Civilian Tactical Law Enforcement: What is the 'Standard of Care'?

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The opinions in this briefing are those of the author.
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SWAT doctors credited with saving officer's life during raid

11:55 PM CDT on Wednesday, October 17, 2007

By STEVE THOMPSON and TANYA EISERER / The Dallas Morning News

A Dallas police lieutenant shot in the neck during a Wednesday morning raid was expected to survive, thanks largely to two doctors on the SWAT team he led.


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YOU.
HOSTAGE RESCUE TEAM... Be where Special becomes Extraordinary.

FBI Photo

Physician Involvement in SWAT 2009[1]

- 209 Teams
- 47% use physicians in some capacity
- 65% of these are emergency physicians

1. Gildea JR, J Emerg Med (2008) 35(4) 411-4

- Questions:
  - How are the other 50% supported?
  - With hundreds of SWAT operations weekly:
    What is a reasonable minimal standard?
    Achievable across U.S. jurisdictions
    Based on available resources

Where Are We Coming From? 1996[2]

- 150 Teams
- 69% used 'civilian ambulance on standby'
- 94% of these had no specialized joint training

2. Jones JS etal. Prehosp Disaster Med 1996;11:202-6

- Questions:
  - Is this still 'the baseline' nearly 15 yrs later?
  - How many teams continue to plan reactively?
  - *Are we still putting injured officers in police cars?*

Selling integrated tactical EMS to “The Cops”:

www.transport.qld.gov.au

www.thamesems.com

Civilian Trauma Care Setting

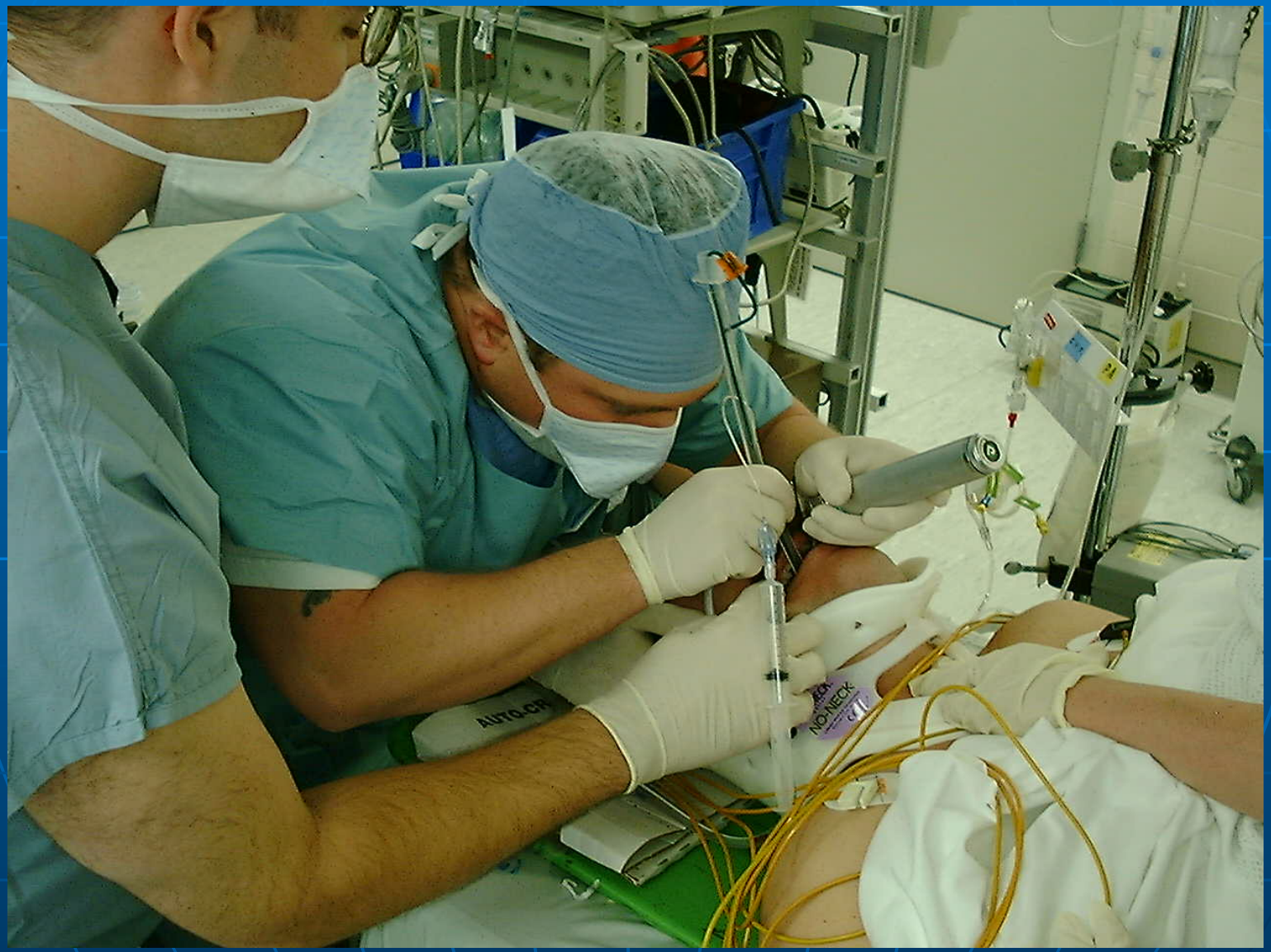


Photo courtesy NOMI

“Wait a second, I dropped my laryngoscope….”

FBI Photo

Recent Military Experience

- In the Iraq AOR:
  - Significant number of penetrating limb injuries (GSW/IED)
  - Self-Applied TQ
  - Rapid Access to EMS
  - Time to definitive surgical care 70 min or less.

Photo courtesy NOMI

Similarities-Law Enforcement

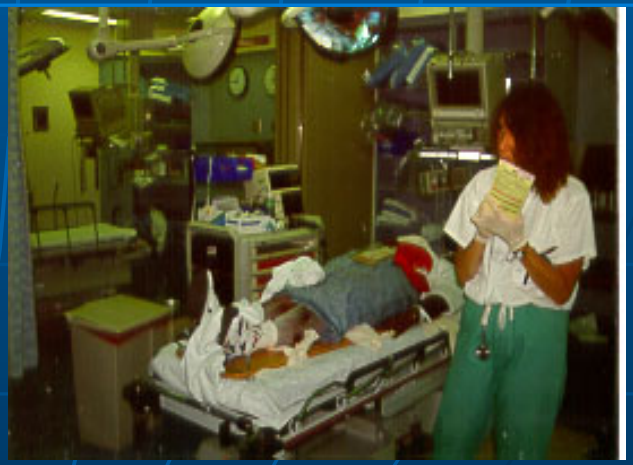
- In the SWAT scenario:
  - Significant risk of penetrating limb injuries (GSW/IED)
  - Self-Applied TQ use
  - Rapid Access to EMS
  - Time to definitive surgical care 60 min or less.

FBI photo

Goal: Rapid, Seamless Transition of Emergency Care

From within the Exclusion Zone-

To the Emergency Care System outside.



FBI photo

Sure, *everything* in here is important.

But *nothing* in here is a substitute for

- The Medical OPLAN
- Rapid entry into The System
- Velocity

FBI Tactical Medical Bag

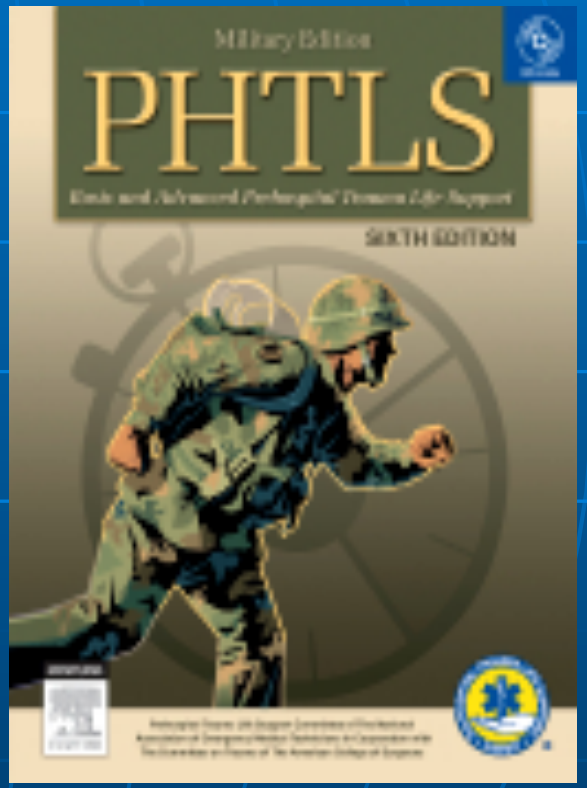
Configured IAW

BLS Table of Allowance 7.0, 10/2009

ALS Modifications for EMT-P only

- They Learn From Us.
- We Learn From Them.

- It doesn't all fit.
- Some of it really does.



Military "Care Under Fire" Phase[1]

- Return Fire and Take Cover
- Move Casualty to Cover and apply self aid
- Airway generally deferred until next phase* (*in civilian terms, "scene safe")
- Stop life threatening external hemorrhage
  - By casualty self aid (self applied TQ)
  - Apply TCCC recommended TQ over clothing, 2-3 in proximal to bleeding site

1Tactical Combat Casualty Care Guidelines 2008

CSH Baghdad-2006 Tourniquet Study[2]

- 232 patients
- 87% survival
  - When applied *before shock developed: 90%*
  - When applied after shock ensued: 10%
- Complications
  - Transient nerve palsy: 1.7%
  - Amputations *caused* by TQ: zero

CSH Baghdad-2006 Tourniquet Study[2]

- In 5 patients with wounds deemed treatable by TQ who did not receive them:
  - "Lost pulse within minutes, died pre-hospital"
  - "Arrived w/o VS within 15 min of wounding".

CSH Baghdad-2006 Tourniquet Study[2]

- These 5 fatalities who did not receive TQ were matched against 13 patients with similar Injury Severity Scales and Abbreviated Injury Scores:
  - Survival rate with TQ: 77%
  - Survival rate w/o TQ : zero

[2] Kragh JF etal. J Trauma 2008;64:S38-50

CSH Baghdad 2006 Tourniquet Study

- "Some field witnesses reported that active external bleeding had stopped…and that they had underestimated the speedy lethality of uncontrolled limb bleeding"

[2] Kragh JF, etal. Annals of Surg 2009;249:1-7

What Can We Apply to Civilian EMS?

Photo: Amedd.army.mil

- Do we recognize "the speedy lethality of uncontrolled bleeding"?
- Does the short-term complication rate of TQ justify its use when speed is essential?
- Once the utility of TQ is recognized in specific settings, can we collect data clarifying outcomes in the civilian sector?

Hemostatic Agents

QC inc.photo. Not a product endorsement

- Misconceptions of the role of these agents persists.
- Need to emphasize primacy of pressure techniques and TQ vs. hemostatic dressings.
- Recent studies by US Army Institute of Surgical Research:
  - Resulted in D/C of use by the US Army of hemostatic agents other than "Combat Gauze" pending further study.

On-Scene Care Should Never Trump Definitive Care

- Hemorrhage
  - Low threshold for TQ use.
  - Hand-Off to Local EMS outside perimeter
  - If Definitive Care is Close-Leave TQ On, Primary Assessment and Go
- Airway
  - AFTER scene safe. (NOT under fire)
  - Simple adjuncts (NPA/Suction/Position/BVM)
  - If Definitive Care is Close & the above works, Primary Assessment and Go
- All SWAT Operators Get Basic A/B/(C = TQ) training
- All Receiving EMS Get LE Scene Safety training
  - 'The Phase Line is The Hard Line'

Acknowledgements

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- Special thanks to our colleagues in military medicine
  - Trauma and Injury Subcommittee-Defense Medical Board
  - Naval Operational Medical Institute
  - U.S. Army Institute for Surgical Research
  - Dr. John B. Holcomb, MD , FACS

- And our definitive care colleagues who are there for us. Every time.

FBI Photo