Clinical Practice Guidelines: Other/Active armed offender

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Date	February, 2021
Purpose	To ensure a consistent appproach to the management of an active armed offender.
Scope	Applies to Queensland Ambulance Service (QAS) clinical staff.
Health care setting	Pre-hospital assessment and treatment.
Population	Applies to all ages unless stated otherwise.
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Active Armed Offender

February, 2021

The Queensland Ambulance Service (QAS) role in response to terrorist or criminal activities focuses upon its relevant service capabilities under the QAS *State Major Incident and Disaster Plan* (SMID). The risk management profile for these types of incidents underpins the need for procedures to be in place for securing the workplace, health and safety of QAS personnel, as well as for the management of operational activities and infrastructure. The QAS response role and the necessary risk management profile for each threat level and transition needs to be carefully considered.

Australia New Zealand Counter Terrorism Committee (ANZCTC) defines an Active Armed Offender Incident (AAOI) as:

> *"An armed offender who is actively engaged in killing or attempting to kill people, and who demonstrates their intention to continue to do so while having access to additional potential victims."*[1]

The term Active Armed Offender (AAO) encapsulates the violent criminal behaviours of an armed offender/s and is not defined by the choice of weapon, tool or device.

The QAS in conjunction with the Queensland Police Service (QPS), have identified processes when dealing with terror related events.

QAS officers should in circumstances of an AAOI, attempt to undertake the ANZCTC suggested response principles utilising ***Escape***, ***Hide*** and ***Tell***:[2]

- **ESCAPE** as a primary option. If safe to escape, remain calm and evacuate the location while maintaining appropriate cover where possible. Consider removal of high visibility clothing (QAS Safety Vest).
- **HIDE** if escape is not possible. Locate a secure room or area, blockade doors, turn off lights, place phones on silent and cover windows for concealment.
- **TELL** – if it is safe to do so, information should be provided immediately to police via triple zero (000). Consideration should always be given to providing information and advice to others who may be unfamiliar with the site, the nature and extent of the threat, and what they should do to remain safe.

SITUATIONAL AWARENESS is defined by ANZCTC as the ability to quickly recognise and interpret an event, make sound decisions based on those interpretations, and establish early, effective and continuous lines of communication between the incident site and the controlling agency.[2] This will provide ongoing and accurate information about the situation to responders.

Without compromising your personal safety, it is important to ensure situational awareness to quickly recognise, interpret and report the AAOI. The inclusion of Situational Awareness is fundamental to the safety of all officers and members of the public. QAS officers may inadvertently find themselves in a situation that may compromise their safety.

Additional response strategies to consider include, but are not limited to:

- Strategies to minimise offenders access to other victims.
- Establish a form of communication to external agencies. Provide as much detail on the location, type of incident, any known injuries and description of offender if possible.
- Assess your ability to run, avoid the situation or if necessary when confronted by the offender, use physical force.
- Be aware of secondary hazards such as fire, gas, unstable debris, locked or inaccessible doors and exits.

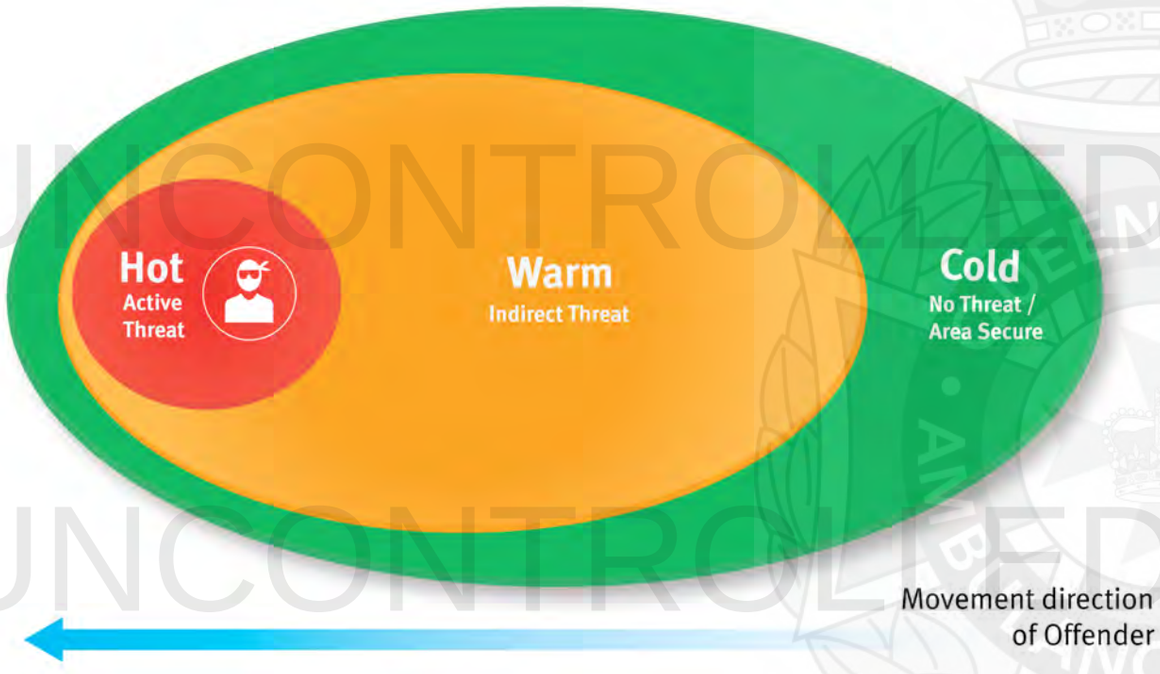
Tactical Emergency Casualty Care (TECC) is a term used to describe the strategic implementation of evidence based pre-hospital emergency care in high threat environments. It differs from military tactical medicine as it takes into account special patient groups (e.g. elderly anticoagulated patients and small children) as well as the injury patterns typically seen in civilian terror incidents.

At the core of TECC are three distinct zones:

Hot Zone (Active Threat) – a dynamic area of operations where there is an active threat of harm (safety risk to patients, bystanders and emergency response personnel).

Warm Zone (Indirect Threat) – a dynamic area of operations where a potential threat exists, however the threat is no longer considered direct or immediate

Cold Zone (No Threat/Area Secure) – an area of operations where there is no threat present and the scene is considered to be an area of absolute safety.



The QAS in conjunction with the QPS, have a detailed process and training framework for specifically trained paramedics who are permitted to enter the Warm Zone ***ONLY*** under limited circumstances and with appropriate ballistic Personal Protective Equipment (PPE), while accompanied by a police response unit. The advancement of QAS officers into the Warm Zone is strictly limited to specifically trained paramedics only. All additional QAS resources involved with AAOIs must remain within the safety of the Cold Zone and follow direction from the QAS Forward Commander.

No QAS officer is to intentionally enter a known Hot Zone at any time.

If an ambulance officer finds him or herself within the Hot Zone, they are to immediately find cover and safety, and as soon as possible withdraw to the Cold Zone.

The clinical management of patients and role of all ambulance officers is strictly dependent of the zones of care:

Hot Zone (Active Threat)

- **Find cover or safety.**
- Ambulance officers should encourage patients (if ambulatory) to move to their location as to limit ambulance officer exposure to threat.
- Beyond consideration of **haemorrhage** control with direct pressure or arterial tourniquet and unconscious patients being placed in the **recovery position**, no further clinical care should be undertaken.
- As soon as possible withdraw to the Cold Zone.

Warm Zone (Indirect Threat)

- **Maintain awareness of potential threat at all times.**
- Conduct primary survey: Circulation, Airway, Breathing (C-A-B)
  - identify and control **external catastrophic haemorrhage** with arterial tourniquet or direct pressure
  - consider **airway positioning** and **basic airway adjuncts** to maintain patent airway (NPA and/or OPA)
  - consider **bilateral chest decompression** and/or **chest seal application**.

Cold Zone (No Threat/Area Secure)

- Consider other clinical interventions as required.

QAS Response Framework

Once specifically trained paramedics have arrived on scene, they must proceed immediately to the QPS Forward Command in the Cold Zone and liaise with the QAS Forward Commander. If the specifically trained paramedic is requested by the QPS/ QAS Forward Commander, as per their training they will proceed to the Warm Zone with the protection and assistance from the SERT/PSRT QPS Response Units and ballistic PPE.

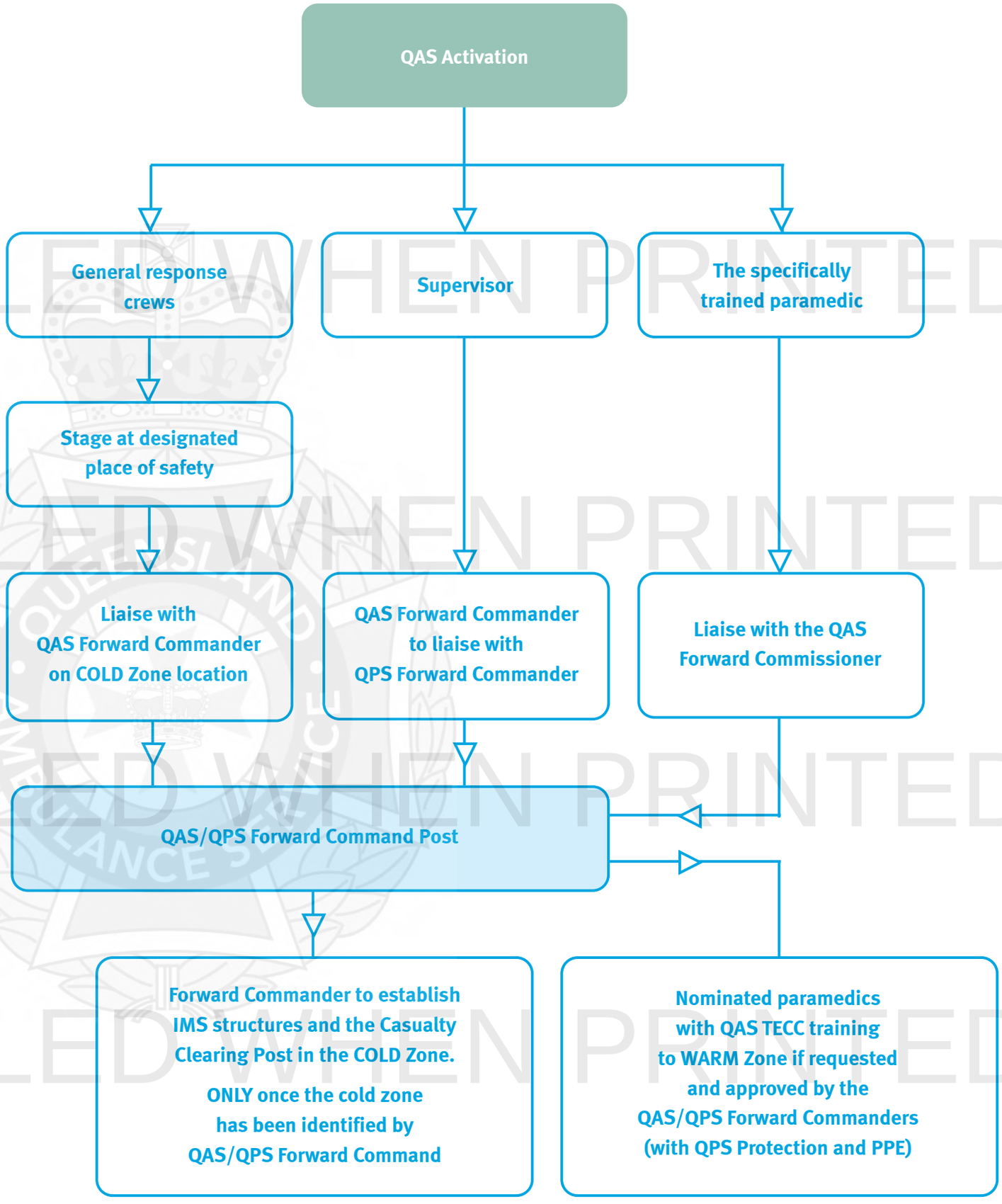
The primary responsibility for a specifically trained officer is rapid triage, the management of immediate life threatening injuries and coordination of patient extrication to the Casualty Clearing Post located in the Cold Zone, where normal QAS IMS structures will be established by the QAS Forward Commander.

If an officer at any time feels uncomfortable or unsafe and decides to withdraw, that is the decision of the QAS Officer and must be upheld.

No entry into the HOT Zone is permitted by any QAS Officers.

Please ensure that this cordon is maintained and entry into the Hot Zone is not persuaded by QPS.

The officer must maintain situation awareness and their personal safety must be the priority during the incident. All Ballistic PPE must be worn and maintained as per the standards.



CPG: Clinician safety
CPG: Standard cares

HOT ZONE (active) care:

- FIND COVER OR SAFETY.
- Beyond consideration of haemorrhage control with direct pressure or arterial tourniquet and unconscious patients being place in the recovery position, no further clinical care should be taken.

WARM ZONE (not secure) care:

- MAINTAIN AWARENESS OF POTENTIAL THREAT AT ALL TIMES.
- Conduct primary survey (C-A-B)
  - Identify and control external catastrophic haemorrhage with arterial tourniquet or direct pressure
  - consider airway position and basic airway adjuncts to maintain patent airway (NPA and/or OPA)
  - consider bilateral chest decompression and/or chest seal application.

COLD ZONE (secure) care:

- Consider other clinical interventions as required

Manage as per:

Relevant CPG

Transport to hospital
Pre-notify as appropriate