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

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The opinions in this briefing are those of the author. They do not necessarily represent the opinion of the Federal Bureau of Investigation or of the United States Government.
SWAT doctors credited with saving officer's life during raid

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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.
TODAY’S FBI. IT’S FOR YOU.

HOSTAGE RESCUE TEAM... Be where Special becomes Extraordinary.
Physician Involvement in SWAT 2009

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

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

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

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”:
Civilian Trauma Care Setting

Photo courtesy NOMI
“Wait a second, I dropped my laryngoscope....”
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.
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.
Goal: Rapid, Seamless Transition of Emergency Care

From within the Exclusion Zone-

To the Emergency Care System outside.
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

- 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

- 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
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”
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 et al. J Trauma 2008;64:S38-50
“Some field witnesses reported that active external bleeding had stopped... and that they had underestimated the speedy lethality of uncontrolled limb bleeding”

What Can We Apply to Civilian EMS?

- 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

- 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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