Office of Medical Services (OMS)

Active Shooter Incidents
The Challenge for EMS

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Definition

• Active Shooter (Defn)  
  An individual actively engaged in killing or attempting to kill people in a confined and populated area.

-FBI
Some Statistics

• Active Shooter events often occur in small/medium sized communities with limited public safety resources and budgets
• Mean Total Time: 12 minutes. (Less than 5 min in 37% of cases)
• 98% involve a single shooter
• Improvised explosives seldom involved (2%)
• In just over 50%, shooting still in progress when first police arrive.

• Shooter often shifts target to police on their arrival, or kills self
• Initial police response is often a single officer, sometime w/ partner
• When responding alone, the officer:
  – Must engage the shooter 75% of the time
  – If the shooter is engaged, the officer is shot 1/3 of the time
Some Common Elements

- Can occur in any community
- Very high rates of fire
- High risk of serious wounding of multiple targeted persons
- High likelihood of injuries to both civilians and police

- Short duration
- Wound patterns require rapid initial treatment of two subsets:
  - Survivable wounds that can be stabilized by TQ/external pressure
  - Survivable wounds that require surgery in an Operating Room.

- Enhanced but manageable risks to rescuers
  - Resources and Risk Tolerance vary in each community
IMPORTANCE OF TIME

• Duration of Incident
  – VA Tech  8-9 min  174 rounds
  – Fort Hood  10 min  214 rounds
  – Newtown  5 min  154 rounds

• Time to First Victim Contact (EMS)
  – Columbine  40 min
The Hartford Consensus: THREAT, A Medical Disaster Preparedness Concept

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Mass murder through active shooter and explosive events has been at the forefront of our news. Despite improvements in both law enforcement tactics and emergency trauma care, additional integration of the core functions of the public safety response to these events has the potential to maximize survivability. From the mass casualty shooting at Columbine High School in Littleton, CO, through the shootings at Sandy Hook Elementary School in Newtown, CT, an examination of events will demonstrate some improvement. However, we must continue to hone our response.

Perhaps no incident has changed both law enforcement and fire/rescue/emergency medical services (EMS) response like the Columbine High School shooting. At that time, traditional law enforcement response doctrine dictated waiting for tactical personnel to arrive to secure the school. During this waiting time, some of the fatalities and some of the morbidity among survivors were due to unchecked hemorrhage and shock.1 Nearly 8 years later, a clearer transition in active shooter response was evident on the campus of Virginia Tech University, when the initial response included 2 tactical medics who provided care, predominately hemorrhage control and airway management, long before the scene was secured.2 The mass casualty shooting incident at Fort Hood military base resulted in 13 dead and 31 wounded. An officer was able to stop the shooter, but sustained bilateral thigh wounds with significant hemorrhage from the left lower extremity. An Army medic controlled her hemorrhage with a Combat Application Tourniquet (CAT, Composite Resources) applied to the left thigh after direct pressure and improvised tourniquets failed to control the hemorrhage. Further advances in law enforcement and fire and rescue response were evident in the response to the Aurora, CO movie premir shooting. Continuing the trend of moving effective care earlier in the active shooter response, several of the wounded were rapidly extracted from the scene and transported to hospitals and trauma centers by police vehicles.3 The incident at the Sandy Hook Elementary School in Newtown, CT was a different scenario. The shooter used a semi-automatic weapon with high velocity ammunition; more than 150 rounds were fired in less than 5 minutes. Twenty-six individuals were shot and died almost immediately.4 Unfortunately, a rapid response for medical care would not have saved these victims. However, this mass murder of first grade students and their teachers has heightened awareness of these horrific events and has initiated calls for measures to improve response and reduce the tremendous burden of these events.

THE HARTFORD CONSENSUS CONFERENCE

On April 2, 2013, representatives from a select group of public safety organizations including law enforcement, fire, prehospital care, trauma care, and military convened in Hartford, CT to develop consensus regarding strategies to increase survivability in mass casualty shootings. Representatives at the Hartford Consensus Conference recognized the necessity of the groups’ combined constituency to realize that goal. The organizations represented in Hartford are listed in Table 1. A concept document resulted and became known as the

Disclosure Information: Nothing to disclose.
U.S. Fire Administration

Fire/Emergency Medical Services Department
Operational Considerations and Guide for Active Shooter and Mass Casualty Incidents

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FEMA
Effective Local Response

- The elements of a more effective response already exist.
- Must be employed in a form compatible with resources in a given community.
- No single approach is applicable across U.S.

AP photo
TRADITIONAL RESPONSE

CIVILIAN

Hot: DANGER
  - Law Enforcement
  - SWAT Teams

Warm: NOT SECURE
  - Fire Rescue

Cold: SAFE
  - EMS
CURRENT RESPONSE

MILITARY

HOT DANGER

WARM NOT SECURE

COLD SAFE
“ThREAT” Roles Defined

LAW ENFORCEMENT:
- Eliminate/Contain The Threat ("No more victims")
- Early access hemorrhage control/
- Identify non-compressible hemorrhage for evac

Fire/Rescue/EMS:
- First Assessment closer to POI
- Re-Triage/Prioritization (MCI)
- Continue Treatment
- Evacuation to Appropriate Center

Threat Suppression
- Rapid Extrication
- Assessment (including triage)
- Transport (to definitive care)

Ultimately, the ability of non-TC hospitals to perform "damage control surgery" may require consideration in some communities.
Office of Medical Services (OMS)

• Joint planning by local public safety leaders-
  – Law Enforcement and Fire/Rescue/EMS
  – Common plans with common language
  – Agreed levels of benefit vs. risk
  – Joint training

• Assistance to local leaders
  – State and Regional Partnerships
  – DOJ and DHS
  – National Organizations
    • Medical
    • Fire/Rescue/EMS
    • Law Enforcement

Local Incidents

Local Response
For More Information
On the Active Shooter Initiative
And the Role of the FBI:

Visit www.FBI.gov
- And search “Active Shooter”