Planning and Training for an Active Shooter Event

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Caryn Thornburg has been in the health care industry since 1976. She is a retired U.S. Army combat veteran, having served in third-world countries in field hospitals and on medical response teams in austere conditions following disasters. Caryn is a member of the State Mission Support Team and Secondary Workgroup for the HICS IV Revision project. She is also an instructor for CHA's Active Shooter, IAP and HICS trainings. She has participated as a member of the Statewide Medical and Health Exercise Workgroup and in the CDPH Surge Capacity project and the Emergency Food Advisory Group. Caryn worked with the Bay Area Urban Area Security Initiative Medical and Public Health projects to sustain and improve the region's capacity to prevent, protect against, respond to and recover from terrorist incidents and catastrophic events. She also worked for U.S. Army at the Regional Training Site – Medical as a training supervisor and exercise planner for field hospitals, aviation, transportation and logistical supporting units.
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Active Shooter Situation: Options for Consideration
Federal Occupational Safety And Health Administration (OSHA)
The State of California
  - Division of Occupational Health and Safety
  - Health and Human Services Agency, Department of Public Health
The Joint Commission

CalOSHA

- Title 8 of the California Code of Regulations (CCR), Section 3202, mandates all California employers develop an Injury and Illness Prevention Program (IIPP)
- The IIPP must detail the means and methods each employer will use to ensure the safety and health of its employees
- There are no standards specific to Workplace Violence (WPV), but CalOSHA will evaluate policies and procedures thru the Illness and Injury Prevention Program

Health & Safety Code: 1257.7

Plan Components
- The plan may include, but shall not be limited to security considerations, relating to all of the following:
  - Physical layout
  - Staffing
  - Security personnel availability
  - Policy and training related to appropriate responses to violent acts
  - Efforts to cooperate with local law enforcement regarding violent acts in the facility
The individual or members of a hospital committee responsible for developing the security plan shall be familiar with:

- The role of security in hospital operations
- Hospital organization
- Protective measures, including alarms and access control
- The handling of disturbed patients, visitors, and employees
- Identification of aggressive and violent predicting factors
- Hospital safety and emergency preparedness
- The rudiments of documenting and reporting crimes

The Joint Commission’s Sentinel Event Database lists 256 such incidents since 1995, but the organization believes those numbers to be significantly underreported. Violent crimes are consistently among the top 10 types of sentinel events reported to The Joint Commission each year.
The Joint Commission has identified several high risk or security sensitive areas based upon years of hospital surveys from across the country. Their security sensitive areas include:

- Maternity
- Pediatrics
- Emergency Department
- Pharmacy
- Operating Rooms
- Psychiatry

The hospital plans activities to minimize risks in the environment of care. Risks are inherent in the environment because of the types of care provided and the equipment and materials that are necessary to provide that care.

EC.01.01.01
The hospital manages safety and security risks. Safety incidents are often intentional. Security protects individuals and property against harm or loss. Security incidents are caused by individuals from either outside or inside the hospital. Includes WPV.

EC.02.01.01
On October 5, 2011 a joint ASIS/SHRM Workplace Violence Prevention and Intervention American National Standard was issued to help organizations implement policies and practices to quickly identify threatening behavior and violence affecting the workplace, and to engage in effective incident management and resolution.

The standard is a consensus of documents from professionals in the security, human resources, mental health, law enforcement, and legal fields.

The recommendations are broad which allows flexibility to organizations who will need to implement specific prevention and intervention strategies appropriate for their environment.
NYPD Study 1996 – 2012
324 Cases Reviewed

- 98% involved only one (1) shooter
- 97% were male
- 83% stopped by others (security, law enforcement, bystanders) or killed themselves
- 36% involved more than one weapon
- 281 attacks involved one victim

Operational Concepts
For Hospitals, By Hospitals

Introduction

According to a 2012 study by Johns Hopkins University School of Medicine, hospital-based shootings are rare, but recent attacks in Mississippi, Pennsylvania, and California — and non-hospital gun violence in places like Colorado and New York — can attest to the number of lives affected by these deadly events. With each devastating occurrence, we ask the same questions: Why did it happen; could we have been better prepared; and how do we prevent it from happening again?

**Hospital-Based Shootings in the U.S.: 2000 to 2011**

154 hospital-related shootings were identified
- 91 (59%) occurred inside the hospital
- 63 (41%) occurred outside on hospital grounds
- Occurred in 40 states
- 235 injured or dead victims
- 91% were men, representing all adult age groups
- The ED environs were the most common site (29%), followed by the parking lot (23%) and patient rooms (19%)
- Hospital employees composed 20% of victims
  - Nurses 5%
  - Physicians 3%
- In 23% of shootings within the ED, the weapon was a security officer’s gun taken by the perpetrator

10 Hospital Shootings in 2012
(16 Additional non-health care shootings the same year)

- Mercy Health Partners Hackley Campus – Muskegon, MI
- St Vincent’s Hospital – Birmingham, AL
- University of Maryland St. Josephs Med Center – Townson, MD
- University Hospital – Augusta, GA
- Kindred Hospital – Sycamore, IL
- Akron General Medical Center – Akron, OH
- Erie County Medical Center – Buffalo, NY
- Scott & White Hospital – Temple, FL
- Hospital for Special Care – New Britain, CN
- Earlander of Hutcheson – Fort Olgethorpe, FL

3 Hospital Shootings in 2013

- Leigh Valley Hospital – Allentown, PA
  - Shot and killed his wife and then shot himself in the hospice unit
- Adventist Medical Center – Portland, OR
  - Fugitive bank robber told a staff member he had a gun and would use it on the employees
- University of Texas Southwestern Medical Center
  - Executive assistant fatally shot and killed in parking lot by her estranged husband
Recommendations

While predicting such events is nearly impossible, being prepared is not. Security experts from the Department of Homeland Security (DHS), various law enforcement (LE) agencies, and the International Association of Healthcare Security and Safety (IAHSS) have noted some key recommendations to guide hospitals in preparing an Emergency Action Plan (EAP) for an active shooter event.

Components of an EAP

- Conduct an independent and realistic assessment
- Emergency escape procedures, identify evacuation routes and practice evacuating each route
- Prepare a safe hiding place
  - Cover – protection from gunfire
  - Conceal – out of the view of the shooter
- Establish an effective access control plan
- Maintain facility-wide communication
- Preferred method for reporting emergencies
Components of an EAP (cont.)

- Train staff to work with law enforcement
- Use plain language, not codes
  - Caryn vs. Lisa's opinion
- Keep it Simple
- Take Action
- Practice – Drills
- Stay informed

CHA HPP Active Shooter Training Courses

- 672 people attending 17 training courses across California
  - 2 courses in Tennessee, 80 people attending
- Across the state, ranges of whether hospitals have plans: from high of 85% to low of 15% of hospitals in the local area that have plans
- Hospitals with AS policy ranges from high of 79% to low of 12% of hospitals in the local area with AS policies
- 98% report information was useful
- 96% report needing more training
- No area across the state reports 100% of hospitals have AS plans or policies

CHA HPP Active Shooter Training Courses: What's Needed Next

What the audience is telling us:

- Administration and executive buy-in information; policy development; exercise design ideas; mini exercises/group breakouts/discussions
- Addressing clinical aspects of active shooter responses
- Active practice, mini exercise
- Active shooter activities guidance
Did not realize full breadth of training including administrative components
- Being proactive-practicing training/planning; learning from previous events; communication between all agencies involved
- Checklist and guidelines
- Concept of survival mindset
- Continued education

Discussion of scenario gave me a lot of insight into others thought process and reasons for what's happening at their facility.
- I am in law enforcement and got a lot more from this class than I expected.
- Interaction with healthcare professionals who provide options that are well thought out and based on solid principles/research.
- No plan is perfect, there are many holes in ours.
- Sobering thoughts and awareness from the stories and statistics of the shooting incidences.

Controversial concept in various response models, when applied to the healthcare setting are:
- Fight back
- Lockdown – preventive vs. emergency
- Evacuation
- “En Loco parentis”
- “Duty to Care” = negligence
- Moral and Ethical dilemma
Lockdown

- Lockdown involves 3 key elements:
  1. Preventing the **entry** into the building/site
  2. Preventing people from **exiting**
  3. Preventing the **movement** of people on the property, with the goal of excluding or containing staff, patients and visitors

Lockdown Considerations

- Having an **emergency lockdown** option for situations where there is an imminent risk to patients and staff, such as an active shooter
- A **preventive lockdown** or “soft” option for the vast majority of situations where this high level of risk is not initially apparent will improve the reliability of lockdown implementation for healthcare entities, such as out-of-control visitor or drunk in the ED brandishing a knife

Scalable Lockdown Levels

- United Kingdom
  - Partial: a specific part or building
  - Portable: moved from one location to another
  - Progressive: incremental lockdown
  - Full: preventing entry or exit
**Control Zones — Defense Plan**

**Using Concepts Staff Already Understand**

DECON Principles:
- **3 Zones**
  - Hot – Shooter
  - Warm – Hide Out
  - Cold – Run/Get Out

**FIRE – Evacuation**
- 1. Room/dept. with the shooter
- 2. Rooms/depts. on both sides of the shooter
- 3. Rooms/depts. across the hall from the shooter

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**Evacuation — Run**

- In the healthcare setting, some embrace the Run component as the first option despite the fact that it means some patients might be left behind
- If you stay with patient, potential for both to be killed is greater; if you get out you can call authorities and potentially save more lives
- Evacuation removes the targets, which lowers the body count; staff are already trained in evacuation for fire; the training remains the same for an active shooter event

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**In Loco Parentis**

- The term in loco parentis, Latin for “in the place of a parent,” refers to the legal responsibility of a person or organization to take on some of the functions and responsibilities of a parent
- Do we not have the same responsibility in healthcare to take care of our patients who are unable to take care of themselves?
Overlooked Planning and Response Considerations

- People who have been prevented from functioning by an external force
- Use “People-First” disability names
  - Person with a disability (PWD)
  - Person with access or functional needs
- Deaf people or hard of hearing people
- Visually impaired
- People with limited English proficiency

Duty To Care

Nurses in Disasters

- When does my “duty to care” for my patients usurp my duty to care for me?
- We have an ethical “duty to care” for our patients, but also an ethical duty to care for ourselves and our families
- How do we choose to do what is right?
- Furthermore, what is right?

Ethical and Moral Dilemma

- Healthcare workers have consistently shown to be reliable responders, and their compassionate nature typically compels them to respond to those in need, even when it puts their own safety or well-being at risk
- What if he/she or the medical team face very difficult — almost unthinkable — situations and decisions regarding life and death, as in a Active Shooter Event?
Ethical and Moral Dilemma (cont.)

- A registered nurse has an ethical obligation to put patients ahead of themselves, but in times where the registered nurse is in imminent danger by providing patient care, how can she balance the ethical obligation to protect herself?
- ANSWERS may be within the State Statutes/Regulations and the California Department of Public Health Standards and Guidelines for Healthcare Surge During Emergencies – Foundational Knowledge and Volume I: Hospitals

Legal Implications

Registered nurses would think about legal implications. Is there a law compelling her to respond, even if she has concerns about security and ethics? Is her license protected? What is her assurance that she would not become an easy target for lawsuits for negligence or malpractice, especially in circumstances of scarce resources or where she is practicing outside of her normal specialty area?

Board of Registered Nurses

- Nursing Practice Act, Business and Professions Code. The Disciplinary Proceedings under Article 3 Section 2750-2765, Section 2761 Grounds for Action www.rn.ca.gov/regulations/bpc.shtml#2761
- The board may take disciplinary action against a certificate or licensed nurse or deny an application for a certificate of license for unprofessional conduct:
  - Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions
Four Elements of Negligence

There are **four elements** of negligence as defined as a legal concept. Must prove all four.

1. Duty of care: someone must take a reasonable try at making sure someone can’t get hurt from their actions.

2. Breach of duty: if you do something that has hurt someone else, you’ve breached the duty of care. Failure to uphold “standards of care.”

   - Expert Witnesses, Scope of Practice, National Standard, Local or Regional Protocols or Standing Orders

3. Factual causation: it has to be proven that negligence happened.

4. Damages: the jury or court has to prove how much damage was caused, and place a dollar figure on it. Awarded based on medical expenses, pain and suffering, funeral expenses, loss of consortium, punitive damages.

**MUST PROVE ALL FOUR COMPONENTS OR IT IS NOT NEGLIGENCE**

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Facility Countermeasures

- Security at entrances
- Metal detectors
- Armed officers
- Camera surveillance
- Key swipe access
- Key pad access
- Visitor P&P
Weapons in the Health Care Environment – Armed Guards

“When you examine the facts surrounding shootings in healthcare facilities you find that almost a quarter of them are in the ED and of those 50% of the shootings are the results of LE or security losing control of their firearms to a hostile person. Statistics on ‘hit potential’ or how many rounds actually hit their target…NYPD has about 18%, which means they miss 82% of the time…In a hospital where are those rounds going to be going? Is your hospital willing to commit to training guards to the level of SWAT or ESU?”

—Frank T., Law Enforcement

Threat Assessment Teams (TAT) (U.S. Secret Service and the U.S. Department of Education)

GOAL: Managing threatening situations and creating a safe environment

- Threat Assessment Team (TAT) is a cross-functional, multidisciplinary team approach to assist in assessing threatening situations and developing risk abatement plans that minimize the potential risk for violence
- Defined process for investigating, evaluating, and managing targeted violence into strategies to prevent violence in the healthcare setting

Response Models

1. RUN, HIDE, FIGHT
2. 4 A’s
3. Window of Life
4. ALICE
5. Move, Secure, Defend
The 4 A's
Dignity Health and Center for Personal Protection & Safety

- Accept an emergency is occurring
- Assess what to do next so you can save as many lives as possible, which depends on your location
- 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)
- Alert law enforcement and security

Window of Life
Safe Havens International

1. A person’s first responsibility is for his or her safety
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
3. A third responsibility is to those in your workplace — i.e., outer buildings
4. A fourth responsibility is to notify public safety
“ALICE” is an acronym for five steps the program’s 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: a semi-secure starting point from which to make survival decisions; if you decide to not evacuate, secure the room
- Inform: using any means necessary to pass on real-time information
- Counter: 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

Bonneville Joint School District
No. 92 in Idaho Falls, Idaho

- Move, Secure, Defend
  - Move to a secure location
  - Secure the location (lockdown)
  - Prepare to defend if required
- Staff outside of the immediate area at the onset of a lockdown move to a predetermined location

People in Need of Support
Post-Event

Your facility has just experienced a traumatic event that threatened the safety of individuals and/or has made many of them feel helpless. The event felt unpredictable and uncontrollable. Your sense of safety is shattered, it will have an affect on those who personally experienced the trauma, those who witnessed it, and those who pick up the pieces afterwards, including emergency workers and law enforcement officers. It can even occur in the friends or family members of those who went through the actual trauma. It can sometimes take weeks, months, or even years before someone may appear to need help coping with the trauma or event.
Psychological First Aid (PFA)
National Child Traumatic Stress Network
and National Center for PTSD

- For use immediately following an event
- Evidence based modular approach used by mental health and disaster response workers to help individuals of all ages in the immediate aftermath of disaster and terrorism
- Designed to reduce the initial distress caused by traumatic events and to foster short and long term adaptive functioning and coping

www.nctsn.org/content/psychological-first-aid

Psychological First Aid (PFA) (cont.)

- It doesn’t assume all survivors will develop severe mental health or long-term difficulties in recovery
- Based on a understanding survivors will experience a broad range of early reactions (physical, psychological, emotional, behavioral, spiritual)
- These reactions may cause enough stress to interfere with adaptive coping, and recovery may be helped by support from compassionate and caring responders

Basic Objectives of PFA

- Establish a human connection in a non-intrusive, compassionate manner
- Enhance immediate and ongoing safety, provide for 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
Connect survivors ASAP to social support networks, including family, friends, neighbors
Support adaptive coping, acknowledge coping efforts and strengths, and empower survivors; encourage people to take an active role in their recovery

Provide information that may help survivors cope effectively with the psychological impact of the event
When appropriate, link the survivor to another member of a response team, organization, mental health services, public-sector services and organizations

Requires survivors to accept responsibility for their own healing process. It specifically avoids providing rationalization for an individual’s behavior. It also avoids the tendency for people to become dependent on medications and/or individuals providing help.
Use a series of educational tutorials to teach the survivor how to anticipate and overcome the common problems of emotional wounding following a traumatic event using IRO-STEPS.
SEEDS Principles
IRO-STEPS Strategy

- SEEDs
  - Specific, Early, Educational Directions

- IRO-STEPS
  - Injury Recovery Orientation, to
  - Stimulate positive thinking,
  - Tackle unrealistic fears,
  - Educate about options,
  - Plan for the future,
  - Stop unrealistic expectations

Eye Movement Desensitization and Reprocessing

- Incorporates elements of cognitive-behavioral therapy with eye movements and other forms of rhythmic, left-right stimulation; these back-and-forth eye movements are thought to work by “unfreezing” traumatic memories, allowing you to resolve them

- Currently being used to help individuals who have PTSD (post-traumatic stress disorder)

Developing a Training Program

- Who?
- How?
- Learning Strategies
- During an investigation CalOSHA will:
  - Review your Policy, Emergency Action Plan and training program, to include all documentation
  - Conduct random survey among employees to inquire: “What is the Active Shooter Policy?” “What is your response and role if Active Shooter response plan is implemented?” “How is this communicated to you?”
CalOSHA Mandated Training
IIPP — Workplace Violence

- Training and instruction about how to recognize workplace security hazards, measures to prevent workplace assaults and what to do when an assault occurs, including emergency action and post-emergency procedures, 3203(a)(7)
- Training of all employees, supervisors and managers
- Employers with employees at risk for workplace violence must educate them about the risk factors associated with the various types of workplace violence (I-III) and provide appropriate training in crime awareness, assault and rape prevention and defusing hostile situations; also, employers must instruct their employees about what steps to take during an emergency incident

CalOSHA Training Component Considerations

3220 — Emergency Action Plan
- Emergency escape procedures and emergency escape route assignments
- Procedures to account for all employees after emergency evacuation has been completed

6184 — Employee Alarms Systems
- The employee alarm system shall provide warning for necessary emergency action as called for in the emergency action plan, or for reaction time for safe escape of employees from the workplace or the immediate work area, or both
- The employee alarm shall be distinctive and recognizable as a signal to evacuate the work area or to perform actions designated under the emergency action plan

Communication Strategies (Alarm Systems)

- Call boxes in parking lots
- Digital displays (LED, LCD) – changeable messages
- Emails
- Intercoms/overhead paging
- Loudspeakers
- Phone trees/telephony
- Pop-up computer messages
- Sirens
- Social Media Portals – Twitter, Facebook, Instagram, LinkedIn
- Text Messaging
- Direct Connect on cell phones
- Voice Evacuation Systems (Connected to the Fire System)
- Software
Developing a Training Response Program

- Phases of Training a model for approach
- Directors, supervisors, managers
- Full facility staff, including MDs and per-diem staff
- Environment of care countermeasures and HR policy issues
- Facility recovery issues and aspects

Best Practices

- “Casey’s Drill”
- SD – ICE Boxes
- Safe Room Packets
- Red Card – Green Card
- WILD Practice
- Sound of Gunfire
- “Safety Huddle” daily at change of shift
- 5-minute “what if” discussion

In Summary

- Hospital-based shooting are relatively rare compared with other forms of workplace violence; however, the unpredictable nature of this type of event represents a significant challenge to healthcare organization and the development of effective deterrence practices
- The presence of a gunman in a hospital setting is frightening, yet active shooters have become increasingly more common in California and across the nation
- Studies show you and your response give you the best chance at survival
Presentation References

- CalOSHA Guidelines for Workplace Security
- New York Police Department (NYPD)
  2012 edition of its “Active Shooter: Recommendations and Analysis for Risk Mitigation” Report
  www.nctsn.org/content/psychological-first-aid

Educational Tools

- CHA HPP Courses and Materials
  - www.calhospitalprepare.org/active-shooter
- HASC Active Shooter Drill Materials
  - www.hasc.org/active-shooter-drill-resources
- RUN, HIDE, FIGHT – free on YouTube
- Quick Series Active Shooter Response Guides
- Videos and on-line training programs $$$$  
- Shots Fired for Healthcare – DVD
  - Available for purchase from Center for Personal Protection and Safety at www.cppssite.com

Educational Tools (cont.)

- U.S. Department of Homeland Security:
  - Active Shooter How To Respond Booklet and Wallet Cards
  - “How to Respond When An Active Shooter Is In Your Vicinity Poster” customized to your facility
  - Active Shooter Situation: Options for Consideration
- FEMA EMI IS-907 Active Shooter: What You Can Do
Concluding Comments

Thank you for your participation

Questions?