“Shots Fired”
A National Perspective on Responding to Terrorist Actions

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The world has changed.

And so has the nature of the threat.

Objectives

• Describe the paradigm shift that governs the law enforcement approach to ‘active shooter’
• Appreciate the continuum of care that extends from field management to hospital care
• Review steps for ensuring trauma/burn surge capability
April 20, 1999

Columbine — Paradigm Shifter

- Both had self-inflicted fatal wounds
- Occurred within 45 minutes from start of incident
- No significant law enforcement entry for 1 hour
- No medical operations inside for 4 hours
- 12 students & 1 teacher killed; 24 wounded
- Teacher bled for > 2 hours before dying
Paradigm Shift

EMS/fire/rescue must be involved earlier in the care of the victims

• Threat suppression
• Hemorrhage control
• Rapid Extrication to safety
• Assessment by medical providers
• Transport to definitive care

Hartford Consensus, Jacobs, 2014

Shared responsibility between law enforcement, fire/rescue and EMS

• Optimal outcome depends on communication between all public safety responders
• The response requires coordination between law enforcement and the medical/evacuation providers
• Such coordination includes jointly developed protocols for an integrated response to these events
Rescue Task Force

First arriving EMS personnel (NOT tactical medics) team up with two patrol officers (NOT SWAT) and move quickly into the “warm” zone along cleared areas to initiate treatment and evacuation of victims.

Discussion Paper

Health and Medical Response to Active Shooter and Bombing Events

John L. Hick, Dan Hanfling, Bruce Evans, Sheldon Greenberg, Roy Alson, Suzet McKinney, and Matthew Minson

June 17, 2016

Key Points

• Prepare for acts of mass violence
• Medical support for/with law enforcement
• Broaden “citizen first responder” training/education (e.g., public access tourniquets)

Initial Hospital Actions and Priorities

• Ensure perimeter security
• Initiate triage of wounded
• Implement surge response plan

Focus on surge “capability” planning and response (e.g., trauma and burn surge; management of cases in non-trauma/burn facilities)
**Key Points**

**Augment Hospital Plans**
- Increased security posture and “crowd control”
- Rapid screening of victims, triage and hemorrhage control
  - Tourniquet application; tourniquet takedown
  - Tranexamic acid (TXA) protocol
- Surgical triage and decision making process — damage control surgery; vascular surgical set-ups; massive transfusion protocol implementation
- Mental health support for responders (e.g., PSYStart)
Medical Surge Response

- Tourniquet use
  - Put on
  - Take down
- Key resources — Considerations given to Crisis Standards of Care planning:
  - Substitution; Adaptation; Re-use
  - Massive transfusion protocol (blood products availability)
  - Damage control surgery
  - Chest tubes
  - Vascular trays

February 27, 2016, Prince William County, Virginia
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Key Challenges

- Minimal alert time for receiving hospitals
- Communications difficulties
- Security and crowd control at hospitals
- Providing Situational Awareness and mobilizing all hospital departments to provide clinical services for the influx of severely injured patients

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