



Solutions for Unified Critical Communications



Active Shooter Preparedness and Response in Healthcare | Steven M. Crimando

Agenda

- Assumptions you may have about active shooter incidents
- Understanding the active shooter threat
- Understanding defense tactics for active shooter incidents
- How Everbridge can help your organization quickly notify staff and patients during active shooter and other emergencies

LinkedIn Member? Join our LinkedIn Everbridge Incident Management Professionals Group

QUESTIONS?



Use the Q&A function to submit your questions.



@everbridge
#activeshooterprep



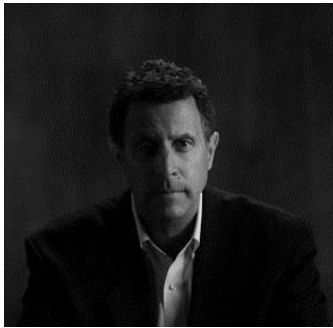
We'll send out a recording after the event

Today's Presenters:



#activeshooterprep

Steven M. Crimando
Principal, Behavioral
Science Applications



Nelson Daza
Director, Product Management
Everbridge



**ACTIVE SHOOTER PREPAREDNESS AND RESPONSE
IN HEALTHCARE**

Headlines vs. Trend Lines: Beyond Run > Hide > Fight



Active Shooter Incident Management in Hospital & Health Care Settings



BEHAVIORAL SCIENCE APPLICATIONS
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About the Presenter

Steven Crimando, MA, BCETS, CHS-V

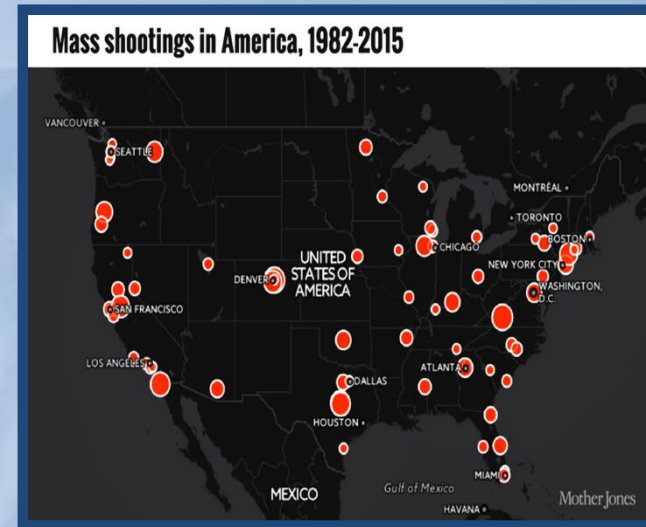
- Consultant/Trainer: U.S. Dept. of Homeland Security; U.S. Dept. of Justice; National Criminal Justice Training Center; U.S. Health & Human Services Administration; OSHA; United Nations; NYPD; U.S. Military, others.
- Diplomate: National Center for Crisis Management; American Academy of Experts in Traumatic Stress.
- Board Certified Expert in Traumatic Stress (BCETS); Certified Trauma Specialist (CTS).
- Police Surgeon, International Society of Police Surgeons, New Jersey Police Surgeons team.
- Advisor, Active Shooter Rescue Task Force (Morris County, NJ)
- On-scene Responder/Supervisor: '93 and 9/11 World Trade Center attacks; NJ Anthrax Screening Center; TWA Flight 800; Unabomber Case; Int'l kidnappings, hostage negotiation team member.
- Qualified Expert: to the courts and media on violence prevention and response issues.
- Author: Many published articles and book chapters addressing the behavioral sciences in violence prevention, disaster and terrorism response.



Discussing active shooter incident response on the Dr. Oz Show.

Realities of Modern Life

- The possibility of an Active Shooter Incident is no longer a question of if, but rather when and where.
- Incidents can occur at any time and at any place. No type of location or geographic area is immune.
- Hospitals and health care settings present unique challenges in Active Shooter planning and response.
- Active Shooter events evolve rapidly and end quickly, often before law enforcement can arrive. **In the initial phase, bystander intervention and civilian response are essential.**



Assumptions

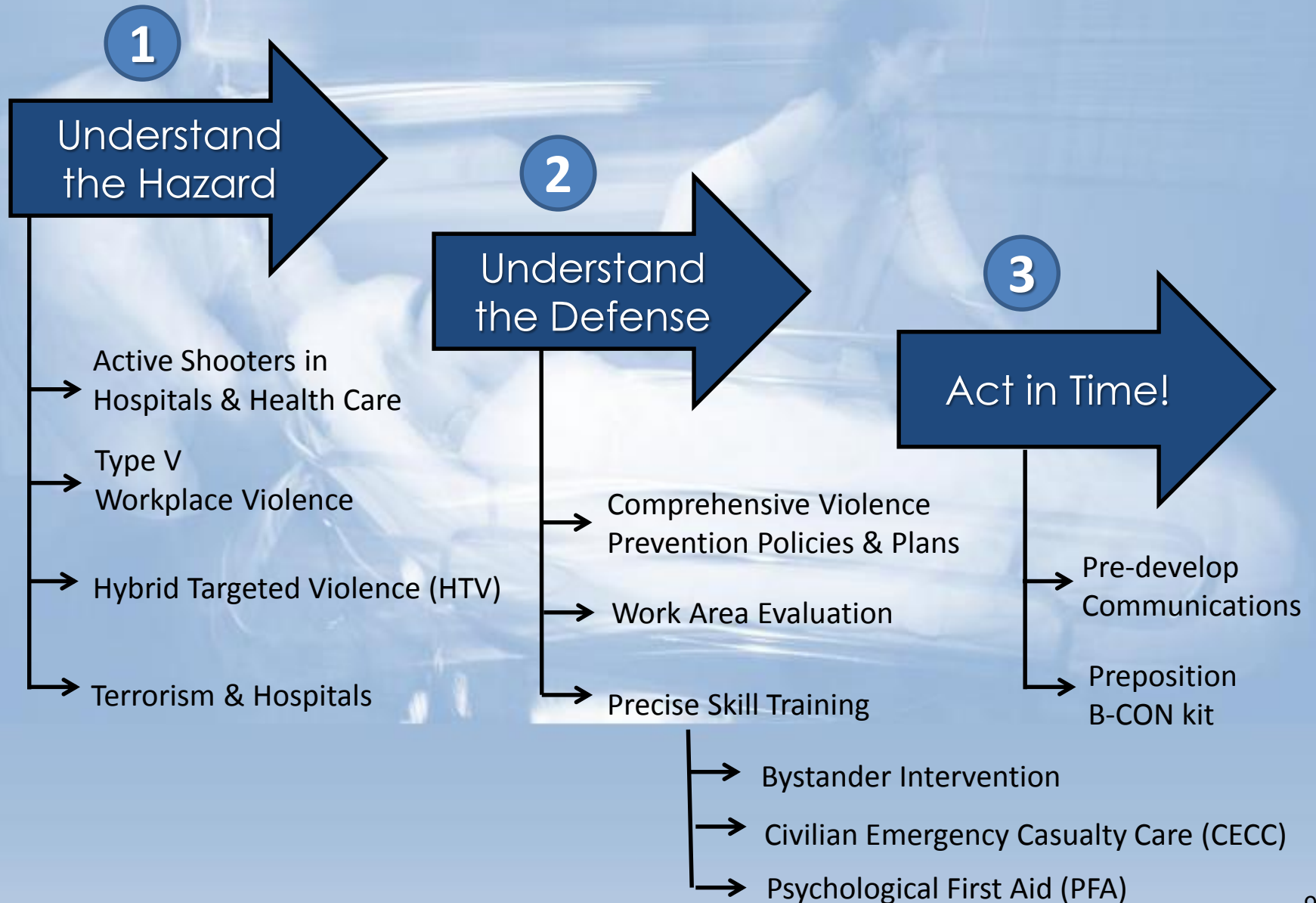
We will assume that participants have:

- A fundamental knowledge of general recommended response strategies (Run>Hide>Fight).
- Access to key planning guidance's (i.e., [“Active Shooter Planning and Response in a Health Care Setting Guidance”](#) and [“Incorporating Active Shooter Incident Planning into Health Care Facility Emergency Operations Plans”](#))
- An interest in optimizing the violence prevention and active shooter response capabilities at their facilities.

This program **will not** be all inclusive:

- Hospitals and health care settings are complex workplaces.
- Each work area has unique characteristics requiring attention.
- There is not “one-size-fits-all” active shooter plan for hospitals and health care environments.

The General Mitigation Approach



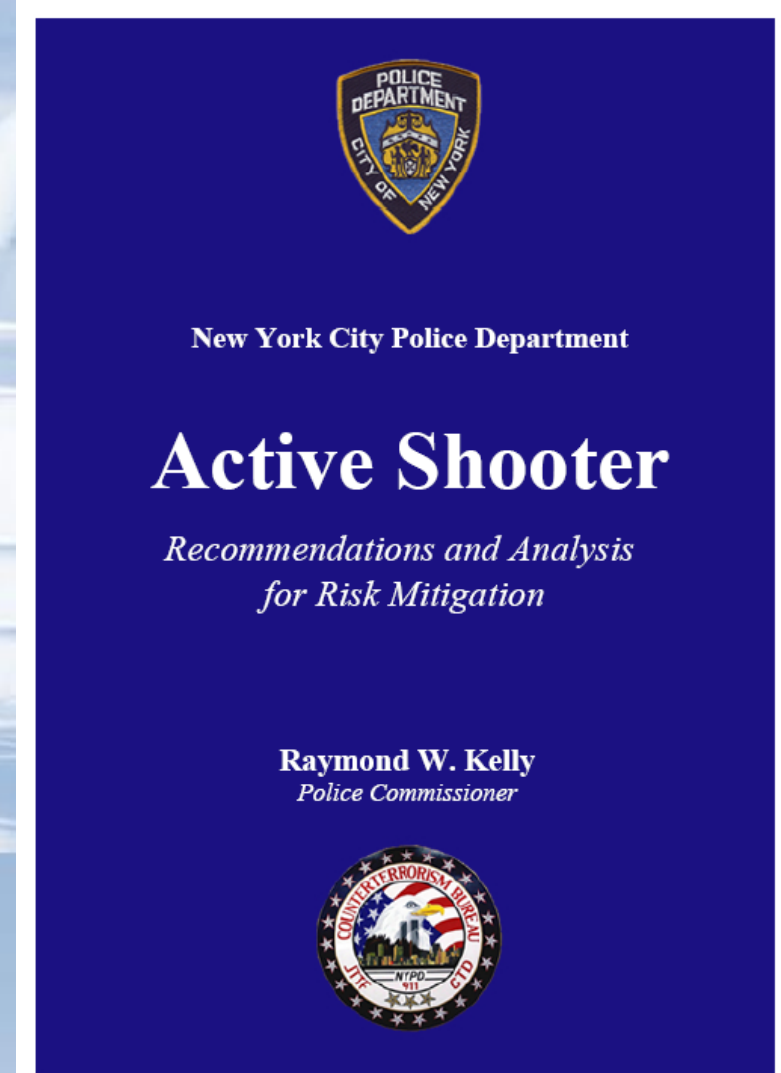
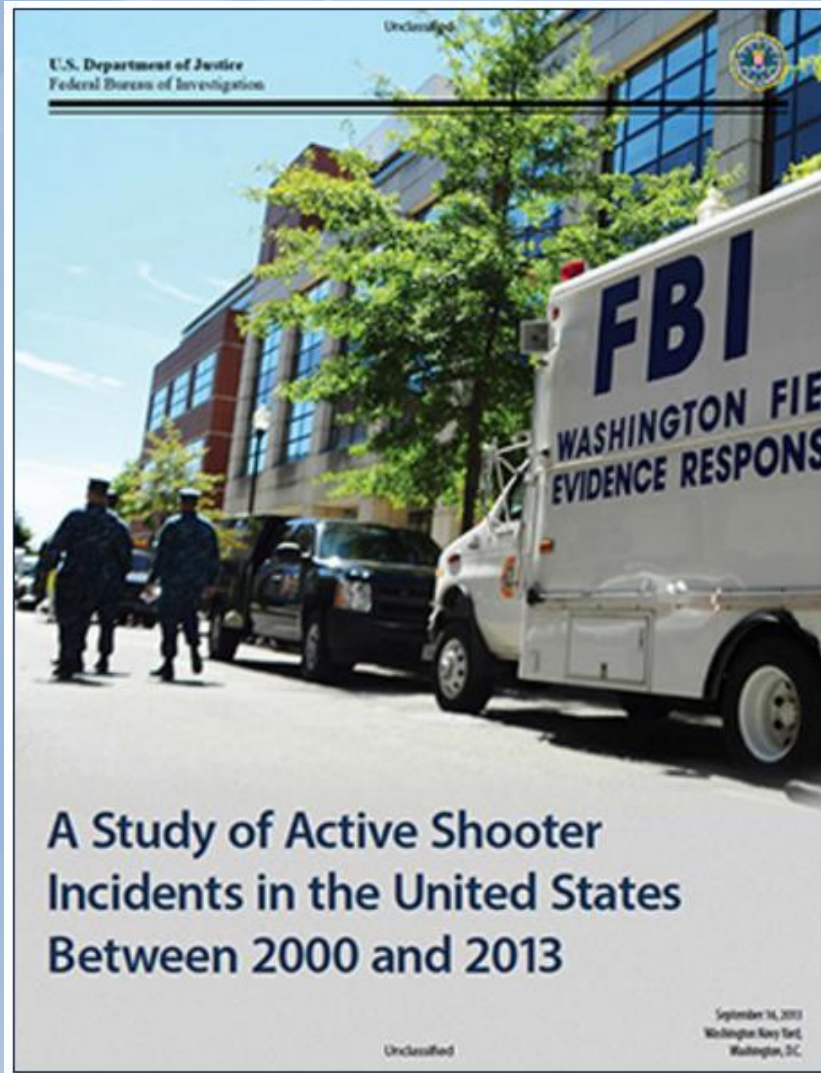
Section One: *Understand the Hazard*



Shootings in Hospital & Health Care Settings

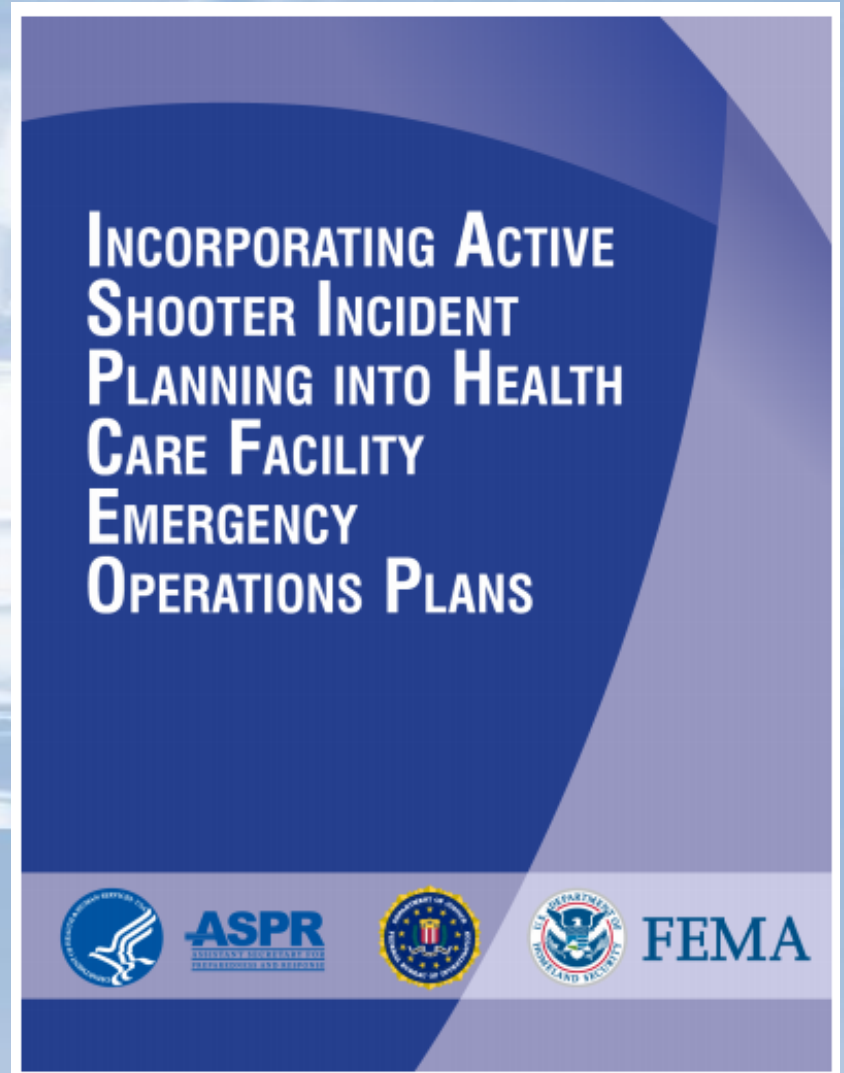
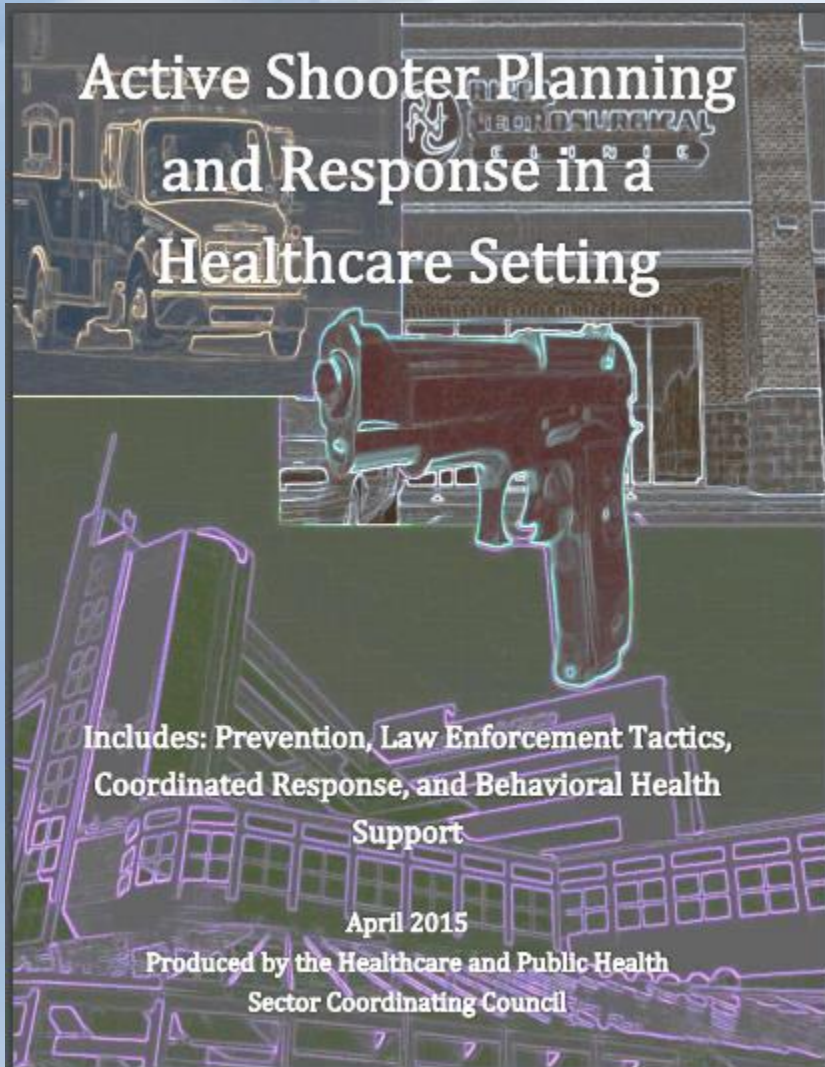
Primary Resources:

General Active Shooter Guidance



Primary Resources:

Specific Hospital/Health Care Guidance



An Important Distinction:

Active Shooter vs. Shooting Incident

- “Active Shooter is a term used by law enforcement to describe a situation in which a shooting is in progress and an aspect of the crime may affect the protocols used in responding to and reacting at the scene of the incident.” (FBI, 2015)
- The U.S. Department of Homeland Security defines an Active Shooter as, “an individual actively engaged in killing or attempting to kill people in a confined and populated area.” (DHS, 2013)
- In these pre-planned (predatory=“cold blooded”) events, the Shooter has prepared to injure and kill as many people as possible before he is stopped.
- Active Shooter incidents average 12 minutes in duration; During this events, on average another person is shot every 15 seconds.
- 69% are over in 5 minutes or less. 60% end prior to arrival of Law Enforcement personnel.

An Important Distinction:

Active Shooter vs. Shooting Incident

- A Shooting Incident is typically spontaneous and emotionally driven (affective=“hot blooded”) rather than predatory (i.e., not pre-planned).
- These unplanned events are often opportunistic or angry reactions. They include:
 - A shot fired in hospital or health care setting
 - An accidental discharge of a weapon
 - A gun fight between two or more individuals
 - Other scenarios
- It is important when notifying police and initiating a response that this difference is kept in mind.

Hybrid Targeted Violence (HTV)

- HTV is defined as the use of violence, targeting a specific population, using multiple and multifaceted conventional and unconventional weapons and tactics.
- The HTV attackers often target several locations simultaneously.

Frazzano, Tracy L., and G. Matthew Snyder. "Hybrid Targeted Violence: Challenging Conventional "Active Shooter" Response Strategies." *Homeland Security Affairs* 10, Article 3 (February 2014). <https://www.hsaj.org/articles/253>

Examples of HTV Incidents

Examples include:

- Beslan School Siege
- Mumbai Siege
- Westgate Mall
- Paris Attacks
- Boston Marathon
- San Bernardino



While HTV attacks are not exactly new, or unheard of in the U.S., intelligence estimates show that international extremist groups are very interested in initiating, supporting and inciting this kind of attack on American soil.

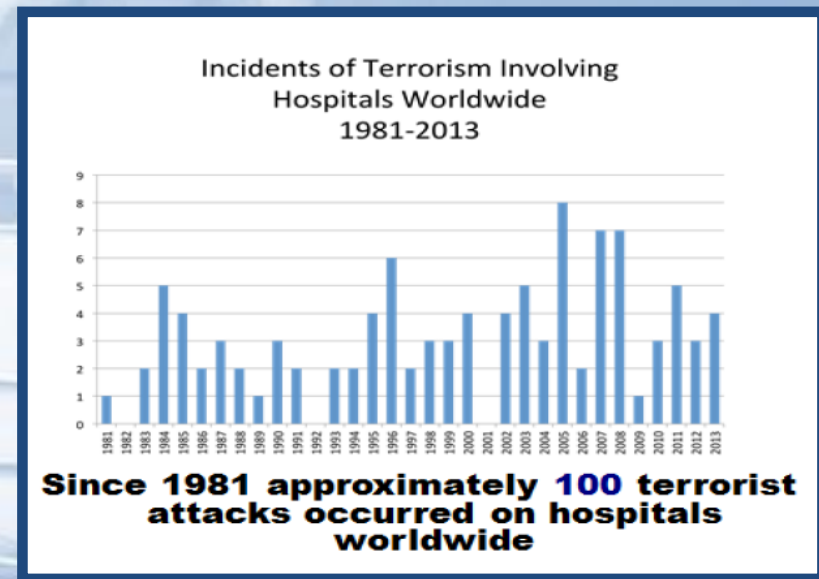
Elements of HTV

HTV attacks differ from the more common Active Shooter incidents:

- Well-trained, tactically competent, and willing-to-die perpetrators.
- Multiple operators (attackers) working in small tactical units.
- Effective internal and external communications/coordination.
- Purposeful luring of first responders to inflict even more carnage.
- Use of fire to complicate first-responder operations and cause further damage.
- Potential use of CBRN agents.
- Use of high-powered military type weapons and explosives, including suicide bomb vests.

Terrorist Attacks on Hospitals

- Approximately 100 terrorist attacks have been perpetrated at hospitals worldwide, in 43 countries on every continent, killing 775 people and wounding 1,217 others.
- Hospitals are an attractive primary or secondary targets.
- An attack on a hospital can distract Police and EMS from the primary target of attack, and also confound the removal and treatment of the wounded from the site of the primary attack.



International Institute for Counter-Terrorism: "Terrorist Attacks against Hospitals: Case Studies." Oct. 2013.

Nightmare Scenario:

Any Shooting Incident

The large number of patients, visitors and medical staff on hand in hospitals and health care settings mean that a shooting incident may produce multiple casualties.

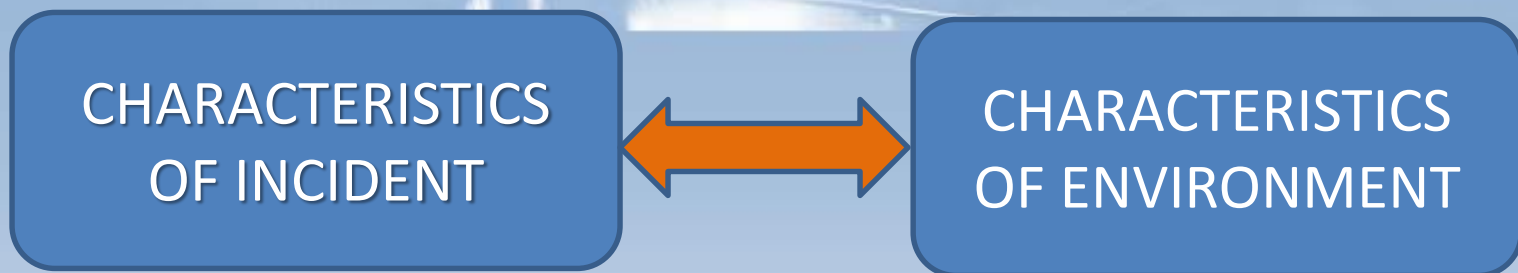
A true “Active Shooter” (i.e., seeking maximum casualty count) in a healthcare setting is a nightmare scenario.

Hospitals and healthcare settings are:

- Soft targets
- “Target rich” environments
- A defined Critical Infrastructure sector with cascading effects when disrupted

Active Shooter Incidents in Hospital/Health Care Are Different

- Active Shooter incidents in healthcare facilities present unique challenges; healthcare professionals may be faced with a decision about leaving patients; visitors will be present.
- Patients or staff may not be able to evacuate due to age, injury, illness, or medical procedures in progress.
- Complexity of environment/ Areas of Special Concern.
- Different in characteristics of shooting incidents.



Ethical Challenges

- Healthcare professionals have a **Duty to Care** for the patients for which they are responsible.
- Since Active Shooter scenarios are highly dynamic, some ethical decisions may need to be made to ensure the least loss of life possible.
- **Every reasonable attempt to continue caring for patients must be made**, but in the event this becomes impossible without putting others at risk for loss of life, certain decisions must be made.



Special Patient Areas

- Prisoners/Forensics Units
- High Profile Patients/VIPS
- Behavioral Health Units
- Others



Special Areas of Consideration

- Emergency Department (ED)
- Operating Room Suites (OR)
- Neonatal Intensive Care Units (NICU) & Newborn Areas
- Intensive Care Unit (ICU)
- Radiation Laboratories, Nuclear Medicine, and Other Radiation Areas
- Infectious Disease/Quarantine Areas
- Biohazard Areas and Laboratories
- Medical Gases
- Kitchen Areas
- Pharmacies



Special Areas Example:

MRI Suites



There have been instances of officer's firearms pulled from their hands or holsters, hitting MRI machines, and in some situations, discharging.

- The Missile Effect is the tendency of the extreme strength of contemporary MRI magnets to draw ferromagnetic materials into the center of the magnet.
- Iron-containing materials, including steel, can be drawn to an MRI with such force that they become airborne, **accelerating at speeds of up to 40 miles per hour.**
- This effect has frequently and repeatedly resulted in accidents jeopardizing the safety of patients and staff, as well as the MRI equipment itself.

Hospital Shooting Incidents: *A Closer Look*

“Hospital-Based Shootings in the United States: 2000-2011.”
(Johns Hopkins, 2012)

- 40 states
- 154 hospital-related shootings in 148 hospitals
 - 235 injured or killed
 - In first six years: Averaged 9 incidents/year
 - In last six years: Averaged 16.7/year

Consistent with
non-hospital
trends.

Size Matters

- 51% of U.S. hospitals have 100 or less beds: 13% of shootings.
- 40% of U.S. hospitals have 100-339 beds: 53% of shootings.
- **9% of U.S. hospitals have 400 or more beds: 34% of shootings*.**
(*highest incidence of shootings: 99.8 events/1,000 hospitals.)

A Closer Look: *Locations*

- 59% inside of the hospital
- 41% outside of the hospital
- Most common locations:
 - Emergency Department (29%):
Almost a third of the incidents
 - Parking Lots (23%)
 - Patient Rooms (19%)



A Closer Look: *The Shooter*

Shooter:

- 91% male (compared to 96% male in NYPD study of general population)
- Represented all age groups 18>80+ y.o.; Shooters in ED settings tended to be younger

Motives:

- Grudge/Revenge (27%)
- Suicide (21%)
- Ending life of ill relative (14%)
- Escape attempt by prisoner (11%)
- Societal violence (9%)
- Mentally unstable patient (4%)



A Closer Look: *The Victims*

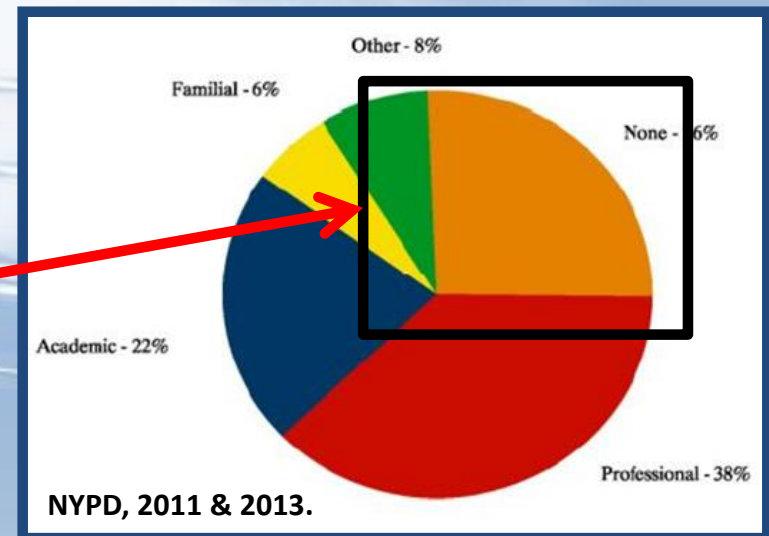
- The majority of incident had only 1 victim
- 10% of incidents had 3 or more
- 55% were “innocent victims”
- 45% were the perpetrators (59/84 by suicide)
- 13% were patients
- 5% nursing staff
- 3% physicians



Closer Look:

Relationship Shooter to Victim

- Most incidents involved a determined shooter with a specific target.
- **Most Shooters had a personal relationship with the victim(s).**
 - 32% Current/Estranged intimate relationships
 - 25% Current/Former patients
 - 5% Current/Former employees
 - 13% No obvious association
- In non-hospital settings, 26% of victims have no prior relationship with the shooter.
- Hospital shootings are targeted and personal;
- Non-hospital shootings are more random and are not based on personal grudges.



Section Two:

Understand the Defense



Shootings in Hospital & Health Care Settings

Workplace Violence Continuum



Active Shooter or mass shooting incidents in the workplace are a possibility but are statistically rare and represent the most extreme type of workplace violence.

Responsibilities of Employers

OSHA: General Duty Clause:

(1) shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees;

The JCAHO and state regulatory authorities, as well as best practices and industry standards, also play a role in establishing such responsibilities.

Note: Hospitals may be held legally liable in the wake of active shooter incidents in the event that the “security plan, training, or actions was negligent.”

Hodge JG Jr, Nelson K. Active shooters in health care settings: prevention and response through law and policy. J Law Med Ethics. 2014;42(2):268-271.

Type I: Criminal Intent

- Perpetrator has no legitimate business relationship with the establishment.
- Primary motive: theft.
- Deadly weapon used, increasing the risk of fatal injury.
- Workers who exchange cash, work late hours, or work alone at greatest risk.
- **85% of all workplace homicides are Type I.**
 - Robbery, shoplifting and trespassing incidents that turn violent.



Areas handling medications and/or cash are higher risk for Type I incidents.

Type II: Customer/Patient



- Perpetrator is a customer or patient of the worker or employer.
- Violence occurs in conjunction with worker's normal duties.
- Some jobs have an increased level of risk.

Healthcare and social service workers are almost **four times more likely to be injured** as a result of violence in the workplace than the average private sector employee.

-Bureau of Labor Statistics, 2013

Type III: Worker-to-Worker

- Perpetrator is an employee or former employee.
- Motivating factor is often interpersonal or work-related conflicts, losses or traumas, and may involve a sense of injustice or unfairness.
- Type III violence accounts for about 7% of all workplace homicides.
- Managers and Supervisors are at greatest risk of being victimized.



Type IV: Intimate Partner

- Domestic violence in the workplace.
- Perpetrators not employees or former employees.
- Women more often targets; men more often perpetrators.
- Risk of violence increases when one party attempts to separate from the other.



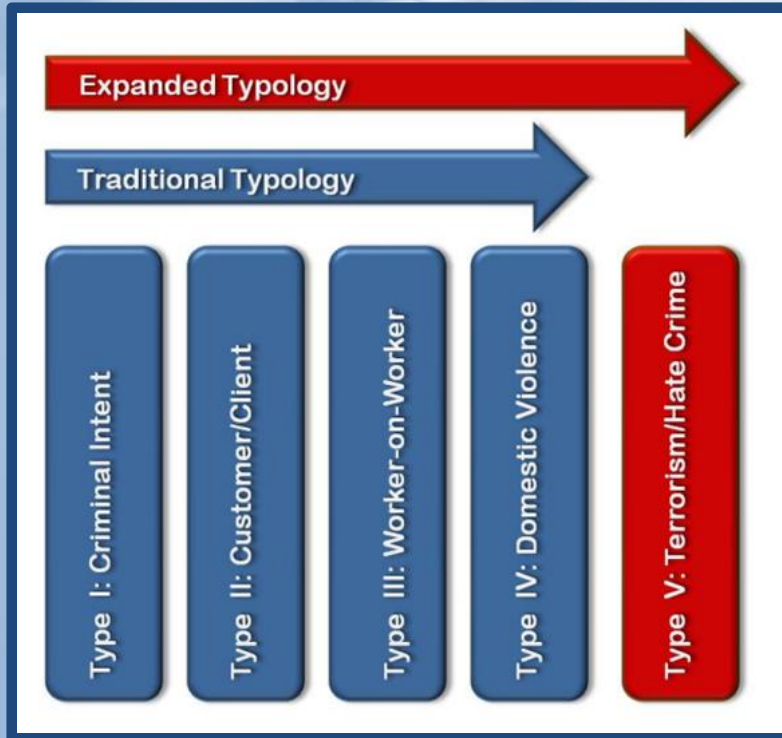
Type V: Ideological Violence

- Violence directed at an organization, its people, and/or property for ideological, religious or political reasons.
- Violence perpetrated by **extremists**; environmental, animal rights, and other value-driven groups may fall within this category.
- Target selection is based rage against what the targeted organization does or represents.



The recent shooting incident at a Planned Parenthood facility in Colorado Springs is an example of Type V workplace violence.

Benefits of an Expanded Typology



More representative of our current situation.

- Creates understanding that some extremist-driving violence may be directed at the workplace.
- Allows for more inclusive training:
 - Warning signs of workplace violence and
 - “Seven Signs of Terrorism”
- Promotes “force-multiplier” effect with more eyes and ears.

Work Area Evaluation

- What happens in the ED can be radically different than what happens in the ICU in terms of violence potential.
- Different areas of the health care and hospital settings have different degrees of exposure to the various types and sources of violence.
- Different areas within any given health care or hospital facility may have different degrees of exposure to different risks.
- To optimize preparedness, response and recovery capabilities, **each area requires its own evaluation, plans and exercises.**

Unique Risks and Resources

While there are benefits to multi-department exercises, each has its own unique risks and resources:

- **Risks:**

- Who are the most likely perpetrators?
- Who are the most likely victims?
- What are our unique challenges (e.g., moving patients, behavioral challenges, etc.)

- **Resources:**

- Exits and escape routes
- Safe or Shelter Rooms
- Areas of cover or concealment
- Unique improvise weapons for “Fight” response



Bystander Intervention:

Stop the Killing

- Unlike other violent crimes, the **active** aspect of an Active Shooter incident inherently implies that both law enforcement personnel and citizens have the potential to affect the outcome of the event based upon their responses. (FBI, 2015)
- Staff serves as the first on-scene responders – **are they trained FOR THIS?**
- **REMEMBER: Train employees that Fight is always the LAST RESORT...only if no other options are available.**

Precise Skill Training: *Example-“Fight”*

Employees best address frightening challenges when they have a reasonable degree of:

Concern (Threat)

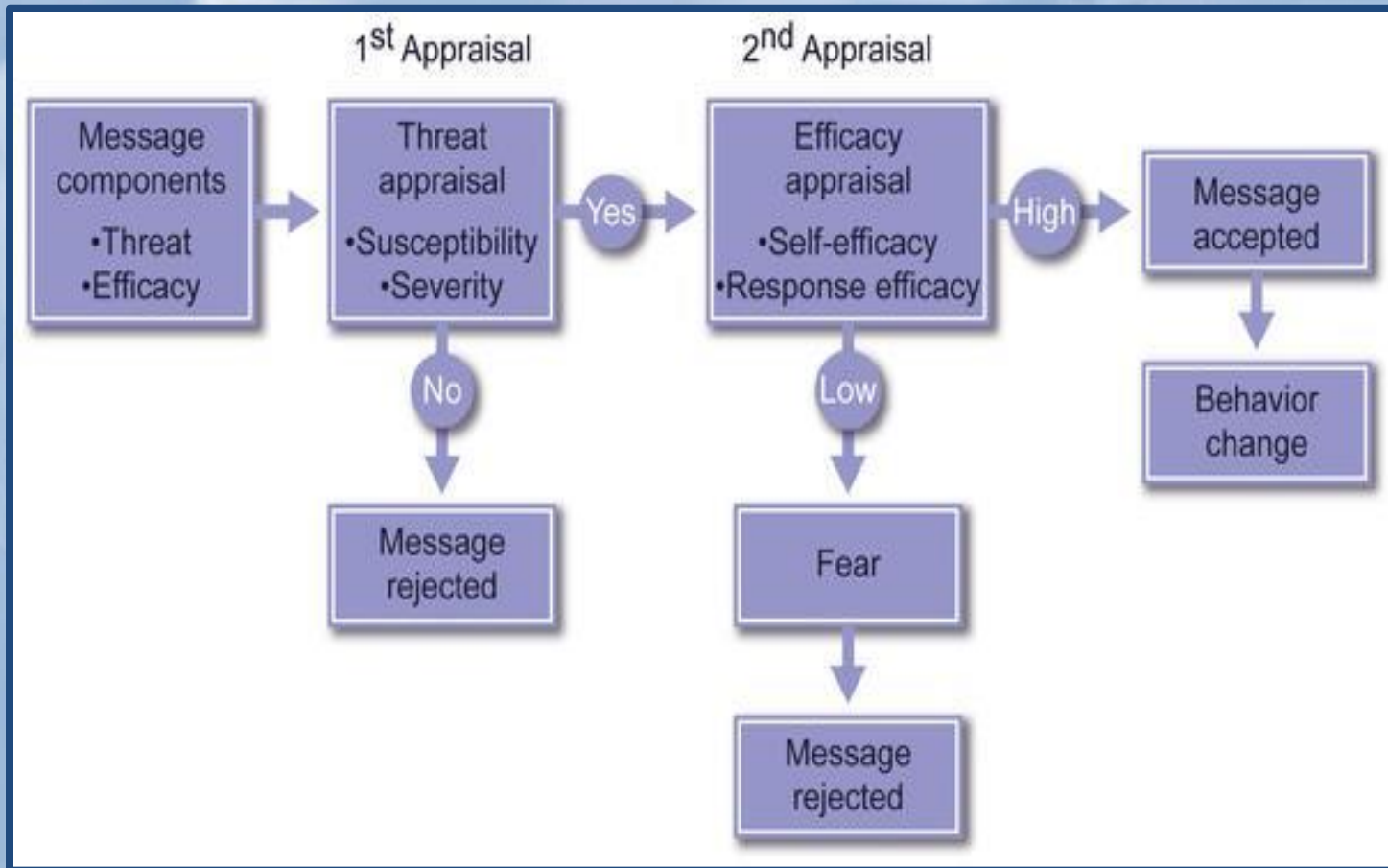
- Severity-How bad/dangerous is it?
- Susceptibility-Does it threaten me?

Confidence (Efficacy)

- In self
- In the organization’s ability to respond

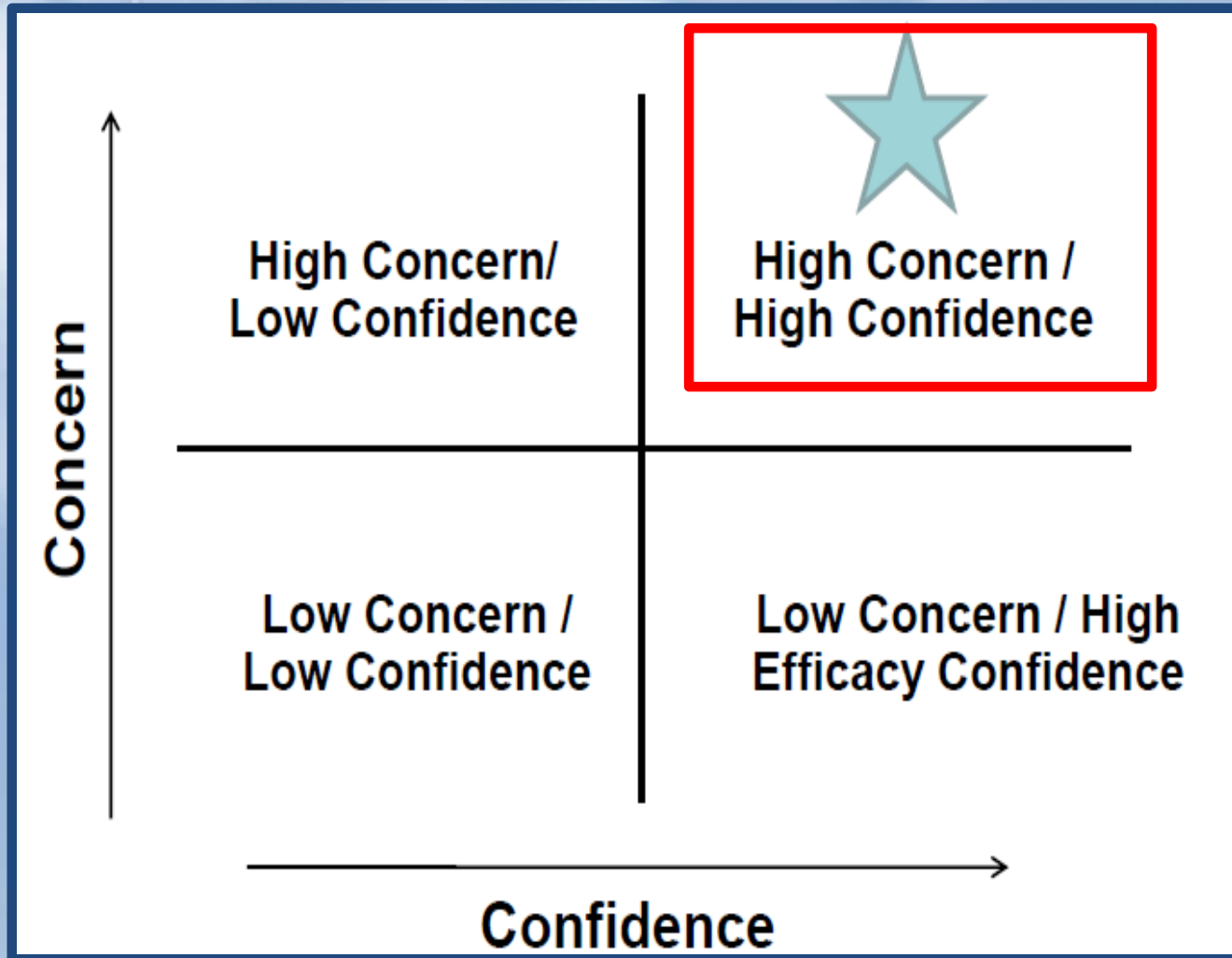
(Witte, K., 2000)

Threat Control vs. Fear Control



Research demonstrates people go through a sequential appraisal process in decision-making related to crisis response.

Response Categories



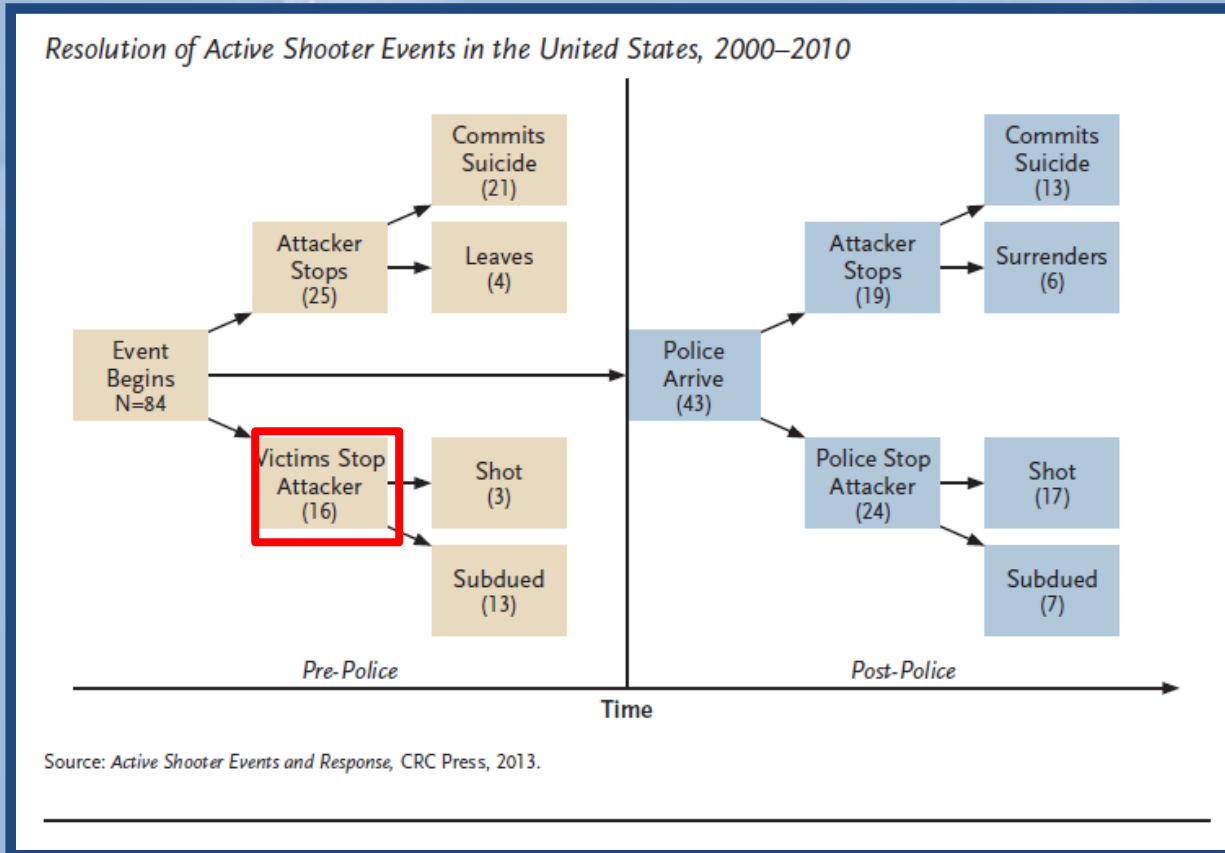
Perceptions & Attitudes

Research participants also indicated significant attitudes including:

- *“My response makes a difference.”*
- *“I can do what is expected of me.”*
- *“I have an important role in the response.”**

* Those with perceived “important roles” declared substantially higher rates of participation

Bystander Intervention



Bystanders are your initial First Responders positioned to Stop the Killing.

Even when law enforcement was present or able to respond within minutes, civilians often had to make life and death decisions, and, therefore, should be engaged in training and discussions on decisions they may face.

Training to Fight

Fight means:

- **Distract**: Interrupt the Shooter's focus.
- **Disrupt**: Interrupt the Shooter's momentum/rhythm.
- **Disarm**: Interrupt the Shooter's access to weapons.

Many of those you train will have no prior experience being near or touching a firearm. Teach them to push the weapon:

DATTS: Down, And to The Side

Not up or Straight Down

Use Teams
Use Improvised Weapons
Use Surprise



Bystander Intervention: *Stop the Dying*

- **National Average:** It takes approximately 7 to 15 minutes for first responders to reach the scene and often longer for them to safely enter and start treating patients.
- Victims who experience massive trauma don't have that much time and can often bleed to death in as little as three minutes.



Bystander Intervention: *Stop the Dying*

OLD SCHOOL

- Stage-and-Wait (No EMS or fire response until scene is completely secure)
 - **How long will it take to completely clear and secure a scene?**
 - **What happens to the victims?**
- Access by EMS, in some cases, could take up to 30 minutes before initial patient contact – likely longer.
- Mortality rates are high as patients “bleed out” prior to medical contact while our resources are waiting in staging.
- “One size fits all” mentality regarding response and treatment could result in a mass fatality instead of mass casualty.

An Accurate Picture of Casualties



The most common cause of preventable death in an active shooter incident is the failure to control severe bleeding.

- A high percentage of victims will have head wounds.
- **90% of deaths occurred prior to definitive care***
 - 42% immediately
 - 26% within 5 minutes
 - 16% within 5 – 30 minutes
 - 8-10% within 30 minutes to 1 hour
- **Golden Hour** – most die within 30 minutes of injuries that require simple interventions

*Matthew Dreher, “The Active Shooter and Your Quick Response

Departments Must Train Citizens to be First Responders During Active Shootings

DECEMBER 3, 2015

By **Justin Baumgartner**, *Faculty Member, American Military University*

Fourteen people are dead and 17 more are reportedly wounded in San Bernardino, California after the deadliest mass shooting in the United States since the 2012 Sandy Hook school shooting in Connecticut. The most recent [FBI Active Shooter Survey](#) reports that such active shooter events are on the rise. To help prepare a community for an active shooter event, public safety agencies must first change the definition of who is considered a first responder.

The Glendale Police Department conducts an active shooter training program based on the [Run Hide Fight Treat](#) program, which was developed in partnership with the Denver Health Paramedic Division. This training is typically a 4-to-8 hour session, which trains citizens how to protect themselves and safely help the wounded through:

- Hands-on utilization of tourniquets
- Packing gauze in simulated wound channels
- Applying proper pressure on a simulated wound to form a life-saving clot
- Utilizing the jaw thrust maneuver to address potential airway obstructions

The Case for B-CON (*Bleeding Control*)

- The incident doesn't end with "Shooter Down."
- Depending upon the magnitude of the event, law enforcement may need to search, clear and secure every part of the facility.
- Envision the immediate post shooting environment and the response gap.
- Casualty **throw kits** and **wall mounted kits** within potential critical target facilities (similar to AED allocation)
- **Shift from Stopping the Shooting to Stopping the Dying.**

Pre-positioning Civilian B-CON Kits

Wall Kit



Carry Kit



Throw Kit



- Designed to provide bystanders and initial first responders with quick and easy access to essential medical equipment for stopping life-threatening bleeding.
- Throw Kit contains illustrated instructions that take the user through step-by-step procedures to ensure proper care and device application based on what they observe for injuries.

Rapidly Deployable B-CON Throw Kits



- High-Resolution Instructional Card
- Tourniquet
- Occlusive Trauma Bandage
- Petrolatum Gauze
- Tape Board
- Emergency Blanket
- Casualty Marking Card

Rapidly Deployable Emergency Notifications

- Incidents evolve quickly; Time is of the essence.
- Valuable moments are lost if people are milling around in confusion and panic, leaving them vulnerable and exposed.
- Communication that is clear and actionable can help avoid a dangerous event unfolding.
- There's nothing better to foil a shooter than to take away their targets.



Plain Language Messaging

- Authorities (i.e., DHS, FBI, others) suggest **Plain Language** and not code words for Active Shooter incident notification.
- Research shows people do not panic when given clear and informative warnings; They want accurate information and clear instructions on how to protect themselves in the emergency.
- Not everyone will understand a code system, and so plain language warnings and clear instructions should be given to make sure everyone in danger understands the need to act.



Rapid Psychological Support

- It is also important to manage psychological trauma as early as possible.
- Emotional reactions can make someone part of the problem, instead of the solution and put themselves and others at risk.
- Psychological First Aid is intended for the 0-48 hours of an incident. It is ideal for active crisis scenarios.



From “Run > Hide > Fight”

“Psychological first aid (PFA) refers to a set of skills identified to **limit the distress and negative behaviors** that can increase fear and arousal.” (National Academy of Sciences, 2003)

A Distinction: Psychological First Aid vs. vs. Mental Health First

- PFA is intended for anyone experiencing an overwhelming emotional response to a disaster or emergency, with or without a pre-existing mental health condition.

Both are “every person” skills sets. Just as you don’t have to be a doctor, nurse or EMT to use basic medical first aid, you don’t have to be a mental health professional to use PFA.



- MHFA is intended primarily for individuals with a pre-existing psychiatric conditions experiencing a psychiatric emergency.

Take Aways

When planning for Active Shooter Incident Management in Hospitals and Health Care Settings, remember:

- That these are complex and different settings, with special units, special populations and special responsibilities for patient care.
- The nature of Shooters and Shooting Incidents in these settings is different in significant ways that should inform planning, exercising and response.
- Develop compressive violence & response plans (all 5 types).
- Conduct specific work area evaluations.
- Provide precise skill training:
 - Bystander Intervention
 - B-CON
 - Psych First Aid
- Pre-position critical supplies
- Pre-develop critical messages and communications



THANK YOU

For More Information



BEHAVIORAL SCIENCE APPLICATIONS

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888-404-6177

New York Metro Area

917-289-1186

Email:

info@behavioralscienceapps.com

Web:

www.behavioralscienceapps.com



Solutions for Unified Critical Communications



Scenario: Active Shooter

Everbridge Incident Communications

February 2016

Incident Communications – New Incident Workflow

2-Step Process

- **Step 1 – Enter information**
- Step 2 – Review and send

Client administrator customizes:

- Menu of available templates
- Content of template to meet communication goals
- Information user must enter for the message
- User permissions for each template
- Templates available to specific users

The screenshot shows the Everbridge 'New Incident' workflow. The top navigation bar includes 'Dashboard', 'Universe', 'Notifications', 'Incidents' (highlighted), 'Contacts', 'Reports', and 'Settings'. The breadcrumb trail is 'Incidents > New Incident'. The main heading is 'New Incident' with a sub-heading 'Step 1 (of 2) - Select incident & enter details'. A sidebar on the left lists incident types: 'Active Shooter' (selected), 'Active Shooter - Responders', 'Active Shooter - Staff and Visitors', 'Crisis Management Event', 'Fire', 'Medical Incident', 'Security Incident', and 'Vehicle Accident'. The main content area is titled 'Active Shooter - Responders' and contains the following fields:

- * 1 Campus Location: A dropdown menu with 'Outpatient Clinic' selected.
- * 2 Number of Suspects: A text input field containing '1'.
- * 3 Shooter Description(s): A text area containing 'Female. Caucasian. 5 feet 5 inches tall. 25 to 30 years old. Long dark hair. Blue jacket. Black pants.'
- * 4 Shooter Last Known Location: A text area containing 'In lobby and moving toward nurse station in rear.'
- * 5 Next Update: A text input field containing 'as available'.

A 'Next >' button is located at the bottom right of the form.

Incident Communications – New Incident Workflow

2-Step Process

- Step 1 – Enter information
- **Step 2 – Review and send**

Client administrator can set permissions to allow users to:

- Edit Message
- View or edit list of Contacts
- View or edit message settings

The screenshot shows the Everbridge interface for creating a new incident message. The top navigation bar includes Dashboard, Universe, Notifications, Incidents (active), Contacts, Reports, and Settings. The breadcrumb trail is Incidents > New Incident. The main heading is "New Incident" with a sub-heading "Step 2 (of 2) - Incident Review and Send Notification".

On the left, a sidebar menu lists incident types: Active Shooter (selected), Active Shooter - Staff and Visitors, Crisis Management Event, Fire, Medical Incident, Security Incident, and Vehicle Accident.

The main content area is titled "Active Shooter - Responders" and contains the following fields:

- Sender E-mail Address: Security Desk
- Sender Caller ID: United States:8182309775

The "Create Message" section includes:

- High priority message
- * Title: Active Shooter - NEW ALERT
- Body: Hide list of variables. The body text reads: "This is an active shooter alert. Move to your safety area, clear all corridors and stair, and stop all elevators. Shooter was seen near Outpatient Clinic and last known location is reported in lobby and moving toward nurse station in rear. Witnesses reported 1 suspect(s). Shooter description is Female, Caucasian, 5 feet 5 inches tall, 25 to 30 years old, Long dark hair, Blue jacket, Black pants." Estimated # of SMS: 4.
- Include a Voice Recording
- Message type: Standard, Polling, Conference Bridge
- Attach Files

At the bottom, a summary table shows the number of recipients for each category:

*Always send to these contacts			
1	0	0	0
Individuals	Groups	Rules	Map

There is a "Preview contacts" link next to the "Map" column. At the bottom, there is a checkbox for "CLOSE incident after successful send" and three buttons: "Send", "< Back", and "Cancel".

Incident Communications – Select Contacts from Map

- Separate template for staff and visitors with shorter message.
- Post message to CCTV or digital signs.
- Use map to include map-based contacts such as off-campus locations or surrounding businesses.

Incidents > New Incident

New Incident Step 2 (of 2) - Incident Review and Send Notification

Active Shooter

Active Shooter - Responders

Active Shooter - Staff and Visitors

Crisis Management Event

Fire

Medical Incident

Security Incident

Active Shooter - Staff and Visitors

Sender E-mail Address: Security Desk
Sender Caller ID: United States:8182309775

Create Message

High priority message

* Title
Active Shooter - NEW ALERT

Body

Hide list of variables

This is an active shooter alert. Move to your safety area, clear all corridors and stair, and stop all elevators.

Shooter was seen near Outpatient Clinic and last known location is reported as Clinic lobby and moving toward nurse station..

Email/Fax: 2193, SMS: 53, Estimated # of SMS: 3

Include a Voice Recording

Message type:
 Standard Polling Conference Bridge

[Attach Files](#)

Publishing Options

Alertus Web Posting

Web Posting

*Message title and body will be posted to the selected page(s).

*Always send to these contacts

1	0	0	3
Individuals	Groups	Rules	Map

[Preview contacts](#)

CLOSE incident after successful send

[Send](#) [< Back](#) [Cancel](#)

END

Note:

Presentation slides will be available on our blog at blog.everbridge.com

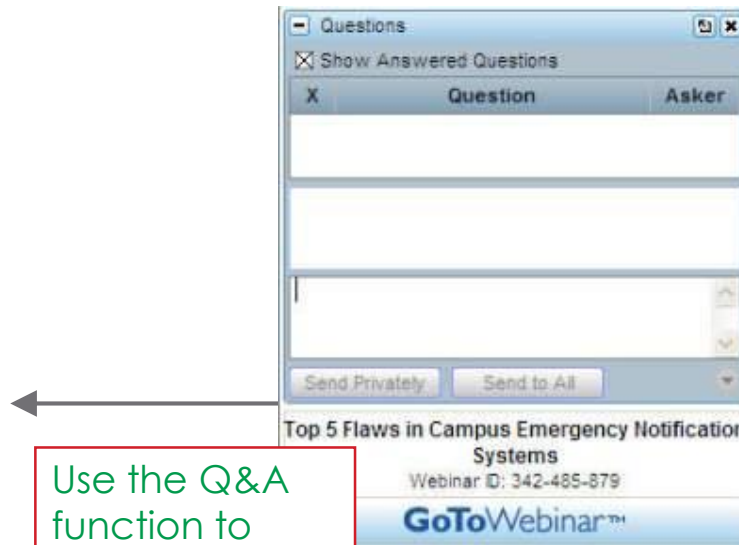
Questions?

Contact Us:

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818-230-9700



Use the Q&A function to submit your questions.

Thank you for joining us!

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