
PCS
S.A.V.E.
SAFELY ADDRESSING VIOLENT ENCOUNTERS

"Defensive Tactics for Offensive Scenes"

September 2017

Pulse Check

NYSVARA

PCS

PROTECTIVE CONSULTING SOLUTIONS

- Its Monday evening, 2130 hours. You are dispatched to an elderly female having a stroke. You arrive to find the patient on the the floor, incoherent. As you begin to assess her she screams for you to stop “hurting her”. Her Son enters the room....

So…

- What will you do?
- What legalities apply?
- Wasn't the "scene safe"?

PCS
PROTECTIVE CONSULTING
SOLUTIONS

PCS Instructors

Bob Poresky has spent over 35 years developing and teaching the principles of unarmed self-defense. As a paramedic and master defensive tactics instructor, his diverse and extensive instructional experience includes specialized training for law enforcement, security and health care professionals across the Nation.

Shawn Tompkins has spent the past 20 years as a firefighter and paramedic in the Upstate New York Region. He has been trained as a "*Verbal Judo - Communications and De-escalation*" instructor and is certified as a Fitness Trainer with the American Council on Exercise. Shawn has spent hundreds of hours training fellow emergency responders across the Nation to deal with aggressive behavior.

Objectives

- Improve your knowledge to identify and prevent a violent act.
- Discuss tactics to avoid conflict.
- Define levels of "situational safety"
- List examples of violence indicators.
- Discuss applicable scenarios

Goal

Provide basic principles that will make you safer than you were yesterday!


ASSAULT AWARENESS MATH
DISGRUNTLED OR DERANGED PERSON
A DESIRE TO HARM OTHERS
+
ACCESS TO WEAPONS
FIND A PREDICTABLE UNARMED TARGET
=
CALL FIRE DEPT OR EMS
PAUL COMBS
DRAWN BY FIRE
FIRE ENGINEERING
©2014

Data / Scope of Problem

- 52% of EMS personnel had been assaulted
- 8.5% of calls for EMS involved a violent person
- 20% were verbal only in nature
- 79% involved physical and verbal violence
- 89% the patient was the attacker
- 75% of all statistics are made up
- 32% of you are still reading these
- 5% are actually writing these down

Let's Do Our Own Study

Everybody Up

Sit Down IF:

You have *never* been on a call that involved a violent or aggressive person. This includes medical and traumatic emergencies

Sit Down IF:

You have *never* been on a call where you have been sworn at, yelled at, or other wise verbally threatened

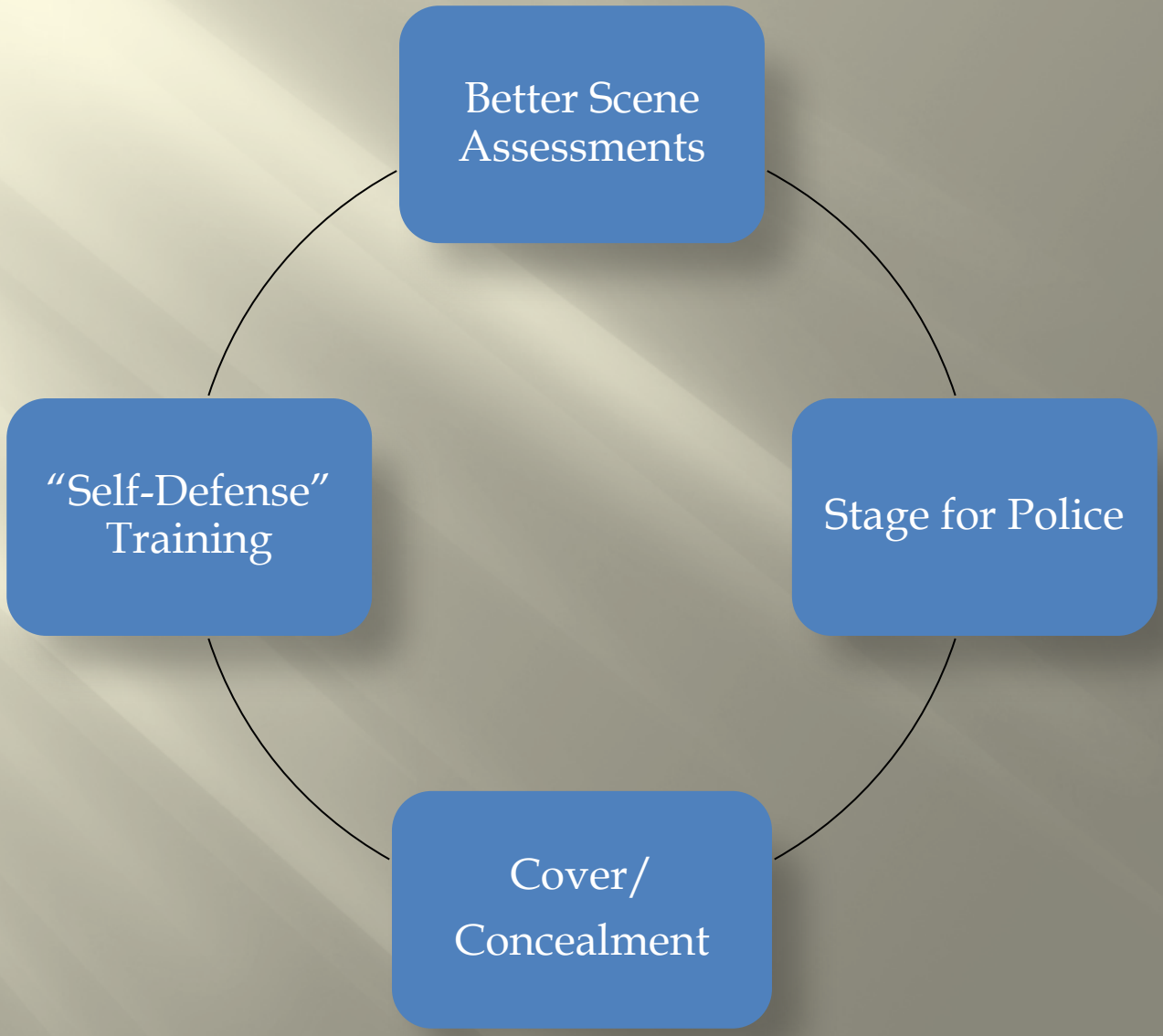
Sit Down IF:

You have ***never*** been on a call where a patient or person has grabbed your clothing or any part of your body, attempted to push you, or assault you in any way.

Introduction to *"Situational Size-up"*

- Same dangers are with you no matter where you are
  - Threats are almost always present
- Violence is rarely "out of the blue"
- Personal life vs. Responder life
  - Person on the street acting strange
    - Personal – Change directions / side of the street
    - Responder – Carefully and strategically approach

Circle of "Scene Safety"



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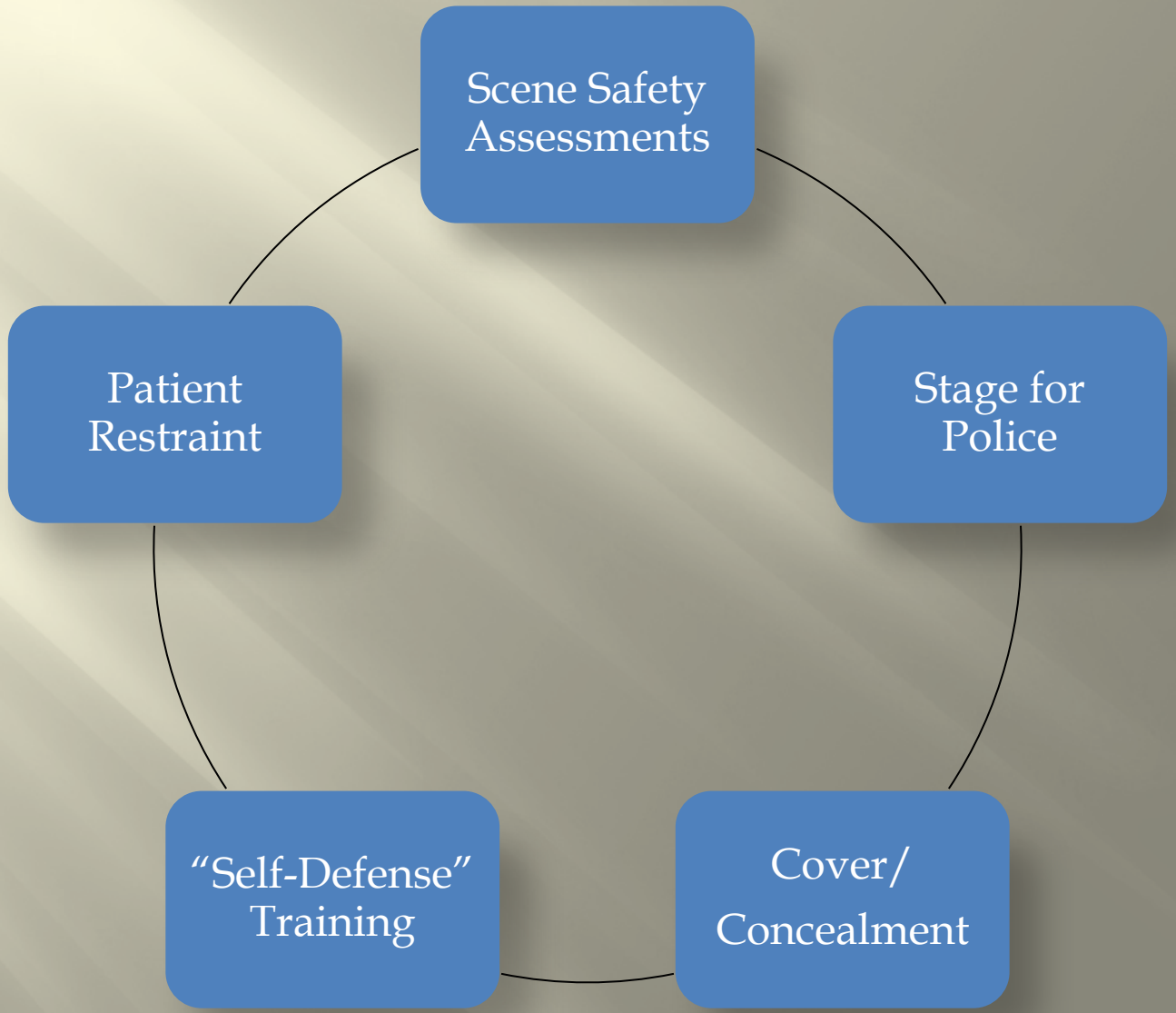


National Registry of Emergency Medical Technicians
Advanced Level Psychomotor Examination

PATIENT ASSESSMENT - MEDICAL

Candidate:_____ **Examiner**:_____

Date:_____ **Signature**:_____

Scenario:_____

Actual Time Started: _____

	Possible Points	Points Awarded
Takes or verbalizes body substance isolation precautions	1	
SCENE SIZE-UP		
Determines the scene/situation is safe	1	
Determines the mechanism of injury/nature of illness	1	
Determines the number of patients	1	
Requests additional help if necessary	1	
Considers stabilization of spine	1	
PRIMARY SURVEY		
Verbalizes general impression of the patient	1	
Determines responsiveness/level of consciousness	1	
Determines chief complaint/apparent life-threats	1	
Assesses airway and breathing -Assessment (1 point) -Assures adequate ventilation (1 point) -Initiates appropriate oxygen therapy (1 point)	3	
Assesses circulation -Assesses/controls major bleeding (1 point) -Assesses skin [either skin color, temperature, or condition] (1 point) -Assesses pulse (1 point)	3	
Identifies priority patients/makes transport decision	1	
HISTORY TAKING AND SECONDARY ASSESSMENT		
History of present illness -Onset (1 point) -Severity (1 point) -Provocation (1 point) -Time (1 point) -Quality (1 point) -Clarifying questions of associated signs and symptoms as related to OPQRST (2 points) -Radiation (1 point)	8	
Past medical history -Allergies (1 point) -Past pertinent history (1 point) -Events leading to present illness (1 point) -Medications (1 point) -Last oral intake (1 point)	5	
Performs secondary assessment [assess affected body part/system or, if indicated, completes rapid assessment] -Cardiovascular -Neurological -Integumentary -Reproductive -Pulmonary -Musculoskeletal -GI/GU -Psychological/Social	5	
Vital signs -Pulse (1 point) -Respiratory rate and quality (1 point each) -Blood pressure (1 point) -AVPU (1 point)	5	
Diagnostics [must include application of ECG monitor for dyspnea and chest pain]	2	
States field impression of patient	1	
Verbalizes treatment plan for patient and calls for appropriate intervention(s)	1	
Transport decision re-evaluated	1	
REASSESSMENT		
Repeats primary survey	1	
Repeats vital signs	1	
Evaluates response to treatments	1	
Repeats secondary assessment regarding patient complaint or injuries	1	
Actual Time Ended: _____		
CRITICAL CRITERIA **TOTAL**	48	

_____ Failure to initiate or call for transport of the patient within 15 minute time limit
_____ Failure to take or verbalize body substance isolation precautions
_____ Failure to determine scene safety before approaching patient
_____ Failure to voice and ultimately provide appropriate oxygen therapy
_____ Failure to assess/provide adequate ventilation
_____ Failure to find or appropriately manage problems associated with airway, breathing, hemorrhage or shock [hypoperfusion]
_____ Failure to differentiate patient's need for immediate transportation versus continued assessment and treatment at the scene
_____ Does other detailed history or physical examination before assessing and treating threats to airway, breathing, and circulation
_____ Failure to determine the patient's primary problem
_____ Orders a dangerous or inappropriate intervention
_____ Failure to provide for spinal protection when indicated

You must factually document your rationale for checking any of the above critical items on the reverse side of this form.

National Registry of Emergency Medical Technicians
Advanced Level Psychomotor Examination

PATIENT ASSESSMENT - MEDICAL

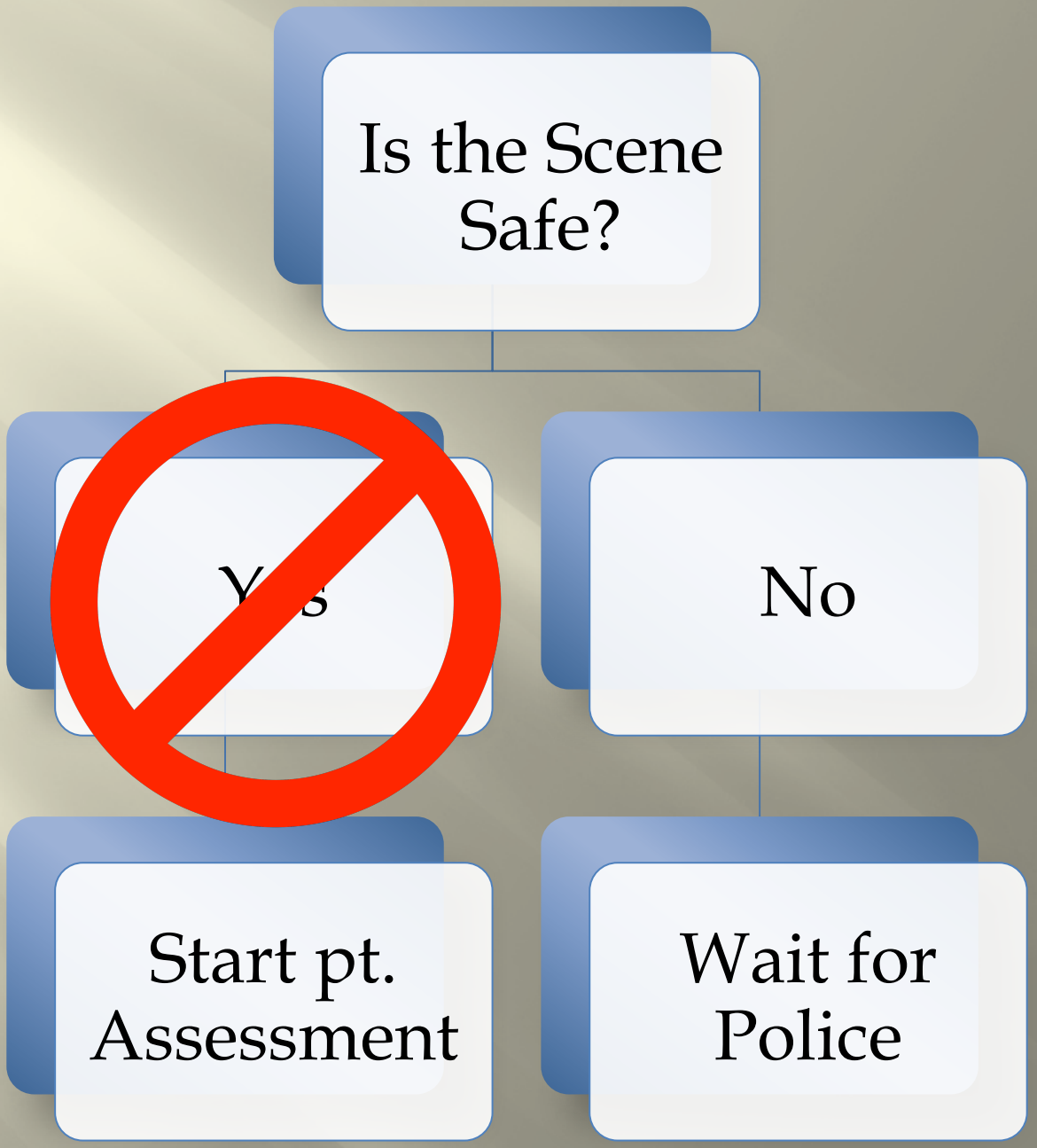
Candidate:_____ **Examiner**:_____

Date:_____ **Signature**:_____

Scenario:_____

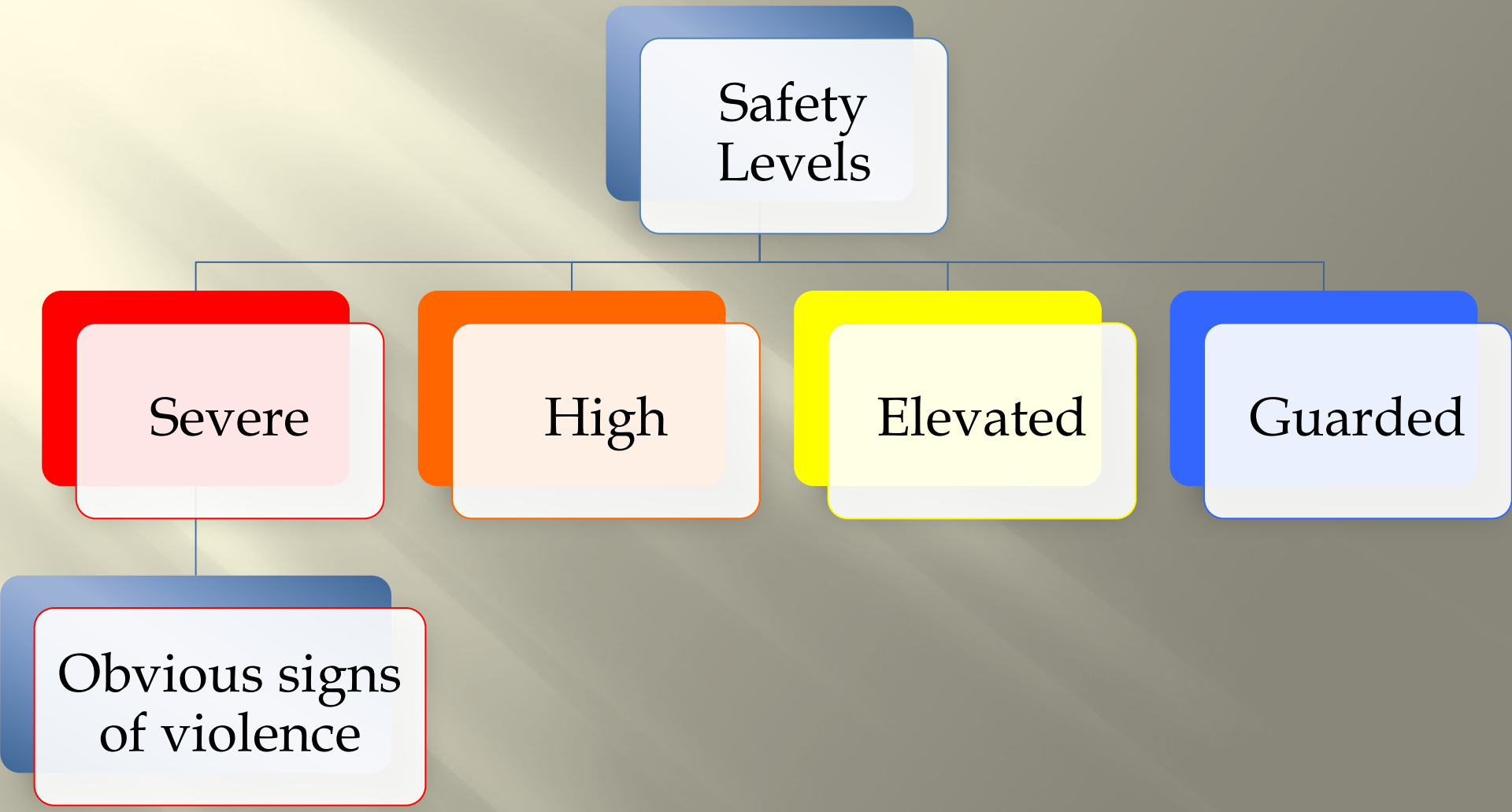
Actual Time Started: _____

	Possible Points	Points Awarded
Takes or verbalizes body substance isolation precautions	1	
SCENE SIZE-UP		
Determines the scene/situation is safe	1	


Is the Scene Safe?
Yes
No
Start pt. Assessment
Wait for Police


HOMELAND SECURITY
ADVISORY SYSTEM
SEVERE
SEVERE RISK OF
TERRORIST ATTACKS
HIGH
HIGH RISK OF
TERRORIST ATTACKS
ELEVATED
SIGNIFICANT RISK OF
TERRORIST ATTACKS
GUARDED
GENERAL RISK OF
TERRORIST ATTACKS
LOW
LOW RISK OF
TERRORIST ATTACKS


Safety Levels
Severe
High
Elevated
Guarded

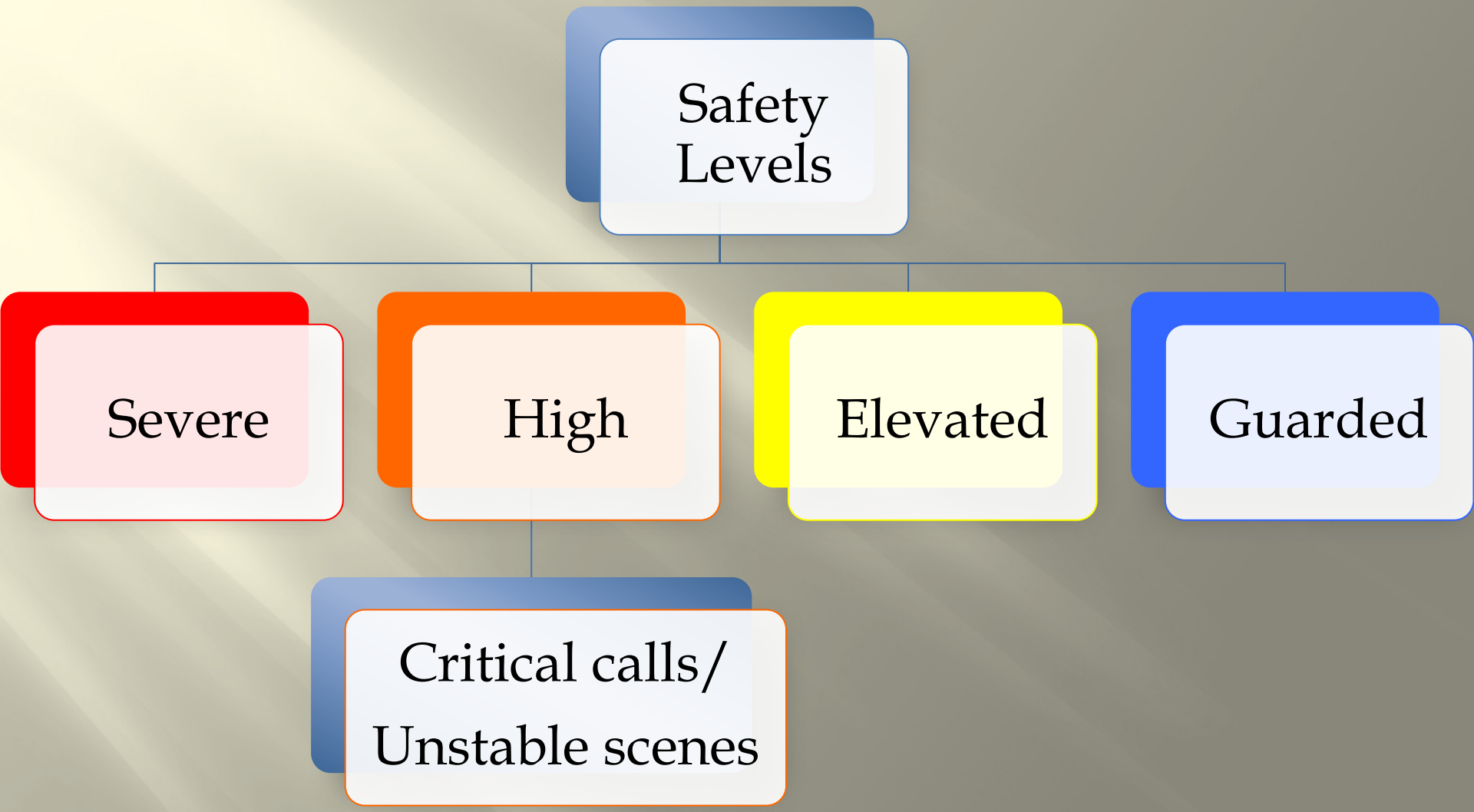

Safety Levels
Severe
High
Elevated
Guarded
Obvious signs of violence

Scene Safety Levels
SEVERE

- Impending, life-threatening incident
  - Riots
  - In-progress crimes
  - Active shooters
  - Explosions
  - Haz-Mats

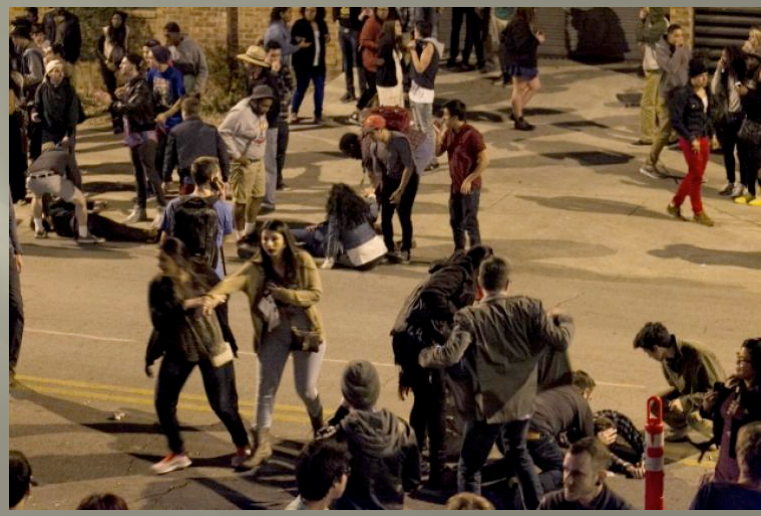

POLICE

Webster, NY
12/24/12


Safety Levels
Severe
High
Elevated
Guarded
Critical calls/ Unstable scenes

Scene Safety Levels
HIGH

- Critical Calls / Unstable Scenes
  - Pediatrics
  - Violent crimes
  - Large crowds
  - Attempts / overdoses
  - Mind altering substances
  - Loud/aggressive family members



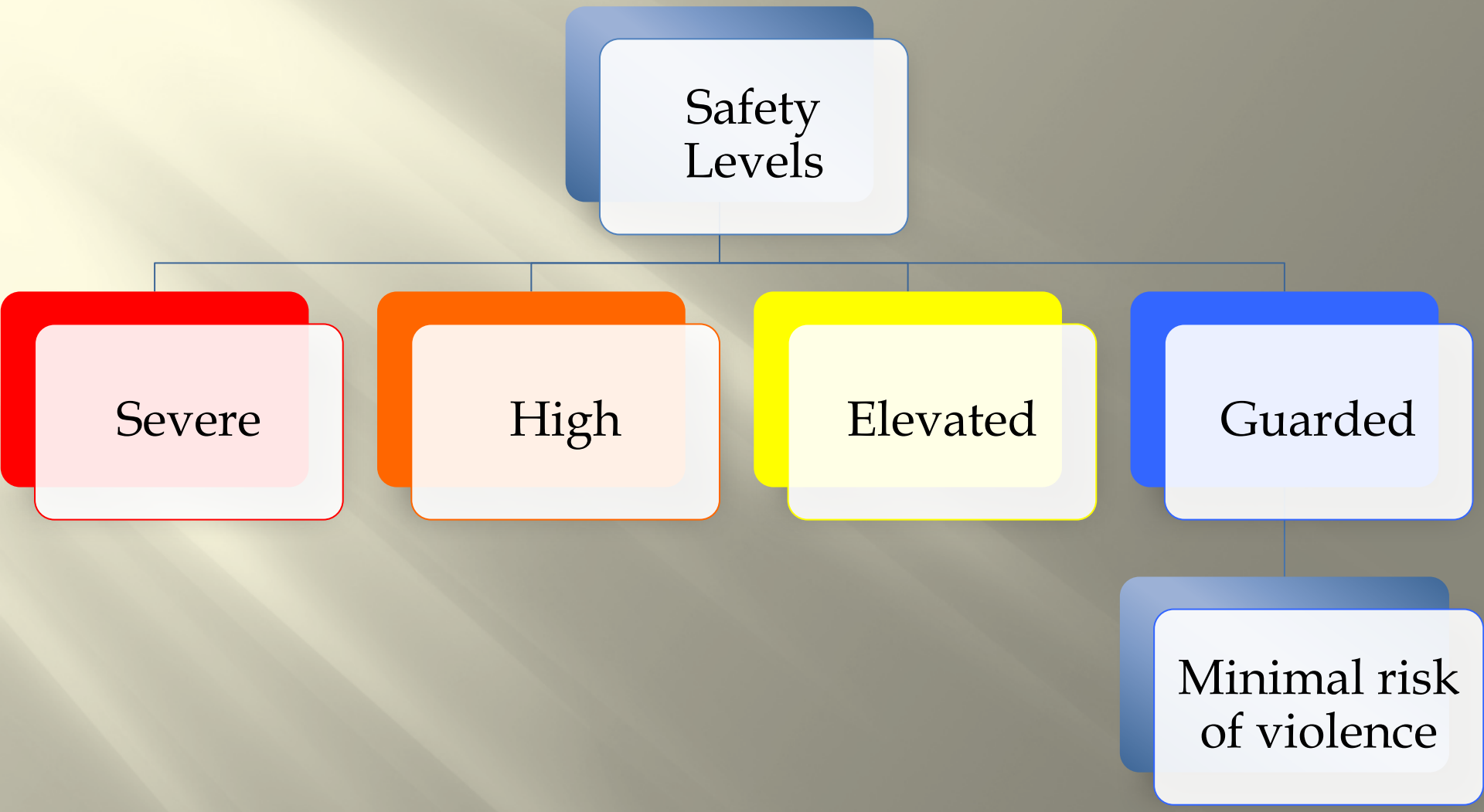

SERVING WITH PRIDE
SINCE
1886
RESCUE / SAFE


Safety Levels
Severe
High
Elevated
Guarded
Situations involving a crisis

Scene Safety Levels
ELEVATED

- "Normal" calls / scenes / patients
  - Seizures
  - Diabetics
  - Chest Pain
  - Respiratory Distress
  - Syncope
  - Falls
  - Stand by's (depending on type)

- MOST dangerous for us


Safety Levels
Severe
High
Elevated
Guarded
Minimal risk of violence

Scene Safety Levels
GUARDED

- Minimal risk of violence
  - Well known patients
  - Facility transfers
  - In our domain (walk-ins)
  - Stand-bys


Corvallis
COMMUNITY BAND

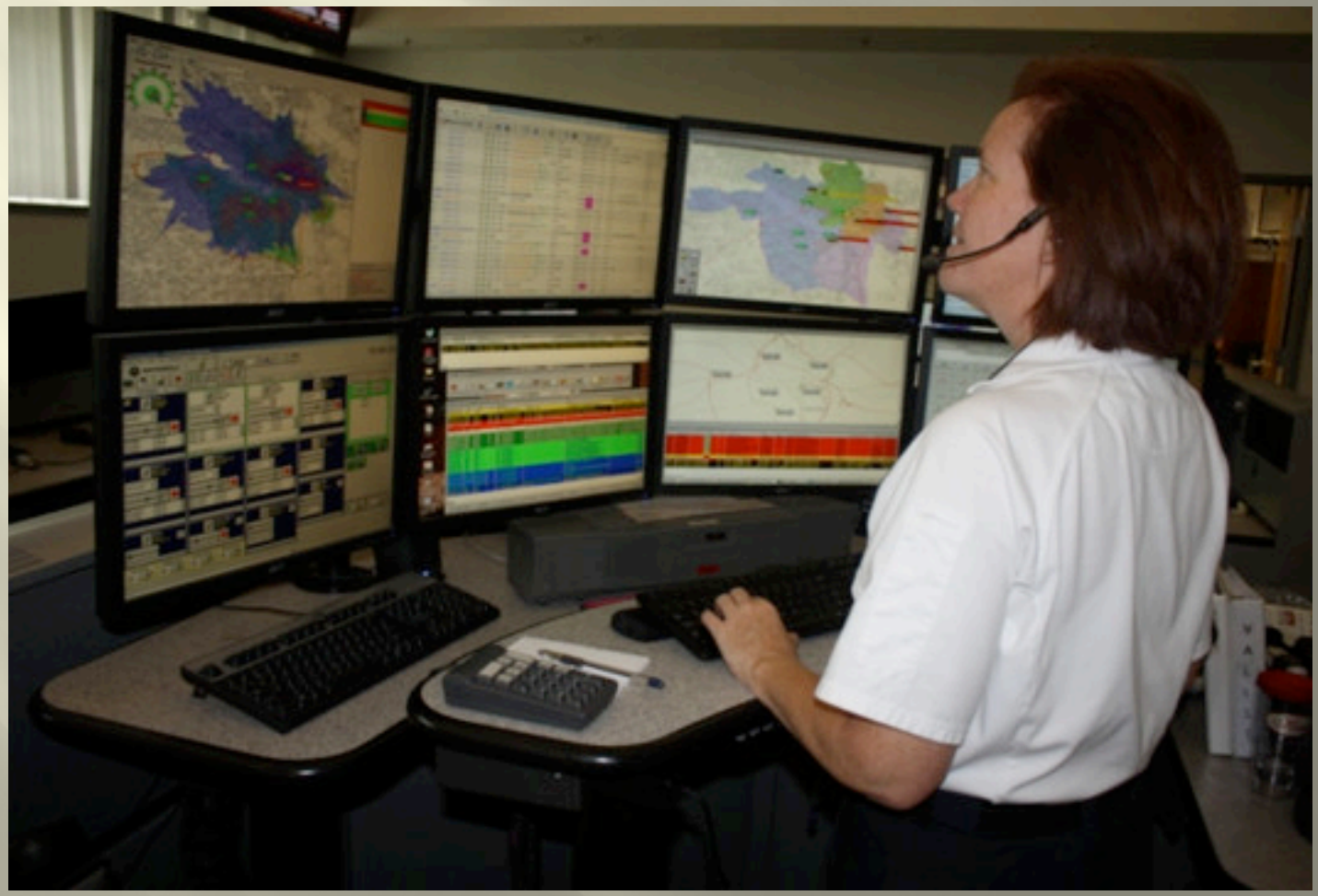

AN AMERICAN
REVOLUTION
50
EAGLE

Scene Safety Levels

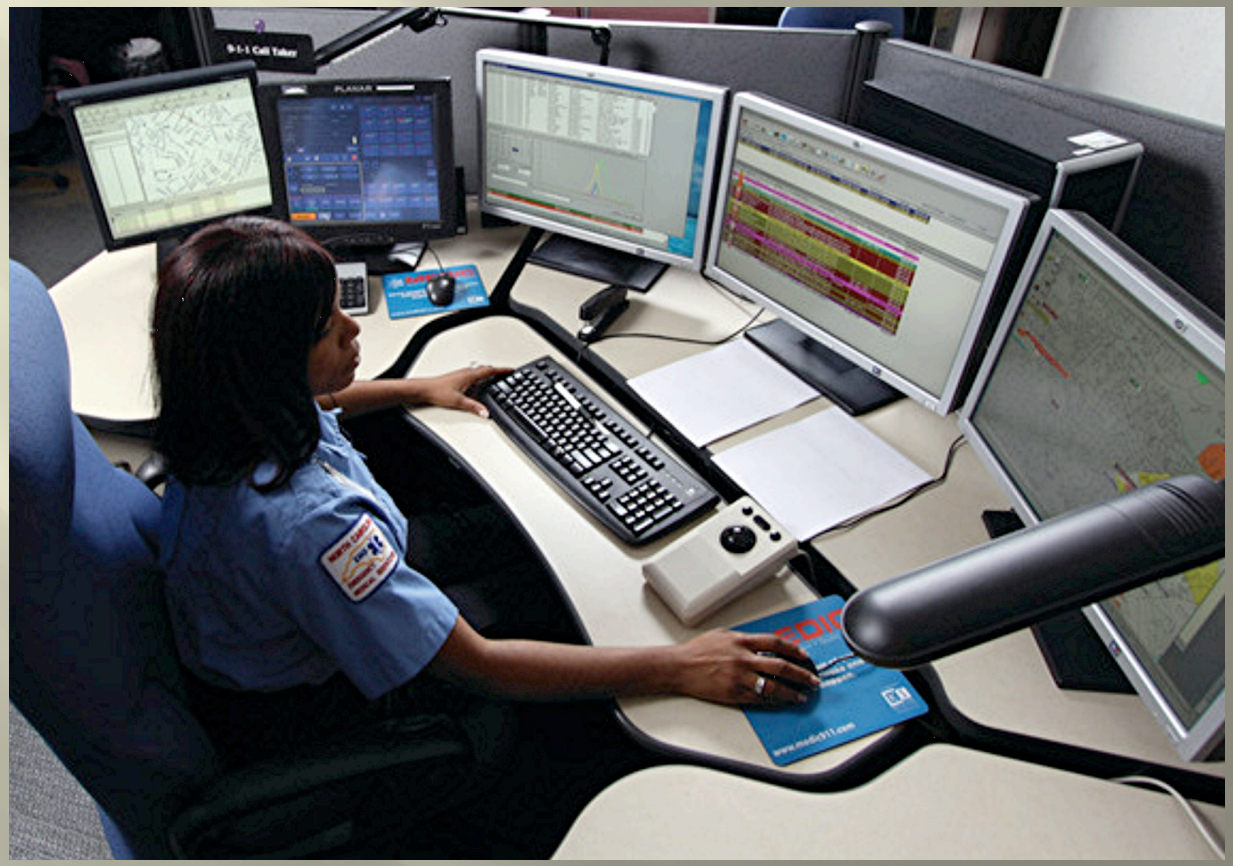
LOW

You can consider it a “low risk” encounter, once you have completed it and are in a safe place.

“Unconscious man on a bench”



“25 male with abdominal pain”




CRACK HOUSE

"Safety Size-Up"
Information – *What happened?*

- Location
- Time of day
- Events / Holidays / Anniversaries
- Nature/Mechanism
- Past Experience
- Additional Info /Updates

"Safety Size-Up"
Arrival – *What's happening?*

- "The View"
  - Street
  - House
  - Room
  - Area
- "The Approach"
  - Doors
  - Windows
  - Hallways
- Senses
  - Sight
  - Smell
  - Hearing
  - Gut
- Information from:
  - Bystander
  - Relatives
  - Patients

"Safety Size-Up"
Prediction – *What may happen?*

- Read the situation and people
- Past experience with similar situations
- Paint a picture for yourself

Is It Possible To Predict ?

- Sixth sense / gut feeling
- Have you ever "predicted...."
  - A car will pull out in front of you
  - You left the stove on
  - You shouldn't stay in the bar you are at
  - A person you have just met is a bad person
  - Your child wasn't safe
  - Something bad was going to happen

Trust Your Instincts

YOU FEEL….

- Suspicion
- Hesitation
- Anxiety
- Apprehension
- Persistent fear

BUT YOU…

- Rationalize
- Justify
- Minimize
- Excuse making
- Refusal

Signs of Impending Confrontation

VERBAL

- Speeds up
- Change in pitch
- Increase in volume
- Repetitive words
- Sarcasm
  - "Sure I'll sit down"
- Nervous laughs

PHYSICAL

- Fist clenching
- Knuckle cracking
- Body posture
- Removing clothing
- Pacing
- Teeth grinding

Conflict

Not all conflicts are created equal

- Verbal vs. Physical
- Armed vs. Unarmed
- Unsuspecting vs. Planned
- One vs. Several
- Trained vs. Untrained
- Large vs. Small
- Focused vs. Distracted

Cover / Concealment

- Cover
  - Any material that can reasonably be expected to stop the travel of a bullet. Cover will consist of hardened, thick, bulky material and manmade structures.

Cover / Concealment

- Concealment
  - "Conceals" you from view. Any object that prevents you from being seen is technically concealment. A thick bush, large tree, dirt mound and so on could be concealment.

Risk Vs. Benefit

- Life
  - Yours
  - Partner
  - Patient / Bystander
- Property
  - Money
  - Ambulance
  - Drug box
- Ego

Statistically Common Attacks

ning grabs

t grabs

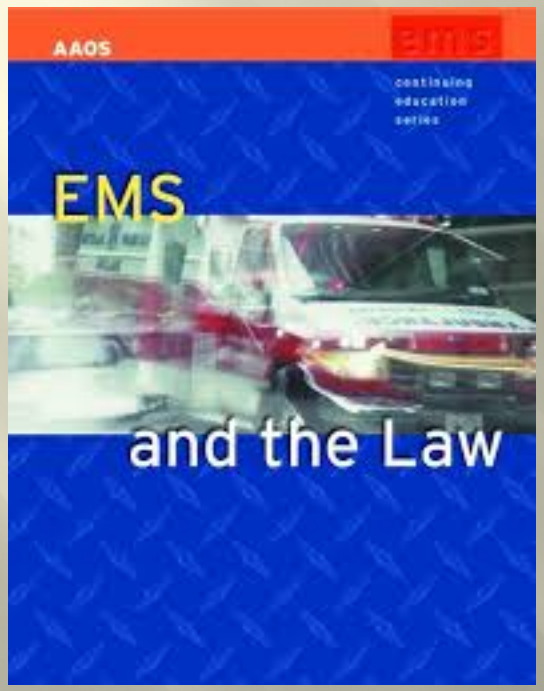
swings

ds

sitions

Current Trends in Healthcare Defense

Legal Considerations



Self Defense

- Legal term where the law allows a person to use physical force against another person
- Must have *"reasonable fear"* that physical safety is threatened
- Force *only necessary* to protect self and ESCAPE
- Does not allow for retaliation

"The use of physical force, which would otherwise constitute an offense, is justifiable when.."

- A duly licensed physician, or a *person acting under a physician's direction*, may use physical force for the purpose of *administering a recognized form of treatment* which he or she reasonably believes to be necessary to *promote the physical or mental health of the patient.*

- (a) the treatment is administered:
  - with the consent of the patient
  - if the patient is under the age of eighteen
  - to an incompetent person, with the consent of the parent, guardian or other person entrusted with the patient's care

  - OR:

- (b) the treatment is administered in an emergency when the physician, or person under his direction, reasonably believes that a reasonable person would consent

  - Article 35 – NYS Penal Law

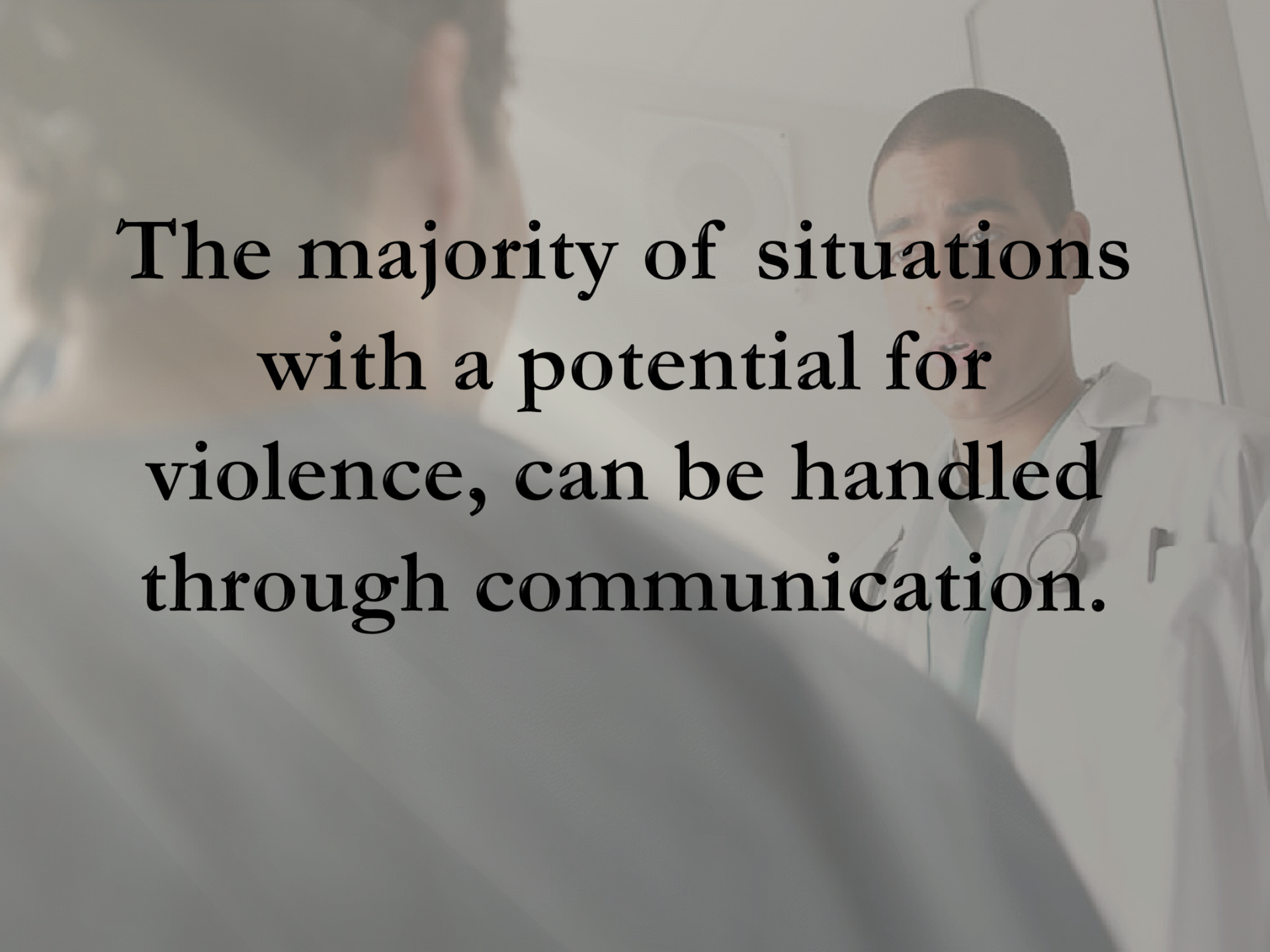
Societies View on Violence

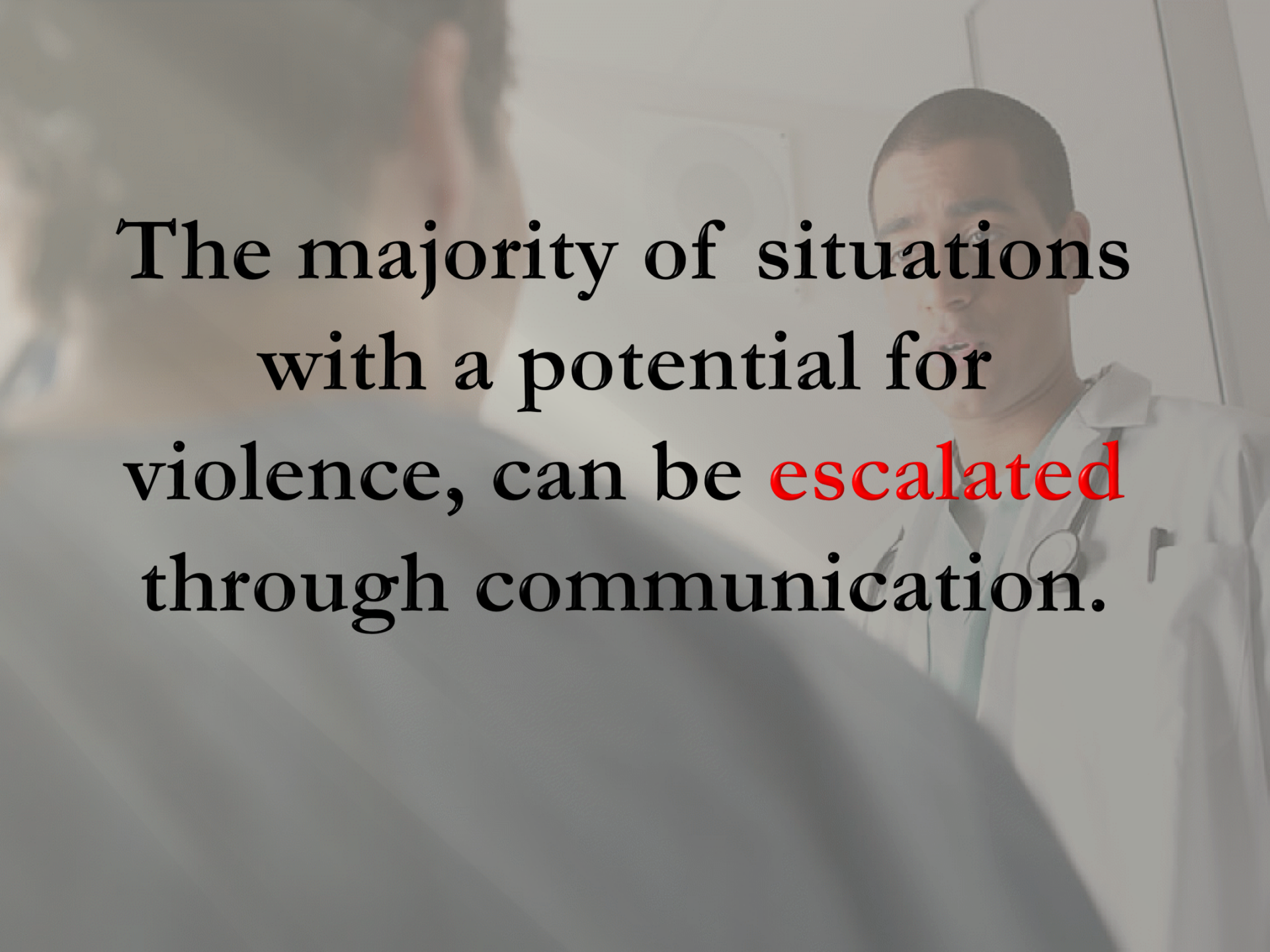
- We live in a litigious society
- Everything is done under surveillance
- Everything is scrutinized
- What's done today *will* be news tomorrow


PARENTAL
ADVISORY
EXPLICIT CONTENT


FOX 10
9:02
63°

If we train in "non-escalation", we won't need "de-escalation"


The majority of situations with a potential for violence, can be handled through communication.



The majority of situations with a potential for violence, can be escalated through communication.

Thoughts….

- **"We treat people like ladies and gentlemen not necessarily because they are, but because we are"**

  North Dakota Highway Patrol

- **"As we make people powerless, we promote their violence rather than control"** **Shawn Smith**

- **"It's not enough to be good anymore, we must look good and sound good, or it's no good"**

  Dr. George Thompson

More Thoughts..

- Respond to people – don't react
- Avoid phrases like:
  - You need to relax
  - Calm down
- Use "We" instead of "I" or "You"
- Everyone has "good reason" for what he or she does
- If you can't control yourself, you can't control the situation

Handling Verbal Assaults

- Think before responding
  - You're not in a contest if you're not a contestant!
- Acknowledge
  - Look through the eyes of the other person
- Do not allow it to become personal
  - Control your ego "Keep your cool"
- Redirect
  - Confirm common goals

No Threats

- **NEVER THREATEN unless you are prepared to take the next step:**
  - **"You're going to the hospital or else…"**
  - **"You don't have a choice"**
  - **"There are 4 of us and 1 of you"**
  - **"Do you want to go in handcuffs?"**
  - **"I'm not going to tell you again"**

Once you have made a threat, you have ceased all negotiations.

Incident Examples

Car Vs Pole Crash

March 2011 – Bellmore Fire /EMS

Person Down

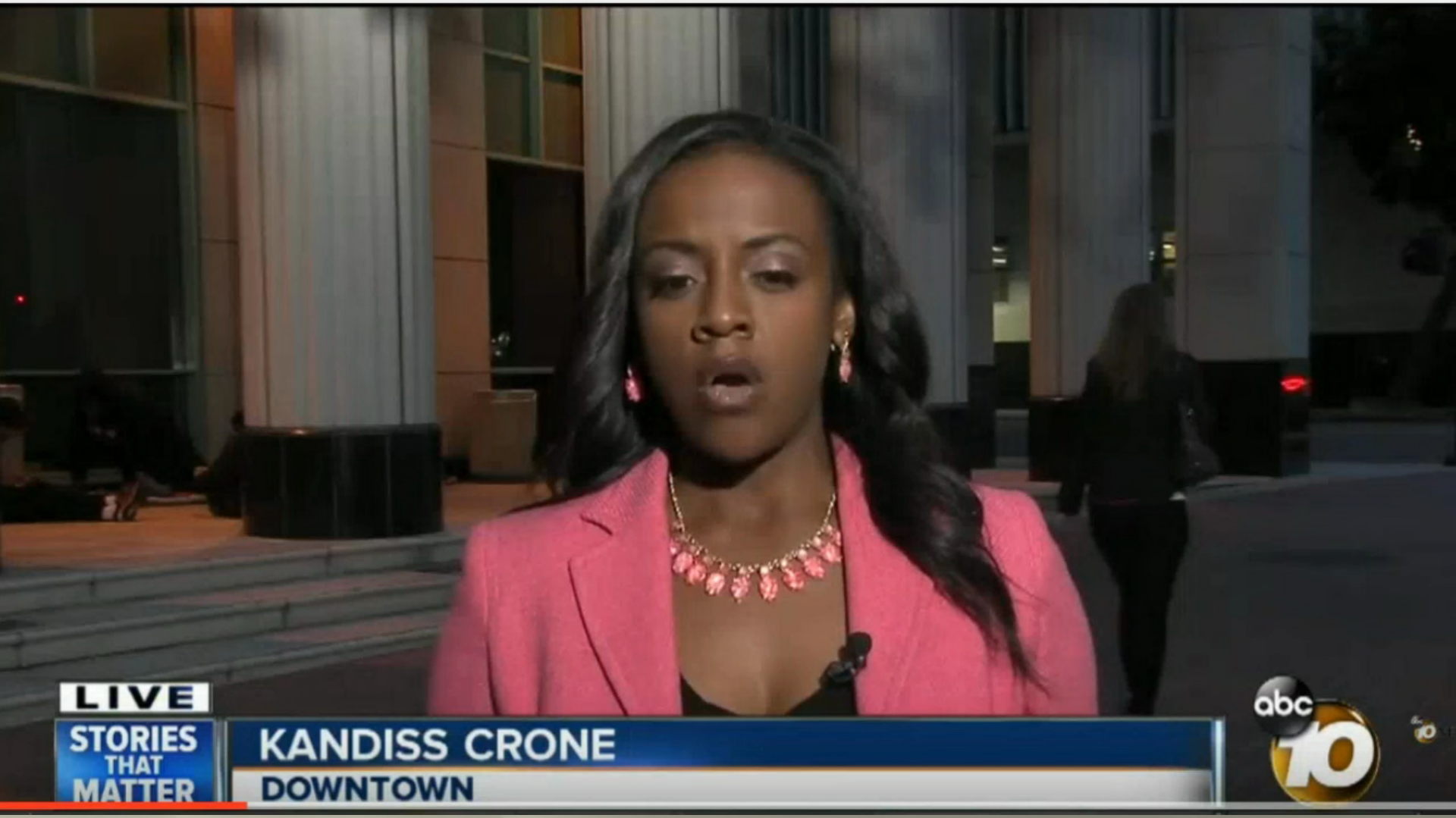
- Upon arrival you find a 30's male on the ground
- There are a few bystanders but nobody with the patient
- They all describe the man stumbling around and then collapsed to the ground
- The patient responds to loud voice by groaning but is otherwise non-verbal
- He has a medical alert bracelet that reads "Diabetic"

As your assessment continues…

- What's the plan?
- What are you options?
- What's your policy?
- What's your training?

San Diego – Firefighters Stabbed


abc
10


LIVE
STORIES THAT MATTER
KANDISS CRONE
DOWNTOWN
abc 10


GO BOLTS
STORIES THAT MATTER
MAN ACCUSED OF STABBING FIREFIGHTERS FACES A JUDGE
RYAN JONES CHARGED IN ATTACK CAUGHT ON CAMERA
abc 10
HEADLINES
CURRENTS
NATIONAL CITY: PARTLY CLOUDY
64°
7:06
65°
0:46 / 1:57
CC
HD

Suwanee Georgia - April 2013

- 55 year old male with chest pain
- “things took a drastic turn when Brown took off the blood pressure cuff and told them: "I hate to do this, but now for the real reason why you're here,”. Brown then pulled out a gun and pointed it at the firefighters.
- “firefighters had no reason to think this situation would turn violent. This call seemed to be no different ... They were caught off guard.”

Cape Vincent - January 2009

- First response rescue dispatched to male who is short of breath
- Reports indicate the male becomes increasingly agitated.
- He makes several statements about harming the crew
- He eventually retrieves a shot gun from his bedroom and fatally shoots a paramedic

Upstate NY – May 2014

- Dispatched to meet police on the scene of an EDP
- Patient says he was huffing earlier and feels sick
- Police turn patient over to crew as he seems "strange but not dangerous"
- During transport, patient makes several sexual comments
- He eventually unbuckles himself and attempts to tackle EMT

Upstate NY – May 2014

- She breaks free and exits the rig
- Attempts to lock herself in passenger compartment
- He grabs her and pushes her over the seat
- She escapes. She and her partner run
- They radio for help and run - he chases
- Other crew and police arrive shortly after

"Is there any way you could have seen this coming?"

- "No. Well....."
- "I put myself at the head of the stretcher but I'm not sure why"
- "I feel like I angled my feet toward the side door"
- "I had the computer on my lap but I didn't even start the chart"
- "He seemed to talk faster and louder. As he did, I could feel my heart racing"

East Syracuse – April 2009

- Unconscious person
- No history, no trauma
- Crew finds male supine in bed
- They place oxygen on him
- Several police, EMS, firefighters attempt to control him

DeWitt – January 2008

- Crew dispatched to 20's male having a seizure in a college classroom.
- With arrival, patient is attempting to get up but keeps falling over. Witnesses describe a grand-mal seizure.
- He becomes very agitated and makes several attempts to swing at the crew. He is unable to speak coherently.
- Crew asks for police to "step it up"

DeWitt – January 2008

- As police arrive, patient is verbally threatening the crew with physical violence.
- From about 10 feet away, he charges at police who subsequently deploy a “taser”.
- After several minutes, he becomes more responsive and eventually refuses any care.
- He eventually signs a refusal
- And then files lawsuits against fire, EMS, (false imprisonment), and police (battery, negligence)

Prince George's County April 2016

- Concerned neighbor calls 911 to check welfare of male
- Knocks on the door receive no answer
- Occupants' brother (caller) gave credible info that he could be having a medical emergency
- Crew forces entry
- Multiple shots are fired.
- 1 Firefighter dead, 1 injured, 1 civilian injured

Arming Fire/EMS Personnel

- Logistics
  - Who owns the weapon?
  - Where is it stored?
  - Who is it secured while in firefighting mode?
- Training
  - Legalities
  - Weapons retention
  - Marksmanship
- Policies
- Concealed vs. Open

Discussion Thoughts

- "When seconds count, the police are minutes away"
- "As active shooter response becomes more common, wouldn't this help?"
- "We have trained the police to use AED's, Narcan, tourniquets, and fire extinguishers...maybe it's their turn to train us"
- "We would become a bigger target if people knew we carried guns"
- "We get sued enough for improper restraint, can you imagine if we start shooting people?"

So What *Can* We Do?

- First address the "95%" not the "5%"
- Make every attempt to:
  - Not commit to a bad place
  - Travel in pairs when possible
  - Avoid "tunnel vision"
  - Have an exit plan
  - Listen to our instincts

- Encourage management to provide training and policy development
- Train in *appropriate* defensive tactics

Our Training is Based On:

- A series of principles so that you can better control you and your space
- Learning to control a person's structure so they cannot hurt themselves, or anybody else.
- Liability conscious and medically accepted practices.
- Years of real life experience, field practice, and expertise

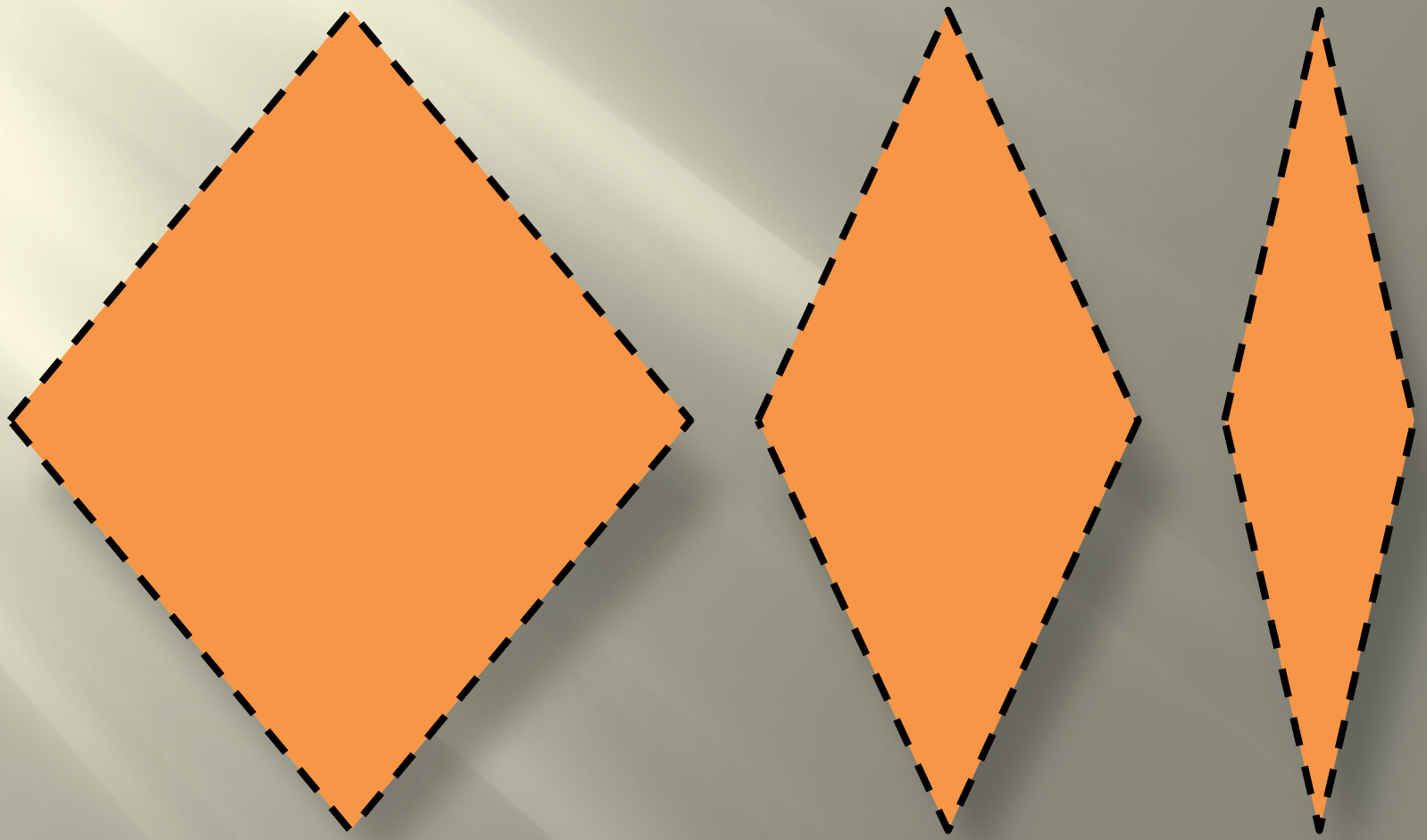
INTRODUCTION TO PRINCIPLES

Principle Vs. Technique

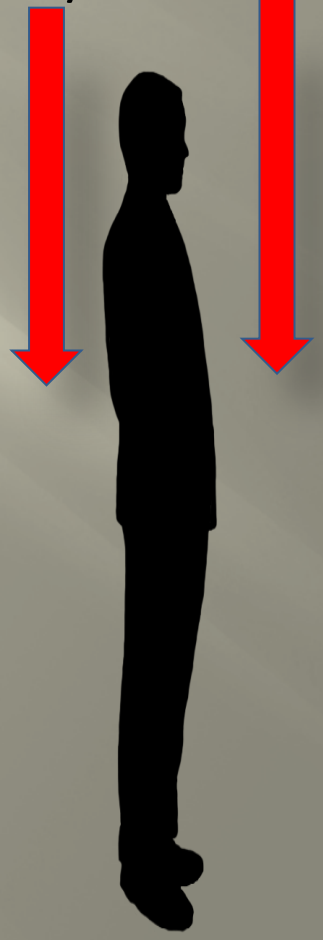
- Technique
  - Specific set of moves that work under specific circumstances
- Principal
  - Underlying premises and rules of function, giving rise to any number of techniques

“The Box Principle”

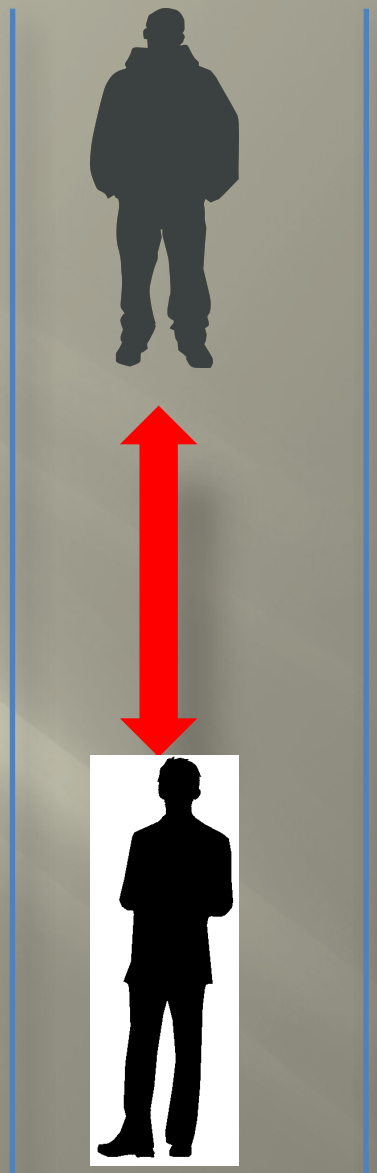
Changing Your Shape



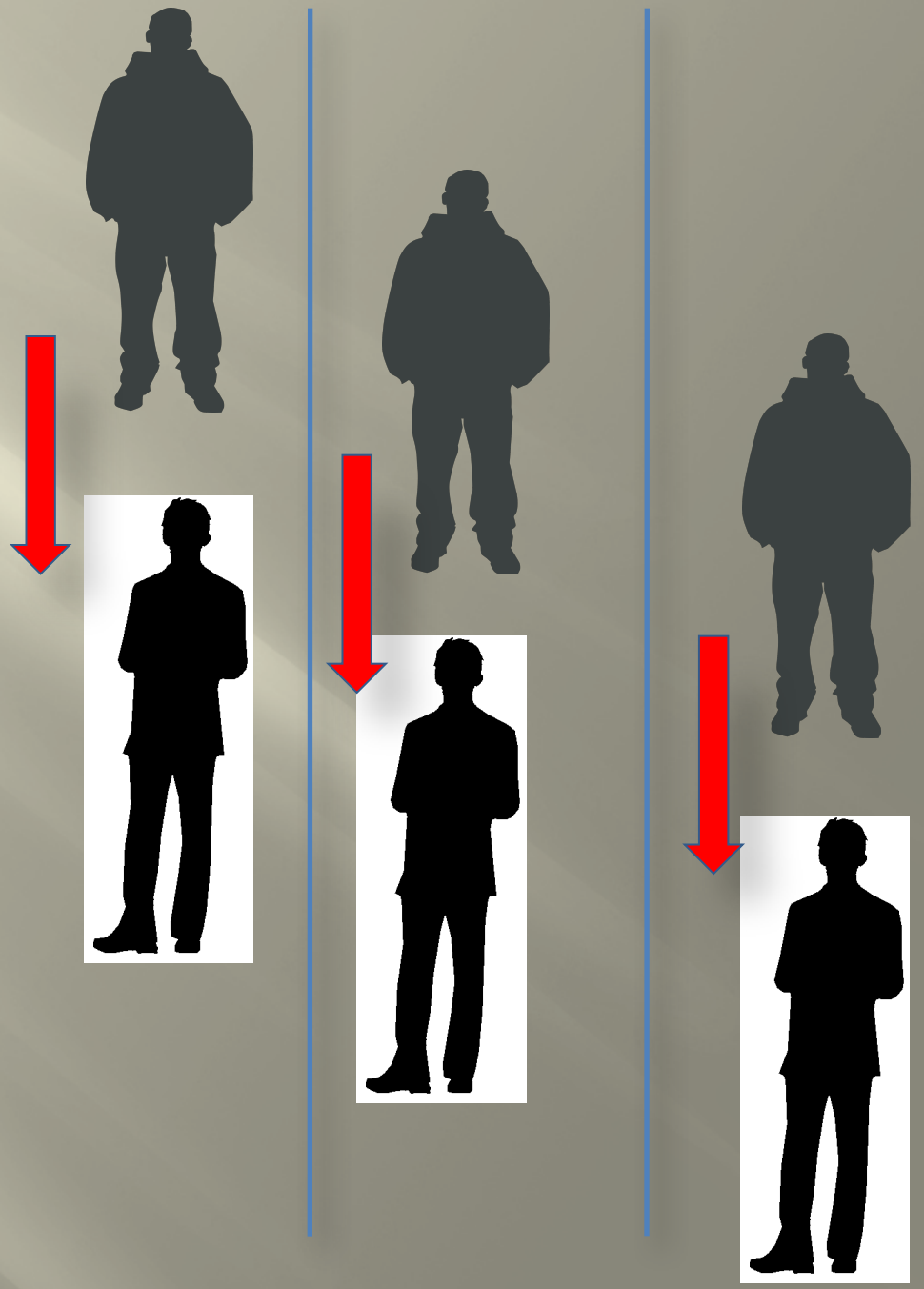
“The Box Principle”



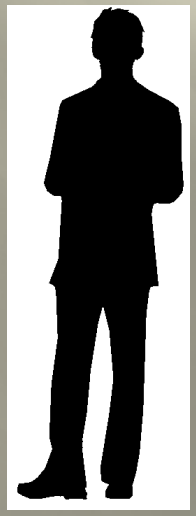
“The Line”



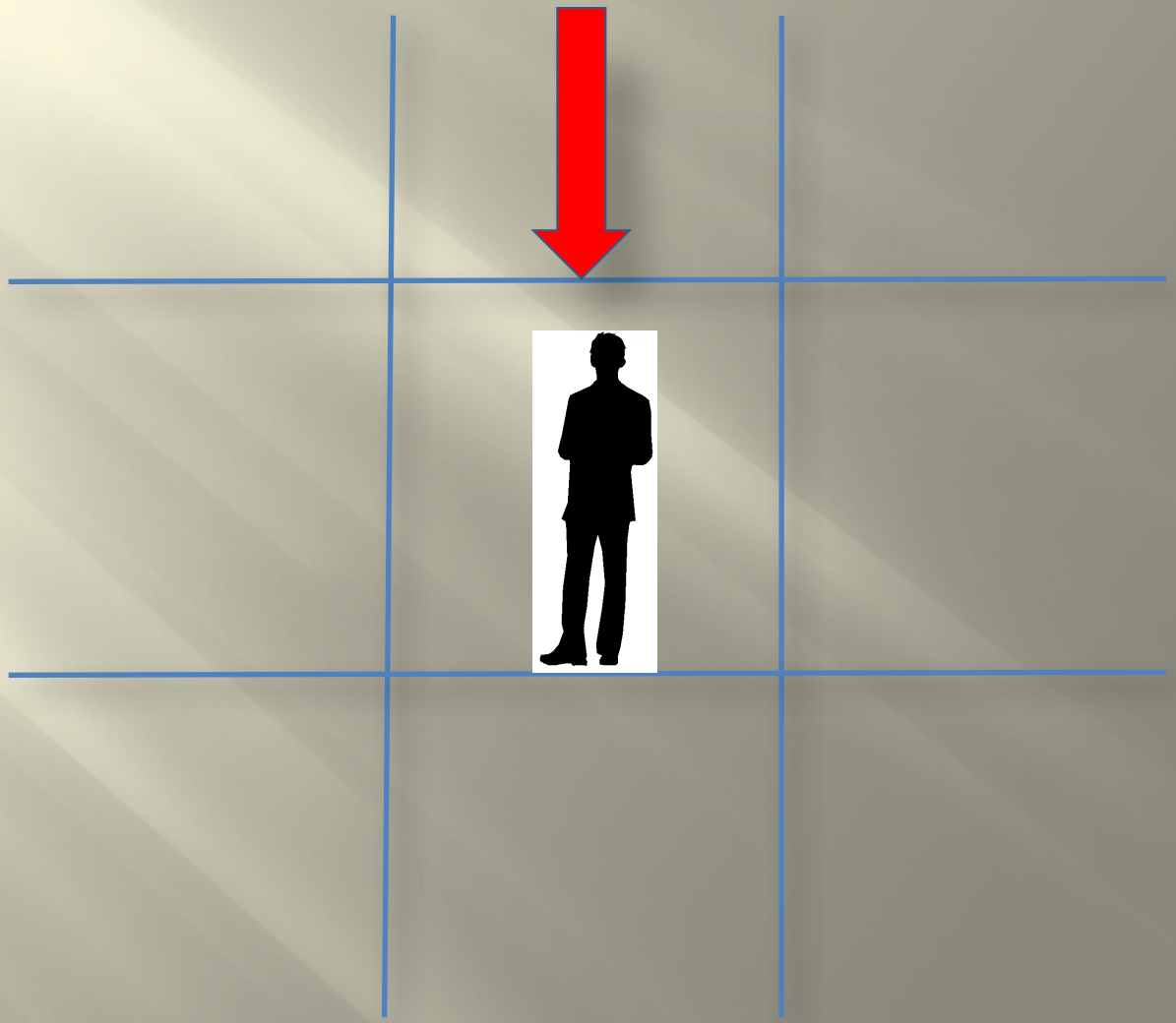
“Instinct”



“Get off the Line”

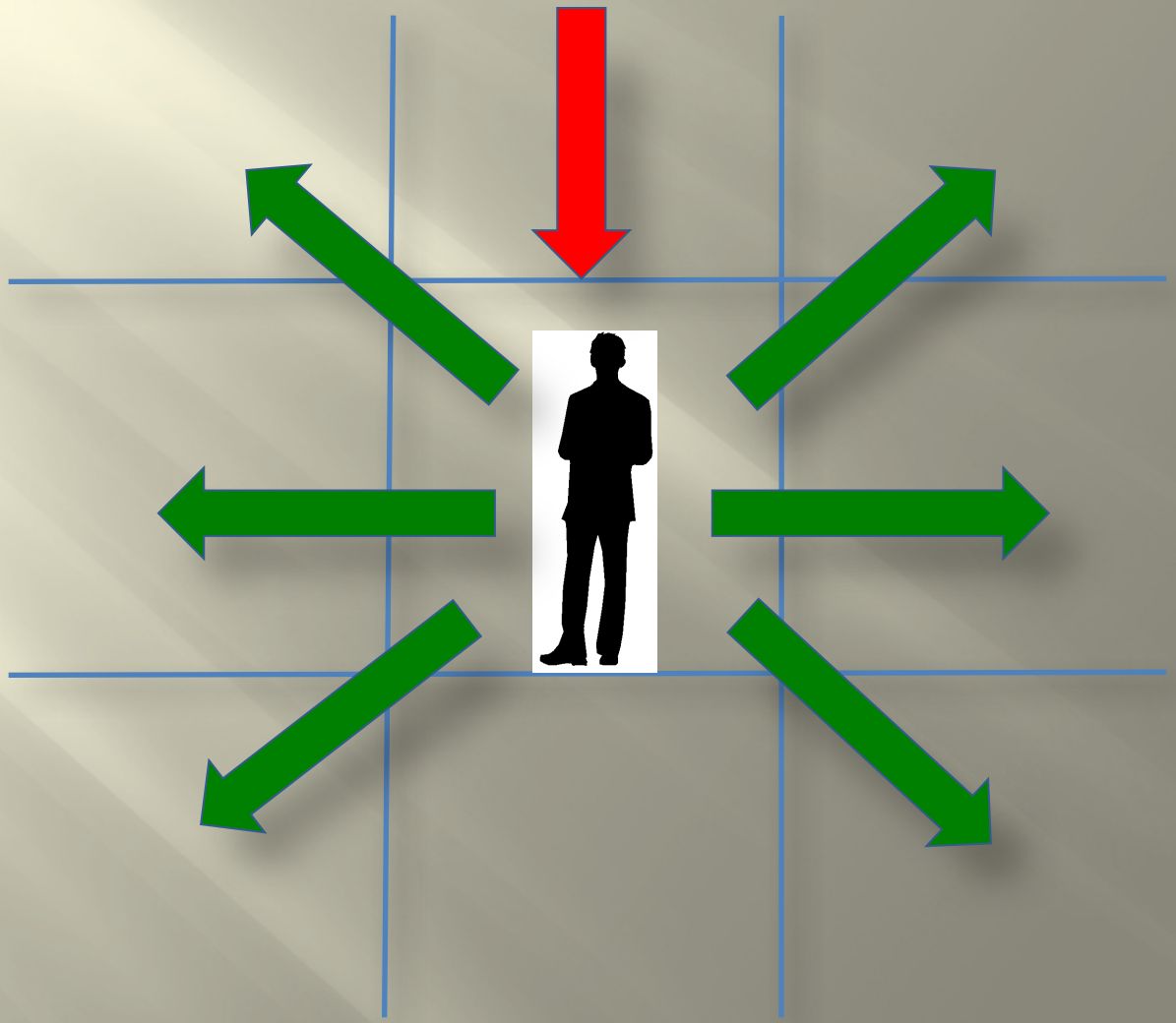


“Getting off the Line”



“Staying on the Line”

“Getting off the Line”



“Block yourself – not the object”

Structural Control

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