ACTIVE SHOOTER PLANNING AND RESPONSE IN A HEALTHCARE SETTING

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Introduction

The Healthcare and Public Health (HPH) Sector Critical Infrastructure Protection (CIP) Partnership brings together leaders in business and government to prepare for and protect against all hazards facing the Sector. The CIP framework focuses on protecting HPH organizations *themselves* during a disaster, so that they may focus on their mission of saving lives. The partnership identifies and prioritizes the most critical elements of the Nation's HPH infrastructure, shares information on risks facing that infrastructure, and implements activities to protect the Sector. The HPH Sector partnership consists of a Government Coordinating Council (GCC) of government partners and Sector Coordinating Council (SCC) of private sector partners. These two groups come together through two joint working groups and six subsectors to address issues of mutual concern. All public and private sector members of the HPH Sector with a role in the HPH Sector's homeland security mission are invited to take part in one or more of the joint working groups.

Active Shooter events are becoming increasingly more common, and while there have been recommendations on how to respond since 2008, these guidelines focused on business settings. In November 0f 2014, a federal interagency group released *Incorporating Active Shooter Planning into Health Care Facility Emergency Operations Plans*, which provides a broad overview of healthcare active shooter planning. That document, along with the additional information included here are provided to assist your facility in preventing, planning, responding to, and active shooter event that occurs in a healthcare setting.

Active shooter events in a healthcare setting present unique challenges: a potentially large vulnerable patient population, hazardous materials (including infectious disease), locked units, special challenges (such as weapons and Magnetic Resonance Imaging (MRI) machines (these machines contain large magnets which can fire a weapon or remove it from the hands of law enforcement), as well as caregivers who can respond to treat victims.

There is no single method to respond to an incident, but prior planning will allow you and your staff to choose the best option during an active shooter situation, with the goal of maximizing lives saved. The best way to save lives is to remove potential targets from the shooter's vicinity. We address some difficult choices that may need to be made in the document.

We hope as you read, review, and implement your own plan, you will provide feedback to our team, so we may update as needed. Feedback may be sent to codeready@hcahealthcare.com. Thank you for all the work you do in keeping our patients, staff, and visitors safe.

We also encourage you to review the healthcare active shooter video produced by the MESH Coalition. MESH, Inc. is an innovative non-profit, public-private coalition located in Marion County, Indiana (Indianapolis) that enables healthcare providers to respond effectively to emergency events, and remain viable through recovery. For more information on the coalition, please use this link.

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Active Shooter events at a healthcare facility present unique challenges; healthcare professionals may be faced with a decision about leaving patients; visitors will be present; and patients or staff may not be able to evacuate due to age, injury, illness, or a medical procedure in progress.

Understandably, this is a sensitive topic. No single answer exists for what to do, but a survival mindset can increase the odds of surviving. As appropriate for your facility or campus, it may be valuable to schedule a time for an open conversation regarding this topic. Though some healthcare staff may find the conversation uncomfortable, they also may find it reassuring to know, as a whole, their facility is thinking about how best to deal with this situation.

Ethical Considerations during a Healthcare Active Shooter Event

Healthcare professionals have a duty to care for the patients for which they are responsible. Since incidents such as an active shooter scenario are highly dynamic, some ethical decisions may need to be made to ensure the least loss of life possible. Every reasonable attempt to continue caring for patients must be made, but in the event this becomes impossible, without putting others at risk for loss of life, certain decisions must be made. The following guidelines are meant to provide issues to consider when making difficult decisions and prompt meaningful discussions and prepare those who might be involved in such an incident before it ever happens.

- Allocate resources fairly with special consideration given to those most vulnerable
- Limit harm to the extent possible. With limited resources, healthcare professionals may not be able to meet the needs of all involved
- Treat all patients with respect and dignity, regardless of the level of care that can continue to be provided them
- Prepare to decide to discontinue care to those who may not be able to be brought to safety in consideration of those who can
- Realize some individuals who are able to avoid the incident will choose to remain in dangerous areas. Prepare how to react to those situations
- To the extent possible, always consider the needs of others as well as yourself. Consider the greater good as well as your own interest

During an active shooter situation, the natural human reaction is to be startled, feel fear and anxiety, and even experience initial disbelief. You can expect to hear noise from alarms, gunfire and explosions, and people shouting and screaming. Training provides the means to regain your composure, recall at least some of what you have learned, and commit to action. We know a trained person will respond according to the training received and will not descend into denial, the untrained will not respond appropriately, descend into denial then into helplessness and will usually become part of the problem. There are several sets of planning guidance that have been developed for active shooter incidents for organizations such as schools, government and business office settings.

The key message of this document is that hospitals and academic health centers represent a very unique set of challenges for active shooter planning. The individual uniqueness of healthcare facilities and the limitations as a result of size, location, critical care access versus acute care, rural versus urban versus suburban, the presence of students, whether you have security, law enforcement availability and response times are just a few of the many challenges when developing a response to Active Shooter. For this reason, we recommend that as you develop your plan, you consider the planning guidance listed below and determine what works best in your particular circumstances. You will notice however that all of the guidance below shares a common set of principles. The first of these principles is that your plan should seek to maximize the protection of life. If possible, evacuation away from the incident will reduce the number of people in harm's way, and facilitate the police response. Another principle is that in the end, individuals will have to make decisions based on their assessment of the situation in how best to maximize the protection of life and what tactics to employ. When all other options have been exhausted, an individual decision to engage or fight the shooter may be the only tactic available. Another important principle for healthcare is that individuals may have a duty of care for patients – in your planning, you should determine any specific requirements that your organization may have and include this in staff training so that they may include this aspect in determining the best course of action to take in maximizing the protection of life.

The primary purpose of your response plan shall be to prevent, reduce or limit access to potential victims and to mitigate the loss of life. Options for consideration in developing your response plan are:

Alice Active Shooter Response

"ALICE" is an acronym for five steps the proponents say can be used to increase your chances of surviving a surprise attack by an Active Shooter. ALICE stands for:

Alert – Can be anything

Lockdown – This is a semi-secure starting point from which to make survival decisions. If you decide not to evacuate, secure the room.

Inform – Using any means necessary to pass on real time information

Counter – This is the use of simple, proactive techniques should you be confronted by the Active Shooter.

Evacuate – Remove yourself from the danger zone as quickly as possible

Run, **H**ide, or **F**ight

Is a three step process to prevent or reduce loss of life in an active shooter event.

Run – is to immediately evacuate the area

Hide – seek a secure place where you can hide and/or deny the shooter access

Fight – where your life or the lives of others are at risk, you may make the personal decision to try to attack and incapacitate the shooter to survive

Window of Life

Window of Life is an emergency response method authored by Safe Havens International. It says a person who is in a crisis has four responsibilities:

1. A person's first responsibility is for his or her safety. You are an important asset in a crisis, not one to throw away lightly. If you are lost, that loss is felt in successive areas around you, much like the ripples in a pond.
2. A second responsibility is to those in the immediate vicinity, those who are within line-of-sight or ear shot of where you are. Recognizing your importance as an asset involves using that asset to help others.
3. A third responsibility is to those in your place. Having protected yourself and alerted those near you, it is important to alert those who will also be affected by the crisis but may have a bit more time to react.
4. A fourth responsibility is to notify public safety. For more information on Window of Life, listen to Campus Safety's interview with Mike Dorn called "Should School Teachers, Administrators Attack Active Shooters?" at http://www.campussafetymagazine.com/WindowOfLife

The 4 As

The 4As is a 4 step process to prevent or reduce loss of life in an active shooter event. They stand for:

1. Accept that an emergency is occurring.
2. Assess what to do next so that you can save as many lives as possible, which depends on your location.
3. Act: Lockdown (lock and barricade the doors, turn off the lights, have patients get on the floor and hide) or evacuate or fight back (last resort).
4. Alert law enforcement and security

Discussing and training for a possible active shooter situation allows each person to consider what he or she would do. As a situation develops, staff may be required to use more than one option. During an active shooter situation, staff will rarely have all of the information they need to make a fully informed decision about which option is best. While they should follow the plan and any instructions given during an incident, often he or she will have to rely on their own judgment to decide which option will best protect lives. Each individual must decide for himself or herself what actions are appropriate based on location and position during such an incident. The goal in all cases is to survive and protect. The safety of patients, visitors, and coworkers also must be considered when making decisions on how to respond. Many staff members are responsible for the care of patients or residents. However, if an individual suspects they may be in danger due to an active shooter situation, the following guidelines will assist the individual to make personal choices and take appropriate actions.

This guide will use the general term "staff" includes employees, licensed independent practitioners, dependent healthcare professionals, students, volunteers, vendors, contractors, and others who work in or are frequently in the facility.

Active Shooter Situations[1]

Police officers, firefighters, and emergency medical services (EMS) personnel (first responders) who come to a healthcare facility because of an emergency call involving gunfire face a daunting task. Though the objective remains the same – protect patients, visitors, and staff – the threat of an *active shooter* incident is different than responding to a natural disaster or many other emergencies.

Emergency calls can involve actual or future threats of physical violence. This violence might be directed not only in or at healthcare facility buildings, students, staff, and areas on campus but also at nearby buildings off campus.

"*Active shooter situations*" are defined[2] as those where an individual is "actively engaged in killing or attempting to kill people in a confined and populated area."[3] Unfortunately, healthcare facilities face *active shooter situations* as well.

[1] This guidance to health care providers has been adapted the federal guidance on dealing with active shooter situations released in June 2013 to schools, institutions of higher learning and houses of worship. The guidance was developed by a White House working group which included the Department of Health and Human Services, the Federal Bureau of Investigation, the Department of Justice, the Department of Education, and Department of Homeland Security, and the Federal Emergency Management Agency.

[2] Other gun-related incidents that may occur in a healthcare facility are not defined as *active shooter* incidents because they do not meet this definition. Instead, they may involve a single shot fired, accidental discharge of a weapon, or incidents that are not ongoing.

[3] The Federal Bureau of Investigation, *Active Shooter and Mass Causality Incidents.* http://www.fbi.gov/about-us/cirg/active-shooter-and-mass-casualty-incidents.

The better first responders and healthcare personnel are able to discern these threats and react swiftly, the more lives can be saved. This is particularly true in an *active shooter situation* where law enforcement responds to a 911 call of shots fired. Many innocent lives are at risk in concentrated areas. This is why it is critical healthcare facilities work with their community partners (e.g., first responders, emergency managers) to identify, prepare, prevent, and effectively respond to an *active shooter situation* in a coordinated fashion.

Active shooter situations are unpredictable and evolve quickly. Because of this, individuals must be prepared to deal with an *active shooter situation* before law enforcement personnel arrive on the scene. While this section addresses how healthcare facilities should plan for *active shooter situations*, healthcare facilities should also plan for other gun-related incidents (e.g., a single shot fired, possession of a weapon on campus).

Preparing for an Active Shooter Situation

Planning

As with any threat or hazard included in a healthcare facility's Emergency Operations Plan (EOP), the planning team should establish goals, objectives, and courses of action for an *Active Shooter* Annex. These plans will be impacted by the assessments conducted at the outset of the planning process and updated as ongoing assessments occur. Create the plan with input from several stakeholders including executive leadership, legal, nursing, security, facility engineering, human resources, emergency management, risk managers, and local law enforcement. An effective plan includes:

- A preferred method for reporting active shooter incidents
- An evacuation policy and procedure
- Emergency escape procedures and route assignments (i.e., floor plans, safe areas)
- Lockdown procedures for individual units and locations and other campus buildings
- Integration with the facility Emergency Operations Plan and Incident Command System
- Information concerning local area emergency response agencies and hospitals (i.e., name, telephone number, and distance from your location)

As courses of action are developed, the planning team should consider a number of issues, including, but not limited to

- How to evacuate or lock down patients, visitors, and staff. (Personnel involved in such planning should pay attention to access and functional needs when advising on shelter sites and evacuation routes.)
- How to evacuate when the primary evacuation routes are unusable.

- How to select effective shelter-in-place locations (optimal locations have thick walls, solid doors with locks, minimal interior windows, first-aid emergency kits, communication devices, and telephones or duress alarms).

- How the healthcare facility and/or campus will be notified when there is an *active shooter* on campus. This could be done through the use of familiar terms, sounds, lights, and electronic communications, such as text messages or e-mails. Include in the courses of action how to communicate with those who have language barriers or need other accommodations, such as visual signals or alarms to advise deaf patients, staff, and visitors about what is occurring. Healthcare facility-wide "reverse 911-style" text messages sent to pre-determined group distribution lists can be very helpful in this regard. Planners should make sure this protocol is readily available and understood by those who may be responsible for sending out or broadcasting an all-healthcare facility or campus announcement. Rapid notification of a threat can save lives by keeping people out of harm's way. An important part of responding to an active shooter event is an emergency notification system. The emergency notification system can alert various parties of an emergency including:

    - Individuals at remote locations within premises and other campus buildings

    - Multi-lingual capability for staff or visitors with cultural or linguistic needs

    - Local emergency responders

    - Other local area hospitals

    - How patients, visitors, and staff will know when buildings and campus grounds are safe.

While there is a sense in the popular culture that a clear warning may induce panic, research shows[4] people do not panic when given clear and informative warnings, and that they want to have accurate information and clear instructions on how to protect themselves in the emergency[5]. For Academic Health Centers, unlike a standalone hospital, not all members of the campus community will understand a code system and so plain language warnings and clear instructions should be given. As appropriate to the community, messaging should address those with cultural and linguistic needs.

[4] Denis S. Mileti, *Public Response to Disaster Warning*. University of Colorado at Boulder. Available at: http://swfound.org/media/82620/PUBLIC%20RESPONSE%20TO%20DISASTER%20WARNINGS%20-%20Dennis%20S.%20Mileti.pdf

[5] For example, "Gunshots reported on 3-West. Take shelter in a safe location."

The planning team may want to include functions in the *Active Shooter* annex that are also addressed in other functional annexes of the facility emergency operations plan. For example, evacuation will be different during *an active shooter situation* than it would be for a fire.

Additional considerations are included in the "Responding to an *Active Shooter*" and "After an *Active Shooter Situation*" sections below.

Every facility must have a security plan. Staff should be trained on their responsibilities in the plan. A facility security plan includes:

- All staff properly display an acceptable identification badge
- Create a culture of safety by empowering staff to report unusual or suspicious activity
- Ensure locked doors remain closed and locked
- Doors with keypad access should have their codes changed at specified intervals and codes are only given to employees with a need for access
- Foster a respectful workplace
- Be aware of indications of workplace violence and take remedial actions accordingly
- Empower employees who come in contact with individuals who seem lost or are obviously not familiar to their surroundings to be helpful and ask if they can be of assistance
- The plan should include information security processes, including compliance with the Health Insurance Portability and Accountability Act.

Modern health care settings can be the site for unusual and dangerous activities. Some facilities have opted to construct safe rooms. Such rooms are designated spaces where staff, patients and even visitors can retreat to in the event of an immediate threat of danger. A designated safe room should be equipped with a duress button, telephone, and reinforced doors.

Sharing Information with First Responders

The planning process is not complete until the healthcare facility EOP is shared with first responders. The planning process must include preparing and making available to first responders an up-to-date and well-documented site assessment, as well as any other information that would assist them. These materials should include building schematics and photos of both the inside and outside of the buildings, and include information about door and window locations, and locks and access controls. Emergency responders should also have advance information on where patients who may be unable to evacuate, such as the operating room, critical care units, nurseries, and pediatric units. Building strong partnerships with law enforcement, fire, and EMS officials includes ensuring they also know the location of available public-address systems, two-way communications systems, security cameras, and alarm controls. Equally important is information on access to utility controls, medical supplies, fire extinguishers, and how to access secured or locked areas of the facility.

Providing the detailed information listed above to first responders allows them to rapidly move through a healthcare facility during an emergency, to ensure areas are safe, and to tend to people in need. It is

critically important to share this information with law enforcement and other first responders before an emergency occurs. Law enforcement agencies have secure websites where this information is stored for many businesses, public venues, and other locations. All of these can be provided to first responders and viewed in drills, exercises, and walk-throughs.

Technology and tools with the same information (e.g., a portable USB drive that is compatible with computers used by first responders) should be maintained in secured locations in the facility from which healthcare facility officials can immediately provide it to responding officials or from which first responders can directly access it. The locations of these materials at the healthcare facility should be known by and accessible to a number of individuals to ensure ready access in an emergency. Every healthcare facility should have more than one individual charged with meeting first responders to provide them with the healthcare facility site assessment, the healthcare facility EOP, and any other details about healthcare facility safety and the facility. All parties should know who these key contacts are.

Exercises

Most healthcare facilities practice evacuation drills for fires and protective measures for natural disasters, but far fewer healthcare facilities practice for *active shooter situations*. To be prepared for an *active shooter* incident, healthcare facilities should train their staff, in what to expect and how to react.

Good planning involves conducting drills which involve first responders and facility security teams, and includes the role of sworn local law enforcement officers employed or stationed in the emergency department or other areas of the facility. Exercises with these valuable partners are one of the most effective and efficient ways to ensure everyone knows not only her or his role(s) but also the role(s) of others at the scene. These exercises should include walks through the healthcare facility and other campus buildings to allow law enforcement officials to provide input on shelter sites as well as familiarize first responders with the campus, including shelter locations, evacuation routes, and locations where patients who may be unable to evacuate, such as the operating room, critical care units, nurseries, and pediatric units.

Each person carries a three-fold responsibility.

First: Learn the signs of a potentially volatile situation and ways to prevent an incident.

Second: Learn the best steps for survival when faced with an active shooter situation.

Third: Be prepared to work with law enforcement during the response.

Preventing an Active Shooter Situation

Warning Signs

No profile exists for an *active shooter*; however, research indicates there may be signs or indicators. Healthcare facilities should learn the signs which might be detectible of an individual who may turn thoughts or actions into potentially volatile situation *active shooter situation* and proactively seek ways to prevent an incident with internal resources, or additional external assistance**.**

By highlighting common pre-attack behaviors displayed by past offenders, federal researchers have sought to enhance the detection and prevention of tragic attacks of violence, including *active shooting situations*. Several agencies within the federal government continue to explore incidents of targeted violence in the effort to identify these potential "warning signs." In 2002, the Federal Bureau of Investigation (FBI) published a monograph on workplace violence, including problematic behaviors of concern that may telegraph violent ideations and plans.[6]

Specialized units in the federal government (such as the FBI's Behavioral Analysis Unit) continue to support behaviorally based operational assessments of persons of concern in a variety of settings (e.g., schools, workplaces, places of worship) who appear be on a trajectory toward a violent act. A review of current research, threat assessment literature, and active shooting incidents, combined with the extensive case experience of the Behavioral Analysis Unit, suggest there are observable pre-attack behaviors, if recognized, could lead to the disruption of a planned attack[7]. While checklists of various warning signs are often of limited use in isolation, the FBI has identified some behavioral indicators that should prompt further exploration and attention from law enforcement and/or campus safety stakeholders. These behaviors often include:

- Development of a personal grievance;
- Contextually inappropriate and recent acquisitions of multiple weapons;

[6] U.S. Department of Justice FBI Academy, Workplace Violence: Issues in Response. Quantico, Va.: Author, 2002. Available at http://www.fbi.gov/stats-services/publications/workplace-violence.

[7] See, Frederick Calhoun and Stephen Weston, Contemporary Threat Management: A Practical Guide for Identifying, Assessing, and Managing Individuals of Violent Intent (San Diego, CA: Specialized Training Services, 2003); Gene Deisinger, Marisa Randazzo, Daniel O'Neill, and Jenna Savage, The Handbook for Campus Threat Assessment and Management Teams (Stoneham, MA: Applied Risk Management, 2008); Robert Fein, Bryan Vossekuil, and Gwen Holden, Threat Assessment: An Approach to Prevent Targeted Violence (Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, 1995); John Monahan, Henry Steadman, Eric Silver, Paul Appelbaum, Pamela Robbins, Edward Mulvey, Loren Roth, Thomas Grisso, and Steven Banks, Rethinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence (New York, NY: Oxford University Press, 2001); Bryan Vossekuil, Robert Fein, Marisa Reddy, Randy Borum, and William Modzeleski., The Final Report and Findings of the Safe School Initiative: Implications for the Prevention of School Attacks in the United States. (Washington D.C.: U.S. Department of Education and U.S. Secret Service, 2004).

- Contextually inappropriate and recent escalation in target practice and weapons training;
- Contextually inappropriate and recent interest in explosives;
- Contextually inappropriate and intense interest or fascination with previous shootings or mass attacks; and
- Experience of a significant real or perceived personal loss in the weeks and/or months leading up to the attack, such as a death, breakup, divorce or loss of a job.
- Few offenders had previous arrests for violent crimes.

In 2007, the U.S. Secret Service, U.S. Department of Education, and the FBI collaborated to produce the report *Campus Attacks, Targeted Violence Affecting Institutions of Higher Learning*, which examined lethal or attempted lethal attacks at U.S. universities and colleges from 1900 to 2008[8]. The report was published in 2010, and featured several key observations related to pre-attack behaviors, including the following:

- In only 13 percent of the cases did subjects make verbal and/or written threats to cause harm to the target. These threats were both veiled and direct, and were conveyed to the target or to a third party about the target.
- In 19 percent of the cases stalking or harassing behavior was reported prior to the attack. These behaviors occurred within the context of a current or former romantic relationship, or in academic and other non-romantic settings. They took on various forms, including written communications (conventional and electronic), telephonic contact, and harassment of the target and/or the target's friends and/or family. Subjects also followed, visited, or damaged property belonging to target(s) or their families prior to the attack.
- In only 10 percent of the cases did the subject engage in physically aggressive acts toward the targets. These behaviors took the form of physical assaults, menacing actions with weapons, or repeated physical violence to intimate partners.
- Concerning behaviors were observed by friends, family, associates, professors, or law enforcement in 31 percent of the cases. These behaviors included, but were not limited to, paranoid ideas, delusional statements, changes in personality or performance, disciplinary problems on campus, depressed mood, suicidal ideation, non-specific threats of violence, increased isolation, "odd" or "bizarre" behavior, and interest in or acquisition of weapons.

[8] 32 U.S. Secret Service, U.S. Department of Education, and Federal Bureau of Investigation, Campus Attacks: Targeted Violence Affecting Institutions of Higher Education. Washington, DC: Author, 2010. Available at http://rems.ed.gov/docs/CampusAttacks_201004.pdf.

Responding to an *Active Shooter Situation*

Healthcare facility EOPs should include courses of action that will describe how staff can most effectively respond to an *active shooter situation* to minimize the loss of life, and teach and train on these practices, as deemed appropriate by the healthcare facility.

Law enforcement officers may not be present when a shooting begins. Providing information on how staff can respond to the incident can help prevent and reduce the loss of life. No single response fits all *active shooter situations*; however, making sure each individual knows his or her options for response and can react decisively will save valuable time. Depicting scenarios and considering response options in advance will assist individuals and groups in quickly selecting their best course of action.

Remember, during an *active shooter situation*, the natural human reaction, even if you are highly trained, is to be startled, feel fear and anxiety, and even experience initial disbelief and denial. You can expect to hear noise from alarms, gunfire, and explosions, and people shouting and screaming. Training provides the means to regain your composure, recall at least some of what you have learned and commit to action. There are three basic options: run, hide, or fight. You can run away from the shooter, seek a secure place where you can hide and/or deny the shooter access, or incapacitate the shooter in order to survive and protect others from harm.

As the situation develops, it is possible you will need to use more than one option. During an *active shooter situation*, individuals will rarely have all of the information they need to make a fully informed decision about which option is best. While they should follow the plan and any instructions given during an incident, they will often have to rely on their own judgment to decide which option will best protect lives.

Respond Immediately

It is not uncommon for people confronted with a threat to first deny the possible danger rather than respond. An investigation by the National Institute of Standards and Technology (2005) into the collapse of the World Trade Center towers on September 11, 2001, found people close to the floors impacted waited longer to start evacuating than those on unaffected floors[9]. Similarly, during the Virginia Tech shooting, individuals on campus responded to the shooting with varying degrees of urgency[10]. These studies highlight this delayed response or denial. For example, some people report hearing firecrackers, when in fact they heard gunfire.

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[9] Occupants of both towers delayed initiating their evacuation after World Trade Center 1 was hit. In World Trade Center 1, the median time to initiate evacuation was 3 minutes for occupants from the ground floor to floor 76, and 5 minutes for occupants near the impact region (floors 77 to 91). See National Institute of Standards and Technology, Federal Building and Fire Safety Investigation of the World Trade Center Disaster Occupant Behavior, Egress, and Emergency Communications. Washington, DC: Author, 2005. Available at http://www.mingerfoundation.org/downloads/mobility/nist%20world%20trade%20center.pdf.

[10] Report of the Virginia Tech Review Team, available at http://www.governor.virginia.gov/tempContent/techPanelReport-docs/FullReport.pdf and http://www.governor.virginia.gov/tempContent/techPanelReport-docs/12%20CHAPTER%20VIII%20MASS%20MURDER%20AT%20NORRIS%20HALL.pdf.

Train staff to overcome denial and to respond immediately. For example, train students and staff to recognize the sounds of danger, act, and forcefully communicate the danger and necessary action (e.g., “Gun! Get out!”). In addition, those closest to the public-address or other communications system, or otherwise able to alert others, should communicate the danger and necessary action. Repetition in training and preparedness shortens the time it takes to orient, observe, and act.
Upon recognizing the danger, as soon as it is safe to do so, staff or others must alert responders by contacting 911 with as clear and accurate information as possible.

Run
If it is safe to do so, the first course of action should be taken is to run out of the building and move far away until you are in a safe location.

Staff should be trained to:

- Leave personal belongings behind;
- Visualize possible escape routes, including physically accessible routes for patients, visitors, or staff with access and functional needs;
- Avoid escalators and elevators;
- Take others with them but not to stay behind because others will not go;
- Call 911 when safe to do so; and

Hide
If running is not a safe option, hide in as safe a place as possible.

Staff should be trained to hide in a location where the walls might be thicker and have fewer windows. In addition

- Lock the doors if door locks are available;
- Barricade the doors with heavy furniture;
- If you are in a specialty care unit, secure the unit entrance(s) by locking the doors and/or securing the doors by any means available (furniture, cabinets, bed, equipment, etc.)
- Close and lock windows, and close blinds or cover windows;
- Turn off lights;
- Silence all electronic devices;
- Remain silent;

- Use strategies to silently communicate with first responders if possible, (e.g., in rooms with exterior windows make signs to silently signal law enforcement and emergency responders to indicate the status of the room's occupants.) Be careful not to expose yourself to the active shooter if they are located outside of the facility.

- Hide along the wall closest to the exit but out of the view from the hallway (allowing for an ambush of the shooter and for possible escape if the shooter enters the room); and

- Remain in place until given an all clear by identifiable law enforcement.

Fight

If neither running nor hiding is a safe option, as a last resort when confronted by the shooter, adults in immediate danger should consider trying to disrupt or incapacitate the shooter by using aggressive force and items in their environment, such as fire extinguishers, chairs, etc. In a study of 41 *active shooter* events that ended before law enforcement arrived, the potential victims stopped the attacker themselves in 16 instances. In 13 of those cases, they physically subdued the attacker[11].

While talking to staff about confronting a shooter may be daunting and upsetting for some staff, they should know they may be able to successfully take action to save lives. To be clear, confronting an *active shooter* should never be a requirement of any healthcare facility employee's job; how each individual chooses to respond if directly confronted by an *active shooter* is up to him or her. Further, the possibility of an *active shooter situation* is not justification for the presence of firearms on campus in the hands of any personnel other than law enforcement.

You may consider these additional actions should you choose:

- Barricade areas where patients are located

- Transport patient in wheelchair, on stretcher, or by carrying to a safe location

- Identify a safe location in your unit before an event where staff or patients may safely barricade themselves during an event

- If the shooter is not located in your unit, know how to lock down and barricade your unit in case of an attempt to enter the unit at a later time

Be prepared to implement your Mass Casualty or Trauma Care Plan as soon as it is safe to do so. Quick hemorrhage control is an important success factor in saving lives. Have medical supplies available and

[11] J. Pete Blair with M. Hunter Martaindale, United States Active Shooter Events from 2000 to 2010: Training and Equipment Implications. San Marcos, TX: Texas State University, 2013. Available at http://alerrt.org/files/research/ActiveShooterEvents.pdf.

set the expectation for staff to assist victims as soon as it is safe to do so because the arrival of Emergency Medical Services may be delayed.

Review the hospital's role in your community's mass fatality plan and be prepared to support this effort.

Interacting with First Responders

Staff should be trained to understand law enforcement's first priority must be to locate and stop the person or persons believed to be the shooter(s); all other actions are secondary. One comprehensive study found that in more than half (57 percent) of *active shooter* incidents where a solo officer arrived on the scene, shooting was still underway when the officer arrived. In 75 percent of those instances, a solo officer had to confront the perpetrator to end the threat. In those cases, the officer was shot one-third of the time[12].

Staff should be trained to cooperate and not to interfere with first responders. When law enforcement arrives, students and staff must display empty hands with open palms. Law enforcement may instruct everyone to place their hands on their heads, or they may search individuals.

After an *Active Shooter Incident*[13]

Once the scene is secured, first responders will work with healthcare facility officials and victims on a variety of matters. This will include treating and transporting the injured, interviewing witnesses, and initiating the investigation.

After the active shooter has been incapacitated and is no longer a threat, human resources and/or management should engage in post-event assessments and activities, including:

- An accounting of all individuals at a designated assembly point to determine who, if anyone, is missing and potentially injured
- Notification of physicians who are located off campus
- Determining a method for notifying families of individuals affected by the active shooter, including notification of any casualties
- Assessing the psychological state of individuals at the scene, and referring them to health care specialists accordingly
- Identifying and filling any critical personnel or operational gaps left in the organization as a result of the active shooter

[12] Ibid

[13] Also see the section of the Guide on Considerations for the Recovery Annex.

- It is important to note that once the active shooter is apprehended or incapacitated, the situation and the location will still be considered an active crime scene. Hospital Administration and key personnel should plan for an extended emergent situation and the Mass Causality or Internal Disaster plan may be activated to manage the continuing situation. This may include altering daily activities in order for law enforcement to adequately investigate and clear the scene, and to rehabilitate the facility to an acceptable level for clinical activity. The Emergency Department may be put on diversion according to local or regional plans.

- Hospital as Crime Scene: Discuss the implications of the hospital as a crime scene with local law enforcement officials in advance. Be prepared to implement an Alternative Care Site plan if required.

- Academic Health Centers: Be prepared to decide when to resume classes and full services

The healthcare facility EOP should identify trained personnel who will provide assistance to victims and their families. This should include establishing an incident response team (including first responders) who are trained to appropriately assess and triage an *active shooter situation* (as well as other emergencies), and provide emergency intervention services and victim assistance beginning immediately after the incident and throughout the recovery efforts. This team will integrate with state and federal resources when an emergency occurs.

Within an on-going and/or evolving emergency, where the **immediate reunification** of loved ones **is not possible**, providing family members with timely, accurate and relevant information is paramount. Your local or regional mass fatality plan may call for the establishment of a Family Assistance Center to help family members locate their loved ones and determine whether or not they are among the casualties. Having family members wait for long periods of time for information about their loved ones not only adds to their stress and frustration, but can also escalate the emotions of the entire group. When families are reunited, it is critical child release procedures are in place where minors might be involved (e.g., childcare or discharged patients) to assure a child is not released to an unauthorized person, even if the person is well-meaning.

Essential steps to help establish trust and provide family members with a sense of control can be accomplished by:

- Identifying a safe location separate from distractions and/or media and the general public, but close enough to allow family members to feel connected in proximity to their children/loved ones;

- Scheduling periodic updates even if no additional information is available;

- Being prepared to speak with family members about what to expect when reunified with their child/loved ones; and

- Ensuring effective communication with those that have cultural or linguistic needs, such as sign language interpreters for deaf family members.

When reunification is not possible because an individual is missing, injured or killed**,** how and when this information is provided to families is critical. Before an emergency, the planning team must determine how, when, and by whom loved ones will be informed if their loved one is missing or has been injured or killed. Law enforcement typically takes the lead on death notifications, but all parties must understand their roles and responsibilities. This will ensure families and loved ones receive accurate and timely information in a compassionate way.

While law enforcement and medical examiner procedures must be followed, families should receive accurate information as soon as possible. Having trained personnel to talk to loved ones about death and injury on-hand or immediately available can ensure the notification is provided to family members with clarity and compassion. Counselors trained in Disaster Mental Health techniques should be on hand to immediately assist family members and staff.

The healthcare facility EOP should include pre-identified points of contact to work with and support family members (e.g., counselors, police officers). These points of contact should be connected to families as early in the process as possible, including while an individual is still missing but before any victims have been positively identified. After an incident, it is critical to confirm each family is getting the support it needs, including over the long-term.

The healthcare facility EOP should consider printed and age-appropriate resources to help families recognize and seek help in regard to a variety of reactions they or their loved ones can experience during and after an emergency. For example, a family that has lost a child may have other family members in the area or at the healthcare facility. It is critical the families and loved ones are supported as they both are grieving the loss and will be supporting their surviving family members.

The healthcare facility EOP also should explicitly address how impacted families will be supported if they prefer not to engage with the media. This includes strategies for keeping the media separate from families and staff while the emergency is ongoing and support for families who may experience unwanted media attention at their homes.

Media

- Coordinate beforehand with all departments and campus locations to provide unified and factual messages to staff, families, and the media using multiple modalities
- Develop pre-agreements with the media concerning debriefings and media holding areas during an emergency
- Designate a facility spokesperson
- If any media outlet calls to obtain information concerning the incident, ensure phone operators know how to respond and where to transfer the calls

Threat Assessment Teams (TAT)

As described in the previous section, research shows perpetrators of targeted acts of violence engage in both covert and overt behaviors preceding their attacks. They consider, plan, prepare, share, and, in some cases, move on to action[14]. One of the most useful tools academic and non-academic healthcare facilities can develop to identify, evaluate, and address these troubling signs is a multidisciplinary TAT. A TAT with diverse representation often will operate more efficiently and effectively. TAT members should include healthcare facility administrators, counselors, current employees, medical and mental health professionals, and residential life, public safety, and law enforcement personnel.

The TAT serves as a central convening body to ensures warning signs observed by multiple people are not considered isolated incidents and do not slip through the cracks as they actually may represent escalating behavior that is a serious concern. Healthcare facilities should keep in mind, however, the importance of relying on factual information (including observed behavior) and avoid unfair labeling or stereotyping, to remain in compliance with civil rights and other applicable federal and state laws.

For the purposes of consistency and efficiency, a TAT should be developed and implemented in coordination with healthcare facility policy and should address any annual training requirements, and how often convene. In addition, staff already working to identify staff needs can be a critical source of information on troubling behavior for a TAT.

The TAT reviews troubling or threatening behavior of current patients and family members, visitors, staff, or other persons brought to the attention of the TAT. The TAT contemplates a holistic assessment and management strategy that considers the many aspects of the potentially threatening person's life—academic, residential, work, and social. More than focusing on warning signs or threats alone, the TAT assessment involves a unique overall analysis of changing and relevant behaviors. The TAT takes into consideration, as appropriate, information about behaviors, various kinds of communications, not-yet substantiated information, any threats made, security concerns, family issues, or relationship problems that might involve a troubled individual. The TAT may also identify any potential victims with whom the individual may interact. Once the TAT identifies an individual who may pose a threat, the team will identify a course of action for addressing the situation. The appropriate course of action— whether law enforcement intervention, counseling, or other actions—will depend on the specifics of the situation.

The TAT may also identify any potential victims with whom the individual may interact. While TATs are not common in healthcare facilities, they have been pushed to the forefront of concern at institutes of higher education following the 2007 shooting at Virginia Polytechnic Institute and State University in Blacksburg, Va., where 32 individuals were killed.

Law enforcement can help assess reported threats or troubling behavior and reach out to available federal resources as part of the TAT process or separately. The FBI's behavioral experts in its National Center for the Analysis of Violent Crimes (NCAVC) at Quantico, Va., are available on a 24/7 basis to join in any threat assessment analysis and develop threat mitigation strategies for persons of concern. The law enforcement member of the healthcare facility TAT should contact the local FBI office for this behavioral analysis assistance.

[14] See Threat Assessment Teams: Workplace and School Violence Prevention. http://www.fbi.gov/stats-services/publications/law-enforcement-bulletin/february-2010/threat-assessment-teams/.

Each FBI field office has a NCAVC representative available to work with healthcare facility TATs and coordinate access to the FBI's Behavioral Analysis Unit, home to the National Center for the Analysis of Violent Crimes. It focuses not on how to respond tactically to an *active shooter situation* but rather on how to prevent one. Early intervention can prevent a situation from escalating by identifying, assessing, and managing the threat. The TAT should consult with its healthcare facility administration and develop a process to seek these additional resources.

Generally, *active shooter situations* are not motivated by other criminal-related concerns such as monetary gain or gang affiliation. Oftentimes situations may be prevented by identifying, assessing, and managing potential threats. Recognizing these pre-attack warning signs and indicators could help disrupt a potentially tragic event.

Employee Assistance Program (EAP)

An EAP can provide practical solutions, information, support and referrals for a wide range of issues, including anxiety, depression, relationship challenges, alcohol and other substance abuse, grief and loss, financial or legal concerns and work/life balance. An employee can talk about issues in confidence with a knowledgeable, caring professional to connect with resources and gain a new perspective, strategy, information or solution.

Psychological First Aid (PFA)

PFA is an evidence-informed modular approach used by mental health and disaster response workers to help individuals of all ages in the immediate aftermath of disaster and terrorism. PFA is designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping.

PFA does not assume all survivors will develop mental health problems or long-term difficulties in recovery. Instead, it is based on an understanding that disaster survivors and others affected by such events will experience a broad range of early reactions (e.g., physical, psychological, behavioral, spiritual). Some of these reactions will cause enough distress to interfere with adaptive coping and recovery may be helped by support from compassionate and caring disaster responders.

PFA is designed for delivery by mental health and other disaster response workers who provide early assistance to affected children, families, and adults as part of an organized disaster response effort. These providers may be embedded in a variety of response units, including first responder teams, the ICS, primary and emergency health care, incident crisis response teams, faith-based organizations, Community Emergency Response Teams (CERT), Medical Reserve Corps, the Citizens Corps, and other disaster relief organizations.

Basic objectives of PFA are:

- Establish a human connection in a non-intrusive, compassionate manner.
- Enhance immediate and ongoing safety and provide physical and emotional comfort.
- Calm and orient emotionally overwhelmed or distraught survivors.
- Help survivors tell you specifically what their immediate needs and concerns are, and gather additional information as appropriate. Offer practical assistance and information to help survivors address their immediate needs and concerns.
- Connect survivors as soon as possible to social support networks, including family members, friends, and neighbors.
- Support adaptive coping, acknowledge coping efforts and strengths, and empower survivors; encourage adults, children, and families to take an active role in their recovery.
- Provide information to help survivors cope effectively with the psychological impact of disasters.
- When appropriate, link the survivor to another member of a disaster response team or to local recovery systems, mental health services, public-sector services, and organizations.

PFA is designed for delivery in diverse settings. Mental health and other disaster response workers may be called upon to provide PFA in:
General population shelters

- Special need shelters
- Field hospitals and medical triage areas
- Acute care facilities (e.g., emergency departments)
- Staging areas or respite centers for first responders or relief workers
- Emergency operations centers
- Crisis hotlines or phone banks
- Mobile dining facilities
- Disaster assistance service centers
- Family reception and assistance centers
- Homes

- Businesses
- Other community settings

Content taken from *Psychological First Aid Field Operations Guide*
http://www.nctsn.org/sites/default/files/pfa/english/1-psyfirstaid_final_complete_manual.pdf.

Training on Psychological First Aid

PFA Training can be provided face-to-face or online. The online version (http://learn.nctsn.org/) is vastly utilized and is a 6-hour interactive course that puts the participant in the role of a provider in a post-disaster scene. This professionally narrated course is for individuals new to disaster responses who want to learn the core goals of PFA, as well as for seasoned practitioners who want a review. It features innovative activities, video demonstrations, and mentor tips from the nation's trauma experts and survivors. PFA online also offers a Learning Community where participants can share about experiences using PFA in the field, receive guidance during times of disaster, and obtain additional resources and training.

The *Psychological First Aid: Field Operations Guide* provides information for adults, families, first responders, disaster relief workers, crisis counselors, and volunteers to help survivors immediately in the aftermath of a traumatic event. Available online at http://www.nctsn.org/content/psychological-first-aid, the guide describes key steps for providing PFA including how to approach someone in need, how to talk to them, how to help stabilize someone, and how to gather information. Appendices include resources about service delivery sites and settings, provider care, and worksheets and handouts.

Following disasters or emergencies, the PFA Mobile App can assist responders who provide PFA to adults, families, and children. Materials in PFA Mobile are adapted from the *Psychological First Aid Field Operations Guide* (2nd Edition). (http://www.nctsn.org/content/pfa.mobile)
(http://www.ptsd.va.gov/professional/pages/pfa_mobile_app.asp)
The PFA Mobile App allows responders to:
Read summaries of the 8 core PFA actions.

Match PFA interventions to specific stress reactions of survivors.

Get mentor tips for applying PFA in the field.

Self-assess to determine their own readiness to conduct PFA.

Assess and track survivors' needs to simplify data collection and referrals.

Psychological First Aid – Field Operations Guide
http://www.nctsn.org/content/psychological-first-aid