“Defensive Tactics for Offensive Scenes”

September 2017
Its Monday evening, 2130 hours. You are dispatched to an elderly female having a stroke. You arrive to find the patient on 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”? 
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
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
You have *never* been on a call that involved a violent or aggressive person. This includes medical and traumatic emergencies.
You have *never* been on a call where you have been sworn at, yelled at, or otherwise 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”

- Better Scene Assessments
- Stage for Police
- "Self-Defense" Training
- Cover/Concealment
Circle of “Scene Safety”

- Scene Safety Assessments
- Stage for Police
- Patient Restraint
- “Self-Defense” Training
- Cover/Concealment
# PATIENT ASSESSMENT - MEDICAL

**Candidate:**

**Examiner:**

**Date:**

**Signature:**

## Scenario:

### Actual Time Started:

- **Points Possible:**
- **Points Awarded:**

<table>
<thead>
<tr>
<th>Task Description</th>
<th>Points Possible</th>
<th>Points Awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnoses verbalizes body substance isolation precautions</td>
<td>1</td>
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### SCENE SIZE-UP

- Determines the scene/situation is safe: 1 point
- Determines the mechanism of injury/nature of illness: 1 point
- Determines the number of patients: 1 point
- Requests additional help if necessary: 1 point

### PRIMARY SURVEY

- Verbalizes general impression of the patient: 1 point
- Determines responsiveness/level of consciousness: 1 point
- Determines chief complaint/apparent life-threats: 1 point

### ASSESSMENT

- Assesses airway and breathing:
  - Assessment (1 point): 1 point
  - Assures adequate ventilation (1 point): 1 point
  - Initiates appropriate oxygen therapy (1 point): 1 point

- Assesses circulation:
  - Assesses/controls major bleeding (1 point): 1 point
  - Assesses skin [either skin color, temperature, or condition] (1 point): 1 point
  - Assesses pulse (1 point): 1 point

- Identifies priority patients/makes transport decision: 1 point

### HISTORY TAKING AND SECONDARY ASSESSMENT

- History of present illness:
  - Onset (1 point): 1 point
  - Provocation (1 point): 1 point
  - Quality (1 point): 1 point
  - Time (1 point): 1 point
  - Clarifying questions of associated signs and symptoms as related to OPQRST (2 points): 2 points

- Past medical history:
  - Allergies (1 point): 1 point
  - Medications (1 point): 1 point
  - Last oral intake (1 point): 1 point

- Performs secondary assessment (as assessed affected body part/system or, if indicated, completes rapid assessment):
  - Cardiovascular: 1 point
  - Neurological: 1 point
  - Integumentary: 1 point
  - Reproductive: 1 point
  - Pulmonary: 1 point
  - Musculoskeletal: 1 point
  - GI/GU: 1 point
  - Psychological/Social: 1 point

### Vital signs

- Pulse (1 point): 1 point
- Respiratory rate and quality (1 point each): 1 point

- Blood pressure (1 point): 1 point
- AVPU (1 point): 1 point

### Diagnostics

- Must include application of ECG monitor for dyspnea and chest pain: 1 point

### Status field impression of patient:

- 1 point

### Verbalizes treatment plan for patient and calls for appropriate intervention(s):

- 1 point

### Transport decision re-evaluated:

- 1 point

### REASSESSMENT

- Repeats primary survey:

- 1 point

- Repeats vital signs:

- 1 point

- Evaluates response to treatments:

- 1 point

- Repeats secondary assessment regarding patient complaint or injuries:

- 1 point

### Actual Time Ended:

**TOTAL** 48

### CRITICAL CRITERIA

- 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 safely 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 not detail 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.*

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P302/10-11
### Scenario: Evaluates past medical history

#### Actual Time Started: __________

<table>
<thead>
<tr>
<th>Possible Points</th>
<th>Points Awarded</th>
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<tbody>
<tr>
<td>TAKES OR VERBALIZES BODY SUBSTANCE ISOLATION PRECAUTIONS</td>
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#### SCENE SIZE-UP

Determine the scene/situation is safe

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**National Registry of Emergency Medical Technicians**  
Advanced Level Psychomotor Examination  

**PATIENT ASSESSMENT - MEDICAL**

Candidate: ____________________________  Examiner: ____________________________

Date: ____________________________  Signature: ____________________________

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Additional details may include:

- Evaluates past medical history
- Determines the scene/situation is safe
- Takes or verbalizes body substance isolation precautions

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Date: ____________________________

**Signature:** ____________________________
Is the Scene Safe?

Yes
- Start pt. Assessment

No
- Wait for Police
Safety Levels

- Severe
- High
- Elevated
- Guarded
Safety Levels

- Severe: Obvious signs of violence
- High
- Elevated
- Guarded
Scene Safety Levels
SEVERE

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

- Severe
  - Critical calls/Unstable scenes
- High
- Elevated
- Guarded
Scene Safety Levels HIGH

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

- Suspicion
- Hesitation
- Anxiety
- Apprehension
- Persistent fear
- Rationalize
- Justify
- Minimize
- Excuse making
- Refusal
# Signs of Impending Confrontation

<table>
<thead>
<tr>
<th>VERBAL</th>
<th>PHYSICAL</th>
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<tbody>
<tr>
<td>Speeds up</td>
<td>Fist clenching</td>
</tr>
<tr>
<td>Change in pitch</td>
<td>Knuckle cracking</td>
</tr>
<tr>
<td>Increase in volume</td>
<td>Body posture</td>
</tr>
<tr>
<td>Repetitive words</td>
<td>Removing clothing</td>
</tr>
<tr>
<td>Sarcasm</td>
<td>Pacing</td>
</tr>
<tr>
<td>“Sure I’ll sit down”</td>
<td>Teeth grinding</td>
</tr>
<tr>
<td>Nervous laughs</td>
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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.
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

- Hair / clothing grabs
- Arm / wrist grabs
- Biting
- Reaches / swings
- Choke holds
- Ground positions
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
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
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.
“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
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
MAN ACCUSED OF STABBING FIREFIGHTERS FACES A JUDGE
RYAN JONES CHARGED IN ATTACK CAUGHT ON CAMERA
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.”
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
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
- 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”
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
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”
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)
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
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”

All of me

1/3 of me
“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
“Training for the REAL World”

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