Guidepost

Oakland County Government Independent After-Action Report

An Analysis of Multi-Agency Response and Recovery Efforts During and in the Aftermath of the Oxford High School Shooting on November 30, 2021

Warning: The information discussed in this report is of a sensitive and traumatic nature involving gun violence, death, AND harm to children. It may be potentially activating for victims and survivors.

September 15, 2025

Guidepost

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I. INTRODUCTION

On November 30, 2021, the lives of Oakland County, Michigan (Oakland County) residents were forever changed by a mass shooting at Oxford High School (OHS) that claimed the lives of four young students – Madisyn Baldwin (Madisyn), Tate Myre (Tate), Justin Shilling (Justin), and Hana St. Juliana (Hana). Six other students and one teacher sustained injuries, ranging from serious to critical, all of which required medical treatment.

In the aftermath of the shooting, Oakland County asked us to provide a comprehensive report evaluating the multi-agency response and recovery effort. Although Guidepost previously reviewed certain aspects of the OHS shooting,[1] this after-action report ("AAR") is focused primarily on the following topics:

- The effectiveness of the response by first responders, including but not limited to law enforcement, fire, EMS, emergency management, crisis counseling, and mental health coordinators;
- Command and coordination, communications including 9-1-1 operations, and interagency information sharing;
- Recovery efforts, including those involving the mental health of the community and first responders; and
- Strengths and weaknesses in protocols, policies, procedures, as well as training within all relevant first responder and governmental entities.

Throughout our review, we engaged directly with victims' families, survivors, first responders, and key personnel within multiple agencies. We thank them for their time and cooperation, particularly the families of Madisyn, Tate, Justin, and Hana.[2] We conclude this report with an *In Memoriam* section in honor of the victims.

[1] The first Guidepost report ("Guidepost 1"), submitted in May 2023, addressed the safety and security policies, guidelines, practices, and measures in place at OHS to minimize the risk of an active shooter. Guidepost 1 analyzed the regulations in place as of 2023 and did not review the measures in place at the time of the shooting in 2021. The second report ("Guidepost 2") focused primarily on the actions of the shooter and certain officials within Oxford High School, including their interactions with the shooter, as well as the school's emergency operating procedures and threat assessment policies.

[2] The four victims will be referred to by first name for the remainder of the report.

II. EXECUTIVE SUMMARY

There is no doubt that the first responders demonstrated courage and dedication under extreme conditions. The deputies from the Oakland County Sheriff's Department (OCSO) who were the first on the scene entered the school without hesitation. After establishing incident command, an OCSO lieutenant exercised leadership and coordination under pressure. Firefighters and Emergency Medical Services (EMS) personnel within the halls of OHS played a critical role in stabilizing victims and facilitating safe evacuation for survivors. Fire chiefs and captains worked together from Addison, Oxford, and Oakland Townships, as well as other neighboring departments, to create a command structure and rally forces to the high school and a staging location.

We emphasize that our review found no evidence of neglect or dereliction of duty by those individual responders. We did, however, identify certain breakdowns in command, coordination, communication, and training, which demonstrate the need for improved rapid response protocols, rescue task force (RTF) training, and enhanced tactical medical readiness. It is vital to victim survival, in cases where the injuries are not inherently fatal, that fire, EMS, and law enforcement agencies are trained to deploy integrated response teams quickly and effectively.

A. Victim Survivability

We conducted a review to determine whether a more rapid emergency response could have prevented the loss of life at OHS.[3] Our review determined that the nature and extent of Madisyn, Tate, and Justin's single gunshot wounds to the head were inherently fatal. Hana sustained multiple gunshot wounds, with resulting abdomen and chest injuries, which were collectively inherently fatal. Even with immediate medical intervention, the experts' consensus is that the outcomes would not have changed.

This conclusion is based upon information from the medical examiner's report as well as an analysis by Dr. Steven Shelton (Dr. Shelton), an independent medical expert. Dr. Shelton is an emergency room physician with extensive experience in a Level I trauma center. He is board-certified in both Emergency Medicine and Emergency Medical Services and has experience working with law enforcement, including participation in RTF initiatives. We asked him to opine as to whether the victims' gunshot wounds: (1) were capable of treatment, (2) were impacted by any delays by first responder agencies in treatment, and (3) were individually or jointly inherently fatal. Dr. Shelton reviewed all photographs and reports from the medical examiner's office. Dr. Shelton also interviewed

[3] We did not analyze whether the response time had any impact on survivors' injuries, as we did not request access to survivors' medical records.

the Oakland County Medical Examiner (OCME) Dr. Ljubisa Dragovic (Dr. Dragovic) and his staff of forensic pathologists who conducted the autopsies. The consensus by professionals from the Medical Examiner's Office and Dr. Shelton was that the trauma inflicted was beyond the scope of survivability. A comprehensive discussion of Dr. Shelton's analysis is set forth later in this report.

B. Oakland County Sheriff's Office

OCSO was transparent and cooperative throughout our review, providing access to internal reviews and dispatch records.[4] While OCSO personnel performed courageously on November 30, 2021, our review identified some deficiencies in: (i) the establishment of a unified command; (ii) communication practices upon entry into an active shooter scene; (iii) protocols related to the division of responsibilities between the OCSO School Resource Officer (SRO) and school security; and (iv) training.

First, there was a delay in establishing a formal incident command at the scene of the shooting. Although multiple ranking officers were present, there was an approximately 25-minute gap before a lieutenant assumed the role of incident commander.[5] During this 25-minute period, although critical objectives were met and the shooter was apprehended, there was some confusion about where resources should be directed and coordination with public safety officials such as fire/EMS was disjointed. Once command was established, law enforcement agencies were aligned with the roles needed to complete the building clears, secure the interior of the building, and create a perimeter around the outside of the building.

There were some breakdowns in communication regarding the locations of officers and victims early in the response. For example, the first two officers to enter OHS, while understandably focused on the apprehension of the shooter, did not provide updates on their own movements, victim locations, or conditions via radio. Best practices suggest that, as the first responders on the scene, they are the "de facto" command and should not only announce their entry point but also provide information about what they saw as they came upon the victims in the hallway. Also, due to a lack of effective communication, some efforts were duplicated. Injuries were reported multiple times and OHS surveillance depicted numerous deputies clearing the same hallways.

[4] It should be noted that OCSO provided us with a PowerPoint presentation assessing law enforcement's actions taken on November 30, 2021. While OCSO's presentation did not acknowledge any performance errors or missteps, we believe that there are areas for improvement as discussed in this report.

[5] The time delay calculation depends upon where the measurement starts. The shooting began at approximately 12:51. The first two deputies arrived at OHS at approximately 12:57 and entered around 12:58. Command was established at 13:25.

Third, there was no protocol at the time detailing the responsibilities of OCSO's designated school resource officer (SRO) in relation to school security. OCSO provides a full-time SRO for OHS and Oxford Middle School (OMS) during the school year. The SRO was not required to remain on campus and was not present at the time the shooting began, having left earlier for an investigation at OMS and a stop at the substation. On the same day, the school security officer was absent on pre-approved leave. Consequently, a part-time armed hall monitor was the sole armed individual at OHS. Going forward, expectations must be clearly delineated regarding SROs and school security. There should be protocols in place between the district/school and OCSO about alternative security measures when school security is unavailable. It should be noted that upon learning of the situation, the SRO sped to the school and he and a deputy (OCSO Deputy 1)[6] were the first to enter and take the shooter into custody.

Finally, at the time of the shooting, despite OCSO's robust active assailant training, deputies and supervisors were not sufficiently trained in incident command and unified incident command. We acknowledge that, since that time, OCSO has instituted programs on those concepts.

C. Fire and Emergency Services

We found that fire and EMS personnel responded quickly and competently. However, similarly to OCSO, there are areas for improvement with respect to (i) command, (ii) communications, (iii) protocols – in this case with regards to staging, and (iv) training.

First, both command and communications were hindered during the incident when OFD fire command moved all fire communications to a different radio channel. This was intended to facilitate information-sharing among all responders. However, fire personnel within OHS were unaware that the radio channel was changed and repeatedly called command on the wrong channel, receiving no response. Dispatch did not intervene to redirect units to the correct channel or have command switch channels.

We recommend that dispatch be alert for misrouted communications and proactively redirect personnel to the correct channel. Additionally, fire departments must review and potentially revise policies and practices of switching radio channels during critical incidents. When a switch occurs, it should be announced by dispatch with a "tone out" to alert all on the channel. County-wide protocols should be adopted to ensure that agencies

[6] Because we refer to responders by their title, we use numbers to differentiate those with the same rank. Those numbers are simply to provide clarity for the reader and have no relation to the responder's seniority or call sign.

know which channels to remain on or between during incidents which call for large multi-agency responses.

Second, the computer-aided dispatch (CAD) system[7] did not utilize specific call types for active assailant incidents, and there was no county-wide operating procedure to guide a coordinated response. We recommend that pre-determined CAD call categories be implemented for active assailant events, not only to streamline dispatch practices but also to ensure that fire and EMS are made aware of developments as they occur. Here, in the absence of clear dispatch protocols, fire and EMS personnel were not informed when the shooter was in custody, delaying their entry into OHS by approximately four and a half minutes.

Third, greater clarity and coordination are also needed with respect to staging. At the time of the shooting, the policy of fire and EMS departments from both Oakland and Oxford was to "stage" their response by waiting nearby until the scene is declared safe. This creates confusion for both personnel within the department as well as law enforcement, who remain unsure when firefighters and EMS members will enter a scene to render aid.

We recommend that Oxford Fire Department (OFD) as well as other departments across Oakland County reconsider staging practices. This requires agencies to evaluate best practice recommendations to forgo staging during active assailant events[8] and clarify whether dispatch instructions to stage are mandatory or advisory. A unified county-wide policy must include specific language on staging, while departments should also develop internal policies that define personnel discretion, staging triggers, and exceptions. Chief officers must assume responsibility at critical events, even if not formally in command.

Finally, during this review numerous fire department members indicated that, when on scene at OHS, they did not feel that they were adequately prepared to deal with the chaos and pressures of an active assailant situation. Departmental training was limited to mass casualty scenarios within EMS continuing education programs. There was insufficient or even non-existent training on the use of ballistic protective gear at the fire department, which was frequently stored away and never utilized by personnel. For many OFD members, the day of the shooting was the first time they donned ballistic vests and helmets. We recommend that fire department chiefs mandate bi-annual active assailant

[7] The CAD system is used by emergency services to manage and coordinate incident response, including receiving calls, dispatching units, tracking resources, and recording incident details. It streamlines communication between dispatchers and field personnel, improving response times and situational awareness.
[8] Such as the Hartford Consensus recommendations, discussed in more detail later in this report.

training with OCSO, so department members will be properly trained in the use of protective equipment.

D. Interagency Coordination Challenges

Aside from their own internal issues, law enforcement and fire departments in Oakland County also share a complicated relationship. We identified deficiencies within the agencies' communication, a lack of joint training exercises, and other coordination problems. These issues do not lend to the most effective use of public safety resources, especially during an active shooter incident.

To strengthen active assailant preparedness, we recommend that first responder agencies in Oakland County adopt county-wide integrated policies that clearly define expectations for law enforcement, fire, and EMS agencies. A county-wide "integrated active assailant response plan" would involve predetermined checklists for supervisors and clear tactical procedures for law enforcement, fire, EMS, and emergency management. This will not only enforce a muscle memory for agencies when tragedy arises but also establish a set of known actions and requirements to ensure preparedness for these types of incidents. This plan also should include implementation of standardized operating procedures, bi-annual joint trainings with OCSO, and annual Tactical Combat Casualty Care (TCCC) or Tactical Emergency Casualty Care (TECC) training. As noted, dispatch systems should incorporate pre-determined CAD call types for active assailant events, and fire departments should prioritize interagency training focused on rapid rescue and medical response. Finally, OCSO and Oakland County fire departments should adhere to the principles of unified incident command especially at the onset of multi-agency events, with key benchmarks such as suspect custody status, command post location, and explosive device identification recorded in CAD systems. Written policies should also involve unified command during explosive ordinance assessments.

E. OCSO Dispatch Communications Division

Dispatch plays a pivotal role in active assailant incidents, especially in public venues like schools where the potential for mass casualties is high. It is evident from the November 30th recordings that the 9-1-1 call-takers maintained a calm demeanor, practiced empathetic listening, and displayed professionalism throughout this incident. Additionally, the students, teachers, and community members who placed 9-1-1 calls in the first minutes provided critical information that enabled the 9-1-1 center to swiftly dispatch units to the right location.

However, we identified an unnecessary delay in dispatching OFD in response to those calls. At 12:52:32, the first 9-1-1 call came in with a definitive report of injury. At specifically 2:19 minutes into the call, at 12:54:51, the caller confirmed a victim shot. At 12:52:59 information regarding shots fired was dispatched to all OCSO units on radio East channel. OFD was not dispatched until 12:59:56. Best practices suggest dispatch should be within 15-30 seconds of receipt of a call, and within no more than 60 seconds. The call data reviewed indicates that the call takers recognized this incident as a confirmed active shooter event well before the decision to dispatch the fire department.

OCSO follows the practice of waiting to dispatch fire departments until confirmation of an injured party is established. Although OCSO asserts that this is based upon directions from fire departments, we suggest that in low occurrence-high threat events such as active shooter incidents, especially those at schools, it is logical that all necessary resources be dispatched even before confirmation of injuries.

Dispatchers should be trained to classify an incident as an active assailant event when callers report any of the following:

- Multiple *victims attacked in a public location with the assailant still on scene.*
- Violence in high-risk occupancies (e.g., schools, hospitals) with an armed perpetrator present.
- A violent attack with the *use or threat of explosives, smoke, fire, or chemical munitions.*
- Any other scenario deemed a hostile mass casualty attack by the dispatch supervisor.

OCSO's CAD system is outdated, as it heavily relies upon manual entry by dispatchers to effectuate the transfer of information. CAD systems should be updated to transition from manual to automated entry. CAD also should flag high-risk keywords such as "shot," "injured," "weapon," "gun," and "active shooter" to trigger appropriate response protocols. Adoption of automated CAD systems and keyword flagging capabilities could help identify active assailant scenarios more quickly.

We additionally recommend that automatic vehicle location practices should not just be within OCSO vehicles but should work with fire and EMS to ensure the closest units are dispatched expeditiously. OCSO should consider consolidating all Public Safety Answering Points into one department to streamline technology, policies, and communication practices

Another issue which we identified was the rerouting of calls from Oxford County to Lapeer County. For example, one call from OHS administration, which proved to be the most valuable for tracing the direction of the suspect, was rerouted to Lapeer. Active shooter incidents can often tax phone systems, as they were not designed for the volume that

often occurs after a tragedy. We recommend that public safety organizations establish county-wide policies for handling misrouted 9-1-1 calls and build relationships with local phone service providers to understand how large-scale incidents affect call coverage and routing. It is important to understand how these incidents put stress on cellular infrastructure and how systems respond to call spikes locally, and in surrounding counties. This will make dispatch centers better prepared for the potential of rerouted calls.

Finally, in the hours following the shooting Undersheriff Michael McCabe provided the public with a direct non-emergency phone number for dispatch to collect information regarding the incident. While reaching out to the public was well-intentioned, the dispatch center received a substantial number of calls, many of which were unrelated. Even the pertinent calls often fell outside the purview of the average call taker's training. It is better to institute a tip-line or non-administrative hotline. Given the changing nature of technology, it may be helpful to explore the use of AI for tip lines and post-crisis information submissions to prevent overload of general dispatch lines. This is growing more common in the expansion of technology in law enforcement.

F. Professional Development and Training

Inadequate training across multiple public safety disciplines had a negative impact on the effectiveness of all agencies' responses. This included a lack of clarity around roles and responsibilities and insufficient joint training across agencies, which hindered coordination. Communication protocols were not well understood, leading to challenges in managing internal and external communications. Our report also notes limited use of technology to capture and analyze training outcomes, which could have enhanced preparedness and response planning. Consistent with many other recommendations, we believe that joint exercises, improved protocols for communication, and proper leadership training must be formalized and mandatory.

G. Reunification Practices

Reunification is the practice of providing a safe location for victims to gather and for critical information to be shared. The "Oxford Community Schools Oxford High School Emergency Operation Plan" (EOP) previously identified Meijer, a large grocery store chain approximately a half mile from the school, as the "reunification location." On November 30, 2021, hundreds of students fled there. Although employees at Meijer were unaware that they were the designated reunification location, the store manager closed the store to customers and welcomed the students. An OCSO Reunification Lieutenant and other deputies arrived at Meijer to take charge of the reunification process. Despite

an absence of formal training in reunification practices, the OCSO Reunification Lieutenant acted with authority and made critical decisions quickly. After learning the shooter was in custody, the OCSO Reunification Lieutenant, in coordination with OHS and OSD staff, worked to ensure that students had appropriate transportation arrangements to return home safely.

While many OHS families reported a positive experience with the reunification process, the approach fell short in providing sufficient communication and emotional support to the families of the victims. The families of Madisyn, Tate, and Hana came to the reunification center with the expectation of reuniting with their children. However, after two hours and no more students arriving from the school, the parents were ushered into a store breakroom where they were informed that their children were killed. Madisyn's and Hana's families were subsequently transported to the OCSO Oxford Substation. Our discussions with Nicole Beausoleil, Buck Myre and Steven St. Juliana suggest that families did not approve of the means and/or manner by which the information was relayed. While they understood that there was no perfect way to convey this information, Nicole Beausoleil felt that the words were emotionally disconnected and significantly contributed to the continued trauma suffered. All agreed that OCSO's delayed disclosure of their children's passing, repetition of additional buses coming, and overall silence gave the impression that officers were not being forthcoming.

The reunification process could be improved by broader staff training and formalized protocols. OCSO never trained on reunification and neither did high school staff. There was no clear reunification plan outlining how students would be transported or released to their parents, nor any provisions for recovering belongings, including vehicles and other valuables, left behind in the aftermath of the incident. Most importantly, the absence of victim resources resulted in the families of deceased victims feeling unsupported and ill-informed while in a situation of extreme duress.

We recommend implementation of Standard Response Protocols and a Standard Response Model aligning with Michigan state guidelines. Anyone who will potentially staff reunification centers, be it school employees, OCSO and/or emergency managers, should be trained in these protocols and best practices. Clear policies should be put in place to determine the roles and responsibilities of relevant agencies. OCSO should have policies for incident assistance centers, including deployment of crime victim services and counselors, to meet the needs of victims and consistent with the concerns of families impacted in the Oxford shooting. Reunification practices would also benefit by a dedicated County team with sufficient financial resources, personnel, and training to manage large-scale events effectively.

H. Oakland County Recovery Efforts

In the aftermath of a traumatic event, support for victims, first responders, and the larger community is essential. In the days and weeks following this incident, Oxford Township benefitted from members of their community looking for ways to help each other. Effective collaboration among Oakland County Emergency Management (OCEM), OCSO, and private industry provided significant value to those impacted in Oxford Township and its surrounding communities.

To provide some semblance of continuity in recovery operations, OCEM maintained the Emergency Operations Center (EOC) for several weeks following the shooting. A grant was secured to establish a peer support team specifically for first responders involved in the Oxford response, underscoring the county's commitment to mental health. Nine months after the shooting, the All for Oxford Resiliency Center opened in late August, where anyone requesting service would receive it, regardless of the day or time. During the first month, staff continued to solicit feedback from users and the community. Staff conducted numerous outreach sessions and social media blasts to ensure everyone in the community was aware of this free resource.

Given financial constraints, much of the county's most successful recovery efforts were in large part due to Oakland County community members. In addition to the citizens of the County demonstrating a spirit of resilience in their support for each other, the generosity of the private sector was evident in the actions of Legacy Center 925 (Legacy Center) and their work with local businesses. Notably the Legacy Center's founder, as well as its Chief Operating Officer and manager Tod Caron (COO Caron), provided essential logistical support such as feeding hungry families as well as emotional and psychological care for the students of OHS and the citizens of Oxford. Local businesses within Oxford, both big and small, were generous with time and resources. They serve as an example to communities across the country. Many of these businesses even took from their own savings to assist the community.

Public agencies, including law enforcement, fire, and the County officials came together to support the Legacy Center's initiative. For example, OCSO regularly provided deputies to ensure that children could attend events and use the space without interference, taking extra measures to protect the parking lot from intrusion. Within a week of operations, there was a mandatory daily leadership meeting with staff from the Legacy Center, OCSO, OCEM, Oxford Village Police, Oakland County Homeland Security, OFD, the Oxford Township Supervisor, and volunteers. OCEM also worked with Common Ground,[9] an organization providing mental health emergency services to those who need

[9] https://commongroundhelps.org.

counseling or emergency shelter, as well as crisis support.[10] Common Ground, OCEM, and the Legacy Center worked collectively to create a vetting process for mental health providers to ensure that the right aid was provided.

Oakland County's recovery framework following the shooting was notably under-resourced and lacked structure. OCEM officials certainly expressed a desire to support families more extensively but were constrained by limited financial resources and infrastructure. Much of the recovery support came from private entities like the Legacy Center with the generosity of other local businesses, to provide meals, counseling, and logistical aid despite pandemic-related strain. Although County government's efforts were well-intentioned, the practical reality is that aid did not materialize in the most efficient manner that was essential to students. Despite Oakland's Emergency Management assurances that all bills would be paid, Oakland Community Health Network wanted firm policies and procedures before providing any care which created a two-week delay in their rendering services. Additionally, while Common Ground had a long-standing relationship with OCSO and did try to dispatch lower-level crisis trained personnel, their own staff stated that this coordination should have been created much sooner. Moreover, while well-intended, there were individuals providing mental health assistance who were not properly trained. There is a difference between mental health assistance and those specially qualified to treat victims of active shooter incidents.

Recovery efforts in Oakland County typically default to individual townships, rendering OCEM's authority absent during times where they are best qualified to lead. The Emergency Operations Center of Emergency Management in Oakland County is located across from OCSO's 9-1-1 dispatch center within the same building. This is a perfect set up for coordination efforts. Unfortunately, that did not occur. Rather, no one from OFD was at the Emergency Operations Center nor was there any OCSO representation. In addition to the lack of OCSO presence, there was no representation from the school district. We understand that public safety organizations wanted to provide resources to the school during a time of crisis. However, that resulted in the Emergency Operations Center having no ability to carry out vital functions since little to no information was relayed back from the scene. There is a consequence of these oversights which include significant delays in information sharing with county executives, area hospitals, and even within first responder agencies.

We recommend that Oakland County develop a structured recovery framework and ensure that it is in place prior to a critical event. The Emergency Operations Center's purpose is to facilitate interagency coordination. Given the skill and training of their staff

[10] Common Ground already was known in the County and had cultivated a relationship prior to this incident with OCSO and Oakland County Prosecutor's Office (OCPO).

in dealing with these kinds of issues, Emergency Management must be an integral part of this initiative. The emergency operations hub is a critical component of response and recovery and must receive priority agency staffing. Law enforcement and fire departments must exercise discipline and not send every ranking member to an emergency scene. It is incumbent on agencies to determine who will respond to the EOC. In many cases, this might be a commander who is in a support assignment or role that would not typically respond directly to scenes. Training is the only way to ensure preparedness, and that includes exercises that involve all members of emergency management as well as first responder agencies. An Emergency Operations Center liaison, who would stay at the incident command post relaying live communication to the center and reciprocally conveying information back to unified command on scene, could be beneficial.

OCEM should also be incorporated into preparing school facilities to reopen after a crisis, this also includes any potential renovations to schools/buildings after a shooting incident, as well as return-to-school/return-to-work procedures. Our review found that despite OCEM Director Robert Seely (Director Seeley) actively taking the initiative to contact school officials in the hours and days following the incident, no one responded. Eventually, OCEM sent EM Specialist 1 to attend OHS in person on December 2, 2021, to explain recovery operations.

Additionally, a careful review of school property conditions is essential prior to returning students to campus. The Township Supervisor engaged assistance from the Legacy Center COO given his construction background. COO Caron documented his findings after a walkthrough of the school. The COO's photographs showed evidence of blood and body fluid remnants, as well as bullet holes and destroyed property. Fortunately, the Township Supervisor was able to delay the reopening for further improvements. Emergency Management officials should be an integral part of the equation when evaluating school safety and preparedness for reopening. Moreover, communities cannot rely on the availability of private industry to meet needs. County government should work with elected officials to have an emergency fund that can be used in these circumstances.

We must also briefly address reports from Oxford residents who believe that Oxford Community Schools (OCS) did not adequately communicate with the Oxford community. The absence of clear communication appears to have strained the relationship between the district, the school board, and the community at large.

III. SCOPE OF WORK

Guidepost worked collaboratively with Oakland County to establish the scope of work for the AAR, which focuses on first responders' operational performance, interagency coordination, and community recovery practices. While the actions of OHS officials may be relevant to certain aspects of our inquiry, the central emphasis remains on evaluating the performance of first responders, not the decisions or conduct of the school.

To address the issues within the scope of the AAR, we asked ourselves some of the following questions:

- Were the practices and procedures used by law enforcement and fire departments effective, or were they informed by outdated or inaccurate *guidance? Are these approaches still in use today?*
- Were there institutional and historical divisions in the relationship between Law Enforcement and Fire/EMS and, if so, did they contribute to response errors?
- Were federal law enforcement agencies inappropriately turned away, thereby rejecting potentially valuable assistance?
- Was the recovery effort effective, and did it serve to heal or further harm an already hurting community?
- Who bears the burden of recovery efforts and what are the costs associated with such programs?
- Did any part of the response effort have an impact on the survival of victims?

In our discussion of these topics, we also highlight current national best practices for responding to active shooter and hostile events. Finally, we make recommendations intended to improve future preparedness and to address practice and policy shortcomings.

IV. METHODOLOGY OF REVIEW

In conducting our review, we collected information from a wide array of sources to develop a comprehensive understanding of the timing and circumstances of the response, reunification, and recovery efforts. The collected information included extensive document production from multiple agencies regarding their actions, policies, and procedures, as well as the acquisition of data such as radio transmissions, CAD entries, FOIA responses, video footage, and audio recordings. We also carried out interviews with key individuals possessing critical knowledge relevant to the review. Leveraging our expert team and their extensive experience with active assailant situations and best practices, we were able to identify various opportunities for improvement to enhance future readiness and rapid response.

We sincerely appreciate the cooperation and transparency demonstrated by the OCSO, OFD, Addison Township Fire Department (AFD), Oakland Township Fire Department (OTFD), and the Office of Emergency Management for Oakland County. We also would like to recognize the strong leadership of David Coulter, the Oakland County Executive, and the Oakland County Government for mandating an independent review.

Finally, we must also acknowledge the generosity of Karen D. McDonald, the Oakland County Prosecutor, and her staff at the Oakland County Prosecutor's Office (OCPO).[11] In this review, as well as in preparation for Guidepost's prior reports, OCPO demonstrated a high level of professionalism and leadership. We are grateful for their efficient facilitation of our access to evidence. OCPO's willingness to address numerous inquiries and their insights into the culture and community of Oakland County were truly valuable.

A. Materials Collected

We collected various materials from relevant agencies, including but not limited to, physical documents, video/audio recordings, PowerPoint presentations, policy and procedure manuals pertinent to individual agencies, dispatch records, and computer aided dispatch records.[12] Our review initially obtained approximately four thousand eight hundred pages of documents, four hundred and fifty audio and video files, as well as additional aerial and school footage for review from the first responder agencies. Over the course of this assessment, we encountered some issues such as delayed information, including late production of documents. It is also important to note that we initially were

[11] It is important to note that while the OCPO works closely with law enforcement and may "respond" or "review" a scene as part of an investigation, a prosecutor's office is a legal entity and not part of the category of "first responder."
[12] See Appendix A for a list of these materials.

told by some County officials to expect body camera video footage from the sheriff's office. Body Worn Cameras (BWCs), along with CAD data, are considered two of the highest value resources in effectively reviewing critical incidents. When we met with OCSO to establish protocols and timeframes for receiving the requested information, the review team was informed that OCSO was not equipped with BWCs at the time of the incident. Consequently, we had to construct a master timeline utilizing data from the CAD, OCSO dashboard cameras, school cameras, law enforcement radio traffic, fire radio traffic, and interviews. This was compounded by the process of identifying numerous 911 calls missing from the CAD and OCSO radio traffic.

B. Interviews

In addition to reviewing videos, documents, and other materials, our team conducted in-person and virtual interviews with a variety of individuals. We spoke to a total of 36 people over the course of thirty interviews. The extent of cooperation has exceeded all expectations, and we greatly appreciate those individuals who were willing to speak with us. The time allotted for each interview often varied depending upon the individual or agency, however, on average most interviews took about two hours to conduct. On occasion, certain interviews required four to five hours given the extremely sensitive or technical nature of the information relayed to our team. Some interviews were conducted in person, and others virtually, depending upon the comfort of the individual. Many if not most interviewees conditioned their cooperation on in-person interviews.

During this review, we were proactively contacted by Oakland County government officials, first responders, and community members to discuss aspects of the review and share information. Given the sensitive nature of the findings, some first responders and community members requested confidential meetings.

It was evident to our team that many law enforcement personnel, fire officials, high school staff, and the community at large, in addition to victims' families, struggle with trauma from this incident to this day. The individuals interviewed included:

- Victims, survivors, and their families;
- Parents of former students;
- Current and former OHS faculty and staff;
- Oakland County Prosecutor's Office;
- Current and former law enforcement officers;
- Current and former fire/EMS officials;
- Emergency management officials;
- Members of the Oxford and surrounding town communities; and

- Mental health professionals.

Additionally, we had the opportunity in this review to meet witnesses who were not available for prior reports. For example, we had the opportunity to speak to the OHS hall monitor, who was willing to discuss her experience on November 30, 2021.[13] Unfortunately, we were unable to speak with certain other witnesses who possessed information relevant to our investigation, including certain current and former members of law enforcement. OCSO confirmed to us that OCSO Deputy 1 and other law enforcement officials declined to be interviewed and would not complete a questionnaire, which we had submitted to sheriff's department leadership upon request. Other individuals with whom we asked to discuss the matters of this report did not return our requests for comments.

C. Tour of Oxford High School

Although Guidepost had access to internal video footage of the school, our review team recognized the importance of experiencing the space firsthand. Conducting an in-person walkthrough allowed the team to better grasp the scale and complexity of the environment that first responders encountered. We are grateful to the school district for their cooperation in granting us access on March 16, 2025, during which we received a formal tour of the facility and its grounds.

D. Engagement of Subject Matter Experts

Our Guidepost team included experts with many years of experience in law enforcement, prosecutions, and investigations. The team was led by a former Drug Enforcement Administration (DEA) Special Agent who has held executive level positions in the U.S. Department of Justice, as well as at publicly traded and privately held companies. During his more than 20 years with the DEA, he served in various assignments and retired as the DEA's Chief of Operations Management. He is credited with establishing and directing all operational policy, procedures, and guidelines for the DEA worldwide, leading DEA's crisis management, disaster recovery, and emergency preparedness programs. In that role, he was the DEA's lead in responding to critical incidents in both domestic and foreign environments, including oversight of the deployment of trauma teams.

Our review also greatly benefited from the expertise of seasoned public safety professionals from Threat Suppression, Incorporated (Threat Suppression). Threat Suppression provided experts in law enforcement, fire services, emergency medical

[13] The hall monitor advised us that she was instructed by counsel not to speak with us until she had completed her deposition.

services, and emergency management with decades of real-world experience, including responding to major active shooter incidents, such as the 2019 active shooter at the University of North Carolina and 2024 U.S. Marshals ambush in Charlotte, North Carolina. All members of the Threat Suppression's team were prior public safety professionals with several still actively serving. They have served on multiple local, state, and federal active shooter task forces and have extensive law enforcement special operations experience. They also serve as educators, providing training for local and federal organizations such as the Department of Defense, Department of Justice, and international organizations.

The Threat Suppression team was led by Dr. Michael Clumpner, PhD, MBA, NREMT-P (President). Dr. Clumpner holds a PhD in homeland security leadership and policy and in 2015 authored the first doctoral dissertation on integrated active assailant response. Dr. Clumpner has spent more than 20 years and 35,000 hours researching active assailant attacks. He currently serves as a senior active shooter/hostile event subject matter expert for the Department of Defense. In 2025, Dr. Clumpner retired as a full-time fire battalion chief with the Charlotte Fire Department with 30 years' experience as a career firefighter/paramedic. Dr. Clumpner served for 10 years as the co-chair of the Charlotte Active Assailant Taskforce. This task force was responsible for providing active assailant training and leadership for 4,000 public safety providers in Charlotte and Mecklenburg County. Dr. Clumpner also served as a deputy incident commander at the 2019 University of North Carolina at Charlotte active shooter event. Dr. Clumpner was the first arriving fire unit and fire department incident commander at the April 29, 2024, U.S. Marshal's ambush in Charlotte in which eight law enforcement officers were shot and four killed. Dr. Clumpner is also a sworn law enforcement officer with Richland County (SC) Sheriff's Department where he has served since 2010 as a SWAT operator and senior tactical paramedic. Dr. Clumpner previously spent eight years as a helicopter flight paramedic at Spartanburg Regional Medical Center, a Level 1 trauma center.

The team also included Kent Davis, MPA, BS, EFO, CFO (Senior Principal Consultant) and Steven Brochu, MS, BA (Principal Consultant). Mr. Davis conducted significant research on fire department response to active assailant events as part of the U.S. Fire Administration Executive Fire Officer program. Mr. Davis served seven years in the United States Air Force Reserves with the 437th Military Airlift Wing and is a 40-year veteran of the fire service. Mr. Davis spent 30 years in the Charlotte Fire Department and retired at the rank of division chief and commander of the Special Operations Division. He served for 10 years as the co-chair of the Charlotte Active Assailant Taskforce, providing training and leadership for 4,000 responders in Charlotte and Mecklenburg County. Mr. Davis served as a deputy incident commander at the 2019 University of North Carolina at Charlotte active shooter event. He is currently the Deputy Fire Chief of the Matthews Fire Department. Mr. Brochu served in law enforcement for more than 28 years and retired

with the rank of deputy police chief from the Charlotte-Mecklenburg Police Department (CMPD), which is the 17th largest law enforcement agency in the United States. Mr. Brochu was also Special Operations commander for 11 years, where he supervised SWAT, the bomb squad, arson unit, civil emergency unit, K-9, and aviation (helicopters). He was also the department's emergency management coordinator and served for 10 years as the co-chair of the Charlotte Active Assailant Taskforce, providing training and leadership for 4,000 Charlotte and Mecklenburg County responders. Mr. Brochu was the tactical operations commander at the 2019 University of North Carolina at Charlotte active shooter event.

Finally, to best assess the survivability of the victims, we consulted with Dr. Steven Shelton, MD, FACEP (Principal Consultant). Dr. Shelton is a widely recognized expert in tactical EMS response and mass casualty care. Dr. Shelton is a practicing emergency physician at Prisma Health Richland Hospital, a Level I trauma center, and is board certified in both Emergency Medicine and Emergency Medical Services. Dr. Shelton is the hospital's Emergency and Disaster Management Medical Director, and he served as the hospital's incident commander during the 2009 H1N1 outbreak, 2014 Ebola outbreak, 2018 Amtrak collision, and the 2020 COVID-19 pandemic. Dr. Shelton has also served since 2011 as an Assistant Clinical Professor in the Department of Surgery at the University of South Carolina School of Medicine. Dr. Shelton was the Lead Medical Manager for South Carolina Urban Search and Rescue Taskforce 1 from 2004-2008 and the medical advisor for the Federal Bureau of Investigation (FBI) from 2007-2016, advising all South Carolina field offices. Dr. Shelton was also a member of the Tactical EMS Taskforce with the National Association of EMS Physicians. Dr. Shelton has served as a sworn deputy sheriff with the Richland County (SC) Sheriff's Department since 2000 and is the department's Medical Director and Chief Tactical Physician with the department's full-time SWAT team.

In addition to the experts discussed above, we worked with an experienced 9-1-1 professional from one of the nation's largest emergency call centers, whose knowledge in crisis management, disaster response, and community resilience further strengthened our review. The combined insights of our expert team ensured a comprehensive, practical, and well-informed approach to evaluating active assailant preparedness and response.

V. OUR REVIEW

Below we provide an in-depth analysis of the response to the OHS shooting. First, we begin with a brief overview of the shooting. Second, we address the issue of victim survivability. Third, we analyze first responder actions on November 30, 2021. In doing so, we set forth: (i) an explanation of best practices related to active assailant situations; (ii) the command structures, policies, and procedures of responder agencies; (iii) detailed timelines of actions by OCSO, fire, and EMS personnel; and (iv) our analysis of those actions and our recommendations for improvement. Fourth, we address the reunification practices by OCSO and OHS. Finally, we address the recovery actions taken in the hours, days and weeks that followed the shooting.

A. Incident Overview

We begin with a brief recitation of the shooter's actions on November 30, 2021, that led to the deaths of Madisyn, Tate, Justin, and Hana. Certain aspects of the shooting and its aftermath are discussed in more detail in other parts of this report. Except for those in leadership, we refer to responders by their titles. A map of the school building is included at the end of this section.

At approximately 12:46:36, the shooter entered the boys' bathroom at the south end of the 200 hallway. The actual shooting itself can be marked at approximately 12:51:12, when the shooter exited the bathroom with the gun in his hand. He raised his arm and fired his weapon at seven children in that hallway within seven seconds. These include Phoebe Arthur[14], Elijah Mueller[15], Riley Franz[16], Kylie Ossege, Hana, John Asciutto, and Madisyn. Students took off running to escape the school, locked down in classrooms, and even broke glass in classroom windows to launch themselves out.

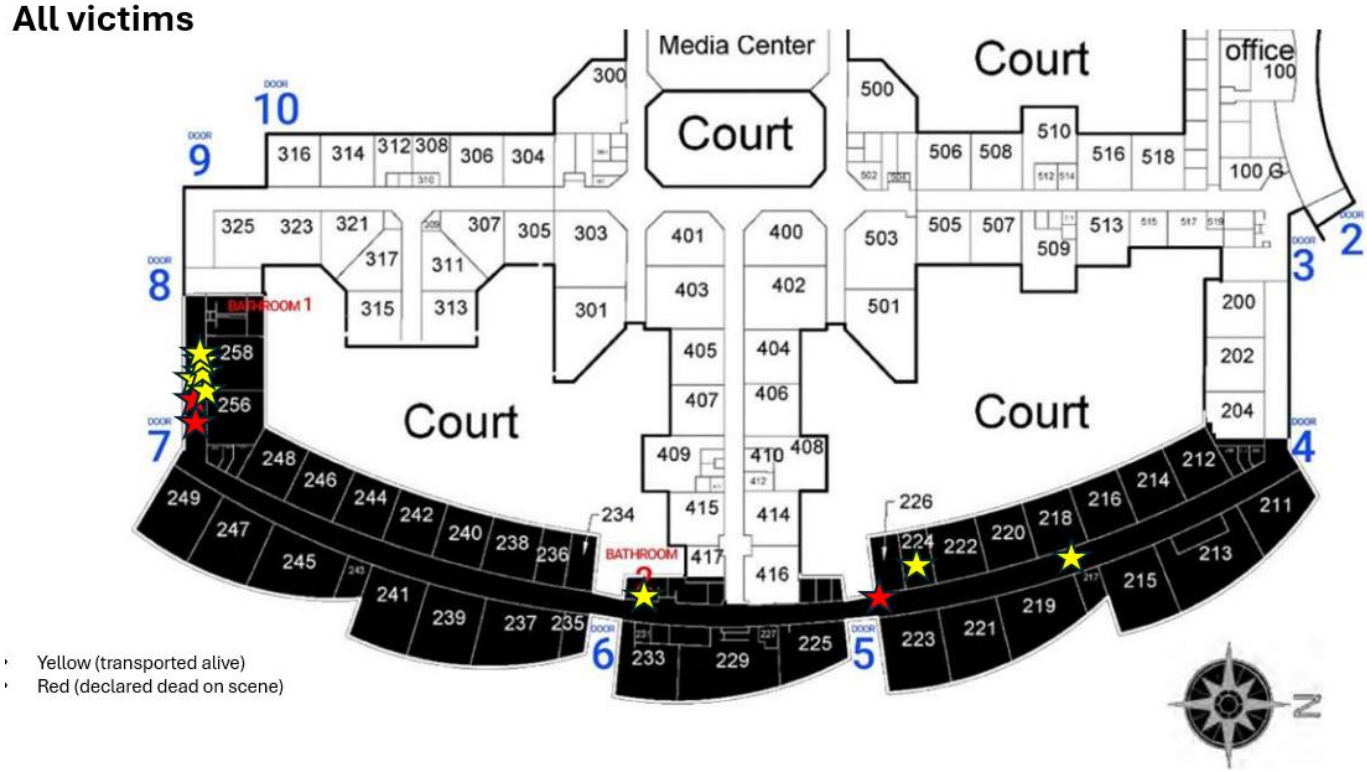
The shooter then turned the southeast corner of the 200 hallway, reloaded his gun, and shot at more students who were running down the long 200 corridor. At one point, he held the gun in both hands, aimed down the hallway, and shot Tate in the head as he was entering the building unaware of the events transpiring in the school. Seconds later, the

[14] In Guidepost 2, it was stated that Phoebe Arthur ultimately was transported to McLaren Oakland Hospital and subsequently transferred to Hurley Medical Center. A review of patient care records from EMS indicate that Phoebe Arthur was actually transported by AFD Alpha 1 to McLaren Lapeer, then subsequently transferred to Hurley Medical.
[15] In Guidepost 2, it was stated that Elijah Mueller was taken to McArthur Oakland Hospital. A review of patient care records from EMS indicate that Elijah Mueller was taken to McLaren Oakland Hospital.
[16] In Guidepost 2, it was stated that Riley Franz was transported by two students to McLaren Oakland Hospital. A review of patient care records from EMS indicate that two fellow students transported Riley Franz to McLaren Urgent Care, who subsequently called 9-1-1. Orion Fire Department Alpha 1 then transported Riley to McLaren Hospital.

shooter wounded another student who was scrambling for safety. He came back to inflict a second wound on Tate, shooting him in the leg. The shooter then methodically walked the long 200 hallway, firing into rooms as he passed them.[17] He saw teacher Molly Darnell sheltered in her office and fired three shots directly at her through the window of a locked door, subsequently wounding her.

For three and a half minutes, the shooter roamed the hallways, shooting intermittently. With no potential victims left in the empty 200 hallway, the shooter entered a bathroom, where he encountered Keegan Gregory and Justin hiding in a stall. After several minutes, the shooter ordered Justin out of the stall and onto his knees, where he shot him execution style with a single shot to his head. The shooter then exited the bathroom and surrendered at 1:00:07.

All victims



[17] During our review we learned of a misconception by some community members that the shooter attempted to gain access physically to several classrooms. We found no evidence supporting this statement. Surveillance footage, witness accounts, and investigation documents show that the shooter fired through doors and windows at visible individuals but never attempted to open closed doors. There is also no evidence to support the theory that he requested for classrooms to be opened. Our review determined that this rumor may have been based on social media footage of students in a classroom lockdown. A sheriff's officer at the door said, "Sheriff's Office, it's safe to come out." When a student responded, "We're not willing to take that risk right now," the deputy used informal language and said, "Come to the door and see my badge, bro." The students feared it was the shooter and escaped through a window, meeting deputies outside. Authorities later confirmed the person was a narcotics officer helping clear the school.

B. Assessment of Victim Survivability

One of the most common questions asked upon completion of an AAR is whether anything could have potentially changed the outcome of the event. As part of our review, we assessed whether any actions in the aftermath of the shooting could have prevented the loss of life.

1. *Victim Injury Timelines*

Below we detail a timeline for each victim's injuries, including when and how treatment was provided.

Madisyn

17-year-old senior, Madisyn, was at the end of the short 200 hallway and was shot at 12:51:19. Madisyn was shot once in the head. Madisyn immediately collapsed where she was shot and did not move. At 13:02:15 an OCSO deputy checked Madisyn. The deputy did not provide care, noting that she had a gunshot wound to the head and was not breathing. At 13:02:27, the Orion Police Department police chief entered the building. He came to Madisyn and started CPR. The police chief was joined by OCSO deputies. At 13:06:31, OCSO deputies told dispatch they had CPR in progress with a patient shot in the head. At 13:08:08, OCSO deputies radioed again that they had a critical patient at Door 7. Simultaneously, other deputies were calling on the radio to say that they had more severe patients at Doors 5 and 6. At 13:12:00, law enforcement stopped CPR on Madisyn.

At 13:13:50, OFD paramedics entered and walked past Madisyn at the direction of law enforcement officers. The paramedics went to care for Hana and Kylie Ossege who were about 20 feet ahead. At 13:19:05, AFD paramedics entered the hallway and confirmed that Madisyn was dead.

Time of Injury: 12:51:19
Time to First Responder Care (LE): 13:02:27 (+10 minutes and 8 seconds)
Time of Death Pronouncement: 13:12:00 (+20 minutes 41 seconds)

Tate

16-year-old sophomore, Tate, entered the 200 hallway at Door 5 from the courtyard. Tate had not heard the lockdown announcement. Tate entered the mostly empty hallway behind another student. Tate turned to his left, following the other student. Tate was unaware that the shooter was coming up behind him.

At 12:51:10, Tate was shot in the head by the shooter who was 100 feet behind him. The bullet struck him in the back of the head and exited his eye. Tate immediately collapsed. At 12:52:20, the shooter shot Tate a second time in the leg. At 12:53:51, Assistant Principal Kristy Gibson-Marshall (AP Gibson-Marshall) reached Tate. She used her school radio to tell other staff that a student is down in the 200 hallway. At 12:54:21, AP Gibson-Marshall encountered the shooter as he passed her in the hallway. She radioed that she saw the shooter and that he had a gun. At 12:54:40, AP Gibson-Marshall knelt down to help Tate knowing the shooter was near her. At 12:55:00, she is seen moving Tate to better assess him. AP Gibson-Marshall then spent two minutes trying to move Tate onto his back to open his airway.

A review of 9-1-1 records indicates a student called at 12:56:38 on the way to Meijer and indicated someone was shot in the head at Door 5. At 12:57:03, AP Gibson-Marshall paused caring for Tate and is seen gesturing to the hall monitor that the shooter had moved south down the hallway. At 12:57:40, AP Gibson-Marshall began CPR and mouth-to-mouth on Tate. At 13:00:43, the first deputies arrived near door 5, but are seen moving forward, presumably to find the shooter. At 13:02:00, another OCSO deputy arrived by Tate, and assumed care. The deputy spent about one minute attempting to determine if Tate was breathing and had a pulse. The deputy then placed Tate in the recovery position. At 13:03:02, deputies radioed dispatch that EMS was needed at Door 5. At 13:04:00, an OCSO deputy resumed CPR on Tate. Another officer arrived with an automated external defibrillator (AED) and attempted to connect it to Tate. At 13:04:21, deputies again radioed that they needed EMS at Door 5. At 13:05:00, deputies again urgently requested EMS to Door 5. At 13:05:48, deputies advised dispatch that the scene was secure and that they had a student with a gunshot wound to the eye. At 13:06:16, deputies again urgently requested EMS to Door 5. At 13:06:31, deputies advised dispatch they were doing CPR at Door 5 for a victim with a head injury. At 13:06:08, another deputy stated that the first EMS unit needed to come through Door 6. At 13:07:09, deputies advised they had a victim with a gunshot wound to the head that was still breathing and that they needed EMS first. At this time, there was only one ambulance on scene. Another deputy instructed deputies over the radio to start transporting patients in patrol cars. At 13:09:50 two deputies moved Tate to a deputy's SUV patrol car parked outside Door 5. The in-car cameras showed that it took the two deputies approximately two minutes to get Tate into the back of the patrol car.

At 13:10:09, the deputy advised dispatch he was transporting one to the hospital. The deputy drove to the rear parking lot and saw an ambulance and fire truck parked near Door 7 and Door 8. He immediately drove to the ambulance, calling out his window for help. However, the fire personnel were inside. The deputy then weaved his way through the parking lot and exited onto North Oxford Road. At 13:11:00 AFD paramedics arrived on North Oxford Road, parallel to Door 6. The deputy drove up to their ambulance as they were getting out and told them he had someone shot in the back of his car. Two paramedics and an EMT accessed Tate in the back of the patrol car. They confirmed that he was in cardiac arrest with a mortal gunshot wound to the head. The paramedics did a four lead EKG and confirmed that he was asystole. Tate was pronounced dead in the patrol car at 13:15:00. It is important to clarify a misconception that Tate died in the deputy's vehicle. Although Tate was officially pronounced by EMS while in the patrol vehicle, our medical expert believes he was already deceased in the school. While AP Gibson-Marshall administered CPR and chest compressions in a valiant effort to resuscitate him, he was unable to breathe on his own without assisted ventilation. As she stated in Miller Hearing testimony, Tate was already blue. Coupled with the absence of breathing and no palpable carotid pulse, our expert assessed that Tate was likely in cardiac arrest when AP Gibson-Marshall first reached him.

Time of Injury: 12:52:10
Time to Bystander Care (School): 12:54:40 (+2 minutes and 30 seconds)
Time to LE First Care: 13:02:00 (+9 minutes and 50 seconds)
Time to Extraction: 13:09:50 (+16 minutes and 40 seconds)
Time to EMS First Care: 13:11:00 (+18 minutes and 50 seconds)
Time of Death Pronouncement: 13:15:00 (+22 minutes 50 seconds)

Justin

Camera footage shows that Justin went to Bathroom 1 at 12:48:24. This was before the shooting started. Justin went further down the hallway to Bathroom 2 and was seen on camera entering at 12:49:48. At 12:50:53, student Keegan Gregory also entered Bathroom 2. The shooting began in the short 200 hallway about 20 seconds after Keegan Gregory entered Bathroom 2. Keegan Gregory later told law enforcement that they could hear the gunshots from the 200 hallway while in Bathroom 2. He said he and Justin opened the door and saw numerous students running down the 200 hallway. Keegan turned and went back into the bathroom and saw Justin emerging from a stall. Justin told Keegan to hide with him in the larger bathroom stall.

At 12:52:50, Keegan Gregory and Justin heard the shooter. Both Justin and Keegan Gregory were texting their families and could hear the shooter outside Bathroom 2. Review of text messages and Keegan Gregory information to law enforcement quietly formulated a plan to run when they heard the shooter move away. At 12:54:52, the shooter returned and entered Bathroom 2. Keegan Gregory stated that they heard the shooter reload his gun in the bathroom. Between 12:55 and 12:56, the shooter kicked open the bathroom stall door where Justin and Keegan Gregory were hiding. The shooter looked at both and moved away. Keegan Gregory stated that he and Justin heard the door open and shut to Bathroom 2 and believed that the shooter had left the bathroom. However, what they likely heard was school monitor briefly opening and shutting the door at 12:58:02. Justin then used the camera on his phone to look under the bathroom stall for the shooter. At 12:58, the shooter went to the bathroom stall and told Keegan Gregory to stay put and Justin to come out of the stall. The shooter then shot Justin in the forehead at close range. The shooter then attempted to gesture Keegan Gregory to get on the ground. Keegan Gregory can be seen bolting out of that bathroom at approximately 12:59:58.

Justin immediately fell where he was shot. Justin was inside the bathroom door, with his head towards the door and his feet towards the toilets and sinks. There is no evidence to suggest that Justin made any attempts to move after he was shot.

The following represents the timeline of deputies in and out of Bathroom 2 after Justin was found:

- 13:03:43, OCSO Deputy 1 entered the bathroom. Deputy OCSO Deputy 1 saw Justin and quickly cleared the bathroom to ensure there were no threats or other victims.
- 13:04:03, OCSO Deputy 1 exited the bathroom, shutting the door.
- 13:04:21, OCSO deputies requested EMS immediately to Door 5.
- At 13:04:35, two more OCSO deputies entered the bathroom. Both deputies exited the bathroom at 13:04:46, shutting the door behind them.

- 13:06:16, OCSO deputies again requested EMS at Door 5.
- 13:06:48, OCSO Deputy 1 entered the bathroom again.
- 13:07:09, OCSO deputies again radioed that they had a patient with a gunshot wound to the head that was still breathing.
- 13:07:48, OCSO Deputy 1 exited the bathroom, again shutting the door.
- 13:08:13, Another deputy entered the bathroom. The OCSO provided the review team with confirmation that the OCSO did not provide any medical care to Justin.
- 13:10:04, OFD Alpha 4 (the first ambulance arriving at the school) entered the bathroom with Justin and immediately provided care. An OFD Fire paramedic was the first medical provider to him. Justin was lying on the floor with his head by the door right where he fell when he was shot. He was lying on his back and vomited. Justin was breathing about 12 times a minute. There was approximately two-liter blood loss around his head with large clots. This was the first medical care that he received.
- 13:10:26, An OFD firefighter brought the stretcher to the bathroom door.
- 13:10:51, Paramedics put Justin on the stretcher.
- 13:11:20, Justin was removed from the school through Door 5.
- 13:13:50, OFD Alpha 4 left enroute emergency traffic to McLaren Oakland Hospital. Enroute to the hospital, two paramedics provided advanced airway control and worked to stop the bleeding from Justin's head.
- 13:33:00 The ambulance arrived at the hospital where the trauma team took over care.
- Justin was declared clinically dead the following afternoon.

Time of Injury: 12:59:31
Time to First Responder Care (EMS): 13:10:04 (+10 minutes and 33 seconds)
Time to Extraction: 13:10:51 (+11 minutes and 20 seconds)
Time to Transport: 13:13:50 (+13 minutes and 19 seconds)
Time to Hospital Arrival: 13:33:00 (+33 minutes and 29 seconds)

Hana

14-year-old sophomore freshman, Hana, was in the short 200 hallway and was shot at 12:51:14. At 12:51:16, she was shot two more times. Hana had a gunshot wound to the left femur/pelvis, a gunshot wound to the abdomen, and a gunshot wound to the chest. Hana collapsed where she was shot. Hana immediately started bleeding heavily from the injury to her left leg and the injury to her stomach. Hana's left pant leg was quickly soaked with blood. Hana was last seen moving on the school's camera at 12:57:00. After that, she was not seen moving again. At 12:58:38, the first two arriving officers in the building, SRO and OCSO Deputy 1 reached Hana. Ten seconds later, they were joined at 12:58:48 by the hall monitor. The SRO threw a Combat Action Tourniquet (CAT) to the hall monitor and instructed her to put it on Hana.

It is visible from hall monitor's body worn camera[18] shows that Hana was unresponsive and struggled with labored, slow breathing. The hall monitor attempted unsuccessfully for the next three minutes to place the CAT on Hana. A review of her body-worn camera footage both shows her difficulty placing the tourniquet, and she can be heard stating that there was a significant amount of blood generally coming from Hana's wounds. When she saw OCSO Lieutenant 1 enter the short 200 hallway, she requested his assistance. At 13:03:42, OCSO Lieutenant 1 placed the tourniquet high and tight on Hana's left leg. The hall monitor continued talking to Hana encouraging her to keep breathing. There is no evidence on the camera to indicate that Hana was providing any response. The hall monitor also can be seen trying to place pressure on her wounds to stop the abdominal bleeding with little success. At 13:14:05, the hall monitor's body worn camera showed that Hana was in cardiac arrest. At this time, two fire captains reached Hana, and removed her backpack to attempt treatment, noting that she was "barely alive."[19] At 13:17:50, an OFD EMT joined to assist. At 13:19:44, paramedics from the AFD arrived with the first medical bag. Hana was pronounced deceased at 13:20:00 by both OFD and AFD paramedics.

Time of Injury: 12:51:14
Time to Bystander Care: 12:58:48 (+7 minutes and 34 seconds)
Time to LE First Care: 13:03:42 (+12 minutes and 28 seconds)
Time to EMS First Care: 13:14:05 (+22 minutes and 51 seconds)
Time of Death Pronouncement: 13:20:00 (+28 minutes 46 seconds)

[18] OHS Security and body worn camera practices are addressed later in the report.
[19] See interviews with OFD personnel.

2. *Review of Decedent's Potential Survivability*

Dr. Shelton considered the pre-hospital care provided, assessed the time to provide pre-hospital care, and determined if the pre-hospital care followed standards established by the Committee for Tactical Emergency Casualty Care (C-TECC) and the Committee for Tactical Combat Casualty Care (Co-TCCC). This involved reviewing a broad range of wound documentation. Dr. Shelton reviewed the video of the shooting in order to physically witness the victims shot (except for Justin) and to see the range at which the bullets were directed at the children. He also reviewed OCME reports, and corresponding anatomical diagrams composed as part of the autopsy as well as law enforcement photographs taken during the autopsy of the victims' injuries. Dr. Shelton also participated in our interviews with Chief Medical Examiner, Dr. Ljubisa Dragovic (Dr. Dragovic) as well as his staff including Administrator/Manager Cas Miarka, Deputy Medical Examiner Dr. Shauna Bryan, (Dr. Bryan), and Deputy Medical Examiner Dr. Bernardino Pacris (Dr. Pacris) to discuss wounding patterns on the deceased. Dr. Bryan performed the autopsies on Madisyn, Tate, and Hana. Dr. Pacris performed the autopsy on Justin.

3. *OCME'S Policies and Procedures*

OCME investigates and determines cause and manner of death in any violent, sudden, unexpected, suspicious, or otherwise unexplained death, inclusive of all jail deaths and deaths in police custody occurring within Oakland County. Dr. Dragovic has worked for OCME since 1989 and served as the Chief Forensic Pathologist/Chief Medical Examiner since 1991.

Dr. Dragovic explained in our interview with him that an autopsy report is standardized for every case. A medical examiner is looking to understand and make identifiable findings in the tissue or on the body for cause of death. He contended that this is standard operating procedure that is accepted across the world.

When asked about forensic opinions, Dr. Dragovic noted that many agencies do not offer forensic opinions in detail. For example, he said the degree of how "lethal" a wound is, he leaves for interpretation of the court. Dr. Dragovic explained that the lethality of an individual wound is not relevant unless there is a specific circumstance, such as a notable time gap between wounds, that distinguishes one rapidly lethal wound from others. Otherwise, it is a question for the court and a forensic pathologist, who will interpret the findings of the medical examiner. Moreover, the OCME will not opine as to "time of death," and will only note "pronouncement."

Each finding has the stamp of approval from the person issuing it in order to make the conclusions minimally subjective. The photography is completed by law enforcement

investigators who are assigned, and they are present throughout the whole autopsy process. The report itself typically is completed shortly after the physical autopsy, depending on the workload of the medical examiner. Dr. Dragovic also raised the caveat that they will not issue reports without a toxicology report, as this is required for a full report. All toxicology is screened in-house and only sent to NMS Labs if further information is needed. Outside of a review of the medical condition of the deceased, we asked if there were any ancillary sources that are considered such as hospital records or EMS reports. He suggested that investigators generally obtain hospital records ahead of time, so those are usually considered by OCME.

Finally, especially in light of the injuries in this incident we inquired about use of specific injury terminology as it applies to gunshot wounds. Specifically, we asked for clarification regarding the meaning of "close-range" gunshots. Dr. Dragovic explained that it is assessed by the findings of gunpowder residue around the wound that enables the approximation of distance of the muzzle from the wound. If none is present, it is reported as "no evidence of close range." The medical examiner's assessment of close range is different than what is more colloquially understood.

4. *Dr. Shelton's Analyses and Conclusions*

Dr. Shelton's analyses and conclusions address each victim's particular wounds and survivability. Although the medical examiner's office determined that the victims were not shot "at close range," this term has a specific definition in the medical examiner's office involving the presence or absence of gun powder residue and puncture abrasions/stippling. It is not necessarily indicative of the actual distance between the shooter and the victim

Madisyn

It is the opinion of Dr. Shelton that Madisyn's injury was not survivable and would not have changed had medical personnel entered the building sooner. Madisyn was shot once in the head at 12:51:19. As is visible in the footage from OHS, she immediately fell to the floor and did not move. At 13:02:15, an OCSO deputy was the initial first responder to assess Madisyn and noted that she had a gunshot wound to the head and was not breathing. This implies cardiac arrest.

Madisyn's autopsy revealed a single gunshot wound to her head, specifically the bullet entered the left parietal scalp (left side of the skull near the back and top of the head) and exited the right temporal scalp (region on the right side of the skull above the ear and extending to the top of the scalp). The report further notes an absence of soot or gunpower residue as well as no "stippling" suggesting that the gunshot was not in "close

range" of discharge. This suggests that the fatal shot was outside the 2.5-3-foot area from the shooter.

Dr. Shelton concluded, and Dr. Dragovic agreed, that this was a lethal wound, which resulted in such catastrophic injuries as subgaleal (bleeding into the space between the scalp and the skull), subdural (bleeding under the dura mater, one of the layers of tissue that protect your brain) and subarachnoid hemorrhage (bleeding occurring in the space between the brain and the membrane that covers it), brain contusions (bruising to the brain resulting from trauma/impact to the brain) and skull fractures. Many of these underlying brain bleeds individually can be lethal. In our conversations with Dr. Dragovic, he confirmed that in this type of wound pattern, consciousness is lost instantaneously, which is a natural reaction of the brain. Therefore, unfortunately, first responder intervention would not have been able to save her life.

Tate

It is the opinion of Dr. Shelton that Tate's injuries were not survivable. Tate's initial gunshot wound occurred to his head at 12:51:10. At that time, he immediately collapsed to the floor. He was shot a second time in the buttocks at 12:52:20. School staff arrived at Tate's side at 12:53:51 (2:41 after the initial wound). AP Gibson-Marshall noted that his face was blue at the time she approached him, and before she started chest compressions and CPR. We asked Dr. Shelton to opine as to the meaning of Tate's blue shade at that time. He explained that it implies cardiac arrest, and more specifically, that he was not getting oxygen flow to his brain and possibly was already deceased. We further asked about the impact of CPR on Tate given his current state. Dr. Shelton explained that CPR and compressions could alter his color, but only due to the external forces of imposed air, however that does not ensure survivability. Finally, given the transport of Tate by means of the OCSO deputy in his vehicle, we asked if that could have contributed any harm. Dr. Shelton stated that in this situation there was little to no risk. A "scoop and run" approach with that kind of injury is the right thing to do in his experience and medical opinion. Dr. Shelton further confirmed that the distance driving to the EMS vehicle had no impact on his survivability either.

A review of the autopsy revealed injuries from two gunshots. The bullet entered his occipital scalp (the area on the back of the head, overlying the posterior cranial bone) and exited his left eye. Similar to Madisyn's injury, there was no evidence of gunpowder residue or stippling. The autopsy report notes an absence of close-range discharge of the weapon, but the recovery of a single projectile. This suggests that the fatal shot was enacted outside of the 2.5 - 3 feet area from the shooter. Dr. Bryan's report notes that Tate died as a result of "multiple gunshot wounds," however, both Dr. Shelton and Dr. Dragovic agreed that the lethal injury was the wound to his head. Tate also suffered the

same catastrophic injuries as Madisyn, including subgaleal, subdural and subarachnoid hemorrhages, brain contusions, and skull fractures. The gunshot wound to his buttocks was not a lethal wound. No first responder interventions would have changed the outcome.

Justin

Dr. Shelton's conclusions were that Justin's injuries were not survivable.[20]Justin was shot in the head at 12:59:31. It is the assumption that Justin immediately fell where he was shot, as there is no evidence to suggest that he made any attempts to move afterwards.[21] EMS reached Justin at 13:10:04. They noted he was unresponsive, with 1-2 liters of blood loss. EMS reported a Glasgow Coma Scale (GCS) of 4. The GCS is a scoring tool to evaluate neurological functions. It is made up of three scores which are eye opening, verbal response, and motor response. Eye opening has a maximum score of 4 for spontaneous eye opening to a minimum score of 1 for no response. Verbal response has a maximum score of 5 for oriented conversation to a minimum score of 1 for no response. Motor response has a maximum score of 6 for obeying commands to a minimum score of 1 for no response. The three scores are totaled for a maximum score of 15 and a minimum score of 3. A GCS of 8 or less is considered "comatose" and a severe traumatic brain injury. The lower the score, the lower the chance of survival. Justin's score of 4 resulted from a 1 for eye opening, 1 for verbal response, and 2 for motor response. The 2 for motor response was based upon an "abnormal movement of extending extremities." This is called "decerebrate posturing." This posture suggests damage to the brainstem, particularly in the lower midbrain or pons area. This area of the brainstem is responsible for basic functions like breathing, heart rate, and muscle tone.

The autopsy report revealed a single gunshot wound. The bullet entered the left occipital skull and exited the left frontal skull. Justin's catastrophic injuries include brain edema (accumulation of fluid in the brain tissue leading to intracranial pressure) with contusions and lacerations, "Duret" hemorrhage (intracerebral hemorrhage within the brainstem connecting cerebrum to spinal cord),[22] thrombosis of the superior sagittal sinus (blood

[20] Access to hospital records was requested but not made available for review. However, Dr. Shelton is not of the belief that it would have significantly altered his findings.

[21] Keegan Gregory who was in the bathroom with him at the time he was shot makes no note that he saw Justin move, and rather noted in a text message that the shooter had killed Justin.

[22] According to an article on Duret hemorrhages authors Walter A. Hall and Anish Bhardwaj note, "Duret hemorrhages are brainstem hemorrhages that occur secondary to descending transtentorial herniation, commonly resulting from severe traumatic brain injury, intracranial hemorrhage, or other causes of elevated intracranial pressure. These hemorrhages typically affect the midline and paramedian regions of the pons and midbrain due to vascular disruption of penetrating arteries. Because they involve critical brainstem structures responsible for autonomic regulation and motor function, Duret hemorrhages are associated with

clot in the largest dural vein in the brain), and numerous skull fractures. During the course of our interview with Dr. Pacris and Dr. Dragovic, we asked about a reference to “anoxic encephalopathy” and whether there was a period of time before that sets in. Dr. Dragovic stated that once the brain is injured and reacts in that fashion, “the chain of complications is set in and there is no going back to normal.” Only in exceptional cases of very narrow brain damage, the person may survive, but in this case, there was no way to increase survivability after the primary damage to the brain. The only “survival” was in a hospital with respiratory support. We further inquired for clarifications on the “complications” from the assault Dr. Pacris noted in the report, namely the bronchial pneumonia. Dr. Dragovic stated that intubation of people placed on life support or the fluid in Justin’s lungs could have caused bronchial pneumonia. OCME believes that any complications occurred within the period post-wound to arriving at OCME.

Finally, we inquired most importantly about the time frame between the gunshot wound to his head and when he received medical care from the first EMS provider. Specifically, we asked Dr. Dragovic and Dr. Shelton whether the nine-minute period between injury and service contributed to his decline. The universal opinion of the OCME and Dr. Shelton was that Justin’s injury was a fatal wound, and in this particular situation, the nine minutes without medical assistance did not contribute to any change in survivability. Dr. Shelton noted that when assessing brain trauma from gunshots wounds – location can matter. Injuries to the mid or lower brain are often the most devastating. He also has witnessed that there is limited care EMS can provide for brain bleeds, which involve scalp bandaging, airway management, IV fluids to manage pressure, and occasionally medication which most EMS do not have readily available. While a delay in treatment does not necessarily exacerbate hemorrhage, Dr. Shelton perceived that the airway issue could have been addressed better, namely the first responder to Justin could have placed him on his side in the recovery position. Dr. Shelton clarified, however, that even with perfect care he did not believe these wounds would have been survivable.

Both medical experts stated that for other types of wounds, including head injuries, timely intervention may be significant. This highlights the importance of promptly addressing injured individuals and indicates that a head injury does not automatically mean the wound is fatal. Dr. Shelton stated that it is difficult to determine whether the OCSO deputy did not adhere to best practices to assessing Justin, as the details of his assignment at the time are unclear. However, he did note concern regarding a nine-minute delay in treatment after a shooter was already in custody. Dr. Shelton added that, ideally, a deputy

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a poor prognosis.” Hall WA, Bhardwaj A. Duret Hemorrhages. [Updated 2025 Mar 28]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK560495/

would know to notify EMS immediately that a victim is in the bathroom, even if EMS are actively attending to other patients. In this situation, given the extent of Justin's injuries, which were like those of Madisyn and Tate, it is likely he would have lost consciousness immediately following the gunshot, without awareness of events after the brain injury occurred.

Hana

Dr. Shelton concluded that Hana's injuries were not survivable. Hana was shot multiple times, beginning at 12:51:14. She was last seen moving on the OHS surveillance at 12:57:00. Hana initially received care and attention from the hall monitor at approximately 12:58:38. Data from the hall monitor's body worn camera revealed a large amount of blood, unresponsiveness, and very labored and slow breathing. This can be classified as Class 4 hemorrhagic shock which has greater than 40% loss of total blood volume and a poor chance of survival. At 13:14:05, body worn camera video showed that Hanna was in cardiac arrest. At this time, first responder paramedics arrived at Hana. At 13:17:00, the two paramedics were joined by another EMT. At 13:20:00, the paramedics pronounced Hana. We note the hall monitor expressed to us in her interview that she had a challenge with application of the tourniquet, which is also visible on her body worn camera. It was clear, however, that she applied wound pressure, and eventually the tourniquet was applied by another deputy.

A review of her autopsy revealed four gunshot wounds. The most serious wound was to the chest. Entrance was to the left upper back and exited the right lateral thorax, causing a pulmonary injury. Injuries from the bullet's path included bilateral hemothoraces, rib fractures, collapse and contusions of the lungs. There was also a finding of heavy bleeding in both spaces around her lungs along with 300 mL and 500ml of blood in the right and left pleural cavities (space between the lungs and chest wall). OCME is of the belief that on-scene care would not have increased survivability. If this was her only wound, she may have been able to make it to the hospital, but it is largely considered a non-survivable injury. The second most serious gunshot wound was to the abdomen. Entrance was in the left lower abdomen and ended inside the right buttock, from which a bullet was recovered. Injuries from the bullet's path include perforation of transverse colon (section of the large intestine that runs across the abdomen) and small intestine along with 100ml of blood in the peritoneal cavity (fluid space within the abdomen that contains majority of the abdominal organs), more in the soft tissue. The third gunshot wound was to the thighs. The bullet entered the left lateral thigh, progressed across both thighs, and exited the right lateral thigh. It is important to note that this was not considered by Dr. Shelton nor OCME to be a "catastrophic" wound. This was the area where the tourniquet application was attempted. Both the OCME as well as Dr. Shelton believe that the

tourniquet would not have made a difference since there was no vessel injury in her thigh area. There was soft tissue hemorrhage without injury to major blood vessels. The least serious of the gunshot wounds was to the left forearm, which included a soft tissue injury, which was also classified as “not catastrophic” in our interview with OCME. When we informed OCME that the video of Hana’s final moments indicated non-verbal moaning, we asked whether that could be tied to “consciousness.” OCME suggested that there is a progressive limitation of perception and consciousness. Therefore, it is possible that it was a “comatose reaction,” not necessarily a perception of pain.

Dr. Shelton opined that each of Hana’s wounds individually could be “potentially” survivable with the chest wound being the least likely and the forearm wound being the most likely. However, these injuries cannot be considered alone. Hana’s death was the result of the additive effects of the multiple serious injuries collectively. A tool utilized in emergency injury assessment is called “injury scoring calculations.” These are used to grade severity and provide an estimation of survivability. The Abbreviated Injury Scale (AIS) is an anatomically based scoring system. Individual injuries within anatomical regions are given scores based on severity. Scores range from 1 to 6, with 1 being minor to 6 being fatal. This data is used to calculate the Injury Severity Score (ISS) and the Trauma Score and Injury Severity Score (TRISS). The ISS is calculated by squaring the highest AIS score in each of the three most severely injured body regions and summing those squared scores. An ISS of 25 or greater receives the highest classification of Very Severe Injury. The higher the score correlates with increased mortality. TRISS uses the Injury Severity Score along with injury mechanism of penetrating versus blunt, age, and Revised Trauma Score to estimate the probability of survival. Hana’s injuries were reviewed and calculated. Her chest injury was the most severe and received an AIS value of 5 (critical). Her abdominal wound received an AIS value of 3 (serious). Her thigh wounds received an AIS value of 1 (minor). These values were used to calculate an ISS of 35 which is within the highest classification of Very Severe Injury. This value was used to calculate a TRISS of 0.033 which translates to a 3.3% chance of survival from her injuries.

Based upon the full analysis of injuries, it is Dr. Shelton’s belief that treatment from medical professionals sooner would not have changed the outcome. Survival following these types of injuries is also contingent upon the time required to reach the nearest hospital capable of managing such severe trauma. In cases involving mass shootings, the challenge of transferring critically injured patients from the scene to an appropriate facility is further complicated. Dr. Shelton noted that most EMS do not have the advanced skills or equipment to attend to these types of wounds on scene sufficient to constitute the level of critical care those types of injuries warrant.

C. First Responder Actions on November 30, 2021: OCSO, Fire/EMS, and Dispatch

The following represents an in-depth analysis of the law enforcement response to the OHS shooting.[23] First, we provide background information on general best practices and guidelines pertaining to active shooter situations. Second, we describe the Oakland County command structures in place at the time of the incident as well as relevant policies and procedures. Third, we give detailed timelines of actions by OCSO, fire, and EMS personnel. Finally, we provide our analysis of different aspects of the response as well as our recommendations for improvement.

We would like to take a moment to note several limitations encountered during our review. One primary issue was that OCSO, and surrounding law enforcement agencies did not have issued BWCs at the time of this event. The only BWC footage was from the hall monitor's camera which was activated about three minutes into the response. Patrol officers were equipped with an audio-only camera that transmitted back the dash camera audio in their patrol vehicle. This audio had limitations in this event, as the audio became broken and unintelligible as deputies moved deeper into the school and away from their patrol vehicles. The SRO's audio was able to clearly pick up the first several minutes of entry up to the arrest of the subject. After that, his audio became unintelligible as he was too far from his vehicle. Additionally, OCSO did not have any radio traffic from Special Operations encrypted radio channels, to include SWAT and EOD. The radio traffic provided by the OCSO was very limited. OCSO did not create a detailed report on everything that happened. Instead, reports referred to other documents, such as officer narratives.

Finally, we also encountered issues in communications with some current and retired members of OCSO. Although we were informed they initially agreed to answer questions in writing, when provided our questions by OCSO command staff, they refused to respond. We acknowledge that OCSO leadership did provide responses to the questions when it was known or available to them. OCSO also acted as an intermediary to those individuals who would not participate in the review.

1. Best Practices that Govern Incident Management for Public Safety Agencies

To properly assess the response on November 30, 2021, we must first establish what constitutes proper protocols and procedures for law enforcement.

[23] Appendix A contains a list of the sources from which relevant data was collected and reviewed for this section.

a. School Security Officer and SRO Practices

The National Association of School Resource Officers (NASRO) has developed Standards and Best Practices for the SRO Program, advocating for their adoption by law enforcement, school safety agencies, and school boards. NASRO defines an SRO as a sworn law enforcement officer assigned to a school in a community-oriented policing role, operating under a triad model that includes duties as a law enforcement officer, educator, and informal counselor or mentor. Best practices for SRO selection recommend a minimum of three years of law enforcement experience, strong communication skills, a commitment to youth development, and a probationary period to assess suitability. Training is considered critical, with recommended components including a NASRO-certified 40-hour basic course, instruction in child psychology, restorative justice, conflict resolution, and cultural humility, along with ongoing refresher training. Additionally, the American Medical Association (AMA) recommends mandatory training in de-escalation techniques and the tracking of disciplinary actions to monitor and address potential bias.

NASRO emphasizes the importance of clearly defining the roles of school administrators and School Resource Officers (SROs) to ensure compliance with district and department policies, as well as local, state, and federal laws. A strong partnership between schools and law enforcement can foster a safer, more supportive learning environment. Successful partnerships are built on mutual understanding, shared responsibilities, and ongoing communication. Recommended strategies include:

Memorandum of Understanding (MOU): Annual review and updates to reflect program improvements.

- Joint Training Initiatives: Cross-training to deepen understanding of school policies and law enforcement procedures.
- Routine Coordination Meetings: Regular discussions to address current and emerging school-related concerns.
- Clear Chain of Command: Teachers and SROs should follow their respective organizational hierarchies
- Information Sharing Protocols: Transparent exchange of policies and procedures within legal boundaries.
- Crime Prevention Through Environmental Design (CPTED): Periodic assessments to enhance school safety.
- Crisis Management Planning: Collaborative development and practice of emergency response strategies.
- Community Education: Outreach to parents on school-related legal matters and safety protocols.

Both NASRO and the U.S. Department of Justice (DOJ) underscore the necessity of a formal MOU between school districts and law enforcement agencies that conforms to NASRO and DOJ guidance.

b. Entry into an Active Shooter Scene

The International Association of Chiefs of Police (IACP) has set forth guidance emphasizing the urgent necessity for swift and effective law enforcement responses to active shooter events.[24] These incidents, often unfolding in mere minutes, demand immediate intervention to minimize casualties and protect lives. Traditional tactics of securing perimeters and awaiting specialized units like SWAT are no longer sufficient. Instead, officers must be prepared to act decisively upon confirming an active threat, even if they are the sole responder on the scene.

Upon arrival, officers are expected to conduct a rapid situational assessment to verify the presence of an active assailant. This involves gathering intelligence from dispatch, witnesses, and individuals exiting the location, as well as listening for gunfire or other indicators of violence. Critical information includes the number and description of suspects, their weaponry, use of body armor, and any signs of explosives. Such details are essential for shaping the tactical response and ensuring the safety of both officers and civilians.

Clear and continuous communication is vital throughout the incident. First responders must relay accurate updates to dispatch, including their location, actions, and observations about the suspect and victims. Communications personnel play a pivotal role by efficiently extracting key information from callers and maintaining contact to provide real-time updates to officers. Their training should emphasize prioritizing questions and managing high-stress interactions effectively.

Once inside the scene, officers may form a contact team tasked with locating and neutralizing the threat. This team may be supplemented by additional units as directed by the incident commander (IC). Even unarmed officers contribute meaningfully by assisting with evacuations and guiding civilians to safety. Officer safety remains paramount; responders should be equipped with protective gear such as ballistic vests and helmets and carry appropriate weapons for the situation.

Following the initial engagement, rescue task force (RTF) teams enter to administer trauma care and evacuate victims. These teams must be well coordinated and prepared

[24] https://www.theiacp.org/resources/policy-center-resource/active-attack.

for potential hostile encounters. Simultaneously, a unified incident command structure should be established, integrating law enforcement, fire, EMS, and facility officials. This command oversees the broader response, including perimeter control, resource coordination, and staging area management.

Training is a cornerstone of effective response. All sworn personnel should undergo rigorous instruction in immediate action tactics, including live simulations and tabletop exercises in relevant environments like schools. Post-incident debriefings are essential to evaluate performance, identify gaps, and refining protocols for future events.

Public communication and community support are also critical components. The Public Information Officer (PIO) must deliver timely and accurate updates to the public, including shelter-in-place advisories and evacuation instructions. Agencies should also prepare to offer victim support services, such as assistance centers, to aid those affected.

Ultimately, the IACP's guidance reflects a shift toward proactive, coordinated, and multi-agency strategies in responding to active assailant threats. While the term "active shooter" is commonly used, these protocols apply broadly to any scenario involving ongoing deadly force, whether from firearms, explosives, or other weapons. IACP's position is consistent with other major police organizations in responding to these types of violent incidents.

c. Best Practice for Incident Command

In an active assailant event, effective incident command and most importantly, the rapid creation of *unified* incident command is critical to ensure successful operations. As identified in response to numerous active assailant events, unified incident command is necessary to quickly stop threats and provide life-saving care to victims. Effective incident command intends to secure the scene and surrounding area through the deployment of first responder resources. "Rapid" creation of incident command is best established within the first five minutes of an incident. A designated incident commander should be equipped to provide responding units with information about what is occurring and what needs to happen when other responders arrive.

Homeland Security Presidential Directive No. 5 created the National Incident Management System (NIMS).[25] NIMS is a program of the Federal Emergency Management Agency (FEMA). NIMS provides a standardized and scalable response for

[25] Office of the White House. (2003, February 28). *Homeland Security Presidential Directive HSPD-5: Directive on management of domestic incidents.* Washington, D.C.: Same.

on-scene emergency command and is critical to ensure effective coordination and communication during emergency events. It was designed to provide a "consistent nationwide approach for federal, state, and local governments to work effectively and efficiently together to prepare for, respond to, and recover from domestic incidents, regardless of cause, size, or complexity."[26]

The NIMS model for incident management is implemented through the incident command system (ICS). ICS is a standardized on-scene approach that assists in managing critical incidents by establishing field-level incident management structures for all responding agencies. ICS 100 – The Incident Command System, "represents organizational 'best practices,' and has become the standard for emergency management across the country."[27] Public safety agencies across the United States have adopted the ICS model of coordination to respond to and manage critical incidents. Starting in 2005, local, state, territorial, tribal, and federal agencies were required to complete training programs ICS 100, 200, 700 and 800 to receive federal preparedness grants.[28] This financial incentive resulted in almost nationwide adoption of NIMS; agencies which have not adopted the ICS model are rare outliers. While the organization of incident management is dependent on agency capacity and the event type/complexity, the ICS model provides organization, management hierarchy, processes, protocols, and common terminology.

Emergency services throughout the United States embrace this concept to organize and ensure scene management in a formal way. An April 2009 incident command policy from the International Association of Chiefs of Police (IACP) formally adopted NIMS as the primary method to prepare for, respond to, and manage critical law enforcement events.[29] The IACP model policy also recommends that all law enforcement officers' complete awareness-level NIMS courses, and all supervisors take advanced NIMS courses. In addition, law enforcement agency training must use established NIMS and ICS procedures. Likewise, the National Sheriff's Association endorsed the 2016 Active Shooter/Hostile Event Guide[30] published by the Interagency Board. This document specifically addresses best practices for an active assailant response, also referred to as Active Shooter/Hostile Event (ASHE) response, which includes incident command. The ASHE Guide calls for law enforcement agencies to establish policies specific to active assailant incident command. These policies must involve rapid creation of command with

[26] Ibid.
[27] https://www.usda.gov/sites/default/files/documents/ICS100.pdf
[28] Federal Emergency Management Agency. (2025). *Twenty years of the National Incident Management* System. Same. Retrieved from www.fema.gov.
[29] International Association of Chiefs of Police. (2009, April). *Model policy for incident command.* Washington, D.C.: Same.
[30] InterAgency Board. (2016). *Active shooter/hostile event (ASHE) guide.* Washington, D.C.: Same.

the first arriving officers as well as the rapid integration of fire and EMS into a unified command.

> *"In most ASHE incidents, the responding law enforcement agency will lead the response with overall command of the incident. However, both the fire service and emergency medical service play an important role by bringing necessary skills."*[31]

Failing to quickly establish an initial command and promptly integrate with other public safety disciplines can lead to severe consequences. "ICS is most critical in the initial response to an ASHE. Without a sound structure of ICS at the beginning of an incident, the rest of the response has the potential to unravel as additional agencies and resources arrive."[32]

Research shows that a smaller number of coordinated responders are more effective and efficient than a larger group of uncoordinated responders.[33] Successful incident command operations in the first five minutes of a critical event often determine response success. These operations include not only "sizing up" a scene, but also a brief description of initial actions, and instructions for additional responding personnel.

> *"A clear picture of the situation and proper coordination during the first few minutes after an attack had a greater effect to minimize harm than the ratio of medical providers to injured people."*[34]

The presence of numerous responders on scene does not ensure rapid threat mitigation or rapid victim care. For example, the shootings at Robb Elementary School in Uvalde (Uvalde), Texas, demonstrated that the presence of 376 law enforcement officers cannot functionally manage an event when there is an absence of actively engaged command and coordination.[35]

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[31] Ibid.
[32] Ibid.
[33] Holgersson, A. (2017). Review of on-scene management of mass-casualty attacks. *Journal of Human Security, 12*(1): 91-111.
[34] Ibid.
[35] Texas House of Representatives. (2022). *Investigative Committee on the shootings at Robb Elementary School: Interim findings.* Austin, TX: Uvalde Investigative Committee; Texas State University. (2022). *Robb Elementary school attack response assessment and recommendations*. San Marcos, TX: ALERRT.

"If you do not understand the equity of each responding agency, you will never be a unified incident commander. At best, you will be an agency commander."[36]

There are generally considered to be three "Cs" of unified command: co-location, communication, and coordination.

Co-location of command is critical for operations. Agency commanders must be physically located in close proximity to each other, described as "hand-holding distance." This proximity should not be any farther than the limits of normal conversation without shouting. Co-location does not mean that agency commanders sit isolated in their individual vehicles; rather, it mandates that the command element of each agency has the most current information to lead their agency and that agency commanders actively engage with each other to accomplish critical tasks simultaneously. "Priorities of the incident are not sequential. Instead, several actions must occur simultaneously, performed by different first responder agencies. To conduct this, there must be interagency collaboration."[37]

Communication ensures that information is converted into intelligence so agency commanders can make rapid decisions with the best information available at the time. Communication also ensures that all relevant public safety disciplines have an active voice in the response. Active assailant incidents result in an overwhelming volume of information for commanders to process. Ensuring that all relevant agencies receive the same information at the same time is critical for operational success.

Coordination is essential as law enforcement, fire, EMS, and emergency management all have their own critical operations to perform to maximize the preservation of life. A unified incident commander is responsible for the overall coordination of the response, ensuring that all agencies quickly obtain their priority objectives.

These priority objectives are also known as an agency's *equity*. As discussed in our analysis below, law enforcement's primary equity was to stop the active threat, identify additional threats, establish containment/perimeter, respond to gunshot victims, clear the school, and conduct a crime scene investigation. Secondary equities in this incident would

[36] Salka, J.J. (2018). Fire scene: Is incident command a fallacy? *Firehouse Magazine.* Retrieved from www.firehouse.com.
[37] Holgersson, A. (2017). Review of on-scene management of mass-casualty attacks. *Journal of Human Security, 12*(1): 91-111.

consist of providing patient care, assisting at the reunification location, and victim services.

d. National Fire Department Standards

On June 17, 2013, the International Association of Fire Fighters (IAFF), a large and influential labor union for fire fighters across North America and Canada, released its first position statement on active shooter response, in which it recommended fire departments have standard operating procedures for active shooter events and use the rescue task force concept at these events.[113] Likewise, the United States Fire Administration released best practice guidelines for active shooter response in 2013, acknowledging that "[e]xtraordinary efforts on the part of local fire/EMS and direct pre-planned coordination with law enforcement is required during the response to active shooter events to affect rescues, save lives, and enable operations with mitigated risk to personnel.[38] That same year, IACP also issued an active shooter position statement reiterating the need for every fire department to have an active shooter response protocol and for fire and law enforcement to train together, among other things.[39]

Following the 2016 attack at Pulse Nightclub in Orlando, Florida, the National Fire Protection Association (NFPA) was tasked with creating a national standard for active assailant response. NFPA is U.S.-based international non-profit devoted to loss prevention caused by fire, electrical, and other hazards.[116] NFPA codes and standards are developed by subject matter experts.

On April 10, 2018, NFPA codified NFPA 3000: Standard for Active Shooter/Hostile Event Response (ASHER) Program. The NFPA 3000 committee was comprised of 58 executives representing a broad spectrum of organizations. These included traditional federal agencies such as the United States Department of Justice (DOJ), FBI, DHS, and Department of Defense (DOD), as well as national law enforcement and fire organizations, medical associations, international associations for emergency services and fire, and distinguished subject matter experts.[40]

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[38] The United States Fire Administration (2013, September), Fire/emergency medical services department operational considerations and guide for active shooter and mass casualty events, Emmitsburg, MD, Federal Emergency Management Agency.

[39] The International Association of Fire Chiefs (October 13, 2013), IAFC position: Active shooter events and mass casualty terrorist events, www.iafc.org.

[40] The NFPA 3000 committee included representation from: United States Department of Justice; Federal Bureau of Investigation; United States Department of Homeland Security; United States Department of Defense; National Security Agency; International Association of Chief of Police; National Sheriff's Association; Major Cities Chiefs of Police; Fraternal Order of Police; National Tactical Officers' Association; National Association of POST Accreditation; International Association of Fire Chiefs; International

The NFPA 3000 code does not dictate tactics; the code dictates competencies, meaning it establishes the skills and abilities that firefighters must be able to apply. At a minimum, the code requires the authority to have jurisdiction to maintain a written statement or policy that establishes the following:

- The existence of an ASHER program;
- A list of stakeholders in the program;
- Functions that stakeholders will perform at an ASHER event;
- Unified command policies specific to an ASHER;
- First responder ASHER training programs; and
- First responders ASHER personal protective equipment standards.

e. Perspectives on Staging Best Practices

Staging is an integral practice in the fire service. Research collected by well-respected fire safety organizations provide guidance as to implementation of safety and staging protocols. These standards are not mandatory and there are some discrepancies among them. For example, one standard recommends waiting to stage until a scene is declared safe, while another suggests firefighters must accept risks to save life.

The best way to understand the term, is to define it by "staging" as a descriptive adjective, and "staging" as an active verb. Staging (adjective) describes the location where uncommitted apparatus and personnel go to await an assignment at an incident. It is typically in a location near the scene, but far enough away to keep personnel from acting at the scene. For large events, staging is typically a nearby parking lot, or somewhere in the direction of travel on nearby major roads. Within this definition of staging there are two levels, I and II.[41] Level I staging means that apparatus is positioned at the scene and personnel stand by their apparatus awaiting an assignment. Level II staging means that apparatus and personnel are situated in a location that is one block away from the scene, awaiting an assignment. Staging (verb) is when fire and EMS personnel are located close by a scene, with the understanding of exposure to potential violence. In this version, fire/EMS will wait on the periphery until law enforcement arrives and secures the scene. Many fire and EMS departments have policies requiring personnel to stage several blocks away from scenes of violence to prevent harm or injury to the responders. It is well

Association of Fire Fighters; National Volunteer Fire Council; National Association of EMS Physicians; International Association of EMS Chiefs; National Association of EMTs; National EMS Academy; Emergency Medical Services Labor Alliance; International Association of Emergency Managers; and internationally recognized subject matter experts.

[41] These classifications are offered to represent the standard or "typical" interpretations. The actual definitions of Level I and Level II staging vary throughout the United States.

established within the industry that a scene is considered, and thereby declared, “safe” when there are no obvious threats to fire or EMS personnel.

NFPA 1500: *Standard on Fire Department Occupational Safety and Health Program* directs the fire department incident commander to stage all fire department resources in a safe area until law enforcement has secured the scene.[42] This standard also provides that if violence occurs after emergency operations have started, the incident commander is to immediately secure law enforcement protection or withdraw all fire department members to a safe area.[97]

NFPA 1500 was targeted primarily at civil unrest, fights, and violent crimes.[43] NFPA 3000, however, is the latest standard issued regarding active assailant events, NFPA 3000 states that all fire departments should have an ASHER program, where fire and EMS personnel integrate quickly with law enforcement to provide care at active assailant attacks.

The National Fallen Firefighters Foundation (NFFF) Life Safety Initiative #12 advises fire departments to have protocols for violent incident response that keeps the firefighters far away from any perceived threats.[44] However, the NFFF also recognizes the need for aggressive action at active assailant events, noting that the rapid response will increase victim survival.[45] The NFFF advises that the response must be well coordinated with law enforcement to minimize risks to fire personnel.

Following the shooting at Sandy Hook Elementary School (Sandy Hook) in Newtown, Connecticut, a group of physicians met in Hartford, Connecticut, to discuss care at active shooter events. A publication called The Hartford Consensus was the result of these meetings.[46] This compendium was approved by numerous leading physicians in the United States. The Hartford Consensus, which we discuss in more detail in the next section, declared that staging is unacceptable for active shooter events.[47] According to

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[42] National Fire Protection Association. (2021). NFPA 1500: Standard on fire department occupational safety, health, and wellness program. Quincy, MA.
[43] National Fire Protection Association. (2025). *Events that involve violence.* Same. Retrieved from www.nfpa.org.
[44] National Fallen Firefighters Foundation. (2015). *Any incident can become violent: Preventing firefighters from becoming targets.* Same. Retrieved from www.everyonegoeshome.com.
[45] National Fallen Firefighters Foundation. (2015). *Any incident can become violent: Preventing firefighters from becoming targets.* Same. Retrieved from www.everyonegoeshome.com.
[46] American College of Surgeons. (2015). *Strategies to enhance survival in active shooter and intentional mass casualty events: A compendium.* Chicago, IL: Same.
[47] Jacobs, L.M. (2014). Joint committee to create a national policy to enhance survivability from a mass casualty shooting event: Hartford Consensus II. *Journal of American College of Surgeons, 218*(3): 476-478.

The Hartford Consensus, "EMS/Fire/Rescue teams must be involved earlier in the care of these victims. They should have direct contact with the law enforcement personnel on the scene."[48] Other research also recognizes that fire and EMS personnel must swiftly recognize and control life-threatening hemorrhage at the point of injury, rapidly remove patients from the crisis site, and expeditiously transport patients to appropriate hospitals. Staging takes up valuable time, and time is one of the most critical treatments that fire/EMS personnel can provide.[49]

The act of staging is often a reflection of a lack of both training and an ability to work with law enforcement during high-risk incidents.[50] It often indicates fire and law enforcement leadership's failing to conduct frequent joint training, as well as fire department leadership's failing to make an adequate risk-benefit evaluation.[51] Staging (verb) at active assailant events is widely recognized as an outdated policy that directly decreases victim survival.

f. Best Practices for Fire and EMS

Best practices for fire and EMS personnel during an active shooter event emphasize a critical evolution from traditional response models to a more integrated and proactive approach. Historically, EMS would stage at a safe distance, waiting for law enforcement to secure the scene before entering. However, modern protocols now advocate for EMS to position closer to the crisis site, prepared to immediately move into the "warm zone" under police escort. This shift enables faster access to victims, allowing for immediate triage and life-saving interventions such as hemorrhage control— which can be the difference between life and death.

The Hartford Consensus established several critical actions for fire and EMS personnel. The consensus had five key components:

[48] Jacobs, L.M. (2014). Joint committee to create a national policy to enhance survivability from a mass casualty shooting event: Hartford Consensus II. *Journal of American College of Surgeons, 218*(3): 476-478.

[49] Remley, M., del Junco, D. Shackleford, S. (2020, October 1). *Joint Trauma System: Evidence-based principles of time, triage, and treatment.* Proceedings from the Special Operations Medical Association Scientific Assembly; Clumpner, M., Lawner, B. & Mehkri, F. (2020, September 10). Prehospital trauma management: We can do more by doing less. *Journal of Emergency Services.* Online ahead of print.

[50] Atkinson, J.A. (2015). *Standard operation guidelines for an active shooter.* Emmittsburg, MD: United States Fire Administration.

[51] Atwater, P. (2012). *Force protection for firefighters: Warm zone operations at paramilitary style active shooter incidents in a multi-hazard environment as a fire service core competency.* Monterey, CA: Naval Postgraduate School.

1. Fire and EMS must be involved early in the care of patients;
2. Staging is not acceptable;
3. Fire and EMS personnel must be trained in TCCC or TECC;
4. Patient care centers around external hemorrhage control followed by rapid transport to an operating room; and
5. All other patient care is secondary, and the efficacy must be clearly indicated.[52]

Dr. William Fabbri, the medical director for the FBI, also published medical best practices for active shooter events. Like the Hartford Consensus, his best practices call for quick action. He specifically advises responders to: (i) rapidly recognize and control life-threatening hemorrhages at the point of injury; (ii) rapidly remove patients from the crisis site; and (iii) rapidly transport patients, prioritizing those with internal bleeding.

In 2015 DHS issued a "First Responder Guide for Improving Survivability in Improvised Explosive Device and/or Active Shooter Incidents."[53] The purpose of the publication is to provide multi-disciplinary first responder guidance. It references strategies for both explosive device and active shooter incidents "from its significant investment in combat casualty care research into the civilian first responder environment."[54] In its recommendations, DHS notes, "First responders should adopt, develop training for, and operationalize the evidence-based guidelines of TECC. Training should be conducted in conjunction with EMS, fire, law enforcement, and medical community personnel to improve interoperability during IED and/or active shooter events."[55]

Deployment into the warm zone requires a balance between urgency and safety. EMS personnel must be equipped with appropriate protective gear, including body armor, and operate in close coordination with law enforcement to ensure secure access routes. Police escorts should create safe corridors for EMS teams to reach and evacuate the injured. Once inside, EMS should focus on rapid triage and controlling bleeding, which remains the leading cause of preventable death in mass casualty incidents.

To support this evolved role, EMS providers must undergo specialized training tailored to high-threat environments. TECC principles, tourniquet application, and coordinated team movement are essential skills. Equally important is the availability of personal protective equipment (PPE) suited for these conditions. Interagency coordination plays a pivotal role

[52] Jacobs, L.M. (2014). Joint committee to create a national policy to enhance survivability from a mass casualty shooting event: Hartford Consensus II. *Journal of American College of Surgeons, 218*(3): 476-478.
[53] Department of Homeland Security (2015). *First responder guide for improving survivability in improvised explosive device and/or active shooter incidents.* Washington, D.C.: Same.
[54] Ibid.
[55] Ibid.

in ensuring seamless operations. Joint training exercises and clear communication protocols between EMS and law enforcement foster trust and operational efficiency.

Effective command and control structures are vital during active shooter events. A unified command post, jointly operated by EMS and law enforcement, ensures cohesive strategy and decision-making. Communication plans must be robust, encompassing both internal coordination and external messaging. A well-developed incident action plan (IAP), practiced regularly, provides a blueprint for response and helps mitigate chaos during real-world incidents.

Beyond tactical considerations, EMS agencies must also address broader concerns. The psychological toll on both victims and responders can be profound, necessitating mental health support and post-incident care. Community engagement is another cornerstone—building trust and awareness within the community can aid in early threat detection and foster resilience. Finally, resource allocation must be proactive, ensuring that medical supplies, personnel, and transportation assets are readily available and scalable to the scope of the emergency.

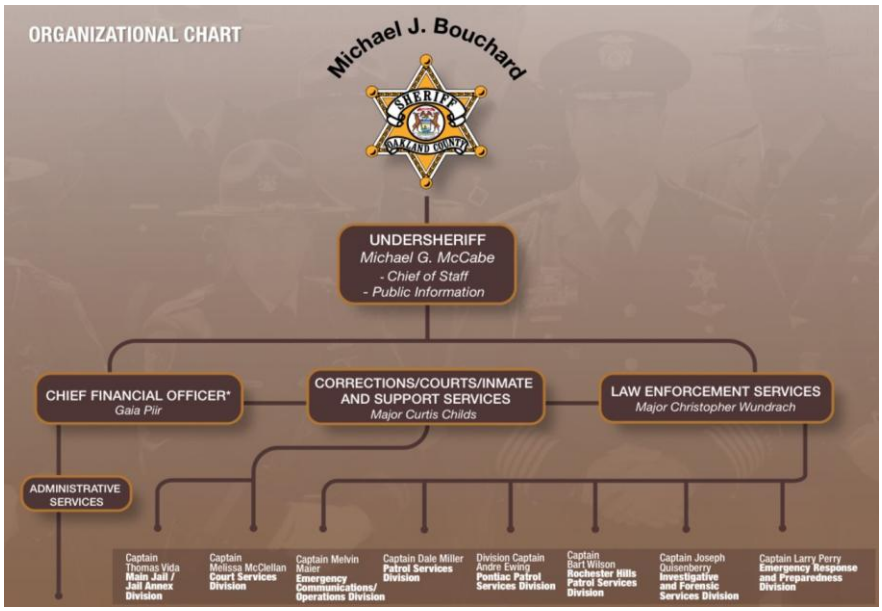
2. *Law Enforcement Command Structure and Responsibilities*

    a. Oakland County Sheriff's Office

OCSO is one of the largest law enforcement agencies in the state of Michigan with 1,400 employees, both sworn and non-sworn officers. The OCSO covers Oakland County and is the primary law enforcement provider for 15 contracted communities and townships. OCSO is the primary law enforcement agency that is responsible for services to OCS. In addition to its responsibilities at OCS, OCSO is contracted to provide law enforcement services to Oxford Township. OCSO is responsible for the Oakland County jail as well.

The following organizational chart provides the leadership positions in 2021.[56] Sheriff Michael Bouchard (Sheriff Bouchard) has served as sheriff since January 11, 1999, and is the longest-serving sheriff in OCSO history. On November 30, 2021, Sheriff Bouchard had left that morning for vacation in Florida, leaving Undersheriff Mike McCabe (Undersheriff McCabe) in charge. When the shooting happened, Sheriff Bouchard had already landed in Florida. He then got on the next flight back to Detroit, arriving later that evening.

[56] https://www.oakgov.com/home/showpublisheddocument/25916/638737747443470000



The OCSO provided a staffing roster for November 30, 2021, which showed 353 sworn and personnel on duty. The staffing is below:

- 1 – Sheriff (out of town at the time)
- 1 – Undersheriff
- 3 – Majors
- 7 – Captains
- 24 – Lieutenants
- 38 – Sergeants
- 5 – Sergeants (Detective)
- 64 – Deputy II (Patrol Investigators)
- 15 – Deputy II (SRO's)
- 102 – Deputy II
- 93 – Deputy I
- 1 – Dispatch Supervisor
- 1 – Quality Assurance Supervisor
- 26 – Dispatch Specialists

Below is the staff for the OCSO Oxford substation on the day of the shooting (staffing numbers are included above)**:**

- 1 – Lieutenant
- 1 – Sergeant
- 2 – Deputy II (patrol investigator)
- 1 – Deputy II (SRO)
- 4 – Deputy II

OCSO Law Enforcement Division (LED) maintains patrol contracts with 10 townships, three cities, and two villages. The division substations are located within the 10 townships, which house the patrol deputies. OCSO is also contracted with the OCS and Oxford township to provide law enforcement services. The Village of Oxford also has a small police department with nine full-time officers, two part-time officers, and 10 reserve officers. During the school year, OCSO provides a full-time SRO for Oxford High School and Oxford Middle School. In the summer, the SRO would supplement patrol staffing for the Oxford substation. The OCS provides 70% of funding with Oxford Township providing 30%.

LED also supervises the patrol units and special teams which include everything from traffic enforcement, motorcycle and mounted units, alcohol enforcement, K-9, and SROs, amongst others. A patrol deputy is a Class II deputy and attends an 18-week academy followed by a 14-week extensive field training program. Patrol deputy is OCSO's term for a deputy who is qualified to "work the road." Many patrol deputies started their law enforcement careers as corrections deputies. The third type is a reserve deputy. Reserve deputies are fully sworn law enforcement officers but not compensated for their time. Reserve deputies must complete the Michigan Commission on Law Enforcement Standards (MCOLES) 120-hour basic reserve officer training course. Upon completion of the course, they must complete a field training program that is dependent on meeting the standard skills required for the position.[57]

At the time of this incident, an OCSO deputy was the assigned SRO for both Oxford High School and Oxford Middle School. In the summer months, the SRO supports patrol operations at the Oxford substation. OHS lies within the OCSO Oxford sub-station area of responsibility for law enforcement services. The chain of command for the assigned SRO is through the OCSO sub-station supervisor and command lieutenant. All requests for public safety response to OHS run through the OCSO Dispatch for appropriate agency dispatch.

3. Fire and EMS Command Structure and Responsibilities in Oakland County

Before addressing the command structure, it is important to understand the long-term impact of financial challenges in the metro-Detroit area and in Michigan overall. As a result of the "Great Recession" from 2007-2009, there were significant budget cuts for local law enforcement and fire departments, and substantial first responder layoffs.[3] In addition to financial issues, the Michigan fire service was also impacted by transitions within departments, and the rural/urban divide. Collectively these issues have affected

[57] https://nleomf.org/wp-content/uploads/2022/09/ERP-Division.pdf

fire service stability and its capacity to efficiently operate. This dynamic is still evident today. While these fiscal issues clearly preceded the shooting at OHS by more than a decade, the impact was still present in 2021, and even currently. As of today in 2025, the state of Michigan has one of the lowest firefighters to resident ratios in the entire Midwest. The low ratios in turn have impacted the manner in which these fire departments operate, including in Oakland County. Fewer than five fire departments mandate minimum staffing requirements of three firefighters per career fire apparatus. Only two departments require four firefighters per truck (Detroit and Lansing). Most career fire departments in Michigan operate two-person fire apparatus. Although NFPA 1710 standards require a minimum of four firefighters on each career engine company, this standard is not followed in Michigan.[58]

In order to deal with these staffing concerns many fire departments use aid agreements. These agreements come in primarily two forms, automatic aid and mutual aid. Automatic aid occurs when departments agree to assist each other through predetermined plans involving resources and personnel. In automatic aid, a 9-1-1 dispatch center automatically sends other departments without waiting for a request. These call types are built out before the event and put into CAD. These agreements are used to bolster resources for incidents where more people or more resources of a specific type (i.e., water tenders/tankers, ambulances, technical rescue resources, etc.) are needed. The second form of aid is mutual aid. Mutual aid is the practice of predetermining what resources are needed from other departments for specific events. For example, a small department with one or two stations may not have the resources or manpower to effectively fight a structure fire. As such, when a structure fire is reported, the department will request aid from other departments.

a. Fire and Emergency Medical Services in Greater Oakland County, Michigan

Oakland County has 62 different villages and townships. Many of these townships have their own fire department, while some of the township's contract with other fire departments. The greatest population density is in the southern part of Oakland County where Oakland County touches Wayne County (home of Detroit, Michigan) and Washtenaw County (home of Ann Arbor, Michigan, and the University of Michigan). Oakland County is no exception to the dilemma of Michigan fire understaffing. For example, career departments in Oakland County routinely operate with only two firefighters assigned to fire apparatus. The largest career department in Oakland County

[58] Union leadership for the Michigan Professional Fire Fighters Union (MPFFU) informed us that they were frustrated by the lack of staffing and resources for the fire service throughout the state. The MPFFU petitioned for minimum staffing requirements as part of contract negotiations, but according to the MPFFU, these efforts were blocked by local fire chiefs reticent to request additional funds and the state fire chief's association.

(Waterford Regional Fire Department) has nine stations. This department experienced significant growth in 2012 when it assumed fire protection for the City of Pontiac and Pontiac's four fire stations.

Because of staffing issues, Oakland County has attempted different strategies. Many of the fire apparatus cross-staff additional ambulances (locally referred to as "jump stations"). In cross-staffing, personnel are assigned to a station and not apparatus. When a call comes in, they either board the firetruck or the ambulance, depending on the call. Most of the career departments are small, with many having two to five stations. Another way the county addresses staffing issues is to use accessibility to several public safety departments. These departments have cross-trained police officer/firefighters. The public safety concept was quite common in Michigan in decades past; however, many of these departments have since split into separate public safety services.

Most of the fire departments in Oakland County provide some level of emergency medical services, however, there are some departments that still do not provide any type of EMS care.[59] Emergency medical care varies by department, with departments providing no emergency medical care, basic life support (BLS) first response, BLS transport, and full-service advanced life support (ALS) transport capabilities. Most fire departments that provide ALS transport also provide ALS fire apparatus. In most cases, the firefighter/paramedic on the fire company can take their ALS equipment and quickly put additional ALS ambulances in service. One strength in Oakland County is the ability for the fire departments to quickly staff numerous additional ambulances by shifting personnel from fire apparatus.

Another practice Oakland County relies upon for supplementing staffing concerns is requests for mutual aid. In 2006, the State of Michigan adopted "Mutual Aid Box Alarm System" (MABAS), a concept that originated in Illinois to provide a statewide mutual aid system for fire and EMS. Oakland County adopted their mutual aid practice in 2007. When Oakland County adopted MABAS, there was one group that included all fire departments in the county. The county was divided into two MABAS groups in 2013: MABAS 3201 (colloquially referred to as "North Oakland'), which is comprised of "combination departments," that have part-time/volunteer members and full-time career members, and MABAS 3202 (colloquially referred to as "Oakway"), which consists of 10 career departments.[60] In the North Oakway, executive and administrative staff are typically

[59] Troy Fire Department is nearly all volunteer and does not provide EMS services.
[60] Career versus primarily volunteer departments also impact staffing and ultimately mutual aid practices. For example, the influences that drive the staffing problems in the southern part of the county appear to be the typical economic downturn problems that plague established fire departments. As the tax base has shrunk and revenues decreased, career staffing is impacted, and layoffs occur. The northern departments

volunteers, with leadership selecting someone familiar with the management of the town. Moreover, for a few fire departments in North Oakland, most promotions in the fire departments were awarded to volunteers to reward them for their service to the community. This meant that volunteer firefighters were quicker to ascend the rank structure in the department than paid firefighters.

Fire department personnel, including chiefs, expressed concerns regarding the cultural divide between the two MABAS groups. We were informed that this division has led to ongoing tensions over the years. For example, the southern Oakway departments believe that they should have more decision-making abilities within MABAS, given the greater population density in the southern area of the County. We were told that this divide even extends to certain pejorative beliefs about fellow departments. For example, North Oakway fire chiefs voiced concerns that career departments perceive members of combination departments as less competent; despite the fact that no evidence exists to substantiate those assertions.[61] Universally, fire personnel, and even law enforcement, has described the dynamic between north and south as independent "fiefdoms," noting that some fire chiefs exhibit territorial behaviors. This type of fragmented fire service is not in the best interest of Oakland County's 1.2 million residents.

Despite this reality, there does not appear to be any progress towards effective collaboration.[62] Rather, fire personnel informed us that there is duplication of effort and expenses, particularly with technical rescue teams and hazardous materials teams. Aside from an impact on morale, these territorial “disputes” have practical implications, including failure to dispatch the closest staffed units to critical events.[63]

Moreover, fire departments in Oakland County do not use automatic vehicle locating (AVL) to dispatch the closest fire truck or ambulance to emergency calls.[64] Although there were discussions in the past about utilizing AVL for dispatching, the county fire chiefs were unable to come to any agreement. The lack of AVL dispatching and county-wide mutual aid agreements results in scenarios where the closest staffed units are not dispatched to life-threatening emergencies.

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have experienced the opposite situation. In the past North Oakway departments were all volunteers, but as volunteerism decreased, the number of personnel to provide the service has reduced correspondingly. The strain of few volunteers there necessitated the hiring of career staff resulting in a combination department.

[61] Interestingly, with the significant reduction in volunteer firefighters nationwide in the last decade, the fire departments in the north have gradually transitioned to primarily paid departments with a few active volunteers.

[62] Consensus from interviews with fire personnel and leadership in Oakland County.

[63] One such event was a 2024 house fire with a fatality in which a staffed fire station two miles from the scene was not notified of the event because it was not in their jurisdiction.

[64] Discussed in further detail in the 9-1-1 Section.

b. Fire and Emergency Medical Services at OFD

In November 2021, Peter Scholz was the OFD fire chief (OFD Chief Scholz), and Matthew Majestic was the assistant fire chief (OFD AC Majestic). OFD Chief Scholz spent 40 years as a volunteer at OFD before he took the job as full-time fire chief in 2008. In addition to his fire chief duties, he was also the emergency manager for the Village of Oxford. OFD AC Majestic is presently the Chief of OFD. He retired as a fire captain from South Bloomfield Fire Department and took the job as assistant fire chief in April 2021. He was the first paid chief at the department with career fire service experience. Under his leadership as OFD chief, he has focused on transitioning OFD from a volunteer department to a career department.

OFD serves the Village of Oxford and Oxford Township. Oxford is primarily a bedroom community and is one of the last large areas of undeveloped land in Oakland County. The village is approximately two square miles and sits directly in Oxford Township. OFD has two fire stations, both staffed 24/7 by career members and is a member of MABAS 3201. OFD Station 1 is located with the building inside the village and rear of the property on the line of the township, and exactly two miles from OHS. The travel time absent traffic is less than three minutes.

OFD responds to approximately 2,250 calls per year, with the majority as EMS responses. OFD has limited technical rescue capabilities, limited to water rescue, ice rescue, and vehicle rescue. There are currently 20 full time firefighters working a three-platoon shift schedule. All full-time members are EMTs, and many are paramedics. In addition, there are four full-time administrative staff, including a fire marshal (paramedic), an office administrator, a deputy fire chief, and the fire chief (paramedic). In addition, the department has approximately 26 part-time and volunteer firefighters (referred to as “paid on call”). Many of these firefighters are EMTs and paramedics as well. There are only five to six that are not licensed EMTs and only allowed to respond to car accidents and fire calls.

OFD currently is restructuring the chain of command, creating three new lieutenant positions. This addition would effectively streamline the captain’s responsibilities to primary oversight of the shift, as opposed to serving as an active participant on the fire apparatus. Both prior to and at the time of the OHS shooting, there was a captain assigned to each shift. The captain would be at Station 1 and part of the response crew. OFD currently has five licensed ambulances, but previously only had four. The first out engine company also had ALS equipment on it.

Daily staffing is a minimum of five, with an average of seven to eight per day. On the day of the shooting, there were four full time members on duty, supplemented by a volunteer

firefighter/EMT, fire marshal, deputy chief, and fire chief. Fire Station 1 typically has three to five members on duty, and Fire Station 2 has a minimum of two on duty. On the day of the shooting, there were two on duty at each station. As personnel cross staff apparatus, they primarily staff the ambulance at each station but will take the fire apparatus to fire calls as needed. Based on the information that has been provided to us, it appears that the OFD has no automatic aid agreements with any fire departments and that no departments other than OFD are dispatched on the initial alarms for any call types.[65]

4. First Responder Timelines on November 30, 2021

The information in this section was compiled from numerous interviews with OCSO active and retired command staff, various fire department command staff and personnel throughout Oakland County, 9-1-1 calls, OCSO recorded radio traffic on the East talk group (including additional patched channels, in-car camera footage, and audio), OCSO deputy written statements from the criminal case file, OHS surveillance video footage,[66] the OHS hall monitor's body camera footage, the hall monitor's interview with OCSO and with Guidepost for this report, and OHS staff interviews.

We broke down the timelines by agency, first the actions taken by OCSO deputies and leadership, and then the actions taken by fire/EMS personnel and command. While there will be overlaps, it is helpful to keep the two timelines separate to understand how they operated. It should be noted that the combined response was massive. In response to the dispatch call and self-deployment, nearly 400 officers from 27 law enforcement agencies responded, along with 164 fire and EMS personnel.

a. <u>OCSO Activity Timeline</u>

The first section of the timeline details OCSO's response actions leading up to entry into the school building.

- 12:51:44: OCSO receives a 911 call for shots fired at OHS.
- 12:52:59: OCSO dispatches over police radio East channel for shots fired at OHS. This dispatch goes to all OCSO units on the channel. Four OCSO substations are on the East channel including Oxford, Orion, Oakland, and Addison. The Oxford substation was staffed with nine sworn members, including the commander. OCSO was staffed that day with 352 sworn members, including all sworn agency members

[65] It should be noted that there were no departments other than the OFD initially dispatched to OHS, and fire departments were self-deploying upon hearing radio traffic about the shooting.
[66] We also acknowledge that OCPO provided access to the OHS surveillance video.

from deputy through command and executives. Transmissions over OCSO East channel begin between responding units.

- 12:53:30: OCSO communications updates units responding that there are no injuries reported yet, but loud noises are heard in the hallway.
- 12:53:31: SRO hears on his school radio "ALICE, this is not a drill." SRO increases his speed in his patrol car and activates his lights and sirens.
- 12:54:00: SRO continues on Highway 24, reaching a peak speed of 91 MPH.
- 12:55:00: SRO turns onto Ray Road reaching a peak speed of 86 MPH. He hears on the school radio something about Door 5.[67]
- 12:55:08: OCSO dispatch advises a student in Room 239 heard 20-30 shots.
- 12:56:58: SRO and OCSO Deputy 1 arrive at OHS as the first law enforcement officers on scene. SRO drives up on the snow-covered grass to Door 7 in the south parking lot of the school. He pulls up close to the door and then puts his car in reverse to back off the door about 15 feet.
- 12:57:12: SRO's GPS indicates his vehicle stopped. SRO then exits his vehicle and walks back to his trunk on the driver's side of his vehicle.
- 12:57:15: OCSO Deputy 1 parks his patrol vehicle behind SRO's car.
- 12:57:51: SRO retrieves his patrol rifle and active shooter go bag from the front passenger seat. He told the review team that he also attempted to put on his plate carrier but was unable to get the carrier on over his duty vest. He then abandons the attempt. OCSO Deputy 1 also gets his patrol rifle and go-bag.
- 12:57:53: OCSO dispatch provides a limited suspect description to responding units – Male with glasses wearing a burgundy jacket.
- 12:57:56: SRO's in-car camera shows that he takes one minute and 10 seconds to retrieve his rifle, active shooter go-bag and attempts to put on his plate carrier. He moves in front of his patrol car towards the exterior of the door. He then checks his rifle optic and waits at the door for OCSO Deputy 1.
- 12:58:08: OCSO dispatch updates units that one child has been shot.
- 12:58:23: SRO opens Door 7 with his access card and enters with OCSO Deputy 1 following behind.
- 12:58:27: OCSO Dispatch updates units that one child is shot in the cheek and missing teeth.

The next section will review the actions taken once the SRO and OCSO Deputy 1 enter the school to the time that the shooter was detained.

[67] Principal Wolf, AP Gibson-Marshall, and AP Nuss all confirmed that they were reporting a student shot at Door 5 and the shooter near Door 5.

- 12:58:29: SRO and OCSO Deputy 1 enter through Door 7. Immediately inside to the left, they observe multiple students who are shot. These students are located in the short 200 hallway. SRO and OCSO Deputy 1 move towards the students.
- 12:58:30: SRO and OCSO Deputy 1 first pass by Madisyn Baldwin who has a gunshot to the head and is not breathing.
- 12:58:38: SRO and OCSO Deputy 1 come to Hana and Kylie Ossege. Kylie Ossege reaches out and grabs SRO's pant leg. He appears to brush her hand off and turns to move in the other direction.[68]
- 12:58:45: SRO tells OCSO Deputy 1 that they need to go the other direction.[69]
- 12:58:48: OHS hall monitor arrives in the 200 hallway and begins caring for Hana. SRO tosses his tourniquet to the hall monitor and tells her to put it on Hana.
- 13:00:07: The shooter exits Bathroom 2 after executing Justin and places his gun on top of the trashcan outside the door. He sees SRO and OCSO Deputy 1 coming towards him.
- 13:00:11: The shooter raises his hands to surrender to SRO and OCSO Deputy 1.
- 13:00:14: OCSO Deputy 1 tells OCSO Dispatch they have people screaming in the 200 hallway.
- 13:00:14: The shooter turns and faces SRO and OCSO Deputy 1.
- 13:00:15: The shooter kneels on the ground.
- 13:00:19: SRO observes the shooter and keeps moving past him not realizing he was the shooter.
- 13:00:21: OCSO Deputy 1 sees the gun on the trashcan and yells, "Gun."
- 13:00:24: OCSO Deputy 1 orders the shooter to lay on the ground. SRO is about 15 feet ahead of the shooter and turns back.
- 13:00:30: SRO and OCSO Deputy 1 have their rifles pointed at the shooter. SRO handcuffs the shooter. AP Gibson-Marshall tells them the shooter's name.
- 13:00:30: OCSO Deputy 1 attempts to call out on the radio. Numerous other units talk over him, making his traffic unintelligible.
- 13:01:05: SRO advises on the radio they have one detained. Dispatch attempts to confirm but does not get a response. This was then confirmed at 13:01:42

As noted above, radio traffic updates from OHS communications had provided a description of the suspect as male wearing glasses and a burgundy sweatshirt. The suspect OCSO Deputy 1 and the SRO encountered was a male with glasses; however, he had different clothing. The suspect had placed the handgun used in the shooting on top of a garbage can prior to surrendering to deputies. The SRO stated in a previous

[68] The SRO's audio (no video) body recorder revealed Kylie Ossege was crying, stating she is shot and that she cannot move. The SRO is heard asking Kylie Ossege where the shooter is located. She says she does not know. The SRO tells Kylie Ossege, "We are going to go find the person that did this to you."
[69] AP Nuss and Principal Wolf are talking on the radio reporting a student (Tate) shot near Door 5.

interview that the shooter could have easily executed him if he wanted. He credits OCSO Deputy 1 with ensuring this did not happen.

It is important to note that the camera footage shows that the shooter displayed behavior that was completely different from the other students in the school. His demeanor was casual with no excitement or panic. He made a very clear and obvious attempt to surrender to law enforcement. The other students on camera were all making very deliberate attempts to flee the school or lockdown. If this was a student and not the perpetrator, an expected behavior would be for them to seek protection with the law enforcement officers. Officers need to be fully aware and suspicious of any behavior that appears bizarre or out of the ordinary.

OCSO1613 (OCSO Sergeant 1's call sign) advises over the OCSO radio they have one detained in the school. While the suspect is being detained, two additional deputies approach and move past the suspect and continue clearing the hallway. Deputies are still searching for unknown suspects as part of their training to continue to search and evacuate.

The next section will review the actions taken once the shooter was detained and through the removal of the last living victim.

- 13:01:05: OCSO unit requests fire to enter at Door 5 for someone shot at Room 228.
- 13:01:18: OCSO unit requests fire and EMS to enter the building at Door 5.
- 13:01:26: OCSO unit advises someone shot at Room 226.
- 13:01:32: OCSO unit advises that fire needs to come to Door 5 for someone shot at Room 228.
- 13:01:42: OCSO Dispatch confirms with OCSO1613 that one is detained. SRO replies to the affirmative that one is in custody.
- 13:02:00: An OCSO deputy arrives to Tate where AP Gibson-Marshall is doing CPR. The deputy stops CPR and puts Tate in the recovery position.
- 13:02:15: An OCSO deputy checks Madisyn and confirms she is deceased.
- 13:02:19: OCSO unit advises that a 17-year-old female is shot in the neck near the main office. She has a towel on her neck. She is conscious and breathing.
- 13:02:27: The police chief from Orion Township Police enters through Door 7. He sees Madisyn and begins CPR.
- 13:03:44: An OCSO deputy enters Bathroom 2 and discovers Justin with a gunshot wound to the head. Justin is unconscious and bleeding heavily.
- 13:03:57: OCSO unit requests fire to enter at Door 7.

- 13:04:00: The deputy with Tate determines that Tate is in cardiac arrest and resumes CPR. AP Gibson-Marshal stated she was yelling for an AED. A deputy arrives with an AED and attempts to connect it to Tate.
- 13:04:03: The deputy at Bathroom 2 who discovered Justin exits the bathroom and closes the bathroom door behind him.
- 13:04:21: Six uninjured female students are extracted from the female Bathroom 2 by two deputies.
- 13:04:21: OCSO unit requests fire ASAP at Door 5.
- 13:04:32: SWAT all-call sent.
- 13:04:48: SRO and OCSO Deputy 1 escort the shooter out of the building.
- 13:05:00: OCSO unit requests fire at Doors 5 and 7 and asks for an ETA.
- 13:05:24: OCSO units are coordinating getting medical kits to victims.
- 13:06:16: OCSO unit requests fire to Door 5.
- 13:06:35: OCSO unit states they are beginning a search of the school.
- 13:07:08: OCSO unit asks where fire is. The unit states fire is needed for a victim who is still breathing. Another OCSO unit tells them to load him into a patrol car and transport him.
- 13:09:02: OCSO unit states that Door 5 and Door 8 are secure for paramedics.
- 13:10:19: OCSO unit asks if anyone is coordinating transportation to hospitals. There is no response.
- 13:11:09: OCSO requests fire to enter. Another unit asks if they can bring fire through Door 7.
- 13:11:46: OCSO unit advises a teacher is shot in Room 218.
- 13:12:35: OCSO unit advises all officers that the kitchen and cafeteria are cleared.
- 13:14:10: OCSO unit advises they are in Room 212 with 16 occupants and everyone is okay.
- 13:15:22: OCSO unit advises multiple people are shot near Door 8 and they need the fire department.
- 13:15:46: OCSO units advises they have four victims at Door 8.
- 13:16:16: OCSO unit advises they are evacuating students out of the westside of the building with escorts.
- 13:18:05: Air-1 announces they will be on scene in three minutes and will be providing overwatch.
- 13:21:34: OCSO unit advises they are walking a teacher out with a gunshot wound to her arm and that they have applied a tourniquet.

The review team extensively reviewed the footage of the camera located just outside of Bathroom 2. After the SRO and Deputy 1 take the shooter in custody, they have a brief discussion on the camera. Deputy 1 then takes out his phone and takes pictures of the

handgun on top of the trashcan. While this is occurring, both the male and female bathroom directly in front of them are not clear. Inside the male bathroom, Justin lies dying on the floor. In the female bathroom, six female students are hiding.

Case file statements from OCSO deputies and investigators show that, while the shooter was detained in the hallway, discussion was ongoing for how and where to transport the suspect. The decision was for the suspect to be transported directly to the OCSO Oxford substation for interview. OCSO Sergeant 1, the initial OCSO investigations supervisor on scene, was organizing this response. Considerations regarding the age and severity of the crime committed by the suspect were part of the ongoing effort to appropriately and intentionally transport and detain the suspect for investigators.

At 13:03:43, OCSO Deputy 1 entered Bathroom 2. OCSO Deputy 1 saw Justin and quickly cleared the bathroom to ensure there were no threats or other victims. At 13:04:03, OCSO Deputy 1 exited the bathroom, shutting the door. At 13:04:21, OCSO deputies entered the female bathroom and escorted the six female students from the bathroom to the hallway for evacuation.[70] OCSO deputies requested EMS immediately to Door 5. At 13:04:35, two more OCSO deputies entered the bathroom. Both deputies exited the bathroom at 13:04:46, shutting the door behind them. At 13:06:16, OCSO deputies again requested EMS at Door 5. At 13:06:48, OCSO Deputy 1 entered the bathroom again. At 13:07:09, OCSO deputies again radioed that they have a patient with a gunshot wound to the head that is still breathing. At 13:07:48, OCSO Deputy 1 exited the bathroom, again shutting the door. At 13:08:13, another deputy entered the bathroom.

Lieutenant Hill confirmed that deputies did not provide any medical care for Justin. The OFD fire marshal informed us that when he entered the bathroom and initially got to Justin, he was lying on his back and had vomited on himself. He also observed approximately two liters of blood surrounding his head. OFD fire marshal stated that very little prehospital care could be given for the execution-style gunshot wound to the head.

As fire department members arrived, OCSO deputies were waving them into Doors 5, 7, and 8. Although there was no unified command, spontaneous linkups occurred between law enforcement and fire personnel. This is referred to as spontaneous RTF and is

[70] The OHS Recovery Coordinator provided information on this encounter that was relayed to her by some of the survivors. As the females exited the bathroom, they passed right in front of the shooter who was seated on the floor in handcuffs. The shooter stared at each female directly into their eyes according to the Recovery Coordinator. The Recovery Coordinator stated that all six females reported having severe nightmares and flashbacks of the shooter staring at them. However, upon reviewing the school video, it appeared that OCSO officers had the shooter looking away from the females when they exited the bathroom.

common at active assailant events. The absence of command and planning or coordination causes these organic response elements to form and deploy.

While this was occurring, at approximately 13:02, a student's father entered the building through an open door near Door 5. He appeared on multiple cameras frantically moved through the halls yelling out, "Lilly," his daughter's name. During this time, he was walking past numerous students who were shot, including CPR in progress on one of the students. He passed by multiple OCSO deputies who did not stop him or challenge him. Students heard the man yelling and some assumed he was the shooter looking for his girlfriend.[71] According to Assistant Principal Kurt Nuss (AP Nuss), he had to repeatedly ask deputies to get the man out of the school. When deputies brought the shooter out in handcuffs, the father lunged at the shooter, screaming at him, "What have you done?"

At 13:09:09, the shooter was transported from the school to the Oxford substation. At 13:09:45, an OCSO unit broadcasted that there is only one shooter and that the person in custody matches the suspect's description.

At 13:09:50, two deputies moved Tate to an OCSO patrol vehicle parked outside Door 5. The in-car camera footage showed that Tate was in cardiac arrest. It took the two deputies approximately two minutes to get Tate loaded into the back of the patrol car. At 13:10:09, the deputy advised dispatch he was transporting one to the hospital. At 13:12, the deputy drove to the rear parking lot and saw an ambulance and fire truck parked near Door 7 and Door 8. He immediately drove to the ambulance, calling out his window for help. However, the fire personnel were inside OHS. As captured by the in-car camera, the deputy is urgently trying to locate any firefighter. The deputy then weaved his way through the parking lot and exited onto North Oxford Road.

At 13:11:00, AFD paramedics arrived on North Oxford Road, parallel to Door 6. The deputy drove up to their ambulance as they were getting out and told them he had a gunshot victim in the back of his patrol car. Two paramedics and an EMT accessed Tate in the back of the patrol car. They confirmed that he was in cardiac arrest with a mortal gunshot wound to the head. The paramedics did an EKG and confirmed that he was in asystole. Tate was pronounced dead in the patrol car at 13:15:00. The vehicle remained on scene with the victim inside and would later be processed as part of the crime scene.

Starting at 13:12:40, OCSO units reported that the kitchen and cafeteria were cleared. Although previously not announced on the radio, this indicates units were starting to clear the school. Units begin to call out of the radio as they encounter students locked down in

[71] The OHS Recovery Coordinator stated this traumatized many of the students, as they were trying to figure out who Lilly was, and if she was a student with them.

classrooms. At 13:16:16, an OCSO unit announces that they are evacuating students from the building. This clearing continues until 13:40:06.

Lieutenant Hill arrived on scene at 13:20:00 and announced on the radio that he was establishing incident command. He also requested units to establish a perimeter around the school, as this had not yet occurred. Lieutenant Hill was not the first OCSO commander to arrive on scene but was the first to formally establish command. As discussed in the incident command section of this review, the OCSO procedures state the first arriving commander will become incident commander. This was not the case in this incident.

OHS surveillance video shows Lieutenant Hill entering the school at 13:25. He had a long gun, his active shooter go-bag, and a large medical bag. He immediately found Melissa Williams (Williams), assistant to Principal Wolf, assured her that she would be safe, and had her escort him to OCSO Sergeant 1, who was located at Room 259. Once there, Lieutenant Hill received a quick report from OCSO Sergeant 1 who stated all surviving casualties were extracted from the building. He then went back to the front lobby at 13:31 and announced on the radio that the command post would be in the front lobby.

Lieutenant Hill described the operations inside of the school as very chaotic with little coordination when he arrived. OCSO records indicate that law enforcement officers from 20 different agencies were all attempting to clear the building. At 13:40:00, Lieutenant Hill used the school's public address system to recall all first responders to the front lobby. This recall was also announced on the OCSO East channel. The camera footage inside the school showed officers coming back and filling the front lobby. The footage also shows officers receiving layouts of the school and orders on where to search. At 13:48:00, the officers began leaving the lobby to go resume the back-clear. At 13:53:01, officers are reporting that the 200, 300 and 400 halls are clear.

As officers encountered students locked down, they announced themselves and requested the students inside to unlock the door and deactivate the Nightlock. If the students did not comply, they waited for a master key and the Nightlock deactivation tool. Officers stated they were not familiar with the Nightlock and did not know how to use the deactivation tool. Lieutenant Hill instructed officers to practice with the tool on an open classroom door to gain proficiency.

At 14:04:03, units advised that the gym and locker rooms were clear. At 14:04:47, units advised the cafeteria and common areas were clear. At 14:28:32, units reported the 100 Hallway, performing arts center, and cafeteria (again) were clear.

As officers encountered classrooms with students, they escorted the students to the front lobby. There, the students would sit and wait for school buses to transport them to Meijer for reunification. At 14:31:12, Lieutenant Hill advised all units that no students were to get on buses unless authorized by command.

At 15:35:00, Lieutenant Hill advised that the third secondary search was now complete. He also advised that an EOD K-9 alerted to the shooter's backpack in Bathroom 1. At 15:35:58, Lieutenant Hill requested the response of the FBI bomb squad and the Michigan State Police (MSP)[72] bomb squad. At 16:08:48, FBI bomb squad members arrived on scene and reported it to the command post. At 16:43:29, the FBI bomb squad's vehicle and trailer arrived. At 17:26:23, the MSP bomb squad was on scene. Both the MSP and FBI began diagnostic operations on the shooter's backpack. However, no one notified fire command of the potential device. The fire department disbanded operations and left the school at 17:00.

At around 16:30, both the United States Attorney for the Eastern District of Michigan Matthew Schneider and Michigan Governor Gretchen Whitmer arrived on scene. United States Attorney Schneider reported to the command post. Governor Whitmer's security detail (MSP troopers) entered the front lobby of the school. Lieutenant Hill advised them that the school was still an active crime scene, and the governor would not be permitted inside. The troopers understood and left the building. Governor Whitmer joined with Undersheriff McCabe to give the 17:00 press briefing.

At 18:19:00, the building was declared safe. Tactical operations ceased, and crime scene investigation began for the interior of the school. Lieutenant Timothy Willis (Lieutenant Willis) then took command of the school. The mobile command post was set up. Porta-potties were brought in and set up in the parking lot. This was done to prevent unauthorized people from attempting to access the school to "use the bathroom." At 18:54:00, the call was closed in CAD. Crime scene investigation continued until 05:30 when the school was turned back over by the OCS.

b. Fire/EMS Activity Timeline

We now present a timeline of events as they relate to fire/EMS actions. The first report of injuries to 9-1-1 dispatchers was at 12:52:32. This was confirmed by means of 9-1-1 calls and CAD notes at 12:55:51. As OCSO vehicles continued to descend upon OHS, the fire department had yet to arrive.

[72] Guidepost requested interviews with the Michigan State Police, who in an email declined to be interviewed citing ongoing litigation of the incident.

On November 30, 2021, OFD AC Majestic and OFD Chief Scholz were having lunch at 24th Street Tavern, located about 300 yards from OFD Station 1. Other OFD personnel had picked up lunch at a restaurant in Oxford and were enroute to Oxford Fire Station 2 to conduct training. At approximately 12:54, OFD AC Majestic stated that he and OFD Chief Scholz heard multiple sirens and saw numerous OCSO vehicles traveling through the town at a high rate of speed. They had their radios but did not hear any dispatch from the fire department. Both assumed it was a law enforcement-only type of call.

Meanwhile, at around the same hour, an OFD captain recounted that they were scanning the OCSO East patrol channel. They heard talk of a "shooting," but could not determine the location. They also heard a Lake Orion police officer radio about a school, which was interpreted as some type of activity at Orion High School. Within that time frame, an OFD captain received a phone call from a friend stating there was a shooting at OHS. This OFD captain had a child at OHS. He immediately attempted to contact her and drove with another OFD paramedic three miles to OHS.

Also, around 12:54, the OFD fire marshal was walking past the radio room at OFD Station 1. He overheard talk on the OCSO East patrol channel regarding a shooting. He went into the radio room with another firefighter and began listening to the radio. Similarly, he was unable to decipher from the radio traffic the location of the shooting. At 12:56, Orion Township Fire Department (Orion FD) Chief Robert Duke (Orion Chief Duke) called OFD AC Majestic's cellular phone to inform him that Orion FD was sending all resources to OHS. In his interview with Guidepost for this review, OFD AC Majestic recounted that he was confused and had no idea what Orion FD Chief Duke was referring to at that moment.[73] Orion FD Chief Duke informed OFD AC Majestic of the active shooter at the high school with reported victims, after which OFD Chief Scholz and OFD AC Majestic immediately left and drove less than one minute to their fire department headquarters. During that 12:56 timeframe, members on duty at OFD recounted that they too were receiving numerous phone calls from their own children who were at OHS, confirming the shooting. The OFD fire marshal also received a call from a firefighter with another department stating that something was happening at the high school.

At AFD, Chief Jerry Morawski (AFD Chief Morawski) and his staff were scanning the OCSO radio and heard about a shooting at OHS. AFD Chief Morawski instructed his two on-duty personnel and administrator/EMT to get in the ambulance and move to AFD Station 2, which was closer to OHS. The ambulance, and AFD Chief Morawski in his command vehicle, quickly took off towards the school and AFD Station 2.

[73] See interview with OFD AC Majestic.

At 12:57:21, OCSO dispatch called OFD Station 1 and spoke with an OFD Captain (OFD Captain 1). The contents of that call are transcribed below:

- Dispatch: *"Hey, it's Brett in dispatch, how are you?"*
- OFD Captain 1.OFD Captain 1: *"I'm good, how are you?"*
- Dispatch: *"I'm all right. Hey, I just wanted to give you a head's up. We are currently fielding a ton of calls about a possible shooting at the high school. I don't have anything for you guys yet, but I'm assuming that is coming real quick. Okay?"*
- OFD Captain 1.OFD Captain 1: *"Alright."*
- Dispatch: *"Yup, thank you."*

During his interview, OFD Captain 1 informed us that he immediately told fellow on-duty members about the potential for a call. OFD members collected medical equipment for the back-up ambulance (Alpha 4), as the first-out ambulance was already on another call. OFD Captain 1 also called Station 2 and told them there was a reported shooting at the high school. At 12:58, OFD Chief Scholz and OFD AC Majestic went to OFD Station 1 to retrieve OFD AC Majestic's vehicle. Upon arrival, they witnessed Engine 1 and Alpha 4 already leaving for the school. OFD AC Majestic retrieved his keys, entered his fire department vehicle, and followed Chief Scholz to OHS, both in marked fire department vehicles.

OFD responded with two ambulances (Alpha 4, Alpha 2) and one fire engine (Engine 1). Alpha 4 is a back-up ALS ambulance from Station 1 and was staffed with the OFD fire marshal and an OFD firefighter/EMT. OFD Alpha 2 is an ALS ambulance from Station 2. It was staffed with two firefighters/paramedics and a firefighter/EMT driver. OFD Engine 1 was staffed with OFD Captain 1 and a firefighter/EMT.

At 12:59, OFD Engine 1 and OFD Alpha 4 arrived at Meijer, a large supercenter grocery chain. Meijer is located at 590 North Lapeer Road, approximately 400 yards from OHS, and less than a mile from OFD Station 1. The normal travel time is approximately one minute. When OFD personnel arrived at Meijer, they encountered approximately 50-100 students who had already fled the school. The review team attempted to determine a rough estimate of how many students fled the building and how many remained in lockdown. In its investigation, OCPO determined that there were 1,700 students present at school that day. There were approximately 100 students absent, which is a normal number of absences. In AP Gibson-Marshall's Miller Hearing testimony, she recalled 1800 students present in the school on November 30, 2021. Our approximation, based upon the number of buses called in, interviews, and testimony reviewed, is approximately 1,000 children fled and 800 remained in lockdown in classrooms.

At 12:59:56, OCSO dispatched OFD for a “medical emergency” at OHS. The only information provided was for the fire department to “stage” for an active incident.[75] OFD AC Majestic informed our review team that at the time he formally received the dispatch from OCSO, he was already at Meijer, in front of Tim Hortons. The members of Engine 1 and Alpha 4 also confirmed they were already at Meijer when OFD was dispatched.

When the call was dispatched from OCSO, an OFD captain and lieutenant were in downtown Oxford, and observed numerous law enforcement cars responding on M24 to the school. At 12:59:29, OFD Alpha 1 cleared a lift assist approximately three miles away and was subsequently assigned to the call. At 13:00:53, OFD Captain 1 radioed all fire companies to stage at Meijer, as it had a large parking lot for fire apparatus. The crew of Engine 1 and Alpha 4 exited their vehicles, placed traffic cones to secure an area, and donned ballistic vests. OFD Captain 1 also requested a “MABAS MCI box (63-OXF-6),”[74] and instructed personnel to respond without lights and sirens as the status of the situation was still uncertain. OCSO then dispatched AFD, Orion FD, and Brandon Township Fire Department (BTFD).

At 13:00, Chief Scholz and OFD AC Majestic arrived at the Meijer parking lot. OFD AC Majestic, OFD Captain 1, and other OFD personnel observed approximately 50 students entering the parking lot from Ray Road at around 13:00.

At 13:01:31, OCSO Dispatch received a 9-1-1 call for child with a gunshot wound to the neck at McLaren Urgent Care Oxford, located at 385 N. Lapeer Road. This was OHS student Riley Franz, who was shot in the neck and transported to the urgent care by fellow students. OCSO Dispatch redirected Orion FD Alpha 1 (ALS ambulance) to the urgent care, as they would pass directly by enroute to the school. At 13:01:40, OCSO Dispatch advised Alpha 2 of a gunshot patient at 465 South Glaspie Street. This address is approximately one mile from the school. This was OHS student Aiden Watson, who fled and was picked up by an individual driving past the school. This person transported Watson to his place of employment at J.P.’s Piano Moving located at 465 South Glaspie Street, where Alpha 2 responded.

OFD continued to stage in the Meijer parking lot for approximately four minutes and 30 seconds. At approximately 13:03, additional OFD personnel arrived and grabbed an active shooter trauma bag that was donated to the department several years before.[75] At 13:04:33, OFD Captain 1 requested additional fire response, while OCSO dispatched

[74] MABAS MCI box (63-OXF-6) is a mutual aid request, as discussed earlier within the Oakland County Fire Department section.
[75] Many OFD personnel during their interviews said that they had never put on a ballistic helmet and vest prior to this incident. This contributed to issues putting on protective equipment.

Oakland Township Fire Department (OTFD). At 13:05:48, OCSO dispatch told OFD to proceed into the school and use Door 5. It is important to note that most fire personnel did not learn for another 30 minutes that the shooter was in custody. At 13:04:00, OFD Alpha 1 was enroute to the school via North Oxford Road. At North Oxford Road and State Street (approximately one quarter of a mile from the school), they encountered Elijah Mueller on Ray Road. Alpha 1 stopped and realized that Elijah Mueller was shot in the face. Alpha 1 immediately began treating Elijah Mueller and loaded him into the ambulance. Elijah Mueller had a gunshot wound on the right cheek with several teeth missing. He also had a gunshot wound to right index finger. At 13:06:36, OFD Alpha 1 transported Elijah Mueller emergency traffic to McLaren Oakland Hospital.

As OFD personnel began to enter the school, OFD Chief Scholz decided to remain at Meijer and direct traffic as evidenced by multiple witness statements and a video posted on YouTube. Numerous members of the OFD expressed frustration and confusion with OFD Chief Scholz's decision to direct traffic instead of commanding the event. OFD AC Majestic stated that in the five months he worked at OFD prior to the shooting, OFD Chief Scholz had not commanded any type of incident. On this day, he did not command the incident, but rather defaulted to directing traffic. One OFD captain informed us that he heard OFD Chief Scholz say that he was going to direct traffic to keep the parents from going to the school. While many in the department acknowledge OFD Chief Scholz's dedication to the Oxford community, he may have lacked experience in these types of situations. Chief Scholz began his fire career as a paid-on-call member in February 1976, rising through the ranks to the chief position in November 2008. Some note that he was never a "career" firefighter. When OFD department transitioned to full time, that was when he was offered the chief position. Although this review team attempted to contact OFD Chief Scholz for an interview, we did not receive a response to our requests.

At 13:06, as OFD Fire units proceeded on Ray Road, they observed hundreds of students walking and running towards the Meijer.[76] It took OFD AC Majestic, OFD Alpha 4, and OFD Engine 1 less than one minute to arrive at OHS. Numerous OFD personnel experienced delays reaching the high school as they weaved in and out of students on Ray Road. When OFD AC Majestic arrived at the school, he observed numerous people attempting to wave him, the ambulance, and the fire truck down. He made the decision to go past the front entrance and go to the rear of the school near Door 5. He stated he was unable to get his vehicle into the front school parking lot because of the number of students fleeing, arriving parents, and responding OCSO deputies. OFD AC Majestic saw one student on North Oxford Road running with blood coming from his face. He later

[76] At the time of the shooting, there was not a sidewalk on Ray Road leading from the school to Meijer. Because there was snow on the ground and no sidewalk, the students were walking in the middle of Ray Road.

learned that this student, Elijah Mueller, had a gunshot wound to the face and the hand. Unbeknownst to OFD AC Majestic, two people had already called 9-1-1 reporting Elijah's injury, and told the 9-1-1 communicator that he was last seen leaving the school near the football field. Elijah ran to North Oxford Road and State Street, where OFD Alpha 1 encountered him.

At 13:06, OFD AC Majestic announced on the radio that he was "in command" and that Level II staging would be at Meijer. OFD AC Majestic then went up to the school and notified OCSO Dispatch there was a victim at Door 8. Meanwhile, at the same hour, Orion FD Alpha 1 arrived on scene at McLaren Oxford Urgent Care. At 13:06:05, the OFD fire marshal radioed that he was located between Doors 5 and 7 and wanted to know if the scene was secure. At 13:06:05 OFD Alpha 4 parked near Door 6. An OFD captain, fire marshal, and lieutenant grabbed the medical bags and stretcher and entered Door 6. At 13:07, OFD Captain 1 assigned the driver of OFD Engine 1 to drive the Alpha 4 ambulance. OFD Captain 1 relocated Engine 1 from North Oxford Road to the southside parking lot of the school by Door 8. At 13:09:55, several OCSO deputies escorted OFD Alpha 4 into Door 6. Two OFD firefighter/paramedics removed the stretcher and trauma bag and went inside of the school. This is the crew is seen on camera at 13:10:04, treating and extracting Justin from Bathroom 2.

Between 13:09 and 13:12, fire department radio communications indicated that both OFD AC Majestic and OFD Captain 1 independently assumed command of the incident. Each identified themselves over the radio simply as "Command."

At 13:11:58, AFD Alpha 1 arrived on scene and parked on North Oxford Road, parallel with Door 6. As they exited the ambulance with the stretcher, an OCSO deputy pulled up with Tate in the rear of his patrol car. AFD Alpha 1 firefighter paramedic and EMT accessed Tate with the assistance of AFD Chief Morawski. They observed that Tate was in cardiac arrest with a gunshot wound to the head. AFD paramedics placed a four-lead EKG on Tate and confirmed asystole. Tate was pronounced dead moments later at 13:15.

At approximately 13:12, OCSO Lieutenant 1 was between Door 6 and Door 7 where he encountered an OFD captain and informed him (1) a suspect was in custody and (2) more students were shot down the hall. Unfortunately, since the OFD captain did not have his portable radio, he was unable to relay that message to other fire personnel. At around the same time, OFD AC Majestic decided to go inside OHS to assume the role of operations. He stated that he had full confidence in OFD Captain 1.

At this time, OTFD Chief Strelchuk parked his Tahoe adjacent to OFD AC Majestic's vehicle and directed OFD Captain 1 to join him at his command post. At 13:12:28, OFD

Captain 1 radioed that the command post was located between Doors 6 and 7. He requested that responding units stage at the storage facility on North Oxford Road to receive an assignment. For the next several hours, OFD Captain 1 and OTFD Chief Strelchuk commanded the fire response. OFD Captain 1 set up divisions and assigned one division at Door 5 and one division at Door 6. In addition, he had a battalion chief from Rochester Hills set up a triage division. OFD Captain 1 also established a landing zone division and placed another chief in charge of handling inbound medevac helicopters.

It is believed at this time, OFD Captain 1 requested a MABAS radio assignment and was given four operating channels. He assigned command operations to MABAS 11, triage to MABAS 12, police talk group to MABAS 13, and landing zone operations to MABAS 14.[77] Fire personnel inside the school were repeatedly trying to call command starting at 13:15; however, they received no response. This was likely because the radio traffic was switched from Oxford Tac 1 to the MABAS channels.

At approximately 13:12, OFD AC Majestic entered the school at Door 6 and encountered an OCSO deputy who informed him that one of his captains went towards Door 7.[78] OFD AC Majestic then proceeded to the exterior of the school to Door 7. At 13:14:00, the OFD Captain and EMS coordinator passed Madisyn on the floor near Door 7. He determined that she was deceased. At 13:14:05, school surveillance shows OFD personnel making first contact with both Hana and Kylie Ossege. Despite numerous attempts by the OFD captain to radio for assistance, he received no response on OFD Tac-1. At 13:19:44, AFD paramedics from the arrived with the first medical bag to treat both Hana and Kylie Ossege. Hana was pronounced deceased at 13:20:00.

At 13:14:18, AFD Chief Morawski arrived at the staging area on North Oxford Road where ambulances were arriving. At this time, there were two staging areas. The primary staging area was at Meijer, and the secondary staging area was on North Oxford Road. At 13:16:05, OFD Alpha 2 paramedics determined that Aiden had a minor gunshot wound to the ankle. Alpha 2 paramedics told the mother she would need to transport Aiden, as they had multiple critical patients at the school. Aiden's mother transported him to McLaren Oakland Hospital where he was discharged later that day. Alpha 2 notified the command and responded to the school.

[77] Although CAD data places this request at 13:45, this appears to be a delayed entry and numerous interviews agree that this occurred at approximately 13:12.
[78] By this time Justin was just removed from the building by that captain and other firefighters.

At 13:17:36, Chief Strelchuk requested OCSO Dispatch to send every available ambulance.[79] OFD AC Majestic appeared on camera entering Door 8 at 13:18:20. Once inside the door, he immediately observed Hana and two other injured students on the ground. He noted that Hana was non-verbal, but her eyes were open. He observed blood on her pants and a tourniquet on her left leg. Phoebe Arthur was on a rolling office chair in the hallway with a fellow 14-year-old student providing direct pressure to the gunshot wound in her neck. At 13:19:00, OHS surveillance footage shows OFD AC Majestic exiting through Door 8. We believe it is reasonable to infer that he was likely engaged in radio communication at that time.[80] At 13:18:00, an OFD captain stepped out of Door 7 to get the attention of paramedics arriving. At 13:19:05, the two paramedics from AFD who previously pronounced Tate as deceased can be seen in camera footage making entry at Door 6 into the 200 hallway with their stretcher and medical bags. At Door 7, the AFD paramedics encountered Madisyn and confirmed that she was deceased with a gunshot wound to the head.

At 13:20:08, BTFD paramedics arrived on scene and are visible on camera making entry into Door 8. This is the first stretcher into the hallway since the shooting occurred. At 13:21:00, AFD entered with a second stretcher. At 13:21:21, OFD Alpha 2 had Kylie Ossege on their stretcher and left the building. At 13:22:00, OFD announced on the radio they were enroute to St. Joseph's Hospital. At 13:22:04, AFD paramedics loaded Phoebe Arthur on their stretcher, and at 13:25:08, they exited out of Door 8. She was the last living patient removed from the school. At 13:28:17, they were enroute to McLaren Lapeer Hospital. At 13:49:16, they arrived at the hospital and transferred Phoebe Arthur to a waiting trauma team.

At 13:22:46, Lapeer County paramedics were directed to Door 4 where teacher Molly Darnell was walked out by OCSO deputies. Molly Darnell had a gunshot wound to the upper left arm that was a through-and-through soft tissue injury. Deputies had placed a CAT on her arm. The tourniquet was placed high and tight. The paramedics determined the tourniquet was not needed and removed it. Lapeer County EMS transported Molly Darnell to Lapeer Hospital at 13:36. At 13:22:50, OFD AC Majestic reentered through Door 8 and at 13:23:40, OFD AC Majestic covered Hana with a coat that was lying next to her.

[79] As will be discussed during the analysis, over the course of this incident there were a number of requests for ambulances made. By this time, it was the third request. This triggered arguably the largest EMS response in Michigan's history, with 50 ambulances and nine medevac helicopters responding to Oxford High School.

[80] Chief Majestic stated in his interview that he was having difficulty transmitting on his radio inside the school and that he had to step out several times to get a radio transmission out.

At 13:26, CAD records and radio traffic indicate that numerous ambulances were responding to and arriving at the scene. Some of these ambulances went directly to the school, some went to the staging area at Meijer, and some went to the staging area on North Oxford Road. In addition, nine medevac helicopters were enroute, some requested by OCSO Dispatch and others self-dispatched. At 13:26:22, AFD Chief Morawski requested law enforcement assistance at staging because of the large number of parents. Likewise, at 13:30:31, Medstar EMS also requested law enforcement assistance at staging for traffic control and to manage the parents. At 13:38:40, Survival Flight and MedStar landed at the high school football field. These were the only two of nine medevac helicopters enroute that landed at the school.

At 14:01:11, Fire Command advised that there were enough ALS ambulances on scene and no more were needed. At this time, approximately 50 ambulances were on scene or enroute. At 14:15, OFD Captain 1 and Chief Strelchuk drove from the rear of the school to the front of the school to attempt unified command with OCSO. At 14:19:20, OFD Captain 1 announced on the radio that fire command had joined law enforcement command on the north side of the building. At 14:22:30, OFD Captain 1, OFD AC Majestic, and OTFD Chief Strelchuk entered the front of the building. Lieutenant Hill stated that there was no need for fire at that time, as all injured patients had been transported from the scene. OFD Captain 1 and Chief Strelchuk created fire command in a conference room right behind the front desk. In this room, several fire departments worked together to determine where injured patients had been transported. At 16:00, mutual aid fire departments began to demobilize and return to service. At 16:59, OFD Engine 1 and Squad 21 returned to service. At 17:00, fire command was terminated, and Oxford Fire units left the school. At 19:26:58, all fire units were in service after a debriefing at the station.

5. Analysis and Conclusions of First Responder Activity

The following sections discuss each public safety agency's response to various aspects of the incident, examining potential areas for improvement in first responder actions. While the activities of each agency are considered individually, there will be inevitable overlaps, not simply in interactions but also in discussion of the relevant facts.

Our analysis begins with OCSO, detailing the involvement of the assigned SRO and school security, followed by a review of OCSO’s activity once arriving at OHS. Next, we will address fire and EMS personnel actions. This section concludes with an evaluation of OCSO’s 9-1-1 Dispatch Center for Oakland County.

a. Analysis of OCSO SRO and OHS Security on November 30, 2021

i. *Security Operations at OHS*

In 2021, OHS security involved an OCSO-chosen SRO, as well as a full-time private security guard, who was himself a retired police officer. In 2021, both the SRO and private security guard were armed while in the school.[81] The SRO and the private security guard had an understanding that "there would be one person in the building with a gun at all times if possible."[82] This "understanding" was never formalized in writing, either in OCSO's agreement with the OCS, or between the SRO and OHS school security.[83]

The SRO and the OHS security guard shared an office located in the front administrative office of the school, adjacent to the assistant principal's offices. The third individual assigned to share space with them was the hall monitor, who did not have a desk in the office. Both the SRO and private security guard had access to computers and, therefore, school surveillance footage. OHS' private security guard spoke with Guidepost in conjunction with a prior report, during which he stated that he typically monitored the video cameras when he was at his desk in the security office.[84] The SRO, however, said that OHS' private security would also be in hallways "making [his] presence known."[85] The SRO and other OHS staff members had access to surveillance footage through their computers, and the only prerequisite was pre-approved access by OHS administration.[86] The SRO noted that the OHS private security officer was the only one who had access from his computer to the wall monitor, so he would need to be onsite in order to allow large monitor access. The hall monitor had no training or knowledge as to how to operate the camera system on either the SRO's or the security guard's computer.[87] The SRO did confirm in our interview that monitoring surveillance video would have been helpful during this incident.

[81] See Guidepost 2, p. 95 ("At the outset of his tenure at OHS, [private security] did not carry a weapon, but in or around December 2012, the shooting at Sandy Hook Elementary School in Newtown, Connecticut prompted the district to allow [him] to carry a firearm").
[82] See SRO deposition, p. 153.
[83] See Guidepost 2, p. 504-505 ("After the shooting, OCS's agreement with the OCSO, and OCS's policy were changed to require that at least one-armed security team member is present at OHS at all times during school hours, with an exception for an SRO called away from OCSO business, in which case OCSO would try to replace the SRO…").
[84] See Guidepost 2, p. 504
[85] Guidepost interview call with SRO (August 27, 2025)
[86] Id.
[87] Interview with hall monitor, June 26, 2025.

The SRO at the time of the shooting had served as the assigned deputy for OHS since 2016.[88] Prior to that time, the school had not had an SRO for almost 12 years. OCSO's agreement with the school district defined the SRO's role as:

> *The purpose of the SRO is to provide for and maintain a safe, healthy, and productive learning environment, emphasizing the use of restorative approaches to address negative behavior, while acting as a positive role model for students by working in a cooperative, proactive, problem-solving manner between the TOWNSHIP and the SCHOOL DISTRICT.*[89]

The private security guard's formal job description was "unofficial district liaison for security concerns."[90] He also was tasked to address reports of harassment via text or social media, as well as other social issues in the school.[91] The SRO's role appeared to differ from the private security officer, and it appears that the SRO was to be involved in instances of actual or possible criminal activity, including threats to OHS.

In 2020, OHS Principal Wolf provided the OHS student newspaper with an explanation that the hall monitor was not a security officer.[92] Despite this classification, her actual role was more nebulous. Even the SRO informed Guidepost that he found her role confusing.[93] She previously worked as a deputy for OCSO, until she retired in 2019.[94] After her time in law enforcement, the hall monitor also worked as an SRO for schools in Clarkston and Brandon Township. A review of her employment contract, as well as public commentary by OHS Principal Wolf, indicates that her prior law enforcement and SRO roles were considered as a basis for her employment. In fact, she learned of the position from the OHS SRO, her former friend at OCSO. He told her that OHS was looking for an individual with prior law enforcement experience to work 20 hours a week and carry a gun.[95] Her contract with OCS did afford her the opportunity to carry a weapon.[96] Despite the fact that she carried a weapon, the hall monitor stated she did not receive any security training from OHS, but rather only attended a conference[97] after actively seeking out

[88] See SRO deposition, p. 10. He has since left OHS and works in private industry.
[89] Oxford Community Schools District School Resource Officer Interlocal Cooperation Agreement, Oxford Township, July 2021; See also Guidepost2, p. 80-81.
[90] Job Reclassification Request for [private security guard]," Steve Wolf, 2014; See also, Guidepost2, p. 81.
[91] Ibid.
[92] Email from Steve Wolf re "Re: [hall monitor]—Newspaper," Jan. 31, 2020
[93] Guidepost interview Call with SRO (August 27, 2025)
[94] Guidepost interview with OHS hall monitor, June 26, 2025
[95] Ibid.
[96] See ibid. When Guidepost spoke with the hall monitor for this report, she indicated during her recent interview with Guidepost that she obtained a concealed pistol license (CPL) while on modified duty patrol, prior to retirement from OCSO.
[97] "SEPLA – Schools, Educators, Police Liaison Association," (https://www.seplainstitute.org/).

permission from the school to attend.[98] She was never provided security briefings, nor any information about ALICE drills. While she distinctly recalled three prior ALICE drills before the shooting, she was never on notice for any of them.[99]

She was instructed by the principal to "report to security" daily and to the OHS private security guard.[100] Her regular responsibilities included ensuring compliance with lunch period times, enforcing dress code, and checking the bathrooms to see if students were vaping or skipping class. Her attire was comprised of a blue jacket with OHS marking, but no badge or title to identify her as an armed security member so law enforcement could readily identify her.[101] OHS would also use her for additional services. For example, private security, unlike OCSO deputies at the time, had access to BWCs. The hall monitor was required to wear her BWC during her shifts and activate the camera during any student encounters where they would act out.[102] Moreover, she would be tasked to accompany the OHS private security guard on "missions," including truancy checks on students.

OHS' private security guard noted that the hall monitor was never supposed to be in a position where she would have to respond as security personnel as she had to do on November 30, 2021, because either he or the SRO were the only two people with that expectation.[103] The SRO likewise said in his interview that that while he informed the hall monitor that he was leaving campus, "[he] never discussed her being in charge or assuming his role."[104] However, it should be noted that in his deposition, the SRO suggested that he relied upon her to "protect" given that she was authorized and able to carry and use a firearm.[105]

ii. *SRO Timeline on November 30, 2021*

On November 29, 2021, the private security guard informed the SRO as well as school administration that he would not be at the school the following day.[106] On the evening of the 29th, the security guard sent a group text message to the school administration

[98] The only training she received was from a conference she requested to attend called SEPLA, in June 2021, which is for school personnel, educations and law enforcement. She attended the training that year with OHS' SRO. See, Guidepost 2, p.82. See also Guidepost interview with OHS hall monitor, June 26, 2025.
[99] Ibid.
[100] Ibid.
[101] Ibid.
[102] See ibid. In her interview with Guidepost, the hall monitor recounted an incident where she activated her camera when called to address an issue where a student was "armed" with a knife.
[103] See Guidepost 2, p. 84.
[104] Guidepost interview call with SRO (August 27, 2025)
[105] See SRO Deposition, p. 176-177.
[106] See SRO Deposition, p. 153.

reminding everyone that he was going to be out, and that the SRO would be at the school all day. On November 30, 2021, the SRO arrived at OHS prior to the start of classes at approximately 07:47. According to multiple OHS staff interviewed, the monitor at the security desk area was not turned on. Although the cameras were operating, there was no visual display. SRO left OHS at 11:40.57 to respond to an abandoned vehicle at Oxford Middle School (OMS), located approximately 3.2 miles from the high school at 1420 Lakeville Road. In both the SRO's and the hall monitor's interviews, it was confirmed that she was the only one he told about leaving OHS that day.[107]

The SRO spent approximately 30 minutes investigating the abandoned car at OMS. He was able to determine that the car likely belonged to someone in the neighboring trailer park. When he went to the trailer park, he was unable to locate the owner and left. He then proceeded to the Oxford substation to follow-up on some official paperwork at approximately 12:30. The substation is located at 310 Dunlap Road, approximately 3.7 miles, and about an eight-minute drive, away from OHS. The SRO stated in a previous interview that he stayed at the substation for approximately 20 minutes to retrieve his case file and confer with colleagues. His vehicle GPS confirmed that he was at the substation for 21 minutes and that he left at 12:51 to return to OHS. As he exited the substation, the shooting at OHS commenced. At around the same time, the hall monitor was ending her shift and had already turned in her BWC and radio as required, by the security office located at the front of the school.

While enroute to OHS, SRO heard over his OHS school radio that there is some kind of problem at the school; however, the audio was broken. His in-car camera from the back seat picked up garbled radio transmission, likely from the school radio. As he was driving on Seymour Lake Road, the radio transmissions became clearer. He heard a male voice (likely Principal Steve Wolf) stating "ALICE, this is not a drill." At 12:53:41, his GPS vehicle speed increased, and the lights and siren were activated. At this point, the shooter was two minutes and 28 seconds into his attack and eight students were shot.

The first two OCSO personnel to enter the high school were the SRO and OCSO Deputy 1 at approximately 12:58:23. They arrived simultaneously at the school, approximately five minutes and 30 seconds after the shooting started. The deputies parked, retrieved long guns and equipment, and made entry into the school approximately one minute after arrival. They were followed by OCSO Sergeant 1 and OCSO Lieutenant 1 at approximately 13:02:00. The SRO and OCSO Deputy 1 encountered numerous gunshot victims. Within approximately two minutes of their arrival at 13:00:30, the SRO and

[107] See Guidepost interview call with SRO (August 27, 2025), See also Guidepost interview with OHS Hall Monitor, June 26, 2025.

Deputy OCSO Deputy 1 detained the suspect following his surrender,[108] which was approximately nine minutes after the shooting began at 12:51:12. Prior to surrendering, the shooter placed the gun on a trash can outside the bathroom.

iii. *SRO's Absence from the School*

The OHS SRO was allowed to leave the school, and there was no identified policy or requirement at that time that the SRO must remain at the school. The SRO only advised the hall monitor, and not school officials, that he was leaving the school and would return before the hall monitor ended her shift. OHS officials informed Guidepost during this review that it was standard practice for the SRO to let an assistant principal know if he was leaving the campus. School staff stated they thought that the SRO was at the school during the shooting, and that the SRO was aware of all updates that OHS staff was sending over internal radio concerning the location of the shooter and location of victims.[109] Going forward, SRO responsibilities should be more clearly defined.

iv. *The SRO's Radio Communications inside OHS*

As the SRO was responding, he was receiving information on his school radio about the shooting, such as victim locations and that the shooting was happening near Door 5. However, his in-car camera recording and OCSO radio traffic indicate that the SRO did not relay any of these updates to responding officers. The SRO was driving at a high rate of speed to get to the school quickly. However, the ability to both drive at a high rate of speed and provide updates on the radio is a standard expectation in law enforcement.

Law enforcement is trained to notify over the radio the entry point they make when entering the building or area of a suspected active shooting incident. At this incident, the SRO did not announce his arrival, or that he and OCSO Deputy 1 were making entry at Door 7. He also did not call out on the radio that there were multiple gunshot victims between Door 7 and Door 8. The SRO confirmed in a recent interview that he did not attempt to talk on the radio, as he was focused on locating the shooter(s).[110]

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[108] On November 30, 2021, Sheriff Bouchard gave a media briefing where he stated, "Deputies stopped the perpetrator with a loaded firearm coming down the hall… deputies interrupted what would be potentially seven more victims." OCSO made additional media comments that deputies stopped the attack, however they failed to note that the perpetrator had surrendered before encountering law enforcement. Camera footage and radio traffic demonstrate that the perpetrator did not have a firearm with him when he was taken into custody. By the time the SRO and OCSO Deputy 1 detained the shooter, he surrendered without any resistance and was on his knees.

[109] School officials stated the day after the shooting, there was a debriefing held for the school staff. During the debriefing, the SRO confirmed he was not at the school and did not arrive until five minutes and 30 seconds after the shooting started. OHS staff described this revelation as "deeply shocking."

[110] See Guidepost interview with SRO (August 27, 2025).

Upon entering, officers are trained to observe or listen for gunfire, screaming, movement of occupants, or other indicators to locate an active shooter. They would then dynamically move to and confront the suspect. The outcome of the incident is decided by the suspect. Frequent outcomes at active shooter events include the suspect fleeing, the suspect committing suicide, the suspect barricading himself or herself, or the suspect engaging in a gunfight with law enforcement. In any case, officers will take necessary swift actions to stop the threat. In these circumstances, radio discipline is critical. Those officers who have entered upon a scene should have priority on the radio to provide feedback to responding units and command. Critical communications include suspect location, victim(s) location, and actions by law enforcement.

v. *Threat Mitigation*

The search can be conducted using several speeds for law enforcement. In the event officers have direct indicators of the suspect's known location, they will dynamically move to the area and towards the threat. Law enforcement is trained to move to the known location of the suspect, quickly bypassing any unknown threat areas. The OCSO active shooter training PowerPoint states, *"When responding to stimulus, move expeditiously to the threat."*

In the event there are no clear indicators of the suspect's location, officers are then trained to proceed using a conventional clear speed of movement. This is slower than the dynamic movement, enabling an officer to hear and process information including observations until other indicators emerge or the suspect is otherwise located.[111]

OCSO's active assailant response training outlines the response mission as the following:

- Seek out, locate and cease the life-threatening behavior of the perpetrator(s)
  - Isolate, contain, eliminate
- Shrink the perpetrator's area of operation
- Evacuate innocents to a safe area
- Direct other teams to injured parties
  - Rescue task force

Both deputies entering OHS immediately turned left down the 200 hallway. All OCSO radio traffic indicates that the 200 hallway had threat activity and visually both deputies would have seen three victims lying on the floor.

As the SRO and OCSO Deputy 1 turned to hallway 200 they approached the victims outside Bathroom 1. They encountered the hall monitor who was known to both deputies

[111] OCSO training video.

as she was retired from OCSO and a former colleague. As discussed, the hall monitor was approved to carry a firearm while working at OHS, and on this day was armed with a handgun.

There was an exchange between the SRO, OCSO Deputy 1, and the hall monitor. What the hall monitor told them is not known, but the exchange was brief as seen in the OHS video. The SRO then handed a tourniquet to the hall monitor and both deputies continued to move to locate the shooter at an appropriate speed. However, there was no update to Dispatch by either deputy about the location of victims. There was also no update to Dispatch that there was an armed hall monitor in civilian clothes inside the building.

vi. *Transition from Threat Mitigation to Victim Response*

Mitigation of an imminent threat is the initial priority when law enforcement responds to an active assailant attack. As noted in the San Bernardino AAR, "Agencies should anticipate and plan a timely transition from the somewhat chaotic active shooter response to a more methodical search for possible suspects, triage of victims, and victim and witness extrication."[112] This means that in the absence of an active or ongoing threat, locating and treating victims should emerge as the priority. Data collected from previous active assailant events suggests that half of the victims will have moderate to critical gunshot wounds. If a victim suffers a major, yet survivable, gunshot wound, their odds of death increase 2-4% every minute until they receive blood replacement or go into surgery.[113,114,115]

Law enforcement's initial entry into a building requires a balance of priorities between locating the threat and victim response. The detention of a known threat does not fully eliminate the need to continue to search for additional risks. Here, the SRO and OCSO Deputy 1 were inside the walls of OHS approximately 61 seconds after arriving. The remaining deputies and law enforcement moved into OHS, as trained, to perform search and evacuation tasks. They entered OHS with the goal of finding and ending the threat. Within two minutes of taking the suspect into custody, OCSO deputies were providing

[112] United States Department of Justice. (2020). *How to conduct an after-action review.* Washington, D.C.: Office of Community Oriented Policing.
[113] Brown, et al. (2025). Prehospital trauma compendium: Transfusion of blood products in trauma- A position statement and resource document of the NAEMSP. *Journal of Prehospital Emergency Care.* Retrieved from https://doi.org/10.1080/10903127.2025.2476195.
[114] Crandall, M., Sharp, D., Unger, E., Straus, D., Brasel, K., Hsia, R., & Esposito, T. (2013, April). Trauma deserts: Distance from a trauma center, transport times, and mortality from gunshot wounds in Chicago. *American Journal of Public Health*, *103*(6): 1103-1109.
[115] Shackelford, et al. (2017). Association of prehospital blood product transfusion during medical evacuation of combat casualties in Afghanistan with acute and 30-day survival. *JAMA, 318*(16): 1581-1591.

care to Tate and Madisyn. Within three minutes, a deputy was providing care for Hana. We do not find these response numbers unreasonable.

During our review, we perceived concerns among some community members regarding footage of the SRO and Deputy OCSO Deputy 1 walking past Kylie Ossege and Hana. The OHS video depicts Kylie pulling on the SRO's pant leg in an attempt to seek help. The SRO's car camera microphone picked up the encounter inside the school. Kylie was calling for help stating she was shot and that she could not move. The SRO asked her where the shooter was. Kylie said she did not know. He told her, "We are leaving to find the person who did this to you." Kylie then reached out for the SRO's pant leg. He appears to "brush her off" and told OCSO Deputy 1 they were going to move down the 200 hallway. As they left her, Kylie Ossege cried out for her mother. Basic human compassion is taxed to see a child in pain, to watch her seek help from law enforcement, and to witness the first responding officer on the scene walking away. It is easy to perceive that as a callous act. However, officers are trained to assume the potential of multiple shooters until an exhaustive search is completed. Officers must also weigh this assumption within the presence of a known stimulus on scene. Common examples of stimuli include, but are not limited to, active gunfire, explosions, and eyewitness accounts.

Training in the area of active shooter response educates officers to move towards the sound of gunfire. However, newer and more nuanced training teaches officers to move towards stimuli. These terms are becoming more prominent and ubiquitous in active shooter training. The term *passive stimulus* is often used to mean shell casings, blood trails, bullet holes, or other indications that something has happened. The term *active stimulus* is often used to mean sounds of gunfire, explosions, people screaming, victims on the ground, or people fleeing. Active assessment of these stimuli will guide officers in their assessment of an ongoing attack. In this event, SRO first responded to the information he heard on his school radio. He then encountered multiple injured victims in the long 200 hallway and moved towards the last known location of the shooter at Door 5.

Law enforcement's assessment of ongoing threats must remain fluid. Keeping abreast of passive and active stimuli also allows first responders to remain aware of and to identify any "*event transitions*." The absence of gunfire or indications of ongoing violence should be a cue to shift priorities to the care of the actively injured. Common event transitions in active assailant attacks occur when the shooter flees the scene, runs out of ammunition, barricades themselves in an area, or commits suicide. As the threat profile diminishes, victim care becomes the main priority.

While we understand that the SRO's and OCSO Deputy 1's actions may be hard to understand from a layman's perspective, their choice to keep moving was entirely consistent with traditional law enforcement training to engage in the pursuit of the shooter. It was consistent with protocols that any state or federal agency would advise. It is important to recall that the responding sheriffs' deputies were unsure of the number of shooters and types of weapon(s) involved at that juncture. However, we do note that the SRO missed a key opportunity to utilize his radio. For example, as he passed by and had that interaction with Kylie Ossege in the 200 hallway, he should have radioed the location of all injured victims seen in that hallway and expressed a necessity for fire/EMS aid.[116] We believe that this measure could have been effectuated based on the lack of "active stimuli" present at the time, such as active gunfire while they were walking the 200 hallway. SRO and Deputy OCSO Deputy 1 were not moving down the hallway in a hurried fashion and did not indicate in their movement that an active threat present was present.

Moreover, the only limited medical treatment the SRO provided before departing the hallway involved tossing the hall monitor a tourniquet for Hana's wound care. This was captured on surveillance video. The SRO did not inquire whether the hall monitor was able to utilize the tourniquet. Perhaps the SRO presumed her ability to use the tourniquet given her prior law enforcement background. However, without ensuring knowledge with use of the device, it has little use in the hands of an untrained individual.[117]

We acknowledge that the total amount of time taken to enter the building and to address treatment by deputies was commendably executed. We do, however, suggest that a keener awareness of stimuli will allow for a smoother transition from active search to treatment mode. Moreover, implementing practices such as using a radio when a responding officer first enters the building can provide a better and quicker response.

vii. *Use of Medical Equipment*

As discussed above, shortly after the SRO encountered Hana, he gave his personal tourniquet to the hall monitor to apply. In accordance with best practices, he bypassed Madisyn, Hana, and Rylie Franz to continue pursuing the shooter. At 12:59:59 two deputies encountered Tate, who was in cardiac arrest with a gunshot wound to the head. AP Gibson-Marshall already assessed Tate and knew that he was in cardiac arrest. She had started CPR prior to the arrival of the deputy. The deputies quickly moved past, pursuing the shooter. This was the correct action to take. However, these deputies did not radio back that they had a victim at Door 5.

[116] We discuss in further detail later in this report when analyzing the fire/EMS response and staging issues.
[117] While we acknowledge that ultimately the use of a tourniquet on Hana's injuries would not be lifesaving, it is important to consider this fact in better training about providing medical equipment for non-civilian use.

At 13:02:00, another deputy arrived to assist Tate. He spent approximately one minute attempting to determine if Tate had a pulse. He then placed Tate in the recovery position (a position in which a breathing victim is on their side to keep their airway open).

Although first aid and CPR training instructs to check for a pulse, this step is often bypassed in multiple casualty events. Instead, responders check for the presence or absence of breathing. This allows responders to expeditiously move through the patients and not spend valuable time checking for a pulse. In addition, responders often operate with very high adrenaline and often have difficulty confirming the presence or absence of a pulse.

In this event, AP Gibson-Marshall confirmed that Tate was in cardiac arrest when she first accessed him. Based on his injury, it is highly likely that Tate went into cardiac arrest immediately after the gunshot wound to his head.

At 13:04:00, another deputy resumed CPR on Tate. AP Gibson-Marshall was calling for an AED. A deputy brought the AED and attempted to connect it to Tate. Another deputy brought in an orange medical bag filled with trauma supplies. At 13:09:50, two deputies moved Tate to a deputy's patrol car for transport. The deputy quickly announced to OCSO Dispatch that he was transporting one victim in his patrol car to the hospital.

The decision to attempt to transport Tate in a patrol car was an appropriate choice. There were no ambulances available to help. The only ambulance on scene was treating another student with a gunshot wound to the head who was still breathing. The deputy attempted to take Tate to where fire and EMS were staged, and if no help was available, he intended to transport Tate to the hospital.

At the 2014 Aurora Century 21 theater shooting, the single greatest factor that increased victim survivability was the decision by Aurora police officers to transport 27 gunshot victims in their patrol cars.[118] Likewise, the medical directors from the 35 largest cities in the United States agreed in 2017 that transporting patients in patrol cars is very beneficial to reducing mortality.[119] Their publication acknowledges that "[g]rabbing a victim and throwing them in the back of a police car may be heresy to some, but police can drive really fast. What these victims really need is an operating room."[120]

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[118] Tri-Data Corporation. (2014). *Aurora Century 21 Theater Shooting: Official after-action report for the City of Aurora.* Arlington, VA: Same.
[119] Gates, H. (2017, June 26). Gathering of the Eagles Part II: Responding to active shooter events. *EMS World.* Retrieved from www.emsworld.com.
[120] Ibid.

However, it should be noted that Tate was placed in the back of the patrol car by himself in cardiac arrest. Ideally, a second provider would be in the back seat to provide care. Also, the transport time to the closest trauma center was 20 minutes. In a case such as this, law enforcement officers should consider intercepting responding ambulances, which is exactly what the deputy did.

At 13:05:04, responding deputies were asking on the radio if medical equipment was needed inside. This was after deputies made multiple requests for EMS assistance inside the school. All OCSO deputies are equipped with a tourniquet in the event they are injured. The SRO handed his tourniquet to the hall monitor to be applied to Hana. Deputies making entry also had medical kits; an orange trauma kit is clearly seen in the OHS video. The kit contained bleeding control medical devices which would enable deputies trained in TECC to treat major bleeding.

Deputies also placed a tourniquet on Molly Darnell, a teacher who was shot in the arm. This was a reasonable decision because the teacher had already put an improvised tourniquet on her arm. As it turned out, the gunshot wound was a through-and-through soft tissue injury to her left triceps. The tourniquet was not needed and a paramedic quickly removed it a few minutes after it was placed.

Medical treatment responsibilities by law enforcement also include facilitating EMS for triage and creating transport corridors to area hospitals. In this event, multiple paramedics stated that traffic was incredibly congested leaving the scene and enroute to area trauma centers. It is incumbent on law enforcement officers who are not needed at the scene to immediately work to secure and close main traffic corridors from the scene to trauma centers. In urban settings, this can reduce transport time significantly.

viii. *OCSO Arrest and Detention of a Suspect*

Taking the suspect into custody safely is a priority with multiple considerations. The suspect's actions dictate much of the encounter and in this case a compliant suspect provided a stable arrest process. The suspect separating himself from the firearm and moving into a surrender position enabled the SRO and OCSO Deputy 1 to both identify him and take him into custody without further incident.

Once a suspect is apprehended, law enforcement should consider several variables. First, officers must arrange appropriate transport, avoiding a scenario where the suspect is brought into the middle of evacuees. Here, the extraction was direct and concise. The SRO and OCSO Deputy 1 coordinated with investigators to move the suspect to their

patrol vehicle and onto the OCSO Oxford substation which has an appropriately equipped interview room.

Second, in ideal circumstances, best practice would be to minimize the access and viewing of the suspect by any of the victims. There has been criticism that several victims were in close proximity and able to view the suspect during their evacuation from a bathroom, inducing additional trauma. However, containing the victims in the bathroom for any additional time may have been equally scrutinized. Also, the decision to hold the suspect at the location where he was taken into custody, while coordinating the logistics of transport, was understandable. Law enforcement's handling of the suspect for case integrity is extremely important. Here, officers minimized interactions by guiding victims away from the suspect's location quickly and, upon reviewing the school video, it appears that OCSO officers had the shooter looking away from the victims when they exited the bathroom.

b. Analysis of OCSO Incident Command at OHS on November 30, 2021

i. *Incident Command Overview*

Composure under pressure is a necessity during inherently chaotic events. We acknowledge that many law enforcement officers and fire/EMS personnel demonstrated poise and made sound, intelligent decisions that contributed to the overall effectiveness of the response. Other deputies were emotionally charged as evidenced by their agitation with fire/EMS.[121] It is indisputable that the scene inside OHS was horrific. This only reemphasizes the need for a calm and composed incident commander to set the tone for all responders and minimize emotional response. Studies conducted by the IACP show that the rapid arrival of a supervisor at critical incidents immediately helps to defuse and deescalate situations and sets the tone for the response to the incident.[122] It is imperative for supervisors to be proactive and offer strong, clear leadership. While the level of command can depend upon the complexity of the incident and the needed resources, the span of control build-out enables appropriate direction and coordination at all levels of response. This is an intentional guide for each level of supervision and command to have responsibilities over a specific number of personnel or area.

[121] These were characterizations made by OFD AC Majestic. An OFD captain and the OFD fire marshal also give the same account. This is notable as the three men were not together in the same location. The OFD fire marshal was at Bathroom 2; OFD AC Majestic and an OFD captain were at the short 200 hallway. Additionally, OFD AC Majestic noted these same issues in a formal complaint to OCSO.
[122] International Association of Chiefs of Police. (2017). *Reporting use of force.* Alexandria, VA: Same.

> *"Regardless of rank or title, crisis event leadership requires calm composure and the ability to make solid decisions with limited information and less than ideal circumstances. This is necessary to quickly implement an effective response, reduce chaos, and save lives."*[123]

While OCSO ranking officers were responding to the scene, our review of the CAD notes and radio traffic indicated limited command and coordination at the school. Typically, a proper command structure from law enforcement will provide frequent updates, directions, and resource requests. There were multiple attempts by units in OHS to broadcast messages on the radio. At 13:00:30, a unit who radioed to enter the school was talked over by several responding units. OCSO Dispatch advised that multiple units were unreadable.[124] This was at the time the SRO and OCSO Deputy 1 were taking the shooter into custody. As confirmed during our interviews and captured on OHS surveillance footage, several deputies exercised some semblance of authority and gave verbal orders. However, there is a distinct difference between giving orders and establishing formal "command." While instructing officers and giving tasks contributes to some semblance of order, it does not establish the broader and more comprehensive responsibilities of strategic and tactical decisions for an entire operation. In this event, with hundreds of officers responding, there was a substantial lack of command directions, both in person and on the radio.

Despite the shooter being apprehended just two minutes after OCSO arrived on scene, and OCSO ranking personnel arriving on scene within the first seven to nine minutes after the shooting began, incident command was not formally established until Lieutenant Todd Hill arrived at 13:20 and initiated incident command at 13:25:00. This constitutes a time gap of approximately ***27 minutes*** after the SRO and OCSO Deputy 1 arrived on scene, approximately ***25 minutes*** after the shooter was in custody, and approximately ***24 minutes*** after OCSO dispatch confirmed the suspect's arrest. Lieutenant Hill ultimately established incident command inside the lobby of OHS by a bench across from the administration offices.

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[123] United States Department of Justice. (2020). *How to conduct an after-action review.* Washington, D.C.: Office of Community Oriented Policing.

[124] At 13:00 there were at least four OCSO units in the school based upon the OHS internal surveillance footage. While we can state the communication was from an OCSO unit we cannot determine the identity because they were "walked on." When multiple units try and talk over each other, it produces a garbled mix of unintelligible traffic. There is no way to determine if it was units in the school talking or multiple units responding that were talking. From the camera footage, we could see OCSO Deputy 1 try to utilize the radio at that time. This allows us only to draw an assumption that OCSO Deputy 1 may have tried to call out and was "walked on."

Once formal command was established, the organization and coordination of law enforcement rapidly improved with clear instructions and accountability from officers. Prior to this, officers were operating independently inside the school with good intent but little direction and disorganization. First responder interviews, camera footage, and radio traffic collectively depict a chaotic scene where numerous officers repeatedly searched the same areas and can be heard making duplicate requests to OCSO Dispatch. Our findings indicate that the lack of OCSO incident command for the first 25 minutes contributed to the delay in fire and EMS personnel entering OHS to treat victims. Although radio traffic communications reveal that at some point notifications were sent to indicate the scene was secure, OCSO did not provide timely indication or consistent information regarding the conditions as "safe." At 13:01:05, OCSO deputies made seven requests to OCSO Dispatch to send fire and EMS inside. Dispatch did not relay this information to OFD personnel until 13:05:48. Our review also finds that communication missteps continued even when fire and EMS were inside OHS.

ii. *OCSO Departmental Policies on Incident Command*

OCSO has two policies that specifically address incident command, both of which were in effect prior to the date of this shooting, General Order #37, "Adoption of the Incident Command System,"[125] and Policies and Procedures #64, "Command Responsibilities at Critical Incidents and/or Major Crime Scene."[126] General Order #37 established that OCSO would utilize the incident command system at any major incident that involved members of OCSO. The procedure directs that the incident commander "*shall be at the scene of the incident and is the highest-ranking officer who initiated/responded to the incident*. *This person will serve in this capacity until relieved by a higher ranked officer or their designee*." (emphasis added).[127]

The policy describes 10 areas for which the incident commander is responsible:

1. Assessing incident priorities;
2. Determining strategic goals;
3. Determining tactical objectives;
4. Developing an incident action plan;
5. Developing an appropriate organization structure;
6. Managing departmental resources;
7. Coordinating overall emergency activities;

[125] Oakland County Sheriff's Office. (2005, July 18). *Adoption of the incident command system.* Pontiac, MI: Same.
[126] Oakland County Sheriff's Office. (2004, February 27). *Command responsibilities at critical incidents and/or major crime scene.* Pontiac, MI: Same.
[127] Ibid.

8. Ensuring responder safety;
9. Coordinating activities of assisting agencies, to include the establishment of a joint command post and/or unified ICS, if necessary; and
10. Authorizing the release of information to the media.

Policy and Procedure #64 gives further directives to OCSO command officers. The policy recognizes command officers as those with the rank of lieutenant and above. The policy states the following directives for initial response:

The first arriving Command Officer on the scene of a critical incident and/or major crime scene shall (emphasis added):

A. Assume direct responsibility of the scene.
B. Make appropriate assignments of personnel.
C. Notify the highest-ranking contracted Command Officer assigned to the jurisdiction of the incident.
D. Notify other higher-ranking Command Officers as required; i.e. Duty Captain, Detective Lieutenant, et cetera.

OCSO policy requires those taking command to announce their presence on the radio as well as their location.

iii. *Incident Command Deficiencies on November 30, 2021*

In this event, there was no clear law enforcement leadership until the arrival of Lieutenant Hill. Lieutenant Hill stated that when he arrived, the scene was chaotic, there was no coordination of search and clearing efforts, and there was no accountability of officers. Multiple on-scene ranking OCSO personnel failed to effectively coordinate and control the law enforcement response inside the school. OCSO Lieutenant 1, the OCSO Oakland substation commander, arrived on scene behind the SRO, OCSO Deputy 1, and OCSO Sergeant 1. However, OCSO Lieutenant 1 did not establish incident command.

Although critical objectives were accomplished, the lack of incident command resulted in several shortcomings. Strategic goals and tactical objectives were not announced to responding and arriving deputies, resources were not effectively managed inside and outside of the school, and unified incident command was not established. There was little coordination of overall emergency activities, especially with regards to victim care. This time gap is too long to properly establish command. As a result, no one ensured the deliberate assignment of tasks or effectively managed the flow of information for critical decision-making. The radio traffic clearly shows officers duplicating tasks and making independent decisions in the absence of coordination. While our review did not identify

any malfeasance, purposeful delay, or dereliction of duty, the noticeable lack of organization is not a practice which benefits anyone in an active assailant situation.

If incident command is established early during an incident, efficiency and management will likely allow better outcomes. Many agencies that have a similar jurisdiction, encompassing multiple substation offices and divided divisions, utilize a formal notification system for critical events. This can include electronic means for text/calls enabling an emergency notification protocol. These are typically backed up with a confirmation requirement. For immediate notification, organizations typically have a command group in CAD. This command group is automatically added onto specific calls (such as active shooter), ensuring broad and immediate distribution of critical event dispatches. Some organizations use mass notification systems such as Everbridge to ensure command staff and special operations notification. Other organizations use more robust and interactive systems, such as Active9-1-1 or IamResponding, to provide notification and two-way interaction.

A. Absence of Perimeter and Access Control

OHS video shows an adult male inside the school who appears to be searching for his child named “Lilly.” The male was allowed to remain in the school and walk the school corridors as deputies are searching for suspects. The male was also allowed to remain passing through the crime scene as the clearing operation was underway.

The deputy's priority is to mitigate any threat. As deputies move to locate, they should take opportunities to remove potential victims that may be in harm's way. In this case a parent in the school could have been injured. More critically, the person could be armed and engage the suspect while law enforcement was conducting the search operation. No one should go unchallenged during these events.

Lieutenant Hill arrived at OHS at 13:20 and requested units to establish a perimeter around the school. At 13:25, Lieutenant Hill subsequently established incident command and a command post in the front lobby.[128] As demonstrated through statements, video footage, and radio traffic, starting at 13:20, there was intentional coordination to align law enforcement agencies with the roles needed to complete the building clears, secure the interior of the building, and create a perimeter around the outside of the building. Patrol deputies, tactical teams, state agencies, federal agencies, and specialized units (such as

[128] An internal OCSO document provided to Guidepost, “Response Time Comparison - Average & Other Incidents 2024-8-17,” compared response times of OCSO to law enforcement in other active shooter incidents around the country. In that analysis, 13:25 was the conceded time when incident command was established by Lieutenant Hill.

bomb and K-9 units) were all organized in an efficient manner beginning at 13:30. Upon arrival, Lieutenant Hill gave detailed updates to OCSO Dispatch and all units. At 13:32:37, he gave the first command update for the incident, which provided the following:

- Units were systematically clearing each room;
- Students were getting sent to the parking lot as the rooms were cleared;
- The shooter, who was a student, was in custody;
- All patients were identified; and
- OCSO command center was located in the front lobby of the school.

Prior to that command, no effective perimeter was established around the school. The parent freely moved through the halls to search for his daughter. The father encountered numerous deputies, none of whom challenged or instructed him to leave. He even interacted with the shooter after his arrest, attempting to physically assault him, which was the only instance where deputies intervened. This was fully captured on OHS surveillance footage. Ultimately, it was school administrators who asked deputies to remove the parent from the school. Intrusions such as these need to be addressed directly and OCSO should have removed the parent promptly.

B. Absence of Command and Coordination

Prior to the establishment of incident command, there was a lack of command and coordination by law enforcement. Video footage from OHS showed multiple deputies continuing to clear and search the same hallways repeatedly from the onset of the incident. Although there is a comprehensive section in this report about incident command, we will briefly mention some critical actions here.

As mentioned throughout this review, the initial law enforcement priority is to identify and mitigate the threat and, to accomplish this, law enforcement must overwhelmingly flood the interior of the structure and find the suspect(s). In this case, there was no stimulus to indicate that there were additional threats after the shooter was taken into custody. There was no effort seen for any coordination to occur in organizing the search.

We do need to mention that U.S. Marshals in tactical gear were inside the school about 20 minutes after the arrival of the SRO and OCSO Deputy 1. These U.S. Marshals are visible on camera directing OCSO deputies to hold hallways. Holding hallways is not necessarily a task relegated to just tactical teams. However, the U.S. Marshals had the wherewithal and training to recognize there was no coordination in that area.

Searches should not be random and some initiative to organize should occur at the lowest level of responder. Efficiency in a critical incident response equates to saving time which ultimately will save lives. The flood of law enforcement into a structure to mitigate a threat will likely see better outcomes by clearing, advising, and continuing the operation in a coordinated way. Calling into command with information about the conditions of areas cleared, such as the locations of victims or those waiting to be evacuated and any suspicious devices, etc., will allow the mitigation units or supporting agencies to move to those cleared areas and conduct their work. By doing so the hot, warm, and cold zones are delineated more accurately throughout the incident.

In this incident, Lieutenant Hill utilized the school intercom to recall all search teams in the school to the front entrance area. He briefed the teams, then redeployed them with school maps to continue clear operations. School maps were available in the lobby to those visiting the school under normal conditions. Lieutenant Hill took advantage of the map availability and issued them out to teams. Although this recall did not create any delay in locating the suspect, recalls can cause inefficiencies in evacuations and transition to the investigative phase of the incident.

Here, however, recalling the ongoing clears was necessary as there was no formal accounting for what areas were already cleared or where students and staff were still needing to be evacuated. The subsequent clears became more organized and thorough only after the recall and redeployment.

Deputies and tactical teams marked the doors of the rooms cleared with an “X” or “SWAT” indicating the rooms were cleared and moved to the next area. This indicated to those moving behind the teams to pass up the marked doors and continue to unmarked or non-cleared areas. Marking doors, hallways or suspected explosive devices is highly recommended to assist in organizing what can be impending chaos.

However, the recall of officers left no security presence in the school despite multiple students still in lockdown. Had there been a second perpetrator, they would have been alerted by the intercom that all officers were going to the front lobby. Even if a recall is necessary, a minimum number of officers should be kept holding and securing hallways.

Decisions can be made at the command level to prioritize the response and ultimately make more sound and critical decisions. Concepts like “hall boss” are used to insert a law enforcement member into an area to act as the proxy to the incident commander. This role supports the overall operation and is the link to that part of the structure for responders. If there are needs or operations to occur there the responders can be led and briefed by those filling that role.

Command should coordinate the entire operation through these hall bosses throughout the incident. Each phase of an incident from response to investigation and demobilization can be better coordinated in this way. They also provide long cover for corridors and can facilitate any response if the threat remerges in their area of responsibility. They can also facilitate evacuations, movement, or area denial if there are static threats like suspicious devices.

Undersheriff McCabe told the review team that when he arrived in Oxford, he elected not to go to OHS. Instead, he went approximately half a mile away, where media was amassing. Undersheriff McCabe was the OCSO's designated public information officer (PIO), and that he went to fill this critical role.

Undersheriff McCabe said that he had complete confidence in Lieutenants Hill and Willis to command the scene. He did not see a need to go to the school. Undersheriff McCabe stated that he had two OCSO majors with him, helping to obtain information. This information came from Lieutenant Willis who was inside the high school, and a lieutenant who provided information from OCSO Dispatch.

C. Self-Dispatching and Accountability

In a significant incident there is a high probability of self-dispatching to occur by agency members. In law enforcement, the fire service, and EMS, there can be a well-intended response by emergency service members to support the incident. This is a consideration that needs to be included in accounting for commanders. From the onset, the concept is to overwhelm a threat area and mitigate the threat. In this case, self-dispatching has merit; however, after a point in the event the overwhelming response of agencies will likely impede operations.

Numerous active shooter after-action reports describe the problems with self-deployment. In many cases, the number of self-deployed officers is between 50-75% of the total law enforcement response. At the 1999 Columbine shooting, 1,000 law enforcement officers responded to the event.[129] At the 2013 Los Angeles Airport shooting, 1,500 law enforcement officers responded.[130] At the 2017 Hollywood International Airport shooting,

[129] United States Fire Administration. (1999). *Wanton violence at Columbine High School:* Report #USFA-TR-128. Emmitsburg, MD: Same.

[130] Board of LAX Airport Commissioners. (2014, March 18). *Active shooter incident and airport disruption after action review: Summary list of observations and recommendations from the Board of Airport Commissioners.* Los Angeles, CA: Same.

2,000 law enforcement officers responded.[131] In a review of 20 active shooter after-action reports, the Department of Justice found that every AAR described the chaotic, uncoordinated, and unrequested self-deployment of responders.[132]

One of the most dangerous aspects of self-dispatching is the concept of swarm ball.[133] This description is derived from little kids playing soccer. Instead of holding their positions, they all run to the ball, leaving huge portions of the field uncovered. Uncoordinated and unauthorized self-deployment leaves jurisdictions wide-open and vulnerable to other attacks or simple routine criminal activity. Any time an active shooter event occurs, law enforcement commanders must consider that the attack is part of a multi-pronged attack. Complex coordinated terrorist attacks have resulted in numerous responders swarming to the first attack location leaving no resources behind for subsequent attacks.

OHS is unique in that many first responders' children attend school there. Numerous law enforcement officers and fire personnel from several counties self-dispatched because their children were there.

Oakland County Tactical Consortium (OakTac) leadership shared that several Detroit Police Department officers were also self-deployed, as they had children in the school. An OCSO Lieutenant who is now a captain in the 9-1-1 Dispatch Center (OCSO Lieutenant 2) stated that OCSO deputies who are federal task force officers were in the federal building in downtown Detroit. They announced there was an active shooter event at OHS, resulting in the deployment of numerous federal agents and TFOs. They responded in a convoy of undercover vehicles running emergency traffic from 44 miles away, a trip that takes about an hour in normal traffic.

A review of the photographs as well as footage from Air-1 showed that most law enforcement officers did an excellent job of parking their vehicles off roads. Many parked their vehicles on the snow-covered grass surrounding the school. At the 2012 Sandy Hook elementary school shooting, the FBI SWAT team had to run almost a half mile in full kit to get to the scene because of traffic and vehicles impeding their access.[134] OCSO Lieutenant 2 told the review team that she called Lieutenant Hill during the event and told him she was worried about officer accountability because she had no way of knowing

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[131] Cedeno, A., Furman, R., Torres, V., & Diefenbacher, J. (2017). *Fort Lauderdale-Hollywood International Airport active shooter/mass evacuation and its impact upon airport operations.* Fort Lauderdale, FL: Broward County Sheriff's Office.

[132] United States Department of Justice. (2020). *How to conduct an after action review.* Washington, D.C.: Office of Community Oriented Policing.

[133] Graves, M. (2013). *Swarm ball: Not just a problem for kids' soccer coaches.* Oxford, MS: Center for Intelligence and Security Studies, University of Mississippi.

[134] Reviewer's debriefing with FBI agents who responded to Sandy Hook Elementary School.

who had responded. Lieutenant Hill acknowledged that he was aware of the situation but as there was no further shooting, the subject was in custody, and it was mid-day, there was very little threat profile.

D. Absence of "De Facto" Incident Command

Law enforcement's primary objective at an active assailant event should be to identify and neutralize threats. The first arriving officer is the "de facto" incident commander. This officer is responsible for providing directions and establishing the response of all additional units to support the operation. In critical situations, a de facto incident commander will provide simple and direct instructions to responding units.

In this situation, the SRO was effectively the de-facto incident commander and was therefore accountable for providing direction and relaying what he encountered as he entered. As previously discussed, the SRO did not make use of his radio until he announced that the shooter was in custody. The SRO should have radioed all law enforcement/dispatch that he and OCSO Deputy 1 were making entry at Door 7. We found no evidence of this type of transmission, something that the SRO also confirmed. We note that as SRO and OCSO Deputy 1 were making entry, there were multiple simultaneous transmissions producing unintelligible transmissions. Unfortunately, OCSO does not maintain a "bonk log" which would indicate who exactly was "keying up" on the radio at the same time. However, here, it is not only the lack of a "bonk log," apparent radio files, or the SRO's dash camera footage that allows us to conclude no radio transmissions were made. The SRO stated to the review team that he acknowledged not providing radio transmissions; however, he stressed the urgency he was under to locate the shooter.

The first law enforcement unit on scene will typically identify their entry point to the structure notifying where the search for the suspect(s) has started. OCSO trains their officers to park at the entry point. This approach can be an efficient manner to identify the initial entry point as responding units would see the patrol car by the initial entry location, negating any requirement for additional radio traffic. However, this approach was problematic for the OHS shooting as responding officers who reported directly to Ray Road by the front entrance would not have seen the SRO's or OCSO Deputy 1's patrol cars parked at the rear of the school. Since the first arriving officer is the initial incident commander, it is imperative for officers to give a brief report to other units as they arrive.

Many public safety agencies use the acronym "LCAN" (Location, Condition, Actions, and Needs) to detail progress reporting on the current operations and relay vital information between incident commanders and deputies in motion at the incident. LCAN or the

downsized “CAN report” are widely used by law enforcement and the fire service to identify what conditions they are facing, and any resource needs anticipated. Using that model, the SRO could have issued a brief report over the radio, such as: “OS1651 is on scene at Oxford High School. I am making entry at Door 7 [Location]. Students and staff are running out of the building. [Condition] No active gunfire. [Condition/Action] Responding officers are needed at Door 7 on the southside of OHS building [Needs].” This concise report would have provided OCSO Dispatch and all responding units with a clear picture of SRO movements, what he encountered at OHS, his course of action, and what assistance was required from responding units.

We previously acknowledged that the SRO’s decision to go to Door 7 was sound. There were operational benefits for entry at Door 7. Parking a patrol vehicle near the point of entry offers a tactical advantage, as the vehicle can be used for breaching if necessary. The vehicle can provide additional cover should the officers find themselves engaged in a gunfight with a perpetrator. Furthermore, the vehicle could also provide close victim extraction ability, if there was an immediate need to do so. As additional law enforcement units arrive, officers will typically continue into the structure at the same point of entry unless updated information diverts them. The reasoning for this practice is to minimize officers encountering each other in opposing positions, and the risk of accidentally engaging each other. That practice, however, was not consistently maintained at the OHS scene. Indeed, many of the responding deputies entered OHS by the front entrance. Lieutenant Hill noted in his interview that deputies were unfamiliar with the door numbering and school layout[135] and did not possess any keys to enter through the locked exterior doors.[136] Again, these are the consequences when a scene is missing a de-facto incident commander who provides guidance and maintains some level of control.

Another visible consequence of this void in communication was duplicated efforts. For example, Molly Darnell’s injury was reported five times on the OCSO radio and OHS surveillance depicted numerous deputies clearing the same hallways. In some cases, the same hallway was cleared three to four times by arriving deputies. This only serves to create waste of resources, and delayed response to fire/EMS for a “scene safe.”

[135] It was not until after Lieutenant Hill’s later effectuation of incident command that any school maps were handed out to deputies. This occurred after the shooter was in custody, and as a means of clearing the classrooms.

[136] Only the SRO had an access card to get into the school that day. Lieutenant Hill mentioned in his interview that technically there were access cards for schools available to deputies or supervisors as well, however we have no information regarding who, if anyone, carried them.

E. Absence of Area Command

Area command is a management structure in NIMS that is used when managing large or complex incidents, or when multiple incidents require coordination. An area command is used when there are multiple incidents, each with their own incident commander. The primary responsibilities of area command are the coordination between the different incident commanders and the effective utilization of resources. The area commander is responsible for setting overall incident priorities and objectives, especially when critical resources are required at each incident.

Multiple "command locations" were established during this incident. In addition to the eventual incident command at the school, there was also command at Meijer for reunification, command at the shooter's house, and law enforcement operations at multiple hospitals. However, OCSO did not establish an area command. The reunification command worked with the school command, and the command at the shooter's house and hospitals operated independently. These various commands had telephone contact with the school command. However, it was not an effective utilization of incident command to put the incident commander at the location of the shooting in charge of all other remote operations. Under an area command approach, one commander would have assumed overall responsibility and coordination for the entire incident that spanned numerous locations. An ideal location for the area commander is at the Emergency Operations Center (EOC).

Rather, what occurred in this incident was that various law enforcement officers took on the role of "hall bosses." A hall boss is anyone regardless of rank, who takes charge in a particular area. The hall boss takes on the responsibility for commanding a small number of responders in a *limited* geographic area, typically limited to a line-of-sight. A "room boss" is similar. As the name implies, they are responsible only for a room. We do not dispute that a hall boss has a critical role in internal command and coordination.[137] The important distinction is that a hall boss and room boss are not equivalent to an incident commander.

OCSO Lieutenant 1 and OCSO Sergeant 1 are examples of individuals who assumed the roles of "hall boss." Further, OHS surveillance depicts other law enforcement officers who exercised the "hall boss" approach. Approximately 15 minutes into the event, one can see multiple deputies going in and out of a hallway with no apparent coordination of effort. However, at 13:20, a U.S. Marshal dressed in tactical gear arrived and physically

[137] In a presentation created by Lieutenant Hill after the event, he lauded OCSO members who took on a position as "hall boss" as evidence of a successful response. See discussion below regarding OCSO's internal AAR.

positioned officers to take and hold areas in 300 hallway. This is a prime example of someone taking charge and assuming the role of “hall boss.” However, for a hall boss to work effectively, there must be an incident commander. The hall boss receives directions from the incident commander, who in turn provides frequent updates on conditions, activities, and needs. Without strategic command, tactical coordination often does not occur.

One concept that is gaining traction in law enforcement is the “Fifth Officer Rule” for early incident command establishment. The fifth law enforcement officer on scene regardless of rank is the incident commander until relieved by the next arriving ranking officer. This ensures that the role of incident commander is established early and that critical directions are relayed to responding units. This also begins with initial coordination and possibly prevents blue-on-blue (officer-on-officer) engagements from occurring.

F. OCSO Communication Failures with the 9-1-1 Dispatch Center

We will discuss concerns regarding OCSO’s dispatch practices in greater depth within its own section, however, it is still relevant to address it here. Incident command issues impact the efficiency and ability of staffers to do their job. Dispatch for the Oxford Township falls under the auspices of the OCSO. Any dispatch protocol that does not align with an agency expectation should be readily apparent in planning for a critical incident response by leadership. Within the context of unified incident command, this is an opportunity to identify and highlight the dispatch-protocol gap and to address what appears to be an indifference to this problem. As evident from witness interviews, even now years after the shooting, this gap has not been addressed. Based on the interviews of agency commanders, there does not appear to be any shift in philosophy. Both OCSO and the fire departments interviewed expressed deep frustrations with each other.

Dispatch protocols must fully embrace the utilization of the incident command system. Dispatchers must also understand the critical importance of incident command and prompt on-scene units to establish command if no one has. The initial notification of this shooting incident was OCSO Dispatch notifying deputies through their radio and CAD. In discussions we had with OCSO command staff members, many were initially unaware of the incident. With the exception of units on the East Patrol dispatch channel, many OCSO command staff members were notified through informal sources (word-of-mouth, text messages, and phone calls) or overhearing radio traffic of the incident through a “scan” feature on the radio. Several on-duty ranking members who responded to this incident stated they did not become aware of the shooting until deputies were already on scene. In some cases, this notification came 20 minutes or more into the event.

c. Analysis of OCSO Resource Allocation on November 30, 2021

i. *Air Operations*

The OCSO utilized their aviation unit to support the incident operations effectively. The OCSO operates two 2001 Eurocopter AS350 helicopters.[138] The OCSO air unit (Air-1) arrived at the school at 14:14:00. As Air-1 arrived, they immediately began tracking two students running from the school attempting to distinguish if they were suspects or students fleeing. The aircraft tracked them for about three minutes as they fled the school. Air-1 was able to respond to several calls about a large crowd of evacuees in a nearby location and Air-1 provided overwatch of that group. Law enforcement air support can become a significant command and control asset along with efficiently providing updates about movement on the ground in the area of the incident.

Air assets at the scene also can quickly provide perimeter and containment support to ground units as well as clear overhead positions. Air support can identify or narrate ground unit activity such as entry points, access locations, and guide support to prioritized areas. Air support can coordinate traffic control points as well as patient transport corridors for EMS. Whether an agency has this capability or can access it through mutual aid, an air asset is truly a force multiplier in these incidents.

ii. *Special Weapons and Tactics (SWAT) Operations*

The mitigation of an active shooter is the responsibility of every sworn member of a law enforcement agency**.** In OCSO, like most agencies, sworn members are trained and equipped to mitigate an active shooter event. An active shooter response is not typically mitigated by a SWAT team in the traditional sense. The deployment of SWAT teams in many circumstances occurs long after there is no longer an ongoing threat. The average length of an active shooter event is four minutes, with the vast majority over in less than 10 minutes.[139] The national generally accepted response time for a tactical team is 30-40 minutes.[140] Although not statistically analyzed due to numerous factors in team make-up and geographical responsibilities, this is a generally acceptable standard.

Once deployed, however, even after threat mitigation is concluded, SWAT members are a valuable asset. SWAT members tend to be selected for their aptitude and are highly trained. They are also typically equipped with the best equipment to which an agency has

[138] McNichol, P. (2022, September 18). One year after hard landing, sheriff's helicopter remains in shop. *The Oakland Press.* Retrieved from www.theoaklandpress.com.
[139] Martaindale, M.H. (2025). *A study of active shooter incidents, 2000-2023.* San Marcos, TX: Texas State University and the Federal Bureau of Investigation.
[140] Patterson, B. (2013, March 14). SWAT response time not a concern, officials say. *Dayton Daily News.* Retrieved from www.daytondailynews.com.

access. SWAT operators are often best suited for a multitude of post-event assignments. To begin, the process of organizing the chaotic conditions that occur during active shooter events can be addressed by SWAT members. They can work independently with little supervision to communicate and stabilize the scene. Team members have situational awareness and can provide incident updates efficiently for command as they move through the incident location.

Team members are trained to clear areas in a systematic way, establish casualty collection points, and may have imbedded EMS capabilities within their operations. They have advanced breaching training and the related equipment to perform that task if necessary. Tactical teams also work closely with EOD operations and can support these mitigation operations. In most cases, the tactical team will arrive long after threat mitigation; however, their skill set is still a vital component to support the overall scene operations.

iii. *Exercise of Explosive Ordinance Disposal (EOD) Mitigation*

OCSO employed EOD mitigation techniques to ensure that explosives or other dangerous materials were not present. A BATFE[141] K-9 escorted by an OCSO deputy entered the bathroom and the K-9 alerted it to the backpack. This could indicate the presence of some type of explosive component or chemical. MSP and FBI remotely x-rayed the backpack (40 pulse x-ray) indicating wires and electronics. A robot was sent in to manually separate the contents from the bag and multiple remote attempts were made. After considerable movement of the bag with no additional threat revealed, the bag was hand entered by an EOD technician. No explosive components or dangerous items were located. After the bag was deemed safe, the search of the school by additional EOD K-9 units was conducted with the use of multiple agencies EOD K-9s.[142]

This was a safety sweep of the school for any additional components or dangerous explosive components. The search was conducted by multiple teams throughout the school. Since students and staff evacuated the school there were multiple bags and other containers left unattended and could not be ruled out as suspicious. As an abundance of caution, EOD K-9s and other diagnostic tools were run past the bags to detect any potentially dangerous components.

[141] Bureau of Alcohol, Tobacco, Firearms, and Explosives (commonly known as the ATF).
[142] See OCSO officer statements from the criminal case file.

iv. *OCSO and OHS Decedent Notifications*

OCSO officials and school personnel went to each deceased victim to identify them. Family members were directed to the reunification center and awaited information on the status of their loved one. The practicality of positively identifying victims is a critical step in the investigation and making a false notification would be remarkably irresponsible. Identification was accomplished through school-issued identification, school system information, and/or personal knowledge of the victim.

Reviewers received feedback from the survivors about what was described as a disjointed decedent notification and follow-up response by OCSO. Understandably the delivery of such news is devastating and life altering. OCSO notified decedent family members then requested they go to the OCSO substation in Oxford. While at the substation they awaited further information from investigators and only received information they described as of little to no value.

OCSO commanders stated that they made the decision to relocate the parents from Meijer as they were demobilizing the reunification center. At that time, there were few parents left. The majority of the personnel there were school staff. OCSO also had a chaplain enroute to the Oxford substation to meet with the parents.

Investigators were in the mode of crime scene processing, interviewing, and conducting a multitude of tasks. Some of this was complicated because of the age of the suspect and requirements that charging occurs within 24 hours of arrest. This does not exempt the lack of information or engagement of the family members by OCSO but does highlight the gap in victim response. Agencies that utilize victim advocates can fill the void left by investigators who are diligently working to move the case forward. Advocates in this case would have had the opportunity to support surviving family members as to the process and advise them what to expect in the coming days and weeks. The advocates can also be their point of contact, alleviating some of that responsibility placed on detectives.

As Hana was pronounced deceased by paramedics, OFD AC Majestic took her coat and respectfully covered her. Covering the victim is a show of respect, indicates someone who is pronounced deceased, and aids to assist in mental health of responders. However, if available a medical sheet could be used in lieu of clothing items. Crime scene integrity is paramount to avoid compromising evidence or cross contamination.

An unacceptable practice that sometimes occurs in mass fatality events is intentionally disassociating victim identifiers from human remains, such as purses and wallets,

personal effects, and jewelry.[143] That did not happen at this event. Responders were careful to ensure that nothing was moved from the victim prior to crime scene investigation, especially wallets, purses, and identification cards. If an identification card is found, best practice is to leave it face up by/on the victim so it can be easily read. This practice occurred at this event

v. *OCSO Crime Scene Investigation and Evidence Collection*

OCSO is a full-service law enforcement agency with a crime scene unit and lab capabilities. The decision by the lead investigative commander to maintain control and process all evidence at the scene was an agency decision for prioritizing evidence and processing in conjunctions with prosecutorial priorities. Federal agencies can be remarkably helpful in these incidents, especially to agencies that do not have these capabilities. In this case, it was reasonable for OCSO to conduct the crime scene investigation using their own resources. The firearm information was traced by the BATFE which identified quickly the purchase source, and the firearm analysis was conducted by the OCSO lab. Federal agencies in a supportive role can and do provide support in many ways. However, if an agency maintains control of the evidence, then they can provide results to investigators and prosecutors without any competitive delay.

The FBI Evidence Response Team Unit (FBI-ERTU) is available to assist local and state law enforcement agencies, even if the event does not fall under federal jurisdiction. ERTU has assisted many agencies with crime scene processing at active assailant events. If an agency wants to maintain possession of the evidence, ERTU can still assist with crime scene processing (assuming the event does not fall with the jurisdiction of the FBI.)

There are options for support by federal agencies from advisory roles all the way through complete support. An agency should evaluate their capabilities thoroughly to include capacity in making the decision to retain or request crime scene support. It is important for law enforcement officials to reach out to their federal partners before an event to determine what resources could be available.

At this incident, OCSO has advanced capabilities from collection to evidence processing and lab analysis. Commanders should always consider the agency's capabilities carefully before requesting or turning away any assistance. In some cases, the agency may be capable but because of the size or multiple scenes it may overwhelm resources.

[143] Organization of Scientific Areas Committees for Forensic Science. (2019). *Mass fatality scene processing: Best practice recommendations for the medicolegal authority*. Washington, D.C.: National Institute of Standards and Technology.

Also, consider the time to process and what is reasonable to expect your agency to be able to accomplish. Considerations should include if the crime scene occurred at a critical infrastructure site like an airport, hospital, or other critical infrastructure. Other considerations can be environmental conditions that dilute evidence integrity. This can be a strain on resources and necessitate soliciting external assistance.

OCSO had the school and suspect's residence to process, and they had the advantage of time for the residence. This could however be a challenge. At the Aurora theater shooting, the suspect's residence was located in a multi-unit apartment complex. Five buildings were evacuated as the bomb squad mitigated the multiple explosives devices in his apartment.[144,145]

Additionally, it is highly recommended to utilize other law enforcement partners to provide another set of trained eyes to view and possibly review the scene for missed evidence. This incident was mostly captured on video and was recreated to locate evidence. Video may not always track the scene and can be cumbersome. Additionally, the video system in the school was motion-activated. There were multiple camera angles near the shooting that did not activate because the cameras did not detect motion. This could make it very difficult to attempt to locate ballistic tracks.

vi. *Familiarity with Door Barricades and Breaching*

Door barrier systems can be an asset to provide area denial to the suspect during an active shooter event. However, problems may arise. According to OCSO interview statements, one of the students stated, "They were too scared, and no one put on the Nightlock. Someone shut and barricaded the doors and turned off the lights." For those classrooms that did use the Nightlock, deputies had difficulty using the provided tool to disengage the system due to tight tolerances on doors and carpeting.

In the same way these systems deny access to the suspect, they also deny access to law enforcement or medical personnel. For these systems to be truly effective, the responding emergency service agencies need to be fully trained and aware of the systems and be able to access any removal tools or keys to defeat the system. In this case it was a delay for law enforcement in evacuating students and staff. There was a slight delay in accessing teacher Molly Darnell who initiated the door lock and Nightlock. When law enforcement came to her door, she refused to open it. When AP Nuss came to the door

[144] Tan, A. (2015, September 9). Bomb squad robot enters Aurora theater shooter's booby-trapped apartment in newly released videos. *ABC News.* Retrieved from www.abcnews.com.
[145] Tri-Data Corporation. (2014). *Aurora Century 16 Theater shooting: After-action report for the City of Aurora.* Arlington, VA: Same.

and told Molly Darnell to disengage the Nightlock, she refused, stating that she did not trust anyone. OCSO deputies used the Nightlock tool to access her.

As seen at the 2018 Capital Gazette mass shooting in Annapolis, Maryland, the perpetrator deployed the building's active shooter barricade device to prevent people from fleeing and to stop law enforcement from entering. Law enforcement must be able to efficiently defeat these barriers if needed.

vii. *OCSO and Victim Services*

In this review one overarching theme by the victims and survivors was perceived lack of response and resources offered at the incident and immediately following. Admittedly during interviews, the OCSO stated they did not have a victim-centered approach. They prioritized resources to the arrest and prosecution of the offender. Offender accountability should not be minimized. However, there are several models of victim-centered response that are proven and would allow both to be prioritized.

Victim advocates and victim service models are becoming more prevalent in law enforcement agencies. More specific models have trained civilians to provide support and personal contact to victims or survivors as investigators focus on preparing the case. Cases such as homicide, sexual assault, domestic violence, traffic fatalities, and juvenile crimes all benefit with a trained advocate to advise and guide victims and survivors through the criminal justice process. The International Association of Chiefs of Police law enforcement-based victim services model highlights many of the advantages as well as ways to start programs embedded into a law enforcement agency.[146]

It must be noted that OCSO recognized this deficiency at the Oxford shooting and subsequently created Disaster Assistance Response Team (DART). The team has mental health training and victim service training. They respond to mass casualty events and become the official liaison between OCSO and the family.

d. Analysis of OCSO Internal AAR and Publication of March 14, 2025.

During this after-action review, OCSO submitted an opinion editorial article (op-ed) published on March 14, 2025, in the Detroit Times.[147] This op-ed contained information about the actions of OCSO Dispatch on November 30, 2021. It appears that this op-ed also unnecessarily spars with fire department leaders.

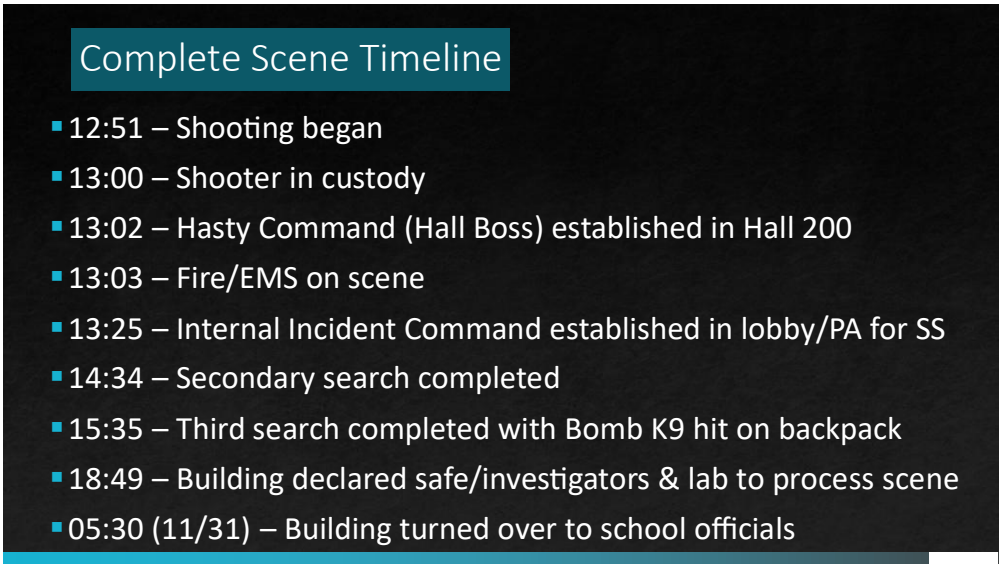
[146] International Association of Chiefs of Police. (2023). *Key considerations: Law enforcement-based victim services*. Alexandia, VA: Same

[147] Staff. (2025, March 14). Letter: OCSO's performance during Oxford shooting saved lives. *The Detroit News.* Retrieved from www.detroitnews.com.

The op-ed suggested that OCSO's actions on November 30, 2021, occurred without error or delay, and stated that OCSO's own partial after action analysis, "showed that the fundamental priority touch points that correspond with national best practices were achieved."[148] This kind of publication does not instill confidence in the community that there is a recognition of accountability for OCSO, nor does it suggest a move towards better working relationships with other public safety leaders. Several county officials relayed concerns to Guidepost regarding the article, namely that its tenor creates challenges to interagency collaboration.

The second issue concerns OCSO's internal AAR. As part of our after-action review, we were provided with a copy of OCSO's internal presentation and received a detailed briefing on the event from OCSO leadership. Our review of these slides finds that they do not acknowledge error[149] or areas for improvement. As discussed, we identified errors, delays, and imperfections in the OCSO response. There is no such thing as a flawless performance or response to an incident such as this.

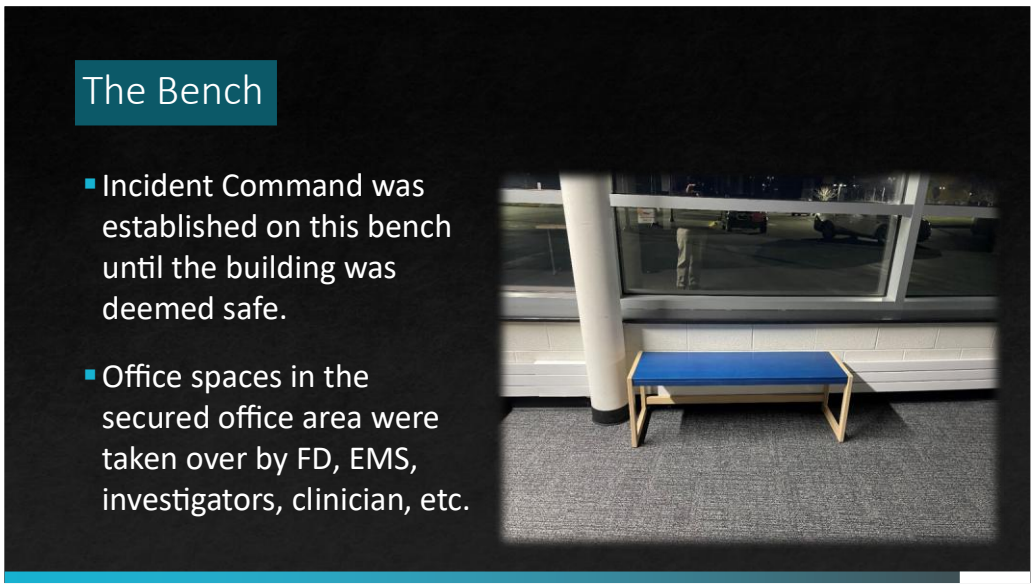
Timeline Slide:



The OCSO AAR provides what is detailed as a "Complete Scene Timeline" and states "Hasty Command (Hall Boss)" at 13:02, following the suspect in custody at 13:00.

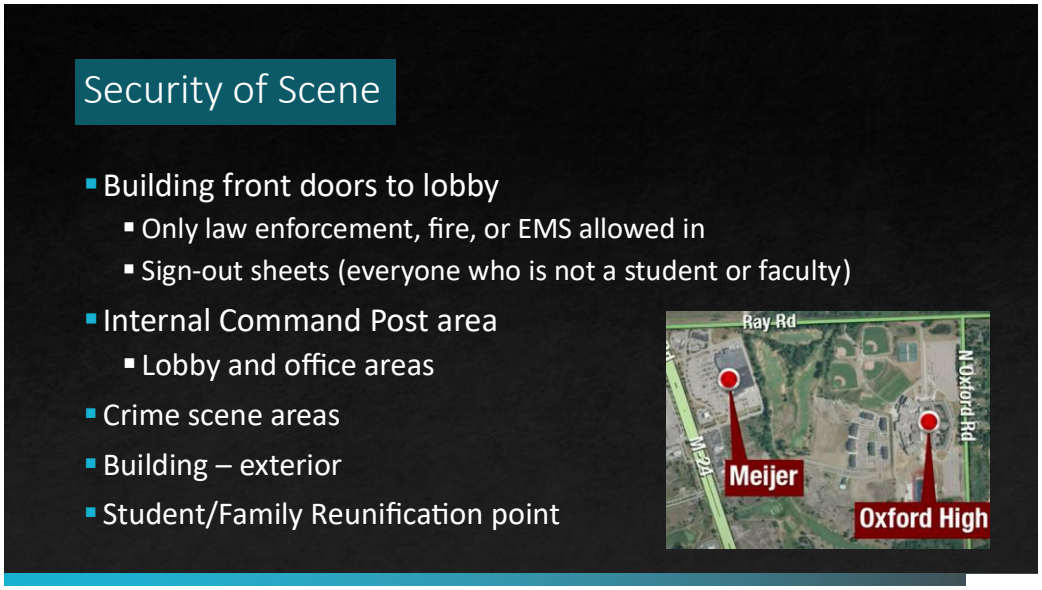
[148] Ibid.
[149] Guidepost was not present during OCSO's internal AAR presentation, so we are unable to account for what Lieutenant Hill stated to the deputies outside of what is written in the slide deck.

The Bench Slide:



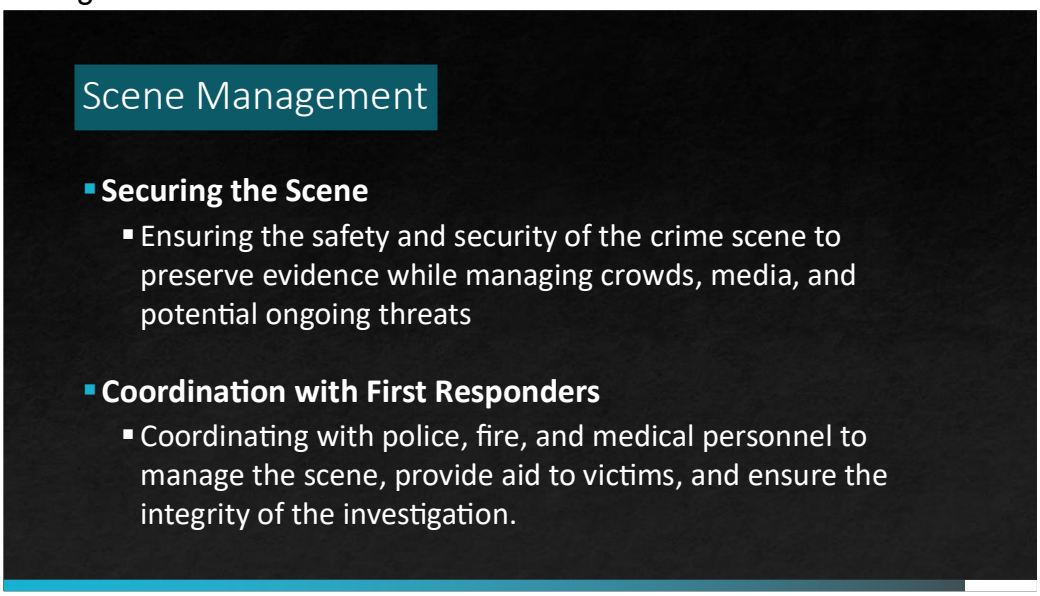
While there was a slide demonstrating the bench that Lieutenant Hill stood on, again this was significantly later into the incident that command was established.

Security of the Scene Slide:



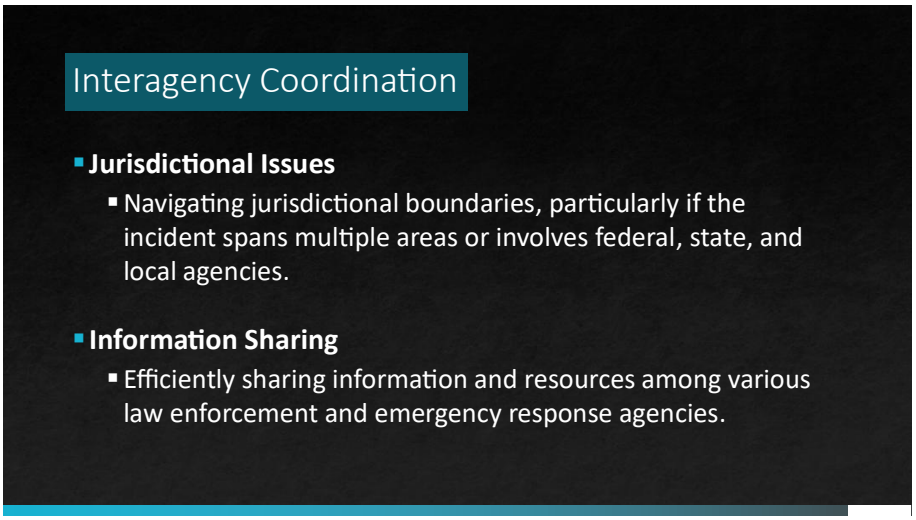
OCSO states that they established security of the scene, however as discussed, we are aware that the perimeter was breached prior to Lieutenant Hill's arrival by a parent of a locked-down student. This was due to the absence of command. That is not acknowledged in this slide.

Scene Management Slide:



In a section on investigative takeaways, there is a slide on scene management. This slide notes securing the scene and coordination with first responders. However, it does not actually acknowledge that this "coordination" did not occur in any meaningful way, or that when fire sought unified command, they were rejected.

Interagency Coordination Slide:

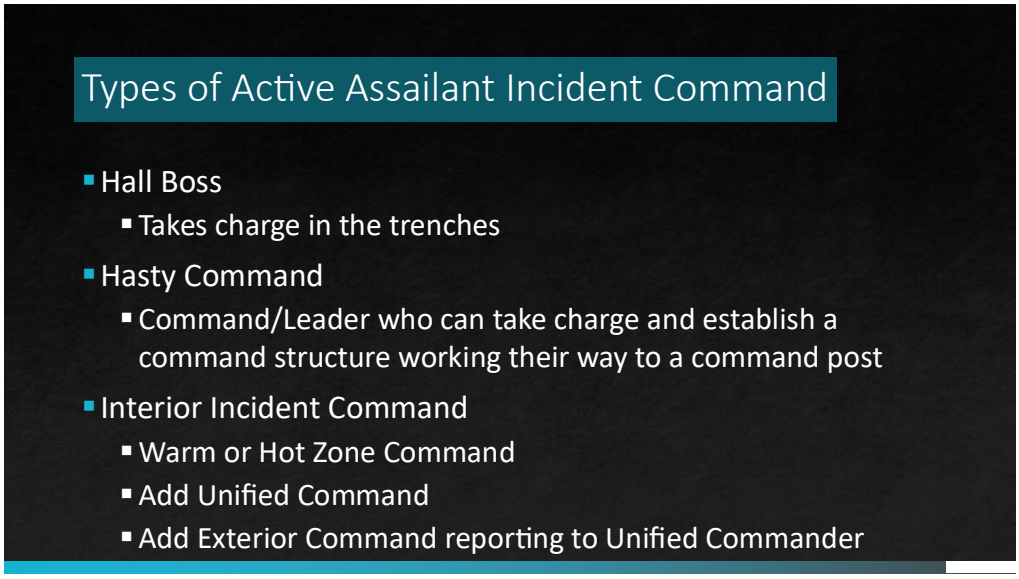


There is also a slide regarding interagency coordination, but it does not appear to acknowledge any communication failures.

In the final section on Key Active Assailant Takeaways, there are several slides that suggest the right approach to these events. While the content of the slides is conceptually

correct, our analysis supports the proposition that they were not actually effectuated on November 30, 2021.

Incident command slide:

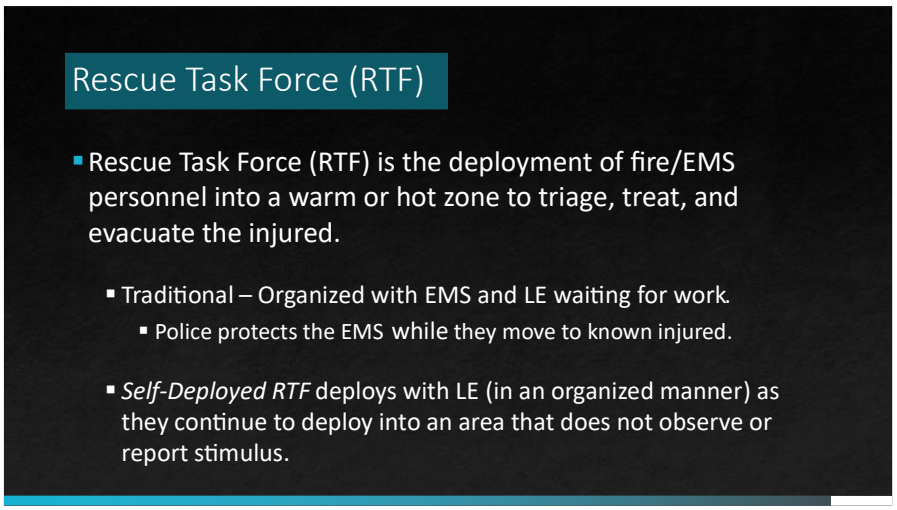


OCSO incident command was delayed and disjointed on November 30, 2021.

Fire Department Protocols slide:

There is still no uniform response to the question presented on this slide between fire services and law enforcement. A number of OCSO command staff still recommend that fire departments be dispatched solely when injuries are reported. This indicates that a lack of alignment with fire/EMS remains an ongoing issue.

RTF slide:



This slide does not accurately portray the measures taken during the incident. OCSO utilized a form of "spontaneous" RTF, but not the traditional "RTF" measures which they were trained to use.

The purpose of an after-action review is to highlight not only agency strengths or opportunities for growth, but to acknowledge what was not perfect. That did not happen within the OCSO internal review. We are hopeful that this independent review provides constructive criticism, paired with encouragement for feasible improvements. The recommendations at the conclusion of this report represent the necessary course of action which we recommend that OCSO implement to improve their incident command practices.

e. Analysis of Fire/EMS Response on November 30, 2021

When fire personnel and EMS units arrived at OHS, the scene was complete chaos. They dealt with a number of challenges, including gaining access to the school. There was significant traffic congestion and gridlock around the OHS perimeter and parking lot. Students who escaped were trying to go home, and parents quickly descended upon OHS to pick up their children.

OCSO's lack of unified command and direction left firefighters and paramedics struggling to assess if the scene was indeed "safe." As several gunshot victims fled on foot and in cars, firefighters and EMS received reports of gun fire within a two-mile radius of the school. For the first 30 minutes, most fire and EMS personnel were unaware that the shooter was already in custody. Moreover, confusion by OCSO personnel, fire, and EMS

whether the shooter was mobile and fled the scene or was actively engaged in continued attacks created additional complication for fire and EMS entry to OHS.

i. *Fire Department Command Deficiencies*

In best practices, we addressed the importance of the "Three C's" of unified command, comprising essential elements of co-location, communication, and coordination. These principles extend to fire department command as well as OCSO.

The initial response by the OFD consisted of the fire chief, the assistant chief, an engine company with a duty captain, two ambulances, an EMS coordinator, and the recruitment coordinator. As we noted earlier in this report, upon arrival at Meijer, Chief Scholz stayed at the grocery store and directed traffic for approximately an hour. Chief Scholz finally entered the lobby of the school at 14:00 and then went and spoke with Lieutenant Hill. OHS surveillance shows that he did not talk on the radio or perform a command role. He was seen talking on his cell phone for approximately 20 minutes; however, we are unable to determine with whom he was conversing.

Fire command was established by OFD AC Majestic at 13:06:32, one minute after arriving at the school from staging at Meijer. He affirmed that the staging area for arriving mutual aid units was at Meijer. However, OFD AC Majestic's radio transmission was partially blocked when OFD Captain 1 also attempted to transmit. A review of the radio traffic shows that at the same time OFD AC Majestic attempted to establish command, OFD Captain 1 keyed up and was talking on the radio. The dual transmission resulted in a garbled message. Muddled communications likely contributed to why OFD Captain 1 and several OFD personnel were unaware that OFD AC Majestic had established command. This was exacerbated by OCSO Dispatch's failure to provide "talk back" feedback, to confirm and announce that command was established. Because of this, some personnel on scene missed OFD AC Majestic's transmission that he was establishing command.

From 13:09 to 13:12, both OFD AC Majestic and OFD Captain 1 each were referring to themselves as "Command" on the radio. It was problematic that OFD AC Majestic initially failed to announce his location on the radio. At 13:12:28, when OFD Captain 1 assumed command, he announced that he was located between Doors 6 and 7. As previously discussed "co-location" is key to establishing command at a scene. It is especially critical in events at large buildings as it allows responding units to know exactly where the incident commander is located. This also allows OCSO Dispatch to assist in coordinating the formation of unified command. Early in the incident, OFD Captain 1 provided frequent updates to responding units and OCSO Dispatch.

Once cleared into the scene, communication became more difficult. Universally, every responder used the same word to describe the event: “chaotic.” Communication is always the second casualty at an active shooter event.[150] It is critical to ensure strong communication to begin to control the chaos. Communication grew increasingly difficult when both OFD AC Majestic and OFD Captain 1 both assumed the role of incident commander. While having two incident commanders is arguably better than OCSO’s situation of having no commander for 25 minutes, better communication practices are needed to avoid mixed signals.

Another issue in command practices regards the MABAS channel usage. OFD Captain 1 requested a MABAS radio channel assignment approximately six minutes after OFD units entered the school. Although the CAD notes state that MABAS channels were created at 13:45:39, every OFD member interviewed believed this happened earlier, somewhere between 13:12 and 13:15. OFD Captain 1 had five MABAS talk group radio channels assigned to the event. He assigned one channel for operations, one for command, one for staging, one for triage, and one for landing zone operations. This takes the incident off the fire department’s primary dispatch channel and moves it to a bank with five bundled channels. This is a standard practice for OFD.

Moving critical operations has a quantifiable cost, namely that responders may not receive notification that operations have moved or changed. In addition, personnel engaged in critical operations may not have the time or ability to move channels. Several OFD personnel stated that this was a longstanding issue with house fires. Firefighters start on the primary dispatch channel. After arriving, the incident commander switches to a MABAS channel. Firefighters expressed frustration that this has occurred while they are engaged in firefighting or victim rescue operations. Moreover, it is a national standard practice not to switch radio channels during critical events. Switching channels can result in inadvertently “orphaning” units. If channels are to be switched, it is non-critical and non-stressed personnel that switch to other channels.[151,152] In the aftermath of the OHS shooting, personnel inside the school missed that the channel switch. Thus, personnel repeatedly called command on the wrong channel and received no response. Again, this was only exacerbated by OCSO Dispatch failing to assist as a safeguard against this. Dispatch should have picked up quickly that a unit was trying to call command on the wrong channel and directed the unit to the correct channel or have command switch to their channel.

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[150] Wood, M. (2019, June 17). Ten lessons from the Fairchild AFB shooting. *Police Magazine.* Retrieved from www.policeone.com.
[151] McCormack, J. (2009. Fireground radio channel: To switch or not to switch? *Fire Engineering.* Retrieved from www.fireengineering.com.
[152] Police Executive Research Forum. (2018). *Managing a critical incident.* Washington, D.C.: Same.

ii. *Fire Department Staging Deficiencies*

> *"As firefighters, we are willing to die in an empty burning building, but we stage at active shooter events. When we stage, we are not doing what is best for the patients." - Chief Paul Strelchuk, OTFD, MABAS 3201 President*

The concept of "staging" generates much debate. The term is not only interpreted and applied differently between fire and law enforcement agencies, but moreover even within each fire department there is no consensus on how it should functionally perform. As discussed earlier, "Staging" can be used as an adjective and a verb; the classification of which can significantly influence how fire/EMS personnel receive their assignments, deploy to incidents, and coordinate with law enforcement counterparts. Our interviews with fire personnel and law enforcement throughout Oakland County detected clear differences in the understanding of staging and the philosophy behind it.

When executed correctly, staging (the adjective) organizes assets and improves efficiency on scene. Staging (the verb) can result in delays and confusion without planning, training, and an actionable game plan. This incident along with the long-standing practice of staging in Oakland County demonstrated widespread confusion. Simply accepting the belief that staging is appropriate at any scene with a potential threat of violence is both narrow and short-sighted.

> *"Policies are often written to maximize responder safety at the cost of the lives of many citizens. Many policies are poorly calibrated to the actual risk of the situation. These policies are created from a series of 'what if' deliberations instead of data from actual events. Assuming more risk will dramatically enhance the speed of operations and save lives."*[153]

A. The Staging Debate in Oakland County

Despite the existence of a national standard which encourages different perspectives on staging, as well as incorporating RTF practices, we found that most Oakland County agencies that responded to the shooting on November 30, 2021, lacked many of the policies required.

[153] Blair, J.P. & Martaindale, M.H. (2024). *The chain of survival: Responding to an active attack.* San Marcos, TX: Texas State University.

Our interviews with members of OCSO further illustrate that amongst high-ranking members of the department there are very diverse expectations of fire and EMS staging practices. There is no universal agreement amongst agencies or even within departments on fire and EMS staging at potentially violent calls. Sheriff Bouchard told the review group that any delay in dispatching the OFD was a moot point, as the fire department would have "staged." Several ranking members of OCSO believe that fire and EMS should stage on every violent call. Others believe that staging is often done unnecessarily. Lieutenant Hill informed us during his interview that he would support an RTF approach that does not utilize staging. In this case, the OFD staged at Meijer for four minutes and 30 seconds, which is supported by our review of radio traffic, CAD notes, firefighter interviews, and written EMS reports. It was only after OCSO Dispatch told OFD the scene was secure, that OFD proceeded to the school.

The first CAD notes available to responding fire and EMS units stated, "stage for active incident." The review team met with three fire chiefs and multiple firefighters. We asked if this was a recommendation or a directive. Everyone stated that they viewed it as a directive from OCSO. Each person interviewed stated that they believed OCSO dispatchers knew more about the call than they did and put those instructions in because they believed that fire or EMS would likely encounter harm if they went into the scene without law enforcement. Numerous fire personnel believed if OCSO Dispatch told them to stage, that this was considered "an order," which could only be overruled by a ranking officer within the department. At OFD, members believe the duty captain, assistant chief, or fire chief could overrule the directive. Additionally, several fire chiefs and firefighters were under the impression that if they were told to stage and did not, they would be personally liable if a firefighter was hurt or killed. OCSO Lieutenant 2 stated that the dispatchers are required to tell fire and EMS to stage any time the dispatcher assumes that there could be any threat of harm. In their dispatch protocols from IAED, it required the communicators to always ensure responder safety. When we inquired if the directions to stage were a directive or a recommendation, OCSO Lieutenant 2 viewed it as a "strongly advised recommendation." The review team believes that the CAD notes entered at 12:59:29 instructing the OFD to "stage for active incident" were based both on the IAED's internal policies and information from 9-1-1 callers indicating an ongoing attack.

OTFD Chief Strelchuk provided Guidepost with extensive information about staging practices that he witnessed throughout his nearly three-decade tenure with the department. He also shared his personal philosophy on staging and its implementation in the county. Chief Strelchuk opposes the widespread use of staging by fire and EMS personnel. His first concern was that staging was exercised too often for calls in which there was minimal or no threat of harm to responders. One example he provided was a

situation where two six-year-olds were fighting. He explained that the call would be coded as a domestic assault call, and responders would be directed to stage because “active violence” was occurring.[154] Chief Strelchuk’s also expressed concern about how staging was handled when there were actual violent incidents. He explained that firefighters, in his department and elsewhere, refuse entrance even when equipped with ballistic protection. He remarked that many firefighters are not willing to take necessary risks at scenes with potential violence to save lives and yet are willing to go full force into a burning building. This echoes the sentiments of Michigan Professional Fire Fighters Union President Sahr, who noted that fire departments default to staging on every potentially violent call, and do not assume acceptable risks to provide life-saving care.

An OFD captain informed us that their union defaulted to following the orders given, especially if it was the safest option for firefighters. Likewise, he stated that every piece of training for firefighters and medics is centered around responder safety first. The captain suggested that when all calls require staging —be it overdose, domestic disputes, or violent acts, it effectively becomes standard practice. Consequently, this cycle makes it nearly impossible for fire and EMS personnel to refrain from staging at active assailant incidents.

It is important to note that despite the Hartford Consensus and growing discussion on staging changes, it is still rare to find a fire or EMS agency in the United States that does not stage on potentially violent calls. However, examples do exist, such as the Charlotte Fire Department (CFD) in North Carolina, which is a no-stage department.[155] With more than 130,000 annual emergency calls, the firefighters routinely do not stage for violent calls, including shootings and stabbings, unless there is specific information that an act of homicidal violence is actively in progress. Even in cases of ongoing violence, it is at the discretion of the company officer if immediate entry can save lives. The Charlotte Fire Department also takes an aggressive posture on active assailant calls. The first arriving fire trucks form a ring around the building to provide cover and concealment for fleeing occupants. Trucks are used as shields for those fleeing the structure.

The CFD’s aggressive response model was tested at the 2019 University of North Carolina at Charlotte active shooter event and resulted in immediate care for numerous students who were shot as no fire apparatus staged for the event. The first arriving fire company provided care to a critically injured student less than 60 seconds after arrival.

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[154] Several members of this review team were teaching in another jurisdiction and witnessed this exact scenario occur. Both the responding fire truck and ambulance staged, waiting for law enforcement to ensure the two children stopped fighting before approaching the scene.

[155] Two members of the Guidepost review team were chief officers at the Charlotte Fire Department and fully acquainted with the staging philosophies and practices of the department and leadership staff.

The model was also tested at the 2024 U.S. Marshal's ambush in which eight officers were shot and four killed. First arriving CFD companies did not stage and immediately began downed officer rescues under heavy gunfire.

It is important to note that the CFD's aggressive model is not by happenstance or through a culture of unnecessary risk-taking. The practice is firmly grounded in data and statistics. CFD has spent more than 30 years departing from outdated staging practices and has experienced only a limited number of incidents involving targeted violence against fire department personnel. In nearly all cases, this happened with law enforcement on scene. CFD continues a no stage policy, based upon a belief that it has saved numerous lives when firefighters rapidly entered hostile scenes. The risk is well worth the documented reward. In cases where shared CAD notes instruct responders to "stage," the fire department company officers do not take this as a directive. Instead, they know they are fully authorized to decide how to respond based on all available information, including monitoring the law enforcement division radio channel. In most cases, the company officers will not stage. Conversely, Union leadership and other fire chiefs shared that in Oakland County, an aggressive safety culture in the fire service has resulted in a decreased level of risk tolerance, and fewer firefighters willing to take necessary risks to save lives. A culture of excessive caution has clearly emerged, which may pose a hinderance to effectively delivering public safety services. Firefighters are taught from the first days in the academy to take reduced risks. Failing to state, "the scene is safe" in EMT class is an automatic failure on state and national Registry examinations.[156]

Recent research suggests that fire departments in the United States have seen a general decline in the willingness of firefighters to take risks in part because of rising fatality rates and aggressive safety training.[157] Chief Strelchuk went so far as to point out that firefighters are willing to take unnecessary risks for unquantifiable results, while failing to take necessary risks at the essential time. He recounted a situation where a group of firefighters were willing to enter an abandoned building on fire with the roof collapsing yet chose to stage a block away on a domestic violence call. He could not conceive how firefighters in ballistics vests would stage and wait while a woman was assaulted by her spouse and yet enter a burning and collapsing building with no occupants. Retired Phoenix Fire Chief Alan Brunacini is renowned for saying firefighters must risk little to save property and risk a lot to save a life. This mantra has become a staple of the fire service.

[156] National Registry of EMTs. (2024). *NREMT skill sheets.* Columbus, OH: Same.
[157] Stehman, P. (2016) *Risk taking behaviors and attitudes in the U.S. Fire Service*. Washington, D.C.: United States Fire Administration.

B. OFD Policy on Staging

OFD's internal policy defines the parameters of staging as follows:[158]

> STAGING:
>
> The first arriving units shall respond directly to the incident scene and begin standard operations. As the incident escalates and the IC requests additional resources, the additional responding units need to be given assignments. The problem is that the IC may not immediately know what units to assign to which tasks. The answer to the problem is to establish a Staging area.
>
> A Staging Area is a resource or marshalling area where units and personnel report, while waiting for an assignment. They should be ready for immediate deployment; this includes wearing full turnout gear.

At this event, enroute, OFD Captain 1 announced to all companies that the "staging" location would be at Meijer, a local grocery store chain. He then instructed all responding apparatus to report to Meijer. OFD Captain 1's instructions followed the OFD Incident Command and Management System Policy.[159] This policy provides that a staging area is to be used by an incident commander if they have requested resources, but do not yet have an assignment.

This poses the issue of a wait and see situation for "scene safe." In active assailant events, it can take hours to declare a scene safe from obvious threats.[160] For example, at Columbine, five bomb squads operated for 72 hours to mitigate 99 explosive devices and 2,000 unattended packages (backpacks and bags).[161] The explosives included vehicle-borne devices, pipe bombs, "cricket bombs" (carbon dioxide cartridges filled with gunpowder and BBs), and two large 25-pound liquefied propane bombs.[162] If there is a potential explosive risk, this can extend it much longer.

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[158] Oxford Fire Department. (2016). *Incident command and management system: Policy #210*. Oxford, MI: Same.
[159] Ibid.
[160] Morrissey, J. (2011). EMS response to active-shooter incidents: How EMS can train to better respond to these inevitable unfortunate incidents. *EMS World, 40*(7): 42-48.
[161] Columbine Commission. (2001). *Report of Governor Bill Owens' Columbine Review Commission.* Washington, D.C.: United States Department of Justice.
[162] Ibid.

C. Analysis of Oakland County Staging Practices

"We have to realize as fire and EMS that quickly entering into an active shooter event is our job. I'm sorry, but we get paid to risk our lives. That's what you signed up to do."[163] *- Captain Mike Morganstern, Orange County (CA) Fire Authority*

There is no universal staging policy in Oakland County. The standard procedure throughout the county is to follow the instructions from OCSO Dispatch. At this event, OFD duty's captain, OFD Captain 1, upon arriving at Meijer at 13:00:53, instructed OFD units to stage at Meijer. Units remained in staging until 13:05:48 when OCSO dispatch told them that the scene was secure.[164] Had OFD not staged, based on the recommendations in the Hartford Consensus, they would have arrived at the school at 13:02. Beginning at 13:01:18, OCSO deputies were requesting OCSO dispatch to send in fire and EMS units as the scene was secure. OCSO deputies made seven more requests to OCSO dispatch for fire and EMS units before OCSO Dispatch told Oxford Fire the scene was secure and to proceed to the school.

The decision to stage in the Meijer parking lot resulted in a delay of medical care of four minutes and 30 seconds. However, OFD is not solely responsible for this delay. OFD Captain 1 was simply following department policy and protocol exactly as instructed, and as chain of command dictates. OCSO Dispatch had a delay of four minutes and 30 seconds to notify OFD that the scene was secure and safe. Combined, this created nine minutes of delayed care.

This is an interesting contrast to the staff at OHS on November 30, 2021. They were all taught to immediately lock down during an active shooter event. This is a fundamental principle of the ALICE training. However, the administrators did not lock down. Instead, Principal Wolf, AP Gibson-Marshall, and AP Nuss all went directly into the line of fire. Wolf and Nuss assisted multiple students to get into classrooms and lock down. Their actions directly saved multiple lives. AP Gibson-Marshall came face-to-face with the shooter. She identified him and confirmed on the radio what was happening. She provided CPR on

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[163] Hartley, E. (2013, July 17). In active shooter cases, Orange County medics go in sooner. *Orange County Register.* Retrieved from www.ocregister.com.

[164] It is important to note that OFD Alpha 1 ambulance was the only unit that did not stage nor go to Meijer. They cleared a nearby call and responded to OHS via North Oxford Road. This resulted in them encountering Elijah Mueller at 13:02:00 at North Oxford Road and State Street, with a gunshot wound to the face.

Tate, even as the attack continued. All three administrators could have locked themselves behind doors. This is obviously the safest thing to do but certainly would not provide the students with the best opportunity for survival.

If fire and EMS personnel were asked "what would you do if it was your family?", it is safe to suggest that universally, every firefighter or medic would respond into the event and not stage. In public safety, this is the nature of the job. There is an understanding that it carries greater risks than the occupations of the general public. One OFD Captain relayed in his interview that he made the choice not to stage for this event.[165] He stated that his child was in OHS on the day of the shooting. Through additional interviews, we also learned that several other OFD responders had children enrolled at the school. Although he received a dispatch to stage at Meijer, instead this OFD captain drove the fire truck up North Oxford Road to the school instead.

The public fully expects that all public safety personnel will take risks to save lives. Beyond this, there is an expectation that public safety personnel will take exceptional risks to save the lives of children. Staging for four and a half minutes at a grocery store while children are potentially dying is not an appropriate course of action. Although we do not believe that the considerable delay in this instance would have altered the tragic loss of life, it is conceivable that under different circumstances it may. As Peter Cox, Watch Commander, London Fire Brigade Special Operations Group stated, *"we cannot stage at active violence events. We have far too great a reputational risk to not be seen doing something."*[166] While we are not advocating that optics should be the main driving factor, it is certainly understandable that public confidence can be shaken when its public safety personnel does not demonstrate a willingness to serve the interests of the people of Oakland County. If the County follows the fire service axiom, "Risk a lot to save a life. Risk a little to save property. Risk nothing to save nothing," it will afford significant progress in facilitating a staging hierarchy based on the priority of the situation.

It is critical to have an effective plan in place to allocate resources without depleting the EMS capability for a county with a population of 1.3 million. Eleven minutes after OFD arrived on scene, at 13:17:16, OTFD Chief Strelchuk requested OCSO Dispatch to provide every available ambulance to the school. These requests resulted in a massive response of 50 ambulances, nine medevac helicopters, and numerous mass casualty trailers. In addition, almost every medevac helicopter in the state was launched for this event, including the United States Coast Guard. Every available EMS resource in Oakland County and Lapeer County was sent. This included numerous fire departments

[165] Guidepost interview of OFD Captain Interview, March 19, 2025.
[166] Cox, P. (2015, March 18). London Fire Brigade's response to marauding attackers. Charlotte, NC. Proceedings from the InterAgency Board Active Shooter Summit.

and private EMS providers. Although well-intentioned, the overwhelming deployment of resources caused road congestion, making it nearly impossible for ambulances to transport critically injured students to trauma centers.

Waterford Regional Fire Department took an alternative approach, which proved to be significantly helpful. The department sent firefighters/paramedics to McLaren Oakland Hospital instead of OHS, to assist with off-loading patients and to help emergency department staff. The crew was able to supplement the hospital and help to provide "decompression services." Decompression occurs when an overwhelming number of patients arrive, and ambulances are needed to transport patients to other hospitals.

While OFD Captain 1 implemented standard incident command control by establishing two divisions, a staging officer and a triage officer, he did not create the position of transportation officer. Most EMS literature opines that the most important priority in this role is to ensure that there is an equal distribution of patients to hospitals. However, that is not true. The most important priority in this role is to immediately work with law enforcement to create effective transportation corridors to hospitals. In this role, both the transportation coordinator and law enforcement determine the fastest and safest route for ambulances to take to trauma centers. The law enforcement officer can work to ensure major routes are secured by other law enforcement officers, allowing ambulances rapid and unimpeded transport to appropriate hospitals.

iii. *Other Fire and EMS Considerations*

A. Hospital Notification

At 13:08:07, at OFD AC Majestic's request, OCSO Dispatch notified all Oakland County hospitals that there was a mass casualty incident occurring. This notification occurred from OCSO Dispatch to area hospitals via radio. The hospitals remained in mass casualty status for approximately two hours. Coordination with the hospitals was managed by Oakland County Medical Control Authority (OCMCA).

There are nine hospitals in Oakland County, with the majority affiliated with Ascension Health, Beaumont Health, or McLaren Health. Victims either self-transported or were transported by EMS to four hospitals in two counties. The hospitals included McLaren Lapeer Region Hospital (a Level III trauma hospital at the time of the incident, now a Level II trauma center), Crittenton Hospital (a Level IV trauma center), McLaren Oakland Hospital (a level I trauma center), and St. Joseph Mercy Oakland Hospital (a level II trauma center).

A two-page questionnaire was sent to the OCMCA to distribute to all four hospitals. St. Joseph's hospital and Trinity Health Oakland responded to the request. The other two hospitals were unable to answer the questionnaire, as they had no staff who could provide the answers. Dr. Alicia Kieninger (Dr. Kieninger), the trauma medical director at Trinity Health Oakland, has presented at conferences about the hospital's response.

St. Joseph Hospital is a Level II trauma center with 497 licensed beds, 11 inpatient operating rooms, 38 critical care beds and a 61-patient emergency department (ED) capacity. There are two trauma resuscitation bays in the ED. There are three trauma centers located within 20 miles of each other. On November 30, 2021, the hospital was in an active COVID-19 surge period. There were 45 patients in the emergency department and seven patients in the ED waiting for inpatient beds (which was actually a low number for the hospital). The hospital was at 81% capacity.

At 13:09, hospital administrators received a text message that there was an active shooter at OHS and the hospital should expect multiple victims. Hospital administrators immediately ensured the ED was notified and prepared, contacted surgical residents, called the operating rooms and requested holds on the rooms, and checked availability of critical staff. The blood bank was contacted and advised to prepare for multiple patients. Anesthesia and radiology were also informed, and they prepared to treat multiple patients.

At 13:10, the ED was locked down. Security was bolstered at the ED and preparations were made for a response by the media. The hospital also created a family reunification and support area at the ED. The hospital also established their internal incident command. The ED initiated plans to decompress the unit and immediately free up beds. Trauma treatment teams were identified and placed on standby in the ED awaiting the arrival of patients. The hospital initiated their disaster registration and patient tracking system. At 13:15, the hospital's security director received notification from law enforcement officers at the hospital to expect at least 20 patients. The hospital administration notified other units within the hospital to ensure they were prepared to respond. The hospital also began to identify alternate care pathways for patients in the hospital to free up bed space. At 13:28, a message was sent to all hospital staff updating them regarding the situation. The hospital incident command team communicated with OCMCA and advised they could have eight critical patients. The ED was also provided with additional cell phones in case radios failed.

At 13:40, Kylie Ossege arrived via OFD Alpha 2 to the ED. Kylie had a gunshot wound to the chest. Kylie was immediately placed in a resuscitation bay and met by the hospital's trauma team and surgical team. Staff stabilized Kylie, after which she was sent to imaging, and then to surgery. Kylie was quickly processed through the resuscitation bay because

of the criticality of her injuries and to keep the bays open for more patients. At 14:02, the hospital incident command was notified that the Oakland County EOC was activated and operational. At 14:03, hospital incident command was told that no more patients would be coming to St. Joseph. The hospital demobilized their mass casualty response at 15:03.

Dr. Kieninger identified several areas for improvement for future events. Communication, both internal and external, was one of the biggest areas. Externally the hospital did not receive timely information about the mass casualty event or an accurate number of potential patients from public safety agencies. This made it incredibly difficult for the administrators to determine trauma activations. Hospital administrators also noted issues with multiple regional response systems trying to provide information about the event. In addition, staff were using informal ties with the community to try and gain information. Many staff members had family in the Oxford community and students at OHS. This led to chaotic communication throughout the hospital. Misinformation was abundant, making it exceptionally difficult to try and plan for the arrival of patients. Dr. Kieninger also identified internal communication challenges, such as all surgeon notification, labor pool staging for physicians, nurses, and ancillary staff, and radio issues. These communication challenges also made it difficult for hospital administrators to effectively ensure resources were prepared for numerous patients.

The lack of clear and updated information from public safety agencies negatively affected all hospitals in Oakland County and Lapeer County as they were all notified of a mass casualty incident occurring in Oxford. The OFD Captain/EMS coordinator received multiple phone calls from hospitals requesting updates when he was inside the school, however he was unaware if he was permitted to provide information. We were advised that Chief Scholz had previously informed members of the department that only himself and OFD AC Majestic were allowed to give information to outside agencies. Because of this, the OFD Captain/EMS coordinator informed the hospitals that he was not authorized to give them information. Ten hospitals went on mass casualty status. This means that elective surgeries were cancelled, surgical suites were cleared, trauma specialists were recalled to the hospitals, emergency departments cleared beds, and more. For a Level 1 trauma center, an average of 100 staff members are dedicated to a mass casualty activation. The hospitals in Oakland County and Lapeer County remained on mass casualty status for several hours until enough information came from the scene for the hospitals to return to normal activity.

B. Confirmation of Deaths

Pronouncement of death at mass casualty events is difficult for EMS providers. Although the physiological manifestations may make the decision easy, providers continue to express confusion and concern about declaring children dead. At the Sandy Hook shooting, the three paramedics who operated inside the building knew the children were deceased from catastrophic injuries. Tactical paramedic John Reed stated that they took the time to run a three-lead EKG on each child for fear that the parents would accuse the responders later that they did not do everything that they could.[167] Likewise, the primary paramedic at the Santa Fe High School shooting in Santa Fe, Texas, Bridgett Enloe, ran a three-lead EKG strip on each deceased child in case of future litigation.[168] At this event, the AFD paramedics encountered Tate in cardiac arrest in the back of OCSO deputy's patrol car. Both paramedics stated that Tate was obviously deceased with an entry and exit gunshot wound to the head. Despite the obvious mortal injuries, the paramedics took the time to run a four-lead EKG to confirm Tate's death. Similarly, fire department paramedics also reported that Madisyn was deceased with a clearly apparent mortal gunshot wound to the head. Despite this, she was rechecked at least four times by incoming responders, and one law enforcement officer started CPR on her after two others had already declared her dead.

Confirmation of traumatic death with a cardiac monitor is widely accepted practice. It is completely understandable that the paramedics defaulted to their standard practice. However, time is of the essence in the response. In mass casualty events, responders must have the degree of comfort to pronounce someone and quickly move on. Empirical evidence shows that without obvious indications that a victim is deceased, responders will recheck the deceased numerous times as they first encounter the victim.

One method to indicate passing is through body positioning, such as the "Fallen Angel." In this position, responders place a deceased person on their back with their hands crossed above their head and their legs crossed at the ankles. The quickest method is to use a hall boss or room boss who positions themselves near the deceased and directs responders to care for the living. Continuous rechecking can have deleterious effects as it often delays providing care to other living victims.

[167] Reviewer Dr. Michael Clumpner's conversation with John Reed.
[168] Reviewer Dr. Michael Clumpner's conversation with Bridgett Enloe.

f. Analysis of Interagency Command on November 30, 2021

An active shooter scenario will always have inherent chaos. If organizations, together, are unprepared to respond in an efficient manner, this chaos will not only linger but overwhelm the entire operation. Unified command at a strategic level brings a clear understanding by each participating agency as to each other's objectives and goals for an incident. The shooting at OHS is an example where the strategic alignment of agencies did not exist at a tactical level. Leadership on both sides left a significant gap which forced deputies, firefighters, and medical personnel to make ad hoc decisions to effectuate lifesaving operations as the event unfolded. OCSO was the lead law enforcement agency. As such, they had jurisdictional command of this event.

Despite the failure to create incident command until 25 minutes into the event, fundamental incident priorities were accomplished. Law enforcement entered quickly and stopped the threat. The search for additional threats occurred, and several deputies began providing immediate medical care for the victims. Fire and EMS personnel then entered the building to treat and extract the injured. While individual OCSO deputies, fire, and EMS members performed well, the response reflected severe gaps between agency leaders that have existed for years. While some integration between law enforcement and fire/EMS personnel occurred without direction from unified command, the coordination and information sharing were limited. Formal policies and procedures between law enforcement and fire/EMS agency leadership could have provided better coordination for the response. When leadership agrees how and where their agency members will operate, the risk of uncertainty of inter-agency operations is limited. Without active collaboration between agencies, it does not appear that improvement will occur.

Our first responder interviews, and review of internal agency documents, radio traffic, and CAD records confirm that fire and EMS response agencies were not included in any law enforcement command element until 90 minutes after units arrived on scene, and an hour after the last injured patient was removed from the school.

The International Association of Chiefs of Police active shooter model policy states, "Unified incident command should be established as soon as possible and located within the convergence of the inner and outer perimeters."[169] The inner perimeter is closest to the hot zone and is tightly secured to protect both responders and civilians. Meanwhile, the outer perimeter serves as a control point for traffic, media, and public access, creating a buffer that facilitates overall incident management. While OCSO's command post hub certainly fit the definition of a convergence of inner and outer perimeters, it was not a unified hub. OCSO and fire maintained two separate command posts for the entire

[169] International Association of Chiefs of Police. (2018). *Active shooter model policy.* Alexandria, VA: Same.

incident. For the first 90 minutes, the two command posts operated without communication with the others. OFD established fire command at 13:06:32. The fire department command post was located on the south side of OHS between Doors 6 and 7. Law enforcement established an incident command post in the front lobby of the school at 13:25:00.

Any attempt of unified command at 14:19:20 was the result of fire commanders seeking OCSO command in the front lobby. Ultimately, fire command was turned away and set up in a conference room within the administrative offices, physically apart from OCSO. It is important to note, however, that other than the attempt for unified command at 14:19:20, fire commanders made no attempts to integrate with law enforcement command until 90 minutes into the event. Both OFD Captain 1 and Chief Strelchuk had access to and were actively monitoring OCSO radio channels, including the OCSO East Patrol channel. Neither appeared to contact law enforcement command on that channel at any time. However, OFD Captain 1 informed us that OFD Chief Scholz instructed him and Chief Strelchuk there was no need for a unified command, and thus OCSO and fire command groups continued to operate independently until fire command was terminated that evening.

The confluence of OCSO incident command challenges, paired with fire/EMS staging issues and a lack of communication all contributed to the inability to effectively establish and execute unified incident command.

i. *Absence of Unified Interagency Incident Command*

A lack of incident command and coordination flowed across interdisciplinary responses. After staging for approximately five minutes at Meijer, OCSO Dispatch cleared OFD units to go to the school. OFD units then proceeded on Ray Road towards OHS. OFD Captain 1 recounted from his command post, the parking lot had no control. There were students, parents, and cars everywhere. The scene was not secure and there was no coordinated law enforcement effort to control the exterior.

Numerous OCSO deputies can be heard over radio transmissions frequently vocalizing frustration as to where fire/EMS responders were located, and why their requests for service were not answered. However, during the course of this event, as evidenced from responder interviews and radio traffic, there was no attempt by law enforcement command to coordinate the integration of fire or EMS to access and treat the victims. All communication was OCSO Dispatch driven. At 13:01:18, OCSO Dispatch told OFD units to enter the school at Door 5. Dispatch did not inform fire units that a suspect was in custody. Moreover, there is no record in the fire and EMS CAD logs that OCSO Dispatch

ever notified them that a subject was in custody. OFD Captain 1 and another OFD captain informed us that they did not know for the ***first 30 minutes*** that anyone was in custody.

> *"Early establishment of a multidisciplinary unified command is critical for synchronization and effectiveness of rescue operations at mass casualty attacks."*[170]

These facts were confirmed by a review of the radio logs where there was no radio communication to fire personnel regarding a suspect in custody. This created a situation, based upon staging practices to await instruction, that fire and EMS units inquired via radio if the scene was secure. The EMS report from the first arriving ambulance indicated that personnel did not know if the scene was secure and were waiting for OCSO to provide directions.

When fire/EMS were finally informed that OHS was secure, it was by word-of-mouth. They were directed to "clear" the Meijer staging and report to the school. Once fire/EMS were present and engaged, they spent an average of four minutes to assess, treat, and extract the injured, in their attempt to exercise expedient response paired with thorough care.

Despite the natural confusion that is always present in a critical incident, the purpose of training is that law enforcement can conduct multiple tasks simultaneously. All OCSO deputies received training on integrated fire and EMS tactics at hostile events. However, numerous fire personnel informed Guidepost that the integrated tactics they were taught were not applied at this event. Integrated tactics require unified command. Without unified command, a rescue task force approach is impossible to employ. Unified command necessitates the rapid inclusion of all emergency services disciplines. This includes law enforcement, fire departments, EMS, and emergency management. Unified command does not simply mean unification of law enforcement resources. Unified command is the coordination of multiple public safety disciplines. This lack of security and physical presence by law enforcement also slowed the response of fire and EMS personnel, as they did not know if a suspect was in custody and saw hundreds of people in the parking lots.

There were also instances where other agencies took on responsibilities for the OCSO. The fire departments took on some traffic responsibilities as a support role. This is typical and sometimes helpful. However, unified command success is dependent on the

[170] Holgersson, A. (2017). Review of on-scene management of mass-casualty attacks. *Journal of Human Security, 12*(1): 91-111.

relationships between agency leadership and known expectations for incidents such as this. Since 2002, ALERRT has taught the model: “Stop the killing, stop the dying” to provide rapid casualty evacuation as a best practice. ALERRT was recognized as the national standard in active shooter training by the FBI in 2013 and has provided training to more than 130,000 law enforcement officers from 9,000 law enforcement agencies in the United States.[171] This simple method is commonly referred to as “Contact, Treat, Extract.”[172] Under this method, law enforcement officers provide threat mitigation, treat the injured, and subsequently extract the injured. This model is also used in areas where it is quicker to formulate a law enforcement response than a fire or EMS response. Contact, Treat, Extract requires limited command and coordination. The downside to this approach, which was used during this incident, is that it can often be the least effective way to utilize law enforcement responders. It can lead to uncoordinated victim transport and minimal care, as fire and EMS providers have limited interaction with patients.

Prior to this event and at the time of this report, there was a lack of engagement between agencies at the executive leadership level. Interviews with the OCSO and multiple county fire departments showed distrust and a lack of collaboration between law enforcement and fire departments. Even in the media, the citizens of Oakland County have been exposed to public feuding between the OCSO and fire departments.[173] Fire chiefs from different departments gave examples of this lack of collaboration between agencies and perceived usurping of purpose by the OCSO. OTFD Chief Strelchuk retold an incident where OCSO responded to a boating accident with missing occupants on a lake. Chief Strelchuk stated that the OCSO attempted a search without notifying the fire department, who has water rescue resources. Chief Strelchuk stated the OCSO only notified the fire department 30 minutes into the event when a deputy questioned why the fire department was not on scene with their boats. Chief Strelchuk expressed frustration that the OCSO’s solution was to create their own water rescue team, instead of collaborating with the water rescue teams already established.

ii. *Absence of Interagency Training*

Our analysis indicates that OCSO does not appear to formally embrace the coordinated model of response. Although OCSO has conducted active assailant training and invited participants from county fire departments, there is no initiative at the department head level to ensure coordination. Likewise, several fire departments have not established written policies or procedures for active assailant response with OCSO. These procedural

[171] Blair, J. P., & Duron, A. (2023). How police officers are shot and killed during active shooter events: Implications for response and training. *The Police Journal: Theory, Practice and Principles*, *96*(3): 411-429.
[172] This is further addressed in the Training Section below.
[173] Chambers, J. (2024, August 15). Life-saving crews dispatched late to Oxford school shooting, fire chiefs say. *The Oakland Press.* Retrieved from www.theoaklandpress.com.

gaps have existed for years and still have not been addressed years following the OHS shooting. The confluence of both of these issues emphasizes the need for interagency training.

Tabletop exercises give agencies a structured environment to strengthen partnerships and evaluate their skills. These tabletop exercises also help to identify gaps in response models. Tabletops are critically important to teach incident command in classroom settings. Full scale exercises are critical to adequate stress plans and policies to determine functionality. In 2020, the Department of Justice published a report examining 20 published AARs from active assailant events. The research found that incident commanders' personal experience in active assailant training exercises directly correlated with their operational success.[174] Those commanders who never served in a command role in an active assailant tabletop or full-scale exercise had significant difficulty commanding an actual event.

There should also be unified executive and command level training for all agency members. Unified training creates opportunities in a monitored environment to build relationships and test the capacity of an agency. This also expands the understanding of all participants as to an agency's priorities and capabilities. Joint plans and policies need to be developed that formally support agency cooperation. These agreements extend beyond individuals and institutionalize agreements, putting them into practice. By agreeing to train and operate collectively, new leadership will continue to improve agency cooperation. Consistent training between agencies reinforces obligations and expectations and improves agencies' comfort when working together. Consistent training would also establish a standard for joint unified command and integrated operations. This training must be formalized and mandatory to be effective.

Unified incident command training should be mandatory for all public safety supervisors, including agency department heads. FEMA offers free incident command training online. Foundational courses include ICS 100: Introduction to the Incident Command System, ICS 200: Incident Command System for Initial Response, ICS 700: National Incident Management System, and ICS 800: National Response Framework. Regardless of rank, every public safety responder should have these certifications. Additionally, FEMA offers advanced incident command training. OCEM routinely offers these in-person courses free of charge for responders. ICS 300: Intermediate ICS for Expanding Incidents and ICS 400: Advanced ICS, should be mandatory for any public safety commander. These courses provide necessary information for personnel who would function in an area command, emergency operations center, or multiagency coordination center.

[174] United States Department of Justice. (2020). *How to conduct an after-action review.* Washington, D.C.: Office of Community Oriented Policing.

iii. *Absence of Sufficient Interagency Communication*

> *"Early coordination of incident activities is critical to mission success. Agency policy should establish provisions for the determination of who will assume the role of incident commander. The incident commander serves as the primary point of contact between public safety communication centers, responding officers, including those who compose the contact team(s), fire and EMS personnel, and other entities that may arrive on scene. The incident commander should establish communication with the contact officers or teams and begin to coordinate their activity and should work with the ranking fire/EMS command officer(s) to form the unified command."*[175]

A. OCSO and Fire/EMS Communication Deficiencies

The communication failures between OCSO and fire were significant and only serve to emphasize the detriment of delayed incident command establishment. Insufficient communication between OCSO and fire command hindered fire and EMS personnel from accurately determining both the number and locations of victims. The only "communication" of law enforcement initiatives to fire command was the passive scanning of the OCSO radio frequency by Chief Strelchuk and OFD Captain 1.

When information was relayed, it was done so informally and not to all responding units. The OFD fire marshal, upon entering OHS, recalled a chaotic scene with no command or coordination. The OFD captain/EMS coordinator stated that, upon entry, several OCSO deputies were yelling and cursing at OFD personnel for "taking so long to get into the school," but no one was in command to provide any direction. OFD Captain/EMS coordinator recollected that when he encountered OCSO Lieutenant 1 between Doors 6 and 7, the lieutenant told him in passing that more students shot were down the hallway, the suspect was in custody, and law enforcement was trying to assess if there was a second shooter. At no time did OCSO Dispatch inform fire command that a subject was in custody, and there was no incident commander to provide that information to fire personnel at that time. Meanwhile, at fire command, separately located, OFD Captain 1 was under the impression that the shooter had fled or was hiding in the school. Although they were aware of no active gunfire, they received no information from OCSO Dispatch or deputies on the status of the event for the first hour. Only after an hour, they "assumed" the shooter was in custody based on the relaxed posture of the deputies.

[175] International Association of Chiefs of Police. (2018). *Active shooter model policy.* Alexandria, VA: Same.

Another communication issue occurred around 13:44:52, when Chief Morawski, North Oxford Road Staging Officer, encountered many parents at the perimeter. Chief Morawski requested OCSO Dispatch to send deputies to assist. One minute later, Star EMS also requested law enforcement to help at the staging location with the large number of parents. After the second request, an OCSO deputy responded and requested OCSO Dispatch to send additional deputies to the fire department's location. This is inefficient. With a unified command model, these types of transitions could have been smoother. A Staging Officer would route requests through the incident commander using on-scene resources. In the absence of a unified command structure, the requests continuously bounced back and forth with OCSO Dispatch.

Another instance of communication gaps occurred when unified command between fire and law enforcement was sought by certain members of fire leadership. OFD Captain 1 saw Chief Scholz for the first time at 14:15. OFD Captain 1 informed us that OFD Chief Scholz instructed him there was no need for a unified command. OFD Captain 1 and Chief Strelchuk attempted to approach Lieutenant Hill, who further denied any need for fire/EMS at that time, as all victims were removed from the scene. While Lieutenant Hill was of the belief that fire command was unnecessary as all victims were removed, there were other opportunities for fire to provide benefit. OFD Captain 1 and Chief Strelchuk created a fire command post inside a conference room in the administrative offices where they worked with other fire department command staff to trace each hospital where victims were sent for treatment. This clearly proved to be a useful task.

Yet another instance of communication and coordination failure occurred around 15:35, when an EOD K-9 alerted to the suspect's backpack in Bathroom 2. Lieutenant Hill requested two bomb squads to respond. Both the FBI and Michigan State Police responded with their bomb squads. In addition, Lieutenant Hill was informed by OCSO CID that the shooter's social media showed pictures of him making Molotov cocktails and to be aware of the potential for improvised explosive devices or improvised incendiary devices. During our interviews with OFD command staff, Guidepost inquired if they considered requesting the hazardous materials team to respond to support the bomb squads. This was the first time that OFD personnel were aware of the backpack or that bomb squads worked on a package in the school. Fire command staff were also unaware of the potential for improvised incendiary devices in the school. It is alarming that three years after the event, the fire department still did not know there were potential explosive or incendiary devices in the school during the incident.

The standard in public safety is that an explosive device is the responsibility of law enforcement pre-detonation. Once a device detonates, the mitigation is the responsibility of the fire department. However, in this case, the lack of communication in the unified

command showed that critical information was not passing between agencies. Had the fire department received this information, they could have ensured a contingency plan was in place to mitigate an explosive device or fire. Instead, fire command released all mutual aid fire departments at 16:00 and released OFD Engine 1 and Squad 21 at 16:59. All fire suppression apparatus cleared the scene just as the FBI bomb squad was arriving and setting up operations. Fire was not made aware of the presence of a possible explosive device in the school, even after law enforcement command requested two bomb squads to respond for the shooter's backpack. Fire command demobilized and returned all fire assets in service just as the FBI's bomb squad was setting up operations to address the bag. Because of the lack of unified command and coordination, there was no fire suppression support on site as the FBI and Michigan State Police worked on the package.

Fire personnel also were not requested to assist with breaching barricaded classroom doors, despite multiple deputies stating they were having difficulty defeating the Nightlock barricade. We do not solely put the onus on OCSO to ensure that fire/EMS equities are met. Commanders with fire/EMS must proactively integrate with command and vocally advocate for their agency's priorities. This did not occur at this incident.

B. OCSO and OCEM Communication Deficiencies

Emergency management is a critical public safety function and needs to have representation at the command post. OCEM did not have any members on scene, as they were staffing the Emergency Operation Center (EOC). This role would have defaulted to OFD Chief Scholz, who was also the township emergency manager, who already indicated a lack of interest in unified command.

OCEM was not included in the incident command. Emergency management had virtually no equities met. OCSO commanders did not communicate with the EOC, no OCSO members were present during the first four hours, no emergency management assistance was requested at the reunification site, and the EOC received no on scene information to share with key stakeholders like county executives and the Oakland County Medical Control Authority.

g. Analysis of OCSO Emergency Communications and Operations

According to the FBI, there were 61 active shooter incidents in the United States in 2021. 9-1-1 centers play a critical role in active shooter responses, frequently serving as the first point of contact. Nevertheless, systematic evaluations of their effectiveness, challenges, and outcomes remain largely absent from traditional active shooter reviews.

During this review, we have heard blame directed at OCSO Dispatch as well as Oakland County's other first responders. Our intention is to provide an impartial and detailed assessment of how OCSO's 9-1-1 system functioned. The 9-1-1 and radio recordings of the communications which personnel staffed at OCSO Dispatch conducted on November 30, 2021, reveal professionalism and empathy. Our findings indicate, however, that there are systemic problems in OCSO Dispatch 9-1-1 practices, as they pertain to the structure, process, and limitations of the technology at the time. The ability of a 9-1-1 center to handle a high *volume* of calls at once and coordinate the response of multiple agencies does not rest on the center's staff alone. It is equally incumbent upon agencies, departments, jurisdictions, and leadership to engage collaboratively, challenge outdated systems, embrace interoperability, and streamline dispatch operations. 9-1-1 centers that dispatch multiple public safety agencies must create a clear pathway and continuously collaborate with these agencies to improve procedures and the delivery of resources. It is equally important that these agencies share a common communication channel to discuss priorities, a shared framework, challenges, future goals, and improvements. 9-1-1 centers must be prepared to handle the influx of callers and the flow of information *for* all and *to* all responding agencies in a manner that is a recipe for success.

We synthesized our data collection within the realm of national standards and widely held best practices. Our analysis begins from the time a caller dials 9-1-1 and ends ultimately with the dispatcher[176] relaying information to responders. Within that framework, we address a number of functional areas during the 9-1-1 process. Given the wealth of data collected, it is important to consider not only organizational structures and technological limitations, but also the "human element." This refers to the role of individual behavior, judgment, and communication during the incident. It involves more than procedural errors and can include how people make decisions under high risk and high stress situations. Misunderstanding, mishearing, fatigue, or substandard conduct are elements considered during the review. It's often the most complex part of incident review, requiring a thoughtful and balanced approach. All of these factors must be considered to draw reliable conclusions and offer practical solutions for better future initiatives.

Upon request, OCSO Dispatch provided all CAD notes, radio recordings, 9-1-1 call recordings, and 9-1-1 call transcripts, OCSO Communications Division training policies and curriculum, OCSO Communications Division policies, as well as protocols and procedures. The review team also conducted numerous interviews with those who responded to this incident, as well as with other industry experts experienced in the

[176] Terminology over the years has changed regarding center call takers. Currently, the term "9-1-1 Operator" is now a "negative" term in the industry. While there is no universal term shared yet, we are using "9-1-1 Call-taker" and "9-1-1 Dispatcher" to show the different positions within the center.

diverse and complex areas of 9-1-1 communications. We also received additional documentation from OFD, ATFD, and Lapeer Fire Departments.

i. *Critical Terminology in 9-1-1 Review*

Throughout our analysis we will refer to a number of terms commonly used within the 9-1-1 center activity. The following lexicon provides some basic definition of words and/or phrases that will appear frequently throughout our discussions concerning the efficacy of the systems in place.

- **Public Safety Answering Points (PSAP):** These are centers which serve as the first point of contact for citizens seeking emergency assistance of all kinds. The purpose of PSAPs is to answer and process emergency calls, convey information to emergency responders, and provide lifesaving instructions when necessary.
- **Call Capacity:** Call System Capacity refers to Oakland County's 9-1-1 call handling system. The center was modernized to operate on a "Next Generation" Emergency Services IP Network (ESInet). Oakland County PSAPs migrated to an ESInet provided by Peninsula Fiber Network in 2016-2017.[177] This upgrade enables interoperability with the surrounding 9-1-1 centers. The system also allows for 9-1-1 text messages to be received and sent. According to OCSO, the 9-1-1 call handling system can accept over 50 calls at once. Depending on the availability of call takers, some calls are answered immediately, others within seconds or minutes, and some are abandoned when the caller disconnects.
- **Call Rollover:** This term is sometimes alluded to as call overflow. When a call is automatically transferred from one 9-1-1 call center to another. This transfer may be due to several factors including:
    - *High call volume* – when the number of 9-1-1 calls coming into the center is greater than the ability of the center to answer them. This can occur due to the size of an incident or merely the number of witnesses attempting to call for help. If a 9-1-1 call is not answered within a certain period, the system may automatically send the call to another call center. The OCSO 9-1-1 Call Center does not utilize the "roll-over" function for calls that are received at their center. In the event of an incoming 9-1-1 call to Oakland County 9-1-1, and call-takers are not immediately available to answer, the call itself will stay in a queue until a call taker is available. However, the 17 neighboring (smaller) 9-1-1 centers have established rollover plans[178] with other nearby centers, including Oakland County 9-1-1, which serves as a receiving center.

[177] https://www.oakgov.com/government/information-technology/clemis/programs-services
[178] Rollover List 2025-02-26 14-54.pdf

- *Call routing errors* – These errors occur when a 9-1-1 caller is sent to the wrong 9-1-1 center. There are a number of common causes for routing errors including, cell tower location issues, tabular routing and/or Geographic Information System (GIS) data errors, or voice over internet protocol (VoIP) phone programming. If the cell phone connects to a tower near a jurisdictional boundary, this could misroute the 9-1-1 call. If boundaries have changed or GIS mapping layers are not updated, this could also misroute a 9-1-1 call. Lastly, if a VoIP phone system was not programmed correctly to route to the local 9-1-1 center, this could cause a misrouted 9-1-1 call.
- *System disruptions*– Redundancy is built into all 9-1-1 systems, however, at times, outages or other technological issues prevent 9-1-1 call centers from being able to answer calls. During these events, calls may be routed to a different 9-1-1 center, or an alternate phone number is provided to the community.
- *Abandoned calls* – These calls occur when a caller dials 9-1-1 but disconnects before speaking to a call-taker. These calls are also called 9-1-1 hang ups. In cases where a 9-1-1 call is disconnected or abandoned, 9-1-1 centers will often call or text the number to re-establish contact.

- **International Academies of Emergency Dispatch (IAED) and Priority Dispatch Protocols**: Oakland County 9-1-1 utilizes Priority Dispatch Protocols that are a national standard and provides a structured methodology for emergency call takers and dispatchers to follow during emergency calls. Call takers and dispatchers are trained and certified in all three protocols that are available: Emergency Police Dispatch (EPD), Emergency Medical Dispatch (EMD), and Emergency Fire Dispatch (EFD). The center utilizes software called ProQA, which facilitates the availability of protocols in electronic form for all fire and EMS types of calls. Oakland County has adopted some ProQA software protocols for law enforcement related incidents, but due to the fluid nature of these types of calls they do not use all of them consistently.
- **EMD/EFD/EPD Protocol Suspension**: The “emergency rule” allows call takers and dispatchers to temporarily suspend or discontinue the IAED Emergency Dispatch protocols in situations where the 9-1-1 system is overloaded or there are scene safety concerns. This allows the 9-1-1 center to answer as many incoming calls as quickly as possible. OCSO’s CTO manual addresses the Emergency Rule policy on page 111 in the EMD/EFD Systems Use Section. Their policy states: “When one is faced with an extraordinary emergency situation they are not held to the same standard of conduct as when not faced with such a situation.”
- **Vertical and Horizontal Dispatch Models:** Vertical and horizontal refer to the mode of transfer from call-taker to dispatcher.

- Vertical Model: Oakland County 9-1-1 operates with a "Vertical" dispatch model, which is common with larger, high-volume PSAPS. In this model, call taking and the dispatching of field units are handled by separate personnel, allowing each to focus on their specific responsibilities within the CAD workflow. When a 9-1-1 call is received, the call-taker enters all relevant incident information into CAD, including the type of emergency, location, and any caller-provided details. The CAD system is configured to automatically route the incident data to the appropriate dispatcher (fire or law enforcement) based on call type, jurisdiction, and dispatch protocols. This process occurs in real time, allowing dispatchers to view the incident, assign units, and initiate response while the call taker continues to update the CAD record with any new information. This "vertical" workflow provides for fire and law enforcement dispatchers to singularly focus on managing field units and radio traffic without the distraction of incoming phone calls.
- Horizontal Model: A "horizontal" dispatch model functions differently, where call-taking and dispatching responsibilities are shared by the same staff member, rather than two different roles. This is often seen in smaller dispatch centers.

- **Computer Aided Dispatch (CAD):** The Law Enforcement Information Technology Standards Council (LEITSC) identified the need for a national standard for CAD functional specifications. CAD systems allow public safety operations and communications to be augmented, assisted, or partially controlled by an automated system. Public safety agencies use CAD to facilitate incident response and communication in the field. CAD systems, in many cases, are the first point of entry for information coming into the law enforcement and fire/EMS system. Typical CAD system functions include resource management, location verification, dispatching, unit status management, and call disposition.[179] CAD system can also identify unit locations using automatic vehicle location data (AVL).

ii. *Public Safety Answering Points Centers in Michigan*

Within the state of Michigan, there are 134 PSAPs operating 24 hours a day, 7 days a week, 365 days a year. These centers serve as the first point of contact for citizens seeking emergency assistance of all kinds. The purpose of PSAPs is to answer and process emergency calls, convey information to emergency responders, and provide lifesaving instructions when necessary. Most calls are 9-1-1 voice calls but also include text to 9-1-1 communications. The 2024 Annual Report to the Michigan Legislature from the State 9-1-1 Committee provides data about Michigan's 9-1-1 systems for the 2023

[179] Bureau of Justice Assistance. (2003). *Standard functional specifications for law enforcement computer aided dispatch (CAD) systems.* Washington, D.C.: Same.

calendar year. In Michigan, PSAP centers handle approximately 5,187,067 wireless calls, 368,320 wireline calls, 487,378 VOIP calls, 29,533 inbound text messages, and 7,091,143 administrative-type calls annually. As of January 2024, all PSAPs were designed for text to 9-1-1 capabilities on a Next Generation 9-1-1 Network.[180]

Oakland County is home to over 1.2 million residents and is one of the most populous counties in Michigan. The Oakland County 9-1-1 center provides emergency and non-emergency call-taking and dispatching for Oakland County Sheriff's Office, nine local law enforcement agencies, and 16 local fire/EMS agencies. The Oakland County Sheriff's Department Communications Division is the largest of these PSAPs, answering approximately 1,600 calls per day. At the time of the incident, this center provided 9-1-1 and dispatch services to 10 law enforcement agencies, 12 OCSO substations, and 16 fire departments throughout Oakland County.

iii. *Oakland County Dispatch Center Technology & Protocols*

OCSO's 9-1-1 technology consists of ESInet (Peninsula Fiber Network + INdigital) as their next generation 9-1-1 (NG9-1-1) statewide network, Motorola Emergency Call Works (ECW) with automatic call distribution for their 9-1-1 call handling system, CLEMIS for CAD, and the fire departments utilize two tone signal notification for station, radio and pager alerting along with Active 9-1-1. At the time of the incident, Oakland County operated on an OpenSky radio system and has since moved to a P25 radio system integrated with the Michigan Public Safety Communications System.

OCSO Dispatch has adopted and follows the International Academies of Emergency Dispatch (IAED) protocols to guide its initial questioning when handling 9-1-1 calls. IAED protocols provide a set of guidelines that centers follow to ensure the accurate and efficient handling of emergency calls. IAED protocols include EPD, EFD, and EMD. While EMD and EFD are mandatory for all EMS and fire incidents, EPD protocols generally allow for greater flexibility. OCSO Dispatch utilizes EFD and EMD in their entirety. OCSO Dispatch only employs EPD protocols in part, due to the fluid nature of some types of law enforcement-related incidents." According to OCSO policy there are 11 protocols that are not mandatorily used within their system. The protocols include, but are not limited to, administrative, driving under the influence, animal calls, deceased person, and officer needs assistance. Our research confirms that this is a common practice, and indeed law enforcement departments across the country have exercised their own interpretations regarding what protocols to adopt of the IAED/EPD.

[180] National Highway Transportation Safety Administration. (2025). *Next generation 911*. Same. Retrieved from www.911.gov.

Moreover, during critical events where an overwhelming number of 9-1-1 calls are made, it is not uncommon for 9-1-1 centers to implement policies that allow for the temporary suspension of IAED Protocols to help process the high volume of calls as quickly as possible in a short period of time. The suspension of protocols is outlined in the OCSO "emergency rule" procedure under the EMD/EFD use policy. In that policy it states, "When call volume exceeds your capability the emergency rule can be instituted."[181] Additionally, emergency situations involving caller safety concerns are often fluid and may require flexible and adaptive questioning. During the assessment of calls at the beginning of this incident, we identified the presence of some EMD and EPD type questioning. However, this was not consistent, and as more calls were received, this line of questioning was discontinued. Additionally, according to dispatch records, referred to as "D cards," some priority dispatch codes[182] were used:

- 26 21-1955 **EMD code 39E01** (Reconfigured Code) (Active Assailant - Shooter) Suffix: G (Gun)
- 26 21-1953 **EMD code 27B02** (Known Single Peripheral Wound) Suffix: G (Gun)
- OS 21-249546 – at 12:56:47 ProQA was used and **EPD code 135C01** (Shots Fired-Heard Only) Suffix: G (Gun) was used.

One of the most important pieces of information call-takers were trying to determine was whether anyone was injured. This has been one of the most contentious subjects between OCSO and Fire/EMS responders following the incident. According to OCSO officials, it is standard practice not to dispatch fire and EMS resources to law enforcement-related incidents unless there is known or confirmed patients with injuries. This was ostensibly an industry standard that the local fire departments set in place. Moreover, over the course of interviews with OCSO and fire department officials, they stated that it was well-established practice not to send fire/EMS to traffic accidents without a report of injuries or shots fired in the area calls. As we will discuss in further detail, OCSO's decision to abide by those two practices in this incident was misplaced, and an oversimplification of a broader practice not to send Fire/EMS until there is a determination that they are needed.

iv. *OCSO Dispatch Activity on November 30, 2021*

According to OCSO and the staffing roster on November 30, 2021, between 06:30 hours and 14:30, the Dispatch Center was fully staffed. The total number of call-takers and dispatchers working was 19 (six call-takers, four fire dispatchers, six law enforcement dispatchers, two supervisors, and one relief position). A dispatch academy class was in

[181] OCSO 2021 CTO Policy Manual, p. 111.
[182] It should be noted that these codes can be manually entered. Simply entering a code for active assailant, does not translate to utilization of the actual protocol, or "script" for questing the caller. In this case, while the code was utilized, the verbal protocol was not exercised.

session on the day of the incident and two dispatch instructors began helping the center respond to the incident. Additionally, one Quality Assurance Supervisor and a Command Sergeant immediately stepped in to assist as well. It is evident from the recordings that the 9-1-1 call-takers maintained a calm demeanor, practiced empathetic listening, and displayed professionalism throughout this incident. Additionally, the students, teachers, and community members who placed 9-1-1 calls in the first minutes provided critical information that enabled the 9-1-1 center to swiftly dispatch units to the right location.

A. The First 9-1-1 Calls to OCSO Dispatch

During the first hour of the incident, OCSO Dispatch received and responded to 149 calls. 111 calls related to the school shooting with 38 received in the first 10 minutes. Of these initial calls, only 18 were from individuals in the school. The remaining 20 calls largely came from parents, individuals who left the school, and from locations where injured students had been taken. Additional 9-1-1 calls were routed out of Oakland to Lapeer County 9-1-1, as discussed below. Undersheriff McCabe noted at a press briefing shortly following the shooting that a high number of calls were also received on the non-emergency and administrative lines.

Upon confirmation with Lieutenant Hill, we have retrieved the following information concerning just 9-1-1 calls:

- Within the first 1 hour = 190 (9-1-1 calls)
- Hour 2 = 341 (9-1-1 calls)
- Hour 3 = 130 (9-1-1 calls)
- Hour 4 = 110 (9-1-1 calls)
- Hour 5 = 109 (9-1-1 calls)
- There are records of abandoned calls.
- Within 5 hours = 880 (9-1-1 calls)

The initial calls to 9-1-1 came into the call center at approximately 12:51:46 from students in classrooms along the 200 hallway, and contained information including shooting location, suspect description, and current situation within the school. A teacher can be heard taking over one of the calls stating, “It just happened right in front of our door.” The teacher went on to say, she heard “5 or 6 shots and could smell something like fireworks.” The 9-1-1 call-taker guided the caller in initiating the school’s internal emergency protocols and advised that there are several calls “coming in” and “everyone is coming.” The school lockdown notification can be heard in the background of these initial calls.

At 12:51:54 the first call providing a description of the shooter was received. This caller was inside the 200 hallway bathroom (Bathroom 1) while the shooter prepared for his

attack. This call was one of two calls in the first 10 minutes to provide an accurate description of the shooter. The caller stated that there was someone inside the bathroom with a gun and described the shooter as “in a hoodie - sweatshirt, plenty of shots fired. I don't know who it is.” The caller stated that, regarding victims shot, "I think so. He left his bag in here. I heard a gun cock. He walked out and heard three shots and heard someone scream. I hear people calling for help. He left his bag here. He had a hat on. Caucasian. He had glasses on. He had a beanie on. Mask. Hoodie - burgundy. I think I have class with him, but I don't know his name.”

Within the initial 4:02 minutes, three calls were received by the 9-1-1 center where callers relayed information about possible injuries in some form. According to call data provided by the OCSO, the first two calls to mention injured victims were received at 12:51:54. These calls were received 45 seconds after the first shots were fired. When the call-taker asked if anyone was shot, she stated “I think there are multiple, multiple gunshots.” This was approximately 1:05 in the call. The other caller said he heard three shots followed by somebody screaming. This statement was at approximately 2:54 into his call to 9-1-1. The third call received at 12:52:32[183], was the first call with what we believe to be a definitive reporting of an actual injury, approximately 1:14 after the first shots were fired. At 2:19 seconds into the 12:54:51 call, the caller provides the following information: “I know one of my friend’s sister is, that she got shot.” Within a short time frame, additional calls were received reporting injured students. Two of these calls came from JPs Piano Moving company and McLaren Urgent care in Oxford, where injured students were present.[184] From this data, a call-taker could determine that shots had been fired, people were injured, people were running from the building, and people were locked down in place.

The CAD notes regarding presumed injuries at 12:51:54 were not entered until 12:55:26. Additional 9-1-1 calls from OHS staff were placed at 12:55:11 and 12:57:59, which also relayed information about injuries. CAD notes detail that this information was first entered into CAD by call-takers and received by dispatchers at 12:55:12 and 12:57:43.[185]

12:55:26	ANOTHER CALLER IS ON THE TX // OXFORD HIGH SCHOOL // UNK SHOOTER // HEARD MULTIPLE SHOTS // IN THE 200 HALLWAY // HANNAH TX: 248-971-6760
12:55:12	ISABELLA DUNNIN 14YO FEMALE -- NOT INJURED -- STS SHE IS OUTSIDE ACROSS THE STREET -- STS HER FRIEND BELLA AND MARLEY FRANZ POSS VICTIMS

[183] The sixth call received by OCSO dispatch overall.
[184] See Fire and EMS Timeline for further details.
[185] Excerpt of CAD notes

12:57:43	THE SHOOTING OCCD IN THE HALLWAY NR THE BACK DOOR DOOR 7 - UNKN RESP TEACHER ACASIA CLIFFOR 248-420-2922 - THIS CALLER HAS A CHILD THAT HAS BEEN SHOT - SHE IS ACR THE STREET FROM THE SCHOOL FROM THE FOOTBALL FIELD - SHE IS WITH 30 KIDS - THE PATIENT IS ELIJIA MULLER AND HE WAS SHOT IN THE CHEEK - HE IS MISSING HIS TEETH

In the current system utilized by OCSO Dispatch, an OCSO dispatcher would have to review those CAD notes and assign resources.

At 12:57:21 OCSO Dispatch called OFD Station 1 and informed OFD Captain 1 "We're currently fielding a ton of calls about a possible shooting at the high school. I don't have anything for you guys yet, but I am assuming that's coming real quick." 12:57:21 was the first time OFD Station 1 personnel were alerted to an incident at OHS. This phone call notification was made 2:30 seconds after the first 9-1-1 call and 1:14 after the second 9-1-1 call regarding victims. OFD personnel interviewed stated that after receiving this call they gathered additional supplies and responded to the Meijer "staging location." Fire department personnel informed us that, a "heads up" phone call prior to incident dispatches is not typical practice and has not happened for incidents since this event. Ultimately, OFD was dispatched[186] at 12:59:56 and instructed to "standby on a medical emergency to assist the county Oxford High."

B. OCSO Dispatch Communications with OCSO Deputies

A law enforcement and fire dispatcher's primary and essential responsibilities are to relay information from 9-1-1 callers to responding officers and fire department personnel. 9-1-1 centers are often challenged by an influx of substantial information obtained during dynamic, high-risk events, all while needing to rapidly identify, prioritize, and relay critical details to responding units. It is imperative that call-takers provide law enforcement and fire dispatchers essential details concerning suspect description, confirmation of injuries, victim locations, best access, and suspect movements as quickly as possible. As noted, the initial dispatch occurred at 12:52:59 when the dispatcher announced to OFD units that there was a call of "shots heard" at OHS, where a caller reported he heard several shots from inside the school. While this information was relayed to OFD, a second call was placed reporting information concerning the shooter. Information from the call-taker to the dispatchers continued to flow while the initial caller was still on the line. The second dispatch occurred 1 minute and 13 seconds after the first 9-1-1 call was taken.

[186] As noted in numerous interviews, OCSO's standard practice was to only dispatch fire/EMS upon a confirmation of injured victims. We have not been provided with any policy or other documentation that defines what "confirmed" means.

Over the next few minutes, dispatchers shared updated information with responding officers via radio traffic and CAD entry.[187]

12:53:30 – "No reported injuries yet" – This statement occurred 1 minute at 21 seconds before the first 9-1-1 call statement regarding shooting victims.
12:55:12 ISABELLA DUNNIN 14YO FEMALE -- NOT INJURED -- STS SHE IS OUTSIDE ACROSS THE STREET -- STS HER FRIEND BELLA AND MARLEY FRANZ POSS VICTIMS
12:55:39 – Dispatcher conveys information from a caller about her friends being injured but stated "still nothing confirmed." - This information was conveyed 27 seconds after the CAD note was entered.
12:56:47 WM WITH GLASSES BEANIE BURG JACKET POSS RESP //
12:57:40 – First information pertaining to a suspect description. This information was conveyed 53 seconds after a CAD note was entered.
12:57:40 ONE WITH A HEAD INJ BY DOOR 5/EMPLOYEE
12:58:08 – Dispatcher reports a caller stating at least one child has been shot. We believe this information was taken from a CAD note entered 28 seconds prior to the statement at 12:57:40.
13:01:05 - One person detained.

9-1-1 call-takers captured the callers' information quickly, and those details were relayed to responding officers within a minute, if not less.

C. OCSO Dispatch's Communication with Fire/EMS

As aforementioned, at 12:59:56 OFD was advised to "Standby on a medical emergency to assist the county at Oxford High." Based on radio traffic, fire/EMS units advised they were enroute almost immediately, as they unilaterally decided to start moving in the direction of the school. A short time later, the fire dispatcher stated, "Scene is not secure, possible multiple injuries, requesting you stage." Shortly afterwards OFD Captain 1[188] on OFD Engine 1 advised, "all personnel to stage, level II staging will be at Meijer," and "dispatch strike me a box alarm, code 1 response at this time." This direction, however, is a non-emergency" response. A code 1 response would prompt the fire or EMS units to respond without lights and sirens, which amounts to a non-emergency direction. In this case, he ordered a "box alarm" which would mostly be firefighting apparatus.

[187] This exchange was put together through lining up radio traffic and CAD logs. The radio traffic is differentiated from the CAD notes with italics.
[188] OFD Captain 1 was referred to within the radio logs by the call sign "Captain 2."

OFD was the first fire department dispatched to OHS at 12:59:29. The first OFD personnel arrived on scene at approximately 13:07:46 with OFD AC Majestic[189] assuming command. The following represents the official time of dispatch for OFD in relation to the time frame of the shooting at OHS:

12:59:29 OFFICIAL DISPATCH TIME FOR OXFORD FIRE DEPT.
8:45 after the first shots were fired
8:12 after the first 9-1-1 call,
5:07 after the first 9-1-1 call regarding victims,
4:46 after the first CAD note regarding possible victims,
3:51 after the 9-1-1 statement OCSO used as confirmation of a victim,
2:37 after the phone call to OFD, and
1:31 after officers responding were advised of confirmed victims.

Following the initial dispatch of the OFD, minimal information was provided to responding units.[190]

12:59:29 STAGE FOR ACTIVE INCIDENT

12:59:56 – Initial dispatch stating multiple victims and that units should stage. This followed the 12:59:29 CAD entry

13:01:40 – Victim reported a different location (635 South Gilespie).

Additional Incident entered:

210001953 26
MEB BRAVO MEDICAL 11/30/2021 TUE

INCIDENT - MEB BRAVO MEDICAL
465 S GLASPIE ST, OXFORD MI
SE SECTOR

		-CAL-	-RCV-	-DIS-	-ARV-	-CLR-
RECEIVER: OSKRYSIAKE	ORIGIN: 911	12:59:44	13:01:06	13:01:43		13:16:22
DISPATCHER: OSWALKERB	BADGES:	00:01:22	00:00:37			
	BEAT: 2601					
	AREA:					
COMPLAIN: VERIZON 248890-2289	+042.569189/-083.441591					

13:01:06	STUDENT AT THIS LOCATION SHOT IN LEG
13:01:42	15-YEAR-OLD, MALE, CONSCIOUS, BREATHING. PROBLEM: STUDENT SHOT IN LEG CC: ACTIVE ASSAILANT (SHOOTER)
13:03:13	AT THE ANKLE
13:03:24	CC: GUNSHOT WOUND DISPATCH CODE: 27B02 (KNOWN SINGLE PERIPHERAL WOUND) SUFFIX: G (GUNSHOT RESPONSE: MEB ***PROQA ANSWERS*** -- THE LOCATION OF THE ASSAILANT IS: IN THE SCHOOL -- HE HAS RECEIVED A GUNSHOT WOUND. -- THIS HAPPENED NOW (LESS THAN 6HRS AGO). -- THERE IS NO SERIOUS BLEEDING. -- THE WOUND IS IN A PERIPHERAL LOCATION. -- THERE IS A SINGLE WOUND. -- HE IS COMPLETELY ALERT (RESPONDING APPROPRIATELY).
13:16:05	PT LEFT WITH PARENTS

[189] OFD AC Majestic was referred to within the radio logs by the call sign "Chief 2."
[190] This exchange was put together through lining up radio traffic and CAD logs. The radio traffic is differentiated from the CAD notes with italics.

13:05:52 – Radio that scene is secure go to Door 4 – this statement was 3:58 after reported one detained, 4:20 seconds after officers called for fire to come to Door 5, and 1:55 after officers requested fire to Door 7.
13:06:32 – Dispatchers reported a call for a victim at the urgent care; Orion Alpha 1 was responding – this was 5 minutes after the 1 minute long 9-1-1 call was placed from the urgent care reporting the victim.
13:08:07 – Dispatcher conveys there are 2 patients at Door 4, 2 patients at Door 7, and 1 patient at Door 6 with a head injury. It is stated that door 6 patient is the highest priority patient. CAD notes entered:
13:04:40 SCHOOL REQ EMS COME TO DOOR 5 & DOOR 7 TO GET TO VICS QUICKER 13:06:31 CPR IN PROCESS TO VIC WITH HEAD INJURY 13:07:34 ADFD REQ BRUCE TWP FOR COVERAGE 13:08:47 DOOR 6 MOST SEVERE PT 13:10:41 BRUCE IS ENR FOR ADFD COVERAGE 13:10:54 GUN SHOT WOUND 218

These radio transmissions continued on the fire department radio channels until "fire command" was terminated around 17:00 hours. Despite the substantial volume of radio traffic from fire department units, very little information relevant to operations was broadcast inside the school. At one point there was communication regarding the number of patients in the 200 hallway, but fire department responders were not made aware of the overall situation within the school throughout the incident, including updated information from OCSO Dispatch's fire dispatch, which only instructed fire department units as to which doors to use for access to patients. A review of the radio traffic revealed the absence of real-time information related to suspect description or descriptions, total number of potential patients, or areas considered established warm zones. At 13:05:52, one of the only transmissions containing information pertaining to the current situation within the school was broadcasted to fire personnel advising that the scene was "secure."

v. *9-1-1 Calls Routed to Lapeer County*

As often occurs in an active shooter event, questions arise around calls made to 9-1-1, either through landline or cellular services. On November 30, 2021, not all 9-1-1 calls placed in Oxford County were routed to OCSO Dispatch. Lapeer County Central Dispatch Center (LCCDC) received multiple calls reporting the shooting.[191] A review of the calls indicates that the majority were parents calling in while simultaneously texting with their

[191] As part of our research, we learned that Oakland and Lapeer County does utilize text-to-9-1-1 systems. Guidepost requested text-to-9-1-1 calls for this incident from both OCSO and Lapeer County. It does not appear that text-to-9-1-1 was used in communications with OCSO Dispatch, as OCSO did not provide any documentation. Lapeer County personnel provided the transcript of a text interaction between their personnel and a student at the school.

children inside OHS. It should be noted that OHS is located 3.8 miles from the Lapeer County line, with the Oxford School District boundaries directly adjacent to it. When a cell tower is at capacity, the cell phone will attempt to connect to the next closest tower(s), which could be near the county line. It is also important to consider that not only 9-1-1 calls were being made; we can assume that students and teachers were also making phone calls at the same time to family and friends, and we certainly are aware that text messages were being sent between those in the school and outside its walls.

A. Williams' Call from OHS to 9-1-1

One of the most important 9-1-1 calls transferred to LCCDC was the call made by Melissa Williams. We had the opportunity to interview Williams, retrace the origins of her 9-1-1 communications, and compare her recollection of the event to the records we were able to obtain. She provided close to real time information to dispatch. Once she obtained access to the security cameras in the office, Williams directed responders based on what she saw as well as what she heard from various staff on the school "walkies."

This call provided the best glimpse of what was going on prior to the arrival of first responders. This information, however, encountered some minor delays as a result of technical difficulties. After receiving notice of an active shooter through the school's internal communication system, Williams attempted to place a call to 9-1-1 via the office landline but received what she believed to be a busy signal. Therefore, she subsequently used her mobile device to call 9-1-1. This call was connected to the Lapeer County 9-1-1 Dispatch Center. The entire 9-1-1 call lasted approximately 28 minutes. Data from LCCDC indicates that the Lapeer 9-1-1 calls did not have timestamps. Data from OCSO Dispatch indicates that the timestamp for receipt of Williams' transferred call was at 12:55:29. The call itself suggests that the transfer took approximately 2 minutes and 7 seconds. Thus, we can draw an inference that Williams' call was placed at approximately 12:52:00, immediately after the incident began.

B. Versions of Williams' 9-1-1 Call

Some community members interviewed during this review stated that there were multiple versions of the recording for Williams' 9-1-1 call. There were allegations by some of "suspected manipulation" rooted in several theories surrounding the length of the recordings, sound quality, as well as simply multiple copies.

Our review involved listening to three separate recordings of Williams' 9-1-1- call. We believe the separate recordings can be easily explained. Recording one is primarily of the call with Lapeer County and is 3:09 long. This call includes the initial call with Lapeer County and is the recording up until Lapeer transfers the call to Oakland County 9-1-1.

Recording two is 8:28 of the longer 28-minute recording. Recording three, provided upon request to OCSO officials, is the recording of the entire 9-1-1 response in Lapeer County to call termination by Oakland County. During investigations, it is common for legal and law enforcement agencies to extract and save portions of calls or videos as separate clips relevant to specific areas of review. While we certainly understand the concern as to why the full recording was not initially produced, we do not believe that there is any indication of nefarious activity. The key issue for evidence integrity is whether the original data was preserved. In this case, there is no indication that the original 9-1-1 recording was altered, as it remained available in its complete form for review despite being spliced at different stages.

C. Williams' Busy Signal Response to 9-1-1 Call

Although dialing 9-1-1 seems simple, there could be technical factors resulting in a caller receiving a busy signal. We are unable to tie this "busy signal" to one source, given the absence of data. Therefore, we provide herein a number of possible causes. The first consideration is if the telephone's carrier is overloaded or at capacity, this could result in a busy signal. Another possibility is if the 9-1-1 center's phone system Customer Premises Equipment (CPE) is overloaded or at capacity and there is no "overflow," this could also result in a busy signal. It should be noted that we reached out to Peninsula Fiber Network (PFN), the 9-1-1 network provider for Oakland and surrounding counties regarding their 9-1-1 network. PFN claims it is not possible that the busy signal came from their 9-1-1 system as there is no resource that provides a busy signal within the 9-1-1 system in the entire state of Michigan. If a call makes it to the 9-1-1 network anywhere in the state of Michigan, it will never receive a busy signal. PFN appears to suggest that the busy signal didn't come from ESInet, their 9-1-1 network. Another consideration, however, is that some 9-1-1 callers believe that they received a busy signal, but sometimes what was heard is a "recording" from the 9-1-1 center, which means they were in queue. In this incident, Williams only recalls a "busy signal" which is the extent of the information collected.

Second, the OHS phone system in 2021 utilized voice over internet protocol (VOIP). Our consultation with industry members suggests that this busy signal could result from within the VOIP network. If the system was set up with insufficient call paths to support the number of calls coming into the office from the individual classrooms, in addition to any outgoing 9-1-1 calls, then Williams may have received a busy signal due to a lack of system capacity within OHS. Due to the length of time since this shooting we have been unable to determine if this was the case.

Finally, in February of 2016 Kari's Law took effect, which was legislation aimed at improving access to emergency services. The law required that multi-line telephone systems (MLTS) allow for 9-1-1 dial from an office system without an additional prefix, such as dialing 8 or 9 first. The complexity to this is that the compliance date was forward looking and did not apply to "Legacy MLTS." This effectively means that any MLTS "manufactured, imported, offered for first sale or lease, first sold or leased, or installed after February 16, 2020" are exempt. This law was implemented prior to the shooting; however, it remains unclear how current the phone systems were at that time. Additionally, Williams could not confirm whether she dialed 9-1-1 directly or used a prefix. Consequently, if OHS had been operating a Legacy MLTS system requiring a prefix for external calls, and Williams omitted this step, she may have encountered what she perceived as a busy signal or been unable to connect.

Again, given the passage of time between the incident and our review, as well as data unable to be collected, we cannot confirm the direct cause of the delay. However, this discussion is valuable. These considerations provide public safety organizations with the awareness about potential contributing factors to 9-1-1 busy signals, so they can make adjustments where possible.

D. Potential Contributions to Cellular Call Rerouting

The second item to address is why Williams' 9-1-1 mobile call was routed to the Lapeer County 9-1-1. Two of the six answered calls by Lapeer County 9-1-1 concerning the shooting were from callers located at OHS, including Williams and a student fleeing the school campus. With 1,700 people in the school, there may have been more cell tower usage than the towers local to the school could have handled, causing both Williams' and the student's calls to connect to a Lapeer County tower. There are two cell towers within a quarter of a mile of OHS. It is possible that with the amount of cellular traffic at the time of the shooting, Williams' call was routed to a tower within Lapeer County. In our interview with the Director of LCCDC, we were informed that this is not a normal occurrence. The director stated that they do not get many calls from within Oakland County, and while they did take a number of calls during this incident, it was not typical. Lapeer County provided Guidepost with six 9-1-1 calls that their call center received from the Oxford incident. A review of these calls confirmed that four were from parents who were not at the school, and the other two were from within the school.

vi. *Analysis of Public Safety Response on November 30, 2021*

Our previous sections of the review discussed the weaknesses within OCSO incident command, as well as concerns within Oakland County fire/EMS departments about staffing issues and MABAS communications. Staffing gaps during critical incidents necessitate early requests for resources from distant jurisdictions to ensure adequate response levels as the incident escalates.

While the request for 50 ambulances to OHS was ultimately unnecessary, this incident highlights a disconnect in the dispatch system's ability to deliver a seamless coordinated response to large scale critical incidents without relying on real-time decision making. First responders on scene reached a point where they did not have enough ambulances for the *known* victims very early in the incident. Additional units were necessary, as the first four ambulances were committed before three of them even arrived on scene. A detailed incident response plan would have saved valuable time in activating additional fire/EMS resources. From the fire service perspective, it is our recommendation that OFD develop predefined response plans that are determined by incident type. This will have a visible impact on the overall effectiveness of responses throughout the county for all types of emergencies.

Nationally, many jurisdictions who have faced active shooter or mass shooter incidents are now in favor of pre-established response plans for these specific types of events. The City of Baltimore authored an After-Action Report on July 2nd, 2023 in response to a mass shooting in the cities Brooklyn Homes community.[192] The first item listed on the improvement plan was: "Enhance Dispatch and Communication" by "[d]evelop[ing] an automatic dispatch profile for mass casualty incidents to ensure a swift and coordinated response," and "[i]mplement a system that prompts the Incident Commander to consider declaring a mass casualty incident based on specific criteria."[193] Similarly, the City of Aurora (CO) also authored an after action report[3], which resulted in such changes as adding battalion chiefs to all gunshot wound calls after Century 16 theater shooting. The after-action review[194] of Pulse nightclub shooting in Orlando, Florida in 2016, resulted in dispatch protocol changes for both Orlando Fire and Orange County Fire.

As previously discussed, the implementation of incident command by law enforcement in an efficient manner, without delay, would certainly assist dispatch in providing the best support. Yet, the responsibility does not solely lie with OCSO. OFD should take the same level of commitment to revamping their procedures and practices. This improvement is

[192] City of Baltimore. (2023). *After-after report regarding the Brooklyn Homes mass shooting.* Same. Retrieved from www.baltimorecity.gov.
[193] Ibid.
[194] City of Orlando. (2016). *Pulse tragedy: After action report.* Orlando, FL: Same.

critical to the success of future incident response. Establishing a structured environment amidst the inherent disorder of active shooter/assailant incidents can provide measure of stability. Furthermore, daily operations for OFD and other departments will benefit from the incorporation of these recommendations, to establish procedures that will ultimately cultivate intuitive responses and optimize the agency's overall functioning.

As can be seen, the effectiveness of public safety and dispatch response cannot be assessed solely by measuring delays within established timelines. Best practice guidelines provide suggested timeframes for ensuring quality assistance to individuals at risk. To provide a thorough evaluation and formulation of recommendations, this analysis will first address both human and technical factors, and then subsequently focus upon the practices and policies within which those how to best account for such influences exist.

A. Human Influences that Impact Incident Response

Human influences affect high stress incidents such as these in several ways, including independent decisions under tension without direction, intake of constant information streams and subsequent processing, and strain from time pressures inherent in the nature of active shooter situations. An example of judgement and decisiveness was exemplified when OCSO dispatch made a call to OFD Captain 1 – an atypical yet split second decision. There was no apparent guidance which instructed OCSO Dispatch to send a prestaging message, but the dispatcher chose to reach out. Handling numerous CAD entries under time constraints with no automation or keyword programming for injuries places additional stressors on dispatchers and can impact their ability to assess injuries and allocate resources efficiently.

Another common human influence in these types of incidents involves emotions and psychological state of PSAP participants. Call-takers routinely engage with individuals who may be experiencing extreme fear or distress, which can affect effective communication and the ability to ask pertinent questions, even with comprehensive training. In this context, the call takers from both OCSO Dispatch and LCCDC demonstrated exemplary performance that merits recognition in this review. They remained composed amidst clearly panicked parents, students, and OHS staff. Their professionalism and empathy were evident during each interaction. Most notably, the LCCDC call taker's evident appreciation that Williams' call from OHS should be prioritized as a transfer back to OCSO Dispatch ensured that the call could receive its due attention.

B. Technical Influences on Incident Response

Considering those human influences, we move now to technical influences, which also can impact an incident as well as demand new and revised policy and procedure initiatives by an organization. These technical influences involve the extent to which a PSAP's CAD system has automation or relies upon manual entry following a call-taker's collection of information. Automation extends beyond data entry, to whether agencies have real-time GPS tracking of public safety vehicles and resources. Other such technical influences involve challenges related to radio discipline. In this incident, there were a number of times where garbled communications occurred. In some instances, this can occur because responders are communicating on the same channel and yet speaking over each other. This can be controlled by establishing policies and practices between OCSO deputies and dispatch to hold radio transmissions with the exception of emergency traffic while on the same channel. The following represents other technical influences which can impact the fluidity of communications during events such as these.

C. Influence of Automatic Vehicle Technology

Since the early 1990s, automatic vehicle location (AVL) technology has offered considerable benefits for 9-1-1 centers, fire departments, and law enforcement agencies. By providing real-time GPS tracking of public safety vehicles, AVL allows 9-1-1 dispatchers to deploy the closest available fire/EMS units, and/or law enforcement officers. The ability to reach the closest available unit significantly reduces response times and improves service to the community overall. AVL also enhances situational awareness for 9-1-1 dispatchers, responding units, and public safety leadership for day-to-day responses. Most importantly, AVL supports operational coordination during high-risk incidents where multiple agencies are dispatched, by allowing the 9-1-1 center to monitor unit locations during these events. When multiple jurisdictions and authorities are responsible for planning for coordinated responses, AVL technology can provide a useful set of performance metrics to enable data-driven decision-making, assist agencies to analyze response patterns, and improve resource utilization and allocation.

While it appears from the OCSO manual that the OCSO does have AVL for their units, it does not extend to dispatch of fire department or EMS apparatus. We acknowledge that an organization's adoption of AVL can be affected by several challenges including financial, cultural, and technical limitations. Initial expenses include those for equipment such as GPS hardware, radios, mobile data terminals (MDTs), software licensing, and additional costs associated with system integration. Many older legacy CAD systems necessitate upgrades to support AVL functionality, which can be costly. In some jurisdictions with labor unions, union representatives have voiced opposition due to concerns about monitoring of personnel, fearing AVL could be used in punitive fashion,

rather than for operational efficiency. Additionally, territorial and political challenges between public safety agencies, be it fire or law enforcement, and other jurisdictions may create resistance, especially if AVL is perceived as enabling 9-1-1 centers to reassign emergency responses traditionally handled by a specific department or agency. Despite perceived challenges, the long-term operational gains and societal benefits from AVL outweigh the difficulties by improving response times, responder and scene safety, incident coordination, and transparency between partner public safety agencies.

As previously discussed, territorial disputes in Oakland County appear to exist within the MABAS 3201 and 3202 groups, rooted in valuing career departments over volunteer. The detriment of these territorial disputes was evident in a 2024 house fire in Oakland County that resulted in the death of one of the occupants. During the incident, a career staffed fire station 2.2 miles from the incident was not initially dispatched. Instead, a volunteer department was dispatched, despite a distance of three miles from the house. This incident was referenced by multiple fire department officials during their interviews as part of this review.

This example underscores the necessity for change in dispatch protocols and moreover in adoption of AVL practices across all public safety agencies, which could trump territorial disputes. The goal is to move the closest resources possible to emergencies. First, in an ideal world, use of AVL dispatch is the most efficient means of relaying help to those in need in the shortest span of time. Second, Oakland County could consider an alternative means to accomplish AVL goals, such as accounting in advance for the closest resources based on station locations and subsequently coupling them to geographically predetermined response plans built to include multiple agencies. This method would also enable an agency to alert the closest available resource to the incident location during the initial dispatch. However, collectively viewed with AVL practice, the level of effort and coordination of this alternative approach is not necessarily any simpler than the progressive change to AVL. The ultimate goal for Oakland County should be to consolidate all dispatch centers. AVL dispatch functions best within a single dispatch center as technological aspects of AVL necessitate sharing vehicle locations and response statuses for all first responder vehicles in the county.

D. Connection between Automatic Vehicle Location and CAD Programming

AVL and CAD programming need not be manual practice, as a county's CAD system can be programed to automatically recommend the closest units. CAD programming for predetermined and specific dispatch codes for various types of emergencies, and the application of response plans for multiple agencies, can dictate how and when the incident is dispatched, as well as who and how many responders are sent. OCSO

Dispatch's current CAD system is configured in such a manner to compel call takers and dispatchers to handle incident calls manually, be it on a day-to-day basis, or during incidents with a high call volume. This manual process can impact on the time required to process and relay emergency information, both internally within the 9-1-1 center and to public safety partners. Specific response plans tied directly to call determinant codes removes the guesswork regarding assignments to incidents. Agencies can even take this enhancement a step further, by linking response plans to specific geographic areas, and predetermining the closest resources to this area or using AVL to identify the closest unit. Including location as part of the calculus allows for proper assistance to be dispatched to support the primary agency.

While these changes will require sharing data across multiple jurisdictions, including updated GIS data, and thus mandate a collaborative effort and governance structure interagency, we strongly suggest it is the best means of overcoming the current technical issues impacting the dispatch practices between OCSO, fire, and EMS. Finally, encouraging this interagency coordination will benefit communications overall, as it will involve balancing operational coordination, legal considerations, and rebuilding mutual trust.

E. OCSO Communications with Media and Impact on OCSO Dispatch

It is not uncommon for law enforcement to reach out to the public for assistance following acts of violence in the community. However, in this vein, another human influence that can materialize is inadvertent errors, despite good intentions. Hours after the Oxford shooting, OCSO Undersheriff McCabe held a press briefing at around 15:00. Amongst updates about the investigation, he also provided the public with a direct non-emergency phone number for OCSO Dispatch to collect information regarding the incident. Specifically, when asked what kind of information they were looking for, Undersheriff McCabe answered, "Any information- if they've heard, if they know anything at all about this young man, or what was going to happen or what happened today, they can call us."[195] It appears that Undersheriff McCabe was in pursuit of immediate access to information after this tragic incident, which is understandable.

This well intended act unfortunately created a ripple effect for OCSO Dispatch for months to come. OCSO dispatchers ultimately spent countless hours over the following weeks and months post-shooting fielding calls and relaying information regarding this and other incidents, in addition to their normal duties discussed earlier in this section. Much of this information was not relevant to this incident, and importantly individuals fielding these

[195] Interview video link: https://www.clickondetroit.com/video/news/2021/12/01/oxford-high-school-shooting-police-briefing-at-3-pm-nov-30-2021/

calls were not trained to synthesize what information was pertinent. All of this was the result of a simple miscalculation and publication of OCSO Dispatch's direct line.

To be clear, benefits can be derived from providing the public with a means to provide information. In the hours following large scale events, there can be instances where a member of the public is a witness to a suspect sighting or interaction which helps authorities apprehend suspects or even solve the case. For example, in 2023, hours following the shooting at Michigan State University (MSU), the dispatch center received reports of an individual approximately four miles away from the campus. The dispatch center decided to immediately dispatch officers based upon the caller's report matching the shooter's description and the caller's insistence that the person was acting very suspiciously. This was ultimately the suspect, who later shot himself.[196] However, even in the case of MSU, analysis found that during the three hours after the gunman fled the shooting sites, law enforcement was dispatched to investigate at least 90 separate 9-1-1 calls about suspicious activities or people across more than 50 other locations. Some of these were even characterized as, "in hindsight … highly improbable" but "had to be chased down."[197]

Taking both OHS and MSU into consideration, it simply demonstrates the need for actionable intelligence plans in the hours after an incident. Moreover, providing an administrative line utilized in a call center's day-to-day communications, as was done in the case of Oakland County, is not a feasible solution. Agencies should consider utilizing an existing tip line or other non-administrative line to give the public access to providing information regarding the incident or individuals involved in the incident. However, this line should be monitored by someone with the ability or capacity to synthesize information and act. This could be a communications center or fusion center[198], but also alternatively it could involve local Crimestoppers' numbers or utilizing detectives with agencies not affected by the event. Alternatively, some public safety organizations are utilizing artificial intelligence (AI) to handle non-emergency calls. The "call-takers" are AI bots, not humans, who collect the information. Subsequently those with the skills to assess the reliability and priority of the calls can review and decide the best course of action.

It is important to understand where and how these issues arise to account for them within an agency's policies and procedures. As discussed in our recommendations below, many

[196] Staff. (2023, February 19). Police radio reveals terror and confusion in hunt for Michigan State gunman. *The New York Times.* Retrieved from www.nytimes.com.
[197] Ibid.
[198] A fusion center is a focal point in states or major urban areas staffed by various law enforcement agencies to receive, analyze, gather, and share threat-related information between agencies and jurisdictions.

influences can be prepared through proper training and implementation of standard protocols to ensure swift response.

F. Practices and Policies Impacting Incident Response

Failing to account for human and technical influences can often contribute to unnecessary delays, especially where policies and procedures do not have clearly delineated guidance. OCSO follows a "practice" of waiting to dispatch fire departments until confirmation of an injured party was established. While OCSO asserts that this practice came directly from the fire departments, as previously discussed, this is certainly an oversimplification. In low occurrence-high threat events such as active shooter incidents, especially occurring at schools, it is common sense that all necessary resources must be dispatched even before confirmation of injuries. These steps are essential to ensure the highest level of survivability for any victims, and when weighing the risk-versus-reward, these responses are well within acceptable standards.

The second factor contributing to allegations of "delay" in fire response time pertains to when law enforcement was aware of wounded victims on scene. Our discussion of technical influences addressed delays in CAD entries as well as the utility of AVL. OFD was not dispatched until 12:59:29, approximately 8:12 after the first shots fired call was noted, 5:07 after what this review deems the "first confirmed injury," and 3:23 seconds after a CAD note of a head injury at door 5.[199] Additional recordings lead us to believe that dispatch center personnel recognized this incident as legitimate well before the decision to dispatch the fire department. At 12:57:59, a one-sided recording of a phone call was captured by the NW Fire Radio channel, where a call-taker is heard informing a caller that "we got stuff coming in from everywhere. It sounds like it's possibly actually really happening." This call occurred almost two minutes before OFD was dispatched. This was complicated by the "human" delay challenges related to the manual nature of the CAD system. The time it takes to gather information from a caller, type and enter the necessary details into CAD, and then process the call has an impact on timelines. Once the 9-1-1 call information is entered, a dispatcher must open the file and review the notes to see what is reported at the scene, and if additional resources are needed. These are the complications which arise when a CAD system is not automated sufficiently to determine the necessary actions based on predetermined dispatch codes.

[199] 12:52:59 – OCSO Dispatch of Shots Fired
12:54:51 – 9-1-1 call noting confirmation "I know" about a victim shot
12:57:40 – CAD note regarding the head injury, and information was subsequently dispatched at
12:58:08 – OCSO dispatch one child has been shot

Clearly there needs to be better delineated policies concerning when OCSO dispatch communicates with fire after an initial 9-1-1 call of injuries. It took them 1:13 to send deputies and at least more than three minutes to dispatch OFD, exceeding national best practices for responding to potential active shooter incidents. The best practice standards are well established pursuant to Texas State University's ALERRT program and the NFPA. According to ALERRT's 9-1-1 Communicator training, an active assailant attack should be dispatched within 15-30 seconds of receipt of a call, and within no more than 60 seconds. The initial dispatch can be a simple pre-alert stating that all units should respond to a specific address. In addition to the ALERRT standard, the NFPA 3000[200], references standards regarding emergency services communications systems, including NFPA 1221 and 1225.[201] However, NFPA allows additional time for the dispatch of law enforcement related incidents.[202] This additional time is provided to allow for the determination of scene security. The Association of Public-Safety Communications Officials (APCO) provides standard guidance to agencies throughout the nation.[203]

Time matters during large-scale incidents, and faster notification of partnering agencies, including fire departments, EMS, emergency management, and law enforcement, leads to quicker response times. Timely recall of additional personnel, rapid establishment of unified command, and more effective interagency coordination can lead to better outcomes. Additionally, faster notification would allow area hospitals more time to activate their mass casualty protocols, clear emergency departments for additional room and beds, and help transportation coordination with EMS.

G. The Impact of Cell Towers on Calls to 9-1-1 Dispatch

These technical challenges highlight the importance of public safety agencies establishing and maintaining relationships with phone service providers, as well as understanding how these types of incidents impact telecommunications, especially 9-1-1 centers. These relationships should be established with the understanding that, when major incidents occur, there will be a need to evaluate system performance and identify areas for improvement across both 9-1-1 and data networks. While planning for active shooter incidents, another important understanding is how these incidents put stress on cellular infrastructure and how systems respond to call spikes locally, and in surrounding counties. Equipping incident commanders and leadership with this knowledge enhances their decision-making and situational awareness during dynamic high-risk situations.

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[200] See further discussion of NFPA in Fire/Emergency Management Section below.
[201] See NFPA 1221-21 7.4.3*
[202] NFPA 1221-21 7.4.4*
[203] APCO International. (2019). *Call handling and incident processing in emergency communication centers: A research report.* Fairfax, VA: George Mason University.

h. Analysis of Professional Development and Training for OCSO and Fire/EMS Personnel

> *"We have trained for so long on mass casualty incidents. However, we really needed to train on mass chaos incidents. None of our previous training prepared us for what we experienced." - OFD Captain and EMS Coordinator*

Training is critical to the success of any operation, especially events involving mass casualties or large-scale acts of violence. There are more than 85 published AARs from 70 major active shooter events. The tragic reality is that these reports have repeatedly identified the same mistakes over the last 25 years. The DOJ reviewed 20 mass violence AARs published from 1999-2017, which combined had more than 700 findings, recommendations, and lessons learned. The recommendations are often the same regardless of the type of event. Agencies are frequently reminded of their obligations to draft comprehensive policies and protocols, to conduct integrated active assailant training, to practice and understand rapid establishment of unified incident command, to provide law enforcement officers with tactical medical training and equipment, and to always maintain a clear communication strategy. This incident is no different. Again, we appear to observe a recurring cycle where toxic historical patterns are repeating. Our analysis indicates that, notwithstanding the training courses provided, few of the recommended methods, including those related to RTF, were implemented on November 30, 2021. Interviews with members of fire/EMS and law enforcement stress the lack of preparedness for what they encountered, and even for the psychological trauma that ensued. Training must not only be frequent, but it must also be interagency between law enforcement and fire/EMS departments. It also must be formalized, mandatory, and consistent. It is important for all leadership to have a shared understanding of these protocols and consistent definitions of each agency's responsibilities to facilitate coordinated implementation. Consistent does not mean similar, rather these protocols must be identical to provide assurances that public service responders can truly walk lockstep into the unknown.

i. *OCSO Training Practices*

OCSO invested a significant amount of time and money in training for active shooter events. The department has conducted active shooter training for more than 25 years. Starting in 2013, OCSO began teaching integrated operations with fire and EMS personnel. As previously noted, OakTac provided training at the operational level for law enforcement agencies in the county and surrounding areas. Since its inception, OakTac

has had access to funding for training, exercises, equipment, supplies, and other resources to prepare for major incident response. OakTac's articulated purpose is to create a unified law enforcement response model.

Sheriff Bouchard is responsible, in part, for the creation of OakTac. He, along with several other commanders at OCSO, attended a briefing on the 2008 coordinated attacks at the Mumbai complex. Sheriff Bouchard informed Guidepost that he was concerned about the potential lack of coordination with the various law enforcement agencies in Oakland County if a major terror attack happened. Bouchard stated that the goal was to create an organization which would help to properly prepare for complex, coordinated attacks.[204]

OakTac started with six law enforcement agencies and has since grown to a total of 40. There are two main disciplines involved in the OakTac curricula. The first is civil unrest response utilizing the mobile field force concept.[205] The second is active assailant response. Oakland County's Division of Emergency Management, led by Director Thom Hardesty, has ensured the success of OakTac by securing significant federal funds. As a result of this funding, training at OakTac is free for Oakland County public safety departments. In 2014, OakTac received funding from the Urban Area Security Initiative (UASI) program to develop advanced active assailant response training for all members. OakTac initially created a two-day law enforcement active shooter response program that was available at no cost for any law enforcement officer in Oakland County. However, a combination of staffing considerations and time commitment concerns from active service made it impossible to send every OCSO deputy for a two-day training. Moreover, OakTac could not assume the financial obligation of training 1,300 sworn OCSO officers.[206] Therefore, OCSO's Training Division consolidated the UASI funded two-day program into a one-day course. The course was taught to every sworn deputy in the department permitted to carry a gun, including the corrections deputies assigned to the jail.

All sworn deputies are mandated to attend annual training. Training includes, but is not limited to, firearms competency, defensive driving, de-escalation, use of force (often referred to as response to resistance), mental health, legal updates, cultural competency (racial profiling and implicit bias). Every deputy is also required to complete annual scenario-based training. Scenario-based training uses hypothetical situations to help officers learn and make decisions based on real circumstances. This can often involve some form of role playing or can utilize a firearm training simulator. Additional training

[204] We confirmed the accuracy statements from Sheriff Bouchard with members of OakTac leadership as well as County Homeland Security.
[205] The mobile field force concept was developed by DHS to provide an efficient and effective method to assemble, deploy, and control a platoon or squad sized tactical element from on-duty personnel.
[206] OakTac receives the majority of their funding from grants, primarily UASI grants. While there was no cost to participants, there is a cost for OakTac to put on the training.

includes the use of tourniquets, and administration of medications such as naloxone. Extensive specialized training is required for individual units, to include crime scene investigation, motorcycle units, mobile field force, dive team, SWAT, and so forth.

MCOLES was created in 1965 and has authority granted through Michigan Public Act 203 of 1965 and Executive Order 2001-5. MCOLES is led by a 15-member commission and is organizationally situated as a division of the Michigan State Police. MCOLES is responsible for creating and enforcing standards for local and state law enforcement agencies in Michigan. MCOLES creates standards and training, programs and services, assesses law enforcement agencies, provides training funds, and offers free training courses to law enforcement officers.[207] MCOLES requires a minimum of nine hours of tactical operations training for recruits.[208] The training standards require this block to address active violent attacks. The training hours can reside in other blocks of instruction, including firearms, first aid, incident command, and interpersonal skills. The standard is quite specific and detailed as to the minimum level of training the recruits must have. Based on this standard, OCSO's training program exceeds these requirements. Michigan is only one of two states, Texas being the other, that requires annual active assailant training for all sworn law enforcement officers.[209] Starting in 2020, all officers are required to have a minimum of eight hours of active assailant training each year.

A. OCSO Training Facilities

Sheriff Bouchard and numerous OCSO commanders suggested in their interviews a need for a new state-of-the-art training facility. OCSO currently has several different training facilities. These facilities are split between OCSO Headquarters, the Oakland County Jail, Oakland County International Airport, and Oakland Community College. OCSO also utilizes a former middle school in Brandon Township and turned it into a training facility. Many members of the OCSO used their own time and resources to modify the building. Sheriff Bouchard has made this building available for free to any law enforcement agency that wishes to train there. Numerous local, state, and federal agencies have accepted the offer and currently use the building. Sheriff Bouchard suggests the facilities, equipment, and technology are antiquated and not a reasonable or sustainable option for effective long-term training.

[207] Michigan Commission on Law Enforcement. (n.d.). *MCOLES commission history*. Same. Retrieved from www.michigan.gov.
[208] Michigan Commission on Law Enforcement Standards. (2024). *Tactical operations: VI.C.1.5-VI.C.1.7.* Same. Retrieved from www.michigan.gov.
[209] Churchill, L. & Kriel, L. (2024, February 8). Check your state: Here are the active shooter training requirements for school and law enforcement. *PBS.* Retrieved from www.pbs.org.

In 2021, Sheriff Bouchard asked Oakland County to construct a new $88 million law enforcement training facility.[210] The proposed 300,000 square foot building would be built in Pontiac on 88 acres of county-owned land. The facility would also include a new 9-1-1 communications center, emergency operations center, and strategic storage facility for law enforcement equipment. Both the 9-1-1 center and emergency operations center currently operate in a cramped building that was constructed in the 1940s. County Executive Dave Coulter provided $1 million to conduct a feasibility study. Since 2021, there has been no advancement in the construction of this facility. We were told that the defensive driving facility where 1,200 sworn members attend annual training also is in need of updating.[211]

Oakland Community College has the Combined Regional Emergency Services Training Center (CREST). This facility consists of classrooms and live burn buildings. In addition, there are buildings that make up a simulated village. These buildings include a fire station, gas station, houses, a bank, and more. The facility offers valuable training, but it cannot accommodate the annual training needs of 1,300 sworn members because of insufficient space.

B. OCSO's Active Assailant Training Videos and Courses

Sheriff Bouchard and Lieutenant Hill informed Guidepost that OCSO prioritized active assailant training in 2000, following the 1999 shooting at Columbine High School. Since then, the program has continuously evolved, as law enforcement's response to active assailant incidents adapted to new standards of national best practices. In 2017, the OCSO Training Division created a solo deputy response training video and an open-air tactics video. That same year, OCSO began teaching RTF principles at an active assailant event. This course taught a traditional RTF concept, which consists of fire/EMS personnel partnered side-by-side with law enforcement under its force protection. The combination team would then operate together in an active assailant event.

As previously discussed within the OCSO response analysis, our review of internal OCSO training programs indicates that deputies are taught both basic and advanced response tactics. The active assailant training provided by the OCSO contains historical context and reviews of significant events. The three tactical priorities expressed are (1) isolate the threat, (2) contain the threat, and (3) eliminate the threat. The course emphasized the use of long guns for superior accuracy, large-capacity magazines, and the ability to

[210] Cavitt, M. (2021, August 4). Oakland County discussing construction of $88 million law enforcement, emergency response facilities. *The Oakland Press.* Retrieved from www.theoaklandpress.com.
[211] This is noteworthy, given statements made by leading fire/EMS officials including OFD AC Majestic and AFD Chief Morawski as well as OCSO personnel who informed us that several deputies nearly incurred accidents while responding to the school.,

penetrate body armor. Deputies were instructed to ensure they were properly equipped. Recommended equipment for an active shooter event included extra magazines of ammunition, first aid kits, tourniquets, and breaching tools. Lieutenant Hill confirmed that OCSO does not issue “go-bags” or “bail-out bag,” which would be designed to have all necessary equipment at the ready. The course teaches many best practice techniques, such as keeping lights and sirens activated right up to the building to let the perpetrator know that law enforcement has arrived. This tactic has proven very effective in switching a perpetrator’s mindset from homicidal to suicidal. If this switch does not occur, the hope is that the perpetrator will direct their attention to law enforcement and away from innocent civilians.

This training requires deputies to make immediate entry and further guides them on the critical and difficult decision to bypass victims when a threat is still active. However, the training also instructs deputies to provide intelligence on the radio to other units and the incident commander about the location of injured victims, suspects, explosives, and other critical information observed.[212] Deputies are to notify dispatch of their actions, including arrival and their entry point into the building.

The priority is to immediately conduct RTF operations to get fire and EMS personnel inside. OCSO training covered the implementation of RTF. The training instructs deputies to communicate with the incident commander as fire and EMS personnel enter the building. The training also teaches how to conduct victim extractions, including formations, carries, and vehicle rescues. In our interview with Lieutenant Hill, he stated that current active assailant training focuses on officers quickly arriving and flooding the building to neutralize the threat. The officers are required to assign a hall boss position to begin coordinating operations in their area. Once the fire department arrives, they are to quickly deploy into the building, creating a spontaneous RTF. This training follows national best practices for active assailant response. However, the training previously provided had fire personnel deploy into the building from a staging location.

An advanced version of OCSO’s course provides additional training for solo deputy response, dual deputy response, breaching, and asymmetric threats. This course again addresses at length utilization of the RTF. The course teaches that RTF operations fall under law enforcement command. All RTF operations are directed by the law enforcement incident commander. Deputies are instructed to remain on their designated radio channel and fire personnel will remain on their radio channel to ensure efficiency and accountability. OCSO training instructs deputies not to conduct a methodical secondary search until all injured victims are evacuated from the scene. This is critically

[212] This is noteworthy, as discussed supra, there was no evidence in our analysis that any information was radioed by the SRO as he passed by living and deceased victims in the hallway.

important. The two goals in response to an active assailant event are to “stop the killing” and “stop the dying.” Once the immediate threat has been neutralized, the primary focus shifts to prevent the imminent loss of life among casualties. While a secondary search is essential, they must yield to the urgency of lifesaving measures. Rapid intervention and triage ensure that those in critical condition receive the care they need before resources are allocated to broader assessments. If at any time a threat emerges or reemerges, law enforcement will immediately transition back to “stop the killing” and engage the threat(s). A delay in evacuating the injured results in a subsequent delay in conducting secondary searches.

C. Analysis of OCSO Training

Successful incident command operations require robust agency policies and procedures and repetitive training. Training must encompass all ranks, with supervisors and commanders receiving advanced training through the use of tabletop exercises and full-scale exercises. Table-top and practical exercises must occur at least every two years, incorporating lessons learned from any previously published AARs.[213] Here there was no clear path for commanders at OCSO to develop and teach incident command roles and responsibilities. The agency utilizes traditional para-military roles of command and control; however, it is not clear how the command-level development is accomplished at OCSO. (OakTac)[214] provided training at the operational level; however, there was limited unified command training prior to this shooting.

Incident command is only successful if agency leadership fully embraces the concept and establishes clear expectations for the rapid implementation of command. Members of the OCSO stated that at the time incident command training was primarily offered to lower ranks in the department. OCSO provides incident command training for their members. All deputies are required to complete the FEMA online NIMS 100 and 200 courses. Personnel who are promoted to sergeant are required to complete the FEMA online course NIMS 700 and 800 courses. Personnel who are promoted to the rank of lieutenant and higher must complete the FEMA in-person NIMS 300 and 400 courses.

Although the reviewers requested training documents, the OCSO did not provide any documentation showing incident command training throughout the ranks of the department. Supervisor and commander training on critical decision making needs to be

[213] United States Department of Justice. (2020). *How to conduct an after-action review.* Washington, D.C.: Office of Community Oriented Policing.

[214] OakTac, established in 2009, is a collaborative effort in Oakland County to provide consistent law enforcement training for the agencies in the county and surrounding areas. See in depth discussion of OakTac in the Professional Training Section.

ongoing in-service training. External agencies that are also part of a unified response should be part of the training to both develop agency and individual relationships. Succession of supervisors and commanders as well as areas of responsibility will never be a static condition, instead, this should be institutionalized within the agency. We were informed that just prior to the shooting at OHS, OakTac created a new program to address unified incident command at active assailant events. This course titled, "High-Risk Unified Commander" (HRUC), trains front-line supervisors to simultaneously address threats while providing coordinated victim care. Prior to the OHS shooting, OakTac personnel said the course was minimally attended by OCSO personnel. It should be noted, however, that following the shooting, the OCSO has fully embraced the training and sent many personnel. This eight-hour course is now widely taught and specifically trains command operations in the first 30 minutes of the event.

ii. *Oakland County Fire Departments' Training*

There appears to be a disconnect in Oakland County as to who is responsible for creating active assailant policies and protocols and who is responsible for administering the training. Despite this, the ultimate responsibility for fire department response lies with the fire chief. NFPA 3000 clearly puts this responsibility within the authority having jurisdiction at the local level.[215] NFPA 3000 requires every jurisdiction to have an emergency operations plan that addresses preparedness, mitigation, response, and recovery for active shooter/hostile events.[216] Likewise, position statement from the International Association of Fire Fighters, the International Association of Fire Chiefs, and the United States Fire Administration all require fire departments to have an active assailant policy. This disconnect is further evidenced by the fact that there is currently no integrated active assailant operations policy between OCSO and the 16 fire departments in communities served by OCSO.

OFD represents themselves on its website as an "all-hazards fire department."[217] However, in addition to the absence of active assailant policies, they have conducted limited training on such events since 2017. OFD is not alone in these deficiencies. Other fire departments within Oakland County represent themselves as an all-hazards fire departments but lack policies and training for active assailant events.

At the very least, adequate training must have enough repetitions so that responders can function with automatic activities (often called "muscle memory") to sustain operations. In

[215] National Fire Protection Association. (2024). *NFPA 3000: Standard for Active Shooter/Hostile Event Response (ASHER) Program*. Quincy, MA: Same.
[216] Ibid.
[217] Oxford Fire Department. (2024). *Fire suppression division*. Same. Retrieved from www.oxfordfiredept.com.

ultra-critical, high-stress operations, the goal is for someone to revert to established muscle memory to allow them time to employ deductive reasoning. The psychologists consulted for this review emphasized the significance of balancing rational logic with emotional responses. It is a completely normal physiological response to experience high levels of emotion in critical events. However, training allows the brain to balance emotions with logical reasoning. A trained brain can place emotions to the side for analysis at a later time. Following the shooting at Uvalde, the DOJ found that law enforcement officers need a minimum of eight hours of training.[218] Using this model, fire and EMS personnel should also have a minimum of eight hours of training. The training should cover multiple topics, including mass casualty incident management, TECC or TCCC, unified incident command, and integrated operations with law enforcement. These topics are not exclusive to active assailant events. Many EMS training institutions now interweave mass casualty incident management training and TECC/TCCC into annual online EMS recertification hours. Unified incident command training is a staple for the majority of fire department operations. Integrated operations with law enforcement are not just needed at active shooter events. Integrated operations are needed at barricade events, fire-as-a-weapon events, vehicle-as-a-weapon events, civil unrest, and more.

A. OFD Training Practices

OFD conducts frequent training. The members on shift are required to do three hours of both formal and informal training each day. A large portion of the training consists of state continuing education requirements for EMT and paramedic licensure. As a combination department, they also provide training for two nights each month. The training varies from fire suppression to rescue. OFD is currently building a training tower at Fire Station 1 to increase its capacity to offer additional training. EMTs and paramedics are permitted to attend TCCC or TECC training if they desire. Training time, however, is not compensated. OFD personnel revealed that few members are willing to attend training without compensation. This follows a nationwide trend in public safety where full-time members will not attend off-duty training unless compensated. All department members are allowed opportunities to attend active assailant training as well. In the interviews with OFD personnel, they indicated that they had limited exposure to active assailant training. They stated their last active assailant training prior to the Oxford shooting occurred three years before. Several paramedics in the department were not familiar with TCCC or TECC and did not know that training opportunities were available to them.

OFD AC Majestic was aware of OakTac and the training opportunities it offered but noted that it focused primarily upon law enforcement response. OFD AC Majestic stated that he was one of the original people in the county that helped teach active assailant training

[218] Department of Justice. (2024). *Critical incident review: Active shooter at Robb Elementary School.* Washington, D.C.: Office of Community Oriented Policing Services.

when he was at West Bloomfield Fire Department and was very familiar with integrated active assailant response. OFD AC Majestic suggested that MABAS groups were responsible for creating training for the fire departments. Our review found no evidence that either MABAS group developed or provided active assailant training. OakTac created and offered the training county-wide for free in 2014, the consensus was that northern county fire departments rarely participated.

When the review team asked OFD AC Majestic if OFD had an active shooter response protocol, he directed us to the OCMCB's protocols. These protocols do not contain any reference to active assailant response. The protocols discuss a variety of trauma treatment modalities. The development of operations plans and procedures is incumbent on the individual agency, including internally at OFD. OFD AC Majestic told the review team that he believed that the department's mass casualty incident protocol sufficed for active assailant events. When the review team discussed the requirements in NFPA 3000, OFD AC Majestic stated he had no problem creating an active assailant protocol for the department, but that he expected it would need to be a collaborative effort with the OCSO. Unfortunately, this incident showed that brief interactions with active shooter training are often not enough. It is only through multiple training sessions involving numerous scenarios that responders develop preparedness.

As of the date of our report and research, OFD did not have an active assailant policy. Fire department personnel told us that previous active shooter training did not adequately prepare them for this event and additional training was needed. OFD personnel stated that they were still unclear about what to do in an active assailant attack, and how integrated operations would function with the OCSO and Oxford Village Police Department. Interviewees further mentioned that there were few attempts for collaboration with the OCSO. Some interviewees recalled a comprehensive active shooter exercise at OHS in 2013. Subsequently, however, training on using ballistic vests and the RTF concept was at best sporadic. Moreover, there was no training on active assailant incident command or communications. In addition, there has been no required TCCC or TECC training for department paramedics or EMTs.

IAFF has advocated that every fire department should be required, at minimum, to establish a robust active assailant protocol and conduct annual training. Union officials expressed concern that many fire departments in Michigan had not made active assailant preparedness a priority. We were informed that fire and EMS instruction is frequently confined to mass casualty training within the context of EMS continuing education programs. Most often, a fire department's ballistic equipment is locked in the EMS closet. Fire departments also rarely have the equivalent of a CAD-call category for "active assailant." OFD also appears to lack training in equipment used in active assailant events.

OFD personnel received a donation of ballistic helmets and ballistics vests prior to the shooting. On the day of the shooting, OFD members put on the vests and helmets for the very first time. Several members had difficulty trying to figure out how to size the vests and helmets. In addition, at least one paramedic stated that they had never opened the active shooter trauma bag and were not familiar with any of the equipment in it. From information received from the Oakland County Medical Control Authority, this bag was donated to the OFD in 2015. OFD members stated there was no training provided when any of the equipment was donated.

It is essential for all public safety personnel to train on every piece of issued equipment. Daily checkoff sheets can encourage members to review each piece of equipment at the start of every shift. Formal training must accompany the delivery of all new equipment. The OFD Captain/EMS Coordinator stated that he wished the trauma bags in the command cars would have advanced life support equipment, such as intravenous fluid and saline locks. However, this request was denied after the shooting by the Oakland County Medical Control Authority, citing licensing laws that prevent ALS equipment on non-ALS certified vehicles.

B. Analysis of OFD Training Practices

OFD personnel said that they attended two trainings prior to 2021. The first active assailant training was in 2013 at OHS. This was a full-scale exercise involving OCSO and OFD. The school staff participated, but not the students. The exercise used blanks in a firearm and blood pellets to simulate the sights and sounds of an actual event. This exercise predated RTF training. In this exercise, the OCSO used the traditional diamond formation of four officers to enter and neutralize the threat. Once the school was deemed clear and safe, OFD personnel would enter to treat and extract the injured. OFD Captain 1 recalled that Chief Scholz was not receptive to the RTF concept and did not want fire personnel to enter into scenes of violence.

The second active assailant training session occurred in 2017. OCSO was implementing the RTF concept and invited the 16 fire departments for areas served by OCSO to participate. OFD sent personnel for this training. Those who were in the department at that time recall attending. The training was approximately four hours in length. OFD were informed about TECC and TCCC. The training instructed fire personnel to respond to a staging area and then wait to be escorted entry by the OCSO deputies who would provide force protection to them. The personnel who attended said the quality of the training varied. On some days, their personnel were with veteran OCSO deputies. On other days, they were with non-sworn correction officers who carried a gun. Several OFD personnel stated that the training taught them that they would always be escorted by a deputy with

a long gun. The reported issue with this training was that it was only offered when members were off-duty and therefore not compensated for their time. This resulted in very little participation by OFD.

Several Oxford firefighters recalled doing RTF training at the OCSO Orion training facility about a year prior to the shooting. However, notably every firefighter interviewed stated that the operations at OHS were not like anything to which they had trained with the OCSO. In those training scenarios, OCSO would use deputies to act as firefighters. Multiple OFD personnel noted concerns regarding the varying levels of experience among deputies participating in the training sessions. In particular, they were concerned about training with corrections deputies who would likely never escort the firefighters into an event.

OFD received donated active shooter medical bags, ballistic vests, and ballistic helmets. However, some members who responded to the shooting stated they had never received any training on the equipment and never opened the active shooter bag before opening it inside the school. They were not familiar with pressure dressings, tourniquets, or hemostatics (blood clotting infused bandages). OFD lacked the requisite knowledge for donning and tightening ballistic vests and helmets. We cannot explain nor justify how some members had not trained with this equipment, when it was placed on the trucks several years prior to the shooting.

Unfortunately, since the attack, there has been no active assailant training at OFD. Members state that there is a lack of internal training, and a lack of external training with the OCSO. In addition, there has been no TCCC or TECC training for department paramedics or EMTs. Medics in the department were not familiar with this training and did not know that any opportunities were available for them to attend. The OFD did not have an active assailant policy or procedure at the time of the attack. Since the attack, the OFD still does not have an active assailant policy or procedure. OFD personnel stated that they are still unclear about what to do in an active assailant attack, and how integrated operations will occur with the OCSO and Oxford Village Police Department.

iii. *Interagency Training*

One way to ensure that all public safety agencies clearly understand their roles and responsibilities is to create a county-wide active assailant integrated response plan. This plan should give expectations for any type of mass violence event, including active shooters, mass stabbing, vehicle-as-a-weapon, explosives, and more. At a minimum, this plan should address the following:

- Scope and purpose;
- Standardized terminology;
- Incident command, including unified incident command;
- Agency roles and responsibilities;
- Communication;
- Operations, including hot zone, warm zone, and cold zone;
- Reunification;
- Mass fatality management; and
- Recovery.

Law enforcement agencies within Oakland County should all agree on common operations and expectations. Likewise, fire and EMS agencies should all agree on common operations and expectations. A county-wide policy will provide the standard expectations for law enforcement, fire, and EMS response regardless of the agency. All agency executives would review and sign the agreement every five years. Within the agreement, each public safety discipline (law enforcement, fire, EMS, 9-1-1, and emergency management) would review their discipline response annex annually.

At this event, there was no established policy or understanding between the OCSO and fire departments on active assailant response expectations. We are deeply concerned that no such policy or understanding exists today. Despite the concerns that arose between agency leaders, no one has taken the initiative to provide corrective action or establish expectations between agencies. The OCSO has had an active assailant policy for more than two decades. OFD still does not have an active assailant policy or procedure today, a shortcoming which we cannot justify or explain. Unfortunately, we doubt that OFD is the only public safety agency in Oakland County that does not have an active assailant policy and procedure.

A. Training on Integration Models for Law Enforcement and Public Safety Agencies

In this incident, common terminology was neither used, communicated, nor understood by agencies, primarily as the result of limited or no communication between agencies. This was yet another interagency issue that all public safety leaders should have addressed prior to this event. Formal agreements by all law enforcement and fire/EMS agency leadership would have provided better coordination for the response. It is critical for leadership to agree on how and where their agency members will operate at active assailant events. This will ensure that when critical incidents occur, established agency expectations ensure seamless operations. The logical follow-up to this is consistent training practices for all agency members.

The most widely taught concept is the RTF model. In RTF formation, law enforcement teams with medical personnel move to victims, perform triage extraction, or in some cases treatment. This is an efficient way to provide lifesaving support to victims for incidents such as the OHS shooting. This task, however, starts with leadership and flows down to the tactical level of operations. Agreements, policies and most importantly training are required. Moreover, integrated policies must include comprehensive communications plans, including intra-agency and inter-agency communications.

There are four common ways to provide medical care at a hostile mass casualty event. These models are based the "zones" of a hostile event.[219] The hot zone is an area where an imminent hostile threat exists. This may be a ballistic threat, bladed threat, explosive threat, chemical release, or any other type of hostile attack modality. The warm zone is an area where no obvious threat exists; however, a threat may emerge at any time. The cold zone is an area cleared and secured by law enforcement in which no threat exists.

In the RTF model, fire and EMS personnel are escorted into the warm zone to treat and extract those that they find. There are two types of RTFs, incident command initiated and spontaneous. With an incident command-initiated RTF, unified command designate law enforcement officers to escort a specific fire or EMS unit. While most commonly taught, it is the least used RTF model. The most common RTF model is the spontaneous RTF. In this model, law enforcement officers organically meet up with a fire or EMS unit and escort them into the warm zone. Although this makes accountability more difficult, it is often much faster than waiting for command to form up RTFs.

The second model is the use of protected corridors. In this model, law enforcement clear an area, and then hold the area. Fire and EMS can then operate in that protected corridor without officers assigned to each unit. This model was utilized at Oxford. This model has several advantages. It reduces the number of law enforcement officers needed to provide protection for fire and EMS. It allows fire and EMS the ability to move freely in a protected area. It requires the least amount of command and coordination. It provides the quickest way to move resources in and out of the warm zone. Most agencies now are fully adopting the protected corridor concept for RTF operations.

The protected island concept means that law enforcement surrounds a large area and then have fire and EMS work inside the area of protection. This concept is typically used in open air attacks or attacks in large indoor areas like a cafeteria or mall food court. This was not a viable option to use at Oxford.

[219] National Fire Protection Association. (2024). *NFPA 3000: Standard for Active Shooter/Hostile Event Response (ASHER) Program*. Quincy, MA: Same.

The fourth model is called contact, treat, extract. This is solely a law enforcement model. This model is typically used when it is too dangerous to allow fire and EMS personnel to enter. This concept is also used in areas where it is quicker to muster a law enforcement response than a fire or EMS response. This model is frequently used in rural areas served by volunteer fire or EMS agencies. This model was used at Oxford to extract Tate from the building.

B. Analysis of OCSO and Fire Training Practices for Active Shooter Events

OCSO's training PowerPoint acknowledges inherent chaos in active assailant situations, and advises, "Do not try and manage the chaos, just gently guide it- like herding cats." We respectfully disagree with that characterization, as the fundamental principle of public safety is grounded in effectively managing disorder. Law enforcement, fire, and EMS responders are called to scenes that have surpassed the ability of those on scene to manage the incident. There is a clear expectation that once responders arrive, the scene will immediately begin to improve. It is imperative for all first responders to begin to forcibly manage the chaos once they arrive. This cannot be done by OCSO alone. Interagency management, using shared practices and procedures, can turn chaos into order. First responders who teach that scenarios are impossible to control, only serve to undermine staff readiness and ensure less than ideal results. The Absence of Sufficient Joint Training and Incident Command Exercises

The Executive Director of OCMCA informed Guidepost that the agency also noticed an absence of unified incident command among OCSO and the other responding agencies. OCMCA explained law enforcement struggles with the idea of shared authority and even other agencies in the county do not know how to facilitate it.[220] Throughout our review we have identified similar issues. As outlined in our data collected, OCSO and fire departments cannot even reach a consensus regarding attendance at training courses or approaches to collective response during events.

This suggests that prior joint training efforts have not yet led to improved outcomes. First responder agency leadership needs to mandate joint training which should include coordination between components across Oakland County. This can be something as simple as a "lunch and learn," where fire department personnel and deputies practice movement and clearing the fire station, for example. After a 30-minute training session, they could share a meal. This approach would reinforce integrated operations, and help builds relationships with the men and women who will have to stand side-by-side in actual

[220] Interview with OCMCA Executive Director.

assailant scenarios. We also recommend that the first responder agency executives meet on a quarterly basis to discuss ongoing initiatives and emerging threats.

Moreover, numerous organizations have identified a gap between traditional NIMS ICS training and active assailant incident command training. As a result, organizations have worked to create training courses specific to active assailant incident command. C3 Pathways in conjunction with the Texas State University's ALERRT Program created the Active Shooter Incident Management (ASIM) course. Other public service organizations have created similar active assailant command training. One such example is the practices of the Charlotte-Mecklenburg Police Department (CMPD), Charlotte Fire Department (CFD), and Mecklenburg EMS (MEDIC) agencies. Starting in 2016, all three agencies required commanders to attend a four-hour active assailant training course. This course included a 90-minute lecture on integrated response, command, and coordination. This was then followed by two tabletop or practical exercises of increasing complexity. This training was mandatory for all CPMD lieutenants, captains and majors; all CFD battalion chiefs and division chiefs; and all MEDIC supervisors and managers. CMPD has now implemented the same training at the sergeant level. Likewise, CFD requires captains who are operating in a battalion chief role to attend as well. This command group consists of more than 400 members from all three agencies. Active assailant command training is now a mandatory course that is presented at least every two years, if not sooner.

A consideration adopted by many agencies to demonstrate their compliance with professional standards is through accreditation. Accreditation status, such as the Commission on Accreditation for Law Enforcement (CALEA), is when an agency voluntarily goes through a third-party assessment made up of law enforcement experts. This process has several phases including external assessment, self-assessment, standard compliance, independent review, and ongoing maintenance. When an agency enters into an accreditation process, they demonstrate to the community the agency's willingness to be evaluated both internally and externally. In addition, they demonstrate the desire to adopt professional standards and make improvements where there is opportunity. Accreditation also means that the agency demonstrates their adherence to these standards with reoccurring reviews. Accreditation ensures a minimum standard is set. As an agency meets a benchmark, they can certainly go beyond these standards. Agencies also become mentors to one another through accreditation. OCSO is not CALEA accredited.

C. Integrated Response Training Considerations

Many active assailant after action reviews discuss the overwhelming chaos that accompanies these events and the overwhelming stimuli that is difficult to replicate in training scenarios. Recognized stimulus should include noise (radio traffic, fire alarms, sirens, people screaming, gunfire, and so forth), sprinklers, smoke, simulated blood, radio system malfunctions, darkness, denial-of-entry tactics, and asymmetric attack tactics. The purpose is to provide an environment with overwhelming stimuli to train responders to focus only on critical operations. Training must focus on responders making critical life-or-death decisions without hesitation. Since Columbine, law enforcement active assailant training has focused on officers moving past living victims to find the threat.

Here, we acknowledge that the SRO was able to follow his training and continue searching for the shooter while a critically injured student tried to grab onto his pant leg. Proper active assailant training often involves role players grabbing onto officer's pant legs to get them to stay. This type of training is critical. OFD personnel expressed frustration and confusion about making decisions as to which critically injured students would receive care and transport. This presents the well documented ethical challenges of disaster triage.[221] This ethical challenge is sometimes referred to as "playing God"; that is, responders may be forced to choose who will live and will who die. Responders are always taught to do the "most good for the most people." Responders are often taught in triage that there is an "expectant" category, in which the victim is still alive, but has mortal injuries. Responders are taught to recognize this condition and move on if there are limited resources. If additional resources arrive, the victim can be upgraded to critical. Although responders are taught this category, they consistently do not use it at mass casualty events.[222] The OFD Captain/EMS coordinator shared similar sentiments with us in his interview, stating that Justin's injuries were likely fatal, and believed he should have moved on to victims who had a greater chance of survival He further opined that OFD needed training that addresses this kind of situation. "No one was ever going to leave him, even though we all have the triage training." Many first responders will encounter a mass casualty event once in their career.[223]

To expect that responders will deviate from their normal practice is falsely optimistic and is inconsistent with published research. Mass casualty training must be an extension of everyday operations. To this point, OFD paramedics stated that it is next to impossible for medics to make decisions at ultra-rare events that are different from daily operations.

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[221] Erbay, H. (2022). Hearding cats: Ethics in prehospital triage. *Signa Vitae, 18*(1): 15-22.
[222] Pepper, M. Archer, F. & Moloney, J. (2019, August). Triage in complex, coordinated terrorist attacks. *Prehospital Disaster and Medicine, 34*(4): 442-448.
[223] Hodgson, L. (2020). How violent attacks are changing the demands of mass casualty incidents. *Journal of Homeland Security Affairs, 17*(1): 1-45.

> *Providers are emotionally unable to limit themselves to perform minimal lifesaving interventions permitted during triage. Instead, they continue to treat the patients aggressively as if they were in normal circumstances. Triage is counterintuitive to normal operations and thus leads clinicians to make erroneous decisions.*[224]

The assessment by the OFD paramedics is correct. Numerous research studies have found that at ultra-rare events, medical providers will continue to operate exactly as they do in daily operations.[225] It is not a realistic expectation to assume a different outcome.

iv. *Training for 9-1-1 Dispatch Communications*

The state of Michigan only requires 9-1-1 dispatchers to attend one week of training for initial certification.[226] However, the OCSO dispatcher academy is three weeks.[227] In addition, each dispatcher is required to complete a 19-week training program under direct supervision of three different communications training officers (CTO).[228] During this time, trainees complete 29 formally appraised areas of job competency with a CTO over 83 certified training days. Completing these competencies allows them to certify for a solo assignment and discharge all the duties and responsibilities of a communications officer on a solo basis for the remainder of their probationary period.

The Oakland County Sheriff's Office Communications Training and Evaluation Program meets key standards and best practices for 9-1-1 training programs. These include basic telecommunicator course, specialized (in-house) training, on-the-job training utilizing communications training officers (CTO), protocol certifications (EMD, EFD, EPD), and knowledge of county geography. The 2021 training manual does not reference "active shooter training"; however, this type of training is not typically taught in basic telecommunicator training programs and is considered a specialized topic, offered in advanced training classes.

[224] Federal Emergency Management Agency. (2018). *1 October after-action report.* Washington, D.C.: Department of Homeland Security.
[225] Auf der Heide, E. (2006). The importance of evidence-based disaster planning. *Annals of Emergency Medicine, 47*(1): 34-49.
[226] Oakland County Sheriff's Office. (2021). *Oakland County Sheriff's Office Emergency Response and Preparedness Division Training Unit*. Pontiac, MI: Same.
[227] Ibid.
[228] Ibid.

As of the conclusion of this incident review the OCSO Communications Division has not provided any records demonstrating any training specific to the handling of active shooter incidents by communications center personnel.

v. *Additional Training Considerations*

In addition to the explicitly defined training requirements previously discussed, this section serves to identify additional areas—though less immediately evident—for which deputies should be readily prepared in advance of an active assault.

A. Use of Equipment Training

Responding deputies to the school were not familiar with the Nightlock barricade. Deputies had to conduct "just-in-time training" to figure out how to use the tool to unlock the device. It is incumbent on the SROs to relay information about active assailant barricade devices to other deputies and the Training Division prior to events such as these. This also requires the SRO to be fully aware and comfortable with the use of such instruments.

B. Off Site Training for Non-Standard Building Layouts

Second, mental health providers relayed that several officers had difficulty clearing the long 200 hallway because of the curvature in the hallway. The officers told the mental health providers that they were experiencing nightmares of clearing the school, stating that they could not see around the corners and were not trained to clear in curved hallways. The long 200 hallway is unique in the curving 200-yard length. Although it is difficult to duplicate this in an off-site training location, law enforcement trainers need to discuss clearing in non-standard designs. Active assailant training programs need to discuss considerations for non-standard building design, such as glass elevators, large atriums that extend multiple floors, parking decks, cubicle "farms", industrial plants, and more.

C. Reunification Training

Law enforcement agencies rarely train for reunification operations. In most jurisdictions, reunification is the responsibility of emergency management. However, multiple active assailant AARs have described challenges that accompany reunification. Most importantly, there are significant security challenges, especially if the perpetrator is not in custody. It is critical for law enforcement supervisors to have some type of introductory training on reunification operations. In this case, the OCSO Reunification Lieutenant was instructed to respond to the scene and coordinate activities at the reunification site at Meijer. The OCSO Reunification Lieutenant stated that he had never received any training on reunification and had never participated in reunification in his career.

D. Training for Crisis Driving

The EMT driver of Oxford Fire Alpha 4 said that when they departed the school with Justin, numerous OCSO deputies responding to the scene nearly collided with the ambulance. The crew also stated that numerous law enforcement vehicles were traveling up M24, including driving in the wrong lane of travel. This made it very difficult for the ambulance to drive to the hospital. The EMT driving stated that law enforcement vehicles were running red lights at a high rate of speed, making travel incredibly difficult and requiring the ambulance to slow and sometimes stop at green lights.

Likewise, the EMT driving the Oakland Township ambulance gave an almost identical recollection of multiple law enforcement officers nearly colliding with the ambulance and running students and parents off the road. The driver of AFD Alpha 1 specifically chose to transport north to Lapeer Hospital (at the time a Level III trauma center- now a Level II), because of the massive number of law enforcement officers responding from the south.

Numerous fire department members from several departments shared personal experiences of dangerous driving by law enforcement officers. Personnel stated that ambulances were almost hit, pedestrians were almost hit, and many other cars were almost hit. Many shared that this reckless driving continued for almost two hours after the shooter was in custody and after ambulances were returned from the scene.

D. OCEM's Contributions to the Oxford Community after the Shooting

OCEM provides coordination of services throughout Oakland County to prepare and respond to natural and man-made disasters. OCEM works with prevention, protection, mitigation, response, and recovery. OCEM also provides several critical community programs, such as Amateur Radio Public Services Corp, Community Need to Know, Hazardous Materials Program, Early Weather Warning Program, StormReady, Skywarn, the Local Emergency Planning Committee, and incident management training.

OCEM provides services to all of Oakland County and the 62 townships. Michigan is a "home rule state," that is, services are to be provided at the lowest government level possible. Because of this, each township with a population greater than 10,000 has a designated emergency management coordinator. Depending on the size of the township, the emergency management coordinator often has other duties. Only a few townships in Oakland County have a full-time emergency manager. The Emergency Management Act of 1976, Public Act 390, outlines the responsibilities and authority of emergency managers in Michigan as well as "provide for planning, mitigation, response, and recovery

from natural and human-made disaster within and outside this state."[229] At a high level, emergency managers in Michigan have little legal authority. The Act states that emergency managers are in charge of response and recovery from disasters. However, that authority is simply assisting as requested. Individuals involved with emergency management in Michigan find challenges in their state. As numerous interviewees stated to the review team, natural disasters are not prominent in Michigan and emergency management is not a priority. Notably, emergency management is often a service provided by law enforcement. In fact, the state's emergency management division is a section of the Michigan State Police, and its emergency management director is Colonel James Grady, the State Police Commander.

Within Oakland County, OCEM has virtually no authority over individual townships, and recovery from an event is the responsibility of the individual township. However, in this incident, Oxford Township sought OCEM resources and did wish to consult with their staff's expertise. Both Chief Scholz and OFD AC Majestic were involved in county emergency management meetings and discussions. OFD Chief Scholz was the emergency manager for the Village of Oxford and the township at the time of the incident. OCEM receives $450,000 each year from the state to run the office. These funds are used for projects that benefit the whole county. Annually, the cost to run OCEM is $3 million, a cost that is paid by county funds. The county emergency management plan addresses response and logistics, but not recovery. This is not an oversight, as each township with a population greater than 10,000 is responsible for their own support and recovery plan. OCEM has several full-time employees that provide extensive assistance to the townships and agencies in the creation of their recovery plans.

In addition, school districts and larger businesses in the county have their own recovery plans. Likewise, here the Oxford school district had very limited recovery plans. The EOP provides, "If school resources prove to be inadequate during an incident, the Administration Office will request assistance from local emergency services, other agencies, and industry in accordance with existing mutual aid agreements and contracts."

1. *Analysis of Oakland County Emergency Operations Center Operations*

One of the critical response functions provided by Oakland County's Office of Emergency Management is opening and staffing the county's Emergency Operations Center (EOC). The EOC is in the OCEM building and is conveniently located across the hall from the OCSO 9-1-1 center. The purpose of the EOC is to facilitate interagency coordination, communication, and collaboration. FEMA states that a functioning EOC is essential for

[229] State of Michigan. (2025). *Emergency Management Act: Act 390 of 1976.* Same: Retrieved from www.legislature.mi.gov.

emergency response and recovery.[230] The EOC is a vital component to bring agency leaders together to collect information, share information, coordinate decision-making, and establish operational goals. The goal of the EOC is to effectively support incident management activities at the scene. FEMA recognizes the following primary responsibilities of an EOC:[231]

- Ensure effective communication with agency and stakeholder decision-makers;
- Serve as a liaison between government agencies;
- Collect, analyze, and share information;
- Identify and address issues before they present, or as they present;
- Support incident needs and requests through a single point;
- Ensure sustainment of operations by providing food, water, sanitary supplies, and more;
- Create a detailed log that chronologically lists all activities related to the incident;
- Coordinate plans and future needs with agencies and stakeholders;
- Provide coordination and policy direction at the senior executive level;
- Ensure the dissemination of timely, accurate, and accessible information to responders and the public;
- Create and administer an effective recovery plan; and
- Ensure scalability and flexibility to increase the size of the EOC or demobilize the EOC.

Here, the EOC was opened at approximately 14:00 and by 16:00 it was nearly fully staffed. The majority of participants were virtual at first, utilizing pre-existing COVID-19 EOC protocol. The EOC was physically staffed by eight members of Emergency Management, deputy county executives, and the OCMCA, with approximately 12 people total. Although OCEM opened the EOC, the lack of representation by the OCSO for several hours significantly hindered EOC operations.

The Oakland County Fire Incident Management Team self-deployed early into the event. However, no one from OFD was at the EOC. This was understandable because of the small size of the department and the need for every available member to respond to OHS or backfill the empty fire stations.

Those involved at the EOC all stated that there was a total absence of any OCSO representation in the EOC. OCSO members told us that designated representatives from the OCSO did not go to the EOC, instead responded to the scene. Multiple people in the

[230] Federal Emergency Management Agency. (2022). Emergency operations center how-to quick reference guide. Washington, D.C: Same.
[231] Ibid.

EOC stated that there was no representative from the OCSO for the first four hours. About four to five hours into the event, an OCSO sergeant arrived at the EOC. This was the highest ranking OCSO officer to report to the EOC. The lack of physical representation by a ranking OCSO commanders created an information gap, as the other agencies in the EOC were attempting to anticipate needs, provide resources, and effectively communicate with multiple stakeholders.

The representatives in the EOC were initially unable to carry out vital functions because of the lack of information coming from the scene. This resulted in significant delays in information sharing with county executives, area hospitals, first responder agencies, and more. OCSO Lieutenant 2 attended some EOC meetings briefly via Zoom, but informed us that she was very busy running the 9-1-1 center and did not have time to go to the EOC. She stated that the lack of ranking OCSO representation in the EOC made it difficult, as she was trying to pull double and triple duty.

In addition to the lack of OCSO representation, there was no representation from the school district. The EOC had no contact with anyone from the OCS for the first 72 hours despite repeated attempts to contact them. The EOC was unable to assist the school district in any way because of the complete lack of communication. The EOC remained operational throughout the night of the event with meetings every hour virtually. At 05:30 on December 1, the EOC was demobilized when the OCSO turned the building back over to OCS. EOC members continued to meet virtually with meetings occurring daily and then weekly before all EOC operations terminated.

2. *Support for Initial Recovery Operations*

OCEM Director Seely was one of the first law enforcement officers to arrive at the April 10, 2009, murder-suicide at Henry Ford Community College in Dearborn, Michigan. Director Seely stated that there was no recovery operation or recovery support at that incident. Director Seely vowed to himself that if another event happened, he was going to aggressively support recovery. To do this, he spent significant time researching recovery operations at other school shootings and mass violence events. This preparation and dedication paid huge dividends at this event.

As mentioned, OCEM repeatedly attempted to contact school officials in the hours and days after the shooting, but to no avail. On December 2, three days after the shooting, OCEM sent representative EM Specialist 1 to the school to explain OCEM was there to support recovery operations. He was assigned as an Assistant Superintendent and Administrative Assistant liaison. OCEM was holding frequent virtual meetings for EOC stakeholders. The OCS personnel attending the meetings were not senior executives. All

decision-making occurred at the OCS cabinet level. Multiple stakeholders involved in these meetings expressed frustration that the school representative was unable to make decisions on behalf of the district.

Likewise, a representative from Oakland Schools was on the call. Oakland Schools is a government educational service agency that provides support to 28 public school districts in Oakland County. OCS is one of the districts that Oakland Schools supports. Oakland Schools does not have administrative authority over OCS. Oakland Schools provide services to the small districts leveraging quantity and size to provide cost savings. Oakland School also provides teacher training and vocational services to the 28 public school districts. Multiple representatives from county agencies expressed frustration with the lack of support that Oakland Schools provided in the EOC meetings. During the meetings, the Oakland School representative was asked for an update as to what Oakland Schools was doing to assist Oxford Community Schools. The representative would briefly turn on her camera and microphone and state, “No update.” County officials stated that personnel at Oakland Schools were reportedly critical of recovery operations but provided no input or assistance to EOC operations. OCEM performed a critical role in the recovery operations for the Oxford community.[232] OCEM maintained the EOC for several weeks following the event, simply to coordinate recovery operations.

E. Reunification at Meijer

Reunification is a critical component of the public safety response at active assailant events. Although the formal definition of this term, and the location for its realization, has changed over time, the basic concept is simple. Following acts such as the OHS shooting, there must be a place and practice established to bring surviving victims together in a safe environment and to provide a hub where critical information can be shared. OHS Emergency Operation Plan (EOP) previously identified Meijer as the “reunification location.” On November 30, 2021, in accordance with this established directive, hundreds of students immediately fled to the nearby Meijer grocery store, which was only half a mile from the high school. Although employees at Meijer were unaware that they were the designated reunification location, the store manager quickly took charge upon seeing the children flooding into the store. The manager closed the store to customers and immediately welcomed the terrified students.

OCSO deputies and the OCSO Reunification Lieutenant arrived at Meijer to take charge of the reunification process. Despite an absence of formal training in reunification practices, the OCSO Reunification Lieutenant acted with authority and made critical

[232] This is explained in depth in the Recovery Section of this report.

decisions quickly. Moreover, Lieutenant Willis provided him with an essential update - the shooter was detained, and there were no indications of additional suspects. This knowledge provided law enforcement at reunification with some assurance that the threat of any suspect at the reunification site would be low. Based on this information, he and OHS/OSD staff worked to ensure that students had transportation to get home. Within two hours, nearly hundreds of OHS students were able to return home to their families after suffering such a traumatic experience.

The families of Madisyn, Tate, and Hana came to the reunification center with the expectation of reuniting with their children. However, after two hours, and no more students arriving from the school, the parents began to realize that their worst nightmare was a reality. The parents were ushered into a store breakroom where they were informed that their children were deceased. Hana and Madisyn's families were subsequently transported to the OCSO Oxford Substation. Tate's father, Buck, drove home to get his wife.

We acknowledge that our review determined an overwhelming positive response to the reunification process by many OHS families. This did not include, however, the families of the deceased victims. Our discussions with Nicole Beausoleil, Buck Myre and Steve St. Juliana suggest that families either did not approve of the means and/or manner by which the information was relayed. While Nicole, Buck and Steve understood that there was no perfect way to convey this information, Nicole felt that the words were emotionally disconnected and significantly contributed to the continued trauma suffered. All agreed that OCSO's delayed disclosure of their children's passing for an excessive period, repetition of additional buses coming, and overall silence gave them the impression that officers knew more than they let on. As discussed in further detail below, apart from the unavoidable trauma that the grieving families were suffering as a result of the incident itself, much of the additional distress could have been avoided through proper practices and procedures. This is important because although no one could take away the loss and anguish of those families on November 30, 2021, proper training and preexisting protocols could have prepared OCSO to act in a more comforting and efficient manner.

Guidepost interviewed the OCSO Reunification Lieutenant who oversaw the reunification center, as well as other OCSO affiliated staff, in addition to OHS staff members. We reviewed community engagement correspondence and conducted interviews of Oxford community members as well as family members of OHS victims. Unfortunately, since OCSO did not utilize BWCs at the time, there was no camera footage available. Furthermore, we found limited radio traffic and minimal CAD notes from the reunification area.

1. *Background on Reunification Practices*

As previously stated, reunification is a critical component of an emergency response to any active assailant event. Reunification is essential to ensure that loved ones are quickly reunited following a critical event. The formal concept of reunification was started by the National Transportation Safety Board (NTSB) in 1996, following several major aviation accidents.[233] The Aviation Family Assistance Act was passed by Congress and codified a coordinated response to aviation accidents. This act and subsequent work by the NTSB created the foundational framework for reunification on the heels of mass casualty incidents.

Following the NTSB's lead, many organizations and agencies established family reunification policies and procedures. Tragically, due to multiple mass shooting events, it was clear that reunification must be a critical public safety response priority. The lack of an effective reunification process has documented consequences. Studies have demonstrated that delayed reunification of family members with pediatric patients has an increased effect on pediatric mortality. Mortality increased from 14% to 16% for pediatric patients in trauma centers who did not have a family member there within 12 hours.[234] In addition, unaccompanied pediatrics had medical costs 21 times higher than accompanied pediatrics. The study cited that pediatric patients have unique medical, psychosocial, and logistical needs after a disaster. The study also found that family members help to "push" pediatric trauma patients through an intrinsically slow system.

Failure to establish a reunification center can even increase 9-1-1 call volume. After the Paramus Mall shooting, retired Police Chief Ken Ehrenberg reported that law enforcement had to quickly add 10 dispatchers to their team of four and reroute calls to other New Jersey counties, New York City, and Pike County, Pennsylvania, due to the surge in emergency calls primarily from family members and friends seeking information on loved ones.[235,] Chief Ehrenberg observed a nearly 70% surge in 9-1-1 call volume. Calculating averages, it equates to approximately 25-30% of 9-1-1 calls in the minutes and hours after an event as people try and find their loved ones.

Delayed reunification also results in family members taking action to reunite with their loved ones. At the 2018 Butler High School shooting in Matthews, North Carolina, parents were instructed to go to the reunification location one mile from the school at Elevation

[233] National Transportation Safety Board. (2023). *Federal family assistance framework for aviation disasters.* Washington, D.C.: Same.
[234] Barthel, et al. (2013). Delayed family reunification of pediatric disaster survivors increased mortality and inpatient hospital cost. *Association for Academic Surgery, 184*(1): 430-437.
[235] Staff. (2012, November 15). Paramus mall shooting: Police release video and 911 calls. *WJLA News.* Retrieved from www.wjla.com.

Church. However, the parents all went to the school, as their children were still inside the school. The parents were communicating with the students on their cell phones. One student was suspended for opening a door and allowing parents to enter the school during the lockdown.[236] This demonstrates that family members will go to where they know their children are, and they will take action to get to their children as quickly as possible.[237]

2. *Reunification Terminology*

Following both the Orlando Pulse nightclub shooting and Vegas Route 91 shooting, many agencies quickly realized that the term "*family reunification"* was limiting. Many of the people who needed the services at the reunification centers in Orlando and Las Vegas did not use the reunification headquarters because they were not family to the victims. In 2022, the DOJ Office of Crime Victim Services recommended discontinuing the utilization of the term *family* with reunification center or assistance center. As a result, the broader terms "reunification center" and "incident assistance center" are now widely accepted. It is critical to understand that a reunification location is not a catch-all location for people to seek information about their loved ones. A reunification center is part of a tripartite structure of centers, collocated and working together, encompassing Reception Center, Reunification Center, and Incident Assistance Center (IAC).

In our experience from review of numerous active shooter events, families of the deceased will go to the reunification location fully expecting to be reunified with their loved ones- as the name would imply. One such example was the shooting at Sandy Hook. Parents all gathered at the Sandy Hook Volunteer Fire Department, located at the entrance to the school property. As the buses gradually stopped coming, parents quickly realized that this was not solely a reunification location. Approximately five hours into the event, teachers and volunteer firefighters notified the remaining families that their children were deceased.[238] The reunification location quickly became an IAC. This mistake is preventable by understanding what a reunification location is, and what a reunification location is not.

3. *Reunification Transition to Incident Assistance Center*

The first part of the reunification process is "check-in." This location is called the reception location or reception center. At this center, staff take down the information of the person

[236] Staff. (2018, November 1). Butler High School student suspended for allegedly opening door to parents after shooting. *Queen City News.* Retrieved from www.qcnews.com.
[237] Recall as well, the OHS parent who went to the school to look for his child, whom OCSO deputies did not prevent from entry.
[238] Posey, C. (2021, August 2). *Lessons learned from a Sandy Hook parent.* Proceedings from the 2021 ALERRT Active Assailant Resiliency Summit in San Marcos, Texas

who is trying to locate their loved one.[239] In the case of a school shooting, the staff also document all necessary information on the student. The basic information would include the student's name, grade, classroom and/or anticipated location when the event happened, phone number, physical description, and clothing. If the parent states that they have spoken with the student and they are safe and unharmed, the parent is then moved into a reunification location to await the arrival of the student. As students arrive, they are taken to the reunification location. If a parent states they have not spoken with the student and have reason to believe that the student was injured in the event, the parent is moved to the incident assistance center IAC.

The IAC must be physically separate from both the reception center and reunification center. This is done purposefully to allow the parents a quiet area with one-on-one attention by responders. This is also an attempt to prevent both inaccurate as well as devasting information spreading to parents who are still waiting to know the status of their child. If a parent does not know the status of their child, they will remain in the reception center. Here, staff will continue to provide constant updates. It is critical to ensure the staff coordinates their communication with unified incident command, and a Joint Information Center (JIC), if established.

[239] For ease of reading and in context with this event, we will refer to the person seeking information as the parent and we will refer to the loved one as the student.

4. Responsibility for Center Staffing

After the 2013 D.C. Navy Yard shooting, a reunification center was established for the thousands of employees and their families. However, no one oversaw the center. Upon subsequent review, there was a formal District of Columbia family reunification plan. However, the plan never established who was in charge. Instead, the plan stated that the responsible agency could be the D.C. Department of Human Services, the D.C. Office of Emergency Management, the FBI, or the American Red Cross.

> *"The ambiguity of who was responsible for reunification was a critical flaw in the plan. Furthermore, municipal agencies were unaware of the plan. The D.C. Metropolitan Police Department and the D.C. Fire Department had no input in the creation of the plan. Reunification was considered a public health issue, not a critical function of emergency response. Because of this, the plan was never implemented early on. First responder agencies had not trained or exercised on reunification."*[240]

Creating and staffing a reception center, reunification center, and incident assistance center is a critical response function for a public safety emergency. As such, this responsibility lies with the leading agency to ensure this is an incident priority after neutralizing the threat and providing emergency medical care to the injured. Aside from immediately supporting law enforcement, fire, and EMS operations, this is a critical response priority for emergency management departments. In fact, in many jurisdictions, establishing and operating these centers is the responsibility of emergency management teams.

The responsibility does not lie solely with law enforcement and government entities. In a situation such as OHS, the school district also plays a critical role in center operations. The school district provides staff and administrative information, such as student records. This role is especially critical in younger student populations when determining who is authorized to pick up students. Failure to properly vet if the person is authorized can have devastating consequences. Public safety personnel should defer to school administrators to determine the release of students. Staffing foresight is especially vital, as reception and reunification centers typically remain operable only in the immediate aftermath of an event. These centers demobilize within approximately four hours, as all students are evacuated from the school. Conversely, IACs may remain operational for days and even weeks after an event. IACs frequently grow in size as the hours continue. After the Pulse

[240] Washington, D.C. Metropolitan Police Department. (2014, July). *After action report: Washington Navy Yard September 16, 2013; Internal Review of the Metropolitan Police Department.* Same. Washington, D.C.

nightclub shooting, the IAC was relocated four times in the first 24 hours to accommodate the rapid growth.[241] The final incident assistance center was established at the Camping Word Stadium.[242] More than 60 government and community agencies were represented. A total of 956 individuals and 298 families received care and support from the center.[243]

In the same vein, the Las Vegas Metropolitan Police Department established an IAC following the Route 91 shooting at the Las Vegas Convention Center.[244] This center was open 24-hours a day for the first 72 hours. The center then converted to nine-hour a day schedules. The Las Vegas Fire Department incident management team staffed the center. IAC began providing a wider range of services including ground and air transportation, onsite childcare, lodging, crime victim benefits and compensation, legal assistance, identification services, counseling and spiritual care, therapy using service dogs, consulate services, return of personal effects, and donation management.[245]

The center assisted more than 4,200 families and received more than 14,000 phone calls. On October 20, 2017, the center was shut down following the opening of the "Vegas Strong" Resiliency Center. As these two case studies show, it is critical for public safety officials to have a formal plan in place to immediately open a reception center, reunification center, and incident assistance center.

5. How Students were Directed to Meijer

OHS administrators and OCSO commanders were well-informed that Meijer was designated as the school's reunification location for many years prior to the shooting in 2021. In our interview with several school staff members, we determined that Meijer and the schools' football stadium were the two potential locations presented in active shooter training as reunification locations. Although school staff recalled that "sending students to Meijer" was a conversation in the schools' ALICE drills, they did not receive an official directive that Meijer was the firmly established reunification location.

Although Meijer is clearly identified in the school's EOP, the school district and OHS did not provide any type of written memorandum of understanding (MOU). Our research suggests that there was an informal agreement between OHS and Meijer. For example, OCEM Specialist 1 suggested that this discussion might have occurred 10 years prior to

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[241] Williams, R. & Drozd, O. (2017, September 27). *Orlando Fire Department and Orange County Fire Department debrief of the Pulse Nightclub shooting.* Orlando, FL: NFPA 3000 Committee Meeting.
[242] Ibid.
[243] Ibid.
[244] Federal Emergency Management Agency. (2018). *1 October after-action report.* Washington, D.C.: Department of Homeland Security.
[245] Ibid.

the shooting. However, it appears that by the time of the shooting, the Meijer store manager had changed, and was unaware of any prior discussion, suggesting that there was not an updated conversation with the store staff in 2021.

As discussed in Guidepost 2, OHS administrators stated in interviews that they understood Meijer was the school's reunification location. The staff stated that this was often discussed in emergency response training. Multiple OHS employees urgently guided panicked students to seek safety at Meijer. OHS school staff stated that as soon as the shooting happened, hundreds of students fled the school. The OHS school secretary immediately went out of the front entrance and went with staff to the north parking lot to direct students to Meijer. For the next 45-60 minutes, she and other staff members continued to tell fleeing students to go to the store. As OHS school secretary left the building, she grabbed two rolling briefcases containing vital student information. These two briefcases were kept in a secure location in the front office and are designed to be used by school staff in the event of off-site reunification.

Many parents quickly collected at the doors of OHS. Parents were instructed by school staff to get students away from the school quickly. This was discernable on camera as collected from the hall monitor's activated body worn camera. The footage showed what can only be described as a thoroughly chaotic scene in the parking lot as parents were gathering their children and friends to leave. As a result of the chaos in the parking lot, many students did not ultimately go to Meijer. The OCSO Reunification Lieutenant who led the reunification location, indicated that most of the students who went to Meijer needed transportation home.

6. Reunification Leadership at Meijer

The OCSO Reunification Lieutenant was in his office located in Pontiac when the shooting took place. Approximately five minutes into the event, an OCSO deputy informed him about the shooting at OHS. Several OCSO deputies were listening to the radio, trying to determine what was happening. Once the OCSO Reunification Lieutenant confirmed the active shooter event, he and his deputies assigned to the Narcotics Enforcement Team (NET) all responded to the school.

The OCSO Reunification Lieutenant and his deputies arrived primarily in unmarked vehicles with lights and sirens.[246] During our interview, the OCSO Reunification Lieutenant recalled that traffic was very congested on M-24, a major throughway in Oxford, with public safety vehicles responding to the area. He passed two ambulances heading south with lights and sirens, which he presumed contained patients. While

[246] These are vehicles consistent with what the NET team would primarily use.

enroute, the OCSO Reunification Lieutenant received a call from Lieutenant Willis, requesting him to take the lead at Meijer and coordinate the reunification. Lieutenant Willis also provided information that the shooter was in custody. OCSO CAD notes indicate that at 13:17:36, NET advised that they were enroute to the scene. Given the notification time and a 25-minute drive from Pontiac—factoring in passing two ambulances—the OCSO Reunification Lieutenant likely arrived at the school around 13:30, about 38 minutes after the incident began.

When the OCSO Reunification Lieutenant arrived at Meijer, the scene was total chaos. Students and customers were walking around. OCSO and OFD had previously instructed first responder units to “stage” at Meijer. As a result, many law enforcement officers were in the parking lot awaiting their task at the school along with fire department officers who were not engaged in a particular assignment. While most law enforcement officers responded to the school, a few remained at Meijer to help with the reunification location. To best facilitate reunification and the protection of the students and families, the OCSO Reunification Lieutenant immediately ensured the store was closed and removed all customers. The students were gathered throughout the store and in the parking lot. He ordered all the officers to gather students in the garden center portion of the store to attempt a head count. The students all complied and quickly filled the garden center.

7. *Identifying Students and Reunification with Families*

While security was a consideration, it was not a priority, as the known suspect was in custody and numerous law enforcement officers were at Meijer. The immediate priority was to collect the students in one place, and to determine who was there. Once the students were in the garden center, law enforcement officers and OHS staff went student-by-student and wrote down names on paper. This was a difficult task at best, and there appeared to be no formal system of accountability. Law enforcement officers and OHS staff moved groups of students into the store as they arrived. Multiple OHS staff members all began to arrive at Meijer. Most teachers and faculty all came, resulting in approximately 150 OHS staff assisting with reunification operations. As OHS school secretary had the two important briefcases, she positioned herself at the front of the garden center to facilitate check-in and check-out.

The teachers all worked to collect students in groups by their classroom. As fifth period was just beginning, the teachers quickly worked to locate their students and provide order. As the classes were collected, they moved deeper into the store and out of the garden center. OHS school secretary recalled that most of the students were on their phones and already talking with their parents. This helped tremendously, as arriving parents knew

their children were at Meijer and knew they were okay. Students also were talking with their parents and arranging rides with other families arriving.

Both the OCSO Reunification Lieutenant and OHS school secretary recounted that the emotional state of the students ranged widely. Some of the students were hysterical and some were calm. Students who were in an emotional crisis were immediately engaged by school staff or law enforcement when they came into the garden center. The OCSO Reunification Lieutenant recalled that Meijer was very welcoming to the students and allowed them any food and snacks that they wanted without charge. This small act helped to calm down distressed students,[247] and to distract them before their families and/or friends came for pickup. The goal was to keep everything as orderly as it could be under the circumstances.

As OHS staff and families arrived, everyone began to offer help. Numerous law enforcement agencies provided about 20 additional officers. Although more law enforcement support could have been helpful, the OCSO Reunification Lieutenant stated that he did not want to take resources from the school. He also noted that minimal intelligence gathering occurred at Meijer. Only one student stated that he witnessed the shooting, but he was unable to provide sufficient information to identify the shooter. The OCSO Reunification Lieutenant passed along his information to Lieutenant Willis, but the decision was made to release him, as he could be interviewed later. OCSO and OHS staff made the executive decision that the best course of action was to transport students home as quickly as possible using any means necessary. As these were all high school students, there was no formal system to ensure only authorized people could pick up. Many students were arranging travel home with friends. In most cases, parents were in contact with their children to coordinate travel home. OHS school secretary said that OHS staff would talk with the parents to confirm that it was okay for their children to leave with someone else. As students left, OHS staff attempted to document where the students were going and with whom each student departed. A few of the students decided to simply walk home from Meijer after they arrived.

When parents arrived and could not find their children, the OCSO Reunification Lieutenant radioed Lieutenant Hill and asked if more buses were coming. Students were still arriving on foot 90 minutes into the event, after learning from other students to proceed to Meijer. About two hours into the event, the buses came less frequently, and by approximately 15:00, OHS buses were no longer arriving. Both the OCSO Reunification Lieutenant and OHS school secretary stated that the panic of parents increased when fewer buses began arriving. We inquired about whether translators were

[247] Meijer also did not report any issues with the students.

a consideration. Both the OCSO Reunification Lieutenant and OHS school secretary stated there were no students or families that needed translators. This is important to consider especially for schools that serve multilingual students and families. In addition, the OCSO Reunification Lieutenant noted there were no issues with students with physical or cognitive disabilities that he identified at Meijer. We note that during our review OHS provided information that several students had significant physical and cognitive disabilities. However, OHS school secretary said all the students received direct attention from OHS staff, and there were no issues with students with disabilities at Meijer.

As aforementioned, the families of Madisyn, Tate, and Hana were at the reunification location. OCSO Reunification Lieutenant and OHS school secretary both recalled that it was a very emotional and difficult situation as the buses stopped coming. OHS school secretary does not remember which family it was, but one of the families of the deceased was panicking when they realized no more buses were coming. Both OHS school secretary and OCSO Reunification Lieutenant described the time as "emotionally devastating." At approximately 17:00, the three families were escorted into a staff breakroom at the store. There, an OCSO Lieutenant informed the families that their children were deceased. As soon as this notification was made, the parents of Madisyn and Hana were told to go to the OCSO Oxford Substation. At approximately 19:00, the reunification location was fully demobilized.

8. Disclosure of Deceased Students and Victim Services

Dr. Megan Wade (Dr. Wade) is a reserve deputy with the OCSO, academy graduate as of April 2021. Since October 2021, she had been employed part-time as a psychologist with Beati Bellicosi Psychotherapy PLCC, which included her work at OCSO. She also held a full-time position as a licensed clinical psychologist at the Veterans Administration (VA) in Detroit. In her interview with Guidepost, she recalled her interactions that day and how she became involved with the victims and families.[248] On the day of the OHS shooting, she was on duty in Detroit when Dr. LaMaurice Gardner (Dr. Gardner) contacted her within the first hour of the incident. Dr. Wade stated that she was dispatched to the Meijer reunification site by Dr. Gardner and recalled wearing civilian attire rather than an official uniform.

She informed Guidepost in her interview that her role was to accompany chaplains to provide death notifications to families, as well as to provide on-scene support at OHS. As

[248] It is important to note that Dr. Wade readily admits to her inability to recollect specific aspects of reunification. She informed us that she arrived late and was following orders as requested. She said at times she may be making assumptions as to the facts.

to the family notifications, she stated that she believed each family was separately informed about their children, but she was not fully certain since she was somewhat outside the room. Dr. Wade asserted that Madisyn's family was previously informed and that she was only present for notifications to Hana's family. Afterwards she circulated through the parking lot to aid survivors and bystanders. Dr. Wade's recollection was that she first encountered a friend of Tate's and then participated in the notification to Tate's parents and brothers. She could not recall if the chaplains or OCSO deputies led this disclosure.

We inquired whether there were benefits or detriments to informing families in group format or individually, to which she explained there are benefits and detriments to both approaches. There are times when informing individuals in a group allows them to find a sense of comradery in loss. However, even then she suggests that each family should receive individualized attention. We also inquired about the way death notifications should be addressed. She stated that it was important to be fully informed at the time of disclosure, to not overpromise or provide false hope, and provide information in a definitive, but humane manner.

After leaving Meijer, Dr. Wade reported to OHS at Gardner's request for first responder support. She conducted a group debrief with several school personnel. She also assisted with debriefs for several law enforcement officers who treated critically injured students. Subsequently, Dr. Wade provided care for deputies and staff at OCSO Dispatch until almost 02:00 in the morning.

Dr. Wade also provided an explanation of the International Critical Incident Stress Foundation counseling protocols, which recommend:

- Utilizing the rest/information/transition model within 24 hours, which involves one-on-one engagement and tailored counseling based on each individual's account;
- Scheduling formal critical incident stress debriefs 7–10 days after the incident, including a group walkthrough of the event and focusing on each participant's level of involvement;
- Continuing to offer group and individual sessions in ensuing days/weeks; and
- Monitoring sleep, mood, and warning signs of trauma reaction.

The families of the deceased students recounted their experiences, many shared the prevailing narrative that support, and services were absent. Nicole Beausoleil described that, despite her efforts to provide a photograph of her daughter Madisyn, neither deputies, school officials, nor counselors communicated information regarding the ongoing search or any related actions. She observed that the officers appeared unresponsive and their movements were aimless. Although she could not recall which

OCSO lieutenant delivered the tragic news, she distinctly remembered it being conveyed in manner she characterized as, “the most disturbing way.” Nicole remembered the delivery was simply, "We don’t have good news for these three, they are deceased." Nicole recounted this death pronouncement and shared that the very delivery of these words has continued to impact her as a component of the trauma she endured. She further noted that after learning of her daughter’s death, she found herself lying on the supermarket floor in a pool of her own tears. There were no deputies or victim services personnel who provided support, or even a hand to lift her from the ground. At one point the only interaction she had was with a member of clergy who encouraged that they “pray.” Nicole expressed discomfort participating in religious practices that were not part of her own beliefs. Buck Myre similarly suggested that his family along with Madisyn’s and Hana’s were provided with no information about when they could see their children, why they were not able see them at the time of the disclosure, and moreover, why the information about their children’s death was delayed. They were simply told that their children were dead.

All the families strongly believed that OCSO and school officials knew that their children were dead and kept avoiding the conversation. Nicole remembers speaking to an OCSO lieutenant and asked about Madisyn and believed then that he knew. She thought “when he looked at the picture and looked at me he had to say something to walk away from me quickly.” Buck recounted waiting for hours and only being told by deputies that they would check the buses, knowing that Tate and the others were dead. Tate, Madisyn, and Hana’s families were instructed to then leave to go to the OCSO substation. Both families confirmed no specific information was relayed, and that the only thing they received that day was the time to report to the medical examiner’s office to identify their children.

9. Analysis of OHS/OCSO Reunification Practices and Suggestions for Improvement

In the aftermath of this tragedy, OCSO and OHS faced challenges due to a lack of formal training and protocols for reunification, resulting in some level of chaos, confusion and unmet needs for victim’s families. While group notifications can foster unity, individual attention remains essential. Experts stressed the importance of transparency, compassion, and accuracy when delivering death notifications. In addition to training, we advise on the necessity for structured MOUs with reunification centers and a proviso for effective reunification plans. Ultimately, these insights seek to provide comprehensive preparation to ensure compassionate, coordinated responses in times of crisis.

a. OHS Communication of Meijer as Location for Reunification

As aforementioned, Meijer was identified in the school's EOP; however, it was never formalized. The issue with informal agreements is the potential for leadership changes on both sides. By the time of this incident, the original Meijer store manager had changed. While Meijer staff and management was incredibly generous and quick to accommodate the influx of students, families, school staff and law enforcement, there was nothing requiring them to do so. Although an MOU is not typically legally binding, it promotes clear collaboration and ensures all parties understand their obligations. The MOU can involve assigning a party in the school's administrative offices to call a specific line at the business to inform them that orders were given to students to congregate. It can predetermine if the business will assign certain departments or rooms for meetings, including places for parents, students, and law enforcement. For organizations like Meijer, this means everyone associated with the business knows the store is committed to being a safe space for children during crises. The MOU can also be integrated into leadership training, ensuring important information persists despite staff changes. For OHS leadership, this ensures that their EOP is communicated to a nearby business or businesses and helps address potential issues related to its implementation.

b. OCSO Lacked Specific Training Practices for Reunification

According to our interviews and the training documents provided, OCSO did not provide any comprehensive training to supervisors and/or commanders about reunification procedures and practices. In this event, the OCSO Reunification Lieutenant, who oversaw the reunification center, confirmed that he never received any training on reunification. He also stated that in his career at the OCSO, he never participated in any type of reunification event. Despite this lack of training, we acknowledge his rapid and effective decisions to try to make the transition from the chaos of OHS to Meijer less emotionally traumatic and to assist families in their pursuit of reuniting with their children. However, his ability to perform well at this event should not be interpreted as a guarantee that other law enforcement supervisors and commanders will be able to provide the same results. Moreover, while we credit the OCSO Reunification Lieutenant for his actions under the circumstances, the struggles he identified could have been better addressed had there been well-established practices in place to guide all participating agencies.

As aforementioned, the OHS school secretary stated that she had never received training on reunification at her previous job at Lake Orion Schools or at OHS. She was not aware of any reunification training provided to OHS staff. She also was not aware if any staff that helped at Meijer had any training. She did not believe anyone did, as they were all doing their best to try and determine what to do. In her interview, the OHS school secretary did discuss a more recent event that occurred on October 24, 2024. OHS

received a call stating there was a man with an AK-47 inside the school.[249] The school immediately went into lockdown, and this triggered a massive law enforcement response. The call was determined to be false and originated from the Netherlands. This type of hoax call is often referred to as "swatting," where someone gives a detailed call to elicit a major law enforcement response. OHS school secretary stated that the school evacuated, and students again went to Meijer for reunification. She noted at this event, OCS appeared much better prepared. She stated that OCS administrators arrived quickly and were wearing traffic vests with designated positions. She stated that they had student reunification cards with a tear-off section for parents to write their information as they picked up their students. OHS school secretary stated this reunification practice was smoother than the day of the shooting.

c. Necessary Metrics for an Effective Reunification Plan

As reiterated several times, reunification is a critical function of public safety emergency response. Failure to plan, prepare, and rapidly execute reunification is a significant public safety failure. At a minimum, to establish an effective reunification plan, the following criteria must be part of the calculus[250,251,252]:

- Identify the parties responsible for orchestrating the operations center;
- Determine what resources will be allocated to the centers and from what sources;
- Determine which agencies will staff the centers;
- Define who will qualify as a victim and which individuals (victims, families) are eligible for services;
- Determine communication form to be used to inform the public about center services;
- Have provisions in place to accommodate people with special, physical or mental needs;
- Have provisions in place to accommodate people with language barriers, such as translators;
- Establish formal procedures for the check-in and check-out of victims, families, and care providers;
- Establish formal procedures for surviving victim identification, such as a process to identify them, as many get sent to hospitals as John Does and Jane Does;

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[249] Staff. (2024, October 24). Oxford High School placed on lockdown after 'swatting' call from Netherlands, officials say. *WXYZ News*. Retrieved from www.wxyz.com.
[250] United States Department of Health and Human Services. (2018). *Tips for healthcare facilities: Assisting families and loved ones after an MCI.* Washington, D.C.: Administration for Strategic Preparedness and Response.
[251] Washington, D.C. Metropolitan Police Department. (2014, July). *After action report: Washington Navy Yard September 16, 2013; Internal Review of the Metropolitan Police Department.* Same. Washington, D.C.
[252] Federal Emergency Management Agency. (2018). *1 October after-action report.* Washington, D.C.: Department of Homeland Security.

- Establish formal procedures for decedent identification and medical examiner operations. The decedent identification is typically spearheaded by the medical examiner's office. However, a helpful practice is to provide a spot at the reunification center;
- Establish formal procedures for on-site crisis counseling;
- Facilitate and provide low/no-cost transportation options for those who qualify for center services;
- Determine key concerns and variables to properly assess security considerations;
- Establish procedures for consulate and embassy services; and
- Establish procedures for returning personal effects, to include access to vehicles at the event location.

In 2024, the State of Michigan adopted the Standard Response Protocol (SRP) and the Standard Reunification Model (SRM) from the I Love U Guys Foundation.[253] The I Love U Guys Foundation provides formidable instructions on reunification that every jurisdiction should adopt. Their SRM and SRP provide a functional framework for reunification for people of all ages. This protocol and model establish not only a common language, but also a flexible process for response and reunification.[254] We recommend that all schools train administrative staff and educators in both response and reunification. The school's EOP should reflect the utilization of the SRP and SRM. This demands that district leadership have extensive training on managing reunification centers.

The Oakland County School Safety Consortium (OCSSC) consists of members of OCEM, public schools, and private schools. Other schools outside of Oakland County are also allowed to join if their county does not offer a similar working group. OCSSC assists with developing the best practices for schools to adopt. As a result of our conversations with Director Seeley, of OCEM, we confirmed that all member schools are currently drafting reunification plans, with assistance from emergency management. OCSSC is also engaged in creating a county reunification team that can respond quickly to any crisis event, including natural disasters. This includes the development of a fully equipped trailer with necessary equipment to support the team. The goal is for a school to begin reunification internally. As team members from different schools and the county arrive, they can seamlessly assume operations. OCEM stated that they are actively writing a comprehensive plan for the team. OCEM informed us that they are also working with the Oakland County Health Department ("OCHD") to staff reunification centers. The Health Department has a number of employees who could provide rapid assistance. The main

[253] Michigan State Police. (2024, September 3). *New resources available to assist K-12 schools with emergency planning*. Lansing, MI: Office of School Safety.
[254] It is also noteworthy that the Department of Defense has now adopted the SRM and SRP along with tribal, and many states agencies.

concern is the availability of Health Department staff for nights and weekends. It is the opinion of this AAR Review that OCHD is an excellent option to consider as it provides trained personnel quickly to begin reunification operations.

At the time of the shooting, OCMCA representatives were present in the emergency operations center. They worked on communicating with hospitals and determining where patients were transported. In incidents involving potentially larger scale crises, the OCMCA will need to have a physical presence both in the EOC and at the reunification location. OCMCA can serve a vital role not only in identifying missing patients, but also to help trace where "missing" patients were ultimately transported. In large-scale events, such as the October shooting in Las Vegas, this type of reunification was a critical part of the operation.[255]

As applied to the shooting at OHS, the reunification center was within walking distance of the school. If the center was located further, buses would have been necessary to transport the students.[256] The distance between a reunification center and active assailant radius presents another logistical consideration that the incident and center commanders need to address. A reunification plan must contemplate the potential of mass transportation of victims to the location center. At the Aurora Century 21 theater shooting, hundreds of witnesses and moviegoers were transported by buses to Gateway Elementary School for reunification.[257] This also presented additional security challenges, as law enforcement did not know if there was another suspect.[258]

An often-overlooked part of reunification is the practice of returning personal effects left at the incident location. After the OHS shooting, there were hundreds of personal items left inside the school as students and staff fled. One of the pressing personal concerns was gaining access to vehicles left in the school parking lot. At 18:21:58, a 9-1-1 caller states she was a teacher at the school, and she would like to know how she and her coworkers could retrieve their cars from the school. Likewise, Buck Myre was making requests to OHS and the OCSO to retrieve Tate's keys to his pickup truck. Prior to demobilizing a reunification location, it is important to establish a process by which personnel effects are identified and returned.

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[255] Federal Emergency Management Agency. (2018). *1 October after-action report.* Washington, D.C.: Department of Homeland Security.
[256] When OCSO deputies cleared classrooms, they brought the OHS students to the lobby where they boarded buses to go to Meijer. However, given the distance here, buses while helpful to students were not necessary.
[257] Tri-Data. (2014). *Aurora Century 21 Theater Shooting: Official after action report for the City of Aurora.* Arlington, VA: Tri-Data Corporation.
[258] Ibid.

Many OHS staff members left critical personal effects inside the school when the shooting happened. Some of the personal effects included cell phones, purses, car keys, computers, tablets, prescription eyeglasses and more. OHS school secretary stated that two days after the shooting, staff members were allowed to come back to the school to collect their items and vehicles.

Personal effect management at an active assailant event can sometimes be a massive undertaking. At the 2017 Hollywood International Airport shooting, more than 25,000 personal items were left in the airport.[259] These items include cell phones, wallets, purses, passports, government identification, computers, tablets, car keys, and strollers. Private vendors often charge hundreds of thousands of dollars to categorize every item and reunite them with their owners.

It is important to know that the FBI's Victim Services Response Team (FBI VSRT) is available for free to assist in mass violence incidents. This group of highly trained special agents, analysts, and victim specialists is specifically designed to deploy to crisis and mass casualty events, bringing numerous experts to assist those involved. FBI VSRT specializes in victim identification, notification, communication, data analysis, and family member support. This team also specializes in collecting, managing, cleaning, and returning personal effects collected from crime scenes. It should be noted that OCSO declined all offers from FBI VSRT for assistance.

As a result of the OCSO declining FBI VSRT assistance, the school district was responsible for reunifying personal effects with their owners. OHS staff were asked to come into the school in the immediate days after the attack to collect all the personal items scattered throughout the school. OHS staff were burdened with the possibility of blood or body fluid on the items, determining the owner, and subsequently returning the item back to its owner. Multiple OHS staff informed us that this was a psychologically devasting exercise and resulted in substantial emotional and mental health implications for all involved. The Recovery Coordinator and mental health provider hired by the OCS, echoed the same sentiments in her interview with Guidepost. She spoke to the significant toll this operation took on school employees, who should not have been back within the school walls so close in time to the violent incident.

[259] Kennedy, K. & Spencer, T. (2017, January 7). IDs, phones, bags among 25k items lost in airport rampage. *Associated Press.* Retrieved from www.ap.org.

d. OCSO Responsibility for Staffing and Security at Reunification

OCSO was quick to see that the school sent students to Meijer for reunification. Lieutenant Willis was at the command post at OHS and quickly notified the OCSO Reunification Lieutenant to respond. Prior to the OCSO Reunification Lieutenant's arrival, law enforcement, fire, and EMS units were in the Meijer parking lot, as this was a designated staging area for responders. This large number of public safety units at the store provided a robust physical presence that increased security. Although no one was in charge of reunification prior to the OCSO Reunification Lieutenant's arrival, there were significant public safety resources immediately available. Although the OCSO had no formal plan, policy, or training on reunification centers, the OCSO Reunification Lieutenant and the dozen law enforcement officers with him quickly filled critical roles. Along with the arrival of school personnel, all agencies were able to quickly and effectively establish an operational plan. Staffing reunification centers is a primary responsibility of local public safety. At this event, the OCSO quickly met this challenge and performed very effectively.

Furthermore, there must be a metric in place for assessing security concerns. Lieutenant Willis informed the OCSO Reunification Lieutenant of a suspect in custody and a weapon recovered. The OCSO Reunification Lieutenant knew there was a search for additional suspects; however, there was no obvious indication of multiple suspects. In addition, none of the hundreds of students arriving at Meijer gave any information indicating multiple shooters. All this information was critical in his considerations for reunification center security. the OCSO Reunification Lieutenant informed us that if someone was not in custody, or if there were multiple suspected perpetrators, he would have requested a robust law enforcement response. Thus, Meijer would have had tighter security, students would be searched for weapons as they arrived, and his primary goal would be the acquisition of actional intelligence from the students. In addition, the release of students would be much slower and more methodical, requiring an authorized guardian to pick up the child.

The OCSO Reunification Lieutenant used proper tactical practices for reunification center operations. As previously noted, however, it is not advisable to proceed without formal practices simply because the actions of one commander proved to be proficient without any formal policy. There is no promise that such a result would be the same every time. In addition to the tighter security, the response of the bomb squad's explosive ordnance disposal (EOD) K-9s would be necessary as students arrive with bags and backpacks. An active community manhunt for an active shooter suspect provides significant law enforcement challenges. As such, many officers would be dedicated to the manhunt. A robust law enforcement package to the reunification center would likely take a

considerable amount of time to muster. The OCSO Reunification Lieutenant rightfully sought to identify students who were direct witnesses to the shooting.

e. Efficiency in the Process of Reunification

As with any active shooter event, this event provides an excellent opportunity to evaluate procedures and methodology for reunifying students. Following a school shooting, parents simply want their children, and they want them right away. The OCSO Reunification Lieutenant said the decision to go slow for potential legal liability purposes would have led to irate parents, greater unrest, and additional security concerns. It is recommended that law enforcement officials balance operational requirements with empathy and examine the potential responses they would exercise if their own family members were similarly affected. We do not expect premature disclosure of information or require law enforcement to share details on ongoing investigations. Rather, we urge recognition of the human impact on families and children. Communities must be able to trust that law enforcement will share relevant information promptly, when appropriate.

OCSO Dispatch received numerous 9-1-1 calls from parents. However, most of the calls were to report the shooting and not asking about reunification with their children. The OCSO Reunification Lieutenant informed Guidepost that every student who arrived at reunification was on the phone with their parents. OCSO and OHS benefitted from the messaging that occurred between parents and students prior to reunification, as it appears to have prevented OCSO Dispatch from being inundated with additional calls from concerned parents. Therefore, the more formal reunification “reception center” was ostensibly virtual. In addition, a sole suspected shooter and confiscated weapon also expedited reunification. The age of the students also was helpful to OCSO and OHS officials on scene, as it was perceived that the children were of an age that they knew with whom they were allowed to leave. This allowed the reunification process to be further accelerated.

However, it is important to emphasize that law enforcement agencies and school districts must have known and established policies and procedures for reunification of minors. This policy must be vetted and approved by legal counsel and risk management. At events involving school students, law enforcement should confer with school administrators prior to releasing any students. If in doubt, always err on the side of caution and release minors only to authorized guardians through a formal process. Always ensure that students in a mental health crisis receive immediate aid and are not allowed to leave without a guardian’s permission. When determining reunification procedures, use school dismissal as a guide. If students are typically allowed to leave school dismissal with anyone they want or walk home, then there may not be a need to put additional safeguard

measures in place at a reunification center. If students are dismissed only into the care of authorized guardians, then this process must be followed.

f. Challenges in Transitioning from Reunification to Incident Assistance Centers

Madisyn, Tate, and Hana's families were at the reunification center expecting a relieved and joyful reunion. Gradually, the parents' fears began to materialize that they could not reach their children by phone, and the buses were no longer coming. The three families were escorted into a store breakroom and informed that their children were dead. As one would fully expect, this information immediately resulted in immense anguish. The lack of responses to their inquiries and insufficient coordination contributed to a collective sense of frustration following this interaction. The parents stated there were no crime victim specialists and no counselors there. Dr. Wade concedes that she arrived late, so she was not sure about the details at Meijer. After waiting at Meijer, families felt that their time was wasted yet again at the OCSO's substation. The three bereaved families agreed that no information was communicated to them about the investigation or even when they would be able to see their children.

While group notification is acceptable, Dr. Wade stated that families should be approached on an individual basis. The families were not afforded this opportunity. She also stated that information dissemination should follow established procedures, which is not consistent with the traumatic manner in which families recall learning of their children's passing. Dr. Wade noted that clergy may provide support to victims and can serve a useful role. However, prayer should not be mandated, and it is generally advisable to have representatives from various religious backgrounds present.

This underscores the need to promptly create an IAC as soon as information is available that there are seriously injured or deceased victims. An initial IAC is often adjacent to the reunification center, but in a place that offers privacy and quiet. This area must have a dedicated law enforcement supervisor with direct information from the incident command post. In addition, the IAC must have senior administrators from the school and the school district. Law enforcement should also have crime victim service personnel respond. In the absence of availability of crime victim service personnel, special victim unit personnel can also respond. The goal is to quickly put personnel in the IAC that are trained in grief counseling and death notification. At this event, there was a Chase Bank located in the parking lot of the Meijer. This would be an ideal place to create an IAC. The bank is quiet, secure, and there are offices and conference rooms.

In multiple fatality events, the medical examiner's office is often involved at the IAC. In cases of devasting injuries to the deceased, the medical examiner may need to ask the

families multiple questions to determine the identity of the deceased. At the Uvalde mass shooting, the medical examiner requested parents provide DNA samples to assist with victim identification.[260] The medical examiner elected to use this method to spare the parents from having to view photos. Many of the bodies were horrifically damaged by numerous gunshot wounds. Unfortunately, this has occurred at many mass shootings, including Sandy Hook, Sutherland Springs First Baptist Church, Charleston AME Church, and more.[261,262,263]

Although this did not occur at the Oxford shooting, public safety personnel must always assume this may occur at mass shooting events. At active assailant events, human remains can be highly fragmented, comingled, or even burned.[264] Family members want to know very quickly the status of their loved ones. However, the medical examiner's office typically will not conduct official death notification until the body is irrefutably identified.

F. Journey to Recovery

Guidepost was tasked with assessing the "recovery efforts" to the shooting at OHS. However, we wanted to preface this part of the review with the caveat that it is at best naïve to presume that everyone "returns to normal" or that there is one definition of "normal." Following a critical event, there is a new normal.[265] This new normal does not operate in a vacuum and carries the trauma of event reminders. Mass shooting/active assailant events often redefine people's character. Their identity is often fully subsumed by the event. These events fracture a community to the bedrock. Oxford is no different. This can even come from acts such as expressing solidarity as "Stand with Parkland" and "Oxford Strong," which while commonplace to unite people after a tragedy, certainly tie all who experienced the event to the place of its occurrence. After an attack, they become rebranded as victims of the event or a survivor. Many survivors strive not to allow the event to "define" them. However, reality is often more complicated.

In this event, like many before, the reviewers heard this same theme. Victims' families, survivors, responders, government officials, and more expressed frustration that they

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[260] Griffin, A. & Farberov, S. (2022, May 26). DNA swabs were needed to identify Texas school shootings victims. *The New York Post.* Retrieved from www.nypost.com.
[261] Atia, A., Halligan, L., Brezina, L. et al. (2021). Distribution of wounding patterns in casualties from mass shooting events. *Trauma, 25*(2): 99-107.
[262] Texas Rangers. (2021). *Sutherland Springs Baptist Church mass casualty event.* Austin, TX: Same.
[263] Dewey, R. (2016). *Coastal Crisis Chaplaincy's role in the Emmanuel AME Church shooting.* Charleston, SC.
[264] Wiersema, J.M. & Woody, A. (2016). The forensic anthropologist in the mass fatality context. *Academy of Forensic Pathology, 6*(3): 455-462.
[265] NFPA 3000 also recognizes the term "steady state" to refer to a new normal.

could not shake the identity infused with this event. Those interviewed discussed traveling to other states. When people found out they were from Oxford, they immediately asked them about the shooting. Unfortunately, this type of branding often remains until the memory of the event has long faded from public recollection. To this point, words such as Columbine, Sandy Hook, Parkland, and Uvalde are now synonymous with mass shooting events.

One commonality with every person interviewed was the deep mental wounds this event created. More than three years after the event, nearly everyone interviewed still had significant difficulty talking about the event. Several interviewees discussed long-lasting mental health problems they continued to have.

The interviewers on this team used a trauma-informed approach to facilitate the interviews. This approach acknowledged and recognized the interviewee's thoughts, feelings, and emotions to create a safe and supportive environment. The technique minimized re-traumatization and allowed for more accurate information gathering. For some of those interviewed, this was the first time that they had discussed the event with anyone. Many interviews took much longer than expected, as the interviewees experienced episodes of significant grief. Even while responders were still on scene and in the early stages of the response, there was a recognized need for immediate mental health assistance.

These events are so catastrophic that they leave an indelible mark on the individual timeline of people's lives. Life memories are often defined as occurring before the tragedy or after the tragedy. Recovery also looks very different depending on the person. Each person's journey is different. The response section of this document stopped the morning of December 1, 2021, at 05:30 when the OCSO turned the building back over to the OSD. Although the OCSO maintained a few officers in marked vehicles in the parking lot for the next 24 hours, the response phase of the operation was complete. It is at this point that the recovery phase begins.

The information contained in this section came from numerous interviews with responders, OSD staff, county officials, OCSO commanders, OCEM personnel, mental health providers,[266] and community stakeholders. In addition, information was obtained from records kept by OCEM, and records kept by the Legacy Center. The review team also looked at hundreds of photographs taken during recovery operations.

[266] No mental health providers discussed any specific individuals or care provided. The providers and the review team ensured strict patient confidentiality.

1. *OCSO Recovery Efforts*

The OCSO created the Disaster Action Response Team (DART) because of the OHS shooting. This team has specially trained staff to provide crime victim services after a large-scale mass casualty event. The DART members received training in trauma-informed response, crisis intervention, and critical incident stress management. The DART members are separate from the OCSO's peer support team.

The Oakland County Prosecutor's Office has a crime victim service unit. However, the OCSO realized gaps existed in cases where the perpetrator was deceased. In those cases, the Prosecutor's Office did not have a case and typically would not engage with victims and families. DART was created to help bridge this gap and provide additional services. The goal of DART is to serve as a liaison with the victims and families through the investigation and court proceedings. The DART member provides information and resources but does not participate in criminal investigations or interview victims or their families.

Dr. Gardner has worked as a licensed psychologist since 1994. In 1995, he went through the reserve academy at the Oakland County Sheriff's Office. He joined the crisis negotiation team and then advanced as a SWAT operator. He is still a reserve officer with the OCSO and holds the rank of lieutenant. He is the department's psychologist. Dr. Gardner stated that he is also the psychologist for the Detroit Police Department, Michigan State Police, and five federal agencies. He stated that he served for two and a half years on the FBI's Detroit Joint Terrorism Taskforce conducting psychological analysis of potential mass violence threats. He is currently a lead psychologist with the International Association of Chiefs of Police, and he is the chair of the mental health section with the National Tactical Officers Association.

Dr. Gardner stated the shooting at OHS was the kickoff for an initiative about mental health. Each year, deputies at the OCSO receive eight hours of mental health training. The training focuses on peer support, mental wellness, suicide prevention, and more. As mentioned before, Dr. Gardner is assisted by a second law enforcement psychologist, Dr. Megan Wade, who is also a reserve deputy.

On November 30, 2021, Dr. Gardner was at his office at the Pontiac Veterans Medical Center when he received the SWAT page for Oxford High School. He called an OCSO sergeant and asked if it was legitimate, or a swatting call. The sergeant confirmed it was legitimate. He then activated the red and blue lights on his personal car and fell in behind another Bloomfield law enforcement officer responding. The normal 45-minute drive took about 20 minutes. He arrived sometime after 13:30, as Lieutenant Hill was already in command. He performed the role of a SWAT operator for the next hour, helping clear

rooms. After he finished clearing, he met up with Jim Etzin from OakTac and began reviewing video footage in the front office.

Lieutenant Hill saw Dr. Gardner and told him that he needed to switch into “doctor mode.” He then set up in the nurse’s station to provide psychological first aid. Lieutenant Hill then began to cycle people through to see him. He talked with the first responders who were in the building, and those who provided medical care. He also talked with school administrators and staff who were in the hallways. Several deputies and a federal agent who had children in the school came for assistance. In total, he talked with approximately 20 people.

Dr. Gardner then asked Dr. Wade to go to OHS and conduct a “defusing.” She left the reunification location and went to OHS to assist Dr. Gardner. Dr. Gardner stated that he encountered a variety of emotions from responders at the school. He stated the “avalanche” of emotions typically did not manifest until the event was over. As officers completed their response, he saw anger, shock, and denial. Dr. Gardner stated that public safety members are typically discouraged from showing sadness, grief, guilt, and anxiety. However, culture allows them to be angry. That is why he saw anger with many responders. Dr. Gardner told the responders that it was okay to normalize their emotional reactions. He advised them to go home and hug their families. He told them they would likely have trouble sleeping and cautioned them against using alcohol as a sedative.

Dr. Gardner received a call from OCSO Dispatch stating that they needed help. He then directed Dr. Wade to go to OCSO Dispatch while he remained at OHS. Dr. Wade went to OCSO Dispatch and remained there until 02:00 talking with staff.

On December 1, 2021, the OCSO mandated a critical incident stress debriefing (CISD) for everyone involved with the incident. 110 willing people showed up for the first session. CISD sessions of this size are very rare. Most sessions are 10-20 people. At the second session that day, he had 65 responders. After two debriefings, Dr. Gardner recognized his own limitations and had Dr. Wade conduct the third debriefing.

“Helper fatigue” (also known as compassion fatigue) is a clearly recognized mental health phenomenon. Mental health professionals can be personally affected by the trauma shared with them. In many cases of critical event trauma, mental health professionals need to decompress with other mental health professionals. This phenomenon not only affects mental health professionals but can also affect clergy.

"After burying 16 children, I couldn't absorb anymore grief myself. I was on empty. I made the hardest call of my life. I called the Diocese and told them that I had to go on a sabbatical. I felt like I was abandoning my church, but if I didn't take time off, I would not survive." - Fr. Basil O'Sullivan, Dunblane's Holy Family Church[267]

On December 2, 2021, Dr. Gardner had a critical incident debriefing with the staff of OHS. Likewise, the staff were shocked, angry, and grieving. The staff expressed deep concern about students, injured teachers, and coworkers. Dr. Gardner had significant credibility with the staff because they knew he was at the event and saw many of the things that they saw.

Additional debriefings were held on December 3, December 5, and December 11, 2021. These debriefings were for OSD personnel, responders, and OCSO corrections officers. These sessions resulted in multiple school staff and first responders scheduling individual counseling sessions. Dr. Gardner stated that it is important to have a trained clinician who is both familiar with first responder culture and evidence-based PTSD treatment. In most cases, the cheapest option for critical event mental health counseling is not the best. Dr. Gardner's advice follows mass violence response best practices.[268]

2. *Oakland County Recovery Efforts*

A cornerstone of emergency management is recovery. OCEM quickly requested support from the Oakland County Health Network (OCHN). OCHN is a private company in Oakland County that primarily provides mental health services to Medicaid recipients. OCEM took OCHN on a tour of the Legacy Center. The tour began at 1500 on a Friday after. At 1530, OCHN staff stated they had to leave, as it was a Friday and their workday was over. The tour was less than 10% complete and left the staff at the Legacy Center extremely frustrated. When OCHN re-engaged the following week, they stated that their hours were Monday-Friday from 0800-1700 and that they would not see any students after hours.

[267] Lamont, C. (2018, September 15). Shared grief: Priest who comforted families after Dunblane massacre becomes unlikely film star after US trip in Sandy Hook Netflix documentary. *The Scottish Sun.* Retrieved from www.thescottishsun.co.uk.

[268] Foskett, J. (2019, October 15). Q&A: Fire chief who responded to Las Vegas shooting shares advice on MCI planning. *FireRescue1.* Retrieved from www.firerescue1.com.

For two weeks, OCHN requested numerous meetings before providing any help. OCHN was not set up to bill private insurance patients. Although the county offered assurance that all bills would be paid, OCHN wanted to establish policies and procedures before providing any care. OCEM expressed significant frustration with OCHN. However, after this event, OCEM stated that OCHN did a complete restructuring to provide crisis response counseling. They have established multiple billing methods and after-hours crisis response. OCHN has also established a process by which they can coordinate numerous mental health services. OCEM stated that OCHN has now become a very valuable partner for the county to assist with crisis response.

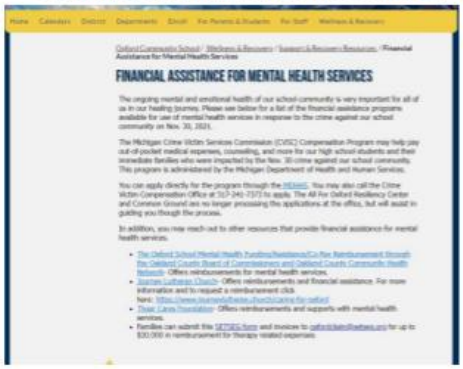
OCHN's model was successfully tested at the June 15, 2024, splash pad mass shooting in Rochester Hills that left nine injured and the perpetrator dead. The Oakland County Crisis Response Organization (OCRRO) was created in response to the 1991 Royal Oak post office shooting that left five dead (including the perpetrator) and seven injured. OCRRO is a mental health service that focuses on critical incident stress management. OCEM stated that OCRRO had a rouge employee go to Oxford and meet with responders. She promised mental health services that never arrived. The employee also handed out her business card with a FEMA logo on it and represented herself as affiliated with FEMA. OCEM contacted FEMA who stated they had no affiliation with her. Responders in Oxford immediately became wary of OCRRO and did not utilize their services.

Oakland County Executive's Office became aware that multiple students were having trouble accessing mental health services because of money. Students could not afford to pay the deductibles. The county put $250,000 into a fund to help students pay for mental health expenses. On January 17, 2025, members of the Oxford School Board met with several families of Oxford students. At this meeting, SET SEG, the school's insurance provider notified the families that the insurance policy covered $30,000 in mental health costs for each student.[269] SET SEG had previously not notified students or families about this coverage. The County Executive's Office and Common Ground were also unaware the SET SEG provided this coverage to the school. SET SEG advised the families that they had already paid out $500,000 for 100 people who accessed the funds.

[269] Meeting held on 01/03/2025 by OCS School Board members and victim's families. The OCS board meeting minutes were provided to Guidepost by a community member.

b. SET SEG: Claim Process and Communication for 1600+ 'Victims'

- Victim (as defined by SET SEG (pg. 8 of 2021-2022 Safeguard coverage form) means a person who has been directly exposed to and harmed by a school violent act. A victim includes Students, Parents or legal guardians of students, or employees including FT, PT and temp, any person visiting premises for purposes related to students' education including student teachers, Substitutes, guest speaker, volunteer, Parents, legal guardians, spouses or children of a victim.
- All Victims are entitled to receive 30K for mental health services from SET SEG. Many victims remain unaware of this benefit even today.
- After much persistence, the district has published the info on the website and sent email (2).
- Discussed with Todd the need to send dedicated communication to all Victims. Recommended to pull all registration emails from 2021 and email the available services and process for obtaining reimbursement.
- The process of obtaining this funding should not be as difficult and the district and insurance company should not question what is deemed as "therapy" to receive.



FINANCIAL ASSISTANCE FOR MENTAL HEALTH SERVICES

ACTIONS:

1) Confirm no time limitation exists for submitting claim for of up to 30K per Victim. (John)
2) Ensure claim is proactively filed with SET SEG for each Victim (John)
3) District to pull list of all Victims present in the building on 11/30 and associated email. Propose clear communication to all Victims/Parents the services available and the simple process to obtain reimbursement. Communication should include at minimum SET SEG (up to 30K) and State of Michigan Crime Victim Compensation.

[270]

a. <u>Common Ground Mental Health</u>

Common Ground is a comprehensive mental health crisis agency that has operated in Oakland County for more than 50 years. Common Ground is a non-profit, 501(c)(3) organization. Common Ground offers 24/7 behavioral and mental health intervention services. These services include both physical and online services. Common Ground has a 24/7 staffed behavioral health urgent care at their Pontiac headquarters location. In addition to operating the All for Oxford Resiliency Center, Common Ground runs the Rochester Hills Resiliency Center and the United Resiliency Center at Michigan State University. Common Ground does not require patients to have medical insurance to utilize

[270] Oxford Parent Advocacy Agenda (January 3, 2025).

their services. Common Ground also staffs the 988-suicide prevention hotline for Michigan callers. This hotline receives more than 88,000 calls a year.[271]

Prior to the OHS shooting, Common Ground had a longstanding relationship with the OCSO, particularly with Sheriff Bouchard. Together, Common Ground and Sheriff Bouchard worked to help people avoid jail time by utilizing alternative behavior correction methods. Additionally, Common Ground helped to counsel victims and families who experienced traumatic events. Common Ground also has a good working relationship with the Prosecutor's Office as Common Ground provides services to victims of crime as the case moved through the judicial system. In addition, Common Ground provides services as long as they are needed, even after judicial adjudication.

i. *Common Ground's Operations the Day of the Shooting*

On the day of the shooting, Common Ground executives were in a leadership meeting. They began to receive notifications of the incident. They immediately dispatched their expert-level crisis clinicians to Oxford. These clinicians were onsite at Oxford within two hours and immediately began to provide crisis counseling services. As the magnitude of the incident became apparent, Common Ground also dispatched lower-level crisis trained personnel to supplement the other clinicians. The clinicians responded to the Meijer where they met up with other clinicians from Oakland Community Health Network. The clinicians immediately began to provide services for both students and staff. Back at Common Ground headquarters, the executives realized this was going to be a long and intensive operation and began working on a master plan. Within just a few days, Common Ground became involved in operations at the Legacy Center. The response by the community to help at the Legacy Center was overwhelming. Essentially everyone was assuming the role of mental health clinicians. Everyone wanted to help, but there was little control and no vetting of resources.

After the first week, Common Ground worked with Legacy Center's COO Caron and OCEM Specialist 1 to create a basic vetting process for mental health providers. This process included checking their license in the state database and ensuring that no student was alone with a mental health provider. Inside the Legacy Center, there was a counseling service called Soothe Your Soul. The personnel at Soothe Your Soul quickly worked to manage access for mental health providers to talk to students. Together, COO Caron, OCEM Specialist 1, Common Ground, and Soothe Your Soul began to coordinate and control the mental health services. They were also quickly assisted by County Community Engagement Coordinator Carolyn Krause from the County Executive's Office.

[271] James, J.D. (2024, July 17). Michigan marks two years of 988 crisis hotline, but awareness lags nationwide. *Bridge Michigan.* Retrieved from www.bridgemi.com.

She helped to organize meetings and began planning for the Oxford Resiliency Center. The quick control of mental health services was critical, as community members were not trauma informed and were attempting to help. Although they all had good intentions, the consequences of untrained people providing mental health first aid can be catastrophic.

Dr. Gardner also echoed this concern. He explained that there were multiple types of mental health first aid training. For example, anyone can receive a certification in mental health first aid after completing a three-hour course.[272] Additionally, anyone can obtain a mental health first aid instructor certification after only three days of training.[273] While these courses are beneficial to the community, they do not provide the qualifications needed to operate in a major crisis environment. Responders must be cognizant that a certification in mental health first aid is not a substitution for mental health licensure and the legal ability to provide mental health care.

Common Ground staff stated that this control and coordination should have been created much sooner. A vetting process for mental health providers is essential. Community members were getting very frustrated and wanted to help but were limited in what they could do. Additionally, it is essential to identify tasks that are appropriate for community members so they can also participate

ii. *All for Oxford Resiliency Center*

Shortly after the shooting, the county asked Common Ground to operate a resiliency center. Common Ground agreed to do this. This worked out well, as Common Ground staff were able to inform people that the center was coming. They provided updates and sought information from the community, the school district, and the OCSO as to what services they would like. The opening of the center was highly anticipated in the community.

The DOJ Office for Victims of Crime (DOJOVC) began providing technical expertise, assistance, and a $3 million grant. The DOJOVC has a formula that they use to determine approximate square footage of a center. This formula incorporates several variables, including the number of victims killed, the number of people injured, the primary witnesses to the event (those that saw or heard the event), the people in proximity to the event but did not witness the violence, and estimated number of families affected. The equation also is dynamic, in that it shifts with time and can begin to compress as the anticipated needs change. The DOJOVC also provided recommendations on the location; not too

[272] National Council for Mental Wellbeing. (2025). *Mental health first aid for teens and adults.* Same. Retrieved from www.mentalhealthfirstaid.com.
[273] Ibid.

close to the scene but not too far from where people are willing to travel to receive help. Obviously, some communities are limited in the availability of ideal locations. The DOJOVC also advised the county to open the resiliency center as quickly as possible. Oakland County OCEM worked diligently to find a space in Oxford that was appropriate.

Director Seeley found property with a large church that was recently closed. This property appeared ideal. However, he quickly learned the property was owned by OCS. DOJOVC strongly cautions against creating a resiliency center that is owned and/or operated by the organization where the attack occurred. Primarily, this is because the organization is also a victim and will likely utilize the service as well. Secondarily, victims may blame the organization for the attack and may not feel comfortable going to the resiliency center. In addition, there can be concerns about confidentiality and liability.

After spending extensive time in Oxford, OCEM Director Seely determined that there was not a suitable location. As he was preparing to leave Oxford, he saw office space for lease in a strip mall. He was previously unaware of the property and went to see if it was available. The property was a former real estate office that had a reception area, multiple offices, a kitchen, and a breakroom. The location was ideal and required no upfit or renovation. The county quickly realized that it would be easier for a third-party organization, such as Common Ground, to sign the real estate lease. By utilizing a third-party, it prevented bureaucratic red tape and delays. Common Ground was able to secure the lease within days, compared to taking several months with county government procedures.

Nine months after the shooting, the All for Oxford Resiliency Center opened in late August 2022, one week before school started after Labor Day. After opening, the center operated with open hours. Anyone requesting service would receive it, regardless of the day or time. During the first month, staff continued to solicit feedback from users and the community. Staff conducted numerous outreach sessions and social media blasts to ensure everyone in the community was aware of the free resources.

The center operated as a hub of resources. There were numerous organizations in the community offering a variety of counseling services. These organizations included Easter Seals, Oakland County Health Network, private providers, comfort dogs, and many more. Common Ground recognized that there was no one size fits all mental health response for victims of trauma and wanted to ensure that numerous organizations with a variety of counselors and services participated. Each service provider that came to the center was assigned the role of case manager (victim advocate). This person’s role was to determine the resources needed and provide multiple options. It is common for trauma victims to see multiple counselors before they find one that is best suited for their needs. One of the

most well received services was OCSO's comfort dogs. We were informed that the presence of both the dogs and the deputies provided a strong sense of calm and security. The presence of the comfort dogs was also a significant motivator for students to come to the center.

As soon as the center opened, questions began about when the center would close. The DOJ grant provided funds to operate for three years. A one-year extension was possible in this case because the perpetrator survived the incident. Common Ground told everyone up front that the center would close at some point; however, access to free resources would continue indefinitely.

On April 14, 2025, the center closed. However, a new resiliency center opened 45 minutes away in Rochester Hills because of the 2024 splashpad shooting. Although Common Ground continues to provide virtual and mobile services in Oxford, those wishing to go to a physical location are welcome to go to Rochester Hills.

b. OHS and the District's Impact on Recovery

Before beginning this section, it is important to note the lack of published research regarding best practices for recovery after a mass shooting event. Regardless of where the shooting occurred, there are frequent debates about temporary memorials, permanent memorials, location usage, return to school, and much more. Schools have two core objectives: (1) keep children safe at school, and (2) facilitate effective learning. Everything else is secondary. If schools cannot accomplish these two tasks, they have fundamentally failed.

There are three recognized events that often result in a high degree of distrust of schools. These include death or serious injury of a child at school, physical abuse of a child at school, and sexual abuse or exploitation of a child at school. When these events happen, the community often loses trust in the school and school district. For those directly involved with the event, the moral injury is so great that many will have incredible difficulty understanding how the school could have let the event occur. Schools must realize that it will take extensive time and effort to rebuild trust. Some will never trust the school again. For school shootings, this is evident time and time again with the large number of students who never return to that school. These students will attend school elsewhere, do virtual education, or home schooling. Previous school shooting events indicate that as many as 30-50% of students will not return following a mass shooting. For some of the returning students, their parents did not want the students to attend but had no alternative and sent them back to school.

School shootings are multifactorial and are often the result of systemic inadequacies and failures. These events are typically not the result of momentary lapses of judgment or the failure of a single protocol.[274] Because of this, schools will often face monumental hurdles in regaining the trust of the community. This distrust is frequently summed up in the resounding questions everyone asks after these events: “How did you let this happen?”

Schools will face a long and arduous task of regaining trust if there is not an aggressive, comprehensive recovery strategy immediately implemented. This recovery strategy cannot be haphazard. The strategy must incorporate many components, including (1) a comprehensive communication strategy the focuses on timely sharing of information, (2) admit fault and accept blame, (3) immediately identify and correct gaps that allowed the crisis to occur, (4) provide aggressive and comprehensive mental health support to students, family, staff, and recognized stakeholders, (5) actively involve the community as a partner to rebuild trust, and (6) become a role model for school safety and security.[275]

Ineffective school leadership directly affects campus safety.[276] It manifests through poor communication, a lack of timely intervention, and insufficient response to conflict.[277] During the course of this review, numerous parents told Guidepost that the district’s communication with them was poor and was often driven by what they believed to be motivated largely by limiting the school’s exposure to liability. Families believed that the school lacked a timely and robust response, resulting in a near total erosion of confidence that OCS was able to provide a safe learning environment. It is incumbent upon school leaders to establish a clear safety vision, actively promote safety and security awareness, and model safe behaviors.[278] This is never more critical than following a significant crisis event, such as a school shooting. Without clear leadership and direction, school crisis response can result in panic and confusion.[279] These untoward effects have long-term negative implications for student safety.[280]

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[274] Reynolds, H.L. (2022). Reimagining school safety. Proceedings of the 2022 AERA Annual Meeting. https://doi.org/10.3102/1882099.
[275] Pitner, et al. (2017). School safety, victimization, and bullying. *Encyclopedia of Social Work.* https://doi.org/10.1093/acrefore/9780199975839.013.1194.
[276] Tompkins, A.L. (2025). Guardians or bystanders? Examining school shooting responses in the Southern United States. *Journal of Educational Research and Practice, 15*: 1-21.
[277] Ibid.
[278] Lazim, et al. (2022). A systematic literature review on leadership practices for safety in the education sector. *Journal of Sustainability, 14*(14), Article 8262.
[279] Eadens, et al. (2018). Gun violence and school safety in American schools. *The Wiley Handbook of Educational Policy*: 383-405. https://doi.org/10.1002/9781119218456.ch17.
[280] Reynolds, H.L. (2022). *Reimagining school safety. Proceedings of the 2022 AERA Annual Meeting.* https://doi.org/10.3102/1882099.

i. *OHS Reaction to Student Memorials*

On the night of the shooting, many people arrived at the school to observe what was happening, offer support, and give condolences. The OCSO had an established perimeter around the school, including the exterior of the school. In addition, the OCSO had an active scene on North Oxford Road at the deputy's patrol car with Tate. Because of the large crime scene area, people were not able to get close to the school. This prevented an ad hoc memorial from forming that night.

However, on December 1, 2021, at 0800, the OCSO gave the school back to OCS. At this point, there was no formal OCSO security, other than one or two patrol cars for visual presence. Ad hoc memorials quickly began to spring up around the exterior of the high school. People brought flowers, teddy bears, cards, pictures, candles, shirts, and other items. Memorials were established at the football field, the tennis courts, the sign at the south parking lot, near Doors 7 and 8, and at the main entrance of the school.

AP Nuss stated the OHS had to bring in maintenance personnel that morning to put paper over the windows in the 200 hallway. He stated that numerous people were coming to the school and attempting to look into the windows to observe the crime scene. The maintenance personnel at the school were required to traverse through the horrific biohazard crime scene to cover the windows.

OCEM had the knowledge and foresight to tell school administrators that they need to pick one area for a memorial. Otherwise, the pop-up memorials would quickly get out of hand all around the exterior of the school. The decision was made to move all memorial items to the school's welcome sign located at the south parking lot. This provided a very visual representation of the school, provided ample parking, and placed the memorial location at the edge of the school's property. School employees and OCEM employees walked the campus, gathered up all memorial items left, and relocated them to the new temporary memorial.

[281]

Within a day, the memorial quickly grew. However, frequent wind and snow damaged the memorial, causing immediate negative psychological effects on many who saw the memorial destroyed. OCEM quickly came up with a solution. They placed two pop-up tents over the memorial, which provided temporary relief from the snow. However, these tents could not withstand the wind. In response, OCEM installed much larger commercial tents and anchored them to the ground with large bricks. In addition, a wall partially surrounding the memorial was installed to block the wind and allow people to write condolences.

A local church provided volunteers to maintain the memorial. Volunteers removed dead flowers and dirty teddy bears, cleaned up the area around the memorial, and ensured that messages were appropriate. OCEM provided guidance to the school and volunteers about appropriate decorum for removing items from the memorial, which occurred at night or when no one was at the memorial. In addition, items removed from the memorial were placed in bags and put in storage at the school. To note, there were very few instances of inappropriate messages.

Additionally, no one recalled having anything left for the shooter. In cases where the shooters die during the attack, it is common for people to create a memorial for the shooter. This happened at Columbine High School, Virginia Tech, and numerous other

[281] Photograph from “Memorial at Oxford Schools to come down this weekend” (Wed, January 19, 2022) https://upnorthlive.com/news/local/memorial-at-oxford-schools-to-come-down-this-weekend.

mass shootings.[282,283] Although the shooter in this event did not die, staff were very vigilant for any messages posted for him or objects left for him.

The memorial was up for approximately seven weeks. There was near universal consensus to remove the memorial prior to school resuming to allow the students a sense of normalcy. Prior to the removal, there was discussion about how to capture the memorial for posterity. OCEM Specialist 1 suggested utilization of a special technology adapted for fatal vehicle accident reconstruction. OCEM Specialist 1 was familiar with this technology from his tenure at West Bloomfield Police Department. With the assistance of West Bloomfield Police, OCEM reached out to NOAR Technologies, the supplier of the digital recording equipment. NOAR Technologies, a Michigan-based company, agreed to document the memorial for free.

NOAR Technologies documented the temporary collection outside of OHS and created a permanent virtual memorial online, which will remain operational indefinitely as a tribute to the victims. At www.ohsvirutalmemorial.com users can virtually travel through the memorial, read messages, and see remembrance items left. NOAR Technologies also created a memorial video and with a publicly accessible forum where users can leave condolences.

Although the virtual documentation of the memorial was handled with care, communication that the physical memorial would be dismantled was lacking. The families of the deceased stated that they received a phone call from the school district on or about January 17, 2022, informing them that the memorial will be removed the next day and to retrieve what they wanted from the memorial. The families were upset about the short notice, but many retrieved items they wanted to keep.

The following day, school employees, volunteers, and OCEM began the delicate process of dismantling the memorial. Previous school shootings have shown that removal and disposal of memorial items can be very contentious.[284] OHS administrators spoke with administrators and survivors from the Douglas High School shooting about best practices for memorials. The consensus was that memorials are a no-win situation for the school. While it is common to want to commemorate a shooting with a memorial, memorials in

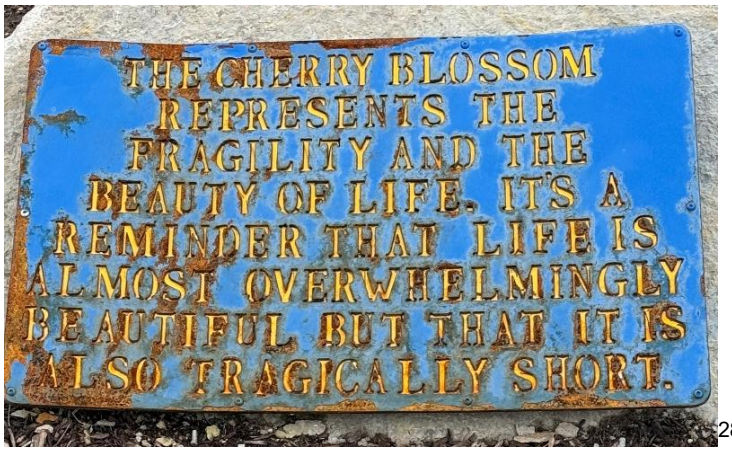
[282] Lowe, P. (1999, May 27). Killers' kin thank cross builder. *The Denver Post.* Retrieved from www.denverpost.com.
[283] Breed, A.G. (2007, April 23). Virginia Tech memorial has room for Cho. *The Chronicle*. Retrieved from www.chron.com.
[284] For example, following the Sandy Hook tragedy, commemorative teddy bears left in the snow were deemed destroyed. When the school attempted to dispose of them, it sparked emotional responses and tension among grieving families.

schools often fall short of recognizing the needs of future generations of students who may not want constant reminders of the tragedy. This puts the school in the difficult position of trying to honor current students and those lost, while preserving the innocence of future generations. In this case, the school decided to let the students decide how to proceed.

In making these decisions, schools should consider consolidating the memorials at a single public access point to allow people to visit, while maintaining the operation, mission, and security of the school. Schools must also be cognizant that once a memorial goes up, it is never going to come down; no one wants to be the person who tells people to get rid of a memorial.

ii. *Permanent Memorials*

At the front entrance to the school, there is a rock with a plaque and tree.



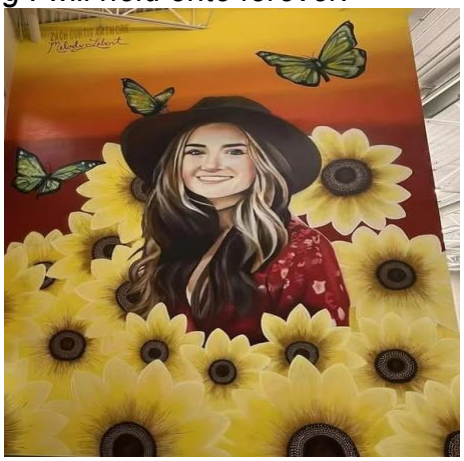
[285]

The OHS gym wall bears a banner honoring all four students killed.

[285] The plaque states, "The cherry blossom represents the fragility and the beauty of life. It's a reminder that life is almost overwhelmingly beautiful, but that is also tragically short."

Friends of Madisyn commissioned a mural to honor her talent in photography and art.[286] The mural is housed at Clarkston High School. Madisyn attended Clarkston for three years before transferring to OHS. Professional muralist Zach Curtis volunteered his time and posted the photograph on social media with an explanation of its meaning.

> *Each butterfly has a portrait of either Hana, Justin, or Tate inside the wing. This project was organized by her classmate Aiden as well as melody who painted it with me. Melody designed the background based off a painting Madisyn had done on a skateboard. It was a bittersweet honor to be able to help the community heal with my art and is something I will hold onto forever."*[287]

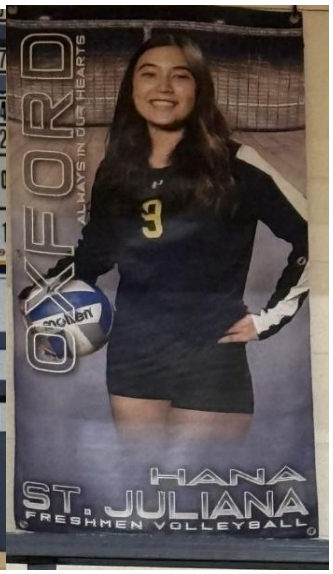


A large 42 was painted on the football field. and a replica football helmet to honor Tate.[288] The #42 football jersey is given every year to one player who embodies Tate's spirit.[289]

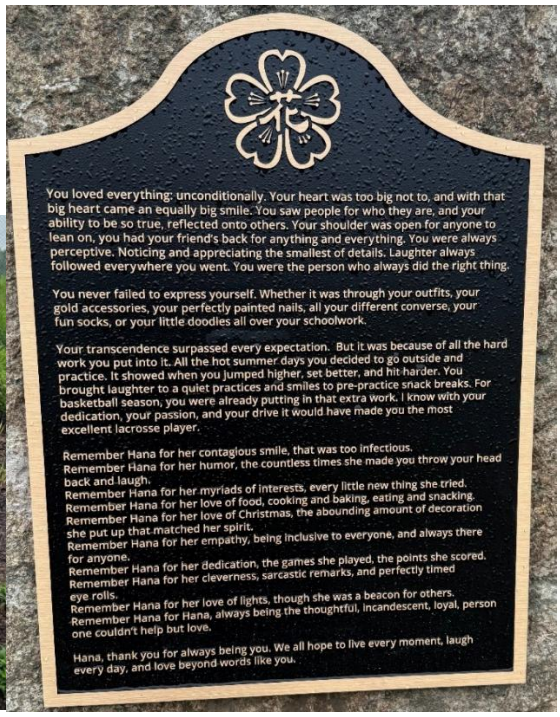
[286] Mackinder, M. (2021, December 22). Mural project to remember Oxford victim, former CCS student. *The Clarkston News.* Retrieved from www.clarkstonnews.com.
[287] Retrieved from www.facebook.com/zachcurtissartwork.
[288] Bailey, T. (2023, September 1). Oxford High School receive giant replica football helmet in honor of shooting victim. *CBS News*. Retrieved from www.cbsnews.com.
[289] Rush, D. (2023, September 6). #42 on the gridiron again. *The Oxford Leader*. Retrieved from www.oxfordleader.com.

On June 24, 2024, “Justin’s Nature Walk” was created along the Polly Ann Trail near OHS. A boulder surrounded by smaller rocks, a plaque that commemorates Justin Shilling, and several trees planted in the nature walk area, were installed in his honor.

The OHS gym floor bears a flower, and two banners are on the walls to remember Hana:



On June 1, 2025, the Hana St. Juliana Memorial Garden opened at Seymour Lake Township Park, approximately five miles from the school. This garden petitioned by the St. Juliana family commemorates Hana’s life but also was designed so that everything was in groups of four, to recognize all four fallen students. The garden was primarily funded with donations and took a year and a half to construct.



In addition to these individual memorials, OHS incorporated Tate, Hana, Justin, and Madisyn's birthdays into the school calendar. On Madisyn's birthday, there is a focus on art. On Tate's birthday, OHS students are encouraged to wear their favorite sports jersey. On Justin's birthday, it is a day to tell jokes as he was always laughing and smiling. On Hana's birthday, people share her love of flowers and wear leighs. On the anniversary[290] of the shooting each year, school is closed for Wildcat Remembrance Day. If the anniversary day falls on a Saturday or Sunday, the preceding Friday is Remembrance Day. School administrators have purposefully molded Remembrance Day into a day of community service instead of a day of grieving. Although mental health and resources are available for all, those who were less affected are encouraged to volunteer for community projects.

A community committee was formed after the shooting to discuss a single permanent memorial; however, there was no consensus, and several people left the committee. Those involved with the committee described the meetings as controversial, with no decision on how to move forward. There are currently several discussions ongoing about a permanent memorial. Buck Myre has organized a group to raise $4 million to create a permanent memorial. The Myre, Shilling/Soave, and St. Juliana families have all pursued individual memorials for their children.

[290] The review team recognizes the word "anniversary" often invokes thoughts of celebration. Many survivors and victim's families use the word "mark" (e.g., one-year mark) to explain anniversary dates of mass shooting events.

The families of the deceased also asked to have pictures of Tate, Hana, Justin, and Madisyn in the school. However, the school denied the request stating that the pictures would trigger other students. These families also expressed frustration at OHS because there were memorial activities held where they were not informed. Guidepost was informed that the school did not contact grieving families for several reasons. OCSO told Assistant Superintendent Jill Lemmond that there were potential threats against school staff by family members and people in the community. In the days after the attack, the school removed the families of the deceased from electronic mailing and physical mailings, despite some families having siblings in the district. Their reasoning was to avoid traumatizing them with school recovery operations. This is a common practice following deaths at schools, and even workplace deaths. However, the families felt that this abrupt removal was insensitive. The families wanted to be included in all of the communications.

c. The Legacy Center and COO Caron

Legacy 925, more colloquially known in the community as “the Legacy Center,” is a massive family entertainment complex located one mile from OHS. The Legacy Center is a 208,000 square foot building with an additional 12,000 square foot building located on the property. There are 32 tenants in the building. The building has a large indoor go-kart track, laser tag, ax-throwing, a trampoline park, a golf simulator, arcades, bowling, escape rooms, a dance studio, exercise rooms, restaurants, and more. The Legacy Center is a hub for activities in Oxford. Legacy 925 is privately owned and operated by a Michigan native, who began a business out of college in the medical device field. When his company was bought, he bought properties in the area, one of which ultimately became Legacy 925. The owner currently resides in Europe. In his absence, Legacy 925 is managed by COO Caron. Following the shooting at OHS, the owner informed COO Caron that he had an open checkbook to do as much as he could to assist the Oxford community.

Only a day after the shooting, it was clear to COO Caron that students from OHS chose the Legacy Center as the place to congregate. By the second day, many more students arrived at the Legacy Center. Sensing the potential for the salve that this venue could become, COO Caron made an executive decision to stop all public events and open the Legacy Center only to OHS students, OHS staff, and first responders. The Legacy Center opened each day at 08:00 and closed when the last student departed the premises. Some nights this meant that the Legacy Center did not close until almost midnight.

By the second day, staff at the Legacy Center detected fraudulent fundraisers, which unfortunately can arise after mass violence events. Sheriff Bouchard rightly characterized

these opportunistic criminals as “bottom feeders.”[291] Criminals often take advantage of situations such as these by establishing fraudulent GoFundMe pages for victims of mass violence events. Fortunately, the Legacy Center notified OCSO, and the fundraisers were quickly shut down. By the end of day two, COO Caron realized it was necessary to conduct meetings to establish ground rules as to who was in charge. Within a week of operations, there was a mandatory daily leadership meeting with staff from Legacy 925, OCSO, OCEM, Oxford Village Police, Oakland County Homeland Security, OFD, Oxford Township Supervisor Curtis, and volunteers. After several weeks, the school district began sending a representative.

On day three, OCEM came to the Legacy Center and OCEM Specialist 1 met with COO Caron. The Legacy Center quickly became a major operation, with more than 1,000 students utilizing the premises, and hundreds of volunteers staffing it. OCEM Specialist 1 offered the support of OCEM, which COO Caron immediately accepted, and facilitated the creation of a command post for operations. This included the involvement of OCEM, OCSO, county administrators, and other stakeholders, non-inclusive of OHS and the district. Legacy 925 was staffed for the next three months to support the mission of the Legacy Center. COO Caron kept a running list of individuals from the government and first responder agencies who assisted.


TEAM Dec 8th 2021

[redacted] Office of public communication

[redacted] Homeland Security Specialist Emergency management Division AKA Santa Clause

Robert Seeley Cheif of emergency management

[redacted] Oakland County Sheriff

Pete Scholz Oxford Fire Department

[redacted] Oxford Fire Department

Jack Curtis Oxford Township Supervisor

[redacted] Chaplain

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[291] Nichols, A.L. (2024, June 17). Updated: What we know about the mass shooting at Rochester Hills splash pad. *The Michigan Advance.* Retrieved from www.michiganadvance.com.
[292] Tod Caron’s list of Legacy 925 Team members (December 8, 2021)

Similarly, OCEM Specialist 1 kept photographs of the team leadership and role affiliations, which provided a means for us to visualize the strategies that the Legacy Center sought to establish in building this essential team.

The Legacy Center morphed into a de facto Incident Action Center. In addition to the physical support, OCEM Specialist 1 advised COO Caron to document the entire experience. COO Caron maintained a daily journal documenting the everyday activities at the Center. This record offered valuable chronological information to the review team regarding actions taken, as well as documenting the clear needs that were fulfilled by the Legacy Center's generosity.

i. *Media and OCSO's Relationship with the Legacy Center*

COO Caron was concerned with the security and privacy of the students. He stated that media representatives offered substantial payments to tenants of the Legacy Center to arrange interviews. He acknowledged that tenants could make their own decisions but requested their cooperation in prioritizing the safety of the children, a request which all tenants followed. The Legacy Center and OCSO built a close reciprocal relationship which allowed for the OCSO to engage students regarding the investigation in a safe space while simultaneously providing robust security. OCSO was supported by law enforcement officers from numerous jurisdictions.

The Legacy Center had uniformed officers, undercover officers, off-duty officers, and retired officers working throughout the interior and exterior of the building. For the first month, officers were located throughout the Legacy Center and never more than 30 seconds away from intervening should something happen. Although media issues continued, the Legacy Center had the support of law enforcement. COO Caron recounted an incident involving a man who entered the premises while concealing a microphone within his coat. Although he assured COO Caron that he was not affiliated with the media, the individual subsequently approached several children. It was later determined that he was a reporter. The reporter approached a group of children and immediately began interviewing them. The children were visibly panicked from the interaction with the reporter. With the assistance of an OCSO deputy, COO Caron was able to have the reporter removed from the premises.

[293]

Following these interactions, Caron sent a memo for OCEM Specialist 1 to distribute to 62 news outlets advising that the Legacy Center was private property, and that media was not allowed.

Letter to Media Outlets Dec 9th 2021

My name is Tod Caron and I am the Chief Operating Officer for The Legacy center located in Oxford Michigan. I am writing this letter as a plea to allow our community to morn and heal. It is no secret that many of the kids from the Oxford High school have chosen The Legacy building to seek counseling as well as just be with classmates, friends and family following this horrific tragedy.

We have instituted a strict "NO MEDIA" policy on our property as well as within our building only due to the actions of the media. The morning after the tragedy we caught a national Fox reporter covering his credentials and microphone while following kids around asking questions and after repeated attempts to get hm to leave I had to ask the police to intervene. Just yesterday we had a couple reporters wearing Oxford sporting attire they had purchased as they arrived in town also harassing kids receiving therapy.

Due to the above mentioned reasons we are forced to ask our local Sheriff trespass any media representatives that violate this policy. The Legacy Center is not anti media and we also house 34 privately owned tenants spaces that have also agreed unanimously to be a media free zone for the kids and families.

I would be happy to discuss this policy and we will modify it as the situation improves.

Thank You for understanding,
Tod Caron

COO:
The Legacy 925

[294]

[293] Legacy Center photography – courtesy of Tod Caron.
[294] Tod Caron's letter to media outlets (December 9, 2021).

OCSO also patrolled the parking lot looking for out-of-state license plates to identify potential rental vehicles. Using this technique, the OCSO successfully intercepted a reporter attempting to gain unauthorized access. COO Caron also had his staff place paper over all the windows in the facility to prevent pictures being taken. Students stated universally that protection from the media was one of the greatest services afforded to them by the Legacy Center. The media was consistently present in downtown Oxford. By establishing the center on private property, they were able to effectively remove reporters for trespassing and protect the students. COO Caron recommends this as best practice for other centers.

ii. *Oxford Township Businesses*

Within a few days of the Legacy Center's opening to students, local restaurants began bringing food to the Legacy Center. The first tractor-trailer to show up was full of donated lasagnas. When staff realized that many OHS students received free or reduced lunches, they established a meal service that served 400-1,000 meals every day to students, families, and members of the community. This meal service continued for three months. Every night, the Legacy Center served dinner at 17:00. The lines to receive food began forming every day at 16:00. Pictures provided by COO Caron showed lines filled with hundreds of people wrapped around the outside of the building in the falling snow waiting for dinner. Through the help of many dedicated volunteers, the Legacy Center was able to serve meals every day, even on Christmas Eve and Christmas Day. All the restaurants in Oxford contributed food. COO Caron praised the efforts of these businesses. Local restaurants donated tens of thousands of dollars' worth of food. Despite the staffing and financial challenges caused by COVID-19-19, numerous establishments continued their support until their financial resources were depleted. The owner of one local restaurant used their retirement savings to help.

iii. *Other Services Offered at the Legacy Center*

In addition to being a place to congregate and be fed, the Legacy Center became a place where the recent trauma could be addressed. One example was the introduction of hundreds of therapy dogs for students. The Legacy Center created a credentialing system by which only certified therapy dogs were allowed. Another form of support came by way of a sign company, who donated 50,000 "Oxford Strong" signs for the community.

On the first day of the giveaway, lines wrapped through the building out the door, around the building, and to a McDonald's located a quarter mile away. The signs brought many people to the Legacy Center who did not realize the resources that were there. Thousands of people came to pick up a sign.

Mental health counselors were also available at the Legacy Center. Below is an example of a flyer that was provided to the public at the end of December 2021, announcing free access to mental health professionals at the Center.

Another example of therapeutic service was access to art for students to share emotions on the walls and doors of the center. COO Caron recalled that this began when a female student used a dry eraser marker to write on the glass entrance doors. Other students saw this and wanted to write messages as well. COO Caron went to Meijer across the street to obtain shopping carts full of street chalk and dry-erase markers. Students started writing everywhere. All of the walls in the 208,000 square foot building were covered floor-to-ceiling.

 [295]

Mental health counselors reported that these writings allowed them to watch the students move through the stages of grief. The counselors watched as the messages transitioned through denial, anger, bargaining, depression, and acceptance following the Kubler-Ross stages of grief.[296] A few of the students wrote hateful messages about the shooter. A cadre of volunteers came in early every morning and reviewed all of the messages and erased inappropriate messages. Writing on the walls was one of the students' favorite activities at the Legacy Center.

[295] Legacy Center photograph courtesy of Tod Caron.
[296] Tyrrell, P., Harberer, S., School, C. & Siddiqui, W. (2023). *Kubler-Ross stages of dying and subsequent models of grief.* Washington, D.C.: National Library of Medicine.

[297]

First responders wrote messages as well. The Legacy Center staff were also able to use this opportunity to intervene with responders who were having severe mental health crises after the shooting. In one case, staff identified a law enforcement officer experiencing a significant mental health crisis and counseled with the officer until 03:00. Many of the officers who provided security at the Legacy Center took advantage of the mental health counseling services available. When the Legacy Center finally terminated incident support services three months later, they preserved a small area with the writings, which was permanently sealed with acrylic as a memorial.

Approximately one month in, some students started exhibiting destructive behavior at the center. There were repeated acts of vandalism both inside the Center and on the property. These included smearing feces on the walls in the bathroom. The Legacy Center immediately engaged the mental health counselors to assist. The counselors were able to work individually with the students to provide specialized care.

[297] Photography of Legacy Center courtesy of Tod Caron.

iv. *Legacy 925's Relationship with the Oxford Community Schools District*

Although the school district was not initially involved with the Center, the Center quickly started filling needs of the student population that were previously filled by the district. COO Caron learned that OHS held an annual Secret Santa Christmas sale where items donated at a reduced cost were available for purchase by the students. Similar to the food scarcity issues, many of OHS students were unable to give or receive holiday gifts without the Secret Santa sale. In 2021, the Legacy Center staff organized the event at the Legacy Center and people in the community donated thousands of dollars of items.

Secret Santa Shopping Dec 17th 2021

It has been brought to our attention that the school buildings are closed and will not allow the elementary PTA groups to retrieve their items for the Secret Santa Shopping event or use the school to hold the event.

My team has sourced a dollar store in Utica that sold us a large amount of items that can be used for this event. The Legacy Family have fronted the money and I have personally picked up the items as well as many donated items from local businesses.

We will hold Secret Santa Sale in the Event center and staff it accordingly. I have contacted the local sheriff to request help with parking and security as well as my normal retired or off duty police officers will be in plain clothes throughout the building offering protection. If we have any problems please let me know asap via the walkie talkies and I will have police presence available immediately.

Let's make this super special for the younger kids some of them do not even understand the magnitude of this tragedy and rely on the Secret Santa Shopping day at school to provide gifts for their families.

Thank You
Tod

[298]

The event was a huge success and brought much joy to the community.

[298] Letter from Tod Caron concerning the Secret Santa Shopping Event (December 17, 2021).

 [299]

The OCS school board also wanted to host an event at the Legacy Center with all students on December 16, 2020, as a soft introduction to prepare students for the reopening of OHS. OCSO assumed the lead on security, and on the day of the event more than 300 K-9 officers arrived in the very early morning to sweep the building and the parking lot. Some officers drove more than eight hours to help.

That day, the main indoor go-kart attraction at the Legacy Center was also reopened for student use. While the initiative aimed to provide engaging recreational opportunities, staff quickly observed that the effects of the November shooting were still deeply felt. The sound of screeching tires from the go-karts caused several students to respond with distress, having mistaken the noise for gunfire. Staff promptly substituted the go-karts with large tricycles for the remainder of the event. The program continued without further incident. However, because of this experience, COO Caron decided that go-karts would no longer be operated during OHS student activities at the Legacy Center.

The Legacy Center continued to serve as a focal point for the school. The Legacy Center hosted the OHS wrestling practice and wrestling match. This was the first OHS sporting event held since the shooting. Caron advised this was the first state sanctioned wrestling match held in a location other than a school in Michigan's history.

[299] Photography of Legacy Center courtesy of Tod Caron.

Wrestling event to be held Dec 22nd 2021

With the Oxford High School being closed until further notice we have been asked to host a sanctioned Oxford wrestling meet here at The Legacy Center. I have had numerous meetings with the coaches and staff and we have set the date of December 22nd. This event is going top be huge and emotional so please plan on working this night. We will be installing the mats from the Hugh school tomorrow afternoon in Axe Social and moving furniture.

Please do not walk on the mats.

Please be vigilant and watch the crowd closely. Use your walkie talkie to contact me if ANYTHING looks suspicious or out of place. You are expected to search back packs or get someone to assist you. Reminder we are private property so we have a right to search people as well.

This event is a strict NO MEDIA event per the players and I will be enforcing this accept for one photographer from Oxford TWP invited to document this event.

Police will be assisting with parking as well as both plain clothes and uniformed officers inside the building. Im told some of the victims families may attend for their first outing and we need to make sure they are taken care of.

If you see anyone trying to speak to kids that is not a police officer or wearing a proper volunteer badge let me know immediately.

[300]

[300] Legacy Center Photography and notes – courtesy Tod Caron

The Legacy Center further extended its welcome to elementary and middle school students of Oxford, since many of these students had siblings who attended OHS. COO Caron wanted to make sure the Legacy Center was open and inviting for them as well. COO Caron ensured arts and crafts instruments were available by consulting with Meijer, who sent a tractor trailer of donated supplies. The Legacy Center became a place where people could support the school as activities gradually started returning to "normal." During the first week that OHS fully reopened, the Legacy Center hosted free coffee and breakfast for OHS parents. The Legacy Center did this to provide a place for parents to come who were afraid of being more than a mile away from their children during school. Many parents took advantage of the opportunity to stay close to their children.

COO Caron recalled only one concerning event regarding the school board. There was a tenant within the building who owned a coffee shop and happened to also be an OCS board member. A parent of a student at OHS began stalking the board member and making threats that he was going to kill the board member. The Legacy Center had the parent removed for trespassing and OCEM worked with the OCSO to provide protection for those involved. Outside of that incident, there were no other reported violent issues regarding parents and the Legacy Center.

v. *Legacy Center Funding and Interactions with Politicians*

COO Caron noted that there were promises made to reimburse the Legacy Center and local businesses for their generosity. However, no one was ever fully compensated by the state or federal government. According to COO Caron, FEMA initially said that there was $100 million in COVID-19 money that would be released to help fund the recovery. This never occurred. Some businesses were eventually offered a check for $1,200 to help offset their massive losses, however local businesses felt that this was insufficient.

The Legacy Center incurred financial liabilities to provide this service. The 32 tenants who rented space lost money. Within a month, they were unable to pay rent. Tenants at the Legacy Center who were closed for three months had no revenue. There were also significant costs incurred cleaning and stocking the building, which had more than 1,000 daily users, and the Legacy Center continued to pay its employees to fully staff the operations. Caron informed us that Legacy Center's total losses exceeded $4 million. Without the tremendous generosity of the owner of the Legacy Center and the tenant businesses, the Oxford community would not have had access to any of the benefits the Legacy Center provided.

G. Oxford Community Schools' Response to the Shooting

Aside from the first responder analysis, Guidepost was tasked with assessing the Oakland County government's response as well as leadership from Oxford Community Schools. Our review identified challenges to OCEM, including limited authority, fragmentation with management practices, low prioritization and resources, and challenges in coordination efforts. We further identified issues concerning the Oxford Community School District, much of which was impacted by the presence of the COVID-19-19 pandemic. School safety training and staffing shortages diluted focus on preparedness and was at the time more focused on health and welfare of students based on the pandemic. Finally, our review identified issues with the OCS school board's crisis communication, remediation response, and recovery plans.

1. *Coordination, Governance and Preparedness of the Oxford Community Schools District and School Board*

The Oxford Community Schools District serves Oxford Township, the Village of Oxford, as well as five other townships and two other villages. Geographically, it is one of the largest school districts in Michigan. The district comprises the following schools: five elementary schools (Clear Lake Elementary School, Daniel Axford Elementary School, Lakeville Elementary School, Leonard Elementary School, and Oxford Elementary School); one middle school (Oxford Middle School); one high school (OHS); two alternative schools (Oxford Bridges High School and Oxford Crossroads Day School); and one virtual school (Oxford Virtual Academy).

In the 2021-2022 school year, the district enrolled 5,919 students and employed 1,019 people, including 392 teachers, 32 administrators, and 423 non-instructional staff.[301] The District is governed by the Board of Education (the "Board") and the Superintendent. Board members (formally known as "trustees") are elected by school district residents to four-year terms. Entering the 2021-2022 school year, the Board members were: President Thomas Donnelly, Vice President Chad Griffith, Treasurer Korey Bailey, Secretary Mary Hanser, Trustee Dan D'Alessandro, Trustee Erick Foster, and Trustee Heather Shafer. The 2021-2022 school year, the district Superintendent was Timothy Throne, and his cabinet included Ken Weaver, Deputy Superintendent of Curriculum and Instruction; Anita Qonja-Collins, Assistant Superintendent of Elementary Education; Sam Barna, Assistant Superintendent of Business and Maintenance; David Pass, Assistant Superintendent of Human Resources; and Jill Lemond, Assistant Superintendent of Student Services.

[301] Michigan School Data. (2023). *Student enrollment counts report.* Same. Retrieved from www.mischooldata.org.

2. *Michigan School Safety Legislation*

To provide some context regarding a school district's obligations, a brief review of some legislative history in Michigan regarding school safety obligations is necessary. The requirements concerning drills have undergone considerable changes and amendments over the years. In 2006, two pieces of legislation passed regarding drills where occupants of school buildings were restricted to the interior of the building. The bills amended Act 207, PA 1941, the Fire Prevention Code, and required all K-12 schools to perform a *minimum of two drills* in which the occupants are restricted to the interior of the building for each school year. Notably, "a drill conducted under these acts shall include security measures that are appropriate to an emergency such as the release of a hazardous material (shelter in place) or the presence of an armed individual on or near the premises (lockdown)."[302,303] In their drill policy packet, Michigan State Emergency Management noted that the lockdown/shelter "shall be conducted and recorded by school officials," but did not require the way it was to be recorded. A suggested template was offered.[304] 1941and Act 207 were amended several times prior to the shooting in 2014 and 2015, and subsequently after the shooting in April 2025. A Michigan State Police School Safety Drill Requirements form published in 2023 stated a requirement for a minimum of five security drills in schools, three by December 1, 2023, and two after December 1, 2023.[305]

Additional legislation that took effect March 21, 2019, also required schools to conduct a biennial review of their emergency operations plan with at least one law enforcement agency. The code proceeds to define the focus of these operations plans, which are included but not limited to: "(a) *School violence and attacks*; (b) *Threats of school violence and attacks*; *(c) Bomb threats*…(g) *Parent and pupil reunification*… (i) *A plan to train teachers on mental health and pupil and teacher safety*; (j) *A plan to improve school building security*; (k) An *active violence protocol*; (l) *Continuity of operations after an incident*; [and] (m) *A vulnerability assessment*.[306] (Emphasis added). It appears; however, that these reviews did not involve any requirement to report to state officials what schools were doing to thwart shooters.[307]

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[302] Michigan School Lockdown/Shelter-in-Place Drill Policy School_Lockdown_Drill_Policy_Packet.pdf (2006)

[303] The following constitutes the history of the legislation. **History**: Imd. Eff. June 16, 1941 ;-- CL 1948, 29.19 ;-- Am. 1965, Act 200, Imd. Eff. July 16, 1965 ;-- Am. 1973, Act 199, Imd. Eff. Jan. 11, 1974 ;-- Am. 1978, Act 3, Imd. Eff. Feb. 7, 1978 ;-- Am. 1998, Act 45, Imd. Eff. Mar. 30, 1998 ;-- Am. 2006, Act 187, Imd. Eff. June 19, 2006 ;-- Am. 2006, Act 337, Imd. Eff. Aug. 15, 2006 ;-- Am. 2014, Act 12, Eff. July 1, 2014 ;-- Am. 2014, Act 481, Eff. Mar. 31, 2015 ;-- Am. 2024, Act 36, Eff. Apr. 2, 2025

[304] Michigan State Police. (20060. *School lockdown legislation.* Same. Retrieved from www.michigan.gov.

[305] Michigan State Police. (2023.) *School safety drills, documentation, and reporting requirements.* Same. Retrieved from www.michigan.gov.

[306] MCL 380.1308b(3)

[307] Krafcik, M. (2019, November 3). Michigan doesn't track districts providing school-shooter drills for students. *WWMT News.* Retrieved from www.wwwmt.com.

It should be noted that with respect to OHS preparedness, the last time that OHS, OFD, and OCSO trained together on active assailant response prior to the shooting was in 2013. This was confirmed by OFD Captain 1, who recalled the use of role players, blanks, and fake blood, and OHS staff.

3. *An Analysis of Oxford Community School Preparedness*

The COVID-19 pandemic impacted OHS like many schools in the United States. In the 2021-2022 school year, schools were just a few months into the return to in-person learning. Significant distrust existed between parents and school administrators as they managed return to classes, vaccination mandates, and masking policies. That mistrust exploded when the attack occurred on November 30, 2021. Several mental health professionals involved with the recovery of the OHS shooting specifically discussed the COVID-19 backdrop and the general distrust of government operations. In addition, multiple county officials also confirmed the general distrust of government operations by the Oxford community. Particularly, they all referenced the conservative culture of the Oxford community and reluctance to accept masking, vaccines, and social distancing.

The COVID-19 pandemic also impacted OHS's preparation for this type of attack. Following the pandemic, OHS was understaffed. For example, school administrators were compelled to take on functions that were not part of their job, such as serving in the cafeteria, housekeeping, and other duties to keep the school open and functioning. Our research suggests that OHS administrators were pulled in multiple directions and struggled to direct their full attention to administrator duties.

The pandemic also impacted OHS' ability to do full training for ALICE drills. According to Assistant Superintendent of Business and Operations, Sam Barna, "Training shutdown and programs that did not have the bandwidth to adapt to virtual training. Live ALICE drills did not occur at all and were cancelled in totality."[308] As part of the Guidepost Report 2 investigation, the district acknowledged that there were longer delay time between drills, but suggested that the pandemic influenced those delays, in large part to school closings and additional public safety measures for social distancing.[309] We acknowledge that the potential priority shifting created by the continued COVID-19 aftermath could have conceivably created a crisis for educational institutions balancing where the perceived threat was greatest. Nevertheless, the Michigan Department of Education published

[308] Guidepost interview of Sam Barna, Assistant Superintendent of Business and Operations March 1, 2023.
[309] It is worthwhile to note that in our interview with Carolyn Krause, she said that the county health department and OHS were at odds because of the mask mandate which they made enforceable on the district. This toxicity between the health department and the school reared its head later post shooting when help was offered to OHS and the district rejected their involvement.

guidance before the start of the 2021-2022 school year, reminding schools of the vital importance of conducting safety drills. Moreover, our previous review of the district's/OHS' response as it pertains to the training for ALICE drills, lockdown tools, and return to school plans did not properly prioritize safety.

a. Alice Protocols at OHS

As addressed in Guidepost 2, the OCS contracted with the ALICE Training Institute to establish standardized procedures for active shooter attacks and to deliver comprehensive training throughout schools. Students and staff received instruction through a PowerPoint presentation that outlined the core components of the ALICE protocol. This included key elements such as lockdown procedures, communication practices, when counter threat activity is appropriate, and importantly how to evacuate the school safely. Furthermore, two scenarios requiring ALICE protocols were presented, which required participants to assess the situations and determine whether the proper decision was lockdown or evacuation.[310]

The 2019-2020 OHS Staff Handbook incorporated the ALICE procedure in an active shooter situation, and sets for the following course of action to take in the event of an ALICE alert:[311]

1. The announcement: "All students and staff - we are in a situation. All students and staff are to implement ALICE procedures now!"
2. Go to door, bring in any students from hallway, lock door.
3. Contact the office to report any students not assigned to you.
4. Wait for further directions.

That protocol is further supported by the OHS EOP issued in November 2019, states:
"Any school faculty member, who observes or is made aware of an immediate dangerous threat, shall immediately call 9-1-1 and notify all other persons present in the school vicinity."[312]
These provisions instruct that said observer should announce "lockdown" and should try to convey as much information as possible regarding the threat/shooter – including location and direction of the moving danger and any description that could help identify the assailant. In the case of OHS, employees had participated in three ALICE active assailant drills in 2019: February 25, 2019, September 30, 2019, and October 25, 2019, that focused on lockdown, barricade, and evacuation procedures. Before the second drill,

[310] In Guidepost 2, we noted that OHS' ALICE response plan did not contain the scenario that unfolded at OHS specifically a threat within school corridors or classrooms.
[311] OHS Staff handbook 2019 – 2020, at 35.
[312] OHS Emergency Ops Plan November 2019, at 66.

the Dean of Students recommended that teachers review ALICE procedures with their classes. This appears to be as a set up for the third drill, which was designed to surprise students. They were expected to implement the procedures they had been taught and trained on in the prior drill.[313] OHS then conducted additional drills – two in 2020 on October 1, 2020, October 27, 2020, and one in 2021, about a month prior to the incident, on October 7, 2021.

i. *ALICE Alert Clarifications*

At 12:52:59, Principal Steve Wolf announced the official ALICE warning, through an alert on the school's public address (PA) system. The audio of this is recorded on a student's phone and was analyzed extensively by Guidepost in a previous report. Principal Wolf stated, *"Pardon the interruption, staff and students. We are going into, a, uh, ALICE lockdown. Please lock and secure your doors. I'd ask the students who don't have the ability to do it now..."* We agree with our prior finding that the remainder of the recording is drowned out by the presence of gunfire near the student recording the message.

Multiple witnesses confirmed that they heard Principal Wolf say, *"This is not a drill. This is not a drill."* However, a number of OHS school employees and students informed us that they could not decipher if the announcement was "ALICE" or "ALICE drill." In Guidepost 2, we provided recommendations concerning how the ALICE policies could be improved, in particular the EOPs shortcomings in directing responsibilities as well as executing the "I" for INFORM in ALICE. We stand by our findings. However, it is important to supplement these determinations further.

In Melissa Williams' 9-1-1 call, she asks a colleague to announce an "ALICE drill" even though she clearly knew that the circumstances were a fully legitimate event. Every ALICE lockdown was practiced by utilizing the phrase "ALICE drill," and thus this is what many defaulted to during the real event. Again, because ALICE and drill were in the same announcement, there was initial confusion if this was a drill. Interviews conducted by OCSO of school employees also found that employees were told "ALICE drill by staff." However, the staff all said that there was clearly something wrong occurring, and most understood immediately that this was not a drill.

Although the confusion regarding the announcement did not critically impact speed or efficacy of the response overall, it provides an important lesson that repeated active assailant drills will create muscle memory in both adults and students. Muscle memory can be a positive element to proper training or a detrimental fault. OHS employees relied on what they did in the drills, and that was to announce, "ALICE drill." It is essential that

[313] See Guidepost Report 2.

training establishes proper and reliable “muscle memory” to distinguish between routine drills and danger. Deliberate effort must be made concerning how a lockdown will be announced. There are simple techniques that can be employed to differentiate. If a lockdown drill is occurring, the announcer must first state, “This is a drill, this is a drill, this is a drill.” Following this warning, the announcer would proceed with the lockdown announcement as would be done in a real response event. This brief caveat by the announcer ensures that everyone involved in this exercise unmistakenly can identify the difference in a drill announcement versus a real-time announcement. The use of this procedure also prevents the staff from learning to say “drill” when announcing a lockdown.

OHS did effectively lock down in approximately 30 seconds. The surveillance footage from within the school revealed the immediate effort by everyone in the school to lock down. The shooter was actively hunting for victims for seven minutes as he roamed the 200 hallway. During that time, the camera showed him rapidly walking through completely deserted hallways and firing random shots. This rapid lockdown absolutely saved many lives. Both students and staff members responded to the alert, including students actively pulling OHS staff into classrooms and activating Nightlock to bolt the doors.

It should also be noted that the OCS has since changed how they announce a lockdown. Instead of saying, “ALICE”, they now announce, “Lockdown, lockdown, lockdown.” The announcement is repeated several times and followed by pertinent instructions. We concur with this change. Plain language is the simplest way to guide people during an active shooter situation. The use of code words is ineffectual and is well documented to lead to confusion or delay in responding to critical alerts.

4. *The Necessity for Effective Security Camera Usage*

OHS had a robust system of high-fidelity cameras, provided by exacqVision.[314] The camera system covered most common areas on the interior of the school. In addition, there were multiple cameras that covered the exterior of the building. The cameras recorded and the data was stored on drives both local and remote to the school. Administrators at the OSD administration building also have access to all OHS cameras.

On the day of the shooting, multiple school administrators stated that the monitor was not turned on. When the shooting occurred, the large monitor was off in the security office. As previously discussed, while the camera system itself always remained on and operative, OHS’ private security guard would typically turn on the large television monitor in his office to view the cameras when he was at his desk. That monitor was only

[314] ExacqVision was replaced over a year ago by a new system called Axis.

connected to his computer.[315] During her communication with 9-1-1, the dispatcher advised Melissa to observe the real-time camera footage. Melissa proceeded to the security office but was unfamiliar with the operation of the monitor.

Ultimately she relied on the assistance of her colleague to help her bring up the footage on an OHS administration computer. School administrators who had access to the camera system described the user experience as intuitive and relatively easy to understand with training. We noted in Guidepost Report 2 that in the ALICE Response Team Document "…only *one* of the scenarios mentions the video surveillance system as an aid in providing real-time information. The ALICE protocol in the EOP also omits any assignments or use of the video surveillance system for INFORM."[316] It is essential that multiple members of the OHS administrative staff and offices have access and the ability to operate security footage in real time. This can also include setting up multiple access portals for projecting live footage to a large monitor screen, or multiple monitor accessibility within the administrative offices.

5. *Assessing the Efficiency of Nightlock Devices*

In 2018, OHS installed Nightlock devices in all classrooms and offices throughout the school. Nightlock is typically a two-piece device. One piece is permanently affixed to the door and the second piece is in a box next to the door and is slid into the device engaging the locking mechanism as needed. As soon as a lockdown is announced, as trained, the occupants of the classrooms or offices must engage the lock to prevent entry from outside of the door. Nightlock allows people to secure the door from inside of the room, so they do not have to lock the door from the exterior side. Multiple school employees we interviewed over the course of this after-action review suggested that the school placed a high degree of importance on the Nightlock device. Those interviewed stated that upon employment, one of the first priorities of Principal Wolf was to show them how the Nightlock worked. In addition, students were also shown how to engage the Nightlock device.

As soon as Principal Wolf announced "ALICE" at 12:52:59, numerous students and staff throughout the school engaged Nightlock devices. The Nightlock device was even engaged in multiple rooms occupied only by students, exemplifying the OHS' regular training provided to both adults and students alike. 14-year-old Heidi Allen, a student who

[315] Several school administrators had access to the camera system on their desktop computers. In addition, OCS administration had access to the camera footage at the district offices. The camera system is an icon that the user must open to view the cameras.
[316] Guidepost 2, p. 497.

was not struck in the initial barrage of gunfire, was able to assist critically injured classmate Phoebe Arthur into a nearby classroom and engage the Nightlock.

The Nightlock device did prove a challenge for law enforcement after the shooting. OCSO officers and commanders were not aware that the school had Nightlock and were not familiar with how to disengage the device. OCSO officers clearing the school stated they were given an unlocking device by school administrators. The officers had to take the device to a classroom and to train themselves in using the device. Officers also stated there was a limited number of unlocking devices, which slowed the time to clear people from classrooms. In addition, OCSO deputies stated the Nightlock device delayed them getting into Room 224 where teacher Molly Darnell was shot. From the OHS camera footage, this delay was approximately two to three minutes as deputies were trying to disengage the device.[317]

Another challenge concerns the Americans with Disabilities Act §404.2.7, which has very specific requirements for door-locking hardware. Door hardware must meet the following requirements:

- Allow one-hand operation
- Not require tight grasping, pinching, or twisting of the wrist
- Operate with 5 lb. maximum
- Be located 34″ to 48″ above the floor or ground

Nightlock states on their website that their product complies with Americans with Disabilities Act regulations; however, there are published findings to the contrary. On March 6, 2024, the Door Security and Safety Foundation along with the Door Security and Safety Professionals released a position statement on Nightlock following the shooting at the University of Indianapolis.[318] The foundation determined that Nightlock violated standards under the Americans with Disabilities Act, the National Fire Protection Agency, and the International Code Council.

On March 11, 2025, the ALICE Training Institute released a position statement regarding door barricades. The Institute gave guidance on the difference between a door lock and a door barricade.[319] The primary and compelling difference is that a door barricade can function without a door. A door lock is dependent on a functional door. If a device is dependent on a functional door, it then must meet the standards established by the

[317] The camera did not directly view the door. The camera footage showed officers near the door for two to three minutes. Officers who accessed Darnell stated they had trouble disengaging the Nightlock.
[318] Door Security and Safety Foundation. (2024, March 6). *DHI and DSSF issue statement in response to University of Indianapolis Nightlock initiative.* Washington, D.C.: Same.
[319] ALICE Training Institute. (2025, March 11.)

International Fire Code, the National Fire Protection Association, and the Americans with Disabilities Act.

At the 2018 Capital Gazette Newspaper shooting in Annapolis, Maryland, the perpetrator shot through the glass doors, entered the building and barricaded the rear exit door using the Barracuda Intruder Defense system lock near the door.[320] He did this to prevent the people from fleeing and slow down law enforcement and first responders. He then continued through the building killing five and injuring two as they could not escape the building. This sentinel case showed that the perpetrator recognized the active shooter barricade device in his preplanning and intentionally deployed the device as one of the first steps in his attack.

The national initiative *Lock Don't Block*, lists multiple recognized problems with door barricades:[321]

- Barricaded doors can become a death trap for younger students if the teacher is injured or killed.
- Door barricade devices can be used maliciously during bullying incidents or violent attacks.
- Perpetrators can use the door barricade device to slow or stop responding officers.
- The door barricade can delay or prevent people from fleeing the classroom in the event of fire, smoke, or chemical attack.
- The door barricades cannot be used by many people with mobility impairment.
- Door barricades may reduce or eliminate the fire rating of the door.

Door locking devices can slow down first responders, especially if they are not familiar with the device. Door barricades require specialized training to use.

[320] Kilander, G. (2021, June 30). Chilling new photos emerge of Capital Gazette newspaper mass shooting. *The Independent.* Retrieved from www.the-independent.com.
[321] Door Security Safety. (2024). *Opening the door to school safety: Code compliant locks versus barricade devices.* Same. Retrieved from www.lockdontblock.org.

6. *The Superintendent's Notification of the Shooting*

Information concerning the shooting was first relayed to the board by Superintendent Throne's office. An email from Assistant Superintended Weaver relayed "HS- Emergency" about an active shooter situation at OHS. The notice provided that OCSO was present at the scene.[322] The message instructed recipients to wait for further updates and to refrain from responding to questions. At 13:07 this email was also distributed to additional OCS personnel.[323]

7. *Issues Concerning the Return to School*

The OCS plan for a "soft" reopening of District schools (other than OHS) was disseminated on December 5, 2021. This two-week plan included trauma training for all staff and half-day schedules for students. Ultimately, school was cancelled for the entire district because of multiple threats directed toward OCS. On January 5, 2022, a town hall was hosted to discuss the district's plan for reopening OHS and returning students to school.[324] On that same date, Principal Wolf provided details to the OHS community via email on the tentative return plan for OHS students, acknowledging that the timeline would look different for each student and emphasizing, "Our first focus is to improve, then maintain the physical, social, and emotional well-being of our students and staff. Our second focus is to slowly integrate academics back into our plans and schedule." In advance of the town hall that day, Superintendent Throne disseminated the "Tentative Plan on OHS Return" to the community:

> *With OHS not ready to be fully opened yet, we have created a two-week alternate hybrid schedule for our Oxford Middle School and Bridges students in order to share the OMS building with our high school students and staff. The alternate hybrid schedule will be in effect beginning Monday, January 10 - January 21. Each principal will send detailed plans and schedules to all OHS, OMS, and Bridges families later today. We hope this slow transition together at OMS will help in the healing process and ease our high school students back in a familiar academic setting… Renovations to OHS are scheduled to be completed during the week of January 17. Our tentative plan is to host three open house opportunities for our OHS students and families to visit the high school together before we transition back to the building the week of January 24*.

The decision when a school should reopen following a school shooting or another critical event is a difficult decision, however there are several important factors to consider.

[322] Email from Weaver re: "HS- Emergency," Nov. 30, 2021.
[323] Email from Weaver re: "FW: HS – Emergency – For your information only,", Nov. 30, 2021.
[324] Community Telephone Town Halls, Oxford Community Schools, 2022. *See Also:* "Tele-town Hall Content Outline," Oxford Community Schools

These factors include, (1) damage done during the attack, (2) if the school is in law enforcement or prosecutor possession, (3) length of time left in the school year or before a major holiday break, (4) age of the students, (5) type of school such as standard or boarding school, (6) number of deceased, (7) input from students, family, and the community, and (8) plans in place to renovate or close the building.

It is critical to note that there is no widely accepted opinion on the optimal time for a school to reopen. To that point, there is widespread debate about location usage after a mass shooting event. Nearly every major event will have news articles dedicated to the public debate surrounding what to do with the locations. There is no established best practice for what to do with a school following a shooting. In many cases, the school building was torn down after the shooting, and a new school was rebuilt. This occurred at Marjory Stoneman Douglas High School, Sandy Hook Elementary School, and Robb Elementary School. Similarly, this has occurred in other non-educational buildings that were the site of mass shootings, such as Pulse Nightclub, Tree of Life Synagogue, First Baptist Church, and more. There are multiple school shootings in which the building was renovated and school resumed. This includes Platte Canyon High School, Columbine, Santa Fe High School, Abundant Life Christian School, Apalachee High School, Central Visual and Performing Art High School, and Perry High School. In each case, the extent of the renovations varied from quick repair to extensive multi-million-dollar structural changes. There is near universal agreement that the location of the shooting must change enough that it is almost impossible for people to pinpoint the exact location of where victims were shot and/or died. Without these changes, people will continue to fixate on specific locations.

Unfortunately, few changes were made to OHS, except for walling off Bathroom 2, with still no plans about what to do with that area. The OCS Chief Financial Officer stated they did not have the funds to demolish the 200 hallway and rebuild it, which would cost more than $40 million. Despite attempts to pursue additional funding options, none were successful. In addition, OHS does not have an alternative location. The previous high school now stands as Oxford Middle School, which operates at maximum capacity. If the high school was to lose the 200 hallway for extended demolition and renovations, the school would lose 20% of its student capacity. This would likely mean that 400 students would have to transfer to another high school, or the school would need extensive use of portable classrooms. This would cause additional logistical problems and likely anger students and families.

In light of all of these factors, the OCS school board decided to conduct only necessary renovations so that students could return quickly to the building. SET SEG, the OCS insurance carrier, selected ServePro to perform the clean-up and prepare the school for

the return of students. COO Caron stated that numerous contractors and craftsmen offered their services for free or at greatly reduced cost to the school, himself included. However, the district refused the offer after talking with their insurance carrier.

The school was set to reopen on Monday, January 18, 2022. Jack Curtis (Supervisor Curtis), the Oxford Township Supervisor asked COO Caron if he would walk through the school Saturday, January 16, 2022, in the afternoon prior to the Monday opening. COO Caron explained that the township knew of his involvement at the Legacy Center, and that he was also a general contractor. COO Caron recounted to Guidepost that the walk-through was meant to last one hour, but instead it lasted seven. COO Caron said he immediately observed numerous problems, and that the building was completely unsuitable for reopening to the public. COO Caron began the post-incident walkthrough finding two unpatched bullet holes. He also discovered what appeared to be body fluid, blood on the floor, and broken window screens. He told us (i) he observed remnants of blood, scalp, and hair on the windows in the classrooms where students dove out of windows; (ii) student desks remained stacked in barricade formations; and (iii) the stall partition from the bathroom where Justin was shot had been relocated to a nearby mechanical room, while the bathroom door itself was simply locked. COO Caron was concerned that the door would become a shrine and recommended sealing it off with sheetrock.[325]

After the involvement of Supervisor Curtis, it was decided that OHS would not reopen until it was completely ready. By the time COO Caron returned for a second walkthrough, he acknowledged that OHS was in significantly improved condition and that all necessary repairs had been completed. Ultimately, OHS reopened on January 24, 2022.

We understand that some people in the community were upset about the delay in reopening the school, while others believed it was too soon. However, it was necessary to address COO Caron and Supervisor Curtis' findings before reopening. The approximately one-week delay until January 24 allowed contractors to fix many of the problems identified during the walkthrough. The district also created a hybrid schedule from January 5 to January 24 at Oxford Middle School that allowed OHS students and staff to come together and begin acclimating to the academic setting. By the time the school reopened, both the male and female Bathroom 2 areas were completely walled off, preventing any access to that area. In addition, new carpet was installed, and walls were repainted.

[325] Given the extremely disturbing nature of the photographs, we are not including any photographs in this report that Caron showed to our review team.

8. *Challenges with the District's Crisis Communications*

In the aftermath of the shooting, the school district ceased public communications after retaining legal counsel. While the district is entitled to counsel, the resulting lack of communication appeared to have a detrimental impact on the district's communication with students, parents, and the community. Community members expressed frustration with the communication about all school closures in the district. They also expressed frustration that OCS promised to open OHS and then, the night before, sent a communication stating the opening was delayed until further notice. The parents expressed frustration that they were having difficulty preparing their students for return to school, making plans for childcare, and coordinating their employment obligations. Numerous parents expressed deep concerns to Guidepost about the lack of communication from OCS and the perceived lack of transparency and accountability of OCS employees and board members.

Rapid, transparent, and effective communication is critical to the recovery process and an effective return to school after a shooting. It is also helpful in addressing misconceptions and factual distortions. Ultimately, Oxford Community Schools decided to conduct an independent investigation and Oakland County, Michigan decided to conduct an after-action review, which help to provide greater transparency. We hope that both these actions have significantly contributed to the community's recovery process and will be utilized to improve future communications.

VI. Recommendations

As seen in the report, there are numerous standards, white papers, position statements, and other materials that provide a compendium of best practices at active assailant events. This report includes more than 200 citations and references to established best practices and active assailant research findings.

As discussed, NFPA 3000 is the national codified standard on integrated active assailant preparedness, response, and recovery. Every public safety agency must be familiar with this standard and make concerted efforts to comply with the best practices listed. Since 2017, more than 100 experts from 50 internationally renowned organizations have compiled and modified these recommendations. Many of the recommendations below are discussed in the NFPA 3000 code.

As with any critical incident, there are many lessons to be learned. These lessons often result in change not only with the organizations involved, but with other similar organizations. This review team understands that not all findings and recommendations are equally important. Likewise, many of the recommendations in this report are likely pertinent for many organizations outside of Oakland County. To assist with delineating our recommendations, we have divided the recommendations into three tiers. The tiers are used as guidance, and each organization may upgrade or downgrade the recommendation based on organization leadership decision.

Tier 1: These are critical action steps that Oakland County agencies should rapidly implement to ensure compliance with recognized best practices and industry standards.

Tier 2: These recommendations follow best practices. However, there may be individual agency limitations that preclude adoption, including organizational, financial, technological, and manpower constraints, or other reasons. Each agency should make efforts to analyze the recommendation and attempt to incorporate the findings into operational practice. Adoption of some of these recommendations may take time, money, or both.

Tier 3: These are best and most promising practices for everyone, including the report readers, to discuss within their organization and determine if implementing these practices is feasible and will increase operational efficiency. It is important to note that although Tier 1 and Tier 2 recommendations are directed at Oakland County, the findings are likely to apply to numerous public safety agencies.

A. Oakland County Government Recommendations

- Ensure a formal AAR is conducted for all multi-agency critical events in the county. AARs should identify strengths and weaknesses with the response. Incorporate lessons learned into future training. (Tier 1)
- Involve all responding agencies and disciplines in the AAR. (Tier 1)
- Utilize experts from other agencies and/or organizations to assist with the AARs to provide expertise and objectiveness. (Tier 1)

B. All Public Safety Agency Recommendations

1. *County-Wide Active Assailant Plan*

- Establish a county-wide integrated active assailant response plan that incorporates law enforcement, fire, EMS, 9-1-1, and emergency management. Include clearly written policies and procedures for law enforcement, fire, EMS, and emergency management's strategic and tactical priorities at active assailant events. (Tier 2).
- Clearly identify in the plan each public safety discipline's equity at active assailant events. (Tier 2)
- Create active assailant checklists for law enforcement, fire, EMS, 9-1-1, and emergency management supervisors and command staff. (Tier 2)

2. *Incident Command*

- Embrace incident command in all operations. (Tier 1)
- Establish incident command training in the academy and continue incident command coursework as a requisite for promotion, including training about active assailant incident command. (Tier 1)
- Dispatch should prompt on-scene units to establish command if they have not done so in a multi-agency critical event. (Tier 1)
- Establish rapid unified incident command at the initiation of all multi-agency critical events, incorporating fire and EMS. (Tier 1)
- OCSO should establish and record critical command benchmarks over the radio and in CAD, to include at a minimum: (1) suspect down or suspect in custody, (2) location of the unified command post, and (3) location of known or suspected explosive devices. These critical response benchmarks should be rebroadcast on all channels with an alert tone. (Tier 2)

- All Oakland County public safety agencies should address area command and NIMS complex management structures in policy and training. (Tier 2)
- Adopt the "Fifth Officer Rule" where, barring exigent circumstances, the fifth law enforcement officer on scene at critical events regardless of rank is the incident commander until relieved by the next arriving ranking officer or if command was previously established by arriving officers. This ensures that the role of incident commander is established early and that critical directions are relayed to dispatch and responding units. (Tier 3).
- Establish a rapid notification process for OCSO command staff and Special Operations units to be used at critical events. This process should include a command CAD page or other rapid notification system. Utilization of a phone tree is not acceptable. (Tier 1)
- Chief officers should take charge at critical events. Even if they do not take command, the highest-ranking person is still ultimately responsible for operations. Agency policy should clearly address this expectation. (Tier 1)

C. OCSO Recommendations

- Ensure arriving officers provide an LCAN report. (Tier 1)
- Ensure through training that officers understand the importance of critical information sharing on the radio. (Tier 1)
- Ensure written policies and procedures call for fire department support during explosive ordinance assessment and mitigation. (Tier 1)
- All active assailant practical training should include the rapid creation of incident command, followed by the rapid formation of unified command. (Tier 1)
- Incident command training should begin at the communications center level. (Tier 1)
- Ensure that integrated active assailant response includes the different models of integration, such as contact/treat/extract, RTF, protected corridor, and protected island. (Tier 1)
- OCSO and other stakeholders should participate in tabletop training every two years. (Tier 2)
- Agency leaders should ensure frequent training opportunities to train responders and identify gaps in response capabilities. This training should be formalized and mandatory. (Tier 1)

- Ensure through training that all public safety responders are proficient with all issued equipment, including ballistic protection and medical equipment. (Tier 1)
- Consider an accreditation program for OCSO, such as CALEA. This is an opportunity to compare agency training, policies, and procedures to national standards with a consistent and reoccurring review of the agency. (Tier 3)
- SROs should provide an annual update to their chain-of-command and the OCSO Training Division on any active assailant barricade devices in use at the SRO's school. This update should come no later than the first day of the school year. (Tier 1)
- Ensure through training that law enforcement officers are familiar with different barricade devices that may be installed in buildings. (Tier 1)
- OCSO should exercise discipline to not send every ranking member to an emergency scene. The EOC is a critical component of response and recovery and should receive priority agency staffing. OCSO should send a ranking member with agency authority to the EOC as soon as OCEM notifies agencies that the EOC is opening. (Tier 1)

D. Fire/EMS Recommendations

- Establish a county-wide active assailant fire department standard operating procedure that clearly identifies minimum expectations for training, ballistic equipment, and response operations. (Tier 1)
- Create and utilize pre-determined active assailant CAD call types for the entire county. (Tier 1)
- Every fire department must have an active assailant policy that meets the standards set forth in NFPA 3000. (Tier 1)
- Fire departments in Oakland County should establish formal guidelines regarding staging practices. (Tier 1)
- Fire and EMS agencies should evaluate the recommendations of the Hartford Consensus to refrain from staging at active assailant events. (Tier 2)
- Fire departments should establish formal guidelines regarding whether law enforcement dispatch instructions to stage are a recommendation or a directive. (Tier 1).

- The fire department county-wide integrated active assailant policy should not only establish expectations of all fire and EMS agencies within the county but also have specific and direct verbiage addressing staging. (Tier 1)
- Fire departments should also establish ***internal*** policies regarding staging. (Tier 1)
- A county-wide ASHE plan and staging go together, but that does not obfuscate the responsibility of departments to develop their own independent policies. (Tier 1)
- Internal department policies should include the level of discretion fire personnel have with regards to staging and a list of exceptions and/or triggers for different staging levels at active assailant calls. (Tier 1).
- Consider utilizing arriving fire apparatus to ring the building to provide cover and concealment for fleeing occupants. (Tier 3).
- Utilize MABAS MCI box alarms to call for additional EMS resources instead of piecemealing the response or requesting a county-wide all-call. (Tier 1)
- Establish the role of transportation officer during active assailant events. This officer will also be accompanied by a fellow ranking law enforcement officer and will jointly establish effective routes for ambulances to take to trauma centers. This aids law enforcement as well, who often will need to coordinate with other agencies to block traffic and shut down key roads. (Tier 2)
- Ensure there is adequate ballistic protective equipment for responding personnel. (Tier 1)
- All personnel should be proficient with all issued equipment, including ballistic protection and medical equipment. (Tier 1)
- Emphasize the use of lightweight litters to move patients instead of using stretchers. (Tier 2)
- The two MABAS groups should work together. At the very least, these two groups should meet twice a year and include law enforcement participation. (Tier 2)
- Assign a fire/EMS chief officer and fire/EMS units to hospitals where patients are expected to arrive. (Tier 1)
- Train on the different models of medical care at active assailant events. (Tier 1)

- Review departmental policy on switching radios channels during critical events and establish notification practices. If fire radio channels should be switched, dispatch should announce this with a radio tone. (Tier 1)
- If an incident occurs within a building, support the building's fire sprinkler system earlier into an active assailant event to prepare for fire-as-a-weapon or explosives. (Tier 2)
- Add a heavy hazardous materials unit/team to all active assailant dispatches to support the bomb squad. (Tier 2)
- Assign a fire department liaison from both MABAS groups to OCSO Dispatch to assist in identifying proper calls for fire/EMS responses. (Tier 2)
- EMS responders should provide timely information updates to hospitals, including patient numbers, patient priority status, and anticipated destination hospital. (Tier 1)
- Once a mass casualty incident is declared, incident commanders should make every attempt to provide updates: at a minimum, every 10 minutes. (Tier 2)
- Ensure that all personnel receive training on the different models of integration, such as contact/treat/extract, RTF, protected corridor, and protected island. (Tier 1)
- OFD should implement a formal policy requiring timely debriefings after all critical events, train officers in facilitation and potential issues (such as gag orders), and integrate peer support. Direct engagement with frontline personnel is essential to rebuild trust and reinforce a culture of transparency and accountability. (Tier 1)

E. <u>OCSO Dispatch Recommendations</u>

- An active assailant response should be declared when any of the following information is provided by a caller: (Tier 1)
  - Three or more people violently attacked (shot, stabbed, etc.) in a public location and the attacker is still on scene.
  - An attack in a high-risk occupancy (such as a school, hospital building, government building, and so forth) in which the perpetrator conducted potentially homicidal violence, is still armed, and is still on scene.
  - A violent public attack in conjunction with the use or threat of explosive devices.

- A violent public attack in conjunction with the use of smoke or fire.
- A violent public attack in conjunction with the use of chemical munitions by the perpetrator.
- Any other call deemed a hostile mass casualty attack as determined by the dispatch supervisor.

- Training should instruct responders to utilize readback of all critical information to ensure information is heard, understood, and stated again for responding units. (Tier 1)
- Broadcast critical command decisions on all event radio frequencies to ensure responders are aware. (Tier 2)
- Implement AVL practices in conjunction with fire and other emergency management departments in Oakland County. (Tier 2)
- Ensure CAD programming is up to date and compatible with AVL dispatching practices. (Tier 1)
- Move from manual to automatic CAD entry practices. (Tier 1)
- Utilize keywords in CAD to flag situations related to “shot,” “injured,” “weapon,” “gun” and “active shooter.” (Tier 1)
- Institute predetermined response plans for fire and EMS agencies to be dispatched on incidents, such as active assailant incidents. These plans should predetermine what agencies should respond, as well as what resources they should provide based on the geographic location of the incident. These plans will provide a level of consistency throughout the county while preventing confusion in dispatch procedures. (Tier 1)
- Ensure all fire and EMS responders are notified that an active assailant suspect is in custody or neutralized. (Tier 1)
- Ensure fire and EMS resources are immediately dispatched when any homicidal violence is suspected by the call-taker, regardless of confirmation of an actual victim. (Tier 1)
- Consider consolidation of all PSAPs into one department to best effectuate and streamline technology, policies, operational practices, and communication, including AVL implementation across the county. (Tier 2)
- Unless and until all PSAPs are consolidated, there should be a policy across the county on how to address misrouted 9-1-1 calls. (Tier 1)

- Consider utilizing artificial intelligence (AI) as an option for tip lines or post-crisis information submissions to avoid flooding the PSAP's general line. (Tier 3)
- Establish relationships with local phone service providers and educate them regarding the impact of active assailants or other large-scale events that affect coverage and transfer of calls to 9-1-1 centers. (Tier 3)
- Establish a 10-minute incident timer at each console that requires the incident commander to give a status update every 10 minutes during the incident until the event is under control. (Tier 1)
- Create active assailant scenarios to be added to the CTO Training Manual for initial telecommunicator training. (Tier 2)

F. OCEM Recommendations

- Ensure senior-level representation for all primary response agencies in the EOC when it opens. The representative should have decision-making authority for their agency. The representative should be identified in advance, with redundancy in place to ensure a representative will respond. (Tier 1)
- Conduct EOC exercises for a variety of hazards to ensure that agency representatives understand the importance of the EOC, and functions performed in the EOC. (Tier 2)
- Identify EOC stakeholder roles and responsibilities in advance. This will encourage needed input from relevant stakeholders during EOC operations. (Tier 2)
- Emergency management officials should ensure that they have a functional recovery plan for major disaster events. Although it is difficult to anticipate every type of disaster, there should be an established operational framework that can provide guidance. (Tier 1)
- Create an EOC liaison position at the unified incident command post to ensure timely communication is flowing to the EOC and from the EOC to the commanders. This position can help to provide continuous situational updates that include all public safety disciplines. (Tier 2)

G. Reunification Recommendations

- Oakland County should adopt the Standard Response Protocol and Standard Reunification Model. (Tier 1)
- Ensure that school employees are trained on the Standard Response Protocol and the Standard Reunification Model. (Tier 1)
- Ensure that law enforcement officers who may supervise reunification centers are trained in the Standard Reunification Model and reunification best practices. (Tier 1)
- Establish policies and procedures that clearly establish which agency is responsible for reunification at mass casualty events. (Tier 1)
- Establish policies and procedures addressing security considerations at reunification centers. (Tier 1)
- Determine the reunification process for releasing students to guardians. (Tier 1)
- Ensure that each township emergency manager has a functional plan for reunification in their jurisdiction. (Tier 1)
- Clearly establish and identify which public safety agency is responsible for reunification within Oakland County. (Tier 1)
- Ensure that the Oakland County Medical Authority has a role in reunification and in the incident assistance center to help identify if victims are at hospitals. (Tier 1)
- OCSO should have a policy on incident assistance centers, including the rapid deployment of crime victim services and counselors to support family members. (Tier 1)
- Ensure that the county reunification team has the financial resources, personnel, and training to effectively manage reunification at large-scale events. (Tier 2)
- Continue to explore a partnership with OCHD to staff reunification centers. (Tier 2)
- Establish policies and procedures for the creation of Incident Assistance Centers for families of the injured and the deceased. (Tier 2)
- Ensure the OCMCA is involved with reunification center plans and procedures to ensure the exchange of patient information. (Tier 2)

- Ensure the OCME is involved with Incident Assistance Center plans and procedures for decedent identification and next of kin notification. (Tier 2)
- Ensure OCSO ranking members are familiar with the FBI's Victim Services Response Team and the assistance they can provide. (Tier 2)
- Ensure that public safety organizations conduct reunification exercises once every two years. (Tier 3)
- Adopt plans and procedures for extremely large reunification operations involving 1,000+ people. (Tier 3)
- Ensure that reunification plans include language translators and disability translators. (Tier 3)
- Ensure that reunification plans include the identification and return of personal effects. (Tier 3)
- Identify MOUs to facilitate reunification locations. Ensure these MOUs are signed and updated annually. (Tier 3)
- OCEM should create a one-hour introductory training model for reunification operations for public safety personnel. This training should highlight the State of Michigan's adoption of the Standard Reunification Model. Oakland County public safety agencies should require personnel to attend this course if there is an expectation that they could operate at reunification locations. (Tier 3)

H. Recovery Recommendations

- Each agency at the county level should work with elected officials to create a pool of emergency funds that can be quickly utilized to create a temporary resiliency center (such as what happened at the Legacy Center) until a formal resiliency center is operational. (Tier 2)
- OCEM should establish MOUs with other facilities in Oakland County, similar to the Legacy Center, in case a future event requires a similar location. (Tier 2)
- Ensure a standardized policy is in place to vet mental health providers during a crisis event. This responsibility can lie within county government, for example, with the Health and Human Services Department. (Tier 2)
- Identify locations for gathering where activities and services for children can be organized. (Tier 2)

- Enforce no media policies and assign a liaison to assist in communications with the media. (Tier 2)

I. Mental Health Recommendations

- Every agency should have a robust mental health and wellnesses program prior to a critical event. Simply having EAP as a resource is not acceptable. (Tier 1)
- 9-1-1 communicators should be included in critical incident defusing and debriefings for all critical events. (Tier 1)
- Funding agencies should review the incident location's insurance policies to determine whether coverage is available for mental health care. (Tier 2)
- Local and state emergency managers should reach out to federal programs that could provide crisis funding such as the Department of Justice's Office for Victims of Crimes. (Tier 2)

J. Integrated Training Recommendations

- Utilize the incident command system in all multi-agency active assailant training exercises. (Tier 1)
- Public safety supervisors should attend incident command training for active assailant events every two years. (Tier 1)
- Expand active assailant training to cover active shooter events, mass stabbing, vehicle attacks, fire-as-a-weapon, explosives, chemical attacks, and similar situations. (Tier 1)
- Ensure that active assailant policies, procedures, and training account for hostage events, multiple perpetrators, mobile perpetrators, and multi-site attacks. (Tier 1)
- The OCSO training facilities and 9-1-1 Dispatch Center are in need of modernization. The county should evaluate the development of a new, modern training facility and dispatch center to address aging infrastructure, support advanced law enforcement training, and enhance emergency response capabilities. This investment would ensure operational readiness, improve public safety services, and accommodate future growth across the county. There should also be some consideration to improve upon the current Emergency Operations Center. (Tier 2)

- Conduct tabletop exercises every two years involving all Oakland County public safety agencies. (Tier 2)
- Conduct full-scale exercises every four years including law enforcement, fire, EMS, emergency management, and medical examiner's office. (Tier 2)
- Incorporate TECC/TCCC training annually into law enforcement, fire, and EMS training. (Tier 1)
- In addition to formalized interagency training, fire and law enforcement should engage in relationship-building activities together to promote teamwork and camaraderie among their members. (Tier 3)

K. OHS and the Oxford Community School District Recommendations

- School districts should develop a recovery plan for an active assailant event. This plan should address renovations/demolition, return to school, memorials, and more. (Tier 1)
- All school districts that have armed staff in the school should clearly define the staff member's responsibilities and duties during a violent event. All armed staff members should receive, at a minimum, quarterly training specific to their duties and responsibilities when armed. (Tier 1)
- Training for ALICE Alerts should involve clarifications so as not to confuse participants when an actual incident occurs. There should be clear protocols in place and language to assist in differentiating between drills and real-life situations such as announcements stating "This is a drill, this is a drill, this is a drill" when a drill occurs. Lockdown announcements should not use code words or code names. Announce, "Lockdown, lockdown, lockdown." (Tier 1)
- Training in the use of surveillance video systems within a school should not rest solely within the security officials. Administrative staff within range of camera access should all be trained in the technology. (Tier 1)
- All Oakland County schools should notify local law enforcement, OCSO, and the local fire department if they have installed any type of door barricade device. These agencies should all have a high degree of familiarity with the locking device. A cautionary note should be placed in CAD so responders are aware of the device. (Tier 1)
- Oakland County school districts should reevaluate the use of the Nightlock device and consider alternative lockdown options. (Tier 2)

- Schools should carefully consider their communication practices with the community. They should prioritize transparency and understand the implications of silence on students, parents, and those in the community. (Tier 3)

VII. IN MEMORIAM

“The song ended, but the melody lingers on." Irving Berlin

After action reviews are designed to acknowledge achievements, critique failures, and provide recommendations to help mitigate or prevent tragedies in the future. They typically focus only on facts surrounding an active assailant incident. However, the innocent lives lost on November 30, 2021, remain ever present in the hearts of their families and their community.

We extend our sincere gratitude to all the families for their generosity of time and openness. Nicole Beausoleil taught us of her daughter’s Madisyn’s mental fortitude, brilliance, and commitment to kindness. Madisyn regularly provided words of inspiration to her mother which echo in her mind daily. Buck Myre shared the transformative work of 42 Strong, the Tate Myre foundation. 42 Strong was created to facilitate a better future for students in Michigan and throughout the nation.[326] Jill Soave told us of Justin’s own commitment prior to his death to be an organ donor. Justin’s organ donation saved the lives of six people, while his tissue donation helped countless others. We witnessed the beauty of the Hana St. Juliana Memorial Garden, a labor of love by Steve St. Juliana and his family to honor not just their daughter, but her fellow classmates lost on November 30, 2021. The garden exemplifies the beauty, joy, and meticulous care that the St. Juliana family identifies as central to Hana's character. Steve continues to promote change in the Oxford community and school system to protect future generations of children.

The following photographs and words come directly from the Beausoleil, Myre, Shilling/Soave and St. Juliana families, with their permission, in memoriam of their children.

[326] https://42strongtate.org/

Madisyn Baldwin

Madisyn was always a bright light in the darkest of days. Her smile and laugh were beautifully contagious. She carried herself with a positive and radiant energy that everyone could feel when she walked into a room. She loved people with her whole heart and was so careful not to leave anyone out.

One of the biggest and most important aspects of Madisyn's life was the love she had for her family. Madisyn cherished them immensely. She was a patient, kind, and compassionate soul who adored children, especially her siblings who led her to become a devoted supporter of autism awareness.

Her studies were important to her, and she aimed for excellence in all she could. She had big plans to graduate high school with all A's and attend college to become a Behavioral
Analyst and to study neuroscience. Madisyn was a gifted artist who loved to draw, take photographs, and creatively write.

Madisyn was competitive and determined. She would never turn down a challenge. If you challenged her, you better be ready to keep going until she won. She was even learning to ride motocross on weekends and treasured her motocross family. Thanks to her dad and uncle, Madisyn was a Michigan State fan through and through since she was able to talk. Her favorite color was green, so it makes sense that this was her favorite team.

To have her as a daughter, granddaughter, niece, friend or girlfriend one should consider themselves lucky, as she was an amazing soul. The world lost an incredible person that day, but her spirit lives within us. Everyone that was blessed to meet sweet Madisyn loved her.

Our world will never be the same without Madisyn in it. Spread kindness in her name whenever you can, love hard, dream big, and never settle for less than the best.

Tate Myre

Tate Myre, our beloved son, brother, and friend, was a gift to our family and everyone he met. To us, he was “Tater,” a nickname that captured his warmth and the joy he brought into our lives. Tate lived with a deep sense of accountability - always doing what he said he would, always showing up for those who needed him, and always striving to be someone you could trust. His life was a testament to the power of connection, and through his unwavering loyalty and trustworthiness, he left an indelible mark on our hearts.

Tate’s days were filled with moments that defined him. He cherished hunting and fishing trips with his dad, Buck, where they’d share quiet moments in nature, trading stories and laughter by the water or in the woods. With his mom, Sheri, Tate loved their ice cream dates, where they’d talk about everything and nothing, his smile lighting up the moment. He shared a special bond with his brother Ty, carpooling to school together, singing to their favorite songs, and taking the field as a “dual brother” backfield for Oxford High School’s varsity football team. Ty, a senior, blocked and cleared the way for Tate, their teamwork a reflection of their unbreakable bond. With his oldest brother, Trent, Tate grew up wrestling under his coaching, jumping on the backyard trampoline, shooting hoops in the driveway as young brothers, their goofiness echoing through our home. Whether it was helping him edit his high school football highlight tape, staying after wrestling practice to fine tune his low single, or sending lifting videos and new workouts back and forth, they were funny meatheads together.

Tate was born with a gift for connection. He had a way of making everyone feel seen, whether it was a classmate, a teammate, or a stranger. He earned your trust with his actions, not just his words, and his loyalty was unshakable. Tate was the friend who showed up, the brother who listened, the son who made us proud every day. His accountability shined through in everything he did - playing football, wrestling, or simply being there for someone in need.

Our family will never be the same without Tate. There is a permanent hole, and we miss him every single day—his laugh, his kindness, his steady presence. The tragedy of November 30, 2021, took our Tater from us, a loss that words cannot fully capture. Yet, in our grief, we find hope through the legacy Tate left behind. Through the 42 Strong Foundation, we honor his gift for connection by fostering peer-to-peer mentoring, helping others combat loneliness and build trust, just as Tate did. His life inspires us to live with purpose, to connect deeply, and to hold ourselves accountable to one another.

We carry his memory forward, not just in our hearts, but in our actions—striving to make a difference in his name. Tate, you are our baby, our brother, our light, and our inspiration. We love you forever, and we promise to live out the values you embodied every day.

Justin Shilling

If something is worth doing, it's worth doing right. When it comes to life, Justin did it right. We will always be amazed by his work ethic and continuous drive to do the best that he could. It was through his strong determination that Justin was able to succeed on so many levels. Justin always looked wide eyed at the future, eager to get out there and make a difference. The truth is, he already made a difference in the lives of so many just by being who he was. Justin lived by the Golden Rule. Do unto others as you would have them do unto you. A true empath and bright light. His smile and laugh, contagious. His sense of humor and wit, epic. His love of fine dining, classic. His heart and soul, warm and inviting. His mind, sharp yet kind. His personality, dynamic and charismatic. His sense of style, iconic. Justin worked hard and took great pride in all he achieved, including student council, baccalaureate status, WEB leader, freshman mentor, and a lettered athlete. The heart of any team. He loved freely and deeply.

You never hesitated to say I love you. Remember Justin for his love of nature, the sky, photography, and a deep love for his friends and family. Justin humbly and consistently went out of his way to brighten someone's day. Justin always looked out for others, even in his final moments. Never missing an opportunity to use his voice for good. Justin also loved a wide variety of music. He can be quoted saying, "Play Binary Sunset, it's my favorite." You may have caught him singing, as he often would. Noble and wise beyond his years. He gave the gift of life through organ donation. In the end, only kindness matters. We can all be more like Justin. May his light and legacy live forever!

I'll fly a starship across the universe divide
And when I reach the other side
I'll find a place to rest my spirit if I can
Perhaps I may become a highwayman again
Or I may simply be a single drop of rain
But I will remain
I am the sunlight on ripened grain. I am the gentle autumn rain.
I am a thousand winds that blow. I am the diamond glints on snow.
I will miss you.
I was needed elsewhere, I had to go.

For the Love of Nature Fund...The Forever Justin Shilling Foundation

The primary purpose of the fund shall be to conserve and protect the environment in memory of Justin Shilling, one of the victims of the Nov. 2021 shooting at Oxford High School.

Scan the QR code shown here or visit https://bit.ly/Fortheloveofnature

Checks can be sent to:
Four County Community Foundation
PO Box 539
Almont MI 48003

Hana St. Juliana

You loved everything: unconditionally. Your heart was too big not to, and with that big heart came an equally big smile. Even when your smile alone could brighten a person's day, your presence literally brightened people's lives. You made everyone feel special, and your ability to be so true, reflected onto others. Your shoulder was open for anyone to lean on; you had your friend's back for anything and everything. You were always perceptive. Noticing and appreciating the smallest of details. Laughter always followed everywhere you went. You were the person who always did the right thing. You never failed to express yourself, whether it was through your outfits, your gold accessories, your perfectly painted nails, all your different Converses, your fun socks, or your little doodles all over your schoolwork. Your transcendence surpassed every expectation. But it was because of all the hard work you put into it. It showed when you jumped higher, set better, and hit harder. You brought laughter to a quiet practice, and smiles to pre-practice snack breaks. For basketball season, you were already putting in that extra work. I know with your dedication, your passion, and your drive it would have made you the most excellent lacrosse player.

Remember Hana for her contagious smile, that was too infectious.
Remember Hana for her humor, the countless times she made you throw your head back and laugh.
Remember Hana for her countless interests, every little new thing she tried.
Remember Hana for her love of food, cooking and baking, eating and snacking.
Remember Hana for her love of Christmas, the abounding amount of decoration she put up that matched her spirit.
Remember Hana for her empathy, being inclusive to everyone, and always there for anyone.
Remember Hana for her dedication, the games she played, the points she scored.
Remember Hana for her cleverness, sarcastic remarks, and perfectly timed eye rolls.
Remember Hana for her love of lights, though she was a beacon for others.
Remember Hana for Hana, always being the thoughtful, incandescent, loyal person one couldn't help but love.

Thank you Hana, for always being you. We all hope to live every moment, laugh every day, and love beyond words like you.

VIII. APPENDIX A: AGENCY MATERIALS PROVIDED

The agencies are listed below alphabetically, not based upon content provided.

Oakland County Emergency Management

- Weekly Partners' Meetings
- Oxford SitReps (Situation Reports)
- Legacy Center Incident Command Post (ICP) Images
- Incident Action Plans (IAP) and Incident Command System (ICS) forms
- Oxford-Related URL's.docx
- Published_-Oxford_-Final_Protocol.pdf
- Restaurants donating food.pdf
- Temp Memorial - 1.jpeg
- 12.15.21 Slotkin Meeting.pdf
- 12.16.21 Meeting notes.pdf
- 12.3.21 DTE Outage Oxford.JPG
- 12.30.21 OXFORD VICTIMS UPDATE.pdf
- 3.14.22 Guest list for OSD Presentation.docx
- 3.14.22 Presentation to OSD.docx
- DTE STRFD - Oxford Twp.pptx
- Initial response docs.pdf
- Mental Health Resources OXFORD FD.pdf
- MH Counseling-Resource Flyer-Legacy.pdf
- Oxford IMT notes.pdf
- Oxford OakEOC Export.pdf

Oakland County Prosecutor's Office

- OHS security camera footage viewing
- Sheriff's department vehicle footage
- Autopsy reports
- OCSO Case File

Oakland County Sheriff's Office

- Training Presentations
- Staffing and Organization Charts
- Response Time Comparison - Average & Other Incidents 2024-8-17.xlsx
- OCSO Presentations on Oxford Shooting
- Policies

- Oxford Criminal Case File[327]
- Dispatch Documents

    - CTO Manual 2021
    - 2021 CTO - Policies, Rules, and Regulations
    - Timeline 11-30-21 Oxford FD with highlights and notes.xlsx
    - Radio Traffic
    - Dispatch Rosters
    - D-Cards
    - AVL (Automatic Vehicle Location) data
    - 9-1-1 Calls
    - Calls for service at the Oxford FD from Jan 1, 2021, until Dec 31, 2024: 26-OXT FD CFS 21-24.xlsx
    - Oxford Township Fire Department Dispatch Procedures: 26-OXT FD.pdf
    - PROQA Response Codes by Incident Type.xlsx
    - Rollover List 2025-02-26 14-54.pdf

Other

- Todd Caron's Legacy Center notes and photos
- Versions of 9-1-1 Calls placed on November 30, 2021, by Melissa Williams
- Documents received from the general community (FOIA docs including SET SEG coverage, reports, meeting minutes, formal complaints, appeals)
- Emails from community members

[327] Some community members informed Guidepost that they were under the impression that the OCSO did not interview school staff. We were able to confirm that the OCSO along with other local, state, and federal agencies conducted more than 1,000 interviews in the days following the attack. Many of these interviews were not included in the criminal report that was obtained through FOIA. Only those interviews that provided direct value to the criminal charges filed against the shooter and his parents were included in the report. The absence of interviews in the report is not an indicator that the interviews did not occur. The case report was designed to prosecute those charged with a crime, not investigate the response by the school or responders.

IX. APPENDIX B: OHS SHOOTING TIMELINE

Below is the Oxford shooting timeline the review team created based on OHS video, radio traffic, 9-1-1 calls, CAD notes, the school monitor's body worn camera footage, in-car audio, and responder interviews.

Time:	Event:
12:46	4th hour classes end. Shooter exits Room 256.
12:46:36	Shooter enters Bathroom 1
12:49:48	Justin enters Bathroom 2.
12:50:53	Keegan Gregory enters Bathroom 2.
12:50:55	Tate enters the courtyard.
12:51:11	SRO (OS1651) leaves substation headed to OHS.
12:51:12	Shooter exits Bathroom 1
12:51:13	Shooter shoots and injuries Phoebe and Elijah.
12:51:14	Shooter shoots at Hana, Kylie (wounded), and Riley (wounded). Riley eventually exits the building.
12:51:15	Shooter moves east in short 200 hallway
12:51:16	Shooter shoots at and wounds John Ascuitto. Shooter shoots Hana again
12:51:19	Shooter shoots at Madisyn Baldwin (deceased). John Ascuitto stumbles as he tries to run, exits through Door 7.
12:51:21	Shooter runs around corner to move north in 200 hallway. Elijah Mueller runs out of the 200 to the 300 hallway and exits the building. Substitute teacher from Room 249 intercepts him and calls 911.
12:51:25	Shooter shoots at a student who later discovers a bullet in her backpack days later.
12:51:29	Students entering the 200 hallway from the courtyard are met by a stream of students running north
12:51:30	Shooter shoots near rooms 244, 245 and 247.
12:51:38	Shooter shoots near rooms 240 and 238
12:51:44	First 911 call is made by a student in room 256. The teacher takes over the call for the student. Students states there is someone shooting in the school.
12:51:54	911 call by a student who was in Bathroom 1 with the shooter.
12:52	5th hour classes are supposed to begin.
12:52:04	Female student helps Phoebe move out of the 200 hallway into room 258. Engages Nightlock.
12:52:05	A student enters a mostly empty 200 hallway from the courtyard.
12:52:07	Tate enters a mostly empty 200 hallway from the courtyard, several feet behind the other student.
12:52:08	Shooter fires into Classroom 236, not striking anyone.
12:52:09	911 caller stated they are a teacher in Room 256 and they can hear loud noises in the hallway.
12:52:10	Shooter shoots at and hits Tate (deceased).

12:52:12	Shooter shoots Aiden Watson (wounded) outside of room 218.
12:52:14	Riley gets up and runs out of Door 8.
12:52:19	Substitute teacher in Room 249 escorts her students out of the building through Door 7.
12:52:20	Shooter shoots Tate a second time.
12:52:26	Shooter moves past the 400 hallway.
12:52:29	911 caller states he heard shots inside the building. Caller states there is a school shooting.
12:52:32	First 911 call reporting injuries. Caller reports one person is shot (believes it is REDACTED that is shot.) She makes the statement 2:19 into the call at approximately 12:54:51.
12:52:33	Principal Wolf announces over the PA system that the school is going into ALICE. This announcement followed a "3131" emergency call to the school front office by a teacher in room 237. Melissa Williams answered and was informed a teacher heard gunshots. She immediately notified Wolf.
12:52:36	Aiden and another student exit the building through Door 4.
12:52:41	911 caller reporting shots heard inside the school
12:52:41	911 caller reporting a shooting at the high school.
12:52:54	Shooter faces Room 224 and shoots teacher Molly Darnell (wounded) who is inside.
12:52:59	OCSO dispatches all Oxford OCSO units to OHS for reports of shots fired at OHS.
12:53:50	911 caller states they heard five to six gunshots right in front of their classroom
12:53:11	Shooter pauses to change magazine for a second time. Puts used magazine in pocket.
12:53:26	OS1610 and OS1611 leave the substation enroute to OHS. | Car-Car: Units start alerting that active shooter at OHS.
12:53:30	OCSO dispatch advised units no reported injuries. Second caller is a teacher advising loud noises outside her classroom.
12:53:32	Shooter turns around outside of Room 214 and begins moving south. Prior to this, he had continued north in the 200 hallway, shooting into classrooms.
12:53:37	Shooter pauses, likely a reaction to seeing AP Gibson-Marshall. They are moving toward each other.
12:53:40	Shooter shoots into several classrooms not striking anyone.
12:53:41	While traveling from the Oxford substation to OHS, the speed of SRO's car jumped from 44 mph to 56 mph. Continues increasing speed to reach the school. Hears chatter over the school radio about someone down at Door 5 (Tate).
12:53:51	911 caller reports someone in a hoodie is walking around shooting. Unsure if anyone has been hit. There are two people along with the caller hiding in the bathroom.
12:53:51	AP Gibson-Marshall reaches Tate.
12:53:59	911 caller near the pool reporting hearing gunshots in the school. Did not see anything.
12:54:21	Shooter passes AP Gibson-Marshall.

12:54:24	911 caller states she is a teacher in the 200 hall and heard gunshots in the school. She has 10 people in the room with her.
12:54:47	911 caller states he is a student in Room 239 and heard 20-30 shots.
12:54:51	Statement is made on the 9-1-1 call that the caller believes one person is shot.
12:54:52	Shooter enters Bathroom 2.
12:54	Keegan texts his parents, "Someone in here."
12:55:00	AP Gibson-Marshall starts providing care for Tate.
12:55	Keegan texts his parents, "He's in the bathroom."
12:55:08	Dispatch to units: "20-30 shots heard from student in Room 239"
12:55:11	911 call reporting a injured student (Elijah) across the street from the football field. 2nd 911 call reporting injuries.
12:55:12	911 caller is a 14 year-old female student. She is outside of the school across the street. She thinks two of her friends might be victims.
12:55:26	911 caller is a student at the school in the 200 hallway. Reported hearing multiple shots. Unknown information about the shooter.
12:55:29	911 call transferred from Lapeer from student enroute to Meijer. During this call the operator talked to another Lapeeer operator who was on the phone with Melissa Williams. This call had the first report of a victim with a head wound by door 5.
12:55:39	Dispatch to units: "Student caller leaving building and reporting two friends are possible victims."
12:55:53	911 caller states they are in the bathroom near the Wildcats mural. The subject left a backpack in the bathroom.
12:55:53	911 caller states he is a student and heard 6-8 loud noises that sounded like gunshots. He is directed to go to safety near the football field.
12:55:58	OS1550 enroute to OHS.
12:56	Keegan texts his family group chat four times, "He saw us", "I'm with the other person", "He saw us", "We are just standing here."
12:56	Keegan states that he and Justin were whispering trying to figure out if the shooter was still in the bathroom, to which they confirmed he was using the camera app Justin's phone
12:56:12	OS1517, OS1521, OS1522, OS1503 enroute to OHS.
12:56:38	911 caller (12:55:29 call) reporting they are going to the Meijer in a Grey Dodge Avenger. This same phone call reported one shot in the head by door 5 (Tate).
12:56:47	911 caller reporting the suspect is a white male with glass, wearing a beanie, with a burgundy jacket. Heard 20-30 shots.
12:56:53	911 caller at the school heard shots but did not know where they are coming from. They did not see or hear anything else.
~12:56	OFD Captain-1 receives a phone call from a firefighter at Addison Township Fire saying he thought he heard on the radio there was a shooting at OHS.
~1256	Chief Robert Duke from Orion Township Fire calls Chief Majestic and tells him about the shooting.

12:55 – 12:56	Shooter kicks open bathroom stall where Keegan and Justin are hiding together. Shooter stares at them and then walks away from the stall. Some time later, Keegan and Justin hear the bathroom door open* and attempt to see if the shooter left.
12:56:09	Melissa Williams's 911 call connects with operators in Lapeer County.
12:56:58	SRO pulls up very close to Door 7. SRO backs up his car to make sure there is enough room for the door to open. Deputy 1 pulls up just behind SRO. (Exterior camera at Door 7 was not working on 11/30/21)
~12:57	OFD Captain-1 assigns Lt/Fire Marshall/Paramedic to the backup ambulance along with rookie EMT.
~12:57	Oxford firefighters are receiving multiple calls on their cell phone from their kids stating there is a shooting at the school.
12:57:03	School monitor is moving south in the 200 hallway and reaches AP Gibson-Marshall and Tate. AP Gibson-Marshall informs the school monitor that the situation is not a drill and gestures south.
12:57:12	SRO parks and exits his car.
12:57:15	OCSO dispatch calls Oxford Fire Department and tells OFD Captain-1, "We are taking numerous calls for shots fired at the high school. We don't have anything yet, but we probably will."
12:57:19	911 caller reporting a shooting at the school. Caller is in Room 245. There are no injuries.
12:57:34	Potts draws gun from holster following AP Gibson-Marshall's gesture.
12:57:35	911 caller reporting he is outside the school and heard five to seven shots. He is now walking on Ray Road towards Oxford.
12:57:40	AP Gibson-Marshal starts CPR on Tate.
12:57:40	Dispatch to units: "Possible white male, glasses, burgundy jacket." OS2027 asked if there is an active shooter at Oxford High School.
12:57:40	911 caller reporting someone with a head injury at Oxford High School.
12:57:43	911 caller is a teacher reporting a shooting in the hallway near Door 7.
12:57:43	911 caller is across the street from the school near the football field. A child has been shot. He is missing his teeth. Caller is with 30 other students who fled.
12:57:53	Update by dispatch - description of suspect: "(inaudible race desc.) Male with glasses / burgundy jacket."
12:57:56	SRO is outside of Door 7 with his rifle and go-bag in hand. Appears to be waiting for Deputy 1.
12:58	Keegan texts his family, "He's standing here", "I see the gun", "OMG", "I love you guys."
~1258	Oxford Fire crew at Station 1 begin collecting medical supplies from the EMS supply room. OFD Captain-1 called Station 2 and told them something was happening at OHS.
*12:58:02	School monitor turns her body 90 degrees to move west and reach the door of Bathroom 2. School monitor pulls the door open, makes a small movement forward, but then stops. She remained for two seconds before pulling back at 12:58:04. She briefly looks north, to where she came from, before continuing south.

12:58:08	Dispatch update to units: "A caller is reporting a child shot."
12:58:23	SRO opens Door 7 with his access key card and enters the building with Deputy 1 following behind.
12:58:20	Principal Wolf arrives to AP Gibson-Marshall. He stands near Door 5 and continues to look outside for any law enforcement and then back down the hall towards Door 6.
12:58:29	SRO and Deputy 1 enter the short-200 hallway and move toward the victims.
12:58:35	Lapeer County 911 reporting a student with a head injury near Door 5. Caller is Melissa Williams. Caller does not have eyes on the shooter.
12:58:38	SRO and Deputy 1 reach Hana and Kylie
12:58:47	Kylie grabs SRO's leg. He shakes her off.
12:58:48	School monitor reaches SRO, Deputy 1, Hana, and Kylie Ossege. School monitor begins assisting the students. SRO provides the school monitor with his tourniquet.
12:58:59	911 caller reporting the shooter left a backpack in the bathroom. Caller states the backpack is red.
**b/t 12:59:19 – 12:59:23	Melissa Williams's 911 call is transferred to Oakland County from Lapeer County.
1259	Chief Majestic and Chief Scholz arrive at Station 1. They see the E-1 and Alpha 4 ambulance leaving for Meijer. Majestic retrieves his department vehicle and proceeds to Meijer behind Chief Scholz.
12:59	Keegan texts his family, "he killed him." Justin sent his last text at 12:58 (text messages were not time-stamped to show seconds). Prior to Keegan's text, the shooter returned to the stall Justin and Keegan were hiding in, told Keegan to stay put, and ordered Justin out of the stall. Shooter then shot and killed Justin. Keegan then sent the text. Then the shooter returned to the stall and directed Keegan out. Shooter was motioning for Keegan to get on the ground with the gun and as he moved the gun away from Keegan, Keegan ran behind the shooter's back and out of the bathroom.
12:59:15	Lapeer County advised they were sending multiple EMS units
12:59:29	OCSO sends the request for OFD from LE console to fire console. OFD is dispatched for a medical standby at OHS. Advise fire to stage for an active incident.
12:59:31	911 caller reporting hearing gunshots in the school but cannot see anything.
12:59:31	Possible visible reaction by AP Gibson-Marshall and Principal Wolf to hearing Justin get shot. AP Gibson-Marshall told law enforcement that she was doing CPR on Tate when she heard gunfire behind her (from the bathroom). She stated that she paused CPR thinking she was going to be shot by someone coming up behind her.
12:59:32	Officers are inside OHS, in the main office. Call out (inaudible) the 200 (hallway)
12:59:35	AP Gibson-Marshall stops CPR on Tate.
12:59:46	OC1610 and 1615 making entry by the main office.
12:59:56	OCSO dispatches Oxford Fire to a "medical emergency" at OHS.
12:59:58	Keegan exits Bathroom 2.

12:59:59	AP Gibson-Marshall begins CPR again on Tate. AP Gibson-Marshall begins mouth-to-mouth.
13:00:07	Shooter exits Bathroom 2. At some point, he placed the gun atop the trashcan outside the bathroom, between the boys' and girls' bathrooms.
13:00:11	Shooter raises his arms to surrender as SRO and Deputy 1 approach from the south.
13:00:12	"1 with a head injury outside of Door 5."
13:00:14	OC units advise there is screaming in the 200 hall.
13:00:14	Shooter turns to face SRO and Deputy 1.
13:00:15	Shooter kneels on the grounds with arms still in the air.
13:00:15	LE units advised to stage at Meijer.
13:00:19	SRO walks past the shooter, initially not realizing that he is the shooter.
13:00:21	Deputy 1 notices the gun atop the trashcan and yells, "Gun!"
13:00:24	Deputy 1 orders the shooter to lay on the ground.
13:00:30	SRO and Deputy 1 have their rifles pointed at the shooter. SRO handcuffs the shooter. They learn of the shooter's name from AP Gibson-Marshall.
13:00:30	Units in OHS calling Dispatch: "Dispatch we also need (radio interrupted unable to transmit)". "51 10-9" requested). Several "radio bonks". Dispatch confirms to units they are "unreadable"
13:00:36	"A1 staged on Oxford FD".
13:00:43	OCSO deputies reach AP Gibson-Marshall and Tate.
13:00:49	911 caller reports they are with a student and have fled the building. The shooter had on a grey sweatshirt and grey sweat pants.
13:00:53	OFD Captain-1 announces to all fire companies to stage at Meijer. OFD Captain-1 requests MABAS MCI box alarm 63-OXF-6. Oxford Fire Alpha 2 advises they are staging at Meijer. OFD crews arrive, put out traffic cones, and don ballistic vests.
13:00:53	Approximately 30-50 students are in the back parkiing lot of Meijer.
13:00:54	OCSO units reporting one down in front of Room 226.
13:00:58	911 caller reporting the shooter had a black pistol.
13:01:05	SRO announced on the radio, "One detained." Dispatch attempts to confirm.
13:01:05	OCSO unit requests fire to enter at Door 5 for one shot at Room 228.
13:01:14	911 caller is a whispering student in the 400 hallway. 25 others with him. He does not know anything about the shooter. He heard from other kids that there were two shot.
13:01:18	OCSO request fire and EMS to enter the building at Door 5. Units in OHS call dispatch - second request for fire
13:01:26	OCSO units advise one down at Room 226.
13:01:32	OCSO units advise fire to respond to Door 5. There is a victim in Room 228.
13:01:40	OCSO advised Oxford Fire Alpha 2 of a shooting victim at 465 S. Glaspie. (Student Watson)
13:01:41	Dispatch to SRO: "Did you say one detained?" SRO: "Yes, one detained."
13:01:53	911 caller is staff. They are in Room 222 with another staff member. They have no kids with them. They were multiple shots but never saw the shooter.

13:01:54	One confirmed detained.
13:02:00	Four deputies enter Door 7 and move into the short 200 Hallway.
13:02:00	OCSO deputy arrives to Tate. Checks pulse. Puts him in recovery position.
13:02:15	First deputy checks Madisyn; determines she is deceased and moves on.
13:02:19	OCSO units advise 17-year-old female shot in the next neck near the main office area. She has a towel on her neck. Is conscious and breathing.
13:02:25	OCSO dispatched Oxford Alpha 2 to JP's Piano at 465. S. Glaspie for a 15-year-old-male shot in the leg.
13:02:27	REDACTED police chief starts CPR on Madisyn.
13:02:47	911 caller reporting the shooter was possibly a male student in all black clothing.
13:02:48	OS8909: "We have lots of cars heading that way. What is the status?" Dispatch: "We have one detained. Unknown if this is still active."
13:02:54	OCSO dispatched Addison Township Fire
13:03:02	Dispatch: "1613 is this the only shooter?" 1613: "Nothing confirmed." Dispatch: "Do you have a description of the subject?" 1613: "Grey pants, black hoodie, and black stocking cap."
13:03:00	Two more deputies enter Door 7 and go into the short 200 Hallway.
13:03:02	"Need EMS at Door 7 and Door 5."
13:03:00	Keegan texts his family that he reached the front office.
13:03	Lapeer County advises they are enroute with nine officers. They will reporting to staging at Meijer.
13:03:26	911 caller is a teacher in Room 244. He has 20 kids in the room.
13:03:30	Two deputies enter and clear Bathroom 1.
13:03:40	OCSO Lieutenant 1 enters Door 7 and goes to the school monitor.
13:03:40	OCSO dispatched Brandon Township Fire
13:03:41	Deputy 1 opens the door to Bathroom 2.
13:03:44	OCSO first enters the bathroom with Justin.
13:03:57	OCSO units request fire to Door 7.
13:04:00	OCSO deputy with Tate resumes CPR. Officer arrives with AED and attempts to connect it.
13:04:03	OCSO leaves bathroom and closes door.
13:04:14	Statement made by school staff during 911 call from Melissa Williams regarding multiple victims. First 9-1-1 caller reporting multiple victims.
13:04:15	OCSO Lieutenant 1 places a tourniquet on Hana.
13:04:21	Four uninjured female students are extracted by OCSO from the female bathroom.
13:04:21	Unidentified OCSO unit: "Need medical at Door 5 ASAP."
13:04:32	SWAT all call.
13:04:33	Fechter requests additional departments. OCSO has already sent Orion, Addison, and Brandon. (MCI box).
13:04:40	"School req EMS come to Door 5 and Door 7 to get vics quicker."
13:04:48	SRO and OCSO sergeant escort the shooter out of the building through Door 7.

13:04:50	OCSO Lieutenant 1 opens Room 258 and talks with Phoebe and Haley. He keeps them in the room.
13:05:00	Request "Where is medical we need them at Door 7 and 5" - Dispatch advises "stand by we have them enroute to both doors Ill get an ETA"
13:05:14	OCSO at Door 5 asking where medical is.
13:05:21	Rochester Hills Police advise they have all available units enroute.
13:05:30	OCSO Lieutenant 1 goes and checks on Kylie for about 30 seconds.
13:05:47	School staff member Pam Fine makes a second ALICE announcement to remain in ALICE.
13:05:48	Scene secure for EMS by units in OHS: OHS Units advise dispatch they have one with gunshot to the eye and let them (EMS) know scene is secure.
13:06:00	OCSO Lieutenant 1 exits the short 200 Hallway and enters the 300 Hallway.
13:06	OFD Chief Scholz remains at Meijer to direct traffic.
~1306	Chief Majestic drives past a student with a bloody face (Elijah) on North Oxford Road leaving the parking lot.
~1306	Hundreds of kids are walking down Ray Road from the school going to Meijer. No sidewalks, so the kids are walking in the middle of the road.
1306	Numerous people are trying to wave down the Oxford ambulance as it arrives to the school.
1306	Oxford Fire Alpha 4 ambulance on scene and parks parallel to Door 6.
13:06:05	Oxford Fire states on the radio they are pulling up to Doors 5 and 7 and requesting if the scene is secure.
13:06:10	Superintendent Weaver arrives and goes to Hana and Kylie to help the school monitor.
13:06:12	911 caller from Room 228. They heard five shots but did not see anything. They have kids and are staying in the room.
13:06:16	OCSO 0412 requesting medical to Door 5. The scene is secure.
13:06:30	Superintendent Weaver provides care to Riley.
13:06:31	"CPR in progress to vic with head injury."
13:06:32	Chief Majestic announces he will be fire command and that Level II staging is at Meijer.
13:06:35	OS1517 advised they are starting a secondary search.
13:06:48	Deputy 1 enters Bathroom 2 again.
13:07:00	Principal Wolf enters and goes to help the school monitor with Hana.
13:07:08	Ambulance request. Requesting EMS response to Door 6 first.
13:07:09	OS1503 reporting a gunshot wound to the head at Door 6 that is still breathing. Another deputy advises him to load him up and go.
13:07:14	OCSO dispatched Oakland Township Fire
13:07:48	Deputy 1 exits Bathroom 2.
13:08:07	OCSO dispatch places all hospitals on MCI alert.
13:08:07	"Per County on scene, you two victims at Door 4, one victim at Door 6 with a head injury, and two victims at Door 7."
13:08:08	3 victims at Door 5, three at Door 7. One critical at Door 7.

13:08:13	Another OCSO deputy enters Bathroom 2.
13:08:20	OFD Captain-1 requests every available ALS unit from all surrounding departments. He declared a mass casualty incident. He asked OCSO Dispatch to notify all area trauma hospitals.
13:08:47	"Door 6 for most severe pt."
13:09:02	Deputy reporting Door 5 and Door 6 secure for EMS.
13:09:02	OS1603 reporting OS1403 is transporting the shooter to the substation. The shooter states there are approximately five victims. The shooter states he acted alone.
13:09:02	911 caller reporting she saw a black pickup truck driving erratically and hit a curb. Vehicle almost hit multiple people. Unknown number of occupants. Vehicle is traveling towards Lapeer.
13:09:12	OCSO units advising Door 6 is secure for medical.
13:09:34	Gunshot wound patient in Room 218.
13:09:45	OCSO units advise only one shooter reported and described.
13:09:50	OSCO deputies move Tate to an OCSO deputy's patrol vehicle and drive him to an ambulance parked outside the school.
13:09:55	Oxford Fire Alpha 4 enters Door 6 and goes to Justin.
13:10:00	Lapeer County 911 does a county-wide all call for all ALS ambulances to respond to the staging area at Meijer.
13:10:04	Oxford Fire Alpha 4 arrives at Bathroom 2 and begins treating and extracting Justin.
~1310	OFD Captain 1 assigns the driver of OFD E-1 to drive the Alpha 4 ambulance. OFD Captain-1 gets in E-1 and moves it to the southside of the school by Door 8.
13:10:09	Radio traffic of a unit transporting a patient to the hospital.
13:10:26	An Oxford firefighter brings a stretcher to Bathroom 2.
13:10:41	Bruce Township Fire enroute to Addison to cover.
13:10:54	"Gun shot wound 218."
13:10:54	911 caller in Room 503. They heard gunshots but did not see anything. There are 30 people in the room. There are no injuries. They have barricaded the door.
13:10:55	"Command Post: 911 advises command post set up at the..... (inaudible)" OCSO dispatch talking in the background of a 911 call.
13:11:09	Car-Car:Officer asks for medical - response by another unit "We can bring them in door #7 where are you?"
13:11:20	Justin is removed from the school by OFD.
13:11:28	16A1 advised only one patient at McLaren Urgent Care.
13:11:28	OCSO unit requesting medical to Door 7.
13:11:43	01A1 is at Door 6.
13:11:46	OCSO unit reports a possible victim in Room 218. Third hand information. | Car-Car: Officer advises a victim is down in room 218 a teacher. Response -"we are checking"
13:11:57	911 caller in Room 244. There are about 15-20 people in the room.
13:11:58	Addison Fire is at Door 6.

13:12:00	Chief Majestic tells OFD Captain-1 he is going inside. OFD Captain-1 takes command from Chief Majestic. Chief Strelchuk arrives and OFD Captain-1 gets in his truck with him.
13:12:00	Three more deputies enter the short 200 Hallway.
13:12	Madisyn is pronounced dead.
13:12:06	OCSO units advise again there is someone shot in Room 218.
13:12:07	Williams' 911 call states the camera shows the shooter in a black COVID mask, black hoodie, and grey jeans.
13:12:22	911 caller states teacher Molly Darnell in Room 224 is shot. A tourniquet is applied. The caller is not with the patient.
13:12:26	"Star EMS is not avail to assist."
13:12:28	"CMND post betwn door 6/7... All responding units to stage on Glaspie near the storage."
13:12:38	Oxford Alpha 4 transporting to McLaren.
13:12:40	OCSO units reporting the kitchen and cafeteria are clear.
13:12:54	"Reports of a staff member shot in the arm in Room 224." | Dispatch to all units: Dispatch announces that they received information that staff member in room 224 shot in the arm.
13:12:57	Lapeer County EMS enroute with 5 ALS, MedStar enroute with 2 ALS
13:13:00	OCSO Lieutenant 1 has looped the 300 Hallway, through the 400 Hallway, and came back to the short 200 Hallway. He goes back to Room 258 and talks to Phoebe and Haley.
13:13:21	Oxford Fire Alpha 4 departs scene with Justin to the hospital
13:13:32	Lapeer has all available units staged at Meijer.
13:13:33	Oxford Fire has two personnel enter the short-200 hallway.
13:13:36	"Medstar is enr to Meijer."
13:13:37	Oxford Fire Squad 21 enroute with three.
13:14:00	A deputy takes a knee in the hall at Bathroom 1 with his pistol out, covering towards the 300 Hallway.
13:14:00	School monitor's BWC shows Hana in respiratory arrest. Her face is very cyanotic.
13:14:00	OCSO Lieutenant 1 wheels Amanda out in a chair and places her in the hallway. Haley is still holding pressure. He is then talking to OFD EMS Coordinator and pointing. An OFD fire captain enters the short 200 Hallway.
13:14:17	911 caller states he son is in a room by the theater. He does not know if anyone is with him.
13:14:18	Addison Fire Chief Morawski assigned staging.
13:14:18	There are four patients at Door 8.
13:15:00	OCSO Lieutenant 1 moves to Door 7 and is repeatedly looking out the door, presumably for more help. He will remain here until 13:24.
13:15:00	Dispatch to all units: "One is detained still unsecured scene still active - Unit requests medical to door #8 for multiple victims."
13:15:00	Fire command requests Bloomfield Township's ALS ambulances.

13:15:10	OFD fire captain checks on Phoebe.
13:15:16	Addison Township Alpha 1 ambulance arrives on scene.
13:15	Tate is pronounced dead in the deputy's vehicle by Addison Township paramedics.
13:15:22	Deputy reporting multiple victims at Door 8.
13:15:29	911 caller is a student in Room 503. The are 30 students and one teacher in the room. No one is injured. The door is barricaded.
13:15:42	OCSO units advising multiple victims at Door 8 by the football field.
13:15:44	Another 911 caller from Room 244 advising 15-20 people in the classroom and there are no injures.
13:15:46	Units in OHS advises four victims at Door 8
13:16:00	OCSO Lieutenant 1 talks to Superintendent Throne at Door 7.
13:16:03	OCSO units advising four victims at Door 8.
13:16:05	Oxford Alpha 2 leaves the patient with a GSW in the foot with the parents. Clears and responds to OHS.
13:16:16	Deputy to Command, "Be advised we are clearing classroom by classroom. We are sending students out the west door."
13:16:55	"Alpha 2 is at State and Glaspie."
13:17:00	OFD EMS Coordinator is talking on the radio.
13:17:10	Student monitor goes to Phoebe and talks with her.
13:17:16	Chief Strelchuk requests every available ambulance to respond.
13:17:34	"McLaren Oakland adv of gunshot wound pt."
13:17:36	Narcotics Enforcement Team advised they are enroute with numerous plain clothes officers.
13:17:39	Command requesting Star EMS for multiple patients.
13:18:00	Two unidentified school employees enter the short 200 Hallway (believe one is the elementary school principal).
13:18:20	Chief Majestic on camera entering Door 8.
13:18:23	Chief Majestic seen on camera entering the short 200 hall. He checks on Kylie for 20 seconds.
13:18:24	Addison Fire paramedics begins caring for Phoebe. She is subsequently transported via ambulance.
13:18:33	911 caller reported a suspicious male is running towards the gravel pit where brown khaki pants and a camouflage jacket.
13:18:55	Chief Majestic seen on camera exiting Door 8 with his radio in his hand.
13:19:10	OFD EMS Coordinator exits Door 8 trying to direct more ambulances in.
13:19:50	Brandon Township enters with a medical bag through Door 8.
13:19:52	911 caller behind the school said he sees kids running towards the apartments and one has a flare gun. Caller states he saw the kid get into a pickup truck. Caller gave detailed description of the truck and license plate.
13:20	Brandon Fire brings a stretcher in and places it next to Kylie. Two more Brandon paramedics enter. Several medics are now assessing Hana.
13:20	Hana is pronounced dead by paramedics in the short-200 hallway.

13:20:10	Fire command asked who is enroute. "Medstar, Lapeer County EMS, Rochester Hills, Brandon, Addison, Oakland." Command requested Bloomfield Township and West Bloomfield.
13:20:10	Star EMS advised they are are sending multiple units.
13:20:15	Lieutenant Hill is arriving. He requests outside perimeter to secure students and keep parents from getting into the scene.
13:20:15	OCSO sergeant confirms the gun has been secured.
13:20:15	Deputy bringing one out of Door 4 with a GSW to the arm.
13:21:00	Second stretcher enters the short 200 Hallway. This stretcher is placed next to Phoebe. Medics are now caring for Phoebe.
13:21:15	Three USMS operators enter the short 200 Hallway and move to 300.
13:21:34	Request team to clear / walking one with GSW to the arm out of Door 4.
13:22:13	OCSO units advise there is one with gunshot wound to the arm at Door 4.
13:22:37	OCSO places Survival Flight on standby
13:22:46	Dispatch sends officer with medic to Door 4 where victim with GSW is waiting.TQ applied on victim
13:22:58	Chief Majestic is back in the 200 hall.
13:23	"Int M1 enrt to Ox High"
13:23:16	OCSO units advised tourniquet placed on the patient with a GSW to the arm.
13:23:22	OS1054 advising teacher shot in Room 224.
13:23:40	Chief Majestic places a coat covering Hana.
13:23:44	Deputy reporting Lapeer County EMS is at the front. Asking if any units need EMS. | advising all units they have medic and advise any priority patients. Response by officers no additional patients identified. If we have more we will call for it (EMS)
13:24	"ADFD 21-683/BRFD 21-1450/ORFD 21-3214/RHFD 21-7054/SPFD 21/1406
13:24:46	OS403 "More medics are pulling up. Who needs them?"
13:25	"BRT heading to Door 8 for 1x victim."
13:25	All living patients were removed from the building.
13:25	Camera shows Lieutenant Hill entering the lobby. He has a long gun, his AS bag, and a large medical bag. He meets Melissa Williams within 30 seconds. They leave towards Door 2 and into the school.
13:26:22	Addison Chief 1 (Staging) requesting LE assistance due to a high amount of parents.
13:26:39	S.O. Rourke has arrived. There are two deputies in back hallway of theater. They have " Jim" from security with deputies. S.O. Rourke is wearing a grey hoodie and tan hat.
13:26:57	Lapeer County EMS on scene with five ALS ambulances. MedStar on scene with two ALS ambulances.
13:27:46	911 caller reporting two people walking northbound at 650 State Street.
13:27:43	"BLT enr w/ 2 rigs."
13:28:17	"A1 enr Lapeer MOH SM 0."
13:28:51	"Survival Flight ENR."
13:29:03	Star sending three ambulances.

13:30:31	Medstar EMS at staging, requesting LE for traffic control.
13:30:42	Lapeer County undersheriff reports he is in the office viewing camera footage. The shooter is a white male with COVID mask, dark jacket, light hoodie, grey pants, white shoes.
13:31:09	"Division C//south side of the building//Doors 8 and 7."
13:31:20	Lieutenant Hill reenters the lobby. He heads to the bench.
13:31:21	OCSO units report the 400 hallway is clear.
13:31:40	Ray at Lapeer is shutdown to all non-essential traffic.
13:31:50	911 caller reporting her daughter is hiding in a storage closet by the cafeteria. She wanted to make deputies aware.
13:32:27	Situation update announcement by OCSO sergeant (1603): systematically clearing each room sending students to the parking lot - Believe 1 shooter (student) in custody and believe all patients have been identified and moving the command center to the front offices of the school.
13:33	Oxford Fire Alpha 4 at hospital.
13:33:22	Command is now moving to the front office.
13:34:04	Buckhorn Towing enroute to help with traffic.
13:34:10	Suspect arrival to substation
13:34:19	911 caller reporting two suspicious kids on the Pollyann trail. States they have black clothes and black backpacks. They are suspicious because everyone else is in groups and these two are together. Caller gave detailed description of the two individuals.
13:34:43	Suspect is at the Oxford Substation. SIU is enroute.
13:36:23	Officers requesting a K-9 to track on a blood trail from Door 17.
13:36:44	School announcement over the PA telling all students and staff to report to the front of the school.
13:37:55	Shooter's dad calls 911 and reports that his son goes to school at OHS and he is missing a gun from his house. He is requesting a deputy to respond to his house.
13:38:27	"ADFD CHF1 in charge of staging."
13:38:40	Survival Flight landed at the high school football field.
13:38:46	Survival Flight has launched.
1339	STFD M1 arrived in staging.
13:40:06	Command-dispatch: Direct SWAT personnel directed to front office
13:41:16	Command requesting all SWAT personnel to regroup and report to the front office.
13:41:53	"Casualty point is Door 8."
13:44:04	Per Sergeant REDACTED, suspect confirmed he acted alone.
1345	STFD M1 moved to parking lot to set up LZs. Survival Flight landed. MedStar helo landed.
13:45:39	"Command on MABAS 11 / Triage MABAS 12 / PD Talk MABAS 13 / Survival Flight on MABAS 14."
13:46:29	STAR EMS on scene.
13:48:00	Backclears begin.

13:48:24	"Multiple students hopped the fences west of the football field towards the apartments. OCSO units to check for injuries."
13:48:46	Oxford Fire Alpha 2 returns to the OHS.
13:49:15	Air 1 reports seeing no kids at the apartments.
13:52:50	10 ambulances now reported in staging.
13:53:01	200, 300, and 400 halls clear.
13:55:45	911 caller states her granddaughter was in a closet at the school and is now walking toward Meijer.
13:56:54	Command - OHS units: Command advises that there will be an announcement in the school for "All staff and all students to come to the front office"
13:56:57	OCSO reports the buildings is still unsecure.
13:59:05	10 ambulances in staging and several ambulances in the front.
14:01:11	"Per Bat 1 / enough ALS units on scene."
14:04:03	OCSO units advise the gym and locker room are clear.
14:04:26	"Starting IMT and CST divisions."
14:04:47	The cafeteria and commons area are all clear.
14:08:01	Mobile command is enroute. Internal command post is at the front office.
14:12:39	Rooms in the 600 hallway are clear.
1415	Chief Strelchuk drives vehicle to front of school to find OCSO command and make unified command.
14:18:24	Media staging area is at the McDonalds across the street from Meijer.
14:18:51	Area around 24 and Ray Road is secure. Businesses can all come out of lockdown. Meijer to remain in lockdown until all students are secure.
14:19:20	"Fire command is joining LEO command on the north/alpha side of building."
14:19:40	Parents need to go to Meijer to get their children. Lieutenant REDACTED is command. Parents will need to have identification to get their kids. Command post is at the northwest side of the building.
~1420	Chief Strelchuk enters the school and sees Lieutenant Hill on bench giving orders.
~1420	OFD Captain 1 sees Chief Majestic and Chief Scholz in the lobby. OFD Captain 1 told Chief Scholz they need to create unified command with OCSO. Chief Scholz said they were not going to do that.
~1420	Fire command was created in a conference room inside.
14:20:29	Command to OHS Units: Command requests any units still conducting secondary search to report out - Gym, 126, Performance arts, mechanical room ,as well as cafeteria areas still being cleared.
14:21:13	Units doing secondary searches in 100 hall, performance arts, cafeteria.
14:25:33	911 caller states REDACTED left a diabetic monitoring device in Room 223 and wants to know how she can get it.
14:28:32	Performing arts area is clear on the secondary.
14:29:17	Additional marked units are needed in front of Door 3 for the perimeter.
14:31:12	School bus enroute to the front of the school to help evacuate. No one is to get on it without command authorization.
14:34:00	Secondary search complete.

14:34:22	ER nurse at APR Rochester advised student John Asciuto arrived POV with a gunshot wound to the hip.
14:39:54	Command-dispatch: Command advises that Oxford Middle school can come out of lockdown and release students - will not be able to use Ray Road.
14:40:15	Command advised Oxford Middle School clear to unlock the school and release students. Ray Road is closed.
14:41:21	Mobile command is on scene and setting up by the flag poles.
14:39:54	Command-Dispatch: Command advises the media is being moved to the Legacy Center near the McDonalds
14:44:13	Media staging moving to the Legacy Center.
14:53:22	911 caller at FR ROC advised they have a student in the ER with a non-life-threating gunshot wound transported by another student.
15:00:00	First media interview is conducted.
15:04:30	Suspect is enroute from Oxford Substation to Childrens Village.
15:16:39	Units requesting Air 1 to search the gravel pits for students that may have fled. Air 1 is refueling and will advise.
15:21:45	Dispatch - All Units: Dispatch advises all units the channel patch OS North-East/East is being taken down (Unpatched)
15:22:38	911 caller states that he heard shots in the area of Drahner and Lakeville yesterday. He thinks it might have been the suspect practicing. Would like a deputy to come.
15:29:55	911 caller reporting her son was student the school and he is now home safe.
15:31:57	Suspect is at Childrens Village.
15:35:00	Third search completed with bomb K9 hit on backpack.
15:35:58	MSP bomb squad activated per command. Requesting bomb squad, K-9, and robot. MSP is paging out the team.
15:38:58	Consulate of Italy in Detroit called 911 stating there are several children that attend this school that are Italian nationals. They are asking to be informed if any of them were involved.
15:41:38	911 caller states she is a licensed therapist. She is willing to offer her services if anyone wants to talk to her.
15:56:28	911 caller states a student is posting on social media about the shooting and they think he is somehow involved.
~1600	Governor Whitmer's detail briefly stops at OHS.
16:05:14	Multiple FBI agents are on scene reporting to the command post.
16:08:48	FBI bomb squad is on scene and reporting to command.
16:12:00	Addison Fire clears the scene.
16:26:18	U.S. Attorney for the Eastern District of Michigan is on scene in an unmarked vehicle. He is reporting to the FBI command post in the south parking lot.
16:33:35	Units are sitting on the suspect's house waiting for a search warrant.
16:43:29	FBI bomb squad trailer is on scene. Reporting to the command post.
16:46:04	Units are at the substation with the affected families.
16:50:48	Air 1 has cleared the gravel pit. There are no students. Command advised Air 1 can clear the scene.

16:50:00	Porta-johns enroute to OHS
1659	Oxford engine and squad released from OHS
17:00	Governor Whitmer is on scene, and second press briefing is given by McCabe.
17:00:00	CISM at Oxford Fire Department
17:26	MSP bomb squad is on scene.
17:32:47	Salvation Army is on scene.
17:58:42	OCSO forensic unit is on scene and going to the command post.
18:00:00	Building declared safe and CSI begins to process scene.
18:26:58	911 caller states she is a teacher at the school, and she would like to know how she and her coworkers can get their cars from the school.
18:54:04	Closing the response call out in CAD. Creating clones so other units can create new calls as needed.
~20:00	Governor visits EOC.
20:00	Third media briefing at OCSO headquarters. Sheriff Bouchard is leading this briefing.