

Global Event Summary

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Global events continue to demonstrate the value of tailored high-threat prehospital trauma care and rescue response frameworks. The recent Navy Yard shooting in Washington, DC, and the extended, dynamic attacks at the Westgate Mall in Nairobi, Kenya, demonstrate the complexities facing our first responders. Although formal after action reports (AARs) will not be released for months, several key points are apparent. First, threat mitigation and rapid rescue continue to be a challenge for “first on scene” responders. Aggressive actions need to be taken to safely shorten the distance from responder to casualty. The days of “stage and wait” are over. Second, interagency coordination remains critical. In dynamic active violent incidents, a common operational and response language is vital. Incident Command System and Unified Command (UC), as outlined by the National Incident Management System (NIMS), provide a common baseline operational framework; TECC provides the common threat-based trauma care guidelines. Finally, coordinated interdisciplinary response models need to be implemented to reduce deaths from preventable causes.

TECC Guideline Updates

The C-TECC Pediatric Working Group (PWG) conducted a thorough literature review and presented recommendations to the Guidelines Committee regarding Pediatric Specific TECC Guidelines. The guidelines were approved by the C-TECC and sent to pediatric trauma, critical care, and emergency medicine specialists for external review. The TECC Pediatric Appendix with draft guidelines is published in this issue of JSOM.

New Organizational Position Papers Supporting TECC

Tactical Emergency Casualty Care offers an all-hazards approach to the provision of trauma care in the high-threat prehospital environment: active shooter, bombings, MCI, structural collapse, etc. Two key position papers were released in the past 6 months supporting TECC guidelines in response to active shooter events. First, the International Association of Fire Fighters (IAFF) endorsed TECC as the trauma care standards in active shooter and rescue task force response models. Second, the U.S. Fire Administration Active Shooter Position Paper (http://www.usfa.fema.gov/downloads/pdf/publications/active_shooter_guide.pdf) endorses TECC as the standard for provision of trauma care in the high-threat environment.

Outreach and Training

FEMA sponsored three TECC Technical Assistance (TA) programs in September with committee members providing high-level strategic sessions in Charlotte, NC, Portland, OR, and San Francisco, CA. The FEMA TECC TA programs are designed to assist municipalities, cities, and regional organizations with the deployment of interagency TECC programs. Major metropolitan public safety agencies including the Philadelphia and Northern Virginia police departments have conducted TECC Train the Trainer courses to increase their staff’s ability to integrate the guidelines into evolving response paradigms.

The Committee for Tactical Emergency Casualty Care welcomes new Board of Advisor members:

Dr. Don Jenkins	Medical Director, Trauma Center, Mayo Clinic, Rochester MN
Dr. Corey Slovis	Chairman of Emergency Medicine, Medical Director, Metro Nashville Fire Department and Nashville International Airport
Dr. Phillip Spinella	Associate Professor Of Pediatrics, Director, Translational Research Program, Division of Pediatric Critical Care, Washington University in St Louis
Dr. Carol Cunningham	State Medical Director, Ohio Department of Public Safety, Division of EMS, National EMS Advisory Council
James McGinnis, PA-C, 18D, MPAS, USA (R)	Visiting ASSISTANT PROFESSOR OF CLINICAL RESEARCH & LEADERSHIP, The George Washington University
Dr. Dave Slattery	Medical Director, Las Vegas, NV Fire Department
Mr. Michael Touchstone	Deputy Chief, Philadelphia Fire Department, National Association of EMS Managers
Peter Slattery, MD	Operational Medical Director, Las Vegas Fire Department
Kevin Gerold, MD	Medical Director, TEMS Section, National Tactical Officers Association
LT Tracy Frazzano	City of Montclair, NJ Police Department
Peter Carlo, PA-C	Assistant Medical Director, Las Vegas SWAT
Scott Sasser, MD	Director, International Health Programs, Associate Professor, Department of Emergency Medicine, Emory University
Alex Isakov, MD	Director, Emory Flight; Assistant Medical Director, Grady EMS; Associate Professor, Department of Emergency Medicine, Emory University
Isaac Ashkenazi, MD	Professor, Faculty of Health Sciences, Ben Gurion University; former Director, NPLI, Harvard University
August Vernon	Forsyth County Emergency Management
Duane Caneva, MD	Medical Liaison Officer, Customs and Border Protection
Michael Touchstone	EMS Training, Philadelphia Fire Department
SGT James Gordon	City of Los Angeles Police Department
Allen Yee, MD	Operational Medical Director, Chesterfield Fire/EMS Agency
Jay McGinnis, PA-C	Program Director, Health Intervention and Disaster Response, The George Washington University School of Medicine and Health Sciences

Conclusion

The C-TECC would like to honor those who served and those who lost their lives 20 years ago on 3 October 1993, in the Battle of the Black Sea, Mogadishu, Somalia. Their sacrifice has led directly to some of the most swift and efficacious changes in combat trauma care in history.

Please join us on 16 December 2013 at SOMA for the winter open session C-TECC meeting. More information is available at www.c-tecc.org.

TEMS Going Forward . . .

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The TEMS community nationally is in a state of dynamic change. The increasing episodes of active shooter events nationally and internationally have caused many leaders to consider how they would manage such an event if it occurred in their area of responsibility. The trend is consistent regardless of the size of the locale.

Evidence of the increasing concern is demonstrated by the release of several position papers on tactical medicine by the International Association of Fire Fighters (IAFF). These position papers cover the following areas: IAFF Active Shooter Position Statement, IAFF RTF (Rescue Task Force) Training Position Statement, and the IAFF Tactical EMS Position Statement. These papers can be found through the search function at www.IAFF.org. Firefighters continue to provide the largest numbers of TEMS providers to the law enforcement arena.

Leadership has to consider the type of response they can field in an active shooter event and the elements that lead to an effective response. This elements include types and numbers of personnel, equipment available, the TTPs (tactics, techniques, and procedures) developed and practiced, and the training that produces competent first responders whether nonmedical professionals or those with medical credentials.

Many jurisdictions, agencies, and organizations are seeking training through the myriad mix of training opportunities. It is frequently a hit-or-miss proposition with many schoolhouses and instructors making a variety of claims. However, the National Tactical Officers Association (NTOA) in combination with their tactical medical training partner, the Center of Operational Medicine–Georgia Regents University (COM-GRU), offers the only tactical medical training courses based on the National TEMS Initiative and Council (NTIC) findings and the Tactical Emergency Casualty Care methodology. The NTIC is a competency-based standard centered on 17 domains in five areas of practice: Patrol Officer (First Responder), Tactical Operator, Medical Provider (EMT-physician), Tactical Team Commander, and Medical Director. TECC are best practice treatment guidelines based on TCCC and are focused in nonmilitary operational environments; they provide a large spectrum of treatment considerations for the civilian provider. The system has a direct relationship to the three-phase approach of TCCC. The comparable areas for TECC are Direct Threat (Care under Fire), Indirect Threat (Tactical Field Care), and Evacuation (Tactical Evacuation Care).

The meeting of the NTIC that was scheduled for the preconference period of the SOMA Conference in Tampa, Florida, in December 2013 will be rescheduled for a time in the near future. Organizational and administrative changes will be accomplished prior to the next meeting. This will facilitate the communication and future endeavors of the organization.

COM-GRU welcomes the addition of Andy Pennardt, MD, FACEP, LEO, COL, U.S. Army (soon to be retired) to the faculty of the Emergency Department and to his position as the Medical Director for Tactical and Military Medicine, Center of Operational Medicine, Georgia Regents University. Dr. Pennardt will bring more than two decades of Special Operations medical experience to the TEMS arena. Additionally, Dr. Pennardt will succeed Dr. Richard Schwartz of COM-GRU as the director of the NTIC. All in the TEMS community look forward to the contributions of Dr. Pennardt.

Inclusion of Tactical Emergency Medical Support (TEMS) in Tactical Law Enforcement Operations

Dr. Kevin Gerold, NTOA TEMS Section Chair

The National Tactical Officers Association (NTOA) Board of Directors recently approved a revision to the Tactical Emergency Medical Support (TEMS) Position Statement. The updated position statement, initially published in 1994 and revised in 2007, reflects changes in law enforcement operations and advances in medicine. The NTOA was a pioneer in recognizing the contribution that a TEMS element makes to the success of a mission-driven law enforcement operation and remains a leader in TEMS advocacy and training.

When the TEMS Position Statement was last revised in 2007, the Tactical Combat Casualty Care (TCCC) Guidelines that included the liberal use of tourniquets were emerging as an effective model for reducing potentially preventable combat associated deaths. The increasing threat from active violence incidents such as those that occurred recently in Tucson, Arizona, Boston, Massachusetts, and Newtown, Connecticut, were not yet a priority.

The revised position statement recognizes the need for all police officers to have basic TEMS medical training. As law enforcement first responders to active violence incidents, patrol officers are now trained and equipped to intervene to end active killing using tactics that were once reserved for special operations teams. Where TEMS was conceived to support special operations teams, the time has come to provide patrol officers with basic TEMS training and equipment in order to potentially save the lives of victims, bystanders, police officers, and suspects in the event they are wounded.

A position statement is important because it defines TEMS, provides directions for those wishing to act, and outlines priorities for the future. This Position Statement represents the evolution of TEMS as a specialized area of medical practice. It acknowledges that there is no single model for providing care during law enforcement operations and that its basic principles should be considered core law enforcement skills relevant to all police operations.

TEMS Position Statement

The National Tactical Officers Association (NTOA) recognizes TEMS as the mission-preplanning, preventative care, and medical treatment rendered during mission-driven, high-risk, large-scale, and extended law enforcement operations. The TEMS scope of practice includes medical interventions that further the health and safety of all law enforcement personnel and is intended to reduce the incidence of injury, illness, disability, and death associated with police operations. TEMS adapts and incorporates sound medical practices with police tactics for use in operations characterized by competing mission objectives, diagnostic uncertainty, limited resources, and performance decrement under stress to permit the delivery of effective medical care in an unfolding law enforcement mission.

The benefit of TEMS programs to law enforcement is sufficiently established to where TEMS is now a standard of care for law enforcement special operations. TEMS is not intended as a replacement for EMS services; rather, it is an operational medical element that complements these resources in order to promote the success and safety of the law enforcement mission.

The ability of TEMS providers to work and train together effectively requires a common nomenclature, interoperability standard practices, and a TEMS national consensus curriculum. The NTOA supports the efforts of the Committee for Tactical Emergency Casualty Care (C-TECC) and others to foster the development of standardized taxonomy and evidence based clinical practice guidelines tailored to the law enforcement mission.

TEMS Position Statement

NTOA: TEMS Position Statement / TEMS: National Tactical Officers Association 10/9/13 <http://ntoa.org/site/tems/tems-position-statement/print.html>

The NTOA encourages ongoing research to determine the most effective methods and equipment for providing care under conditions that typically exist during law enforcement operations. This research should include determining the most effective training techniques for learning and skill retention; including the use of high-fidelity simulation, to ensure that medical personnel are able to perform their lifesaving skills effectively when called on to do so.

The NTOA further recognizes that police officers are often the initial responders to active violent incidents. The ability to control life-threatening hemorrhage, triage casualties, establish secure casualty collection points, and coordinate care with existing EMS responders are core law enforcement skills and all police officers should have the basic medical skills and equipment to save the lives of victims, bystanders, police officers, and suspects in the event they are wounded. Federal, state, and local governments should provide the funding necessary to train and equip all police officers for an effective law enforcement response to casualties.

The NTOA recommends that special operations teams (SWAT, SERT, etc.) include properly trained tactical emergency medical services (EMS) providers. These TEMS providers are capable of developing medical threat assessments, implementing risk reduction strategies, providing logistical support, coordinating operations with local EMS, and rendering immediate medical care within the tactical environment of a law enforcement operation.

1. Special operations teams should tailor the medical capabilities of a TEMS element to their needs and operating environment, which can include all levels of medical providers. While there is no single, best, or one-size-fits-all approach to providing medical care during law enforcement operations, there are core competencies known to reduce the risk of potentially preventable deaths and disability; these require mastery by all TEMS providers.
2. Properly trained and equipped TEMS providers should deploy in appropriate locations according to the mission need and their respective team protocols. Doing so permits them rapid access to casualties and the opportunity to provide medical countermeasures and better enables TEMS providers to support tactical operations.
3. TEMS providers should serve as consultants to law enforcement commanders on matters of team health and safety and serve as the liaison between law enforcement operations, EMS services, and other state and local healthcare services.
4. TEMS providers may take on additional duties that can include the training of agency personnel in lifesaving medical techniques and managing health and safety matters such as maintaining team health and immunization records.
5. The selection and training of TEMS personnel should occur under written policies and procedures establishing operational guidelines and a defined chain of tactical medical command.
6. TEMS providers should practice under the medical direction of a physician trained and experienced in tactical medical care. The duties of the medical director should include overseeing training, establishing clinical competencies, defining operational medical procedures, and directing a quality assurance program.
7. State and local EMS guidelines should define the scope of practice for Emergency Medical Technician and Paramedic TEMS providers. Law enforcement agencies should encourage and assist EMS jurisdictions with developing this scope of practice guidelines for their TEMS providers.
8. Medical care providers supporting law enforcement operations should undergo TEMS specific training and practice that provides a working competency of medical best practices and tactics. Once trained, programs should require their providers to undergo periodic retraining and skills reviews. Training should be competency-based and include, but not be limited to, tactical theory and techniques, use of specialized medical equipment, TECC, and casualty extraction.
9. The effectiveness of a TEMS program requires that medical care providers remain highly proficient in their medical and clinical decision-making skills. Maintaining clinical proficiency requires that EMTs and paramedics will continue to have ongoing experiences as field EMS providers.
10. States and local government agencies should establish policies that protect TEMS providers against potential civil liability, as well as provide compensation for work-related injury.

IAFF Position Statement: Rescue Task Force Training

Rescue Task Force

Rescue Task Force (RTF)¹ initial and ongoing training for all EMS providers should include Tactical Emergency Casualty Care (TECC) concepts and practical skills applications.

Tactical Emergency Casualty Care

The TECC guidelines are the civilian counterpart to the U.S. military's Tactical Combat Casualty Care (TCCC) guidelines. The TECC guidelines take into account the specific needs of civilian EMS providers serving civilian populations. The TCCC guidelines were developed for military personnel who deploy in support of combat operations. These guidelines have proven extraordinarily successful, and provide the foundations for TECC.

The specifics of casualty care in the tactical setting will depend on the tactical situation, the injuries sustained by the casualty, the knowledge and skills of the first responders, and the medical equipment at hand. TECC focuses primarily on the intrinsic tactical variables of penetrating trauma compounded by prolonged evacuation times. The principle mandate of TECC is the critical execution of the right interventions at the right time.

Indirect Threat Care is rendered once the casualty is no longer under fire (i.e., war zone). Medical equipment is limited to that carried into the field by RTF personnel typically including tourniquets, large trauma dressings, and adjunct airways.

Note: 1. See Active Shooter Policy.



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