APPENDICES:
10. RESCUE TASK FORCE

1. PURPOSE

A. To delineate the standing medical orders for Fire/Rescue individuals functioning as members of the Unified Police/Fire response to the active shooter scenario

2. DEFINITIONS

A. **Hot Zone:** Any area in the area of operations in which there is a direct an immediate threat to persons or providers. Tactical paramedics will not primarily operate in the Hot Zone, but may be required to operate in this zone as various critical circumstances dictate.

B. **Warm Zone:** Any area in the area of operations where there is a potential hostile threat to persons or providers but is not direct and immediate. This is the main zone of operations and for staging for tactical paramedics. The Echelon 2 casualty collection point will be located in the Warm Zone.

C. **Cold Zone:** Any area within the area of operations where the tactical paramedics, along with the tactical commanders, do not reasonably anticipate a significant danger or threat to the providers or patients. The Echelon 3, or main, casualty collection points, Command assets, staged non-tactical Fire/EMS personnel and Fire/EMS and police apparatus are located will be located in the Cold Zone.

D. **Active Shooter:** Any armed person who uses or has used deadly physical force on other persons and continues to do so while having unrestricted access to additional victims

E. **Patrol Officer:** Standard uniformed police officers assigned to monitor specified geographic areas in Arlington County.

F. **Contact Team:** Initial teams of up to 4 patrol officers who form immediately on arrival to scene of active shooter and immediately deploy into building moving rapidly with the goal of initiating contact to contain/eliminate the active shooter to prevent further injury or loss of life.

G. **TEMS:** Tactical Emergency Medical Support team. ACFD paramedics who are detailed to work in specifically with Arlington Police SWAT in a medical support capacity.

H. **SWAT team:** Special Weapons and Tactics team. ACPD officers specially selected and trained to perform high-risk operations that fall outside of the abilities of regular patrol officers.

3. JUSTIFICATION

A. The designated TEMS medics in Arlington County are not always readily available.
   1) Adequate medic response in mass casualty ballistic trauma requires multiple teams working at once to avoid delay to any one patient.
   2) Number of TEMS medics are too few to adequately cover large area or number of injured patients
   3) TEMS medics have a designated role to assist the SWAT team with completion with the immediate tactical goal.
      a) Providing care to large number of injured patients will prevent TEMS medics from completing their immediate goal of supporting the Arlington Police SWAT team.

B. The number and need for immediacy in medical response requires that every street medic in the County be trained to be able to function as an RTF member
   1) Similar paradigm shift to new active shooter police response utilizing street patrol officers instead of waiting for SWAT.

C. ALS providers tasked with providing immediate care to injured persons during an active shooter scenario must operate under dangerous conditions with unconventional hazards.
   1) The purpose of the Rescue Task Force is to mitigate provider risk while rapidly forward deploying stabilizing medical resources to assist in treatment and evacuation of the wounded despite hazardous conditions that might otherwise delay treatment.

4. ELIGIBILITY AND RESPONSIBILITIES

A. Certification as a Virginia State ALS provider

B. Completion of ACFD training program and operational medical director approval to operate as a medic in Arlington County.

C. Completion of annual 4-hour CME on Rescue Task Force operations, procedures, and equipment.

5. EQUIPMENT

A. RTF medics will have a full complement of all usual ACPD ALS supplies and equipment staged in the external casualty collection point in the "cold" zone.

B. RTF medics will carry combinations of approved equipment in special packs designed for deployment into "Warm" zones as predetermined and authorized by the ACFD operational medical director.

C. Below is a list of equipment that may be carried including that beyond current ACPD Medical Treatment Protocols
   1) Military Emergency Tourniquet (MET)
   2) Bolin Occlusive Chest Seal
   3) Hemostatic granules or impregnated gauze
   4) 3¼ inch 14ga chest decompression needles
   5) Nasopharyngeal airways
   6) King LT-D airways
   7) H-bandage pressure bandage
   8) Z-pak or other compressed gauze roll

D. Below is a list of Personal Protective Equipment that each medic on the RTF will be outfitted with prior to deployment into the Warm Zone to mitigate any potential ballistic injury
   1) Level IIIA Ballistic Tactical Vest with Level IIIA bicep protectors
   2) Level IIIA Ballistic Tactical helmet

6. STANDARD OPERATING PROCEDURES

A. Upon notification of Active Shooter scenario, initial responding patrol officers will form contact teams and enter building to contact and contain the active threat according to current police doctrine.

B. These contact teams as they move through the building will identify need for the Rescue Task Force by noting and communicating locations and estimated numbers of injured persons

C. Upon request by the initial contact teams deployed into an active shooter scenario, Rescue Task Force teams will be formed consisting of 2 medics and 2 police patrol officers.
   1) Role of the Police Officers
      a) The police officers role is one of security and movement of the team only. They will not assist in lifting, carrying, or treatment of any patient.
      b) One police officer will have 180 degree front security and one officer will have 180 degree rear security.
      c) The front security officer will communicate with Police Command and all movement in the building will be directed by Police Command. This allows for accountability of each RTF team.
         (1) At no time will the RTF 'freelance' or move outside of their directed destination/area of operation.
      d) At no time will the patrol officers assigned to the team leave the medics further than close direct line of sight.
         (1) Patrol officers must be able to provide effective defensive fire cover for the team at all times.

2) Role of the ACFD Medics
   a) The RTF medics, when functioning in the WARM Zone, will only provide stabilizing treatment in sequence and according to the pneumonic SCAB-E explained in the following section. Standard ACFD patient treatment protocols are suspended during RTF operations.

D. RTF Ingress and Egress corridors will be designated
   1) RTF team will move in and out of the building only through entrances and corridors primarily cleared by the initial contact teams.

E. Resupply
   1) A resupply depot of RTF supplies and equipment will be established by Fire Command near the entrance through which the RTF teams ingress and egress from the building

F. Casualty Collection Points will be designated
   1) If appropriate, RTF teams may establish an internal CCP in a hardened area approved by Police Command.
      a) 1 or 2 RTF teams will be designated to operate this CCP
   2) A temporary Casualty Collection Point 'way station' will be designated at the location of the external RTF supply depot.
      a) This is the destination to which RTF teams will evacuate non-ambulatory casualties.
      b) Non-RTF Fire/EMS personnel will be tasked with immediately evacuating non-ambulatory patients from this temporary CCP to the fixed External CCP in the Cold Zone
   3) Fire Command will establish an External Casualty Collection Point in the Cold Zone
      a) Care will be provided by non-RTF ACFD medics as well as mutual aid assets
      b) Transport assets will be staged at this location

G. Emergency Evacuation Procedures
   1) If the Zone in which the RTF is operating changes from Warm to Hot due to a direct and immediate threat, immediate evacuation of the RTF to appropriate cover will occur.
      a) This may include partial or complete evacuation of the team from the building.
   2) If any member of the RTF is injured during operations, immediate evacuation of the RTF will occur.
      a) This may include partial or complete evacuation of the team from the building.

7. STANDARD MEDICAL TREATMENT PROTOCOLS

A. **Situation(s)** – Maintain situational awareness:

1) Medic will be aware of surroundings, potential threats such as IEDs, and open routes of rapid egress.
2) All patients within a reasonable geographic area, not more than earshot of a quite voice and direct line of sight from the Patrol officers, should be rapidly triaged using START triage.
3) Ambulatory patients should be directed to evacuate area down corridor used for RTF ingress
4) Non-ambulatory patients should be medically stabilized and either evacuated or placed in proper position while awaiting evacuation

B. **Circulation** – Assess for and treat life threatening extremity bleeding

1) Direct pressure in the proximal artery, brachial or femoral, should be immediately applied by kneeling on the artery with body weight. This allows for both hands to be free to apply the intervention.
2) Tourniquets are to be placed immediately on the following extremity wounds:
    a) Total or near-total amputations
    b) Large vessel arterial bleeding
    c) Massive large vessel venous bleeding
    d) Any wound that cannot be adequately controlled with a pressure dressing
    e) If any doubt whether the wound requires a tourniquet
3) Tourniquets are to be initially placed as proximal as possible on the limb regardless of injury location for rapid control of bleeding; essentially "high and over the clothes."
4) Mechanical pressure dressing may be applied for anatomically amenable extremity wounds.
    a) Deep wounds should be packed with hemostatic agent and gauze to transmit pressure deep into the wound to site of bleeding.

C. **Airway (A)** - Assess for airway patency.

1) Basic airway maneuvers are emphasized
2) Any occluded airway or any patient with altered mental status will have a nasopharyngeal airway placed.
3) Casualty will be allowed to assume any position that best protects the airway, to include sitting up.

D. **Breathing (B)** - Assess for any open or sucking chest wounds.

1) Place the designated occlusive chest seal to any trunk wound anterior or posterior from the umbilicus to the trapezius muscles.

E. **Breathing (B)** - Assess for and aggressive treat tension pneumothorax.

1) Any patient with known or suspected thoracic injury and any respiratory distress either initially or that develops during care will have a prophylactic needle decompression
2) Place needle in the second intercostal space at the midclavicular line, ensuring that needle entry is not medial to the nipple line and is not directed towards the heart.
    a) Catheter will be allowed to vent the intrathoracic space.

F. **Evaluate and Evacuate (E)** - Assess effectiveness of applied interventions and initiate evacuation

1) Check tourniquets and pressure dressings for adequacy
2) Assess for unrecognized hemorrhage through a comprehensive blood sweep
3) Reassess for respiratory distress and proactively treat if present
4) Roll patient and examine posterior for injury
5) Place conscious patient in position of comfort and unconscious patient in recovery position while awaiting for evacuation

G. **Evaluate and Evacuate (E)** – Communicate with Unified Command team status

1) If adequate supplies remain and there are untreated patients further in the building, patrol officers should move team further into building to location of untreated patients
2) If no supplies remain or if all patients treated, team should initiate evacuation to available Casualty Collection Point of critically injured according to triage categories.
    a) Patrol officers escort medics and patient during egress
    b) Medics evacuate patient using appropriate effective evacuation carry or other evacuation device