

NIOSH FIRE FIGHTER FATALITY INVESTIGATION AND PREVENTION PROGRAM



SERIOUS INJURY REPORT

Firefighter-paramedic stabbed by patient during involuntary commitment transport – Ohio

F2026-11 OH • September 2026

KEY POINTS

- On July 8, 2026, one career firefighter-paramedic was seriously injured after being stabbed by a patient.
- Fire departments not only respond to incidents caused by violence but may encounter violence at seemingly routine service calls.
- Although the rate of line-of-duty deaths from incidents of violence is not large, violence has been a growing concern because of the increasing seriousness and frequency of attacks on first responders.



Image 1. Medic 6 in station. (Source: NIOSH)

SUMMARY

The outpatient behavioral health clinic called 911 to request an involuntary commitment transport for a patient. Medic 6 was dispatched and arrived on scene first as police response was delayed. The case manager provided the Medic 6 crew with the involuntary commitment paperwork and identified the patient. Unwilling to be transported to the hospital, the patient pulled out a pocketknife. As the Medic 6 officer attempted to deescalate the situation, the patient opened the 4-inch blade and charged the crew. Medic 6 paramedic was stabbed in the lower back. *See Table 1 for contributing factors and prevention actions.*

Table 1. Contributing factors and prevention actions

Contributing factor	Prevention action summary
1. Law enforcement response	Train fire officers and firefighters to request immediate law enforcement response when there is an active or imminent threat of violence with weapons.
2. Perception of risk	Establish and reinforce operational practices to support fire officers and firefighters in anticipating, recognizing, and responding to emerging threats.
3. Active or imminent threat of violence with weapon	Coordinate response procedures with fire departments to effectively and swiftly respond to active or imminent threats of violence on an incident scene.
4. Emergency dispatch protocols for involuntary commitment transports	Update emergency dispatch protocols to ensure the appropriate entity is dispatched for requests for involuntary commitment transports.
5. Response for behavioral health emergencies	Develop and implement a 24/7 mobile crisis team to provide community-based response to behavioral health emergencies and involuntary commitment transports of non-violent patients without medical conditions warranting fire and EMS involvement.
6. Available personnel/adequate staffing	Use fire department and law enforcement data to ensure adequate staffing is available to respond to emergency incidents.
7. Patient notification of involuntary commitment	Inform patients of involuntary commitment in private and secure settings.

BACKGROUND

Table 2. Fire department information

Category	Information
Department type	Career
Bureaus	Operations and administration
Jurisdiction	26 square miles
Population	78,000 residents
Average response	19,500 calls for service, including 16,700 EMS annually
EMS	Advanced life support
Personnel	130
Shifts	Three (A, B, and C)

Category	Information
Shift type	24/48
Shift staffing	29 minimum
Leadership	One chief, two assistant chiefs, and three battalion chiefs

Apparatus, staffing, and communications

The county sheriff's office operates a public safety answering point (PSAP) that dispatches all emergency and non-emergency fire, EMS, and law enforcement response calls. At 14:59, the following units were dispatched for an involuntary commitment transport at an outpatient behavioral health clinic (see Table 3):

Table 3: Units dispatched

Apparatus	Staffing	On-scene arrival
Medic 6	3	15:09
Police 1	1	15:18 (delayed)

At 15:14, the following units were dispatched at the request of Medic 6 officer after the patient produced a pocketknife and stabbed the Medic 6 paramedic (see Table 4):

Table 4: Units dispatched

Apparatus	Staffing	On-scene arrival
Battalion 1	1	15:18
EMS 1	1	15:18
Additional police units	3	15:20

Training, education, and professional development

The fire department provides initial recruit training through a local academy for firefighter and EMS programs. The training spans a total of five months for a minimum of five recruits who graduate with NFPA 1001 Firefighter II and state certification as emergency medical technicians (EMTs). Following graduation, recruits have three years to achieve state certification as a paramedic.

Medic 6 officer had 18 years of total fire service experience at the fire department, with 5 years as a lieutenant. Medic 6 paramedic (seriously injured) had 3 years of total fire service experience at the fire department. Medic 6 EMT had 6 months total fire service experience at the fire department.

Cause of serious injury

Medic 6 paramedic was stabbed in the lower back with a 4-inch pocketknife blade. He was treated at the local hospital and off work for three weeks to recover.

Outpatient behavioral health clinic

This incident occurred at an outpatient behavioral health clinic that provides community-based services. Licensed clinicians provide counseling, therapy, substance use treatment, group services, and nursing care. The clinic also has a full-service pharmacy. When patients are deemed to need services beyond what the clinic provides, they are referred to a partnering mental health hospital.

Occasionally, the clinic transports patients to the hospital who voluntarily elect to receive these services. When deemed necessary, the clinic pursues involuntary commitment (locally known as pink slip) of patients. *More about involuntary commitment and methods in the state of Ohio can be found under [More information](#).*

The main entrance to the clinic on Side Alpha includes two sets of double doors leading to the lobby. A rounded reception desk enclosed with glass windows is directly in front of the main entrance. A waiting area with seating is to the right (towards Side Delta) of the main entrance and leads to a hallway where the pharmacy is located. A short hallway is to the left (towards Side Bravo) of the main entrance and leads to an area with patient examination rooms. The door to enter the area with patient examination rooms requires key card access. The clinic has signs indicating that weapons are prohibited but does not have security screening.



Image 2. Lobby of outpatient behavioral health clinic where the incident occurred. Photo taken post-incident. (Source: NIOSH)

Involuntary commitment transport

The fire department in this incident has been dispatched for involuntary commitment transports for the past four years. A total of 512 involuntary commitment transports were conducted by the fire department in 2025. Most of these calls for service were dispatched between 16:00-07:59 with the majority of calls concentrated in repeat locations. The county PSAP dispatches a fire department medic and a police unit for these calls for service in the jurisdiction. These are dispatched as an “emotionally disturbed person” computer-aided dispatch (CAD) code versus a dedicated involuntary commitment transport type of response code (e.g. involuntary commitment, non-emergency transport). The medic unit will transport the individual to a local hospital with the police unit following behind them in case of any emergency requiring law enforcement intervention. Firefighters interviewed by NIOSH noted that they often stage and wait for the arrival of a police unit before engaging with the individual. They sometimes request the police unit to check individuals for weapons prior to allowing them into the medic unit. They occasionally request a police unit to ride in the medic unit to the local hospital.

NIOSH interviewed county PSAP personnel who noted that the county sheriff’s office is the only entity dispatched for involuntary commitment transports in the rest of the jurisdictions in the county. Fire and EMS are only dispatched in these other jurisdictions when there are reports of medical necessity such as overdose or self-harm of those needing transport.

County mobile crisis team

The county has had a contracted mobile crisis team since 2023 that provides behavioral health emergency response and incident deescalation. The team includes one licensed clinician or social worker from 08:00-17:00 Monday through Friday. The team was originally housed within the fire department’s main station. The team is not dispatched through the county PSAP and uses a privately-owned vehicle for incident response. The team has an account on the fire department’s mobile phone application to view calls for service details. Based upon a set of established criteria, the team self-dispatches to an incident. According to fire department standard operating procedures (SOPs), the team can be requested to respond to an incident by firefighters radioing the PSAP who will call the team on their work cell phone. The team does not provide transportation for individuals who voluntarily elect to go to a hospital or those subject to involuntary commitment. The mobile

crisis team did not respond to this incident.

Personal protective equipment

At the time of the incident, the Medic 6 crew (officer, paramedic, and EMT) were wearing level D personal protective equipment consisting of duty uniforms. Each medic unit is equipped with two sets of ballistic protective equipment consisting of vests and helmets. Each vest is rated for National Institute of Justice level IV protection. This level provides protection from lead core rifle ammunition but is not rated for protection against edged blades and spikes. The department's ballistic protective equipment SOP states that the vests should be worn on any call for service where potential for violence is reasonably expected. This includes threats of violence, shootings, suicide attempts, intoxication and overdose, mental illness impairment, and SWAT standbys. The SOP states the ranking officer or senior member assigned to the incident has the authority to ensure this equipment is used but can discontinue use based on a scene size-up and verified, credible information available. Ballistic protective equipment was not being worn by the Medic 6 crew at the time of the incident.



Image 3. Ballistic protective vest from Medic 6 unit. (Source: NIOSH)

TIMELINE

This is a timeline of events. Sources include dispatch records, audio recordings, and witness statements, among others. This is not an official record of events.

Day 1: July 8, 2026

14:59-15:08

- PSAP received a 911 call from a case manager requesting an involuntary commitment transport at an outpatient behavioral health clinic. The case manager requested paramedics and “maybe” police for response.
- PSAP dispatcher asked if the patient was causing any problems. The case manager replied that the patient “is not causing a problem at this time.”
- PSAP transmitted an alarm assignment and dispatched Medic 6 and Police 1.
- Medic 6 crew read the call notes for additional information and responded.
- Police units in the jurisdiction were attending shift change roll call at the time of this incident. PSAP notified fire department units on a separate vehicle accident response of a delayed police response.
- At this time, the patient had been asked by staff at the outpatient behavioral health clinic to wait in the lobby and was not informed of the staff’s decision for involuntary commitment (emergency hospitalization). The patient paced in the lobby and outside the main entrance on Side Alpha.

15:09-15:11

- Medic 6 arrived on scene and noted some individuals standing outside of the clinic. Medic 6 crew entered

the lobby through the main entrance.

- Medic 6 officer spoke to the receptionist to ask where the patient was located that needed transport. The receptionist replied that she did not know but stated a nurse would be out soon to assist the crew.
- Medic 6 crew stood near the main entrance doors in the lobby. The patient entered the lobby and leaned against the main entrance door wall, approximately 5 ft from the crew.
- A nurse entered the lobby from the patient examination area and spoke to the Medic 6 crew. Medic 6 officer asked the nurse where the patient was located to which she replied that she did not know.



Image 4. Medic 6 crew and patient standing near the main entrance doors in the lobby. (Source: Fire department)

15:12-15:13

- Case manager entered the lobby from the patient examination area and provided the involuntary commitment paperwork (pink slip) to Medic 6 officer. He asked for the location of the patient.
- Case manager pointed to the patient who was still leaning against the main entrance door wall. The patient immediately put their hands in their pants pockets.
- Medic 6 officer asked the case manager if the patient was willing to go to the hospital. She replied that she “thinks so.”
- Case manager asked the patient if they were willing to go with Medic 6 to the hospital. The patient replied that they were not willing to go, and the case manager responded that she “would really like” them to go.
- Case manager walked towards the main entrance, gesturing to the patient that she would walk with them to the medic unit.

15:14-15:15

- Patient pulled a pocketknife out of their pants pocket and tried to open the 4-inch blade with difficulty. Medic 6 officer immediately attempted to deescalate the situation by talking to the patient.
- Medic 6 officer slowly approached the patient. Not knowing the reason for the involuntary commitment, he believed the patient may attempt to harm themselves with the pocketknife. Medic 6 officer planned to swat the pocketknife out of the patient’s hands.
- The patient fully opened the blade as the case manager and Medic 6 crew began to slowly retreat into the

hallway to the patient examination area.

- The patient followed them and stabbed Medic 6 paramedic (seriously injured) in the back. Medic 6 EMT took shelter in a bathroom, while the Medic 6 officer and paramedic entered a patient examination room and secured the door.
- The patient dropped the pocketknife and walked to the hallway leading to the pharmacy. They were eventually isolated in the hallway by staff at the outpatient behavioral health clinic who held the hallway doors closed until police arrived.
- Medic 6 officer radioed the PSAP to “give me police right now” and requested Battalion 1 and EMS 1. PSAP asked if Medic 6 officer needed police “emergent.” Medic 6 officer began to assess Medic 6 paramedic’s injury, applying gauze and dressings to stop bleeding.
- Hearing no response, PSAP repeated asking if Medic 6 officer needed police “emergent.” Medic 6 EMT replied that they needed “police emergent ASAP.”
- PSAP dispatched Battalion 1, EMS 1, and additional police units for an upgraded priority assignment. Chief 1 and Logistics 1 self-dispatched after hearing the “emergent” request for police.
- Battalion 1 responded and requested the PSAP to add an additional fire department unit as well as county sheriffs if police were not available. PSAP dispatched Engine 4 and notified Battalion 1 that a police unit was responding emergent.



Image 5. Patient following Medic 6 paramedic with pocketknife. (Source: Fire department)

15:16-15:21

- Nurses assisted Medic 6 officer in assessing Medic 6 paramedic’s injury and controlling bleeding.
- Chief 1, Logistics 1, Battalion 1, and EMS 1 arrived on scene. Battalion 1 assumed command of the incident.
- Engine 4 and police arrived on scene. Police responded to the hallway where the patient was isolated.
- Chief 1 requested an additional medic unit and informed the PSAP that a firefighter was stabbed. Medic 6 paramedic was loaded into the medic unit and transported to the local hospital for treatment.
- Chief 1 confirmed that no staff at the outpatient behavioral health clinic were injured.

CONTRIBUTING FACTORS AND PREVENTION ACTIONS



Contributing factor · Law enforcement response

Prevention action · Fire departments should train fire officers and firefighters to request immediate law enforcement response when there is an active or imminent threat of violence with weapons.

At this incident, Medic 6 officer attempted to deescalate the situation by talking to the patient after they presented a pocketknife. After Medic 6 paramedic was stabbed and secured in a patient examination room, Medic 6 officer requested the PSAP to dispatch police immediately. The fire department's SOP on incident response and notification provides a tiered procedure for requesting law enforcement response. The procedure requires requests to be made through the PSAP. The tiered procedure assists law enforcement in prioritizing response and determining how to respond per their department's SOPs. The procedure lists: 1) non-emergent for instances where there is no threat of violence, 2) urgent when there is increased threat of violence or a crime in progress, and 3) emergent when there is an active or imminent threat of violence with or without weapons that may result in serious injury or death of a firefighter or citizen.

Fire departments not only respond to incidents caused by violence but may also encounter violence at seemingly routine service calls. Although the rate of line-of-duty deaths from incidents of violence is not large, violence has been a growing concern because of the increasing seriousness and frequency of attacks on first responders [Attwood et al. 2026; NFFF 2014]. NFPA 1550 [2024] recognizes the potential for violence, active shooters, unrest, and civil disturbance as threats that firefighters may encounter during incident response. These threats to firefighter safety may interfere with their ability to perform responsibilities such as patient care and fire suppression [NIOSH 2026a]. NFPA 1550 [2024] recommends that fire departments develop agreements and SOPs with law enforcement agencies. Such agreements and SOPs could establish a standard approach to ensure the safety of firefighters working at emergency scenes. This includes standard communication methods, such as coded language for firefighters that indicate they are in a life-and-death situation requiring immediate law enforcement intervention. Use of coded language, or a standard phrase only known by responders, can warn other responders to the dangers of the situation without triggering hostilities [Attwood et al. 2026; NIOSH 2026a].

Like the fire department in this incident, standard communication methods can be developed in a tiered procedure to assist law enforcement with prioritizing response and determining how to respond per their department's SOPs. Established procedures should include guidance for fire officers and firefighters on when to request immediate law enforcement response. These requests should be made without delay when there is an active or imminent threat of violence with weapons to support timely response and mitigation. Fire departments can provide opportunities for joint training with law enforcement on these procedures, including recognizing situations that may escalate to violence [Attwood et al. 2026]. This may also include training on appropriate steps to deescalate the situation before law enforcement arrives as well as disengagement and maintaining an escape route. Fire departments can utilize NFPA 3000 [2024] for guidance on interagency planning and operations with law enforcement.



Contributing factor · Perception of risk

Prevention action · Fire departments should establish and reinforce operational practices to support fire officers and firefighters in anticipating, recognizing, and responding to emerging threats.

Firefighters interviewed by NIOSH noted a reduced perception of risk when responding to and during the incident. The call for service was located at an outpatient behavioral health clinic where firefighters knew

licensed clinicians were present and weapons were prohibited. The call notes reviewed by the Medic 6 crew indicated that the caller stated the patient was “not causing a problem at this time.” This led them to believe the patient had been notified of the involuntary commitment prior to their arrival. Additionally, the firefighters noted that the patient appeared to be calm during the incident, even when they saw them outside of the main entrance upon arrival to the clinic.

Situational awareness is an ongoing process that includes the perception of risk and can be influenced by system, organizational, and environmental conditions and processes. Situational awareness involves recognizing identified and potential hazards, observing changes in the environment or the emergency scene, and evaluating those changes in relation to organizational safety practices [IFSTA 2024]. Changes and dynamic conditions of an emergency scene can affect firefighter safety during operations. Specific to this incident, situational awareness can support anticipating, recognizing, and responding to potential threats of violence. This can include an initial assessment of the environment, ongoing observation of changing conditions, and consideration of how those changes may affect the perceived level of risk. Finally, recognizing potential signs that a situation may become tense and keeping an identified escape route in mind are elements of response within this awareness framework [IFSTA 2024; Schottke 2022].

Throughout an incident response, situational awareness, including continuous assessments of risk, can be supported through ongoing observation, communication of findings with key personnel throughout the response, and periodic efforts to establish and reestablish a shared understanding of evolving conditions to support effective decision making. Maintaining situational awareness can be applied in a similar way to performing an ongoing risk assessment at a structure fire where information is constantly collected through observation, an evaluation of factors is performed, and decisions for response are made [NIOSH 2026c]. In a setting like in this incident, fire officers and firefighters should attempt to collect a thorough and sufficient patient history from healthcare providers as part of an initial assessment to supplement ongoing situational awareness [Schottke 2022]. This should also include collecting information upon arrival about whether the patient has history of violence or has tried to elope to assess a patient’s risk of agitation. With this information, fire officers and firefighters should also ascertain if healthcare providers would deem restraint or sedation necessary as part of the patient transport [Moskovitz et al. 2020].



Contributing factor · Active or imminent threat of violence with weapon

Prevention action · Law enforcement agencies should coordinate response procedures with fire departments to effectively and swiftly respond to active or imminent threats of violence on an incident scene.

This incident was dispatched when police units in the jurisdiction were attending shift change roll call. Fire department units on a separate vehicle accident response were notified of a delayed police response by the PSAP. As such, police units were delayed in arriving at the incident until after being requested for an emergent response by the county PSAP.

NIOSH has investigated several firefighter fatality and serious injury incidents resulting from violence during routine calls for service [NIOSH 2026b; NIOSH 2026a; NIOSH 2021; NIOSH 2019; NIOSH 2018; NIOSH 2005]. In previous investigations, NIOSH stressed the importance of ensuring scene safety by coordinating with local law enforcement [NIOSH 2026a; NIOSH 2021]. NFPA 1550 [2024] recommends that fire departments develop agreements and SOPs with law enforcement agencies. Agreements and SOPs should establish a standard approach to ensure the safety of firefighters working at emergency scenes including [Attwood et al. 2026; NFPA 1550 2024]:

- Identifying which types of calls and locations may require law enforcement presence during a fire response.
- Response roles and responsibilities, such as law enforcement securing the scene and firefighters maintaining incident management through unified command.
- Ways to mitigate violent interference before law enforcement arrives on scene.

- Next steps when violence occurs after emergency operations have started, such as immediate law enforcement protection or withdrawal of all firefighters to a safe staging area.
- Developing PSAP protocols to support communication across radio frequencies used by law enforcement and firefighters.

Further, coordinated response procedures should identify which types of calls for service and in what geographic areas law enforcement should immediately respond with the fire department to provide scene safety. Geographic areas can be selected using the fire department's community risk assessment results [NFPA 1660 2024]. This can include areas that experience increased rates of crime and other intentional human-caused hazards (e.g. civil disorder). Other data sources may offer useful layers as well. For example, previous NIOSH research found associations between measures in the Social Vulnerability Index (SVI) and the types of calls received, identifying opportunities to integrate SVI with CAD data to support emergency planning and response [Haas et al. 2021]. Combining these data with fire department and law enforcement records may further aid in the identification of geographic patterns in medical, behavioral health, violence-related, and other calls for service; locations where coordinated responses are frequently needed; and periods when overlapping demand affects resource availability.

For this incident, CAD code types such as involuntary commitment transports are applicable data sources to consult. The jurisdiction's PSAP CAD system should be updated with the identified types of calls and areas for coordinated response. Any communication methods developed under these joint agreements or SOPs should also become a part of dispatch protocols. Once these SOPs are in place, fire departments should routinely train with law enforcement agencies and the PSAP to practice maintaining effective joint response procedures. Routine training ensures personnel and resources are prepared to work together and can operate as a functional team [NIOSH 2026a; USFA 2017]. Coordinated response should ensure that law enforcement is present on scene when firefighters are to establish scene safety and respond to active or imminent threats of violence without delay. In some cases, this may involve law enforcement being dispatched first to physically secure a scene before a fire department is dispatched to the incident.



Contributing factor · Emergency response protocols for involuntary commitment transports
Prevention action · Public Safety Answering Points (PSAPs) should update emergency response protocols to ensure the appropriate entity is dispatched for requests for involuntary commitment transports.

County PSAP personnel interviewed by NIOSH noted that the county sheriff's office is the only entity dispatched for involuntary commitment transports in the rest of the jurisdictions in the county. Fire and EMS are only dispatched in these other jurisdictions when there are reports of medical necessity such as overdose or self-harm of those needing transport.

In the United States, most jurisdictions utilize law enforcement for custody and transportation as part of the involuntary commitment process. Even when state laws permit non-law enforcement entities to perform this function, absence of alternative transportation options creates situations where law enforcement serves as the default. Other jurisdictions permit the use of non-law enforcement transportation for involuntary commitment. These include healthcare providers, other government agency personnel, EMS, private transportation, and mobile crisis teams [Swartz et al. 2025]. In addition to complying with state or jurisdictional laws, emergency response entities, such as law enforcement agencies and fire departments, should work with PSAPs to update emergency response protocols to ensure the appropriate entity is dispatched for requests for involuntary commitment transports. These entities should collaborate on these updates to ensure they meet the needs of their jurisdiction as well as the capabilities of their resources. These protocols are standard response assignments predetermined by the location and nature of the reported incident which regulate the dispatch of entities and resources for emergency incidents [NFPA 1750 2026; Levy et al. 2024]. For example, protocols can be updated to dispatch fire and EMS when a request for involuntary commitment transport includes information indicating medical necessity such as active bleeding or overdose. The protocols can also be

updated to ensure that law enforcement is dispatched whenever threats, violence, or weapons have been reported.



Contributing factor · Response for behavioral health emergencies

Prevention action · Authorities having jurisdiction should develop and implement a 24/7 mobile crisis team to provide community-based response to behavioral health emergencies and involuntary commitment transports of non-violent patients without medical conditions warranting fire and EMS involvement.

The county has had a contracted mobile crisis team since 2023 that provides behavioral health emergency response and incident deescalation. The team is staffed by one licensed clinician or social worker from 08:00-17:00 Monday through Friday. Incident responses are coordinated outside the county PSAP, and the team responds using a privately owned vehicle. The team does not have the capability to transport patients.

In the United States, fire and EMS are responding to increasing calls for service. Some of these responses are not always true medical emergencies. While fire and EMS do their best to navigate these calls amid higher priority responses, there are many instances where there simply are not enough resources to go around [Levin et al. 2026]. This is a similar reality for law enforcement, with some reports finding that an average of 10% of law enforcement agencies' budgets were spent transporting individuals with mental illness [TAC 2019]. Authorities having jurisdiction can review and evaluate existing response models and identify alternative or coordinated approaches that may provide more appropriate interventions that improve outcomes for both patients and first responders. For behavioral health emergencies, many communities across the United States have implemented mobile crisis teams as an alternative to traditional EMS and law enforcement-only response. These community-based services provide rapid support for individuals experiencing a crisis. Services offered by these teams include meeting individual needs, providing support, ensuring safety, and coordinating follow-up care [SAMHSA 2025].

SAMHSA [2025] notes that there are variations in service delivery and team composition across the nation for response to calls involving individuals experiencing a behavioral health crisis. But there are generally three types of mobile crisis team service models available for authorities having jurisdiction to consider developing and implementing to address the needs of their communities. These include [SAMHSA 2025]:

- **Behavioral health practitioner-only service** comprised of a minimum of two people with at least one being a licensed and/or credentialed provider to conduct crisis assessment.
- **Co-responder team** comprised of specially trained law enforcement, fire/EMS, and behavioral health professionals.
- **Mobile response and stabilization services** designed to address youth and facility-specific crises.

As an alternative emergency response entity, mobile crisis teams respond to a dispatch request that is initiated by a crisis contact or call for service, meet the individual experiencing the crisis in-person (face-to-face interaction) at any community-based location, and perform a clinical assessment of the needs of the individual in crisis [SAMHSA 2025]. Authorities having jurisdiction should weigh the risks and benefits of the different types of mobile crisis teams with their specific community needs and access to care challenges. When a mobile crisis team is implemented, it should be integrated into the jurisdiction's PSAP emergency dispatch response protocols. Training between the mobile crisis team and other response entities such as law enforcement, fire departments, and EMS is critical to ensure personnel and resources are prepared to work together, can operate as a functional team, and understand each other's roles and capabilities.



Contributing factor · Available personnel/adequate staffing

Prevention action · Authorities having jurisdiction should use fire department and law enforcement data to ensure adequate staffing is available to respond to emergency incidents.

Firefighters interviewed by NIOSH noted that both the fire department and law enforcement agency in the jurisdiction are resource-strained due to high call volume. This requires prioritization of calls for service received. Firefighters noted that it was not uncommon for them to be on scene before police or to subsequently wait more than 20 minutes for their arrival as they were committed to other incidents. For involuntary commitment transports, the firefighters noted that higher priority EMS calls would be received while they waited for police. They explained that these occurrences influenced a normalization of deviance where they would engage with individuals for involuntary commitments without police as they wanted to clear out these transports so they could be available for higher priority calls for service.

Adequate staffing is necessary to meet the needs of the community and ensure safe, effective, and efficient emergency operations [NFPA 1750 2026; NIOSH 2026c]. As noted in an earlier prevention action, consulting incident data by fire or police department across a jurisdiction 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. Data can also support collaborative community care programs overseen by municipal or county leadership, including mobile crisis teams.

Fire departments and law enforcement agencies often maintain standardized reporting systems, typically supported by CAD and records management systems (RMS), that collect specific information on each incident or call for service. Incident reports include the location and nature of the fire or emergency, describe the circumstances of the incident and the operations performed, and identify the members responding to the incident. These structured reporting systems provide a means to document and monitor incidents within their jurisdiction. Using incident CAD/RMS data, leadership may proactively identify locations or individuals responsible for frequent, resource-intensive calls and analyze patterns such as timing, call type, and reason for response. This information can help communities mitigate ongoing risks and allow responders to be better prepared for future calls, improving safety and ensuring appropriate resources are available [NIOSH 2026b; NFPA 1750 2026; NFPA 1022 2025]. This allows fire departments and law enforcement agencies to identify trends as well as resource needs which can be shared with their authorities having jurisdiction and their department members for awareness [NFPA 1750 2026; NFPA 1022 2025].

The availability of data alone, however, may not provide a complete understanding of resource needs. The data also needs to be accessible and available in a way that supports planning and decision making [Haas et al. 2021]. For example, analysis of concurrent calls, response times, periods of limited unit availability, and the frequency and duration of incidents requiring both fire department and law enforcement resources may help identify where operational demand and available resources do not consistently align. Although only available on the fire-service side, the National Emergency Response Information System (NERIS) is a step in the right direction by standardizing fire and emergency response data and providing tools for accessing, analyzing, and visualizing incident information [USFA 2026]. Routinely reviewing available information together can provide authorities having jurisdiction and responding agencies with a shared understanding of service demands and resource needs.



Contributing factor · Patient notification of involuntary commitment

Prevention action · Healthcare providers should inform patients of involuntary commitment in private and secure settings.

At this incident, the patient had been asked by staff at the outpatient behavioral health clinic to wait in the lobby

and was not informed of staff's decision for involuntary commitment (emergency hospitalization). The patient paced in the lobby and outside the main entrance on Side Alpha until the arrival of the Medic 6 crew. The patient became aware of the involuntary commitment while in the lobby in the presence of multiple staff and firefighters positioned around them.

Receiving difficult news can be distressing to patients. Informing a patient that they will be losing some autonomy and control in their lives can be challenging, especially when the patient is suffering from severe mental illness that may impact judgement and emotional regulation. Healthcare providers may be concerned about patient agitation caused by these difficult conversations [Hsiung et al. 2023]. While preventing agitation may not be avoidable, healthcare providers can prepare for these conversations and attempt to deliver this news in a manner that considers the potential reaction of the patient. This includes delivering the news in a physical setting that healthcare providers believe ensures privacy and is conducive to undistracted and focused discussion [Baile et al. 2000]. Equally important is the timing of patient notification and what is communicated. Patients process information differently, and there is variability in health literacy. As such, communications with patients about what is happening, what next steps are, and why, are best when they are not rushed. This includes giving patients the opportunity to ask questions and receive answers [Rivera et al. 2024; Hsiung et al. 2023; Baile et al. 2000]. Considering both setting and time may allow for deescalation prior to involuntary commitment and transportation to another facility. Healthcare facilities can adopt this approach by integrating it into SOPs which also detail procedures for patient management after a decision is made to pursue involuntary commitment. This may involve the engagement of security personnel and an assessment of possession of weapons.

CONSIDER THIS

Although there is no evidence that the following actions would have prevented this serious injury, they are reminders of critical firefighter safety components to use during, before, and after incident operations.

Resources and protocols to address occupational exposure to potentially traumatic events

Following this incident, the jurisdiction's multi-agency peer support team responded. They provided support to Medic 6 paramedic and their crew members. The team provided additional support for the other first responders who were at the scene as well as the PSAP dispatcher who handled the incident. The fire department provided employee assistance program information to all members affected by the incident.

Public safety sector workers, including firefighters and EMS providers, are at a high risk of occupational exposure to traumatic events and stress [Bonumwezi et al. 2022]. NIOSH previously highlighted the potential value of mental health programs for addressing the unique challenges these workers face including the potential health effects that may result from these exposures [Kiederer et al. 2024]. This includes chronic exposure to highly stressful situations as well as acute exposure to catastrophic events such as those in this incident. Research has shown that patient violence can have significant impacts on EMS providers' physical and mental health [Kim et al. 2025]. There is variation among people regarding their threshold for developing symptoms, how adverse events are processed, the coping strategies they use, and their willingness to seek help when their capacity to cope is challenged. These have implications on the mental health symptoms they may experience following a single exposure or cumulative exposures over time. These can also affect their overall well-being, interpersonal relationships, and job performance [NVFC 2021]. Previous investigations have revealed that effective programs deployed by agencies should be multi-faceted, address organizational factors, and focus on building resilience, stress management, post-traumatic stress disorder awareness, and coping strategies [NIOSH 2024]. NFPA 1550 [2024] provides recommendations for fire departments to prepare for and address occupational exposure to potentially traumatic events:

- Establish and maintain a relationship with an appropriately licensed behavioral health specialist that has knowledge and experience working with the fire department culture and traumatic exposure.
- Adopt and utilize a written policy outlining protocols to address exposure, including for the critical injury of a member or a line-of-duty-death.
- Ensure members are aware of and have access to a clear outline of assistance and interventions

available for affected members. This includes the [988 Suicide & Crisis Lifeline](#) that offers 24/7 access to trained crisis counselors who can help people experiencing mental health-related distress.

POST-INCIDENT FIRE DEPARTMENT PREVENTION ACTIONS

After this incident, the fire department implemented changes to its incident response and operations. These changes were based on the department's critique of the incident.

Revised response procedures with law enforcement

The fire chief and police chief began addressing the existing transport SOP and the responsibilities associated with transporting individuals under involuntary commitment when no medical necessity for fire department involvement exists.

Revised PSAP emergency dispatch protocols

The PSAP changed emergency dispatch protocols for all mental health-related response CAD codes at the direction of the fire chief. The fire department will not be dispatched directly to these incidents unless law enforcement is already on scene and specifically requests fire department activation based on medical necessity. Additionally, PSAP dispatchers will no longer attempt to determine whether an individual is calm, cooperative, aggressive, or otherwise safe for a fire department-only response.

Post-incident analysis

Per NFPA 1550 [2024], the fire department began a formal post-incident analysis to document observations, concerns, and recommendations related to this incident. The analysis focused specifically on dispatch procedures, department SOPs, operational practices, and training. This analysis was done concurrently with the NIOSH investigation of this incident.

MORE INFORMATION

Involuntary commitment

Review information previously shared on this subject [above](#).

Involuntary commitment is a legal intervention where a judge, or someone acting in a judicial capacity, orders that a person with symptoms of a serious mental illness and meeting other specified criteria, be confined in a hospital or receive supervised outpatient treatment for a period of time. Procedures for involuntary commitment are established by state law in United States. These procedures are implemented when it is determined that without a hospital-level of care, the person is believed to be at significant risk, in the foreseeable future, of behaving in a way that may bring harm to themselves or others [SAMHSA 2019].

There are two methods of involuntary commitment in the state of Ohio: 1) filing of an affidavit through a court and 2) emergency hospitalization. The former method requires a formal petition filed with a court with a hearing to determine if the individual is a person with a mental illness subject to hospitalization. The latter method allows for a professional (e.g. psychiatrist or other licensed physician, police officer, sheriff) to take an individual into custody and transport them to a hospital when the professional [Ohio 2025; OLRS 2010]:

- Has reason to believe the individual is a person with mental illness subject to hospitalization by court order and the individual represents a substantial risk of physical harm to themselves or others if allowed to remain at liberty pending examination.

The emergency hospitalization process requires the professional to complete state-required documentation (pink slip) that provides details about the person being involuntarily committed. This includes documentation of their name, an assessment, statement of belief they meet the criteria for emergency hospitalization, statement of observation, and information about the professional completing the documentation [Ohio n.d.].

Investigator information

Incident investigator and report author was Dr. Wesley R. Attwood, Senior Investigator, with the Fire Fighter Fatality Investigation and Prevention Program, Surveillance and Field Investigations Branch, Division of Safety Research, NIOSH. A subject matter expert review was provided by David N. Weissman, MD, Director of the Respiratory Health Division, NIOSH; Julian L. Gallegos, PhD, FNP-BC, NREMT, Assistant Professor, Purdue University; and Eric G. Carbone, PhD, Clinical and Forensic Psychologist, CDC/National Center for Injury Prevention and Control. James Wright, MS, LPC, Acting Director, 988 and Behavioral Health Crisis Coordinating Office, Substance Abuse and Mental Health Services Administration, provided a technical review. The NFPA Emergency Response & Responder Safety Division provided a technical review.

RESOURCES

National guidelines for a behavioral health coordinated system of crisis care

This [publication](#) by SAMHSA provides a framework to transform behavioral health crisis care systems and reduce the impact of substance use and mental illness on communities throughout the United States. These guidelines aim to provide accessible and effective responses to behavioral health crises, and support program design, development, implementation, and continuous quality improvement for behavioral health crisis care throughout the nation.

Strengthening police and fire coordination to keep scenes safe

This [article](#) discusses how law enforcement agencies and fire departments can better align responses, improve communication, and prevent interference during fireground operations.

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During report preparation, the author used the CDC PARTs, an AI tool developed by CDC based on ChatGPT (OpenAI, San Francisco, CA; 5.5; *Thinking Level*), to check the report's adherence to the [Domains of Excellence Framework for High-Quality Public Health Science](#). The author reviewed all output and is responsible for the accuracy, integrity, interpretation, and final content of the report.