Career Firefighter Paramedic Suffers Head Trauma after Physical Assault – California

Executive Summary

On July 14, 2025, an Engine 20 (E20) firefighter-paramedic (FFA) sustained head trauma following an assault by a patient during a medical mutual aid response. E20 was dispatched without delay but without lights and sirens (C2) to assist emergency medical services (EMS) Medic Unit 8101 (M8101). E20 and M8101 were dispatched for a 23-year-old male exhibiting abnormal behavior after returning home from work. E20 had a shorter response distance than M8101. M8101 was dispatched immediately (C3). The patient's father (caller) reported that the patient attempted to jump through a window, resulting in lacerations to his arms and back and significant bleeding. The fire/EMS dispatcher (dispatcher) relayed additional details via ProQA through the computer-aided dispatch (CAD) system, indicating the patient was alert, standing, and experiencing a sudden behavioral change. The caller was uncertain whether the patient was violent or if the patient would tolerate responders. The E20 captain (CPT) requested law enforcement officers (LEOs) respond to the scene. M8101 downgraded the response to C2 pending LEO arrival for scene security.

On arrival, E20 conducted a scene size-up from the apparatus due to parked vehicles partly obstructing access to the patient and caller, who were on a sidewalk near a multi-unit residence. The patient appeared agitated, erratic, and verbally aggressive. The patient had visible lacerations actively bleeding and clot formation present. CPT requested an updated estimated time of arrival (ETA) for LEOs and was advised of delays due to police activity in another part of the city. The patient briefly fled the scene but later returned. After discussing whether to wait for LEOs, the crew elected to initiate care, coordinating with the caller to calm the patient and apply wound dressings under FFA's direction.

While the caller treated one arm, FFA began treating the other. However, the patient remained agitated and repeatedly disrupted application of the dressings. As FFA turned to retrieve supplies, the patient shouted and struck FFA in the face, causing him to fall backward against a vehicle and to the ground. CPT and the E20 engineer (ENG) restrained the patient by forcing him toward a fenced area and securing the gate, while another firefighter (FFB) attended to FFA, who was initially unresponsive. M8101 arrived, assisted with patient care, and transported FFA to the emergency department (ED). FFA regained alertness during transport and was diagnosed with orbital and maxillary fractures, a vitreous detachment, and concussion. Following overnight observation and subsequent follow-up care, FFA was medically cleared to return to full duty approximately two months later.

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Contributing Factors

- *Situational awareness and real-time risk assessment*
- *Behavioral health emergency response protocol training*
- *Behavioral health and violence de-escalation training*
- *Systematic tracking and analysis of violent incident trends*

Key Recommendations

Fire departments should:

- *Develop a risk management program that incorporates training, procedures, and controls to support personal situational awareness and real-time risk assessment during emergency and non-emergency operations.*
- *Ensure fire-based EMS behavioral health protocols are implemented into formal fire department training policies, standard operating procedures (SOPs), and job performances requirements (JPRs).*
- *Provide training on recognition and management of behavioral health crises and de-escalation of violence.*
- *Develop SOPs for scenes of violence, civil unrest, or terrorism in accordance with NFPA 1550, Standard for emergency responder health and safety, Chapter 10 and develop reporting requirements for violent incidents toward members.*

Governing municipalities (federal, state, regional/county, and local) should:

- *Analyze fire department and EMS agency data and allocate behavioral health resource availability based on trending emergency calls.*

For further information, visit the program at www.cdc.gov/niosh/firefighters/fffipp/ or call 1-800-CDC-INFO (1-800-232-4636).

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Introduction

On July 14, 2025, a firefighter was seriously injured when struck in the face by a patient. On July 22, 2025, the fire department notified the National Institute for Occupational Safety and Health (NIOSH) of this incident. On September 22-26, 2025, an investigator representing the NIOSH Fire Fighter Fatality Investigation and Prevention Program (FFFIPP) traveled to California to investigate this incident. The NIOSH investigator conducted interviews with command officers, fire officers, firefighters, fire investigators, and other emergency personnel who were on scene at the time of the incident. The investigator reviewed fire department standard operating guidelines (SOGs), training records, dispatch records, witness statements, and investigation documents.

Fire Department

The career fire department provides fire protection and EMS to a jurisdiction encompassing approximately 145 square miles and serving a population of about 530,000 residents. The department responds to an average of 110,000 calls annually. An established EMS division manages more than 90,000 medical aid responses each year and delivers both Advanced Life Support (ALS) and Basic Life Support (BLS) services. The EMS division works as a stand-alone division within the fire department and is overseen by a deputy chief and operates within the policies and procedures of the city, fire department and local EMS authority. All fire department resources, including the EMS division, are a part of a regional automatic aid agreement. The division staffs 18 fully equipped ALS ambulances, 24 engines, 9 trucks, and 1 rescue —with a minimum of one firefighter-paramedic and one firefighter–emergency medical technician (EMT) assigned to each unit. The department is comprised of more than 660 uniformed personnel who work a 48-hour-on, 96-hour-off shift schedule.

Training, Education, and Professional Development

Upon hire, recruits attend the fire academy for NFPA 1010 firefighter I training as well as a designated EMS focused academy. Following the academy, firefighters are encouraged to pursue paramedic training. Throughout employment as firefighter-paramedics and firefighter-EMTs, the EMS division holds regular training to maintain skills and certifications. This includes engagement in multi-company drills to maintain skills on broader scope emergencies, as well as multi-agency drills with local law enforcement and hospital coordinators to prepare for mass casualty incidents.

E20 responders were fully staffed with 4 personnel dispatched to this incident. The status for each firefighter is listed below.

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- Fire Captain (CPT):
  - Serves as EMS captain/supervisor on medical calls.
  - Education: Maintain certifications for advanced cardiac life support, pediatric advanced life support, and other required EMS certifications and clinical time
  - Other officer classes as directed.
  - Due to recent changes in the EMS agency protocol for Behavioral Crisis/Restraint, all CPT were provided training regarding incidents with law enforcement and the FD. This training covered the new protocol and electronic patient care record (ePCR) documentation for behavioral crisis/restraint calls–and includes topics on when to approach, when to not approach, and when to stop after initiating care.
- Engineer (ENG):
  - Under direction of the fire officer, performs specialized firefighting work involving the operation and maintenance of fire apparatus.
  - Specialized technical training for position.
  - Remains with the vehicle while on scene.
- Firefighter A (FFA):
  - Journey-level firefighter classification with EMT or paramedic certification. Reports to company officer for suppression activities and EMS captain for medical emergencies.
  - Education: Maintain certifications for advanced cardiac life support, pediatric advanced life support, and other required EMS certifications and clinical time
  - Was on an overtime shift.
- Firefighter B (FFB):
  - Journey-level firefighter classification with EMT or paramedic certification. Reports to company officer for suppression activities and EMS captain for medical emergencies.
  - Education: Maintain certifications for advanced cardiac life support, pediatric advanced life support, and other required EMS certifications and clinical time.
  - Transferred to the station for this shift.

Behavioral Health Response

The "Behavioral Crisis/Restraint" memorandum provided by the county EMS medical director for all county EMS providers was updated March 13, 2025, to address changes in the law enforcement response protocol to patients in the behavioral health category. The memorandum updating the policy was intended to provide clarity to EMS providers on how to proceed when encountering a potential behavioral health patient, particularly in situations involving an unsafe scene and the absence of LEO. The updated policy did not change ALS or BLS procedures but did provide the ability to disengage care of a behavioral health patient if the scene is or becomes unsafe. When responding EMS providers identify a scene as unsafe, the BLS procedures are as follows:

- Request an EMS supervisor to respond to the scene.
- EMS supervisor contacts appropriate law enforcement supervisor to discuss scene safety and mitigation measures.
- EMS supervisor shall document in the ePCR the law enforcement supervisor contact and the outcome of the discussion on scene safety mitigation.

- EMS personnel shall document that law enforcement was requested to respond.
- In consultation with the on-scene staff, the EMS supervisor shall document a Behavioral Health Rating Scale (BARS) assessment.

The memorandum provides a BARS assessment and expected procedures for each level of the rating scale. Each level provides a score and a patient description (see Table 1). The memorandum states that if a patient scores 6 or greater on the 7-point BARS and there is continued non-response by law enforcement, EMS providers, with EMS supervisor consultation, may elect to not engage with the patient based on scene safety. If the above measures have been completed and 30 minutes have passed, then the EMS supervisor may authorize the EMS providers to leave the scene and return to service. The EMS supervisor must document this release in the ePCR.

Table 1. Behavioral Health Rating Scale (BARS)

Score	Patient Description
1	Difficult or unable to arouse
2	Asleep but responds normally to verbal or physical contact
3	Drowsy, appears sedated
4	Quiet and awake (normal level of activity)
5	Signs of overt (physical or verbal) activity, calms with redirection/instruction
6	Extremely or continuously active, not requiring restraint
7	Violent, requires restraint

Apparatus, Staffing, and Communications

The fire/EMS dispatch center (dispatch center) dispatches county EMS agencies and city fire departments. The dispatch center is staffed by a communications director, a technical system manager, and five dispatchers, which include shift supervisors. Fire departments are dispatched on two channels. The dispatch center uses ProQA software for dispatching. This software prompts the dispatchers through questions based on information received by the caller. Although an audible dispatch routinely occurs, the CAD provides clearer communication to dispatched units with expanded information and supplemental information as it is gathered.

At 20:46, the following units were dispatched for a medical emergency (see Table 2):

Table 2. Units dispatched and arrival time

Apparatus	Staffing	Arrival On Scene
E20	4	20:52
M8101	2	20:56

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Incident Timeline

The following timeline is a summary of events that occurred as the incident evolved shortly after 20:42 on July 14, 2025. Not all incident events are included in this timeline. The times are to the minute and taken from the CAD log, dispatch log, and interview notes.

Time	Fireground Operations, Response, and Details
20:42	• The dispatcher received a call requesting assistance for a 23-year-old male patient bleeding and not behaving normally.
20:43	• Dispatch information was entered into the CAD system using ProQA software.
20:46	• CAD log responses to ProQA-prompted questions: Mental health conditions; unknown if violent; no weapon; not responding normally; talking/standing/sitting up; cut/laceration; injury to other than dangerous area – arms/back; serious bleeding; patient with caller; sudden change in behavior/personality. • ProQA software indicated "Altered Level of Consciousness (sudden change in behavior/personality)" and for the dispatcher to send information to responding units and finish questioning. • CAD reflected E20 and M8101 dispatched for 23-year-old male patient conscious, breathing, psychiatric/mental health conditions/suicide attempts/abnormal behavior.
20:47	• CAD supplemental information indicated "no further information." • M8101 responded C3 – immediately but as safely as possible. • E20 responded C2 – without delay but without lights and sirens.
20:48	• CAD supplemental information indicated that according to the caller, the patient jumped into a window and was screaming and yelling. The caller was unsure if patient would cooperate with responding units.
20:49	• M8101 downgraded their response to C2. • E20 continued C2 response and requested LEO response.
20:52 – 20:55	*This time frame reflects E20's time on scene, which included a scene survey; developing an action plan considering the caller's de-escalation ability; initiating treatment; and the patient assaulting FFA. Times listed below are the only verified times during this timeframe. According to interviews, patient care and the dressing of wounds occurred after 20:54 when E20 CPT confirmed LEO response.* • 20:52: E20 on scene. • 20:54: E20 CPT requested dispatcher to confirm LEOs were enroute; Dispatcher confirmed LEOs enroute with extended response.
20:56	• FFA punched in the face by patient.

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Time	Fireground Operations, Response, and Details
	• M8101 on scene, witnessed the assault and FFA's fall to the ground. M8101 assisted FFB in moving FFA to the stretcher and to the EMS unit and then provided treatment and transport to the ER. • CPT and ENG "rushed" to secure patient against a fence, pushed the patient onto the property of the multi-residential house, and secured the gate.
20:57	• E20 CPT requested LEOs to respond C3 – emergency as E20 departed scene. • E20 and responding LEOs met at a rendezvous point, providing a briefing of events.

Investigation

On July 14, 2025, at 20:42, the dispatcher received a call for assistance for a 23-year-old male patient. The patient's father (caller) reported that the patient returned home from working as a security guard, was not behaving normally, and attempted to jump through a window. He sustained injuries to his arms and back. The caller was with the patient and answered ProQA-prompted questions from the dispatcher. Information about the patient obtained through the ProQA system included:

- Mental health condition
- Unknown if violent
- No weapon
- Not responding normally
- Talking/standing/sitting up
- Cut/laceration
- Injury to other than dangerous area- arms/back
- Serious bleeding
- Patient with caller
- Sudden change in behavior/personality

At 20:46, E20 was dispatched to respond "C2" (without delay but without lights and sirens), and M8101 was dispatched to respond "C3" (immediately, as fast and as safely as possible for an emergency). While E20 and M8101 were enroute at 20:48, the CAD provided them with the following supplemental information:

- The patient jumped into a window
- The patient was screaming and yelling
- Caller unsure if the patient would cooperate with responding units

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M8101 immediately downgraded its response to C2. E20 requested LEO response and continued C2 at 20:49.

E20 crew arrived on scene at 20:52 and observed a male patient outside a residence with another person (caller). The patient and caller were on the sidewalk outside of a multi-unit residential property. There were several perpendicular parking spaces with vehicles between the sidewalk and the roadway. The crew observed the patient bleeding from biceps to forearms and described blood clots hanging from his arms. They also observed the patient was very agitated, exhibiting erratic behavior, rambling, yelling, and pointing at the crew, while the caller attempted to calm the patient. They estimated the patient was approximately 5 feet and 10 inches tall and approximately 200 pounds and described the patient as muscular and fit. CPT inquired about LEO response time. Dispatcher advised that the LEOs were enroute but had an extended ETA due to police activity in another part of the city. CPT discussed the decision to approach the patient without LEOs present with the crew. The crew agreed to approach the patient while waiting for LEOs to arrive. The crew used a calm, slow approach towards the patient, stopping approximately one car length away from the patient and caller.

The patient suddenly took off, climbed over a fence and onto the neighboring property. While the patient was running about the neighbor's property, the caller approached the crew and described the patient as having worked as a security guard earlier and upon return from work, the patient was "acting crazy" for a few hours. The caller denied prescription or illicit drug use. The crew and caller agreed to work together to de-escalate the patient because the patient would listen to the caller. During this time, the patient returned from the neighbor's property. The crew described the patient as being "evasive and cagey" with fists clenched. The patient rambled that "they're gonna kill me…they're gonna hurt me." CPT asked the patient if the crew could apply bandages to help stop the bleeding. The patient yelled back "No," "get out," and "leave." FFA asked whether the caller would apply dressings as FFA coached him. The caller agreed. The patient allowed the caller to apply dressings on one arm. FFA was able to calmly talk with the patient, and the patient agreed to allow FFA and FFB to place dressings on the other arm. FFA and FFB used a slow approach and placed an aid bag on the hood of a parked vehicle. FFB handed supplies to the caller and FFA. The patient abruptly pulled back away and began pacing. FFB and CPT began to back up to increase their distance from the patient. FFA noticed the patient bleeding through the dressings and the cloth wrap loosening. FFA grabbed more supplies from the aid bag. FFA tried to calmly talk with the patient and attempted to fix the cloth wrap when the patient yelled "Oh, you wanna go?" and punched FFA in the face.

M8101 arrived on scene at 20:56 and witnessed the punch to FFA. They described FFA as falling back onto the car's hood and then to the ground. E20 crew members described FFA as unresponsive to verbal stimuli and exhibiting abnormal posturing (involuntary body movements typically seen in patients with brain injuries). The medic crew immediately worked with the FFB to move FFA onto a stretcher, into the medic unit, and departed the scene. CPT and ENG abruptly pushed the patient up against the fence and into the yard before securing the gate. CPT and ENG returned to E20 and departed the scene. CPT requested LEOs to expedite response and to meet at a rendezvous location for an update on events at the scene. M8101 and FFB provided treatment on the way to the ED. FFA was evaluated in the emergency room and diagnosed with orbital and maxillary fractures, a vitreous detachment, and a concussion. FFA was released from the emergency room the next day for outpatient follow-up care for injuries sustained.

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Cause of Injuries

FFA reported being physically assaulted during the incident. The assault involved a strike to the head, which resulted in an orbital and maxillary fractures, a vitreous detachment, and concussion.

Contributing Factors and Recommendations

Occupational injuries and fatalities are often the result of one or more contributing factors or key events in a larger sequence of events that ultimately result in injuries or fatalities. The NIOSH investigator identified the following items as key contributing factors in this incident that ultimately led to the serious injury:

Contributing Factor #1: Situational awareness and real-time risk assessment

Upon dispatch, E20 and Medic 8101 were advised that the caller described the patient as exhibiting abnormal behavior represented by jumping through a window, having outbursts, and questionable cooperation with emergency care. Once on scene, E20 observed abnormal behavior and shouting at the crew. This behavior easily meets the BARS assessment score of 6. Although the patient did not exhibit any violent actions, the patient's appearance and outspoken remarks could support a higher risk of violent tendencies to protect himself, which could justify a BARS assessment score of 7. A BARS assessment score of 6 or greater indicates an unstable scene which detracts from the safety of the crew and delegates authority for the EMS supervisor to not engage the patient until LEOs arrive on scene. CPT was considered the EMS supervisor once on scene.

Recommendation #1: Fire departments should develop a risk management program that incorporates training, procedures, and controls to support personal situational awareness and real-time risk assessment during emergency and non-emergency operations.

Chapter 4 of NFPA 1550 provides criteria that fire departments can use to develop and maintain a comprehensive risk management program, documented through a written risk management plan. A risk management plan should cover a variety of emergency and non-emergency topics, including training and vehicle operations. The risk management process includes identifying and analyzing exposure to hazards, evaluating and prioritizing those hazards, selecting appropriate risk control techniques, implementing control measures for each hazard, and monitoring the results for continued or new hazards. NFPA 1550 addresses risk control as part of the risk management process and as an element that should be documented in the department's risk management plan. A risk management program should be developed and implemented at the organizational level of the fire department, with the written risk management plan documenting the program [NFPA 1550 2024]. Known or anticipated hazards and hazard controls can be implemented in training and addressed in SOPs. NFPA 1550 calls for training, education, and professional development for all members of a department commensurate with duties and functions they are expected to perform.

According to standard paramedic training, scene management is considered a primary responsibility of a paramedic. The CPT, as first arriving officer, is responsible for all scene management. Scene management begins with the information provided during the initial dispatch, any supplemental

information received while responding, and what information the CPT gathers upon arrival to the scene. The crew's familiarity of past requests for service at the same address or area will aid the CPT in developing the initial action plan. For paramedics, situational awareness is defined as "knowing your surroundings, the people and groups in your environment, and the climate of violence or strife" [Mejia A, et al. 2023a]. Safety is managed by situational awareness. A patient can provide cues through behavior and body language that may offer information on the patient's intent for violence: posture, speech, motor activity, and other body language. These cues, along with the paramedic's situational awareness training and experience, can inform the paramedic of the current climate. Paramedics are trained to perform a scene size-up to assess the overall situation and identify factors that may contribute to or increase the potential for violence. They are instructed to maintain situational awareness by observing their surroundings, ensuring a clear means of egress for rapid exit, maintaining a safe distance without turning their back on a patient, implementing verbal de-escalation techniques, clearly defining behavioral expectations, and removing or avoiding objects in the area that could be used as weapons. If safety of the crew, patient, and bystanders cannot be maintained, the paramedic may decide to step back and request assistance.

Real-time risk management is the operational application of the broader risk management process and emphasizes the ability of individuals, crews, or departments to continuously assess and respond to risks as they occur. The ability to accurately assess risks in real time is a cumulative reaction based on training, knowledge, and experiences. The U.S. Air Force describes real-time risk management as managing risks at the execution phase of an activity. This requires the individual or small group to implement "immediate or near immediate action to mitigate risk(s)" [DAF 2022]. Real-time risk management utilizes formal risk management principles at the tactical level. A well-planned activity can easily produce an unexpected outcome. Firefighters can prepare to respond to unexpected outcomes by practicing risk management, anticipating hazardous conditions, implementing controls to reduce likelihood or severity, and communicating changing conditions to all involved. Further, developing real-time risk management skills may lead to improved situational awareness. Both are an ongoing process as hazards can rapidly increase and change during an incident. That is, situational awareness supports continuous risk assessment by helping personnel identify hazards, recognize changing conditions, estimate risk, and determine protective measures that may be required. Situational awareness can function as one tool within real-time risk management. However, these skills are usually developed from practice and opportunities [NIOSH 2022]. The greatest chances for success come when all personnel utilize effective situational awareness, effectively communicate their findings with key personnel, and there is shared situational awareness at all levels of the incident or activity.

For behavioral health risk management, risk reduction is a primary consideration within the risk management process. Risk reduction is accomplished through relationship building and communication. The Substance Abuse and Mental Health Services Association (SAMHSA) provides a trauma informed framework. The SAMHSA framework offers a treatment improvement protocol (TIP) which includes Tip 57 – Trauma informed care in behavioral health services [SAMHSA 2014]. Although this framework is directed towards clinical settings, knowledge can be used in the field. Relationship building can be developed through repetitive calls for the same patient or patients within the same area. Understanding the response history to the same area or patient can support hazard identification, risk assessment, and the development of risk-reduction measures over time.

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Contributing Factor #2: Behavioral health emergency response protocol training

Emergency medical personnel follow established guidelines through delegation of authority from a medical director. In this incident, the medical director authority comes from the county EMS agency. In March 2025, the county EMS agency provided an updated response protocol for behavioral health emergencies for all medical personnel. The updated changes were in correlation with changes in law enforcement procedures for behavioral health calls. Previously, LEO were automatically dispatched to behavioral health calls and would assist medical personnel with scene support and restraint of the patient as needed. Law enforcement agencies changed their response protocol by requiring criminal activity involvement for law enforcement to automatically be dispatched for behavioral health calls.

The updated county EMS agency protocol for behavioral health emergencies provides for scene safety and then appropriate BLS or ALS care. When criminal activity is present or anticipated, the protocol requires EMS supervisor to be requested to the scene while the emergency medical personnel remain at a safe distance. Once on scene, the EMS supervisor should contact the appropriate law enforcement supervisor to discuss scene safety and mitigation measures. This conversation is entered into the ePCR by the EMS supervisor. The EMS supervisor then conducts a BARS assessment (see Table 1). If a BARS assessment results in a total score of 6 or greater on the 7-point scale, EMS providers may elect not to engage with the patient based on scene safety.

The fire department trained all fire captains on the updated protocols. The training addressed changes in law enforcement response when no criminal activity is identified at dispatch. The fire captains received training on BARS to assist in determining scene safety, whether to approach the patient, and conditions under which patient care should be discontinued due to an unsafe scene. Training also included documentation requirements in the ePCR. The fire captains were expected to return to their station and train station staff to implement the updated protocol immediately. The fire department maintained these training records for the fire captains, however, there was no record of this training conducted at the fire stations. For this incident, there was no ePCR initiated by CPT first arriving on scene, requesting law enforcement to respond, law enforcement status, or results of the BARS for assistance in making decisions on scene safety and patient care as would be required by the Behavioral Crisis/Restraints protocol.

Recommendation #2: Fire departments should ensure fire-based EMS behavioral health protocols are implemented into formal fire department training policies, SOPs, and JPRs.

NFPA 1250 [2026] requires fire departments to adopt an official risk management plan for fire and emergency services organizations. The standard states that the plan shall cover administration, facilities, training, vehicle operations, protective clothing and equipment, operations at emergency incidents, operations at non-emergency incidents, and other related activities. The training and education should be commensurate with the duties and functions expected of the members. Training should occur at least twice a year but can be offered more frequently as needed. An SOP serves as a means of communication for all levels of the organization. An SOP may also identify known hazards, the risks of those hazards,

and identify hazard controls to be implemented. The SOP should be reviewed by all involved prior to an activity and updated as additional hazards are identified.

NFPA 1010, Standard on Professional Qualifications for Firefighters, provides professional qualification standards that are written as JPRs which describe the performance required for a specific job and grouped according to the job duties [NFPA 1010 2024]. NFPA 1010 and NFPA 1020, Standard for Fire and Emergency Services Instructor, Fire Officer, and Emergency Medical Services Officer Professional Qualifications Professional Qualifications, Annex B, address how to use JPRs for instructional purposes [NFPA 1010 2024; NFPA 1020 2025]. Training institutions, fire departments, and individual fire service instructors can use NFPA JPRs along with jurisdictional resources in their instruction and evaluation development.

Contributing Factor #3: Behavioral health and violence de-escalation training.

In service areas where behavioral health emergencies are frequently encountered, it is important to seek continued education, training and practical experiences to further develop and maintain skills. The most recent training provided by the fire department was reported as training for the updated "Behavioral Crisis/Restraints" memorandum. This training was delivered by PowerPoint slides to all fire captains and included a walkthrough of documentation within the ePCR. The fire captains trained were then expected to return to their station of assignment and provide the same training to their subordinates. This may have been a valuable time to implement additional behavioral health and violence de-escalation training to align with new response procedures and to further develop and maintain skills.

Recommendation #3: Fire departments should provide training on recognition and management of behavioral health crises and de-escalation of violence.

All paramedics receive training in mental health response, scene safety, and violence de-escalation during initial paramedic training. This training includes scene management and identifying signs of the potential for increasing violence. Paramedics should rely on – when applicable – experience with the patient, the physical address, or the surrounding area of the physical address. Paramedics should look for posturing, speech, motor activity, and other body language. Responders should observe surroundings, ensure escape routes for crew members, ensure crew members do not turn their back to the patient, use verbal de-escalation techniques and provide clear expectations to the patient [Mejia et al. 2023b].

The National Council for Mental Wellbeing offers mental health first aid training (https://mentalhealthfirstaid.org). Courses are designed to teach community members ways to respond when someone has a mental health crisis and how to identify cues and clues of a developing mental health concern. Mental health concerns covered in the course include depression, anxiety, psychosis, substance misuse, and crisis situations. The course takes approximately 12 hours to complete and follows a structured educational framework that prioritizes assessment, listening in non-judgment, and offering support and encouragement. Mental Health First Aid has been found to improve knowledge of recognition of signs and symptoms of mental disorders, beliefs about effective treatments, confidence in helping someone exhibiting symptoms of a mental health problem, and intentions to provide mental health first aid [Morgan et al. 2018]. First responders can benefit from Mental Health First Aid training

as it enhances their safety and effectiveness of the service they provide to callers in a state of mental crisis or experiencing a mental health problem.

The Federal Emergency Management Agency (FEMA) offers online training in de-escalation strategies and professional engagement for EMS, fire department and law enforcement personnel. The training is delivered through First Responder Training (https://firstrespondertraining.gov). Violence de-escalation training is widespread across many industries whose workers deal with the public. It is designed to empower workers with behavioral, verbal and/or physical tactics to ease aggressive behavior from a caller or bystander before the aggressive behavior escalates into physical violence. Bystander training for paramedics and firefighters is designed to help them address conflict that comes from bystanders present at an emergency call. Bystander training has been found to be effective in increasing paramedics' capacity to deal with a bystander while effectively performing their job, their well-being, and job dedication [van Erp et al. 2018]. Violence de-escalation training and, more specifically, bystander training, are both relevant resources for providing skills needed to maintain safe scenes.

Contributing Factor #4: Systematic tracking and analysis of violent incident trends

Paramedics are trained in scene management, which includes relying on past experience with the patient, the address, or the area of the address [Mejia et al. 2023a]. Situational awareness relies on knowing the surroundings, the people and groups in the environment, and the climate of violence or strife [Mejia et al. 2023b]. In this incident, the fire department gathers workplace violence information from each station and submits it as a department as required to the city risk manager. The information is readily available for each fire station to utilize in pre-shift briefings, hip-pocket trainings, and to further develop situational awareness, however there was no formal requirement to do so. Fire and EMS analysts should capture data that can identify concerning trends and provide it to the authority having jurisdiction (AHJ) for policy and SOP development.

Recommendation #4a: Fire departments should develop SOPs for scenes of violence, civil unrest, or terrorism in accordance with NFPA 1550, Standard for emergency responder health and safety, Chapter 10 and develop reporting requirements for violent incidents toward members.

Violence is a concern within the fire service because of the increasing seriousness and frequency of attacks on first responders [NIOSH 2021; NIOSH 2026]. Fire departments should develop policies and SOPs which include training and reporting requirements for violent acts toward members. Analyzing incident data by fire stations across a municipality or county can help identify patterns in response demands and potential safety risks. This data can inform decisions about staffing, training, supplies, and other resources needed to protect responders while meeting community needs. The data can also be used to inform pre-arrival violence risk alerts at dispatch, which can serve as the first point of hazard identification and has been associated with a reduction in violence against EMS [McGuire et al. 2025]. Fire and EMS analysts should ensure that pertinent information is collected and provided to the AHJ to support partnering with governmental agencies and community organizations and ensure training and response policies are further developed [NFPA 1022 2025; NFPA 1750 2026]. The National Fallen Firefighters Foundation (NFFF) provides the Firefighter Life Safety Initiatives Matrix which supports developing violent incident protocols along with building partnerships with governmental agencies and community organizations [NFFF 2024].

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In this incident, the city had a workplace violence program (WVP) in place in accordance with the California Code of Regulations, Title 8, Section 3342, Violence Prevention in Health Care. This program requires reporting of all workplace violence incidents involving city agencies. Information reported is managed and maintained by the city's risk management for five years. Other reporting systems that are available to fire departments and EMS agencies include the National Emergency Response Information System (NERIS) and the National Emergency Medical Services Information System (NEMSIS). Ultimately it is up to each fire department to determine which approach – or combination of approaches – is most feasible and best aligned with operational needs for documenting and analyzing violent incidents.

In November 2024, the U.S. Fire Administration (USFA) launched NERIS to modernize incident data collection (formerly NFIRS) and provide near real-time analytics for local fire departments across the United States [USFA 2024; DHS 2025]. NERIS is a secure, cloud-based platform that captures all-hazards incident data and includes fields to document violence against responders, such as incident modifiers and injury factors (e.g., "hostile acts") [NERIS 2026]. Although NERIS supports standardized reporting, CAD and records management systems (RMS) platforms vary across departments, so some data fields may be optional or inconsistently captured. Fire departments should review their systems and NERIS configurations to ensure violence indicators are enabled and sufficient detail is recorded for analysis. RMS platforms often allow narrative descriptions that can capture violent incidents in greater detail.

The NEMSIS data, collected through ePCR systems, also includes elements to capture violence against EMS personnel during patient care encounters. Within the NEMSIS v3.5.1 Data Standard, the element eOther.06 (The Type of Work-Related Injury, Death or Suspected Exposure) allows for the documentation of violence experienced by EMS clinicians. While these elements exist within the standard EMSDataSet, in 2026, NEMSIS released a new data schema (HAZDataSet) that allows for comprehensive documentation of violence against EMS personnel. Although the HAZDataSet can be incorporated into existing ePCR software, it should be reported separately from the ePCR [NEMSIS 2026]. Capture of violence-related data and completeness depends on local system configuration.

Governing municipalities (federal, state, regional/county, and local) should:

Recommendation #4b: Analyze fire department and EMS agency data and allocate behavioral health resource availability based on trending emergency calls.

AHJs can share incident data with municipal or county-led community care programs so that high-risk locations or individuals associated with repeated violence can be identified and prioritized for intervention. Community partners—such as public health agencies, behavioral health providers, social services, and violence prevention programs—can then implement targeted, non-emergency interventions (e.g., mental health outreach, substance use treatment, housing support, or conflict mediation). By addressing root causes, community care efforts can reduce the frequency and severity of violent incidents encountered by responders.

Co-responder models improve upon traditional EMS and law enforcement response systems integrating public safety capabilities such as rapid stabilization, scene control and public safety management while

recognizing behavioral health crisis response addresses the dynamic human interactions involved that are frequently rooted in trauma, psychiatric illness, substance use disorder, or social instability [Bakko et al. 2025]. Co-responder models allow responders to prioritize de-escalation, therapeutic communication, psychiatric assessment and linkage to care while maintaining operational safety [SAMHSA 2020; SAMHSA 2025; Bakko et al. 2025]. Such an integrated approach may reduce injury to both responders and clients by reducing escalation and ultimately achieving better safety outcomes for the clients and the responders who serve them.

Post-Incident Fire Department Prevention Actions

Based on the fire department's critique of this incident, the fire department implemented:

- Response modifications for medical priority dispatch involving psychiatric/abnormal behavior/suicide attempt depending on the level of severity:
    - Minor or non-emergency – No response. Caller will be transferred to associated partners or 9-8-8.
    - Serious non-life threatening – No dispatch. Law enforcement will be notified to respond and then notify the fire department if response is needed.
    - Life-threatening emergencies requiring a single ALS response – No dispatch until law enforcement determines scene is secured.
    - Life-threatening emergencies requiring multiple ALS response – Dispatch and response prior to confirming law enforcement arrival
    - Regardless of severity, no dispatch or response where a subject is physically violent, expressing threats towards others or responders, or in possession of a weapon.
- The Behavioral Response Protocol - The fire department and city officials held discussions about behavioral health response protocol development over 3-4 years. A joint agreement between the fire department and the police department which defines a policy for responding to uncooperative patients, restraint of uncooperative patients, transportation of restrained patients, and documentations of applied restraints was finalized and signed September 9, 2025.

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Disclaimers

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During the preparation of this work the author(s) used HHS ChatGPT to improve readability and conciseness of text that we had already written. After using this tool/service, the author(s) reviewed and edited the content as needed and take(s) full responsibility for the content of the publication