More on downed officer rescue & important new court rulings

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I. Important Clarification: Should ABC be CBA in treating wounded officers?

Is it true that an old standard of first aid training—attending to Airway, Breathing, and Circulation (bleeding) in that order when treating injured parties—is now obsolete?

In a report about downed-officer rescues published in Force Science News [Transmission #118, sent 3/16/09], Dr. Matthew Sztajnkrycer contended that when caring for downed officers, ABC should be reversed to CBA. In other words, get bleeding controlled first, then worry about airway.

In that article, Sztajnkrycer noted that 2/3 of preventable deaths among combat-wounded soldiers are related to bleeding, and recommended that officers be taught “new combat aid skills accordingly.” However, his survey of law enforcement personnel indicated that officers felt that airway management should take priority over control of bleeding, in keeping with the traditional ABC approach.

A TRAINER OBJECTS. Possibly speaking for more readers than just himself, a senior instructor at a prominent training center who has 15 years of EMT experience, strongly took issue with Sztajnkrycer’s CBA recommendation. He emailed the following:
“American Red Cross and American Heart Assn. protocols for CPR indicate always checking the Airway, Breathing, and then Circulation because if a non-responsive patient’s airway is compromised due to a bad airway position, the small, quick act of opening the airway will save their life.” He recalled personally saving a teenaged girl’s life after an MVA by following just that procedure.

“She was non-responsive and not breathing,” he explained. “Once I repositioned her head opening her airway, she spontaneously began to breathe. Had I attended other issues first, she would have died.”

He cautioned that Force Science News should not suggest that officers “disregard well-established medical protocols that have been in place many years.”

THE RESEARCHER REPLIES. To guard against any misunderstanding on this issue, we offer the following response from Dr. Sztajnkrycer, who is a member of the Force Science Research Center’s advisory board and chairman of the Division of Emergency Medicine Research at the Mayo Clinic:

“To clarify, I am not advocating a general abandonment of the ABC approach. I continue to train civilian medics and doctors in this way, and ABC does serve a valid purpose, especially in conventional medical and trauma care. No airway equals fast death, pure and simple, no matter what else you do.

“The paradigm shift I proposed applies specifically to 2 circumstances: 1) penetrating trauma (from gunshot wounds, IED blasts, etc.), and 2) downed-officer rescue in the setting of an active threat (although it could be expanded to any care-under-fire situation).

“Until recently the military model for battlefield trauma care followed the civilian EMS model, specifically focusing on ABCDE (ABC + Disability + Exposure). If someone was bleeding to death, the approach was to secure an airway, insert chest tubes if needed, and then put in 2 large-bore IVs and deliver a minimum of 2 bags of saline to replace what was being lost, rather than to stop the person losing more blood.

“After the Battle of Mogadishu, Somalia, in 1993 (made famous in the book and movie Black Hawk Down), the medical after-action report raised some serious concerns about transferring civilian trauma-management doctrine to a combat environment. Out of this was born the concept of Tactical Combat Casualty Care (TCCC).

PREVENTABLE-DEATH REALITY. “TCCC took an evidence-based approach to the management of battlefield trauma, and looked at causes of preventable combat death. It found that 2/3 of preventable deaths were due to isolated extremity hemorrhage; soldiers who were shot in an arm and/or a leg only, and bled to death. Most of the remaining preventable deaths came from chest trauma (specifically tension pneumothorax). Only about 5% of preventable deaths were related to airway problems.
“Based on the available evidence, it was decided to emphasize the control of life-threatening bleeding over all other medical issues when providing care in the kill zone. A tourniquet is quick, and saves lives. The rest can generally wait until some cover is found. Hence the different mnemonics CBA, XABC (eXsanguination [blood loss] ABC), and most recently MARCH (massive hemorrhage, airway, respiration, circulation, hypothermia/head injury).

“Will soldiers die as a consequence of this re-prioritizing? Possibly. As many as 5% of preventable combat deaths involve airway issues, and airway management is not considered appropriate for the kill zone. However, the data would argue that emphasizing something quick and easy that will save 13 out of 20 lives is more effective than something that is complicated, slow to perform (and therefore delays extraction from the kill zone and places everyone at risk), and still only saves 1 life out of 20.

EYE-OPENING STUDY. “Interestingly, although ABC is well-entrenched dogma, there is very little solid evidence to support it. It seems to make sense, and has stood the test of time, so we do it. The nice thing about TCCC is that it is supported by an increasing body of evidence that shows that it works.

“In terms of airway management in a tactical setting, there was an eye-opening study presented at the Special Operations Medical Assn. meeting in Tampa last December. It had 2 very important conclusions.

“First, the number of patients requiring airway management remains small, and for the most part their airways are literally bloody messes. These victims have suffered trauma to their faces and necks, and are choking to death on their own blood. Jaw thrust/chin lift will not work in this scenario. Conventional rescue airway devices for emergency ventilation will not work because of all the bleeding (a bummer, since this is our tactical airway device of choice). For the military, the method of choice for definitive combat airway management appears to be a surgical cricothyrotomy.

“Second, the study found that a subset of victims needed airway management not because of direct head/neck trauma, but because of a decreased level of consciousness. However, unlike the case alluded to in the email from the experienced trainer, this is not the MVA victim with a head bonk and blunt closed-head injury. This is someone shot somewhere other than the head/neck, who is unresponsive because of bleeding and shock.

“In this group, no patient survived regardless of airway management. If they had such bad shock that they became unresponsive and needed airway management, they died. This new data would appear to support the emphasis on controlling blood loss over airway management in the kill zone.
“Now, I realize that civilian tactical emergency medicine is different from military medicine in Fallujah or Kandahar. I am also not saying that TCCC is the gospel for civilian law enforcement. For example, in the airway study, cricothyrotomy was chosen over the more common civilian EMS approach of endotracheal intubation in part because it is too logistically difficult for the military to maintain the proficiency of all its medics in medication-assisted intubation.

“However, based upon the evidence coming out of Iraq and Afghanistan, and extrapolating to the rescue of a downed officer, I think there is pretty sound medical reasoning to limit care in the hot zone to quickly controlling life-threatening hemorrhaging if feasible and moving to cover.

EXIT THE KILL ZONE. “What you should not be doing is staying in the kill zone, trying to perform a civilian ABC assessment, and exposing yourself, your team, and the downed officer to more threats.

“To save lives, I am suggesting that under certain very specific circumstances, such as a downed-officer rescue, we take our cues from TCCC and do not focus on airways until we find cover. In other words, reverse ABC to CBA.”

Note: If you Google “Tactical Combat Casualty Care” you will find innumerable articles on this protocol and its 3 goals: To save lives that would otherwise be lost…to prevent additional casualties…and to complete the mission. For instance, the U.S. Army Medical Dept. Journal for April-June, 2005, carries extensive coverage of the subject, with impressive field reports.

Dr. Sztajnkrycer welcomes dialog on this and other subjects related to his downed-officer research at: Sztajnkrycer.Matthew@mayo.edu.

II. More reader feedback on downed-officer rescues

Grossman urges: “Think outside the squad car”

Another great contribution [“Officer-rescue survey results raise key training issues,” Transmission #118]!

A military response to this survey would, I believe, be very similar. However, in a rescue scenario the military response is to “pop smoke” and treat/evac under the concealment of a smoke grenade. (Not “cover”…cover stops bullets, concealment stops vision.)

In my classes I’m trying to get cops to “think outside the squad car,” and one valuable piece of nonlethal military equipment I am suggesting is a smoke grenade in the trunk of every squad car.
Lt. Col. Dave Grossman

Author, On Killing and On Combat

Consider neutralizing the aggressor for the fastest rescue

The hypothetical survey question of how many does a responding officer attempt to save following an IED ignition that wounded 3 fellow officers was interesting.

You might want to develop training to consider the option of protecting the fallen by attacking the aggressor. Neutralizing him may be the quickest means to extricate and save comrades, although that is total speculation on my part.

Integrating current battlefield experiences with trauma medicine is a fantastic idea. It brings to mind the recent story of the marine who mistakenly received female hygiene tampons to the teasing of his unit—until he used one to stuff in a bullet hole of his buddy.

Now each man carries a couple, or so the story goes. Keep up the good work!

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III. Courts rule on cases of hogtying and shooting into a moving vehicle

Two recent federal court rulings supporting officers’ decision-making in force encounters are reported in the latest “Case Notes and Publications” email from Americans for Effective Law Enforcement, the nonprofit organization that monitors and assists with litigation of interest to LEOs and their agencies.

1. In Lewis v. City of West Palm Beach, et al., 5 Florida officers and their employer were sued over the streetside death of an incoherent, unruly suspect that occurred after he was hogtied to immobilize him and prevent him from running into traffic.

The county medical examiner listed the cause of death as “sudden respiratory arrest following physical struggling…due to cocaine-induced excited delirium.” A plaintiff’s expert, however, asserted that the cause was “asphyxia [from] neck compression,” induced by officers struggling to restrain him. The plaintiff, the suspect’s mother, alleged that the officers used excessive force and that the city failed to train them properly.
The 11th Circuit Court of Appeals, however, upheld a district court, which had exonerated the city and the officers of any liability. “Even though most of the officers in this case testified that [the subject] was not a danger to them and was merely resisting arrest, he was…‘an agitated and uncooperative man with only a tenuous grasp on reality.’ Because of his…inability to remain calm, [he] remained a safety risk to himself and to others….

“This was precisely the type of situation where the decisions of the officers confronted with “circumstances that are tense, uncertain, and rapidly evolving” should not be second-guessed.”

**The decision may be accessed in full by clicking here.**

2. In the second case, Swann v. City of Richmond, et al., the plaintiff, a drug suspect, also alleged excessive use of force, this time by 3 detectives who shot and wounded him 5 times while firing at the car he was riding in. The plaintiff was in the backseat of the vehicle and had exhorted the driver to run down the detectives who wanted to question him.

The driver accelerated toward 2 of the officers, knocking 1 to the ground. That officer and his partners cut loose with 9 rounds into the car, striking the driver and the plaintiff nonfatally. One detective, who was positioned near the rear of the vehicle, said he thought the other officers’ shots had actually come from inside the car, although no gun was found there later.

Besides claiming that the force used violated his constitutional rights, the plaintiff alleged assault, battery, intentional infliction of emotional distress, and gross negligence.

A district court had granted summary judgment in the matter and the 4th Circuit Court of Appeals confirmed. All officers, the appellate court ruled, had acted in “an objectively reasonable manner and in their own self-defense.”

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Written by Force Science Institute
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