Translating Military Advances in External Hemorrhage Control to Law Enforcement

Dr. Frank Butler
International Association of Chiefs of Police
26 October 2015
Disclaimer

“The opinions or assertions contained herein are the private views of the authors and are not to be construed as official or as reflecting the views of the Departments of the Army, Air Force, Navy or the Department of Defense.”
Thanks!

• Committee on TCCC
• Joint Trauma System
• USA Institute of Surgical Research
• Dr. John Holcomb
• Dr. Rich Carmona
• Dr. Lenworth Jacobs
• Dr. Norman McSwain
• COL (Ret) Russ Kotwal
• COL Brian Eastridge
• Mr. Dom Greydanus
• MSG (Ret) Harold Montgomery
• COL (Ret) John Kragh
• Dr. David McArdle
• Dr. Alex Eastman
• Mr. Ray Casillas
• Mr. Mike Meoli (SEAL, Ret)
• Dr. Dave Callaway
• Dr. Mel Otten
• Dr. Peter Pons
• Lt Adam Falk
• CAPT (Ret) Barney Barendse
• Dr. David King
• Dr. Scott Coyne
Bottom Line Up Front

• Law Enforcement Officers should routinely carry tourniquets and hemostatic dressings while on patrol or on missions.
• Law Enforcement Officers should obtain training through National Association of Emergency Medical Technicians (NAEMT) courses on how to use these items.
  – Bleeding Control (BCON – 3 hrs)
  – Law Enforcement First Responder (LEFR – 8 hrs)
  – Tactical Emergency Casualty Care (16 hrs)
  – Tactical Combat Casualty Care (16 hrs)
Individual First Aid Kits (IFAKs)

At this point in time, the US Military has more experience with tourniquets and hemostatic dressings than any other Organization in history. (14 years of war and 50,000 + casualties)

Cost: $128

• In 2001 – very few American combatants had tourniquets - no one had hemostatic dressings
• In 2015 - no American combatant goes onto the battlefield without an IFAK that contains both
Trauma Care Lessons Learned from 14 Years of War

• Most (76%) combat fatalities result from very severe injuries and are not preventable

• Most (87%) deaths occur prehospital

• Most (91%) of the deaths that are potentially preventable result from bleeding:
  – Non-compressible (internal) – 67%
  – Junctional (groin, axilla, neck) – 19%
  – Extremity (arm, leg) – 13%

Eastridge – J Trauma - 2012
Combat Fatalities: Two Types

- Non-Preventable:
  - Helicopter hit by a rocket and explodes in mid-air

- Potentially Preventable:
  - Special Forces Soldier
  - Shot in the knee
  - No other major wounds
  - Bleeds to death
The acceptable number of preventable deaths is – ZERO.

Christian Golczynski, 8, receives the flag that covered the coffin of his father, U.S. Marine Staff Sgt. Marcus Golczynski from Lt. Col. Ric Thompson during a graveside service in Wheeler, Tenn.
Death from Bleeding

• I have 10 minutes to speak with you today.
• Imagine yourself just having been injured – and presently bleeding from a large artery or vein.
• You now have just about that long to live.
• Unless somebody stops your bleed.

Dr. Jonathan Woodson
Assistant Secretary of defense for Health Affairs
White House “Stop the Bleed” Forum
6 October 2015
Battlefield Trauma Care: 1970

“All seem uncertain regarding the best method to implement factual knowledge to the man most in need, the front line trooper… citing our ineptness in the field of self-help and first aid … little if any improvement has been made in this phase of treatment of combat wounds in the past 100 years.”

CAPT J. S. Maughon
Mil Med 1970
Tactical Trauma Care at 8000 ft in the Hindu Kush
Battlefield Trauma Care: 2001

- Based on trauma courses NOT developed for combat
- Medics taught NOT to use tourniquets
- No hemostatic agents
- No junctional tourniquets
- Large volume crystalloid fluid resuscitation for shock
- 2 large bore IVs on all casualties with significant trauma
- Civil War-vintage technology for battlefield analgesia (IM morphine)
- No focus on prevention of trauma-related coagulopathy
- No tactical context for care rendered
- Heavy emphasis on endotracheal intubation for prehospital airway management
Tactical Combat Casualty Care (TCCC) : A Different Approach

• Battlefield trauma care research effort – Special Operations and USUHS: 1993-1996
• Combat environment and mission considered
• Combat medic training and equipment considered
• Project included input from combat medics, corpsmen, and pararescuemen (PJs)
• Evidence-Based – INCLUDING requiring evidence for current practice at that time

• Goal – To Prevent Preventable Deaths
Tactical Combat Casualty Care (TCCC)

- First used by Navy SEALs, 75th Ranger Regiment, and Air Force Pararescue in 1997
- PHTLS, ACS COT and NAEMT endorsement 1999
- All of Special Ops adopted in 2005
- Now used throughout the U.S. military
- Allied nations and civilian sector
- Updated on an ongoing basis by the Committee on TCCC
Battlefield Trauma Care: Now

- Phased care in TCCC
- Aggressive use of tourniquets initially
- Combat Gauze as hemostatic agent
- Aggressive needle thoracostomy
- Sit up and lean forward airway positioning
- Surgical airways for maxillofacial trauma
- Hypotensive resuscitation with blood products
- IVs only when needed/IO access if required
- PO meds, OTFC, ketamine as “Triple Option” for battlefield analgesia
- Hypothermia prevention; avoid NSAIDs
- Battlefield antibiotics
- Tranexamic acid (TXA)
- Junctional Tourniquets
Tactical Combat Casualty Care

The Prehospital Arm of the US Military’s Joint Trauma System

- Medics, Corpsmen, PJs
- Combat Lifesavers
- All Combatant Self/Buddy Care
- Includes Tactical Evacuation Care
TCCC: How Do We Know That it’s Working?
Preventable Combat Deaths from Not Using Tourniquets

• Vietnam - 7.4% of total combat fatalities

• Iraq and Afghanistan – up to 2006 – tourniquets just starting to be used – extremity bleeding caused 7.8% of total fatalities - no better then Vietnam

• Iraq and Afghanistan – up to 2011 – tourniquet use by now widespread in US Military - 2.6% of total fatalities – a 67% decrease
Tourniquet Outcomes in TCCC Transition Initiative Report

- **Sixty-seven** successful tourniquet applications identified
- **No** avoidable loss of limbs due to tourniquet use identified

**Butler, Greydanus, Holcomb**

*2006 USAISR Report*

*“TCCC: Combat Evaluation 2005”*
Tourniquets – Kragh et al
Annals of Surgery 2009

- Ibn Sina Hospital, Baghdad, 2006
- Tourniquets are saving lives on the battlefield
- 31 lives saved in 6 months period by the use of prehospital tourniquets (largely CAT and SOFT-T)
- 75% of improvised tourniquets were ineffective
Tourniquets in the US Military

“Tourniquets have been the signature success in battlefield trauma care in Afghanistan and Iraq. Based on the work of Army COL John Kragh and colleagues, the number of lives saved from this intervention has been estimated to be between 1,000 and 2,000.”

Davis et al
Journal of Trauma
2014

And the “1,000-2,000 lives saved” estimate was made in 2008 – six years before the end of the conflicts.
Tourniquet Phobia

• “But - I learned that tourniquets are dangerous and should only be used only as a last resort!”

• This is a medical “Urban Myth” that has cost the lives of thousands of casualties and trauma victims.

• Many thousands of tourniquets were used in the US Military in Iraq and Afghanistan.

• ZERO limbs were lost from tourniquet use in those two conflicts.

• 2 hours of tourniquet time is very safe.
Eliminating Preventable Death on the Battlefield

• Kotwal et al – Archives of Surgery 2011
• All Rangers and docs trained in TCCC
• U.S. military preventable deaths: 24%
• Ranger preventable death incidence: 3%
So - what do these advances in battlefield trauma care have to do with me? I’m a police officer – not a soldier.
With increasing frequency LEOs themselves are exposed to Violent Penetrating Trauma

- 31 August 2006, Trooper Longobardo and SGT. Baker were shot with a .308 rifle.
- Trooper Longobardo returned fire while SGT. Baker, notified other Mobile Response Team members of the ambush.
- Sergeant Baker suffered devastating abdominal injuries requiring multiple surgeries and a lengthy recovery period...but survived.
- Trooper Longobardo had a severed artery in one leg and bled to death on scene.
- Today this would be considered a preventable death because neither he nor his partner had knowledge or access to a tourniquet.
- Trooper Longobardo had a wife and 3-year old son.

John Longobardo
NY State Trooper

Slide – Mr. Mike Meoli
• Our nation demands that the best possible care be provided to our military’s combat wounded
• Do those who protect and serve at home deserve any less?
Tourniquets for Law Enforcement Officers – Who Benefits?

- Injured Officers
- Injured crime victims
- Injured bystanders
- Motor vehicle accident victims
- Suspects
- The families of all of the above
- The Community and the Nation
Ft. Hood Shootings 2009
Officer Kim Munley

• 12 dead; 31 wounded on 5 Nov 09
• Officer Munley got the shooter
• She was in turn shot in both thighs
• Direct pressure and improvised tourniquets used by several physicians unsuccessful at controlling hemorrhage – went into shock
• Saved by Army 68W medic with a CAT tourniquet on left thigh
Inaugural TCCC Course for LAPD and LAFD - 2012

• Life of an LAPD SWAT officer saved shortly thereafter - with a tourniquet

Photos courtesy Mr. Ray Casillas
21 FEB 2013
Encinitas, CA

- Suspect hiding in attic shot a Deputy through a vent with a 12g slug.
- Slug hit above knee shattering bone and causing massive bleeding from femoral artery.
- Deputy Dunford, who had taken a TCCC course 2 months prior, pulled out his recently issued C-A-T TQ and stopped the bleeding.
- ER MD stated that he clearly saved the life of his partner.
Police-Applied TQ Saves Mother of 3 in Atlanta

- Mother of 3 working in her kitchen
- GSW to the leg from a drive-by shooting
- Severe bleeding
Police officers arrived on scene

Applied recently-issued CAT tourniquets

Bleeding controlled – Mom survived
CAT Tourniquet, SGW, RT Lower Ext
Friday night, Houston TX, March 2009

CAT Tourniquet – patient lived

Photo – Dr. John Holcomb
Injured transit police officer went into cardiac arrest following Watertown gunfight

MBTA Transit Police Officer Richard Donohue remains in critical condition at Mt. Auburn hospital

CAMBRIDGE, Mass. — Richard Donohue, the MBTA transit police officer critically wounded in a gun battle with the bombing suspects, had lost nearly all his blood and his heart had stopped from a single gunshot wound that severed three major blood vessels in his right thigh.

* No mention of tourniquet use in the story
Improvised EMS Tourniquet: Houston

2013 -- Died

Photo – Dr. John Holcomb
152 patients at five Level I Trauma Centers
66 extremity injuries – 27 tourniquets applied prehospital – all improvised
“Eight limbs presented to the ED with life-threatening exsanguination and had no prehospital tourniquet in place on arrival.”
“At one collaborative hospital with detailed ED records and photos available, all six improvised tourniquets encountered were venous tourniquets and required replacement with a CAT tourniquet to prevent ongoing extremity exsanguination and effect hemostasis upon arrival in the ED.”
2008 - 2013
105 patients
Mortality decreased from 17% to 3.2% with tourniquets applied prehospital vs in ED
No tourniquet-related loss of limbs

Photos and data courtesy Dr. John Holcomb
Junctional Bleeding – Where you Can’t Use a Tourniquet

• Groin, axilla

• Neck

Use a hemostatic dressing!
CoTCCC-Recommended Hemostatic Dressings

Combat Gauze  Celox Gauze  ChitoGauze

*Always apply with 3 minutes of firm direct pressure!*
Prehospital use of hemostatic dressings by the Israel Defense Forces Medical Corps: A case series of 122 patients

Avi Shina, MD, MHA, Ari M. Lipsky, MD, PhD, Roy Nadler, MD, Moran Levi, Avi Benov, MD, MHA, Yuval Ran, MD, MHA, Avraham Yitzhak, MD, and Elon Glassberg, MD, MHA, Tel Hashomer, Israel

“The 88.6% self-reported success rate in junctional hemorrhage control is encouraging, as junctional hemorrhage is increasingly looked at as the currently most common cause of preventable death in the battlefield.”

Dr. Avi Shina et al
Journal of Trauma 2015
SDPD SWAT Officer Michael DeWitt took a TCCC class just 1 month before incident;

On his way to work he stopped at a SD County Sheriff SWAT incident and helped direct traffic;

When he heard shots fired he retrieved his M-4 Tac-vest with attached IFAK and went in;

Deputies Perez and Johnson were each hit with high velocity rounds (.308);

3 deputies and Off. DeWitt extracted Dep. Perez and Sgt. Johnson to covered safety;

Off. DeWitt pulled **Combat Gauze** from his vest and gave it to Dpty Abutin. They worked as a team and **packed it into the gushing shoulder wound** of Deputy Perez, stopping the bleeding.

Trauma MD said **Combat Gauze** saved his life.
Dr. Peter Rhee, at a memorial service Wednesday, has been an unofficial spokesman for Tucson.
First-aid kits credited with saving lives in Tucson shooting

By Sandhya Somashekhar and Sari Horwitz
Washington Post Staff Writers
Friday, January 21, 2011; 9:57 PM

TUCSON - Some of the first deputies to arrive at the scene of the Jan. 8 shooting rampage here described a scene of "silent chaos" on Friday, and they added that the carnage probably would have been much worse without the help of a $99 first-aid kit that recently became standard-issue.
In the end, 13 of those shot survived, while six did not. One of the injured, Rep. Gabrielle Giffords (D-Ariz.) was the last person still hospitalized until Friday morning, when she was discharged and transported to a rehabilitation facility in Texas.

Doctors and law enforcement officials told reporters here that the incident would have been much worse without a small brown kit devised by David Kleinman, a SWAT team medic who had become concerned about rising violence.

Kleinman cobbled together the Individual First Aid Kits out of simple items used by combat medics in Iraq and Afghanistan: an emergency bandage pioneered by the Israeli army; a strip of gauze that contains a substance which coagulates blood on contact; a tactical tourniquet; shears that are sturdy and sharp enough to slice off victims' clothing; and sealing material that works especially well on chest wounds.

* Dr. Peter Rhee – E-mail 1 Feb 2011
“…..a whole bunch of patients got Combat Gauze.”
San Diego Sheriff Issue
(after repetitive practice TCC class)

Full IFAK on active shooter vest next to issued kevlar helmet stored in trunk of patrol car

TQ with holster for duty belt

Slide – Mr. Mike Meoli
We can sometimes do better at saving lives – and we should.
The Hartford Consensus: ACS Response to Sandy Hook

- American College of Surgeons
- FBI
- White House – Medical Policy
- White House Medical
- Asst Secretary of Defense - Health Affairs
- Asst Secretary of Homeland Security – Health Affairs
- Medical Section – Major Chiefs of Police
- ACS Committee on Trauma
- DoD Committee on TCCC
Life threatening injuries in active shooter incidents such as those in Fort Hood, Tucson, and Aurora are similar to those encountered in combat settings. Military experience has shown that the number one cause of preventable death in victims of penetrating trauma is hemorrhage. Tactical Combat Casualty Care (TCCC) programs, when implemented with strong leadership support, have produced dramatic reductions in preventable death. Recognizing that active shooter incidents can occur in any community, the Hartford Consensus encourages the use of existing techniques and equipment, validated by over a decade of well-documented clinical evidence.

- Emphasis is on early and definitive control of external hemorrhage
- Tourniquets and hemostatic dressings would help make this possible
Hartford Consensus III  
Dr. Lenworth Jacobs

• Recommends tourniquets and hemostatic dressings for EMS/Fire and Rescue/Law Enforcement Officers.

• “All hemostatic dressings and tourniquets must be clinically effective as documented by valid scientific data. The Tactical Combat Casualty Care guidelines for the U.S. military contain objective evidence to support the safety and efficacy of the various options for tourniquets and hemostatic dressings.”
“Aggressive, directed, point-of-wounding TCCC by non-medical troops in the form of self- and buddy-treatment, as well as continuity of TCCC by medical non-combatants represents significant enhancement in the initial echelons of casualty care.”  

JEMS 26 July 2015
White House meeting on this topic 6 October 2015

Emphasis was on BYSTANDERS being able to use tourniquets and hemostatic dressings

Shouldn’t police officers be as well trained as bystanders?
Quality Assurance In Trauma Training Courses
Know What Your Officers Will Be Learning

U.S. doctor sanctioned for 'abhorrent and abnormal' troop training
RICHMOND, VA | BY JOHN SHIFFMAN

- Incorrect messaging
- Instructor drift
- Inappropriate training
- Some vendor-supplied training is expensive
- Need an inexpensive and assured standard!

- “Shock Labs”
- “Cognition Labs”
- Arterial Blood draws
- Sternal IO insertion on volunteers
- Regional blocks by non-medics
NAEMT Courses

Advantages

• Approved curricula
• They QA their instructors.
• Have a system for establishing training sites
• Less expensive than commercial training vendors.
• Certification card at the end of the course.
• NAEMT registry of all who complete the course.
• Options:  Bleeding Control
            Law Enforcement First Responder
            Tactical Emergency Care
            Tactical Combat Casualty Care
Who Directs and/or Funds Trauma Kits and Training?

- Officer self-procured – not ideal

- The Right Way
  - Fire, Police, and EMS organizations should fund
  - Federal/State grants to get started

- Other Ways
  - Philanthropy (Houston Model) – Rotary, Kiwanis, individuals, foundations
  - State or federal law
  - Mandated for eligibility for HHS or FEMA grants
Preventable Deaths in Law Enforcement

In order to further reduce preventable deaths in law enforcement officers and mass casualty victims, we must know what the causes of these preventable deaths are as well.

WHO IS KEEPING TRACK?
EVERY PREVENTABLE DEATH IS A CALL TO ACTION.
"The current case series demonstrates the life-saving potential of commercial tourniquets in the management of penetrating extremity trauma, even when applied by nonmedical first responders in the civilian setting (Table 1). Three of the 4 patients in the case series arrived at the receiving ED in extremis (Table 2), yet were successfully resuscitated and survived to discharge without major morbidity (Table 3)."
“Three of the cases in our paper were police officers who were ambushed and sustained arterial injuries (Lakewood, Colorado July 2014 and Aurora, Colorado December 2014). There is no doubt that they would have exsanguinated without application of a TQ, in one case self applied and in the other two, buddy care.”
Bottom Line Up Front

• Law Enforcement Officers should routinely carry tourniquets and hemostatic dressings while on patrol or on missions.

• Law Enforcement Officers should obtain training through National Association of Emergency Medical Technicians (NAEMT) courses on how to use these items.
  – Bleeding Control (BCON – 3 hrs)
  – Law Enforcement First Responder (LEFR – 8 hrs)
  – Tactical Emergency Casualty Care
  – Tactical Combat Casualty Care
Individual First Aid Kits (IFAKs) - Again

At this point in time, the US Military has more experience with tourniquets and hemostatic dressings than any other Organization in history. (14 years of war and 50,000 + casualties)

Cost: $128

• In 2001 – very few American combatants had tourniquets - no one had hemostatic dressings
• In 2015 - no American combatant goes onto the battlefield without an IFAK that contains both
Thank You!

fkb064@yahoo.com