Medical Journal of Australia

MJA The Medical Journal of Australia

PERSPECTIVE OPEN ACCESS

Community Code Blue: The Sydney Jewish Community's Medical Preparations and Response to the Bondi Beach Terror Attack of December 2025

Aidan Baron[1,2] | Jesse Lenn[1] | Zachariah Seidman[1,3] | Matthew N. Lowy[1,4] | Jeffrey L. Engelman[1,5]

[1]Community Health Support, Sydney, New South Wales, Australia | [2]University of Tasmania, Sydney Campus, Sydney, New South Wales, Australia | [3]Royal North Shore Hospital, Sydney, New South Wales, Australia | [4]Western Sydney University, Sydney, New South Wales, Australia | [5]St George Private Hospital, Sydney, New South Wales, Australia

Correspondence: Aidan Baron (aidan.baron@utas.edu.au)

Received: 7 January 2026 | **Revised:** 7 March 2026 | **Accepted:** 19 March 2026

Keywords: disaster medicine | emergency services | medical | post-traumatic stress disorder | shock | transportation of patients | traumatic | traumatology

ABSTRACT

Ethnocultural minority communities may require specialised emergency response frameworks during mass casualty incidents (MCIs). This article describes the Sydney Jewish community's preparation for, and medical response to, the Bondi Beach terror attack of 14 December 2025. We present a timeline of events during the attack and outline the immediate medical response and recovery actions undertaken in the first hours and days following the incident, including first-hand accounts of responders from the scene. Alongside this account, we present a novel response model implemented by the New South Wales Community Health Support (CHS). CHS is a community-operated, not-for-profit emergency medical response organisation that provides telehealth advice and dispatches volunteer community first responders (including health professionals and trained emergency healthcare workers) to urgent and emergency health incidents within the local community. CHS operates alongside statutory emergency services and is embedded within the community it serves. It is hoped that the lessons identified from this incident may be valuable to the broader international medical community, emergency management agencies and policymakers, and that it may serve as an exemplar for other communities seeking to strengthen preparedness, coordination and resilience in the face of future MCIs.

JEL Classification: Emergency medicine, Mental disorders, Wounds and injuries

1 | Introduction

At 18:42 on Sunday 14 December 2025, two shooters (a father and son pair) opened fire on a large crowd using a hunting rifle with hollow-point bullets and two 12-gauge shotguns. The crowd of about 600 members of the Sydney Jewish community were gathered in Archer Park at Bondi Beach to celebrate the Jewish Festival of Hanukkah. Concurrently, seven other Hanukkah celebrations at community centres, public parks and private venues were occurring in the surrounding suburbs of Sydney. Within the following six and a half minutes, an estimated 103 gunshots were fired (about 83 by the perpetrators and 20 by police returning fire), resulting in 15 deceased victims, one deceased attacker and more than 40 injured survivors [1].

On the day of the attack, Community Health Support (CHS; www.chsnsw.org.au) enacted its Community Code Blue—a protocolised and rehearsed mass casualty incident (MCI) plan that was developed in 2021 in light of the increasing security and terror threat towards the local Jewish community.

2 | Preparing for Disaster: The Community Code Blue

In 2021, the Sydney Jewish community established CHS, a community-owned, not-for-profit health organisation created to empower the community with confidence in a medical emergency. CHS aimed to centralise the community's preparation for and response to urgent and emergency health needs by educating lay members in first aid, strategically placing defibrillators and first-aid equipment in key community areas and creating a community first-responder and telehealth advice service for emergency, urgent and unscheduled care.

CHS has since recruited and trained over 120 active volunteer medical responders and dispatcher/call-takers of all genders and religious expressions, mostly from within the local Jewish community. Some of these volunteers are healthcare professionals; however, the majority are 'trained emergency healthcare workers' who are internally educated in a vocational model beginning at the Australian Qualifications Framework Certificate II level in emergency medical first response [2]. As of November 2025, CHS was providing full-time volunteer medical first responders for a coverage area of about 25 km^2 serving ~150,000 people. When a caller from within the response area (irrespective of religion or ethnicity) calls CHS for assistance, their call is triaged by a dispatcher/call-taker. If the call meets the criteria for a potential medical emergency, the closest geographically located responders volunteer their availability and may be dispatched using their personal vehicles and equipment, while the caller is simultaneously transferred to the Triple-Zero jurisdictional emergency services call centre. Since beginning operations, the organisation has provided care to more than 4000 patients and safely redirected about 51% of requests for emergency assistance away from the jurisdictional ambulance service—New South Wales Ambulance Service (NSWA)—towards alternative care pathways (assessed through follow-up calls of all patients). As an independent and non-governmental organisation, CHS was not a designated agency under the New South Wales State Health Disaster plan (HEALTHPLAN) at the time of the Bondi Beach attack; however, CHS collaborates with NSWA through community partnership engagement projects and is a registered organisation with their GoodSAM Cardiac Arrest Responder App Program [3]. CHS has an ongoing relationship with NSWA through a community liaison paramedic to enable communication and ongoing development.

CHS was also charged with preparing the Jewish community's medical response to MCIs. These plans were combined under a single protocol called the Community Code Blue. This was borne out of a recognition that Australian Jewish communities are ethnocultural minority communities who were identified by the Australian intelligence agencies as being at a significantly higher risk of intentional violence and terrorist attacks [4], and who have specific cultural and religious customs and needs that require additional considerations during a disaster [5–7]. The geospatial concentration of ethnocultural minority communities where individuals live and work in tightly knit and highly interconnected social networks poses an additional challenge by increasing the proportion of the community who are directly affected by disasters [7–9].

The Community Code Blue protocol was developed as an all-hazards medical disaster response plan that incorporates dispatch protocols, standby and staging for responders while maintaining some responders in reserve in anticipation of a second wave attack and a clear doctrine of delivering clinical care in MCI settings.

The CHS doctrine for MCI clinical care features the TST (Ten Second Triage) model by Vassallo and colleagues from London [10]. The advantage of the TST is that it combines simple triage (Are they walking? Are they talking? Do they have a central penetrating injury?) and treatment guidance with a civilian-appropriate model that emphasises the performance of only a select few life-saving interventions, such as arterial tourniquets, wound packing, recovery position and prioritising the rapid evacuation and transport of patients with central penetrating injuries. There is no measurement of vital signs or calculations required. Annual MCI training exercises were conducted from 2021 onwards with a mantra of 'communicate, triage, treat, (assist with) transport'. MCI education prioritised skill stations focused specifically on single participant performance of these interventions so that each volunteer responder had been coached in these interventions, multiple small group high-fidelity simulation sessions and tabletop exercises for leadership.

The performance of cardiopulmonary resuscitation (CPR) has limited utility during MCIs. CPR offers potential benefit in some specialised circumstances such as crowd crush [11, 12] or isolated impact brain apnoea from a blast wave [12–14]. However, in a terrorist attack, the predicted downtime between injury and the arrival of sufficient critical care resources likely precludes any meaningful survival for those in traumatic out-of-hospital cardiac arrest caused by penetrating abdominal, chest and head trauma [12, 15]. For this reason, routine CPR in an MCI involving shooting or stabbing was discouraged in the Community Code Blue protocol.

The use of black triage tags or tags with the words 'dead' or 'deceased' written on them was excluded, as it was potentially morally injurious for responders to tag friends and family as deceased and had the potential to deleteriously impact trust within the community following an incident. Rather, responders were trained to place the person in the recovery position, identify them as 'not breathing' and move on, in alignment with the TST, unless injuries were obviously incompatible with life, in which case the victim's face was covered.

3 | Responding to Disaster: Activation of the Community Code Blue

On 14 December 2025 in response to the terrorist attack at Bondi Beach against the Jewish community celebrating Hanukkah, CHS activated its Community Code Blue protocol for the first time. Following this incident, a comprehensive internal review was undertaken including multi-stage debriefing of all personnel involved, review of response logs, audits of system processes, review of qualitative community feedback, and evaluation of future responder preparedness, training and equipment.

A timeline of events is provided in Table 1, derived from CHS dispatcher logs, publicly available information and CHS

TABLE 1 | Timeline of the response.

Time	Event
18:42	Shooting begins.
18:43	First call reportedly made to NSW Police via the 000 system.
18:46	The first call to the CHS emergency hotline was received at a similar time as partner community safety agencies alerted CHS control to a potential shooting. This was directly transferred to 000 for police and ambulance activation, but emergency telephone lines were already overwhelmed and could not answer incoming calls. The Sydney Jewish community declared a severe security event impacting all other Hanukkah celebrations, in anticipation of the potential for this incident to escalate into a multi-site terror attack.
18:50	Dispatching: Multiple CHS volunteer call-takers/dispatchers were surged using a bespoke mobile application (app) to handle incoming calls from Bondi Beach. Volunteer dispatchers can fulfil their roles using a mobile app, headset, and a portable radio, so were immediately operational from their locations in the community at the time. Eight dispatchers were online within 90 s, answering multiple incoming hotline calls.
18:52	Declaration of an MCI by CHS based on evolving situational intelligence and first-person assessments and deployment of CHS responders to a staging point.
18:53	The shooting stopped and the threat was thought to be neutralised, but the scene had not yet been declared safe to enter due to the complexity of the event precinct—large crowds, multiple injured, an unknown number of attackers and multiple physical obstacles.
18:55	The forward commander from CHS established first contact with police stationed at the edge of the incident zone.
19:03	The scene is declared safe to enter by police and the CHS forward commander and NSWA paramedics enter and make contact with patients. The active shooter phase lasted an additional 6–10 min until police were able to declare the scene safe for entry by paramedics and CHS responders.
19:03 to 19:06	After reconfirming scene safety, the first four CHS responders who were staged nearby on Glenayr Avenue in Bondi Beach proceeded to enter the scene and commence treatment alongside the initial two ambulance crews, zero responders, and lifeguards from the beach.
19:08	A formal situation report over CHS radio confirmed the scene is safe to enter and that there were '30 to 40 gunshot victims' of varying levels of injury. Until this time, the nature and scale of the attack were unclear. This was the first time the extent of the MCI became clarified.
19:06 to 19:22	Triage and initial treatment: 14 further volunteer responders arrived on scene and began triage, patient assessment and treatment alongside the first NSWA crews, lifeguards, members of the public and other first responders. The initial phase of triage and treatment largely focused on the application of haemostatic control in patients with penetrating injuries caused by bullets and shrapnel. This was predominantly using pressure dressings and bandages, wound packing (using QuikClot gauze) and a limited number of arterial tourniquets for limb injuries. Patients were moved from the incident area to the casualty clearing point and treatment area (Figure 1, item 5).
19:18	An Emergency Operations Centre for community medical coordination based at the CHS main office 1.5 km away from the incident scene had been established and was now fully functional.
19:38	Dynamic risk and the fallibility of zoning: Improvised explosive devices were discovered by police in the incident zone, which was communicated to NSWA and CHS. There was uncertainty about the potential existence or location of other devices, making all operational zones potentially unsafe. CHS responders, in partnership with NSWA paramedics and police, evacuated patients from the vicinity and held other walking wounded survivors inside the Bondi Pavilion building away from the known active devices (Figure 1, item 7).
19:48	Second phase of the incident with the benefit of volunteer responders: There was a shift from initial triage, haemostatic control measures and rapid evacuation phase to a second phase caring for non-life-threatening injuries, providing comfort, analgesia and other treatment. The first headcount of CHS personnel on scene had been completed. All CHS responders were confirmed to be uninjured and were treating patients.

(Continues)

TABLE 1 | (Continued)

Time	Event
19:50	More than 40 patients had been identified and were either being actively treated or being transported to the hospital, while some deceased victims were being held in a makeshift morgue collection point adjacent to the treatment area. CHS responders liaised with the NSWA Forward Commander and police to coordinate access of the Jewish Burial Society to manage bodies of the deceased according to Jewish tradition, while providing culturally congruent care to surviving families during a period of hyperacute grief.
20:19	The CHS hotline received a call regarding two medical emergencies at a nearby Synagogue, located about 1.7 km from the Bondi Beach terror attack. Three CHS responders, who had been held in operational reserve were dispatched. Upon arrival, they confirmed that multiple community members were experiencing acute psychological distress due to the unfolding events at Bondi, in addition to a diabetic emergency. All patients were able to be treated without requiring ambulance attendance.
21:10	Third phase of the incident: At this time there were 12 confirmed deaths, 42 patients transported to hospital and the remaining non-severely injured survivors and families were sent home by police and evacuated from the site.
21:36	De-escalation, decontamination and debriefing: CHS responders together with other community agency volunteers were formally stood down from the scene and were taken to a secure community building and assessed for injuries and bloodborne pathogen exposure, decontaminated and received initial psychological triage. A hot debrief[a] by a group of trauma-informed psychologists and social workers under expert supervision by a forensic and critical incident trauma psychologist was conducted. The Police Commissioner of NSW officially declared the events at Bondi Beach a terrorist incident.

Abbreviations: CHS, Community Health Support; MCI, mass casualty incident; NSW, New South Wales; NSWA, New South Wales Ambulance.
[a]A short, team-based reflection used to identify and address immediate clinical, operational and welfare needs after a critical event.

responders. Figure 1 provides a geospatial overview of the attack and response.

3.1 | Dispatching

The nature of the emergency was unclear but limited information suggested a potential MCI. Responders were alerted and placed on standby. The Community Code Blue model was activated and there was a confirmation between managers and dispatchers that some responders would be kept in reserve in the event of a second wave, multi-site attack (as seen in the Bataclan Attack on 13 November 2015, which involved Bataclan concert hall and multiple nearby sites in Paris, France) [16], or other non-crisis related emergencies occurring in the community.

3.2 | Triage and Initial Treatment

The initial CHS responders arriving at the scene described an overwhelming sense of scale and trauma: 'There was just blood everywhere'—CHS Volunteer.

Responders described difficulty identifying priorities despite having a framework for triage given the large crowd, the number of bystanders, physical obstacles, the large incident zone and evolving security threats.

> 'The sheer chaos and scale of the scene, alongside the amount of casualties and number of [bystanders helping] made it very difficult to identify where to begin and to gauge where assistance was most urgently required'—CHS Forward Commander and first on scene.

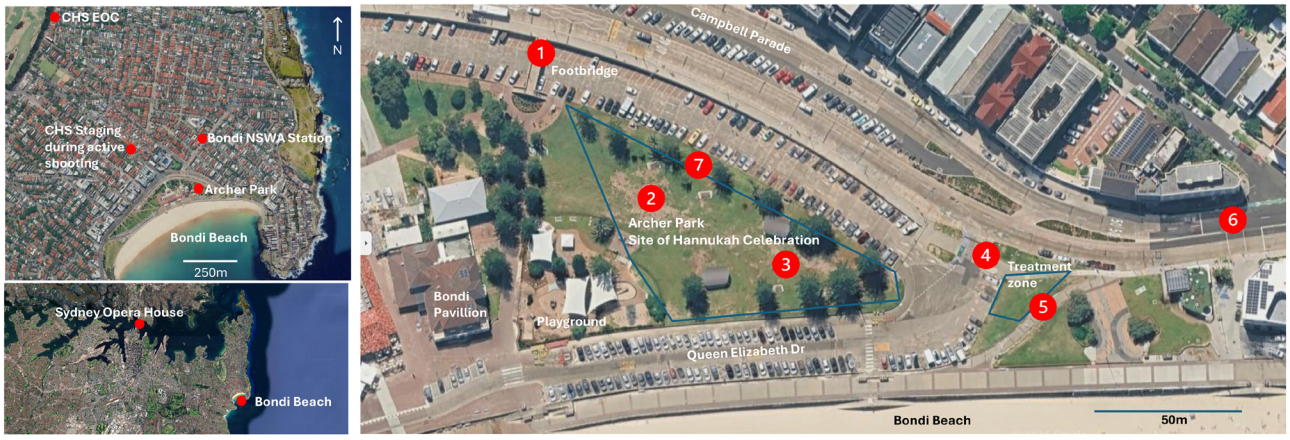
In addition, bystander health care professionals, community lifeguards and police officers provided clinical care. Several of these zero responders (i.e., members of the public at or near an emergency who provide spontaneous care) [17] had initiated CPR before the arrival of medical responders from CHS and NSWA. These zero responders were not told to stop CPR efforts by CHS responders, who rather provided verbal encouragement and continued triage efforts to focus on providing life-saving intervention to other victims. CHS responders deferred the termination of resuscitation to NSWA paramedics.

> 'They [bystanders] had put a belt over the [leg] and it was loose'—CHS Volunteer.

Multiple well-intentioned bystanders had also applied improvised arterial tourniquets that had variable efficacy and required conversion to professional devices, or removal and replacement with more appropriate pressure dressings or wound packing.

3.3 | Dynamic Risk and the Fallibility of Zoning

A suspected improvised explosive device was discovered by police in the incident zone (Figure 1), then a further device in the perpetrators' car. Following the attack, a further three explosive devices were identified. Fortunately, none of the five devices detonated. This attack, similar to recent experiences in the United Kingdom [18], was typified not by hot, warm



1	2	3	4	5	6	7
Perpetrators are seen shooting from the footbridge.	Perpetrators shoot towards Archer Park, where the Jewish Community is celebrating Hannukah.	Initial triage, haemostatic measures and evacuation to casulty clearing point.	Position of CHS and NSWA forward commanders and Ambulance loading point for critical patients.	Makeshift Casualty Clearing Point and treatment area. An adjacent tent was erected as a temporary morgue.	NSWA ambulance staging point.	One of the unexploded devices is located.

CHS, Community Health Support; EOC, Emergency Operations Centre; NSWA, New South Wales Ambulance.
Maps Data, Google © 2026

FIGURE 1 | A geospatial overview of the attack and response. CHS, Community Health Support; EOC, Emergency Operations Centre; NSWA, New South Wales Ambulance.

and cold zones (a system of defining physical areas based on their proximity to a hazard and the potential risk to rescuers operating in that area), but by a dynamic series of hot, warm and cold phases taking place at different times in the same incident location.

3.4 | Second Phase of the Incident With the Benefit of Volunteer Responders

Following the initial phase of haemostatic measures and rapid extrication of patients with central (torso) penetrating injuries [10], the second phase of care involved stabilisation, providing analgesia and reassurance to injured survivors who were awaiting transport to hospital.

CHS responders acted as a force multiplier for paramedics. 'I spoke to the Forward Commander for [New South Wales] Ambulance and she said to pair one of us [CHS responders] up with one paramedic for each patient ... it worked well'—CHS Forward Commander.

It was noted that despite responding in plain clothes, CHS responders wore a uniform reflective vest, which provided an immediately identifiable role on scene distinguishing them from zero responders. 'I went with some of our team patient to patient and made sure there was at least one of us with each of them ... It was hard sometimes because there might have been an off-duty doctor in speedos with a group of people crowded around a patient and nobody was visibly in charge ... so I allocated one of us to each of them [patients]'—CHS Forward Commander.

Responders used multiple methoxyflurane devices as well as performing intravenous cannulation (by health professional volunteers) to facilitate opioid and ketamine analgesia by NSWA paramedics and doctors and volume resuscitation in some critically ill patients.

As high acuity patient numbers lessened on scene, CHS responders were able to provide more routine treatment for injured survivors, their families and families of victims, enabling paramedics to remain focused on other clinical priorities. 'I spent a lot of time near the end of the incident sitting with a patient after she was told about [her loved one's] death, just sitting with her and reassuring her, checking her blood pressure'—CHS volunteer and medical student.

4 | Initial Recovery

4.1 | The First 24 Hours After the Attack

More than one-third of the CHS responder medical kits were declared part of the crime scene and subsequently isolated from use. This posed immediate logistical challenges in the days following the attack. The terror attack had ended, but the community's needs had not. Based on the advice of government intelligence and law enforcement agencies, the threat was perceived to be ongoing and both community and law enforcement resources were stretched. CHS began preparing for a delayed, second wave or copycat terror events the next morning.

Within 24 h of the attack, a ZAKA (search, rescue and recovery) team was dispatched from Israel to attend the established crime scene [19]. ZAKA is a non-governmental organisation based in Israel that specialises in the forensic preservation and recovery of all human tissues of individuals killed in major trauma,

disasters or terror attacks. Their mission is to preserve the dignity of the deceased and ensure compliance with specific Jewish cultural and religious requirements regarding the handling of body parts. According to Jewish law, the entire body of the deceased, including all previously living tissue, must be buried as soon as possible.

4.2 | The First Week

It was recognised that part of the community's healing process, particularly for CHS volunteers, involved providing opportunities for individuals to remain 'activated'—a term borrowed from the Six C's model for Immediate Cognitive Psychological First Aid (cognitive communication, commitment, continuity, control and challenge) [20]—and engaged in task-based activities. This approach helps validate identity as helpers rather than victims of disaster, reducing acute stress disorder rates. Consequently, the implementation of a careful strategy allowed many volunteers to resume responding to medical emergencies within 48 h, provided they were demonstrably fit to resume duty.

In the week following the attack, CHS volunteers provided onsite medical coverage at 19 mass gathering events, including memorials, funerals and daily vigils. CHS volunteers attended over 26 episodes of syncope at these events.

Moshe Farchi, the creator of the Six C's Model, along with a small support team, was flown from Israel to Sydney following the Bondi Beach attack and delivered daily training sessions to almost 2000 community members, including mental health professionals, community leaders and survivor families in order to upskill them in the model.

This initiative was recognised as beneficial by the leadership of community agencies involved in welfare and recovery who subsequently endorsed the Six C's Model as the community's unified model for care. A single hotline for community members to contact for assistance, especially counselling and crisis care, was eventually established. All community welfare agencies agreed to participate in a single triage process with streamlined allocation of roles and caseload for both psychological and physical resource crisis care.

5 | Lessons Learned

5.1 | Zero Responders

The Bondi Beach attack was perhaps unique in that there were an abundance of zero responders—trained lifeguards and off-duty healthcare professionals on scene initiating treatment from the time the attack started, which reduced the therapeutic vacuum substantially (i.e., the time between injury and the delivery of effective interventions which is delayed because traditional models of medical responders cannot access patients due to an ongoing threat) [21]. The challenge was that many of these zero responders had varying notions of which interventions were most appropriate to prioritise and were unfamiliar with CHS and ambulance equipment and clinical priorities.

5.2 | The Strength of Ethnocultural Minority Communities

The strength of ethnocultural minority communities is that pre-existing informal and organic complex webs of interaction and communication are part of the fibre of the community. This anti-fragile [22] character allowed for rapid organisation of people and resources required to preserve the community's customary and religious priorities in the wake of the attack and reduce the extent of collective psychosocial injury.

5.3 | Communication and Co-Location

The CHS's Community Code Blue protocol closely mirrored the channels and protocols established during routine operations and tolerated operational stressors during the MCI. Responders communicated as usual, without the additional cognitive load of adjusting to a rarely used protocol when stressed, resulting in clear dispatch and command of responders. Forward commanders co-located to make informed decisions during the response, a beneficial action highlighted in the United Kingdom's Joint Emergency Services Interoperability Principles (JESIP) doctrine [23].

5.4 | Dispersed Equipment for Mass Casualty Incidents

Despite having multiple large MCI equipment kits in volunteer managers' cars, few of these made it to the scene and were used to their full extent. Following a review of equipment preparedness, CHS has dispersed MCI equipment among its responders into small MCI kits, which included smaller quantities of arterial tourniquets, haemostatic gauze, carry sheets, space blankets and gloves, rather than relying on a limited number of large centrally stored MCI kits that may not reach MCI scenes as rapidly.

5.5 | The Value of Community Responders as a Force Multiplier

While paramedics focused on rapid evacuation of patients with penetrating injuries, CHS responders were able to provide care for patients awaiting transport and augment the overall medical response, lessening the disparity between patients requiring care and the number of available medical responders.

5.6 | The Difference Between Civilian Terror Attack Versus Military Combat Wounding Patterns

The wounding patterns seen in civilian terror attack settings are increasingly recognised as being different to those seen in military combat [24]. Arterial tourniquets played a far less prominent role during the Bondi attack than in overseas combat scenarios. The use of carry sheets (or in this case, improvised stretchers using surf boards and temporary fencing) to effect rapid evacuation of critical patients with central penetrating injuries proved to be a cornerstone of initial triage and

implementation of life-saving interventions. Simple pressure dressings were also the most commonly used items, followed by intravenous access equipment.

5.7 | Responder Safety and the Fallibility of Zoning

The need to prevent injury to responders was balanced against the rescue needs of the injured. Although the risk of harm to responders was mitigated by staging responders until the initial threat was neutralised, the potential for ongoing threat remained. With modern terrorism involving multi-site attacks with intentional second waves of violence, as possibly intended with the improvised explosive devices scattered throughout the area, the concept of fixed hot, warm and cold zones is challenged. Rather, zones should perhaps be conceived as dynamic hot, warm and cold phases of continuous threat development and mitigation across event locations.

6 | Conclusion

Key lessons the CHS has recognised include:

- the benefit of holding responders in reserve;
- the importance of staging while dynamic safety assessments of potentially high-threat environments occur;
- the need for dispersed and smaller MCI bags rather than a few central caches;
- the value of community first responders and zero responders as force multipliers in MCIs; and
- the need to constantly collaborate in preparing community infrastructure and services for coordinated recovery actions after a disaster.

By training each CHS volunteer to implement clinical care or perform MCI dispatch according to the Community Code Blue protocol, we aimed to assist the community in the initial response to the attack and enhance our community's recovery by applying evidence-based practices in a culturally informed manner.

The identity of ethnocultural minority communities is a double-edged sword. The nature of these communities may increase targetability, but also intrinsically serves to enhance anti-fragility and capacity to organise and recover after a disaster.

We hope our experiences and lessons learned may benefit other communities in preparing to respond to future tragedies. We thank all the responders and call-takers, professional, volunteer and spontaneous bystanders who came to the aid of our local community on our darkest day and to the thousands of individuals who continue to assist in our recovery.

Author Contributions

Aidan Baron: conceptualisation, writing (original draft), formal analysis, project administration, writing (review and editing). **Jesse Lenn:** data curation, resources, writing (review and editing). **Zachariah Seidman:** data curation, reviewing, writing (review and editing). **Matthew N. Lowy:** data curation, writing (review and editing). **Jeffrey L. Engelman:** writing (review and editing), supervision.

Acknowledgements

We wish to thank all volunteers, responders and dispatchers who exemplified bravery, compassion and professionalism on the day of the attack and every day since; Darren Chait, Ezra Israel, Lynne Berson, Elan Shilanksy, Jesse Ende, Dani Bersin, Daniel Zeloof, Rachelle Silver, Susan Hertzberg, the Clinical Advisory Committee and the CHS Board of Directors who continue to steward the care of the community; Sean Brayford-Harris, Jeremy Holder and Ben Morey for their support in helping our organisation to provide care for the local community; Tom Quinn and Jeremy Faust; our colleagues in NSW Ambulance Service to whom we are forever grateful; and finally, we wish to thank the many supporters who are the lifeblood of what we do. Written consent was provided for the inclusion of direct quotes by CHS volunteers. Open access publishing facilitated by University of Tasmania, as part of the Wiley - University of Tasmania agreement via the Council of Australasian University Librarians.

Funding

The authors have nothing to report.

Disclosure

Not commissioned; externally peer reviewed.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

This article includes no original data.

References

1. J. Peach, D. Reti, B. Cook, and J. Davidson, *We Analysed the Video Footage of the Shooting. Here's What we Found* (Australian Financial Review, 2025), https://www.afr.com/politics/federal/bondi-shooting-nine-minutes-103-bullets-15-dead-20251215-p5nnvd.

2. A. Baron, C. Sclater, E. Williams, F. Perez, and Z. Doyle, "Defining Non-Health Professional Responders in Prehospital Care as Trained Emergency Healthcare Workers—A Strength-Based Approach," *Paramedicine* 22, no. 6 (2025): 299–300.

3. C. M. Smith, M. H. Wilson, A. Ghorbangholi, et al., "The Use of Trained Volunteers in the Response to Out-Of-Hospital Cardiac Arrest—The GoodSAM Experience," *Resuscitation* 121 (2017): 123–126.

4. M. Burgess, *ASIO Annual Threat Assessment 2025* (Australian Government, Office of National Intelligence, 2025), https://www.oni.gov.au/news/asio-annual-threat-assessment-2025.

5. B. H. Morrow, "Identifying and Mapping Community Vulnerability," *Disasters* 23, no. 1 (1999): 1–18.

6. A. Fothergill, E. G. M. Maestas, and J. D. Darlington, "Race, Ethnicity and Disasters in the United States: A Review of the Literature," *Disasters* 23, no. 2 (1999): 156–173.

7. O. Braun-Lewensohn, "Challenges, Opportunities, and Coping in the Wake of the COVID-19 Pandemic: The Case of Jewish Communities Around the World," *International Journal of Environmental Research and Public Health* 20, no. 2 (2023): 1107.

8. V. H. Storr, L. E. Grube, and S. Haeffele-Balch, "Polycentric Orders and Post-Disaster Recovery: A Case Study of One Orthodox Jewish

Community Following Hurricane Sandy," *Journal of Institutional Economics* 13 (2017): 875–897.

9. H. Chen, H. Chung, T. Chen, L. Fang, and J. P. Chen, "The Emotional Distress in a Community After the Terrorist Attack on the World Trade Center," *Community Mental Health Journal* 39 (2003): 157–165.

10. J. Vassallo, P. Cowburn, C. Park, et al., "Ten Second Triage: A Novel and Pragmatic Approach to Major Incident Triage," *Trauma* 26 (2024): 3–6.

11. S. Choi, S. Do Shin, J. H. Park, et al., "Bystander Cardiopulmonary Resuscitation and Outcomes of Mass Cardiac Arrests Caused by a Crowd Crush," *Resuscitation* 206 (2025): 110476.

12. F. Granholm, D. Tin, and G. R. Ciottone, "Mass Casualty CPR: Flawed, Futile or a First Responder Mandate?," *Resuscitation* 181 (2022): 132.

13. M. H. Wilson, J. Hinds, G. Grier, B. Burns, S. Carley, and G. Davies, "Impact Brain Apnoea—A Forgotten Cause of Cardiovascular Collapse in Trauma," *Resuscitation* 105 (2016): 52–58.

14. J. L. D. Atkinson, "The Neglected Prehospital Phase of Head Injury: Apnea and Catecholamine Surge," *Mayo Clinic Proceedings* 75 (2000): 37–47.

15. Z. B. Perkins, R. Greenhalgh, E. ter Avest, et al., "Prehospital Resuscitative Thoracotomy for Traumatic Cardiac Arrest," *JAMA Surgery* 160 (2025): 432–440.

16. M. Hirsch, P. Carli, R. Nizard, et al., "The Medical Response to Multisite Terrorist Attacks in Paris," *Lancet* 386 (2015): 2535–2538.

17. E. Graham, J. Hall, and K. Porter, "The Zero Responder: A Definition and Report of Current Literature," *British Paramedic Journal* 9 (2024): 38–43.

18. S. Brayford-Harris, M. Mattock, A. Barrett, and C. Park, "Public Order Medicine: An Operational Sub-Speciality Within UK High Threat Medicine," *Journal of High Threat & Austere Medicine* 5, no. 1 (2023): 17–26.

19. N. Stadler, E. Ben-Ari, and E. Mesterman, "Terror, Aid and Organization: The Haredi Disaster Victim Identification Teams (ZAKA) in Israel," *Anthropological Quarterly* 78, no. 3 (2005): 619–651.

20. M. Farchi, M. Ben Hirsch-Gornemann, A. Whiteson, and Y. Gidron, "The SIX cs Model for Immediate Cognitive Psychological First Aid: From Helplessness to Active Efficient Coping," *International Journal of Emergency Mental Health and Human Resilience* 20, no. 2 (2018): 1–12.

21. C. L. Park, M. Langlois, E. R. Smith, et al., "How to Stop the Dying, as Well as the Killing, in a Terrorist Attack," *BMJ* 368 (2020): m298.

22. A. Munoz, J. Billsberry, and V. Ambrosini, "Resilience, Robustness, and Antifragility: Towards an Appreciation of Distinct Organizational Responses to Adversity," *International Journal of Management Reviews* 24 (2022): 181–187.

23. S. Waring, N. Balmer, H. Langley, K. Williams, E. Vaughan-Chantler, and N. Power, "Embedding Collaboration in Disaster Response: Insights From the Joint Emergency Services Interoperability Principles," *International Journal of Disaster Risk Reduction* 133 (2026): 105992.

24. S. Miletta, A. Delport, P. Weinrauch, S. Hendel, and L. Hemingway, "Duration of the Active Threat Phase of Armed Assault Terrorist Attacks and Its Relevance to the Therapeutic Vacuum: An Analysis of the Global Terrorism Database," *Journal of High Threat & Austere Medicine* 7, no. 1 (2025): 28–32.