

The continuing threat of active shooter and intentional mass casualty events: Local law enforcement and hemorrhage control

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No matter the event type and scope, law enforcement officers (LEOs) represent the first responders to each and every active shooter/intentional mass casualty event. Even with the most aggressively integrated operations plan, the response to these events must begin with LEO response, which places LEOs in the position of being the first professional responders who have an impact on survival. Because of this unique role, hemorrhage control must be as much a core law enforcement skill as de-escalation and firearm use. Couple this unique opportunity with the fact that despite major strides in equipment, body armor, vehicle design, tactics, and the delivery of modern trauma and critical care, we have only barely improved our ability to minimize LEO injuries and deaths. To address both problems, it is imperative that we equip our officers with the knowledge and tools needed to mitigate and minimize the consequences of injuries when they occur. We must prepare to teach lifesaving skills to all our officers. What has been limited historically to the tactical team medic or delegated to a civilian fire and rescue or emergency medical services (EMS) agency now must be delivered to the hands of each officer who has the potential for hostile contact. Therefore, our nation's largest law enforcement agencies unanimously support the findings of the Hartford Consensus.

Responding to the active shooter

Today's law enforcement response to the active shooter looks nothing like it did even 15 years ago and, in fact, is again in evolution. Before the Columbine High School shooting, law enforcement response to an active shooter was the purview of specialized units such as Special Weapons and Tactics (SWAT) teams or emergency response teams. However, after active murder continued for more than 49 minutes at Columbine High School, law enforcement agencies worldwide

transitioned from a "surround and contain" posture to a much more aggressive, dynamic response. More recently, using lessons learned from other active shooter events, the law enforcement response has become more dynamic, with groups such as the Texas-based Advanced Law Enforcement Rapid Response Training (ALERRT) Center's advocating rapid, dynamic, and overwhelming responses to these events. A true paradigm shift has occurred, as the response to the active shooter is no longer the responsibility of the local SWAT team, but instead is one shared by every LEO nearby. In the response to continually evolving threats, some jurisdictions are now integrating the law enforcement/EMS response in ways never before thought possible.

Introduction to law enforcement medicine

As the response to the active shooter has evolved, so has the interface between law enforcement and the medical community. Recognizing that LEOs encounter many situations on a daily basis that have some sort of medical component, many have begun to train their officers with skills and equipment that were formerly reserved for their EMS, fire, and rescue colleagues. The LEO may be the first responder to arrive at a motor vehicle collision or cardiac arrest, to respond to calls about psychotic individuals acting bizarrely or depressed and suicidal persons threatening harm, or to treat a partner injured in a shooting. SWAT officers, operating in environments inaccessible to standard EMS providers, must be able to mitigate their own injuries and continue their critical missions. Today, many U.S. police departments are forging relationships with local medical experts for assistance in managing these issues and many others that they regularly face (not to mention a relatively low-frequency but high-impact incident like an active shooter or intentional mass casualty event).

More than 180,000 LEOs in our nation's largest cities (or approximately one of every five U.S. LEOs)...are now capable of saving an injured civilian or one of their fellow officers injured in an active shooter or other situation.

Authors have described some of the components of a comprehensive law enforcement medical support program. They have described the role of law enforcement organizations in hospital disaster preparedness,¹ reviewed the impact of conducted energy weapons programs,² and described the fundamental principles of civilian-sector tactical EMS.³ Other writers have described attempts to prevent in-custody death by involvement of the medical examiner⁴ and attempts to codify the role of the law enforcement agency members as medical first responders.⁵

Hemorrhage control and the law enforcement officer

It would be optimal to have a trauma surgeon at the side of every officer at the time of wounding, but that clearly is not feasible. Law enforcement physicians have been instrumental in pushing medical techniques previously thought to be used only by certified medical providers out to individuals with mere basic training. The translation of these skills from medical textbooks to wide applicability and their implementation by non-traditional responders have saved and will continue to save lives. Based on principles established in the Tactical Combat Casualty Care program, these hemorrhage control techniques are battlefield tested, have been supported by data from both military and civilian sources, and have eliminated preventable deaths in some battlefield spaces by their widespread adoption.⁶ Officers who are trained in hemorrhage control and other medical techniques can treat injured persons until they can receive more advanced medical attention. LEO hemorrhage control programs must contain simple, easily replicable, easily taught, and easily learned skills and must focus on those interventions that can be applied by police officers to the injured at the point of wounding.

Because the predominant cause of preventable battlefield death is exsanguinating extremity hemorrhage,

the use of tourniquets and other hemorrhage control techniques plays a large role in the management of these types of casualties. The table on page 58 lists the contents of a basic downed officer kit issued to every LEO with public contact in the Dallas (TX) Police Department (DPD). The contents mirror those of the Tactical Combat Casualty Care program, and each officer issued these kits receives training to become expert in the use of these pieces of equipment in austere environments.

Some detractors initially thought that the introduction of these skills into the armamentarium of the LEO would distract from other, more traditional law enforcement responsibilities. In fact, they have proven to be very complementary, particularly in response to the active shooter. On June 12, 2015, an assailant in an armored vehicle attacked the DPD headquarters building with automatic weapons and improvised explosive devices (IEDs). While officers returned fire, negotiated the IED-containing suspicious packages, and evacuated endangered civilians, other DPD officers ensured that no one else was injured, provided care to those who were injured, and ultimately ensured that the only loss of life that day was that of the suspect. Even in times of utmost crisis, LEOs are capable not only of performing traditional duties but also of providing care to individuals around them. Because of the dynamic nature of an incident like that one, with two distinct scenes, continuing gunfights, multiple IEDs, and multiple business and residential occupancies at risk, the scene is simply inaccessible to non-law enforcement responders such as EMS and fire and rescue services. Had there been more injuries, care would have been the responsibility of the DPD officers there. What remains clear is that the care described in the Hartford Consensus represents the best response in the unique nexus of the roles of law enforcement, trauma surgery, and public health.

DALLAS POLICE DEPARTMENT
DOWNED OFFICER KIT CONTENTS

SOFTT-W tourniquet

QuikClot Combat Gauze LE

4-inch modular bandage

Latex/EMS gloves

The Hartford Consensus and the Major Cities Chiefs Association

From its inception, the agencies represented by the Major Cities Chiefs Association (MCCA) and many other law enforcement agencies around the U.S. and the world have been supporters and contributors to the Hartford Consensus. In addition to the adoption of the response concepts represented by the acronym THREAT (*T*hreat suppression, *H*emorrhage control, *R*apid Extrication to safety, *A*ssessment by medical providers, and *T*ransport to definitive care), the provision of hemorrhage control has been recognized by many as a core law enforcement skill. Although data regarding specific use of hemorrhage control during active shooter situations are scarce, agencies across the country are reporting multiple lives saved with the use of these techniques. In Tucson, AZ, the police and sheriff's departments have a long history of a law enforcement agency-based hemorrhage control program. Responsible for saving more than 75 lives over the years, it is hailed as a real example of the improvement in community safety when LEOs can provide effective hemorrhage control at the point of wounding.

At the October 2013 meeting of the MCCA, the Hartford Consensus was presented to the membership and its concepts unanimously endorsed. Since that meeting, nearly 45 of the 70 agencies represented by the MCCA have completed or are in the process of training and equipping their LEOs with hemorrhage control training and equipment. This trend translates into more than 180,000 LEOs in our nation's largest cities (or approximately one of every five U.S. LEOs) who are now capable of saving an injured civilian or one of their fellow officers injured in an active shooter or other situation. These officers provide this protection to nearly 80 million Americans.

Additional agencies are coming on board each week, moving their LEOs into the present by training and equipping them with hemorrhage control equipment. Some novel and effective local partnerships exist, but our nation's trauma centers must be engaged and ensure that every law enforcement agency has both the expertise and the resources to develop these lifesaving capabilities.

Conclusions

As threats continue to evolve, our nation's LEOs will continue to be our frontline responders to incidents in which citizens are injured. We must continue to train these LEOs to meet these challenges. For individuals who face these threats or have to respond to these incidents, it is the ultimate community policing program. ♦

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