnel types of weapons.
Casualty Collection Point (CCP)	Designated place near the scene of the incident where patients are initially transported to for triage and will receive further medical and trauma intervention.
Concealment	A full or partial visual barrier used to hide behind to hide your location that can help prevent being targeted. This doesn't provide any ballistic protection. It's the protection from observation. Anything that prevents direct observation from the threat that might or might not provide protection from the threat.
Cover	The protection from firearms or other hostile weapons. A full or partial barrier used to hide your location that offers some level of ballistic protection.
Critical Infrastructure and Key Resources (CIKR)	Assets of the community and region essential to security, public health and safety, economic vitality and way of life. Examples include power grids and water filtration plants, monuments and government facilities, telecommunications and transportation systems, chemical facilities and hospitals.
Emergency Medical Services (EMS)	An organization charged with the treatment and transport of injured or ill patients.
Emergency Medical Technicians (EMT)	A person who is specially trained and certified to administer basic emergency services to victims of trauma or acute illness before and during transportation to a hospital or other healthcare facility.

First Responder	EMS, law enforcement, fire personnel and 911 telecommunicators who are charged with responding to and providing for public safety.
Hazardous Materials (Haz-Mat)	An organized response by hazardous materials technicians that to hazardous materials incidents, including those involving the use of weapons of mass destruction (WMD) and chemical, biological, radiation and nuclear (CBRN) incidents.
Immediate Responders (Citizens)	Individual bystanders who are at the scene of an ASHE incident and choose to help the injured.
Incident Command Post (ICP)	A designated temporary facility or location that signifies the physical location of the tactical-level, on-scene incident command and management organization. It typically comprises the Incident Commander and immediate staff and may include other designated incident management officials and responders from local, state, federal and tribal agencies, as well as private-sector, nongovernmental and volunteer organizations.
Incident Command System (ICS)	A standardized approach to the command, control, and coordination of emergency response providing a common hierarchy within which responders from multiple agencies can be effective.
Individual First Aid Kits (IFAKs)	A kit of supplies first aid supplies that can be worn on the person of a first responder (including patrol officers) that provide an ability to address hemorrhaging and airway obstruction. Basic supplies of an IFAK may include: • Gloves (latex and/or latex-free) • Tourniquets • Hemostatic agents • Chest seal • Nasopharyngeal tube
Mass Casualty Incident (MCI)	Any event where the number and severity of patients overwhelms the initial responding resources and when three or more casualties occur.
Medical Director	A physician who provides guidance and leadership on the use of medicine in a healthcare organization. These include EMS, hospital departments, blood banks, clinical teaching services and others. A medical director devises the protocols and guidelines for the clinical staff and evaluates them while they are in use.
National Incident Management System (NIMS)	A comprehensive, national approach to incident management that is applicable at all jurisdictional levels and across functional disciplines. It is intended to: Be applicable across a full spectrum of potential incidents, hazards, and impacts, regardless of size, location or complexity.
Special Weapons and Tactics (SWAT)	Law enforcement officers with specialized training and equipment that operate in uniquely hazardous

	environments. These teams may be known by other acronyms including Special Response Teams (SRTs).
Rescue Task Force (RTF)	Fire and EMS crews that enter Warm Zone under dedicated law enforcement protection to treat and or remove victims to the treatment-triage area. Several models exist for the deployment of RTFs.
Standard Operating Procedure (SOP)	Written guidance for personnel to deal with a situation.
Tactical Emergency Medical Services (TEMS)	Emergency medical technicians who have received specialized training and equipment. TEMS medics may operate with law enforcement in the hot zones of an incident.
Unified Command	In the Incident Command System (ICS), a Unified Command is an authority structure in which the role of incident commander is shared by two or more individuals, each already having authority in a different responding agency. Unified command is one way to carry out command in which responding agencies and/or jurisdictions with responsibility for the incident share incident management. A Unified Command may be needed for incidents involving multiple jurisdictions or agencies. If a Unified Command is needed, Incident Commanders representing agencies or jurisdictions that share responsibility for the incident manage the response from a single Incident Command Post. A Unified Command allows agencies with different legal, geographic, and functional authorities and responsibilities to work together effectively without affecting individual agency authority, responsibility or accountability. Under a Unified Command, a single, coordinated Incident Action Plan will direct all activities.
Unified Command Post	The physical location where Unified Commanders work face to face to communicate information real time and to manage the incident.
Zones of Operation	Designated zones around an ongoing incident that indicates the threat level to public safety personnel responding to an ongoing incident. Three widely recognized categories of zones of are provided below: **Hot Zone –** An area of operation that is immediately dangerous to life and health (IDLH) where Law Enforcement is actively attempting to locate, isolate and neutralize the suspect(s). **Warm Zone** An area cleared by and actively guarded by Law Enforcement where Rescue Teams can treat and remove patients. **Cold Zone** - A physically safe area outside of the warm zone where there is no direct threat. The Command Post, forward staging areas and Triage & Treatment areas are in the cold zone.