RESPONDING TO A MARAUDING TERRORIST ATTACK:

JOINT OPERATING PRINCIPLES FOR THE EMERGENCY SERVICES

EDITION 3

JESIP
Working Together – Saving Lives

FOREWORD

The foundations to every multi-agency response are the Joint Emergency Services Interoperability Principles (JESIP). However, responders may need to take additional factors into consideration when responding to marauding terrorist attacks (MTA).

This document contains additional principles, which can be applied when responding to an MTA. These Joint Operating Principles (JOPs) have been developed from the operational experience of the three services, as well as learning taken from attacks, exercises and wider national learning.

MTAs, whilst infrequent, can create significant challenges for the emergency services who respond to them. It is therefore vital that the response is co-ordinated at every level. The three emergency services should respond jointly. I**t is highly likely that there will continue to be injury and loss of life until responders are deployed. Therefore, it is essential that the emergency services respond quickly and dynamically in order to save life and neutralise the threat.**

These JOPs enable commanders and responders to regain the initiative; they are to be used proactively, enabling and empowering the response. The response to an attack may involve responders deploying in situations that contain risks and hazards; commanders and responders should put in place measures to minimise the risk to the public whilst maximising the safety of those responders taking proactive action.

An application of the MTA JOPs, which is built upon a foundation of JESIP, will enable rather than inhibit, the response to marauding attacks. They are principles and not a plan, in recognition of the fact that every incident will be unique and require flexibility from commanders and responders. The JOPs can also be applied in whole or in part to a variety of MTA methodologies, from low to high sophistication.

Regular joint training, testing and exercising of the principles contained within this document will support an effective application during the response to an MTA.

This is a live document, and as such will be periodically reviewed to incorporate learning and provide the most up-to-date guidance. This document supersedes the previous doctrine; *Responding to a Marauding Terrorist Attack: Joint Operating Principles for the Emergency Services edition 2*, published December 2020. The updated sections are marked **purple**.

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INTRODUCTION

1.1 **The joint emergency service response to any incident is based on the Joint Emergency Service Interoperability Principles (JESIP). The response to a marauding terrorist attack (MTA) must therefore follow the core JESIP principles.**

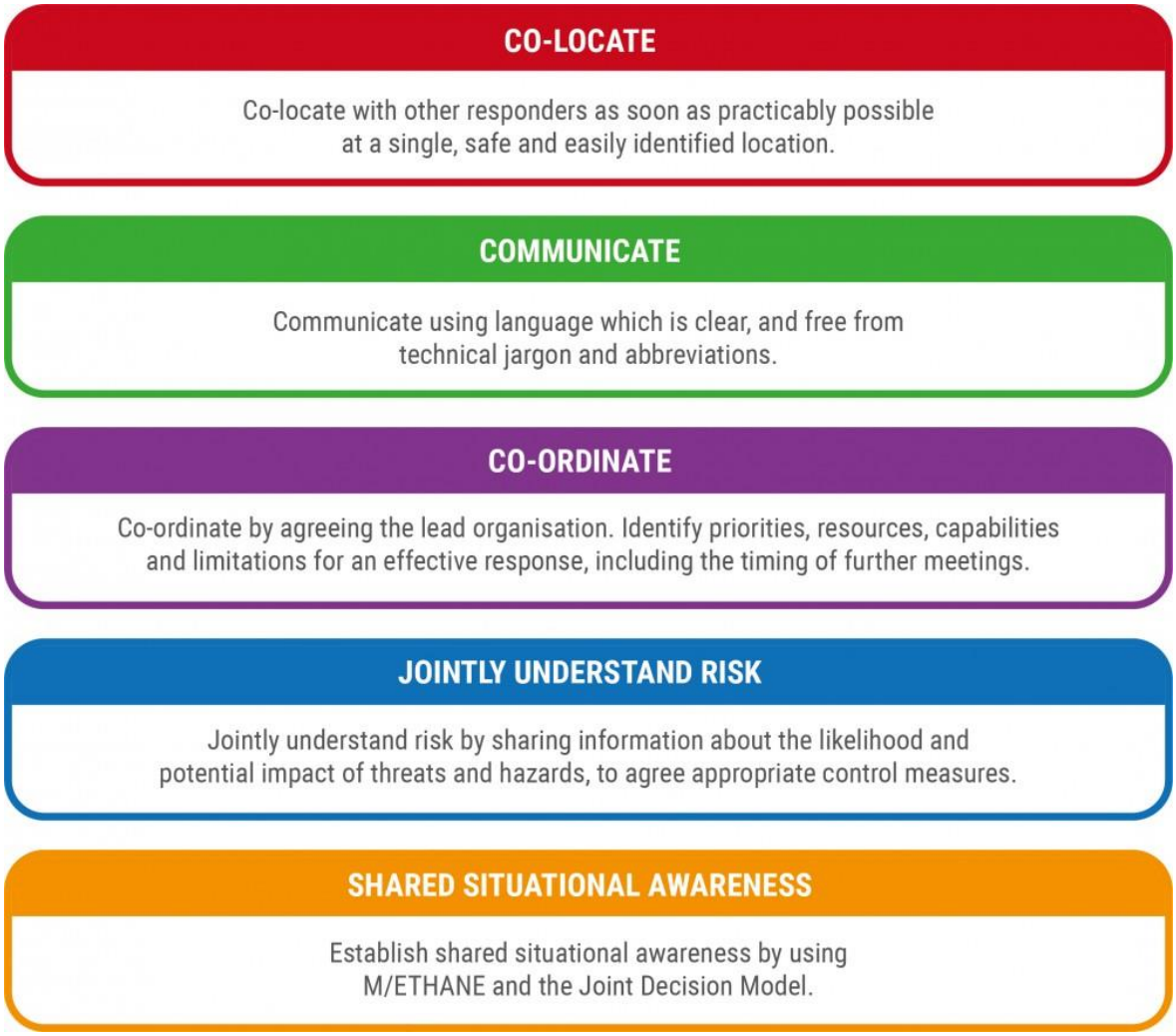


Figure 1. JESIP Principles

1.2 **The Marauding Terrorist Attack Joint Operating Principles (MTA JOPs), which are built upon the foundation of JESIP, are designed to assist the emergency services to deliver a rapid, effective and coordinated multi-agency response to an ongoing MTA, in order to save life.**

1.3 **An MTA may take many forms**. The overarching aim of the emergency services is to rapidly deploy responders to save life by neutralising the threat, delivering emergency medical care and rescuing or removing casualties and survivors. Operational experience has shown that an MTA may be confusing in nature, especially in the early stages. The early stages of an attack are likely to generate conflicting information and a high demand for the emergency services.

1.4 **An MTA will involve an attacker actively and deliberately seeking out new victims.** The 'marauding' element may involve an attacker moving between or within structures or other populated areas searching for victims. It may also include a small number of circumstances where an attacker seeks out new victims with little or no need for such movement; for example,

an attacker discharging a firearm from a vantage point into a crowded area.

1.5 **These principles are not designed specifically to respond to a Chemical, Biological, Radiological, Nuclear and explosives (CBRNe) attack, for which separate CBRNe JOPs exist due to the unique nature of the required response.**[1]

However, attackers may use lower sophistication chemicals as an ongoing attack methodology, which may require an armed response.[2] Therefore, the CBRNe JOPs and Initial Operational Response may be required in conjunction with these principles.[3]

When responding to an explosion where there is no indication of a marauding threat, JESIP should be followed alongside single service guidance covering explosions. These JOPs are only intended for use in response to a **marauding** attack.

1.6 An MTA may include a wide range or combination of methodologies, from lower sophistication to higher complexity attacks. Operation PLATO (see section 1.8) may be declared if a **marauding** terrorist attack involves one or more of the following attack methodologies:

- Bladed weapon
- Vehicle as a weapon
- Fire as a weapon
- Firearms
- Crossbows
- Siege resulting from an MTA
- Chemicals (e.g., acid or alkali)
- Improvised Explosive Devices (IEDs) / grenades

1.7 An MTA may be single or multi-sited, can include single or multiple attackers and may be fast moving with casualties spread over a wide range of locations. There may also be gaps in time and/or proximity between attacks, so commanders and responders should maintain an awareness of potentially linked incidents. Crowded spaces and places, including iconic sites, remain a target for attackers.

1.8 **Operation PLATO is the agreed national identifier for the multi-agency response to an ongoing MTA**. The Operation PLATO declaration is designed to both inform and prepare the emergency services and other stakeholders for the response to an MTA.

An attack that results in the declaration of Operation PLATO is also highly likely to separately be declared a major incident.[4] **The MTA JOPs focus on the inward facing threat mitigation and life-saving activity; the major incident procedures focus on the wider outward facing enabling and supporting functions. It is important that organisations have arrangements in place to ensure that any major incident plans can be implemented concurrently with the PLATO response to deliver an effective response.**

[1] JESIP, 'Responding to a CBRN(e) Event: Joint Operating Principles for the Emergency Services': https://jesip.org.uk/uploads/media/pdf/CBRN%20JOPs/JESIP_CBRN_E_JOPS_Document_On.pdf
[2] For example, the use of an acid spray to attack the public.
[3] Home Office, 'Initial Operational Response to a CBRN Incident': https://collaborate.resilience.gov.uk/RDService/home/121512/IOR-2023
[4] JESIP definition of a major incident can be found at: https://www.jesip.org.uk/joint-doctrine/definitions/

The declaration of a major incident should be shared using a M/ETHANE message.

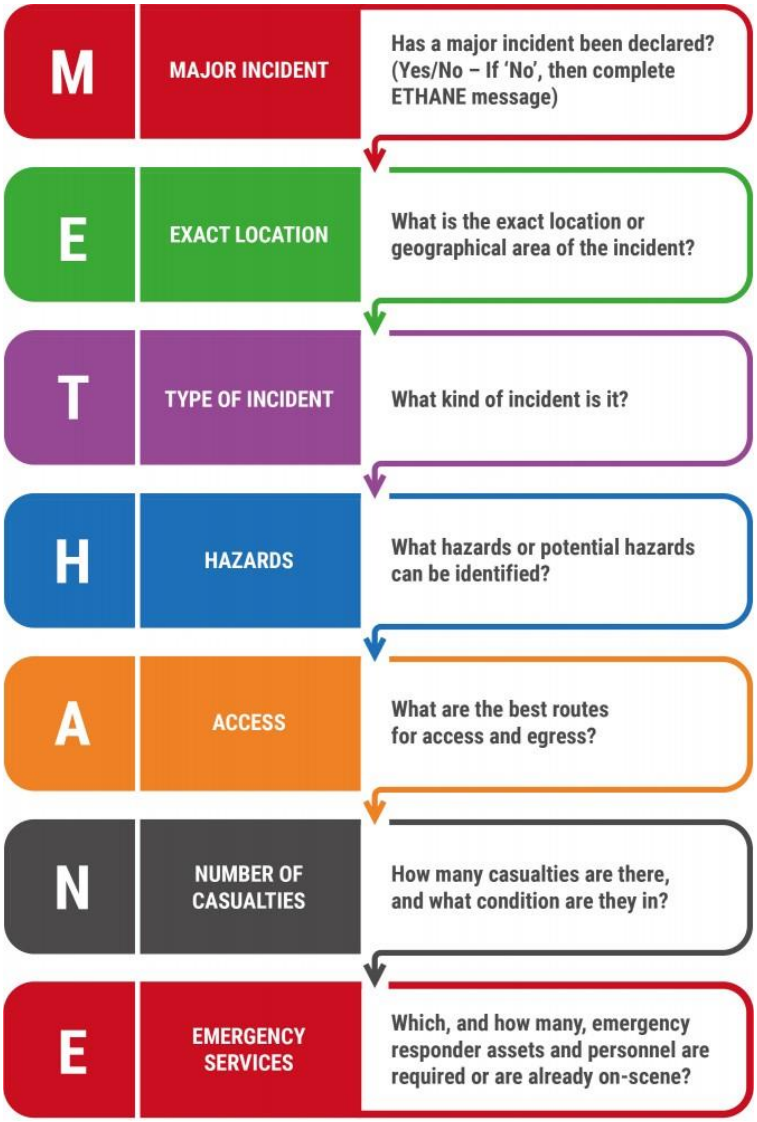


Figure 2: M/ETHANE Model

1.9 It is important that police forces recognise that the declaration of Operation PLATO initiates adoption by the emergency services, of the principles contained within this document. It is not just for the mobilisation of additional armed resources. In response to an MTA, the declaration of Operation PLATO should be made if it is believed that one or more of the following measures is required:

- That the MTA JOPs will be used by the emergency services
- Activate and coordinate the response from emergency service partners (including the mobilisation of specialist responders)
- Prepare responders and commanders for the nature of the threat ("mind-set" preparation)
- Mobilise regional or national armed resources and/or specialist military assets
- Mobilise the national Counter-Terrorism Policing network and partners (including central coordination, intelligence and investigative functions).

1.10 An Operation PLATO declaration will signify to the emergency services:

- An MTA is believed to be underway, and
- The attack methodology requires the implementation of specific measures as detailed within 1.9 above.

1.11 The declaration of Operation PLATO will initiate a multi-agency response to an MTA. These principles provide an adaptable framework to be utilised by emergency service responders and their commanders in delivering a rapid, interoperable, coordinated and effective response. **The police are responsible for the formal declaration of Operation PLATO.**

There may be occasions when a declaration of Operation PLATO is not required as it is assessed that the MTA incident can be effectively dealt with under business as usual arrangements (and there is no requirement for the implementation of any of the measures detailed at 1.9 above). For example, it may be that the threat is not deemed as ongoing, or it is immediately clear that it is a single, small-scale incident.

Where it is assessed that a declaration of Operation PLATO is not required, consideration should still be given to sharing relevant information with the other emergency services via a M/ETHANE message (see section 1.8) to enable shared situational awareness.

Marauding attacks may include those which are not motivated by terrorism (e.g., personal disaffection with an employer).

- **If the attacker's motivation is not known, then Operation PLATO should be declared** and some or all of the principles contained within this document should be used as determined by the relevant commanders.
- **If it becomes known that the attacker's motivation is not terrorism, then the Operation PLATO declaration should be rescinded** and plain speech should be used to share information about what is taking place (and the response required, which may include some of the principles contained within this document).

2. JOINT OPERATING PRINCIPLES

2.1 The following elements will enable the saving of life and an effective response to an MTA:

- Identification of a marauding terrorist attack
- Declaration of Operation PLATO and confirmation of attack methodology
- Control room actions
- Mobilisation
- On-scene activity, including command and coordination, incident zoning (if required) and deployments for casualty, fire and hazards management
- Tactical and strategic arrangements.

These JOPs provide guidance for emergency services in responding to an MTA. They are designed to be adaptable and flexible to allow a scalable response for the varied methods of an MTA. This includes the mobilisation of non-specialist and specialist responders.

2.2 The MTA JOPs are founded upon the following assumptions:

- Effective response arrangements and decision-making are underpinned by the principles of joint working as defined in the JESIP Joint Doctrine.[5]
- Joint decision-making should be based upon the Joint Decision Model (JDM).

Figure 3: Joint Decision Model

- Agencies should identify and appoint appropriately trained personnel, with well-rehearsed plans, to carry out key command and support functions.

2.3 National Interagency Liaison Officers (NILOs) undergo specific training to support the response

[5] JESIP, 'The Joint Doctrine: The Interoperability Framework Edition 3': https://www.jesip.org.uk/joint-doctrine/introduction-to-the-joint-doctrine/

to MTA and other terrorist incidents. All NILOs are security vetted, and operational learning from previous attacks and national exercises has demonstrated the benefits of FRS (Fire and Rescue Service) and ambulance NILOs being collocated at the forward command point (FCP) and other command locations.[6]

[6] Further guidance on NILOs can be found on Resilience Direct (account required): https://collaborate.resilience.gov.uk/RDService/home/52834/NFCC-NILO-Guidance-Document

3. IDENTIFICATION, MOBILISATION, COMMUNICATION AND SCENE ASSESSMENT (IMCS)

IDENTIFICATION

3.1 Any emergency service can report a suspected MTA. When doing so, they **must share all relevant information with other emergency service control rooms immediately**.

3.2 **However, only the police can formally declare Operation PLATO. When a declaration is made, this must be shared with other emergency services immediately**. A delay in sharing a declaration is likely to affect the speed and effectiveness of an appropriate response from other services.

3.3 **It is imperative that the declaration of Operation PLATO is accompanied by a clear statement as to the attack methodology used (or suspected of being used) by the attackers.** This must be communicated across all services and will be essential to ensure the most appropriate and proportionate mobilisation of responders.

3.4 Indications that an MTA is occurring might include:

- Multiple calls into the control room reporting attack methodologies, as listed in 1.6
- A surge in social media reporting attack methodologies, as listed in 1.6
- Attackers shouting religious or ideological slogans
- Attackers actively and deliberately seeking out new victims
- Multiple sites of attack simultaneously, in quick succession, or over a more extended period of time
- Reports of attacks at iconic sites and/or crowded spaces or places
- Reports of attacks against notable people/uniformed staff.

3.5 Early and ongoing information sharing between all responders and control rooms using M/ETHANE is essential. This may come from non-specialist responders who may already be on-scene and unaware of the nature of the incident.

3.6 **If Operation PLATO is initially declared but it later becomes clear that the incident is not an MTA, the relevant police commander must clearly re-define the incident, and this must be communicated to all relevant responders and commanders immediately, ensuring continued shared situational awareness.**

MOBILISATION

3.7 **The emergency services priority in responding to an MTA is the rapid deployment of responders to save life**.

This overarching response will be led by the police, who will deploy appropriate resources to save life by identifying, locating and confronting the threat. It is likely the police will be in possession of information and intelligence which will inform a shared understanding of risk, enabling fire and ambulance commanders to make informed decisions to rapidly deploy their staff. Whilst each emergency service will be responsible for deploying its own resources, fire and ambulance commanders should take into consideration the

information/intelligence and threat assessment provided by the relevant police commander.

3.8 During the response, the lead for fire hazards management and rescue will be the FRS, and the lead for casualty management will be the NHS Ambulance Services.

3.9 **The nature of the emergency service response will be determined by the attack methodology and the threat.**

COMMUNICATION

3.10 **As a priority, the police will instigate the pre-planned tri-service communication link between the emergency service control rooms**. **This should be initiated via the relevant Emergency Services Inter-Control Talk-Group (ESICTRL).[7] The link should be kept open and resourced appropriately for the duration of the incident and should not be terminated until all parties agree that it is appropriate to do so.** This line of communication should be robust, resilient, practised and tested regularly.

Control rooms should ensure appropriate processes are in place for key pieces of information or decisions to be readily identified within incident or command logs. Police forces should ensure appropriate communication arrangements are in place to enable commanders from other emergency services to pass information to and from the officer in charge of the police control room (e.g., force duty officer (FDO) or force incident manager (FIM)) as a matter of urgency.

Information shared should include:

- Declaration of Operation PLATO, including a clear description of the attack methodology using plain language and call information.
- Relevant information, including M/ETHANE message
- Location of Rendezvous Point(s) (RVP) and Forward Command Point(s) (FCP)
- Detail of safe approach routes
- Known or believed location and direction of movement of suspects
- Any other information which enables an effective coordinated response.

SCENE ASSESSMENT

Co-location and Coordination

3.11 Effective command requires multi-agency colocation at both a control room/command centre and the scene (RVP and FCP). Any on scene location used by the emergency services should be checked and secured against potential threats, including discarded IEDs, with protection measures implemented as soon as practicable. The security of such locations should be continuously reviewed and communicated between commanders. **However, this activity should not hinder the rapid deployment of responders in order to save life.**

- Control room/command centre:

  During the initial response to an MTA, it is highly likely that the police tactical command function will be discharged from a control room/command centre. As the response grows an on scene police tactical command function(s) will be deployed.

[7] A list of ESICTRL groups can be found on Resilience Direct (account required): JOL Action Notes (resilience.gov.uk)

To ensure a coordinated response with other emergency services, commanders should deploy to both the police control room/command centre and the scene. Over time, a Tactical Coordinating Group (TCG) and/or Strategic Coordinating Group (SCG), as described within the JESIP joint doctrine (see section 2.2), will be established.

- Rendezvous Point (RVP):

  The police control room will, as a matter of priority, liaise with ambulance and FRS control rooms to determine an RVP for the initial response. Once determined, all emergency services will ensure their resources attend at the RVP. The RVP should:

  - Be located in the Cold Zone (see section 4.7)
  - Be easy to locate
  - Enable the rapid deployment of resources and assets to the scene
  - Be of suitable size and configuration to meet the operational requirement
  - Be regularly reviewed by commanders.

- Forward Command Point (FCP):

  Commanders are responsible for identifying a suitable FCP for the deployment of emergency service personnel.

  The FCP should be situated in the Cold Zone. The location of the FCP, as with the RVP, should be regularly reviewed by commanders.

  Dependant on the attack methodology, which may be multi-sited, there may be a requirement for more than one FCP. The location of the FCP(s) may change during an attack. Therefore, it is vital that command and control structures are maintained to ensure coordination of the incident and maximising the safety of emergency service personnel.

  Where an FCP has not yet been established, emergency service personnel may still deploy, following the establishment of a joint understanding of risk by commanders, in order to save life.

4. SHARED SITUATIONAL AWARENESS AND JOINT UNDERSTANDING OF RISK

4.1 Establishing a shared situational awareness and a joint understanding of risk is a continual process. All relevant commanders should be included within that process, with the aim of rapid deployment in order to save life.

A clear command structure is an essential element in delivering an effective response to an MTA. In the initial stages, the police on-scene commander is unlikely to be a tactical firearms commander (TFC). Where this is the case, they will work under the command of the control room TFC until a ground assigned TFC is in a position to assume the role of on-scene commander.

As the response to the incident builds, considerations should be given to the deployment of additional ground assigned police commanders to undertake outer scene command roles such as outer cordons, RVPs, survivor reception centres, etc. This will allow the ground assigned TFC, who is fulfilling the role of on-scene commander, to focus on working with other emergency service commanders to save life and neutralise any ongoing threat.

4.2 The use of the JDM will enable an effective coordinated response by bringing together the relevant information to establish shared situational awareness and joint understanding of risk from the different agencies. This will enable zones and limits of exploitation (LoE) to be set, where appropriate, and decisions made around the use of non-specialist and specialist responders.

4.3 The absence of an on-scene commander from one or more of the emergency services must not delay this process but may impact any deployment decisions. The absence of key information and intelligence at an FCP (or RVP) may affect deployment decisions by FRS and ambulance. **However, every effort must be made to enable rapid responder deployment to save life.**

4.4 Establishing a joint understanding of risk is necessary to ensure that all responders are aware of the nature of the threat and the risks that they may face. Other organisations that have resources deployed to the scene should be involved in establishing a joint understanding of risk; for example, additional responders such as military personnel. Commanders will need to take this into account when developing their plans.

If there is a lack of agreement in respect of risk assessment which is preventing the deployment of responders to save life, clarity should be provided as a matter of urgency by the agency commander who has the most relevant knowledge in order to better inform the risk perception and enable services to deploy appropriately.

ZONING

4.5 **Not all incidents may require zoning or the use of all three zones.** The application of zones, including LoEs, enables commanders to proactively deploy responders to a scene in order to minimise risk to the public whilst providing a basic structure which supports them in maximising the safety of the responders.

Decisions on zoning should be based on the use of the JDM to establish a shared situational awareness and joint understanding of risk, considering the known threat and risk to the public and emergency service responders**.**

The decision to zone the incident is dynamic and based upon attack methodology and the threat. The deployment of responders into zones is based upon the joint understanding of risk and urgent need to save life.

Responder Deployment

The rapid deployment of resources may include both non-specialist and specialist multi-agency responders. Commanders should decide when and how their responders are deployed (informed by the attack methodology) and remain aware of the positive duty to act. The intention to deploy should be to save life by minimising the risk to the public (including the injured) whilst maximising the safety of responders. This rapid deployment to save life should take place unless there is a credible basis to delay such deployment.

4.6 **The zones are defined as:**

The Hot Zone; an area assessed to contain an active and ongoing marauding threat.

The Warm Zone; an area assessed to contain a potential marauding threat.

The Cold Zone; an area assessed to have no known marauding threat or where appropriate control measures have been implemented. Some cold zones will not require any control measures.

REVIEWING OF ZONES

4.7 **The size, location and necessity for zones should be continuously reviewed and every effort should be made to reclassify zones to accurately reflect the constantly evolving threat and risk**. Zones should be no larger than absolutely necessary and their size should relate directly to the attack methodology. For example, where there is a firearms threat, the hot and warm zones may be considerably larger than those for an incident involving a hostile vehicle attack.

4.8 Application of the JDM will determine whether and what zoning is required. The aim should be to move the hot zone to warm and/or the warm zone to cold as soon as practicable.

4.9 As soon as it is confirmed that any threat has been contained or mitigated, this information must be shared immediately with responding organisations to inform decisions concerning zones.

IED THREAT

4.10 Dependent upon information and/or intelligence, on-scene commanders may need to consider the presence of IEDs during the response to an MTA. Where information and intelligence indicate that a continuing viable explosives threat exists, the use of the JDM and these principles will assist commanders in the appropriate deployment of responders to save lives. All options should be explored to enable the rapid rescue and evacuation of casualties from the affected area.

Post / partial IED detonation

- For any “explosion” put in a minimum 100 metre cordon as there may be a remaining explosive hazard. **However, where there are casualties then the situation may be too dynamic to achieve that immediately. The rapid treatment and movement of casualties will remain the priority.**
- Do not touch or move anything you do not have to.
- Move people away from the seat of explosion as quickly as possible (accepting that casualties may make this a slower process).
- Essential personnel may go forward to protect and save life, following a JDM

assessment.

- Utilise any available hard cover.

- Spend the minimum amount of time in the area as possible and keep the numbers to the minimum required to achieve the operational effect.

- Consider the need for respiratory protection measures. Dust, smoke, debris and CBRN hazards may be present.

SIEGE RESULTING FROM AN MTA.

4.11 The use of the JDM and these principles will have direct relevance to the command and resolution of sieges resulting from an MTA. The police terrorist siege doctrine identifies the requirement for a siege tactical commander (STC) to be deployed to a pre-established TCG and for a siege ground commander (SGC) and an outer scene commander (OSC) to operate from an FCP.

4.12 It is the responsibility of the police to declare a siege. Due to the static nature of a siege, consideration should be given to establishing the FCP in a suitable nearby building or structure. The FCP should include suitable areas for each emergency service and their support teams to operate independently.

4.13 However, regular and structured briefings should take place between the SGC and/or the OSC and other emergency service commanders and/or tactical advisors in the development of plans and contingencies. Commanders may identify zones and appropriate LoE to support interoperable working during a siege situation. The area contained by armed officers is likely to be identified as a hot zone, with the area outside the containment likely to be classified as a cold zone.

BRIEFING

4.14 Commanders are responsible for ensuring that responders are briefed as to the threats, hazards, risks and zones (where zones are relevant). Due to the need for rapid deployment, it is preferable that briefings of personnel are conducted jointly, with input from all three services, and follow the JDM.

4.15 The briefing should include as a minimum:

- **Information and Intelligence –** (e.g., M/ETHANE) What, where, when, how, how many?

- **Risk Assessment –** (e.g., what are the known or perceived threats and risks? What Personal Protection Equipment (PPE) is required? Consideration of zoning and LoE)

- **Powers, Policies and Procedures –** (e.g., Casualty Management Plan, Fire and Hazards Plan, Communications Plan)

- **Identification of options and contingencies –** (e.g., deployment of specialist or non-specialist responders, team structure and size, call signs/team identifiers, Casualty Collection Point (CCP) location, lost communications procedure, agreed evacuation signal) What are we trying to achieve, what is the method?

- **Recommend action(s) to take and review what happened –** Decisions and actions must be recorded and reviewed. As information changes or new information becomes available, commanders should continue to use the JDM to inform their decision-making.

- **Preservation of evidence –** All services should be mindful of the preservation of evidence during an MTA.

RECORDING OF DECISIONS

4.16 Commanders should ensure their decisions and supporting rationale are recorded in accordance with their organisations' relevant policies, including any decision to deploy or withhold resources.

5. CASUALTY MANAGEMENT

5.1 This section provides guidance for the management of casualties in response to an MTA. The casualty management principles are applicable and may be utilised for all attack methodologies listed in section 1.6. The NHS Ambulance Service retains the lead responsibility for casualty management, in line with the Ambulance Service's legal duty of care. The ambulance on scene commander is responsible for the elements of the NHS response to an MTA, directly involving deployment of responders and casualty care. They must be provided with command support roles for the wider incident response, such as operational commanders, NILO's and other functional roles as required.

The overarching priority is to save life. The rapid deployment of responders to deliver clinical care is essential to achieving that priority. This creates a presumption that NHS ambulance responders will be deployed forward as quickly as possible and without unreasonable delay.

5.2 Injuries sustained will vary depending on the attack methodology but are likely to be very different to those commonly encountered. Consequently, a different approach to clinical care is required, balancing the potential for high casualty numbers with the availability of responders able to provide lifesaving care. **The quicker casualties are treated and moved from the point of injury to definitive care will affect survival rates.**

5.3 **A range of tactical options are available and should be considered by the ambulance on-scene commander based upon shared situational awareness, joint understanding of risk, use of the JDM and consideration of the attack methodology.**

These include (not hierarchical):

Responder deployment

- Deployment of specialist Ambulance responders with ballistic PPE
- Deployment of non-specialist Ambulance responders
- Deployment of enhanced clinicians and critical care teams

Casualty care

- Immediate removal – to Casualty Loading Point (CLP) and onward transport
- Treat and Leave - including Ten Second Triage (TST)
- Treat and Take - including TST
- Joint working with FRS and police to maximise the resources available and rapidly remove casualties
- Joint working with military medical resources if deployed

Casualty flow

- Establishment of Casualty Collection Points (CCP)
- Establishment of Casualty Loading Points (CLP)

- Establishment of Casualty Clearing Stations (CCS) if required

The tactical options selected should be informed by:

- Assessment of the incident and use of the JDM
- The threat and joint understanding of risk
- Zoning of the incident (if applicable), LoE and cordons
- The number of casualties, nature of injuries, mechanism of injury and location.
- The availability of responders to provide casualty care, including enhanced clinicians and critical care teams. The deployment and location of such teams should follow existing Trust procedures and be coordinated by the Ambulance on scene commander. The location to where they are deployed (such as the CCP) will depend on where they can optimise casualty outcomes.

5.4 **A Casualty Management Plan, which may initially be basic in nature, should be developed before (but not delay) the deployment of responders. This plan should be briefed to all deploying staff, shared with partner agencies and enable rapid deployment and treatment.**

The plan should be continually reviewed and adjusted, with regards to the threat, mechanism, the joint understanding of risk and types of injuries encountered. The plan's primary purpose is focussed on casualties within the scene, and it must enable the rapid deployment to treat such casualties. The plan must work alongside the Ambulance Service major incident response plans and procedures, enabling coordination of all medical resources deployed and the rapid transportation from the scene for definitive care.

As the incident progresses, the plan should be formalised and approved by the Ambulance Tactical Commander as part of the Tactical Plan.[8]

5.5 **The Casualty Management Plan should include**:

- Avoidance of unreasonable delay in the provision of clinical care to casualties
- The selected tactical options
- Initial locations of entry control, CCP/CLP/CCS and clinical equipment dumps
- The areas that teams will deploy to, including zones and LoE
- The anticipated number of casualties that may require treatment and the nature of injuries
- Composition of and disposition of deploying teams, including joint working with FRS and police, the deployment of specialist/non-specialist responders and enhanced critical care teams, including their specific taskings
- The operating procedures and safe system of work being utilised by enhanced critical care teams
- Any requirement for police to search casualties for weapons in accordance with national powers and policies and how this will be conducted

[8] In line with the National Ambulance Service Command and Control Guidance.

- The quickest route and method of casualty extrication from point of injury to the CCP and onwards to the CLP

- The handover of casualties, enabling their rapid transportation from the scene.

The plan must be discussed as part of the joint decision-making process, ensuring that all commanders understand its contents and implications. It is an integral element of deployment briefings, ensuring that responders are aware of the tactics and procedures to be followed, emphasising the overarching aim of rapid deployment to save life.

5.6 **The initial priority is to provide immediate lifesaving intervention to as many casualties as possible within the shortest possible timeframe. This will maximise survival time until definitive care can be provided.**

The NHS Ambulance Service has a specific legal duty of care to avoid any unreasonable delay in accessing and stabilising casualties. A marauding terrorist attack may generate a significant number of casualties with life-threatening injuries that require immediate medical intervention to prevent death.[9] Rapid intervention based on an assessment of the risks and benefits is therefore required to maximise survival rates. The priority is rapid deployment and management of catastrophic haemorrhage and airway management.

5.7 **The aim of deploying responders is to rapidly assess and treat casualties, then, if required, move on to the next casualty. Personnel deployed may provide limited clinical intervention to stop major haemorrhage and use basic airway control techniques (airway adjuncts/positioning) to allow casualties to breath unassisted.**

Where casualty numbers are significant, rapid and minimal clinical intervention focused on controlling major haemorrhage and placing casualties into a recovery position may provide the maximum benefit to the greatest number of casualties.

The tactic of **'treat and leave'** should be considered in such circumstances. The Casualty Management Plan and responder briefings must make it clear if '**treat and leave'** is being conducted rather than **'treat and take'**. It should be noted that the response is flexible, and commanders may amend tactics according to threat and attack methodology. Responders must be briefed that they are unlikely to be able to stay with a casualty after providing basic treatment.

5.8 **The ambulance on-scene commander will direct and coordinate the casualty management process, such as joint working with non-ambulance emergency responders to deliver life-saving care, including enhanced critical care teams. Responders from the three services have received different levels of first aid training and will be tasked appropriately.**

Maximising the number of responders available to treat casualties will save lives. FRS responders may therefore deploy with ambulance responders to increase the resource available to immediately remove casualties to the CCP/CCS/CLP. Joint working may include mixed teams delivering basic clinical care, or separate teams with FRS performing the immediate removal of casualties to and from CCP locations. The deployment of enhanced clinicians and critical care teams (when available) may be appropriate depending upon attack methodology. The locations of where they will be deployed will be determined by the ambulance on-scene commander to achieve maximum casualty benefit.

Ambulance responders will direct and oversee treatment delivered by non-ambulance staff.

Where non-ambulance responders are conducting initial triage, only the official NHS TST algorithm is to be used.

[9] The characteristics and assumptions of an MTA are described in the National Security Risk Assessment.

5.9 **The uninjured and casualties who can walk should be directed to leave the scene by the safest route. However, experience has shown that many of the uninjured (which may include off duty responders, NHS staff and event first aiders) will stay and assist casualties.**

Emergency responders should not allow bystander activity to distract them from treating the maximum number of casualties possible. Emergency responders can, where possible and appropriate, direct bystanders in the provision of basic interventions which may aid the saving of life. This includes the use of first aid equipment on site or at a venue.

Survivors and casualties may remain hidden from responders, following the advice of '*Run, Hide, Tell*'.[10] Casualties and survivors of gunshots and blasts (IEDs) may suffer visual impairment, confusion, and hearing loss, and therefore be unable to understand verbal instructions.

Survivors may not necessarily follow instructions from responders; therefore, responders may need to provide direction in a firm and clear manner.

A thorough systematic search of the scene is necessary to ensure that all casualties and survivors are located and led to safety. This search should be coordinated between responding agencies to ensure effectiveness and be informed by the Casualty Management Plan.

5.10 **Appropriate triage labelling is essential to avoid the repeated assessment of casualties, particularly as the scene may be complex and confusing. Once a casualty has been assessed and treated, they should be removed for further treatment urgently.** Depending on the circumstances, injuries, and availability of resources, P1 casualties should be considered for movement directly to a CLP.[11] Retrieval of casualties to the CCP will commence on the instruction of the ambulance on-scene commander.

5.11 **A CCP is an area where casualties are grouped, their condition reviewed, and basic clinical care provided. A CCP should be established in the safest location available. The location will need to be jointly agreed and reviewed regularly.**

Establishing and locating the CCP is influenced by several factors, including:

- Attack methodology, joint understanding of risk and location of casualties
- Number of casualties and severity of injury
- Security, protection and ability to establish communication.
- Safe routes in and out for casualty extrication to and from the CCP
- LoE and zones (if applicable)
- Options to conduct an emergency evacuation of the CCP.

Depending on the incident, it may be necessary to establish multiple CCPs. The ambulance on-scene commander should consider the most appropriate method to move casualties.

Subject to the threat and dynamic risk assessment, the use of vehicles should be considered to move casualties rapidly between the CCP, CLP and CCS (if a CCS is established).

[10] Further information can be found at: RUN HIDE TELL | ProtectUK
[11] Injures include, as an example, non-compressible penetrating torso trauma; P1 casualties are assessed by the Ambulance Service as a priority 1 casualty requiring immediate medical intervention.

Dependent on casualty numbers and incident location, the establishment of a CCS should be considered. However, a CCS may be an additional burden on available resources and should only be established if there is an unacceptable delay in casualty transportation to definitive care.

Casualties may have received first or self-aid prior to extrication from the scene, including the use of improvised tourniquets. These may have become hidden or are not required. A thorough check should be made in the CCP to prevent further injury.

5.12 **Should an attack result in a siege, military medical personnel may be deployed.** The ambulance on-scene commander and military medical lead must agree a joint plan maximising the casualty care options available and minimising duplication of assets or resources.

The Ambulance Medical Incident Advisor should be included in developing the joint plan and the onward distribution of casualties. The Casualty Management Plan must be reviewed to include any joint working with the military and approved by both the ambulance tactical commander and military lead, thus ensuring there is one joined up plan. In the event of any disagreement, the NHS Ambulance Service is the lead agency for pre-hospital casualty care.

Ambulance and military medical cooperation may include:

- Joint establishment and resourcing of CCPs
- Joint establishment and resourcing of a CCS (if required)
- Joint working with military and FRS to rapidly move casualties from the CCP to the CLP or CCS (if a CCS is established)
- Establishment of nominated receiving hospitals for any military or responder casualties
- The locations of joint working, such as any handover location, including the process for casualties being passed from the military to the Ambulance Service as applicable.

5.13 **Casualties within the CCP or CCS may need to be searched by the police to determine whether suspected attackers, explosive devices or other weapons are present.**

Casualties suspected of being attackers will receive medical treatment as determined by their injuries. However, the potential presence of weapons should be considered. Responders who suspect that they have identified an injured attacker should notify the police immediately.

The Casualty Management Plan should note if there is a requirement for police to search casualties in the CCP based on threat and risk. When casualties are being moved, any property should be left where the casualty was found. Responders should be forensically aware, but not to the detriment of delivering casualty care.

5.14 **Where casualties may be a potential threat or found to be in possession of weapons, responders will immediately assess the risk, and if necessary, withdraw to a safe distance.**

Commanders should be notified as soon as possible to ensure situational awareness across organisations. There may be a requirement for removing casualties from the scene to pause, or for responders to stay in cover or even evacuate the area.

If responders need to withdraw or evacuate the scene, options for the immediate removal of casualties including those unable to walk should be considered. This will be a dynamic decision and based upon the nature of the threat.

Injured military or police responders in possession of firearms should have their firearms

recovered by authorised military or police colleagues as a matter of urgency prior to their transport to the CCP. Only in exceptional circumstances, when this is not possible, should firearms stay with the casualty. Every effort should be made by police or military colleagues to recover these firearms as soon as practicable. **The handling of firearms should not be undertaken by untrained emergency service responders unless necessary to save life, even then, handling should be kept to the absolute minimum necessary to fulfil those obligations**.

6. FIRE AND HAZARDS MANAGEMENT

This section covers the role of the FRS during an MTA.

6.1 The FRS retains lead responsibility for all firefighting and rescue and hazard management activities during an MTA and will be responsible for firefighting tactics and the provision of firefighting equipment on-scene. Examples may be:

- Abandoned or crashed vehicles
- Damage or partial collapse of structures
- Creation and delivery of a methodical search and rescue plan
- Fires in vehicles or structures
- Identifying and making hazardous materials safe.

The FRS may also provide assistance to the Ambulance Service in the treatment and removal of casualties during an MTA (see section 5.9).

FRS commanders must access risk information and plans which may be available. This information could be contained within mobile data terminals (MDTs) from NILOs or specialist fire safety officers or come from the FRS Mobilising system. Where this information is available it must be used and shared to support the joint understanding of risk, decision making and the creation of a methodical search & rescue plan.

FRS may also need to deploy other local and national resilience capabilities to meet the requirements of the incident. This must be considered by the Incident Commander (IC) and be part of the tactical plan. The list below is not exhaustive but an overview of other capabilities that are available:

- Urban Search & Rescue (USAR)
- Detection Identification and Monitoring (DIM)
- Heavy rescue
- Line/rope rescue
- Water rescue
- Aerial appliances or Drones

The FRS IC can seek support from tactical advisors to aid decision making and operational delivery of other capabilities. For example, NILOs, fire safety officers and Hazmat officers.

FRS commanders must develop a search and rescue plan sharing information of the location of casualties to support the decision making to prioritise those at most risk or trapped. Where information is received from callers who may be hiding (injured or uninjured) to control rooms, provisions must be made to ensure this critical information is passed to the FCP to inform the search and rescue plan.

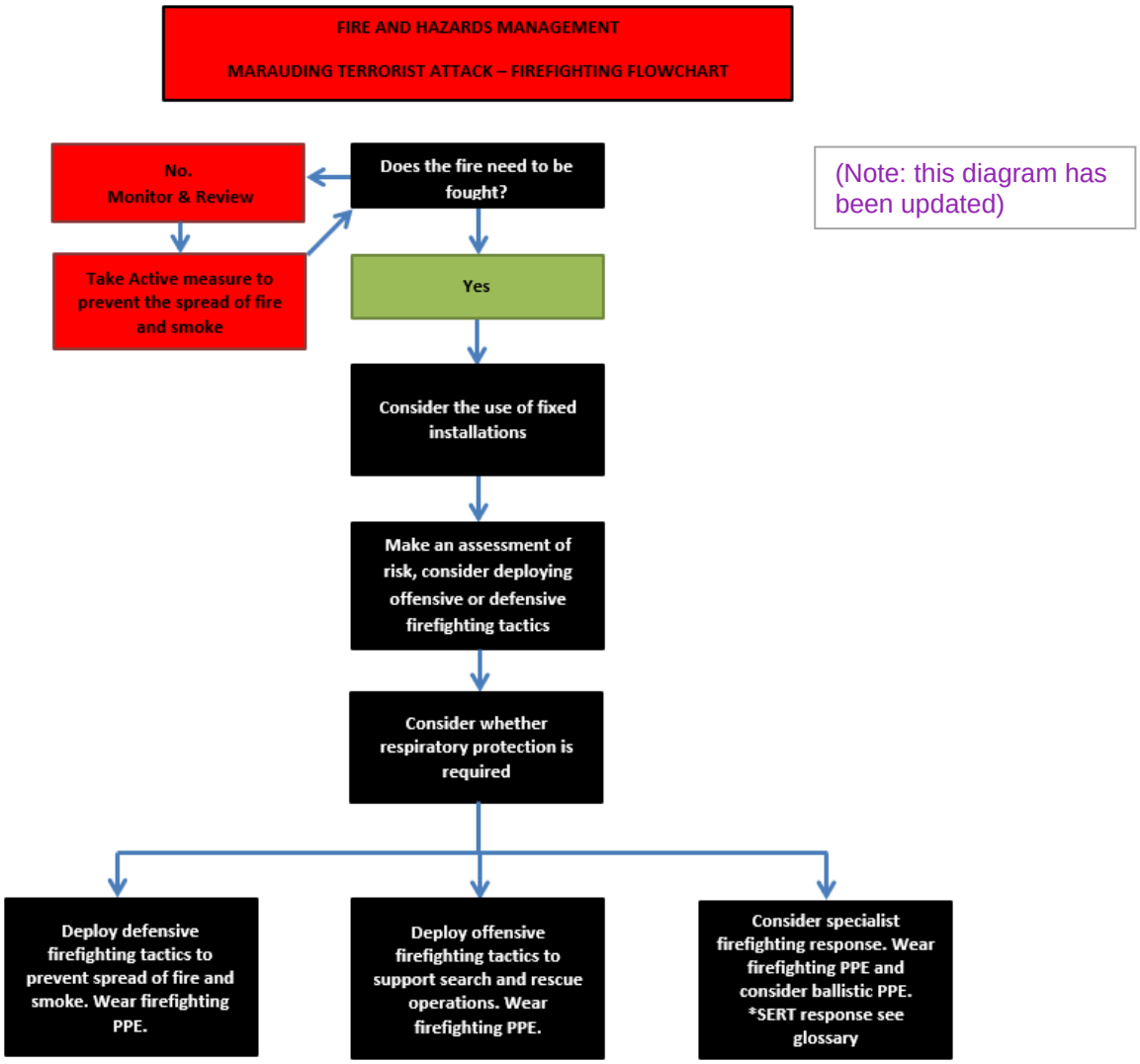
FRS teams must make equipment available at the FCP that may be required to support access, egress and rapid deployment of responders. Whilst not exhaustive, this can include:

- Rapid Intervention Sets (RIS)
- Forced Entry Equipment
- Thermal Imaging Cameras

- Ladders

A deployed FRS team must have at least one radio to support communications. **It may not be practical to use the normal FRS evacuation signal of short blasts with an Acme Thunderer whistle. This will be agreed by the IC, who may choose an agreed code word, for example "landslide", to alert responders as part of an evacuation plan. <u>The agreed evacuation signal must be confirmed with all agencies at the FCP/RVP.</u>**

<u>FIREFIGHTING DURING AN MTA</u>



6.2 Maintaining control of fires will be a priority where there is a threat to life. However, FRS responders undertaking firefighting activities should also consider the need to preserve evidence.

Wherever possible and safe to do so, fires should be extinguished without delay and all responders should consider simple actions to prevent the spread of fire or smoke.

6.3 FRS commanders may direct responders to undertake firefighting activities during an MTA, once a joint understanding of risk has been established. The flow chart above demonstrates the relevant considerations for firefighting during an MTA.[12]

[12] The Metropolitan Police Service, in conjunction with London Fire Brigade, has a warm zone capability consisting of specially trained police responders wearing breathing apparatus, supported by specially trained FRS responders. This capability is only available in London.

6.4 Firefighting tactics are defined as either offensive or defensive:

Offensive Firefighting; FRS responders may be deployed to undertake firefighting and search and rescue operations. This may include the use of structural firefighting equipment and PPE, ballistic PPE and breathing apparatus (BA).

Defensive Firefighting; If the level of risk is considered too high to employ offensive firefighting tactics, defensive tactics may be used to prevent the spread of fire. This may involve the deployment of responders to either undertake firefighting activities from an external position and/or to position fixed firefighting jets/ground monitors.

The operational plan to deploy FRS responders for firefighting or search and rescue operations should always be discussed with partner agencies and communicated to on-scene commanders.

6.5 Firefighting activity may be required to facilitate the police in moving forward to confront the threat. If FRS resources are engaged in other firefighting or casualty management activity, an alternative tactic may be to provide advice and guidance to police officers to enable them to move forward to undertake their tasking. The FRS will offer advice and support on fire development and any fixed installations (i.e., sprinkler or ventilation systems and building fire engineered solutions) which may be utilised to assist in controlling the spread of fire or smoke.

FIREFIGHTING AND CASUALTY MANAGEMENT DURING AN MTA

6.6 As referenced above, FRS responders may be deployed with ambulance responders to assist in the casualty management process. Dependent on the attack methodology, FRS responders may be required to undertake firefighting, rescue and casualty management at the same time. This is reasonably foreseeable. Where FRS personnel are required for firefighting and casualty management, the on-scene commanders must agree priorities based upon all available information and the primary aim to save life.

7. DEBRIEFING AND LESSONS IDENTIFIED

7.1 Where the MTA JOPs have been used, whether during a live incident exercise or training event, there should be a debriefing process to identify single-sector and multi-agency lessons and notable practice.

7.2 All commanders have a responsibility to ensure issues affecting interoperability (and therefore the MTA JOPs) are captured in debriefing activities following a major incident. A plan for debriefing should be considered at the earliest practicable opportunity.

7.3 As stated in the JESIP Joint Doctrine, "…lessons identified from debriefing activities are vital to improving the way we respond to incidents. Inquests and inquiries focus heavily on previous lessons and responder organisations must be able to prove they have identified and shared learning to try to prevent future similar issues." (p.36, JESIP Joint Doctrine: The Interoperability Framework).

7.4 Section 11.2 of the JESIP Joint Doctrine continues:

"It is important to capture lessons while events are fresh in the minds of those involved. Where possible, a joint 'hot debrief' should be held as soon as practicable after an incident. Formal debriefs, which may be held later, should consider the lessons identified and captured from hot debriefs, or equivalent post-incident reviews. All debriefs should involve the full range of responders and control room personnel to ensure the lessons identified are captured from every aspect of the response." (p.38, JESIP Joint Doctrine: The Interoperability Framework)

7.5 Where appropriate, any debrief activity following the use of the MTA JOPs should include representation from the national MTA emergency service leads for subject matter advice.

Where national MTA emergency service leads are not represented at any debrief, and key lessons are identified, they must be passed to the emergency service leads, or representatives, at the earliest opportunity to consider.

7.6 To support emergency services in capturing interoperability lessons, a multi-agency debrief template is available.[13] This template is designed to be integrated into, or used alongside, existing debrief procedures.

7.7 Any lessons or notable practice captured by a debrief should be shared with relevant local and national learning systems/platforms. These may be single sector, such as National Fire Chief's Council National Operational Learning (NOL) or Counter Terrorism Policing's Organisational Learning System (OLS). However, by its nature, any debriefing activity following use of the MTA JOPs is likely to result in lessons identified/notable practice which impact on interoperability.

7.8 As such, it is anticipated that any lessons identified/notable practice should be shared with Joint Organisational Learning (JOL) via the JOL Online platform.[14] It is essential that JOL is accepted as the standard for multi-agency learning and is adopted by all responder organisations to ensure interoperability is continually improved.

7.9 The national MTA emergency services leads and Chair of the Joint Operational Working Group (JOpWG) are engaged with the JOL process and will ensure that any lessons identified/notable practice raised via JOL will be considered in future reviews of the MTA JOPs.

7.10 Organisations and individuals should ensure that they are aware of their obligations to retain, and potentially disclose in the future, material relating to the incident. As well as informing debriefing activity, much of this material may be relevant in a wide range of proceedings,

[13] JESIP Multi-Agency De-Brief Template: https://www.jesip.org.uk/de-brief-template
[14] JOL Online platform: https://jolonline.resilience.gov.uk/default.aspx (account required)

including criminal and coronial proceedings and public inquiries.

Material could include:

- Incident logs
- Briefing and debriefing sheets
- Policy files or decision books
- Operational or tactical advice notes.

ANNEX A – GLOSSARY

This glossary is compiled from terms used within this guidance. It is not intended as a full and complete glossary of emergency service terminology but as a quick reference guide when working with this document.

Casualty Clearing Station (CCS)	An area set up at the scene of an emergency by the Ambulance Service in liaison with the medical incident advisor to assess, triage and treat casualties and direct their evacuation.
Casualty Collection Point (CCP)	A staging area that enables lifesaving interventions to be undertaken before removal to the Casualty Clearing Station.
Casualty Loading Point (CLP)	An area near the Casualty Clearing Station, where ambulances can be manoeuvred, and patients placed in ambulances for transfer to hospital.
Cold Zone	An area assessed to have no known marauding threat or where appropriate control measures have been implemented. Some cold zones will not require any control measures.
Counter-Terrorism Policing Unit (CTPU)	Counter-Terrorism Policing Units are regionally based throughout Great Britain and provide integrated intelligence, investigative and preventative capabilities between key partners.
CT Police Operations Room (CT POR)	Command and control facilities provided by Counter-Terrorism Units for CT operations.
Fire Hazards Management (FHM)	Defensive or offensive firefighting tactics that may be employed to improve conditions for responders and casualties and provide tactical advantage to armed police responders.
Fire and Rescue Service (FRS)	Fire and Rescue Service or Brigade.
Forward Command Point (FCP)	An area, at or near the scene, where the response by the emergency services is managed by commanders.
Hot Zone	An area assessed to contain an active and ongoing marauding threat.
JESIP	Joint Emergency Services Interoperability Principles.
Joint Decision Model (JDM)	A decision model to help commanders make effective joint decisions in a multi-agency environment as described in The Joint Doctrine: The Interoperability Framework.
Joint Understanding of Risk	One of the five principles of joint working by which commanders develop a common understanding of; potential risks, the consequences and likelihood of threats and hazards and agreed control measures required to mitigate any of these to inform the decision-making process.
Limits of Exploitation (LoE)	The furthest point to which groups of emergency responders will operate. The LoE will be jointly agreed between commanders as part of an ongoing joint assessment of risk.
National Inter-agency Liaison Officer (NILO)	A security vetted, trained and identifiable responder who may operate in either a command, tactical adviser or service specific role. They can support pre-planned or spontaneous operations at strategic, tactical and operational levels, including facilitating interoperable working with partner agencies.

On-Scene commander[15]	An appropriate police, FRS or ambulance commander at the scene who is responsible for undertaking an ongoing joint assessment / understanding of risk and for decision-making on the deployment of their organisation's assets at that location. On-scene commanders will therefore ensure the emergency services' response is effectively coordinated at scene.
Outer Scene Commander (OSC)	An appropriate police commander located at the scene of a siege who is in command of the outward facing functions, creating the permissive environment within which the inward facing functions can operate.
Rescue Plan	A tactical option focused on the immediate rescue of a casualty to a safer area.
Rendezvous Point (RVP)	An area established to coordinate the briefing and deployment of arriving resources.
Strategic Coordinating Group (SCG)	Multi-agency body responsible for co-ordinating the joint response to an emergency at the local strategic level.
Siege Ground Commander (SGC)	An appropriate police commander located at the scene of a siege who is in command of the inward facing functions and who provides the link in the command chain between the resources at the scene and the Tactical Firearms Commander.
Specialist Entry and Recovery Team (SERT)	The Metropolitan Police Service, in conjunction with London Fire Brigade, have a SERT capability (this capability is currently only available in London). SERT capability involves qualified police firearms officers wearing breathing apparatus (BA) moving through a smoke-filled environment, supported by specially trained FRS responders, to gain tactical advantage during a MTA incident.
Strategic Firearms Commander (SFC)	Determines the strategic objectives and sets any tactical parameters. Retains strategic oversight and overall command responsibility.
Tactical Coordinating Group (TCG)	A multi-agency group of commanders that meets to determine, coordinate and support the delivery of a tactical response to an emergency.
Tactical Firearms Commander (TFC)	Develops, commands and coordinates the overall tactical response in accordance with strategic objectives.
Tactical Options	Commanders have a number of interoperable options available. They should take a flexible approach to the options they use, i.e. assessed against threat and risk. They should adapt and mix and match options, depending on the circumstances and resource availability.
Treat and Leave	A tactical option focused on saving as many lives as possible within the shortest timeframe; conducted through triage and treatment and delaying casualty removal until sufficient emergency service resources are available to do so safely and effectively.
Treat and Take	A tactical option focused upon saving as many lives as possible within the shortest time frame; conducted through triage and treatment of a casualty followed by immediate removal to the CCP, CCS or CLP.
Warm Zone	An area assessed to contain a potential marauding threat.

[15] For FRS and ambulance, this is the equivalent of the operational commander role as defined in The Joint Doctrine: The Interoperability Framework. However, given the specific nature of police command and control for firearms incidents, the term on-scene commander has been retained for an MTA.