



Tentative Interim Amendment

## NFPA® 3000

### *Standard for an Active Shooter/Hostile Event Response (ASHER) Program*

#### 2024 Edition

**Reference:** Annex E (new)

**TIA 24-1**

(SC 24-8-35/ TIA Log #1780)

Pursuant to Section 5 of the NFPA *Regulations Governing the Development of NFPA Standards*, the National Fire Protection Association has issued the following Tentative Interim Amendment to NFPA 3000, *Standard for an Active Shooter/Hostile Event Response (ASHER) Program*, 2024 edition. The TIA was processed by the Technical Committee on Cross Functional Emergency Preparedness and Response, and was issued by the Standards Council on August 29, 2024, with an effective date of September 18, 2024.

1. Add new Annex E to read as follows, and change current Annex E to Annex F:

**Annex E — ASHER Benchmarks for Victim Care and Survivability**

This annex is not a part of the requirements of this NFPA document but is included for informational purposes only.

**E.1 General.** Time is one of the biggest determinants of survival from an active shooter/hostile event (ASHE). Multiple medical studies<sup>1,2,3</sup> have shown that time to medical care has a direct relationship to survival. This concept is how the golden hour and platinum 10 minutes came to be defined by the American College of Surgeons Committee on Trauma.<sup>4</sup> The faster medical care can be administered to the injured, the greater their chances of surviving the event.

The Active Shooter/Hostile Event Response (ASHER) Benchmarks for Victim Care and Survivability outline the following five fundamental operational priorities to reduce morbidity and mortality from an ASHE:

- (1) Address the active threat: 0–60 seconds
- (2) Establish unified command (UC): 5 minutes
- (3) Initiate point of wounding care: 10 minutes
- (4) Evacuation and transport of first critical victim: 20 minutes
- (5) Transport of all critical victims: 30 minutes

These benchmarks were developed based on medical and forensic data that show victim survivability increases significantly when the injured are provided with rapid treatment on-scene, followed by rapid transport to definitive medical care at a hospital or trauma center.

The time associated with each benchmark begins with the arrival of the first responders to the scene of the ASHE. The benchmarks do not involve any component prior to arrival, such as call taking, dispatching, or response times.

It is important to note that these benchmarks are guidelines, not deadlines, and they should never be used exclusively to measure the success of an ASHER. Each ASHE produces a set of unique obstacles and challenges within a complex, chaotic, and rapidly evolving environment. Factors such as the event type, complexity, location, and incomplete situational awareness could cause a benchmark to be shifted, delayed, or unachievable. Response personnel should prepare to meet each benchmark in Sections E.2 through E.6 as soon as possible or practical based on the unique circumstances of the individual ASHE.

**E.2 Benchmark 1: Address the Active Threat (0–60 Seconds).** Immediately upon arriving at the scene, law enforcement should initiate the process of containment or neutralization of the ongoing or active threat. This could include gathering information, determining access and best routes of travel to the assailant, determining the locations of the victims, de-conflicting information, directing or assisting fellow public safety responders and civilians, and developing an initial plan.

If fire and emergency medical services (EMS) personnel learn that the incident is an ASHE while enroute to the incident, they should pause their response and stage in a safe location or at the designated staging area. If fire and EMS personnel find themselves on the scene of an incident that is, or that turns into, an ASHE, they should evacuate to a safe location and stage, if possible. If evacuation is not possible, they should seek cover and call for assistance.

**E.3 Benchmark 2: Establish Unified Command (5 Minutes).** Within the first 5 minutes after arrival on scene, the designated command staff for law enforcement, fire, and EMS should meet to formally establish UC. Each member of the UC should be co-located at a shared unified command post (UCP), within a very close (“handshake”) distance of one another. This face-to-face interaction is essential to ensure the timely and accurate exchange of information throughout the response operations.

The first law enforcement official to arrive on scene should establish the initial command and assume the role of the incident commander (IC) for law enforcement until a higher-ranking officer arrives and command is passed. This initial command will be focused on tactical operations related to neutralizing or containing the threat.

It will likely be difficult or impractical for fire and EMS to co-locate with the initial law enforcement command, as this officer will likely be inside the structure or hot zone. This necessitates another law enforcement officer or supervisor to take command of the incident in the cold zone. This will provide the opportunity for fire/EMS ICs to co-locate.

Prior to the deployment of fire and EMS personnel to the warm zone, the following information should be known:

- (1) The location(s) of the assailant(s)
- (2) The location(s) that are clear of the assailant(s)
- (3) The location of the warm zone(s)

The primary source for this information will be law enforcement operating in the hot zone. It is imperative that UC is established and UC personnel are co-located within a shared UCP so that critical information can be shared quickly and effectively.

**E.4 Benchmark 3: Initiate Point of Wounding Care (10 Minutes).** Point of wounding care should be initiated within the first 10 minutes after arriving on the scene. Medical personnel should begin providing stabilizing treatment to critical patients in the warm zone while law enforcement continues to address the threat in the hot zone. Warm zone medical care should occur at, or as close as reasonably possible to, the actual point of wounding. Rapid, stabilizing care should be provided prior to evacuation to a casualty care point (CCP) or to an extraction point; however, it might be necessary to move a victim a few feet to an area of better cover or concealment before providing stabilizing care. Victims should be sorted by criticality, with treatment and evacuation prioritization given to those most severely injured. If possible, tag the victims to prevent multiple re-evaluation of the same victims, especially the critical (red tag) or dead (black tag).

Point of wounding care can be initiated by any first responder, including law enforcement. Law enforcement should begin providing point of wounding care if the threat has been neutralized, if there is reasonable certainty that no additional threat exists, or if there are sufficient numbers of law enforcement available.

Determination of the appropriate warm zone response model based on the circumstances of the event is critical for providing timely point of wounding care. The following are the four warm zone response models that can be employed by an authority having jurisdiction (AHJ) for an integrated response to an ASHE:

- (1) Rescue task force (RTF)
- (2) Protected corridor operations
- (3) Protected island operations
- (4) Law enforcement/armed security rescue

**E.5 Benchmark 4: Evacuation and Transport of First Critical Victim (20 Minutes).** The transport of critically injured victims should occur as rapidly as possible, ideally within the first 20 minutes of the ASHER. Transport should never be delayed for a critically injured victim, even if the full scope of the event or total number of casualties remains unknown, and available ambulances should be used to move seriously injured patients as soon as possible. Once all transport resources have been used and none are available, formal triage and transport prioritization can begin.

**E.6 Benchmark 5: Transport of All Critical Victims (30 Minutes).** Within the first 30 minutes of an ASHER, the site should be cleared of all critically injured victims and all noncritical victims should be stabilized and monitored by medical personnel. While some noncritical victims might receive medical care from providers on scene, victims that require definitive care (e.g., those with head, chest, or torso trauma) must be transported to a hospital.

#### **E.7 References.**

<sup>1</sup> Harmsen, A. M., Giannakopoulos, G. F., Moerbeek, P. R., Jansma, E. P., Bonjer, H. J., and Bloemers, F. W., “The influence of prehospital time on trauma patients outcome: a systematic review,” *Injury*, 46(4), 602–609, 2015, <https://doi.org/10.1016/j.injury.2015.01.008>.

<sup>2</sup> Tansley, G., Schuurman, N., Bowes, M., Erdogan, M., Green, R., Asbridge, M., and Yanchar, N., “Effect of predicted travel time to trauma care on mortality in major trauma patients in Nova Scotia,” *Canadian journal of surgery, (Journal canadien de chirurgie)*, 62(2), 123–130, 2019, <https://doi.org/10.1503/cjs.004218>.

<sup>3</sup> Hsieh, S. L., Hsiao, C. H., Chiang, W. C., Shin, S. D., Jamaluddin, S. F., Son, D. N., Hong, K. J., Jen-Tang, S., Tsai, W., Chien, D. K., Chang, W. H., Chen, T. H., and PATOS Clinical Research Network, “Association between the time to definitive care and trauma patient outcomes: every minute in the golden hour matters,” *European journal of trauma and*

[emergency surgery](https://doi.org/10.1007/s00068-021-01816-8): official publication of the European Trauma Society, 48(4), 2709–2716, 2022.

<https://doi.org/10.1007/s00068-021-01816-8>.

<sup>4</sup> Alarhayem, A. Q., Myers, J. G., Dent, D., Liao, L., Muir, M., Mueller, D., Nicholson, S., Cestero, R., Johnson, M. C., Stewart, R., O'Keefe, G., and Eastridge, B. J., "Time is the enemy: Mortality in trauma patients with hemorrhage from torso injury occurs long before the 'golden hour'." *American journal of surgery*, 212(6), 1101–1105, 2016, <https://doi.org/10.1016/j.amjsurg.2016.08.018>.

2. Add a new F.1.2.8 to read as follows: [This should be added to Annex F Informational References, which will be the renumbered existing Annex E after the new Annex E above is added.]

**F.1.2.8 References for Annex E.**

<sup>1</sup> Harmsen, A. M., Giannakopoulos, G. F., Moerbeek, P. R., Jansma, E. P., Bonjer, H. J., and Bloemers, F. W., "The influence of prehospital time on trauma patients outcome: a systematic review," *Injury*, 46(4), 602–609, 2015, <https://doi.org/10.1016/j.injury.2015.01.008>.

<sup>2</sup> Tansley, G., Schuurman, N., Bowes, M., Erdogan, M., Green, R., Asbridge, M., and Yanchar, N., "Effect of predicted travel time to trauma care on mortality in major trauma patients in Nova Scotia," *Canadian journal of surgery, (Journal canadien de chirurgie)*, 62(2), 123–130, 2019, <https://doi.org/10.1503/cjs.004218>.

<sup>3</sup> Hsieh, S. L., Hsiao, C. H., Chiang, W. C., Shin, S. D., Jamaluddin, S. F., Son, D. N., Hong, K. J., Jen-Tang, S., Tsai, W., Chien, D. K., Chang, W. H., Chen, T. H., and PATOS Clinical Research Network, "Association between the time to definitive care and trauma patient outcomes: every minute in the golden hour matters." *European journal of trauma and emergency surgery*: official publication of the European Trauma Society, 48(4), 2709–2716, 2022, <https://doi.org/10.1007/s00068-021-01816-8>.

<sup>4</sup> Alarhayem, A. Q., Myers, J. G., Dent, D., Liao, L., Muir, M., Mueller, D., Nicholson, S., Cestero, R., Johnson, M. C., Stewart, R., O'Keefe, G., and Eastridge, B. J., "Time is the enemy: Mortality in trauma patients with hemorrhage from torso injury occurs long before the 'golden hour'." *American journal of surgery*, 212(6), 1101–1105, 2016, <https://doi.org/10.1016/j.amjsurg.2016.08.018>.

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