Urban Integrated Community Panel
Victor Garcia, Deputy Chief – Medical Division  
*Tempe Fire & Medical Department*

Kyle Brayer, Captain  
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Barbie Marr, General Manager  
*American Medical Response*

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*Tempe St. Luke’s Hospital*
ACTIVE SHOOTER INCIDENTS

• Managing Change
WHY THE CHANGE?

Active shooter incidents are on the rise nationally

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

• Nationally and as an agency, we have not operated as efficiently as we would have liked on these incidents.
COLUMBINE SHOOTING
April 20, 1999

• 13 people were killed;
• 24 were transported to local hospitals and trauma centers;
• 170 patients were triaged through four casualty collection points (CCPs) established near the school;
• 10 critically injured students were transported in the "golden hour" with significant gunshot wounds and penetrating trauma injuries;
• 14 others were transported with explosive shrapnel wounds.
Staging Time at Columbine

• It took over three hours to clear all buildings.

• Fire traditionally waits for areas of violence to be secured by PD before entry.

• Some perished due to extended wait times for treatment.
Fort Hood, Texas November 5, 2009

• 13 Killed
• 32 Injured

13 killed, 32 injured: Ft. Hood, Texas

Sgt. First Class Noe Figueroa waits to get back on base outside Fort Hood's Clear Creek gate in Killeen, Texas on Thursday, Nov. 5, 2009, after a mass shooting on the base. (Jay Janner / AP)
AURORA, COLORADO
Movie Theater Shooting

• July 20, 2012
• 12 Killed
• 58 Injured
• Multiple people transported by PD
Orlando, Florida
Night Club Shooting

• July 20, 2012
• Deadliest shooting in U.S.
• 50 Killed
• 53 injured
• 2 hours before tactical units arrived

http://beforeitsnews.com/politics/2016/06/another-terrorist-attack-but-will-we-ever-learn-
THE CLUBHOUSE SHOOTING
March 12, 2012

- 14 people shot
- 2 with serious injuries
- 12 minor injuries
- Tempe Fire Medical Rescue Department failed to use the Command System correctly.
- A centralized Incident Command system should be immediately assembled between Fire, PD, ambulance service, hospitals, news media.
Why Did We Fail?

• Lack of early communication between police and fire

• Lack of strong and disciplined Command Structure

• Operating off of a “STAGE” mentality
Managing Change

CONCLUSION:

We **MUST** HAVE a completely Integrated approach to how these types of scenes are managed

- How we *communicate*
  - UNIFIED COMMAND
- How we *operate*
  - FD in the “Warm Zone”

https://www.usfa.fema.gov/data/library/research/topics/top_activeshooter.html
Difficulties from the TFMRD standpoint:

- **Logistics** – TFMRD 156 members, TPD 400 members, Ambulance Company
- **Terminology** – PD uses different language
  - Casualty Collection vs Treatment Area
  - Code 4? What exactly does this mean?
  - No standard Active Shooter terminology.
Difficulties from the TFMRD standpoint:

• Fire has an established Command System, PD does not.

• Fire cannot make accurate decisions regarding Active Shooter events without a PD liaison.
  – Treatment?
  – Extrication/Extraction Rescue Teams?
  – Staging?
Difficulties from the TFMRD standpoint:

**Culture**
- Staging vs engaging
- Ballistics on a fire apparatus
- New addition of sectors
  - Extrication Sector,
  - Extrication Teams (ERT)
- Frequent training
Our Risk Management Profile

Extensive data now exists to answer, “Where does this fit in our Risk/Management profile?” As an agency, we historically “staged” on violent Incidents.

• We will risk our lives a lot, in a highly calculated and controlled manner, to protect a savable human life.

We will risk our lives a little, in a highly calculated and controlled manner, to protect savable property.

We will not risk our lives at all to protect lives or property that is already lost.
National Active Shooter Statistics

- There is a **90%** chance of **1 shooter**.
- There is a **60%** chance the event will be over before PD or FD arrives.
- **Hemorrhage control** was found to be the life saving treatment that would save the most victims.
- Many injured expired before help could arrive.

Learning from tragedy: Preventing officer deaths with medical interventions By Matthew D. Sztajnkrycer, MD, PhD, FACEP
Our Program Today

Perfect World

• First FD unit arrives and assumes fire command
• Identifies casualty collection point/treatment and notify alarm room for system wide notification to PD and responding fire units
• Command officer & TPD liaison establish unified command
• Establishment of priority sectors
  • Treatment, Extrication, Transportation, etc.
• Extrication sector with multiple “Extraction Rescue Teams”
  • 2 FD personnel with 2 officers make up an ERT
• ERT enters warm-zone for triage and extraction to casualty collection point (PD lead)

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Integration

• Fire/PD are integral in the success of these violent events
  – Hospitals are equipped and can handle mass casualties, but...
  – For hospitals to be successful with these events, they require our organized efforts for success.
  – Ambulances will go where ordered...
Integration

- How our current system came together
  - SWAT Medic program
  - Fire and PD TLOs
  - National recommendation on response released
  - Updated fire policy established
  - Initial training with TPD SWAT members and all TFMR members
  - Acquisition of ballistic helmets and vests for all TFMR units
  - ERT deployment training with all TPD & ASU officers (full day for TPD personnel)
  - Inclusion of ambulance personnel (PMT/AMR in Tempe)
  - Hospital coordination
  - Reevaluation and continued training phase
Integration

• Keys to success looking back...
  • Build a strong relationship between PD/Fire at all levels
    • Not just command officers – TLO, Captains, Sergeants, etc.
  • Top down support – Fire and Police Chiefs
  • Key to the entire operation is early Fire/PD communication on scene
  • Budget for training early and then schedule recurring interdepartmental drills
  • Continue to prioritize training
    • Quarterly training paramedic CE, online courses, etc.
2016 Joint Training

• Active shooter protocol
• Carrying techniques
• Transport to CCP
• CCR class
• Bleeding control
  • Tourniquets
• Active shooter scenarios
  • ERT teams
Sheila Bryant, RN
Tempe St. Luke’s Hospital
Family Reunification
Barbie Marr, General Manager
American Medical Response