Introduction

Active Shooter Events (ASEs) are highly dynamic, rapidly evolving situations. In 63 incidents closely analyzed by the FBI in which the duration of the event could be determined, 44 were over in five minutes or less, and of those, 23 ended in two minutes or less. They happened so quickly that the shooting was over before police arrived. Unlike other violent crimes, the "active" aspect of an Active Shooter Event inherently implies that both law enforcement, personnel and citizens have the potential to affect the outcome of the event based upon their responses. (FBI, 2014)

To effectively prepare for such a fast-moving and potential devastating threat like an ASE, leaders and decision-makers in hospitals and health care environments should consider four critical concepts in planning, response and recovery.

Concept One: Hospital and Health Care Settings are Different

Active Shooters Events have occurred in shopping malls, movie theaters, schools, and even houses of worship. As such, most of the available guidance addressing Active Shooter Event response is broad-spectrum and intended to be used in many different types of environments. Anyone who works in a hospital or health care facility understands that their work environment is different from those in any other sector. The hours of operation, multiple entrances, high number of staff members, patients and visitors may make the facility both a *"soft target"* and a *"target rich"* environment attractive to a would-be shooter. But there are other more specific concerns and areas for consideration in planning.

Whether in traditional hospital settings, free standing urgent or immediate medical care centers, or other patient-serving environments, areas such as Emergency Departments (ED), Operating Room Suites (OR), Neonatal Intensive Care Units (NICU) and Newborn Areas, Intensive Care Unit (ICU), Radiation Laboratories, Nuclear Medicine, and other radiation areas, as well as Infectious Disease/Quarantine Areas, and Biohazard Areas and laboratories, all require specific work area evaluations for unique vulnerabilities and opportunities to escape or evade a shooter. MRI suites, for example, pose a special risk since the powerful magnet in the imaging machine can tear a weapon from a responding police officer's hands. This can and has occurred, sometimes with the weapon discharging upon impact with the MRI machine. Other areas pose different risks which require special attention in planning and exercising.

Some health care settings may occasionally serve VIPs who come with their own armed security teams. Those security personnel may have different priorities and protocols to follow in a violent event and it will be important to coordinate those plans with your facility's security approach to ASEs. Likewise, if prisoners are transported to your site for evaluation and treatment, they, too, will be accompanied by armed officers who will be following different orders and procedures. Behavioral Health Units, as well as inpatient

forensic units, all raise different concerns and cannot be subsumed under generalized Active Shooter response plans.

Hospital and health care workers also have a special duty to care for their patients, and running, hiding and fighting during an ASE takes on different meaning. Each of those possible action steps must also be tempered with the imperative to protect those in their care. Running and leaving a patient behind raises difficult ethical questions, yet in reality, there are likely to be a number of patients who cannot easily run or be evacuated in a fast moving emergency.

Hospitals and health care environments require a specialized approach in ASE planning. Planners must take into account both the unique settings within their walls (as well as immediately outside) and the unique nature of their workforce, clients or patients. The way an ASE would unfold in a shopping mall is substantially different than a hospital or health care environment, therefore policies, plans, procedures, and even exercises must reflect that they are customized to these special issues.

Concept Two: Shooting Incidents are Different in Hospitals and Health Care Settings

It is strongly recommended that anyone involved in preparing for workplace violence or an Active Shooter Event review the FBI's most recent guidance, *"A Study of Active Shooter Incidents in the United States Between 2000 and 2013"* and New York Police Department's, *"Active Shooter: Recommendations and Analysis for Risk Mitigation"* as primary reference sources. But in addition, be aware of specialized resources such as, *"Active Shooter Planning and Response in a Healthcare Setting"* and *"Incorporating Active Shooter Incident Planning into Health Care Facility Emergency Operations Plans."* It is important to recognize that the nature of shooting incidents in hospitals and health care environments is different in significant ways and these differences should be reflected in all aspects of preparedness and response planning.

One such industry-specific study, *"Hospital-Based Shootings in the United States: 2000-2011"* researchers at Johns Hopkins analyzed 154 hospital-related shooting incidents at 148 different hospitals (some hospitals had more than one incident) in 40 states. In the first six years of the study period, there was an average of 9 incidents each year, and an average of 16.7 in the last six years studied. The total number injured or killed was 235 with the increase in the later years reflecting the upward trend in shooting events seen across the nation in all types of settings.

Other important findings included the facts that 59% of shooting incidents occurred inside of the hospital, while 41% occurred outside, and that the most common locations were the Emergency Department (29%), representing almost one-third of the incidents,

parking lots (23%) and patient rooms (19%). Equally important was the relationship between the shooter and his (94% male) victims. Results suggested that most shooters had a personal relationship with the victim(s): 32% were current or estranged intimate relationships; 25% were current or former patients; 5% current or former employees, and in 13%, there was no obvious association.

In general, most incidents involved a determined shooter with a specific target. This is an important difference from shooting incidents in the general population where most Active Shooters select target rich environments that provide access to a large number of potential victims, but in general, victim selection is random and the shooter in many instances (26%) had no prior relationship with or knowledge of their victim (NYPD, 2010 & 2012). As a point for planning it is helpful to recognize that in the wider community, Active Shooters select locations, not victims, but in hospitals and health care settings, shooter select specific targets or victims based on grudges or vengeance, a desire to end the life of an ill relative, or suicide.

In Emergency Departments, there were also a significant number of instances in which a prisoner or patient was able to take a gun from a guard or officer, and use that weapon to shoot others. Based on these findings, hospital and health care emergency managers and business continuity professionals should make sure that their plans and procedures address these realities, as well as the more general Active Shooter risk.

One useful approach to integration of hospital-specific shootings and the possibility of the more common type of ASEs (i.e., seeking maximum number of casualties, random victim selection, etc.) is to apply the concept of Type V workplace violence in the organization's overall violence prevention program. As a brief introduction or refresher of OSHA's four primary types of workplace violence:

- Type I violence occurs during the commission of a property crime such as a robbery, theft or trespassing. In this scenario, there is no legitimate business relationship between the offender and the organization. The organization or victim is selected because of the perception that there is something of value to be taken, such as cash, medications or electronics. Type I violence is most common in convenience stores, liquor stores, and gas stations, as well as taxis and limousines, where people may work late at night, all alone, and have cash on hand. This type of workplace violence is the most prevalent, and 85% of workplace homicides occur in this type of circumstance.
- Type II violence is the most prevalent in hospital and health care environments and in fact, health care and social service workers are four times more likely to by the victims of violence on the job than any other type of worker in the U.S. (OSHA, 2014). In instances of Type II violence the offender is known to the organization as a client, customer or patient, and the violence occurs during the routine

delivery of services. In some settings the risk of assault or injury by customers or clients represents a real and ongoing threat in everyday work.

- The type of violence most commonly thought of as "*workplace violence*" is Type III; co-worker-to-co-worker violence. There are many instances in which this also involves worker-to-supervisor, and in some cases supervisor-to-worker violence. In Type III workplace violence the perpetrator is a current or former employee of the organization. The motivating factor is often one or a series of interpersonal or work-related conflicts, losses or traumas, and may involve a sense of injustice or unfairness. Type III violence accounts for about 7% of all workplace homicides, and managers and supervisors are at greatest risk of being victimized. It is important to note that even workers who have separated from the organization may still represent a risk of violence in some situations.
- When violence and abuse follow a worker from home to work, it is considered Type IV or *"Intimate Partner Violence."* It is important for employers to recognize that violence and abuse at home are not just personal problems; they can and do intrude into the workplace, sometimes violently with tragic consequences. There are many cases each year, often involving multiple victims, when a former spouse or partner brings their violence or aggression to their partner's workplace. The perpetrator may know their partner's work hours, parking location or other information that may make them vulnerable. The risk of violence increases significantly when one party attempts to separate from the other. Type IV violence is typically a spillover of domestic violence into the workplace and refers to perpetrators who are not employees or former employees of the affected workplace. Women are more often to be targets. Hospital and health care environments may be particularly vulnerable to Type IV violence since the workforce is likely to be predominantly female.
- Lastly, in instances of Type V violence, the violent actor is an extremist of some sort who believes that violence is necessary, justified or deserved in their radical views. In such cases violence is directed at an organization, its people and/or property for ideological, religious or political reasons. Violence perpetrated by extremist environmental, animal rights, and other value-driven groups may fall within this category. In Type V violence, target selection is not based on sense of personal or professional injustice in the workplace, but rather rage against what the targeted organization does or represents. The shooting at the Planned Parenthood clinic in Colorado Springs in November 2015 is an example of extreme ideology driving an Active Shooter Event. Hate crimes and terrorism are examples of Type V violence especially when they are directed against an organization and its employees.

All five types of workplace violence have the potential to evolve into Active Shooter Events. Type V violence blurs the lines between workplace violence and terrorism. Consider these three mass shooting incidents:

1. The Charlie Hebdo attack in Paris in January 2015
2. The attack on the Armed Forces recruitment center and Naval Reserve Center in Chattanooga in July 2015, and
3. The San Bernardino attack in December 2015.

In each instance, the victims were shot while on-the-job and at a work-related function. In the San Bernardino case, one of the attackers was also a co-worker. Each case was motivated by foreign terrorist organization propaganda, and the perpetrators were true believers willing to die for their cause. The media, and often politicians, argue if such events are workplace violence or terrorism; Type V violence is the place where terrorism and workplace violence intersect. Terrorism can and has been targeted at hospitals. Approximately 100 terrorist attacks have been perpetrated at hospitals worldwide, in 43 countries on every continent, killing 775 people and wounding 1,217 others. Hospitals are attractive primary or secondary targets. An attack on a hospital can distract Police and EMS from the primary target of attack, and also confound the removal and treatment of the wounded from the site of the primary attack.

Concept Three: Integrate Active Shooter Preparedness into Workplace Violence Prevention

Active Shooter Events are high-profile incidents that stir emotions, even for otherwise level-headed leaders. Even though most leaders recognize that ASEs are low-probability, high-consequence situations, they may be asked, or ask themselves in the wake of each new shocking headline, “Are we ready for this?” It is not uncommon for organizations to let the *“tail wag the dog”* when addressing the Active Shooter risk; that is to say, creating specific Active Shooter policies and procedures that are divorced from other violence prevention efforts.

Active Shooter Events can be motivated by all and any of the five types of workplace violence. For violence prevention policies, plans and exercises to by effective, it is helpful to integrate the concept of Type V violence into the mix of other types of workplace violence. In the moment that shots are fired, the shooter’s motives are completely irrelevant. Regardless if the shooter is or was an employee, an enraged spouse or partner, a distraught family member or a homegrown extremist, the action steps needed to survive and minimize the carnage are the same. By integrating Type V violence into the organization’s training programs, employees can not only receive information about the common warning signs (e.g., isolation, paranoia, feelings of injustice, etc.) associated with other types of workplace violence, they can simultaneously learn the pre-attack warning behaviors related to terrorism and ASEs . In the San Bernardino case, the

shooter was a covert Jihadist. It was unlikely that co-workers who may have been familiar with the red flags related to workplace violence would have spotted the signs that suggest that someone may be on a pathway to mass violence.

By integrating all five types of workplace violence into the organization's approach to violence prevention it is possible that "*bystander intervention*" can mean more than "*fight*" during an attack. Integrated training serves as a *"force multiplier"* and helps employees better detect and deter all types of violence, including mass violence motivated by a terrorist mindset.

Concept Four: Provide Reality-Based Training and Resources

One of the most pressing realities to convey in training is the concept of the *"response gap."* It is a hard, cold fact that the shooter always has the tactical advantage, at least at the onset of the incident, and until law enforcement arrives when the shooter becomes the *"hunted"* rather than the *"hunter."* Every major Active Shooter guidance stresses the point that during the initial law enforcement response, inbound officers will not stop to assist the wounded. It is also understood that EMS may not be able to enter the *"warm zone"* until the shooter is neutralized and the situation is made safe. Some communities have begun to adopt the *"Rescue Task Force"* model, preparing a limited number of EMS responders to operate in the warm zone with the proper training and equipment. Individuals inside the shooting event who are able to find shelter may be in lock-down mode and tucked away in safe rooms or hard to find places for an extended period of time while officers clear the scene of additional suspects and/or suspicious materials.

Rapid, Structured Communication Saves Lives

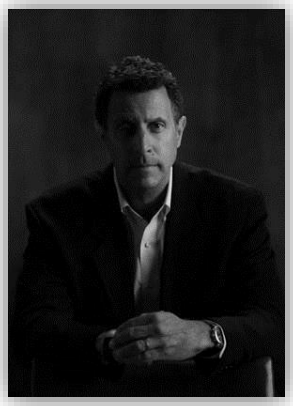
The single best way to protect the workforce and save lives during an Active Shooter Event is to deny the shooter potential targets. Rapid, pre-constructed messages delivered to multiple points upon immediate awareness of the threat can redirect staff, visitors and guests away from harm and toward safety.

ASEs evolve quickly and time is of the essence. Valuable moments are lost if people are milling around in confusion and panic, leaving them vulnerable and exposed. In training, it is critical to convey the concept that in high-threat situations, it is not enough to run from danger; it is equally or more important to run towards safety. Authorities (i.e., DHS, FBI, others) suggest *plain language*, not code words, for Active Shooter incident notification. Research shows people do not panic when given clear and informative warnings; they want accurate information and clear instructions on how to protect themselves in the emergency. Not everyone will understand a code system, and so plain language warnings and clear instructions should be given to make sure everyone in danger understands the need to act.

By pre-developing messages and testing emergency notifications capabilities, leaders and planners can help more quickly and effectively move people away from danger and toward safety. Everything associated with Active Shooter Event response comes down to speed. Rapid communication can help deprive the shooter of their initial tactical advantage and better enable bystanders to intervene in an effective manner.

The great American poet and essayist Ralph Waldo Emerson said it best*, "In skating over thin ice, our safety is in our speed."* In planning for Active Shooter Events, focus on the response gap, realize that everyone in the immediate environment is a potential first responder, so training them as such, and provide the necessary knowledge awareness and skills to succeed. Remember that bystander intervention, beginning with early recognition of the warning signs of violence, as well as specific skills to both stop the killing and stop the dying, will be critical to the success of an Active Shooter response plan.

About the Author



Steven M. Crimando, MA, BCETS, CHS-V is a nationally-recognized expert in the prevention, response and recovery of active shooter incidents. He has developed workplace violence prevention and active shooter response programs for government agencies, hospital and healthcare systems, and multinational corporations. Steve has published many professional articles on this topic and serves as an expert to the media and the courts in the area of active shooter intervention. He can be reached at the offices of Behavioral Science Applications at 888.404.6177 or by email at steve@behavioralscienceapps.com.

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