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PROTECTION | PREVENTION | PREPAREDNESS | RESPONSE | RESILIENCE | RECOVERY

KIDNAPPING & HOSTAGES

A CHALLENGING NEW DYNAMIC

PLUS: Interoperability; Family support during victim identification; Mass casualty management lessons from Paris incidents; Critical space infrastructure and security; Displacement crisis in Europe; Insider threats to critical national infrastructure

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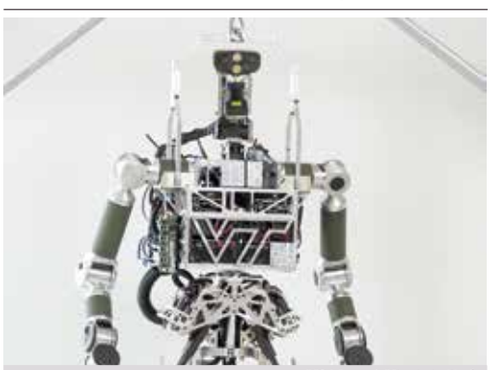

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comment

The geopolitical aspects of the global migration crisis currently appear to be overshadowing those of climate-related issues and human-caused technological disasters.

The world is possibly experiencing its worst refugee crisis ever: around 60 million people around the globe have fled their homes, displaced by conflict, violence or persecution. Predictably, the main – though by no means exclusive – cause of this exodus is conflict, whose attendant effects extend far beyond the communities directly involved.

Eighty-six per cent of the world's refugees are being sheltered by developing countries, says the UNHCR. Mass migration of this scale is an immensely difficult situation to manage with dignity and humanity in any circumstances. The situation in Europe in particular appears to be in danger of spawning far wider consequences, exposing fault lines in European unity and politics, possibly threatening the cohesion of its societies.

This is particularly true with regard to the controversial subject of integration, where public sympathy for refugees has suffered some erosion after incidents of sexual attacks and harassment (page 38).

Our article on page 40 looks at how the European Commission is co-ordinating requests for assistance from those countries at the frontline of the crisis, while possible solutions in terms of border control technology are outlined on page 42.

In case we needed any reminder of why so many people are making the dangerous journey to what they hope will be a safe haven, the article on page 44 reports on the staggering levels of UXO dropped onto civilian communities by airstrikes in Syria, while page 46 looks at the detrimental effect of conflict on urban services. And lest we forget the psychological impacts of war, its effects on mental health are examined in the article on page 32, while sexual violence in conflict is discussed on page 34.

So this is how the narrative of this edition of *CRJ* has been shaped – we can only present the briefest snapshot into how the trauma of conflict not only causes near-inconceivable suffering to those who are directly caught up in it, but also how its effects inevitably seep across borders into neighbouring countries and far beyond.

Emily Hough

Emergency medical support specialists from France's elite counter-terrorist tactical unit – RAID – present some valuable lessons learnt from their responses to the recent terrorist incidents in France

Mass casualty management in high intensity counter-terror ops

High intensity crises threatening the interior security of the French Republic are currently under scrutiny after the recent terrorist events. These incidents involved two response goals: a police operation seeking to eliminate the threat, and a rescue operation, both in the combat zone and in the relief area. These combined operations were under the command of the police officer in charge of prioritising the necessary actions.

France's elite national counter-terrorist tactical unit is the Research, Assistance, Intervention, Deterrence (RAID) unit, whose personnel include tactical emergency medics. RAID has gained unique experience during recent operations in France and Europe; the key success factor in these was the co-ordination between rescue services.

The organisation of emergency medical provision in such scenarios has consequently been adapted, not only to care for the casualties, but also to organise the best possible co-ordinated response between the main parties involved.

Integrated medical support

By having medical support integrated within tactical response teams, as in the case of RAID, damage control resuscitation can be initiated and rapid casualty evacuation can be carried out at the incident scene; these are both major success factors when proceeding with damage control surgery.

In order to fulfil its mission, RAID has set up an operational and adaptable medical process for all kinds of situations with a 'keep it simple stupid' (KISS) approach. This doctrine is now a benchmark between a tactical medical culture and emergency practices.

RAID's medical process is based on three principles:

- Establishment of an exclusion zone where victims will only be treated by RAID's medical team;
- Permanent co-ordination between RAID's operational commander and the Chief Fire Officer (CFO); and
- A dynamic and adaptive casualty flow, bringing the victims towards the casualty collection point according to RAID's tactical medical triage procedures.

Zoning is principally divided between an exclusion zone and a relief zone, as outlined in Figure 1 (p62).

The exclusion zone, which is defined by the authorities in command of the incident, is an area where the security of unprotected personnel cannot be ensured and which is therefore unsuitable for the administration of medical care.

In order to ease the casualty flow, this zone is sub-divided in accordance with tactical combat casualty care guidelines and specific roles are assigned to medical officers. The forward casualty assembly point (casualties nest) becomes the hot spot for tactical medical support. From care under fire to tactical field care, the goal is to organise the flow of casualties towards the casualty collection point after tactical medical triage has been performed.

The RAID commander controls this zone, assisted by a medical officer – the Tactical Emergency Medical Support Director (TEMS – DSM RAID) – who is responsible for the TEMS and co-ordination with the CFO outside the exclusion zone.

The relief zone, which comes under the responsibility of the CFO, has to be adaptable to changing situations. Casualty care points are access points where Emergency Medical Services tend to casualties according to the principles of mass casualty damage control, then organise their evacuation to trauma centres. This zone may include both tactical field care and casualty evacuation processes.

The efficiency of the response relies on smooth co-ordination between police and medical actors. Without being exhaustive – given the wide range of possible situations – the following are some of the tasks that would be undertaken:

- Anticipate the foreseeable scenarios that would involve ▶

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- the medical team (fire, bomb attacks, explosion, population evacuation, enumeration of potential victims, etc);
- Set up the casualty flow according to the zoning and explain its upgradability;
- Define the casualty collection point positions according to the clearing routes;
- Adapt the level of medical care, according to the evolution of the threat; and
- Make sure that the required medical equipment is available in the exclusion zone.

To optimise this vital co-ordination, a CFO liaison officer is seconded to the RAID operational control post. This officer keeps the CFO apprised of the situation in the exclusion zone and anticipates rescue operations. As soon as the crisis begins, hospitalisation processes are defined for rapid casualty evacuation routes (Casevac) outside the exclusion zone. It is important to note that this is not the role of the RAID medical support team.

The year 2015 proved particularly intensive for the RAID medical team as its operational medical doctrine was deployed during three very different major crises. This did, however, allow its operational enforcement protocols to be validated.

The first incident was the mass hostage scenario at the HyperCacher supermarket at the Porte de Vincennes after the *Charlie Hebdo* attacks of January 2015.

The preliminary phase leading up to the hostage rescue operation allowed the RAID Emergency Medical Support Director to allocate roles to each tactical medical physician in the exclusion zone and to manage the casualty flow under the authority of the Operational Commander. The organisation that was in place before the assault (see Figure 2 opposite), in co-ordination with the CFO, the Emergency Medical Support Director of the Paris fire brigade and the SAMU (Ambulance Service) of Paris, allowed immediate provision of medical care for the six RAID members injured during the operation. Efficient relays from the EMS and the fire brigade reduced evacuation delays and patient care in the trauma centres.

The second incident was the marauding firearms terrorist attack and mass hostage taking at the Bataclan theatre in Paris.

On November 13, 2015, multiple co-ordinated terrorist attacks shook the French capital, challenging both the police and medical support organisations. Several RAID teams were engaged at various sites, but the intervention of the medical team at the Bataclan theatre was pivotal.

Three terrorists armed with automatic weapons and wearing explosive vests entered the concert hall, killing dozens of people on the ground floor (the orchestra pit) before retreating to the first floor, taking numerous hostages with them.

The first medical personnel who arrived on scene and treated the victims were from RAID and the Paris special police unit, the Brigade de Recherche et d'Intervention (BRI). Conventional prehospital medical rescue teams remained outside the exclusion zone as the terrorists were still at large. Anticipation and planning of the rescue back-up system during this rapidly evolving crisis was not prepared.

The medical and tactical decisions taken within the exclusion zone by medical officers were carried out with the aim of achieving a dynamic evacuation of all living victims to outside the danger zone, while simultaneously guaranteeing medical support for ongoing operations and the personnel involved.

The enforcement of this doctrine ensured the safety of the casualties and reduced the delay in getting casualties to a hospital trauma centre for damage control surgery.

The first part of the operation was to set up the victim extraction flow from the orchestra pit to the casualty nest located at the entrance to the Bataclan theatre. Two RAID forward medical officers, protected and assisted by police operators, provided medical triage in the pit, along with live-saving measures and tactical evacuation. The support medical officer organised the casualty nest, completing field triage and tactical field care. His aim was to boost casualty evacuation between the forward nest and the casualty collection point.

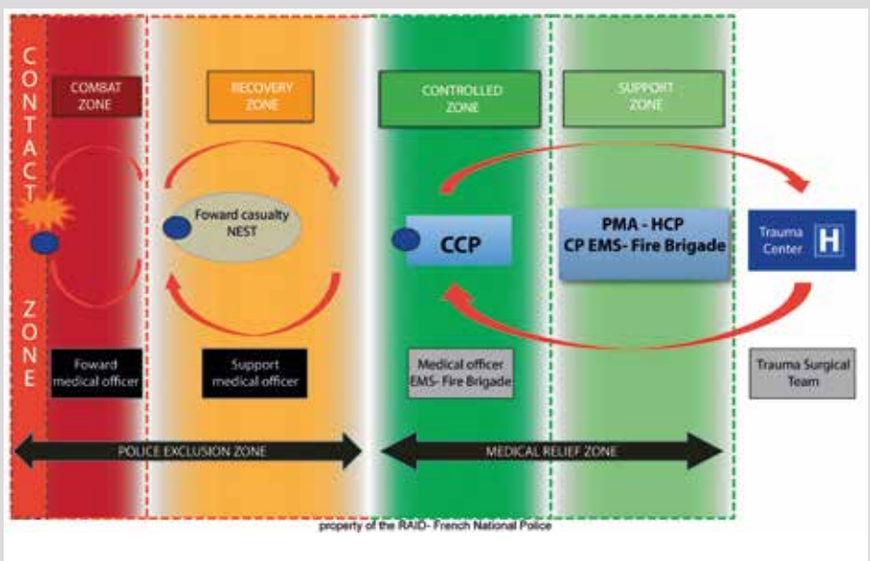
Immediate medical care

The second part of the operation consisted of supporting the assault forces and medical evacuation of wounded civilians to safer parts of the theatre. The threat was still active at this stage, so more than 80 victims were evacuated from first floor windows.

No additional civilian injuries were noted between RAID's arrival and the time when the theatre was finally secured; two members of the police were injured during the operation and were provided with immediate medical care by medical officers on scene.

All of the victims who were alive – whether wounded or unharmed – were evacuated before the operation to secure the zone had ended, in spite of the acute and continued risks that were present.

Figures 1 and 2



RAID's operational and adaptable medical doctrine is now a benchmark between a tactical medical culture and police first responder practices. Zoning is principally divided between an 'exclusion zone' and a 'relief zone' as indicated above

The application of the RAID medical doctrine allowed medical officers to accommodate the massive flow of casualties by liaising with conventional rescue teams and by stressing urgent evacuations. They also provided necessary rescue interventions without becoming caught up in the police action and while maintaining the capacity to treat potentially wounded operators.

The assault of the flat in Saint-Denis on the outskirts of Paris, where the November terrorists were presumed to have taken shelter, once again allowed the RAID medical doctrine to prove its efficiency and adaptability. Seven officers and civilians were injured during this operation and were immediately treated by the forward and

Co-ordination between counter-terrorism units and the emergency rescue services must be institutionalised

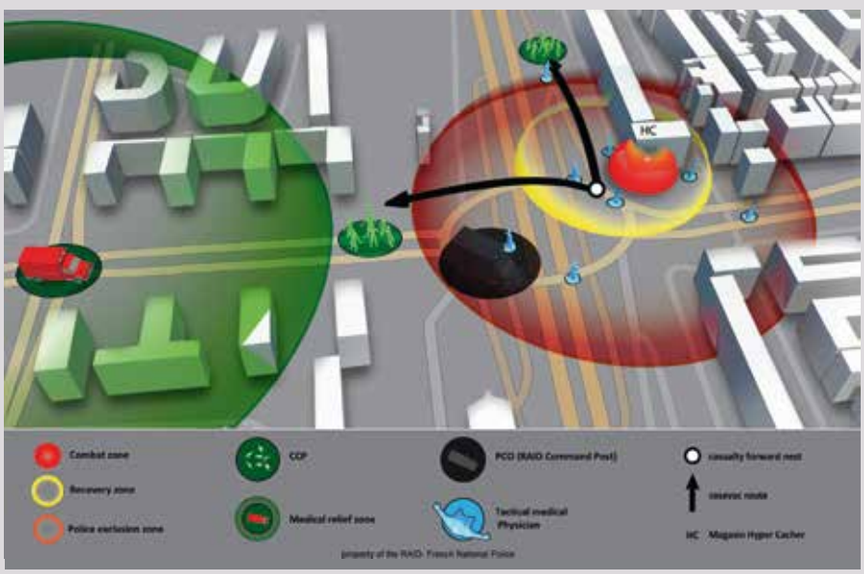
support medical officers. According to procedure, and in perfect co-ordination with the local EMS services, the casualties were evacuated towards the casualty nest and the two casualty collection points.

Turning to the lessons learnt from these three incidents, the immediate case management of casualties during the Saint-Denis and Vincennes assaults, the rapid evacuation of the Bataclan victims, as well as the lack of additional civilian injuries during the attack, all confirmed the efficiency and the expertise of the RAID medical support team preparation. However, each of these operations generated areas for procedural improvement. The RAID medical group has fed these back into the strategic post incident analysis.

For some time, RAID has been considering its interaction with first responders from the police. The intervention of first responders is essential, though this should also embed the rescue component – including early co-ordination between the Police Operation Commander – who is in overall command – and the CFO. This allows rapid establishment of the necessary zoning, including a police controlled exclusion zone and a secured and protected recovery zone.

The Vincennes supermarket hostage taking also demonstrated the efficiency of pre-regulating the flow of casualties, keeping it short and fluid between the combat zone and the trauma centre.

The medical importance of reducing the time between a penetrating wound and damage control surgery being performed is common knowledge. In order to save lives, the priority should be to undertake very limited prehospital care so as to get the casualty to a trauma hospital – where rapid damage control surgery can be carried out – as soon as possible. This should be the priority in incidents involving mass casualties with penetrating trauma. Close collaboration with the EMS is a major success factor in this regard.



Casualty flow organisation during the response to the mass hostage scenario at the HyperCache supermarket, Porte de Vincennes, in January 2015. This allowed the six RAID members injured during the operation to receive immediate medical care

Co-ordination between counter-terrorism units and the emergency rescue services must be institutionalised with a strategic workshop between police forces, fire service and EMS teams. RAID medical physicians are able to link the police culture of managing the threat with the rescue culture of mass casualty management. The TEMS chief should help both operational commanders to build synergic and adaptive processes.

Efficient operating organisations must adapt to deal efficiently with those new forms of crises. It is therefore important to take into account the changing and unpredictable aspects of terrorist attacks. The location and the size of the casualty collection posts are good example of the critical importance of adapting standard contingency plans. Small mobile teams allow the quick organisation of a regular flow from casualty nests to the field medical advanced post or trauma hospitals after primary triage. This mobile dimension allows for the distance between the casualty nests and the casualty collection posts to be reduced. The latter are under the sole responsibility of the rescue teams, but need to liaise with the police operational commander.

It is necessary for all rescue operators to understand the organisation of RAID medical support in order to fulfil the highly effective co-operation that will be required in future crises. This inter-service collaboration aims to optimise crisis management, stressing the best possible casualty evacuation procedures while reducing exposure to risk in highly dangerous situations.

It is possible to improve the Casevac process further, even in the event of a massive inflow of casualties or in a deteriorating situation, but this requires perfect synergy from all relevant stakeholders.

Finally, never give up and always brainstorm to face the future. Crises are unpredictable and we must accept this fact. We have to share joint thinking with all crisis actors with honesty and humility. We have to be prepared to be surprised, and to adjust, even considerably, in real time, with all the other stakeholders in the response system. CRJ

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References

- Tactical Emergency Care during Hostage Crisis*:* Care Principles and Feedback, Annales Françaises de Médecine d'Urgence; *DOI 10.1007/s13341-015-0545-4;*
- Feedback on Terrorist Attacks on November 13, 2015 *(2016)*: Bataclan's terrorist attack management by the tactical medical support of the French Police, Annales Françaises de Médecine d'Urgence *6:3-8,DOI;*
- Tactical emergency medicine: lessons from Paris marauding terrorist attack *(2016):* Critical Care *20:37, DOI 10.1186/s13054-016-1202-z);*
- *Rappold JF, Hollenbach PT, Dania Beadle S et al (2015):* The evil of good is better: making the case for basic life support transport for penetrating trauma victims in an urban environment (2015)*: Journal of Trauma & Acute Care Surgery;79: 343-348;*
- *Lagadec P (2015):* Le continent des imprévus. Journal de bord des temps chaotiques*. Ed Manitoba. Les belles lettres (see page 96).*