GENERAL ORDER 330.15

Response to Potentially Violent and Active Assailant Incidents

EMERGENCY SERVICES BUREAU

Issue Date: **January 30, 2017**
Revision Date: **February 3, 2017**

APPLICABILITY

All Personnel

POLICY

The Howard County Department of Fire and Rescue Services (Department) shall establish guidelines for the safe response to, and management of, violent or potentially violent incidents. In today's world there exists a significant possibility that first responders will become involved in a response to an incident involving violence. Traditionally, violent acts were rarely directed at first responders who were allowed to enter scenes and render aid with minimal risk. Our work environment has changed, and now includes individuals and groups with different value systems that in some cases may place their needs over the impact to innocent human lives. Examples of groups or incidents that may pose an increased threat to first responders and the community include:

- Suicidal Patients
- Domestic Violence
- Assaults in Progress
- Active Assailants in Public Venues
- Terrorist Groups (Domestic or International)
- Sovereign Citizen Groups
- Human Trafficking/Kidnapping Rings
- Violence Related to Immigration Issues
- Gang Violence and Networking
- Gang/Group Members with Military Backgrounds and Combat Experience (Paramilitary)
- Organized Drug Trafficking
- Home Invasions

Emergencies are often chaotic and emotionally charged events. Any situation has the potential to turn violent. The individuals encountered may be or become agitated, desperate, motivated by criminal or other hostile beliefs, or their judgment may be impaired by drugs/alcohol and/or mental illness.

There is an increased need for Department personnel to work closely and in conjunction with the Howard County Police Department (HCPD) and law enforcement (LE) personnel, at both the command and operational levels.

DEFINTIONS

- **Cold Zone -** designated area where no significant danger or threat can be reasonably anticipated. This could be achieved by staying at an adequate safe distance, or by assuming a safe geographic location or other inaccessible area from the incident. The cold zone is the location for staging of resources, the incident command post, and patient treatment or transport areas. The cold zone could also be classified as the "outer perimeter" by LE.
- **Warm Zone -** any area of operations where there is a potential hostile threat to persons or providers, but the threat is believed to be indirect (not direct and immediate). An example of this is an unknown location of suspects in a given area that has been quickly searched by LE and no immediate active assailant or threat found. While secondary threats are still possible as a thorough search has not yet been completed, no credible knowledge of secondary devices is known. It should be noted that established zones may deteriorate quickly and without warning due to active emerging threats. All providers must be aware of this possibility and be prepared to quickly change locations or evacuate. It is imperative that Department providers coordinate all team movements with their LE counterparts.
- **Hot Zone -** the area where a direct and immediate threat exists. Direct and immediate threats are often very dynamic and are influenced by the complexity and circumstances of the incident. Examples of direct and immediate threats include an active shooter, a barricaded suspect, a hostage situation, a high-risk warrant service, and possible terrorist acts. Hot Zones include areas within the range of active gunfire or secondary devices, or when an assailant's specific location is unknown thus negating the ability to determine the extent of their threat. Hot Zones should be considered "***extremely dangerous.***" No Department personnel should be intentionally placed into a Hot Zone environment, with the exception, possibly, of trained Department Tactical Emergency Medical Services (TEMS) providers.
- **Body Armor -** a form of Personal Protective Equipment (PPE) intended to provide limited protection to personnel from gunfire, and is graded according to effectiveness.
- **Casualty Collection Point (CCP) -** a designated area WITHIN a warm zone where casualties may be "staged" as a transitional point to a more secure and safer zone.
- **Triage-Treatment-Transport (TTT) Area -** a designated area in the cold zone where patients are brought for triage, treatment, and transport services. There may be one or more TTT Areas designated depending on the geography and arrangement of the incident.
- **Concealment -** any position that hides a provider from suspect observation, and can be natural or man- made. Concealment does not protect you from gunfire. Natural Concealment includes such things as bushes, grass, trees, and shadows. If possible, natural Concealment should not be disturbed.
- **Cover -** a position that provides protection from bullets, fragments of exploding rounds, flame, radiation effects, biological agents, or chemical agents. Natural Cover includes such objects as logs, trees, stumps, ravines, or hollows. Cover includes shielding behind such things as vehicles, trenches, walls, rubble, craters, or natural barriers.
- **Contact Team -** an immediate action team of LE personnel functioning under the Tactical Branch (or directly under Command, the Operations Section, or the Law Enforcement Branch, depending on the complexity of the incident) with the primary objective of threat suppression.
- **Rescue Team -** a team of either LE personnel or a mixed team of LE and Department personnel functioning under the Tactical Branch with the primary objective of providing essential victim management and rapid patient extraction to the Cold Zone.

- **Tactical Team** - a team of specialized personnel that are extensively trained and equipped to undertake tactical LE activities. There may be other names utilized by LE for tactical response teams, such as Special Weapons and Tactics Team (SWAT).
- **Victim Extraction** - refers to essential patient care and extrication actions that are undertaken within conditions where provider risk is unusually elevated (such as in a Warm Zone where there are risks of active assailants, secondary explosive devices, and other threats). It can be categorized as a limited form of Emergency Medical Responder (EMR) or First Responder level of care, appropriate for either LE or Emergency Medical Services (EMS) personnel to provide. This "indirect threat patient care" includes basic life-saving critical interventions and victim removal only, typically limited to the control of severe bleeding using tourniquets or quick dressings and rapid extraction of the patient to a TTT Area in a Cold Zone.
- **Force Protection** - actions taken by LE to prevent or mitigate hostile actions against personnel, resources, facilities, and critical infrastructure. These actions conserve the operational ability of fire and EMS resources so they can be applied as needed.
- **Improvised Explosive Device (IED)** - a device placed or fabricated in an improvised manner incorporating destructive, lethal, noxious, pyrotechnic, incendiary or chemicals designed to destroy, incapacitate, harass, or distract.
- **Warm Zone Supervisor Team** – a team of at least (2) personnel comprised of (1) Department officer and (1) or more armed HCPD officers, with the objective of helping to guide the Rescue Teams and facilitate communications between the Tactical Branch and the EMS Branch.

PROCEDURES

RISK MANAGEMENT PRINCIPLES:

The central problem during the initial phases of an active shooter incident, usually before specialized tactical teams can be deployed, is the high demand for armed LE officers to focus on threat suppression. This limits the number of armed personnel available for the provision of bleeding control and rapid removal of victims that might be located in Hot and Warm Zones. This demand stress could be exacerbated in cases where there are a high number of injured patients. This creates the following central risk management questions:

- What is the acceptable level of risk for using unarmed providers in Warm Zones during active assailant situations?
- At what point do the benefits of using unarmed and limited-protected providers outweigh the risks?
- Which LE activities are most essential, to the point that elevated risk should be taken using unarmed and limited-protected providers in the Warm Zone to extract casualties?

The lowest risk profile is to utilize providers that are armed, fully protected, trained, and equipped to effectively mitigate emerging threats. Who provides essential victim management should thus depend on:

- The number of LE resources available at the scene.
- The number of victims, the level of difficulty associated with Victim Extraction, and the essential victim management tasks required.
- What required LE tasks outweigh, in priority, the risks of using of unarmed and limited-protected non-LE personnel within a Warm Zone.

Once sufficient LE resources are on the scene to adequately accomplish priority threat suppression tasks, the risk management profile for Warm Zone activity changes. The use of providers for Warm Zone Victim

Extraction who are unarmed, untrained for combat, and who possess limited ability to meet emerging threats with force becomes unwarranted from a risk management perspective.

RESPONSE PRINCIPLES:

Company officers will communicate and coordinate with LE to improve safety and promote consistent inter-agency actions. Company officers will maintain accountability of their crews and situational awareness of the environment.

Early goals for the initial ICs or Command are specified in the *Unified Command Priorities Tactical Operational Guideline* (Attachment B).

PHASES OF RESPONSE TO VIOLENT INCIDENTS:

Staging and Preparation

- Cold Zone – Department units stage in the Cold Zone until LE declares the scene safe.
    - Department units will stage near the dispatched scene at a location that is deemed safe. Staging should be in a sheltered position with an established means of primary and secondary egress from the area. It is NEVER wrong to stage and wait for LE. Units in this phase shall remain staged, allowing LE time to stabilize and secure the scene. The highest-ranking Department officer shall work toward establishing Command in the Strategic Mode (in a command post) as soon as possible, even if its initial location may be moved as the incident progresses. Command shall assure that Howard Fire Communications relay that Department units are staging until the scene is reported to be secure by LE on the scene.
    - Command (or the highest ranking officer responding to the call) has the authority, based on all information available, to either wait for LE to declare the scene safe, or to move the response to that described in the next section, Warm Zone Preparation for Possible Actions.

- Warm Zone (Preparation for Possible Actions) – Department units ***might*** encounter the need to approach the scene, possibly nearing (but not entering) a Warm Zone, to perform recon and assess needs.
    - When possible, all units approaching the Warm Zone should be escorted by LE. Command (or the highest ranking Department officer responding to the call) ***may***, if indicated, exercise the authority using the best information at hand, to assign units to *approach the scene* and *near the outer areas of the Warm Zone (beyond where one would normally stage),* prior to LE declaring the scene secure. Only companies assigned by Command shall approach a potential Warm Zone. The purpose for this action is primarily to gather information or to assess needed actions at the scene.
    - The initial Department Incident Commander (IC) and the initial HCPD IC shall establish, at a minimum, radio communications.
    - The Department and LE ICs shall seek each other out and establish a unified command post at a fixed location.

MCI OPERATIONS, CASUALTY COLLECTION POINTS, AND VICTIM EXTRACTION:

- Cold Zone Operations – Department units deploy one or more TTT Areas in the Cold Zone.
    - The decision whether to deploy multiple TTT areas in the Cold Zone depends on incident arrangement, geography, and available resources.

- Warm Zone Operations – During the initial stages of the incident, when LE resources are limited and the need for LE to pursue the active threat outweighs their need to extract victims to the Cold Zone, there may be a simultaneous need to quickly extract victims to the Cold Zone for treatment and transport. For purposes of Victim Extraction, mixed-asset Rescue Teams consisting of Department and LE personnel may be formed and may operate in areas of indirect threat that have been declared a Warm Zone. These four to six person teams shall provide only limited essential treatment and focus on rapid extraction of injured victims to the Cold Zone. LE team members shall provide armed Force Protection so that unarmed Department medical personnel can focus on essential victim management and extraction.

Department providers shall only be used for Warm Zone operations in accordance with this policy. Appropriate Force Protection, appropriate PPE, Cover, and Concealment shall be maximized. Prior to entering into a Warm Zone, a risk versus gain analysis should be completed.

- All elements of the *Go/No Go Checklist for Warm Zone Mixed-Asset Rescue Teams* (Attachment A) must be satisfied prior to using Department providers for Warm Zone actions.
- Rescue Teams can be deployed for the following reasons:
  - Viable victim treatment.
  - Viable victim removal from warm to Cold Zones.

- All Department personnel making entry into these areas shall don appropriate PPE to include level IIIA ballistic protection (Body Armor and helmet) and eye protection.
  - Donning Protective Equipment and/or participation in Rescue Teams in warm zones ***is only authorized for those providers who have successfully completed all required Active Assailant Department training***. Providers seeking training should contact the Bureau of Education & Training.
  - **On any incident where body armor is donned, the Incident Commander will provide written notification to the ESB Bureau Chief, providing the specific circumstances and rationale for the use of body armor. This written notification shall be made within 24 hours of incident.**

- Once Unified Command has determined the required elements of the Go/No Go checklist are satisfied for Rescue Team deployment, teams can deploy to the Warm Zone to begin victim care as Command directs.
  - Rescue Teams will be referred to by using a team number (e.g. “Rescue Team 1”).
  - Mixed-asset Rescue Teams shall consist of (4-6) personnel and be comprised of two (2) Department personnel and two (2) LE personnel at a minimum, with four (4) LE personnel preferred.
  - Rescue Teams are not to self- deploy into the Warm Zone.
  - Rescue Teams will treat the injured in Warm Zones using the Maryland Medical Protocols section that addresses care within *Potentially Volatile Environments with Life-Sustaining Interventions* (guidelines are proposed at this time).
  - The first two Rescue Teams that enter the area should focus on treating as many patients as possible until they run out of equipment to use, or all accessible victims have been treated. Then these two teams should start the evacuation of injured. Additional Rescue Teams that enter the area should be primarily tasked with

extraction of the victims treated by the initial two teams. If needed, additional teams may be sent into areas unreached by the initial teams or to other areas with accessible victims.

- When a Rescue Team is operating in the Warm Zone, traditional triage *MAY* not necessarily be conducted. Teams are required to use their judgment based on what victims they have access to, and the extent of their injuries. Prioritization of the injured is still worthwhile, but must be weighed against providing quick lifesaving care to victims as they are encountered. Any patient who can ambulate without assistance will be directed by the team to self-evacuate down a protected corridor under LE direction, and any patient who is declared priority-four (obviously dead, or expectant if under mass casualty or limited treatment conditions) should be visibly marked if at all possible to allow for easy identification and to avoid repeated evaluations by other Rescue Teams.
- To facilitate coordination of Rescue Teams inside a Warm Zone, Command *MAY* elect to deploy a Warm Zone Supervisor Team comprised of (1) Department officer and (1) or more armed HCPD officers, with the objective of helping to guide the Rescue Teams and facilitate communications between the Tactical Branch and the EMS Branch.
- Rescue Teams will work within their assigned LE Force Protection at all times.
- Department providers should review the *DFRS Provider Rules of Engagement* (Attachment C).

- CCPs are commonly established within a Warm Zone. Rarely, Command *may* encounter a need to establish a CCP within an interior Warm Zone that includes treatment resources capable of providing levels of care beyond typical essential victim management (beyond what is normally required during the process of patient extraction). Deployment of enhanced care resources to Warm Zone CCPs should only be done when absolutely necessary, as it places treatment resources that are likely limited and more effectively utilized in a Cold Zone at risk of rapidly devolving safety situations and secondary devices. When deemed necessary, as few treatment resources as is possible should be risked. Treatment procedures in the Warm Zone should be guided by principles of patient management as outlined in the Maryland Medical Protocols Appendix 28, *Potentially Volatile Environments with Life-Sustaining Interventions.* The operational focus of a Warm Zone CCP should ALWAYS remain on rapid movement of victims to the Cold Zone as soon as possible. When increased levels of patient care are deployed to Warm Zone CCPs, in order to preserve the one-on-one Force Protection assigned to every unarmed Department provider, mixed-asset Rescue teams shall be utilized to provide the manpower that is deployed to a Warm Zone CCP. These Rescue Teams shall remain together as a team at all times, even if there is additional armed LE Force Protection assigned to protect the CCP area.

ESTABLISHING THE WARM ZONE RESCUE GROUP:

If mixed-asset Rescue Teams are utilized, as soon as is possible, a Warm Zone Rescue Group shall be implemented within the ICS structure, under which all Rescue Team operations shall operate. Up to eight mixed-asset Rescue Teams can be assembled.

A Warm Zone Rescue Group will likely be placed under the LE Tactical Operations Branch (or the supervisor that is directing LE tactical operations) for deployment and supervision. Supervision of this

group shall include both a Department and LE supervisor. However the incident is organized, the first level of mixed-asset team supervision that is positioned in the Cold Zone shall be unified.

DEPARTMENT RESCUE TEAM EQUIPMENT:

An assortment of Body Armor (ballistic PPE) shall be carried on strategically designated field command, suppression, and/or EMS units. A full set of Department provider body armor shall consist of a ballistic protective vest, ballistic helmet, eye protection, tactical flashlight, and tactical radio headpiece. In addition, each Rescue Team member shall equip themselves with body substance isolation supplies and a specialized Rescue Team treatment bag that is designed to treat approximately eight victims. Supplemental Rescue Team treatment bags that, depending on injuries, have enough equipment to treat an additional sixteen victims shall be carried on each MDO vehicle and be available for use by Rescue Teams as necessary.

Each Department provider shall be sized for ballistic PPE on an annual basis, so they can be aware of their needed size. This will be accomplished during initial training, and annually during an in-service training program.

DEPARTMENT RESCUE TEAM TRAINING:

Specialized training for active assailant incidents will encompass the following:

- Awareness Level – All Department personnel shall complete the designated awareness level training. This training is intended to provide basic response principles for all operational providers.
- Operations Level – This training will be available to all operational members, and is the minimum required to participate in Rescue Team operations.
- Technician Level – This level of training is only available for selected providers and is required for participation as a tactical medic on mixed-asset HCPD/Department tactical teams.

REFERENCES

- Department General Order 300.07: Incident Command System
- The Hartford Consensus on Improving Survival from Active Shooter Events (2013)
- FEMA Guide for Active Shooter and MCI (2013-09)
- Urban Fire Forum: *Position Paper on Active Shooter and Mass Casualty Terrorist Incidents (2013-09)*
- *FireScope Emergency Response to Tactical Law Enforcement Incidents* (2013-01-22)
- Active Shooter Awareness and Preparedness (Arlington County, 2014)
- Tactical Emergency Casualty Care (TECC): *Guidelines for the Provision of Prehospital Trauma Care in High Threat Environments* (2011)
- Maryland Institute for Emergency Medical Services Systems, *Maryland Medical Protocols* (2014), *available at:* https://www.miemss.org/home/Portals/0/Docs/Guidelines_Protocols/Protocols_2015_FULL_Web.pdf?ver=2015-04-09-133642-297

SUMMARY OF DOCUMENT CHANGES

New General Order

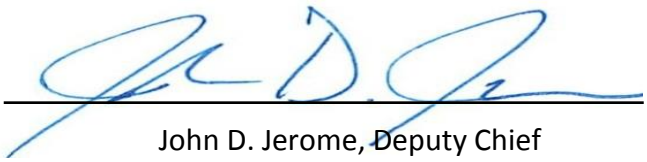
FORMS/ATTACHMENTS

- Attachment A: Go/No Go Checklist for Warm Zone Mixed-Asset Rescue Teams
- Attachment B: Unified Command Priorities Tactical Operational Guideline (TOG)
- Attachment C: DFRS Provider Rules of Engagement
- Attachment D: Internal Memorandum: Response to Active Assailant Events

APPROVED

John S. Butler, Fire Chief
Office of the Fire Chief

Author:



John D. Jerome, Deputy Chief
Office of the Fire Chief

"GO / NO-GO" Checklist for Warm Zone Mixed-Asset Rescue Teams
(DFRS Warm Zone actions should only be undertaken when):

❑ **A risk of lives lost or injured exists.** Otherwise wait for zone to be declared cold.

❑ **Too few armed and protected LE personnel are available to perform Victim Extraction**, or the level of care required in the Warm Zone exceeds typical Victim Extraction (rare).

- Unarmed providers must be withdrawn when the quantity of LE resources become adequate to accomplish required Victim Extraction.

❑ **Unified Command** with LE is effectively established.

- Eventually at a fixed strategic command post
- **Unified Supervision exists at whatever level tactical operations are taking place**. There must be operational integration and information sharing at the tactical deployment level where the mixed asset teams exist. This could be at the IC, Operations Section, Tactical Branch, or Warm Zone Rescue Group level, depending on the size of the ICS structure.

❑ **Warm Zone (are where threat is indirect) can be defined with some degree of confidence** and communicated to interior team members at all times.

- Strong self-discipline must exist to not commit Department resources when the Hot Zone cannot be distinguished from the Warm Zone.
- Warm Zone boundaries are being actively re-assessed throughout the incident.
- Unarmed providers must be withdrawn if a zone deteriorates or the force protection is not yet adequate to declare the zone "warm."

❑ **Cold/Warm/Hot Zone boundaries are clearly declared to all personnel.**

- The use of Level III "point of entry" accountability should be in place. This function will be ideally managed by a Division/Group supervisor as directed by the IC. This position will also function as a "warm zone" resource unit leader.

❑ **Interagency communications are in-place and effective** between involved providers, supervisors, and Command.

- **"Go/No-Go" decision is communicated via the radio** to responding providers and the highest ranking responding Department officer.
- Mixed-Asset Rescue Teams are assembled and properly equipped, including with radios.
- Separate radio channel for Department Warm Zone activities has been established.
- Unified Command and unified tactical supervision have access to interagency radio transmissions.
- Lack of communications integration should generate a "No Go" decision to deploy mixed teams.

❑ **Entry point clearly declared to all personnel.**

Tactical Operational Guideline
Command Priorities

❑ **Define and declare hot, warm, and cold zones of safety.**

- Cold staging zones should be in a location that provides *concealment* (is out of sight), provides *cover* (is protected), and allows for both a *primary and secondary means of exiting or moving from the staged location*. Command may adjust the suggested distances as conditions dictate.
- Consider defining the cold-warm boundary out of sight and **about a block away** for lower-risk incidents such as:
    - Calls of domestic violence where the violence is believed to be over
    - Assaults, shootings, and stabbings where the assailant is believed to have left the scene
    - Accidental shootings
    - Suicidal subjects without deadly weapons
    - Any potentially violent patient that has consumed a mind altering medication or recreational drug (ETOH)
- Consider defining the cold-warm boundary **about three (3) blocks (a quarter mile) away** for higher-risk incidents such as:
    - Active shooting scenarios
    - *Active* civil disorders
    - *Active* gang/crowd violence
    - Crowd disorders with shots fired that are not stabilized
    - Hostage situations
    - Barricaded subjects with weapons
    - Unrelated set fires in an area of potential civil disturbances
    - Area specific looting

❑ **Establish communication with LE, and then establish Unified Command at a common location.**

- Move toward use of a strategic command post in the Cold Zone.

❑ **Determine the need for and location for a Triage/Treatment/Transport.**

- Establish in Cold Zone
- Assign resources to each area.
- Establish an EMS Branch and Director if more than one medical treatment area.
- Establish a single Medical Communications Coordinator under that Director early.

❑ **Establish a Level Two Staging area and Staging Officer**

- Direct all arriving emergency resources to stage and check in with the Staging Officer.
- The Staging Manager will need to be in contact with several entities:
    - Howard Communications (to maintain adequate resources in staging)
    - Command (to receive resource needs from the scene, and to ensure appropriate resource needs are understood).
    - The Liaison Officer (to communicate about what outside agency command, administrative, and informational support resources are available in staging).

❑ **Establish a Liaison Officer early to facilitate interaction with outside agencies.**

- Command, administrative, and informational support resources from outside agencies should be directed to report to Staging and check in with the Staging Manager.

DFRS PROVIDER RULES OF ENGAGEMENT

If your initial size-up assesses a threat of confrontation, do not insert yourself into the situation, wait for police assistance.

If you find yourself in a confrontation where you can remove yourself to wait for police assistance, do it!

Take cover, placing something substantial in between you and the attacker.

Seek concealment, placing anything in between you and the attacker.

If you find yourself in a confrontation from which you cannot remove yourself:

- If confronted with a less-lethal force (no weapons) defend yourself and attempt to control the situation using less-lethal force.

- If confronted with lethal force use whatever means is necessary to eliminate the threat or get out of the way. DO not provoke the attacker, but FIGHT if you are in immediate danger. Negotiation is usually not an option. Disrupt or disable the attacker by any means available. Be aggressive, incapacitate the attacker.

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INTERNAL MEMORANDUM

To: All Personnel

From: Fire Chief John S. Butler

Date: February 5, 2016

Subject: Response to Active Assailant Events

Over the course of the next several months, the Department will embark on a paradigm shift in regards to our responses to active assailant events. This effort will require a cultural change from our personnel and the organization as a whole. I am confident that our organization, being both highly professional and highly progressive in approach, is up to the task. It is important to me that, as we move forward, our members understand the significant thought and preparation that has occurred thus far. This change is not a step that any of our leadership takes lightly, or without careful and active research and consideration.

This endeavor began as a partnership with the Howard County Police Department (HCPD) shortly after the Sandy Hook, CT school shooting in December, 2012, in the form of the County's School Safety Taskforce. That workgroup was tasked with working with the Howard County Public School System to identify issues pertaining to violent incidents in the school system. Upon completion of the efforts with the school system, DFRS and HCPD realized the need to not just address violent incidents in schools, but active assailant threats in a more global sense. A smaller County workgroup was established in the fall of 2013, coordinated by the Office of Emergency Management, to begin to investigate response practices of DFRS and HCPD on active assailant incidents. The workgroup was clearly divided in the initial discussions, but over time both agencies realized that a coordinated and planned approach was necessary if there is to be any chance of successfully providing lifesaving interventions and timely extraction.

Simultaneously, the Governor convened a statewide multidisciplinary workgroup with direction to create a guidance document that could be used by local, state, and federal agencies that operate in Maryland, to include fire and EMS, law enforcement,

emergency management, and training entities. DFRS was fortunate to have two representatives on that workgroup that met regularly for over a year. Also within the last year, our Medical Director, who also serves as the Senior Medical Officer at the Johns Hopkins Center for Law Enforcement Medicine, was given a prestigious opportunity to participate on the Joint Committee for the Hartford Consensus III, whose task it was to revise a model national policy for enhancing survivability from intentional mass casualty and active shooter events.

The County workgroup has continued to meet and participate in various drills and tabletop exercises, discuss terminology, tactics, communications and the importance of Unified Command. Members of the workgroup attended a seminar in Washington DC (Active Assailant Stakeholder Engagement), as well as a "field trip" to Arlington County, VA to discuss their Rescue Task Force (RTF) model of response. Active Assailant policies from departments from all over the country were reviewed in order to determine common threads and best practices. As we were completing our work on a draft DFRS GO, the State of Maryland released its *Guidance to First Responders for the Active Assailant Incident*. Part of the purpose and scope of that guidance document aligns closely with our GO development, stating;

> *"All personnel will be thrust into situations in which they do not normally operate. Law enforcement patrol officers will be placed into tactical situations and may need to provide initial lifesaving care for victims while EMS/fire/rescue personnel may need to enter areas that have not been completely cleared of the assailant."*

Getting back to the paradigm shift, it is clear that the response model for handling active assailant incidents is changing across the police, fire, and EMS communities country-wide. Take a moment to do an internet search, and you will find countless information on this topic, to include; Department of Homeland Security Active Shooter guidance documents, policy endorsements from the International Association of Firefighters and International Association of Fire Chiefs, after action reports from previous incidents supporting the need for change, and of particular interest, the Hartford Consensus recommendations (the Hartford Consensus is a consortium of physicians, trauma surgeons, law enforcement, fire and EMS providers, and others). Common threads you will see in many of these documents include the use of the National Incident Management System and Unified Command, use of the RTF concept for patient treatment and extraction, use of common terminology, combined training with law enforcement, and providing ballistic protection to first responders. It is on these basic concepts that the DFRS GO is built.

Rest assured that it is not the intent or expectation of this program to unnecessarily expose DFRS personnel to situations of clear and present danger. Rather, the mission of this program is to effectively utilize properly trained and equipped DFRS personnel in warm zone environments that have been checked by HCPD. The goal of this program is to save lives by creating a system to quickly access the injured, render prompt lifesaving interventions if necessary (hemorrhage control, basic airway, etc.), and expeditiously extract casualties to a cold zone.

In the coming days, weeks and months, we will begin a multi-pronged approach to accomplishing the objective of training personnel in the equipment, policy and tactics that will go along with the implementation of this initiative. Front-end training will include Battalion level sessions completed over the next few weeks. Topics for this will include an introduction to the Life Saving Initiative kits that will be placed on all front line units, as well as a basic introduction to ballistic protection DFRS has acquired. Also, during the month of February, a "virtual" training program will be disseminated through the Virtual Academy that will provide more details on the medical treatment component in an active assailant environment. Beginning March 1, 2016, companies will rotate to the PSTC to conduct combined training with HCPD, with a classroom session and a practical scenario. We are aware there will be many questions that will arise through the course of this initiative, and we will work diligently to address these. The GO effective date will be some time in the future, once training and a thorough assessment of the process has been conducted.

In closing, I'd like to personally thank some of the team members that took on this critical assignment at it's very onset. Those that should be mentioned are DC John Jerome, AC Gordon Wallace, BC Sean Alliger, Dr. Matt Levy, AC Eric Proctor and the E&T team, HCPD Leadership, and the OEM team, to name a few. I'm sure I've missed some other very engaged participants, and for that I sincerely apologize. Lastly, I'm compelled to reflect on a quote from a fire service legend, Chief Alan Brunacini who once said, "beware of chiefs who say, don't do anything until I get there." Our success or failure on how we respond is directly related to how we accept this emerging threat at the tactical, company level. I have no doubt that we have the talent and professionalism at that level to be successful and cutting edge.