This training publication is a proprietary record of the Pennsylvania Municipal Police Officers’ Education and Training Commission. It has been created strictly for law enforcement training purposes pursuant to the Pennsylvania Municipal Police Officers’ Education and Training Act, 53 Pa.C.S. §§2161-2171 and in accordance with regulations of the Pennsylvania Municipal Police Officers’ Education and Training Program, 37 Pa. Code §§203.1-203.103.

This record contains highly confidential, law enforcement-sensitive information. Accordingly, the record’s dissemination is restricted to law enforcement personnel only, except pursuant to subpoena duces tecum or court order lawfully served upon the Pennsylvania State Police Commissioner, as the legal custodian of Commission records.

______________________________
Lieutenant Stephen L. Kiessling, Acting Director
Municipal Police Officers’ Education and Training Commission
Commonwealth of Pennsylvania

2015
Course Title: Tactical Medicine

Summary of Content

This three-hour course in-service course will address the principles of initial and ongoing casualty care of officers injured in violent incidents. Much of the content of this course is excerpted from the Tactical Emergency Casualty Care course.

Instructional Goal

Promote officer and public safety by introducing officers to the principles and process of Tactical Emergency Casualty Care.

Instructional Objectives

By the conclusion of this section, students will be able to:

1. Recognize the components of the acronym “THREAT” as they apply to tactical medicine.
   (Threat suppression, Hemorrhage control, Rapid Extradication to safety, Assessment by medical providers, Transport to definitive care.)
2. Describe the proper protocol and methods of applying a tourniquet to control severe extremity hemorrhaging.
3. Describe techniques for hemorrhage control that are not amenable to tourniquets, including hemostatic agents and pressure dressings.
4. Discuss penetrating injuries to the torso or airway and their management.
5. Identify methods of assessing a casualty including remote assessment.
6. Identify the medical and tactical considerations that influence officer rescue planning.
7. Discuss “Care in Custody” issues.

<table>
<thead>
<tr>
<th>16-203 Tactical Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Craig K. Hall Paramedic</td>
</tr>
<tr>
<td>Techline Technologies</td>
</tr>
<tr>
<td>________________________</td>
</tr>
<tr>
<td>Jonah Thompson Paramedic</td>
</tr>
<tr>
<td>Center for Emergency Medicine</td>
</tr>
<tr>
<td>________________________</td>
</tr>
<tr>
<td>Officer Eric Weisser Paramedic</td>
</tr>
<tr>
<td>Allegheny County Police</td>
</tr>
<tr>
<td>________________________</td>
</tr>
<tr>
<td>SA Jared S. Zimmerman EMT</td>
</tr>
<tr>
<td>Norfolk Southern Police</td>
</tr>
<tr>
<td>________________________</td>
</tr>
<tr>
<td>Leah Napoli M. Ed.</td>
</tr>
<tr>
<td>MPOETC</td>
</tr>
<tr>
<td>________________________</td>
</tr>
<tr>
<td>Bill Kaiser, M. Ed.</td>
</tr>
<tr>
<td>MPOETC</td>
</tr>
</tbody>
</table>
Section 1- Introduction to Tactical Medicine

“The bravest are surely those who have the clearest vision of what is before them, glory and danger alike, and yet notwithstanding, go out to meet it. —Thucydides”

Dave Grossman, On Combat: The Psychology and Physiology of Deadly Conflict in War and Peace

“The hero and the coward are both scared; but the hero runs in the right direction.”

Despite one’s training, skills, preparation, and commitment to excellence in policing, situations will arise in which an officer may be injured in a violent encounter.

The expanding threats facing American law enforcement officers demands that proper attention be given to managing such casualties.

A. T H R E A T

The acronym THREAT can be used to manage officer injuries in an armed violent encounter. This acronym provides a structure and set of priorities that officers can adhere to when they face such injuries.

- Threat Suppression
- Hemorrhage Control
- Rapid Rescue
- Extrication to Safety
- Assessment by Medical Providers
- Transport to Definitive Care

Threat Suppression is the obvious and critical first step to gain control of the incident so that officers are able to initiate self-care/buddy care. Once an active threat is addressed, officers can then assist others in need until EMS can take over primary medical response.

Approximately 90 percent of combat related deaths occur before the casualties reach a treatment facility.

These deaths are due to severe head injury and/or massive trauma to the body.

Death could be potentially prevented in approximately 15 percent of the cases by employing simple emergent treatment.

1. Preventable Pre-Hospital Deaths during Combat
   a. Severe Bleeding
      Preventable Pre-Hospital Deaths Remedy- Use of a Tourniquet and/or a hemostatic agent with a pressure dressing
   b. Airway Control
      Use positional airway management, e.g. “recovery” positioning (Roll the person on their side with their head resting on their arm). Use a NasalPharyngeal airway when trained and equipped.
   c. Open Chest Injuries / Tension Pneumothorax
      Look for and identify the presence of chest injuries. Use Occlusive Dressings when trained and equipped.
d. Shock

Reduce the chance of shock by identifying and treating injuries in an effort to reduce or eliminate hemorrhage.

Primary Injury Sites from Wars in Iraq and Afghanistan

- Head/Neck – 16%
- Torso – 32%
- Extremity – 44%
- Multiple areas of injury or systems – 8%  

Source- Figures provided by the U.S. Army as of 2010

2. Preventable Pre-Hospital Deaths in Law Enforcement

During the years of 2000 and 2010, 533 line of duty deaths occurred due to felonious assault. Of these deaths, 123 (23%) were identified as potentially survivable. Forty four of these officers had no back-up officer immediately available. Twelve of these officers were injured during high risk warrant service. All were wearing body armor.  
(Source-Sztajnkirycer, 2010)

3. Law Enforcement Line of Duty Deaths

In 2014 there were 133 line-of-duty deaths. Of this number, 49 were attributed to gunfire.

As of July of 2015 there have been 68 line-of-duty deaths. Nineteen of these deaths have been attributed to gun fire.  
(Source- Information provided by the National Law Enforcement Officers Memorial webpage.

B. Phases of Tactical Emergency Casualty Care (TECC)

1. Definition

Tactical Emergency Casualty Care offers a model of best practice recommendations for the treatment of casualties in a tactical/rescue scenario. The TECC method follows the principle of the APPROPRIATE treatment at the RIGHT time.

2. An Overview of the Phases of Tactical Emergency Casualty Care

Tactical Emergency Casualty Care recognizes the nature of armed or violent encounters affects when and how emergency medical care is provided to injured officers, civilians, and suspects.

This system further suggests that during the initial stage of a violent encounter, little if any medical care can be provided until the violent threat is stopped.

TECC therefore recognizes the following phases and the appropriate types and levels of care that can be provided during those phases.

a. Direct Threat

A direct threat is: Any situation in which an imminent or active threat is present.

During the Direct Threat phase of a violent encounter, the priority must be to manage the tactical situation by stopping or eliminating the threat or remaining prepared to engage an imminent threat.
Minimal medical assessment and treatment is appropriate in this phase. Actions not directly related to stopping the threat should be limited to determining whether rescue is indicated, and the safest way and time to institute such action.

b. Indirect Threat

An indirect threat is: Any situation in which an imminent or active threat is not present even though the potential exists.

During the Indirect Threat phase, known or potential casualties should be assessed rapidly for immediate threats to life. Further planning for follow up care and evacuation is considered.

c. Evacuation

The phase in which a casualty is moved from a scene to be assessed by medical personnel and transported to definitive care. Definitive care is care provided in a medical facility. During the Evacuation phase, ongoing or more intensive aid may be rendered until transfer of care to medical personnel is completed.

Section 2- Direct Threat Care

A. Direct Threat Care

During the “Direct Threat” stage, the primary focus is on eliminating the threat. Any care rendered should be self-care by the injured casualty.

Medical supplies are limited, and only LIFE THREATENING BLEEDING is treated if tactically feasible.

Self-care or Partner-aid is limited during this phase and focuses on:

- Mitigating threats and moving to a safer position.
- Conducting a remote assessment of any casualties.
- Directing the casualty to stay engaged in any tactical operation if appropriate.
- Directing the casualty to move to a safer position and apply self-aid if able.
- Stopping life threatening external hemorrhage when tactically feasible.

B. Medical Equipment

1. IFAK – Individual First-aid Kit

An individual first aid kit (IFAK) will include packaged trauma management materials that an officer can carry on their person. Many different manufacturers and styles exist and can include a variety of types and number of items.

IFAKs can contain:

- Tourniquet
- Hemostatic agent
- Medical Exam Gloves
- Tape
- Nasal pharyngeal airway
- Trauma dressing
- Roller gauze

Law Enforcement Officers should carry trauma equipment for self-aid**
2. **Tourniquets – Direct Threat Care**

   Treatment for controlling severe bleeding during Direct Threat Care is the use of a tourniquet. In the event that multiple wounds exist on an extremity, the tourniquet should be placed as high on the extremity as possible to ensure bleeding is controlled. Tourniquets can be left in place for 2 hours with minimal damage to the extremity.

3. **Remote Assessment/Self-Assessment**

   In the event that officers do not have immediate physical access to an injured officer, it may be necessary to remotely assess the casualty. Officers must first assess the tactical situation to determine if a direct threat still exists.

   Immediate access means that an officer is within arm’s reach of a casualty. Immediate access also implies that the officer can access the casualty without compromising their tactical advantage.

   a. **Four Critical Questions To Ask:**

      - Is the casualty acting appropriately?
      - Can the casualty do the right thing?
      - What is the casualty’s work of breathing?
      - Are they dead?

   b. **Interrupting Assessments**

      In some instances, the assessment can stop until the tactical situation improves. Some casualty behaviors will indicate that the person’s mental status is sufficient for the moment. Officers may choose to communicate with the casualty and encourage them to stay in the fight, move to a more advantageous position, and render self-aid if possible.

   c. **Mental Status**

      A mental status check is not a detailed exam. Is the casualty capable of engaging the threat? If not, and they have an altered mental status they should be disarmed of all weapons or dangerous items (OC, flash bangs, etc.) if tactically feasible.

   d. **Breathing**

      The casualty’s ‘work of breathing’ is the next indication of severity. During Direct Threat Care, this is a simple determination: does the person appear to be working harder to breathe, or given the situation are they not breathing enough? Someone involved in a physical altercation, especially one where lethal force is involved, can be expected to be breathing deeply and more rapidly than at rest.

      A patient with altered mental status and minimal or abnormal respiratory effort or sounds should be considered critical.

   e. **Visual Sweep**

      The visual sweep of a casualty should be conducted in a systematic fashion; generally beginning at the head and working down the torso and extremities from more critical areas to least.

      Before any visual or hands-on medical assessment is conducted of a hostile party or unknown person, they should be secured and searched in accordance with departmental policy.
If the casualty is not acting appropriately for the situation and you are unable to touch them, you should attempt to visually evaluate their breathing. They may be breathing faster, slower, more deeply, or very shallowly than seems appropriate.

If work of breathing is so severe that the casualty does not appear to be capable of responding appropriately to a threat, especially if their overall mental status seems compromised, this is an indication of a high-priority for rescue.

If the responder is unable to assess either a casualty’s mental status or quality of breathing, they must ask “is this casualty deceased?” It is important to be blunt and decide yes or no. An officer may be technically incorrect at this point; however the priority must be Threat Suppression and managing the tactical situation.

A casualty of indeterminate status who cannot be successfully evaluated regarding their mental status or breathing, should be considered a low priority until the threat is mitigated. Focus resources where they will be most effective.

4. Rapid Rescue and Extrication to Safety-Direct Threat Care

a. Priority of Life Scale

The priority of life scale is a decision-making tool that encourages law enforcement personnel to only place themselves in peril when hostages, victims, innocent bystanders or other officers are in imminent peril.

If hostages, victims, innocent bystanders, or other officers are not in imminent peril, officers should seek a safer means of responding to, deploying at, and resolving a crisis.

- Hostages or Victims
- Innocent Civilians/Bystanders
- Law Enforcement Personnel
- Suspect/Actor
- Evidence/ Drugs

When officers are in imminent peril, but rescue attempts would likely result in additional casualties, officers must consider the medical and tactical realities before taking action.

b. Initial Tactical Decisions

When an officer is injured to the extent that they cannot continue to engage the threat, they should take whatever actions they are capable of to get to a defensible position.

These actions may include:

- Moving out of the line of fire when possible.
- Moving to a position of cover. If no cover is available or is located too far way, move to a position of concealment.
- When possible, increase the distance between the threat and the officer.
- Use any or all tools and equipment available.
- Initiate self-care.
c. Rescue / Extrication Decision Making Matrix

Making appropriate rescue and extrication decisions in the event of a partner's injury can be difficult. This stress can induce an officer to make decisions that are not tactically appropriate, or to take actions at a time when such actions may likely produce additional casualties. Rescue should not be considered until sufficient resources are available to continue to address the threat.

Use the Four Critical Questions to gather information about the casualty to assist in determining whether rescue or extraction is appropriate.

1) Medical Factors That Affect Rescue Decisions.

A casualty is a high priority for rescue / extraction if they exhibit any of the following:

- The work of breathing is so severe that the casualty does not appear to be capable of responding appropriately to a threat, especially if their overall mental status seems compromised.
- An altered mental status and minimal or abnormal respiratory effort or sounds.
- The casualty is clearly alive but not responding appropriately. E.G. casualty is not attending to severe hemorrhage.

A casualty is a low priority for rescue / extraction until the threat is mitigated if:

- Due to the tactical conditions, a rescue / extrication cannot be carried out with a reasonable amount of safety.
- The casualty is effectively managing their wounds, is in a defensible position, and is engaged in the mission.
- The casualty is of an indeterminate status and their mental status or breathing cannot be successfully evaluated.
- The casualty is dead.

2) Tactical Factors That Affect Rescue Decisions.

- Will the rescue attempt result in further casualties?
- Can the rescue attempt be carried out with tactical superiority?
- Are sufficient personnel and equipment available to carry out the rescue?
- Are sufficient personnel and equipment available to support the rescue?
- How can the rescue be accomplished and what alternatives exist?
- What are the ingress and egress routes?


d. Casualty Encounter:

- Identify the casualty’s location
- Announce your approach to the casualty
- Identify your primary threat area
- Move the casualty to cover using a planned route
Section 3- Indirect Threat Phase

A. Indirect Threat Phase

Care provided during the Indirect Threat phase consists of continuing self-aid, and aid that is rendered to a partner, or bystander, in a location where the casualty is no longer in direct threat of a hostile engagement (usually from behind solid cover or in a hard room).

Tactical supremacy must be maintained and a casualty assessment should be initiated.

Focus on evaluating the casualty’s:

- Bleeding
- Mental Status
- Airway
- Breathing
- Shock

1. Casualty Assessment - Indirect Threat Care

The process of assessing a casualty for immediate life threats that may require some form of intervention is critical to making tactically and medically sound decisions.

All techniques, including rescue, use of tourniquets, and advanced life support are only effective when used to address a known problem.

a. Physical Examination

Physical examination should begin by assessing mental status and performing a sweep for the presence for blood, followed by an assessment of the casualty's breathing.

The goal should be to touch and visualize all critical areas of the body in a systematic fashion beginning with the head, through the torso, axilla, and extremities.

b. Determine Mental Status

Assessing mental status is not a detailed exam. Officers should ask the following questions:

- Is casualty alert and aware of their situation and condition?
- Is casualty capable of providing for their own care?

All casualties with altered mental status must be disarmed of all weapons or dangerous items (OC, flash bangs, etc.).

A casualty with an altered mental status is a high priority for evacuation.

c. Secure Subjects Before Assessing

Suspects / offenders who may present a threat to law enforcement should not be medically assessed until physically secured and searched for weapons and/or dangerous items in accordance with departmental policy.

While securing by handcuffs or other approved method and searching for hazardous items, officers should deliberately but temporarily ignore injuries until the tasks of securing and searching are completed.
Officers should not be distracted from tactical duties until they are relieved, are no longer needed, or they are determined to be medically incapable of continuing.

d. **Visual Observation**

The visual observation of an injury (an injury to one’s self or to a casualty) may be distracting. Minor or non-life threatening injuries often appear to be more severe than they are due to the presence of blood while critical injuries may have little outward sign. Officers must stay in the fight, especially since violent encounters are dynamic situations in which a direct threat may once again present itself.

e. **Record Significant Findings**

Any casualty who has apparent injuries, altered consciousness (mentation), or inadequate breathing should receive a hands-on examination when the tactical situation permits.

This does not need to be a detailed examination but it should focus on immediately identifying critical, life threatening injuries. Mental status and quality of breathing are more reliable indicators of severity.

f. **Perform Hands-on Assessments**

Once the immediate threat has been mitigated (Indirect Threat Care phase), known and suspected casualties should be assessed for life threatening injuries.

The standard method of assessing a trauma patient is to check mental status, then assess the ABC’s (Airway, Breathing, Circulation). During Indirect Threat Care, this method is *not effective*. Massive hemorrhage will kill faster than a simple obstructed airway.

All participants who have been involved in a lethal force encounter should be checked. Not everyone will require hands on physical examination, but rapid evaluation of mental status, work of breathing, and a visual sweep should be considered a standard practice following every force encounter.

1) **Precautions**

Proper protective equipment such as exam gloves and eye protection should be worn. A new pair of gloves should be used for each casualty; cross contamination between exams may transmit dangerous diseases or complicate future forensic investigation.

Standard uniform items and equipment may mask injuries and blood.

In particular, dark colors, body armor, base layer garments, and foul weather clothing may mask, absorb, or retain blood making both visual sweep and superficial pat downs ineffective at locating injuries.

2. **Determine Circulation Status**

Does the casualty have signs of circulation?

Signs of circulation may include: Movement; Breathing; A pulse; and Other signs of life.

If the tactical situation is not under control (e.g. an imminent hostile threat is still present) do not start CPR as it possibly increases the tactical vulnerability of the rescuer.
3. **Determine Presence of Bleeding**

   A sweep should be conducted in a systematic fashion, generally beginning at the head and working down the torso and extremities from more critical areas to least.

   - During this evaluation, casualties are being assessed for immediate threats to life.
   - Explore any abnormalities such as tears or holes in clothing, especially when a painful response is observed to touch.
   - Pay close attention to areas at high risk for hidden, life threatening injuries such as the armpits and along the edge of the protective vest.
   - Penetrating injuries from both firearms and edged weapons may leave little indication on the outside of the uniform other than a small hole or tear and bleeding may be hidden by the uniform and equipment.
   - In this setting, the most common threats are massive hemorrhage, upper airway obstruction, or tension pneumothorax.
   - If a life threatening injury is discovered, phase of care-appropriate interventions should be performed as the injury is located.
     - For example, as soon as massive bleeding from an arm or leg is identified, a tourniquet should be applied before continuing with the assessment.

   Airway management should be limited to positioning the patient to minimize upper airway obstruction or placing an occlusive dressing over an open wound to the torso until the tactical situation permits more in-depth medical care.

   Do not interrupt a search of a suspect to provide medical care. Officers should handcuff or secure appropriately, search for weapons and contraband, then assess for and address life threats.

4. **Tourniquets-Indirect Threat Care**

   During this phase, it is important to reevaluate the effectiveness of any tourniquets used.

   - Ensure the tourniquet is tight and all bleeding is stopped on the extremity.
   - Ensure that the tourniquet has not loosened.

   Mark the casualty’s forehead with a “T” and the time the tourniquet was placed and the location placed.

   Assess severe bleeding that may have been missed in the Direct Threat Care stage by performing a *blood sweep*.

5. **Hemostatic Agents/Gauze- Indirect Threat Care**

   Hemostatic agents such as Combat Gauze, Hemcon, and Celox can be used in conjunction with the application of a tourniquet and when severe hemorrhaging is present at an anatomical position that is not amenable to tourniquets. These areas include: neck, under arms, groin, etc.

   Hemostatic agents/gauze should be accompanied by a pressure dressing after the product is packed or applied to a wound.
a. Use of Hemostatic Agents/Gauze

When using a hemostatic agent, officers should:

- Identify and expose the wound;
- Remove excessive blood, sweat, fluids, mud etc. from around the wound;
- Locate source of severe bleeding;
- Identify the need for a hemostatic agent or gauze;
- Pack the agent or gauze in the wound on the most active bleeding;
- Hold direct pressure for at least 3 minutes;
- Re-assess for effectiveness and ensure bleeding has stopped;
- Secure with pressure dressing; and
- Document use of hemostatic agent.

b. Trauma Dressings – Indirect Threat Care

A pressure dressing may be applied to any wound which is bleeding heavily. Pressure dressings should also be used to dress and bandage wounds after severe bleeding has been mitigated by the application of a tourniquet or the use of a hemostatic agent. Pressure dressings are commonly applied during the Indirect Threat Care stage of a tactical incident. Trauma dressings can be used as a standard dressing or pressure dressing.

1) Proper Application of a Trauma Dressing

- Prepare the dressing
- Identify and expose the wound
- Locate source of severe bleeding
- Identify the need for a pressure dressing
- Place the dressing over the wound with the sterile side down
- Hold or direct casualty to hold dressing in place
- Wrap the bandaging around the wounded area and secure
- Check circulation if applied to an extremity
- If tactically feasible apply direct pressure for at least 3 minutes
- Re-assess for effectiveness and ensure bleeding has stopped

6. Airway and Breathing Evaluation-Indirect Threat Care

Someone involved in a physical altercation, especially one where lethal force is involved, can be expected to be breathing deeply and more rapidly than at rest.

The casualty’s breathing quality should be evaluated.

During Direct Threat, this was a simple determination: does the person appear to be working harder to breathe, or given the situation are they not breathing enough?

During Indirect Threat Care, the casualty’s airway and torso should be inspected for injuries.

a. Determine Airway Status

If the casualty is unresponsive, open their airway.

- Head tilt/chin lift
- Jaw thrust
1) Nasal Pharyngeal Airway (NPA)

A Nasal Pharyngeal airway is a small rubber tube with a flattened dish shape on one end. The device can assist in keeping a casualty’s airway open and should be used if a casualty (‘s):

- breathing is noisy, sounding abnormal;
- breathing is slow, less than 10 per minute; or
- is unresponsive.

A Nasal Pharyngeal Airway can be placed in both the responsive and unresponsive casualty.

Do not insert a Nasal Pharyngeal airway if there is trauma to the roof of the mouth, or if fluids or blood from the nose or ears is present.

Proper Sizing:
- Estimate from the tip of the nose to the earlobe
- Diameter of the right nostril
- Inserted easily using lubrication

7. Determine Breathing Status

Difficulty breathing can be the first sign of a more serious emergency.

Recognizing the signs of breathing problems and providing care often prevent these problems from becoming more serious emergencies.

Responders should evaluate a casualty’s ability to breathe adequately and look for the following signs of a respiratory emergency:

- Abnormal breathing sounds
- Inadequate depth of breathing
- Too slow or too fast breathing rate

8. Torso Trauma

Torso trauma falls into two different categories: Open Trauma and Closed Trauma. The torso will includes everything from the neck to the navel.

a. Open Chest Trauma

- Open chest trauma is caused by penetration of the chest wall.
- Air may enter the wound causing a lung to collapse (Open Pneumothorax).

1) Open Chest Trauma Treatment

Prehospital treatment of an open chest wound is to prevent air from entering the chest cavity. This is done by sealing the wound with an airtight barrier (Occlusive Dressing).

b. Types of Occlusive Dressings

- Plastic
- Aluminum foil
- Commercially made devices
c. When to Apply an Occlusive Dressing
   - Occlusive dressings should be placed over the wound when the patient exhales.
     - Vented commercial devices are preferred.
     - Improvised chest seals should be taped on 4 sides.

9. Tension Pneumothorax and Commercial Chest Seals
   a. Tension Pneumothorax
      Blunt force and penetrating injuries to the torso can cause damage to a lung. This lung damage can cause the lung to collapse.
      This injury can cause both respiratory and circulatory compromise.
   b. Suspect a Tension Pneumothorax If the Casualty Has:
      - A chest injury;
      - Difficulty breathing; and
      - Altered mental status.
   c. Treatment of a Tension Pneumothorax
      - This injury can only be managed in the field by ALS providers, BUT early recognition and application of occlusive dressings to open injuries can save a life.
      - Advising an ALS provider of the symptoms of this suspected injury and early intervention increases a casualty’s chance of survival.
      - Body armor may be moved aside to assess a casualty’s torso if tactically feasible.
      - A patient with altered mental status and minimal or abnormal respiratory effort or sounds should be considered critical.

10. Shock Prevention
    a. Body Temperature Control
       - The human body functions best when at a normal body temperature of 98.6 degrees.
       - A patient in shock can no longer generate their own body heat leading to hypothermia.
       - A hypothermic patient may have uncontrolled bleeding since they lose the ability to form blood clots.
       - If the casualty is too hot, cool them and loosen constrictive clothing including body armor.
       - Limit the amount of fluids but never give fluids by mouth when the casualty has an altered mental status or is unconscious.
         - A conscious and alert casualty can drink water as desired
       - If the casualty is too cold, cover to keep warm. Protect a casualty from the ground temperature by placing some barrier between them and the surface they are laying on.
Section 4 Evacuation Phase

A. Evacuation Care

The phase in which a casualty is moved from a scene to be further assessed by medical personnel and transported to definitive care. The objective of Evacuation care is to maintain or improve the aid rendered during the Direct and Indirect Threat Phases and to deliver the casualty to definitive care.

1. Continuing Care

A casualty assessment, ideally by medical personnel, should be conducted and care should be rendered as equipment and personnel are available.

- Utilize additional resources to affect a positive medical outcome.
- Monitor and maintain proper body temperature.
- Maintain situational awareness and always anticipate a re-engagement.

2. Transport to Definitive Care

Definitive Care is a location where the full spectrum of resources needed to treat the casualty are available. Once triage has been established by EMS, transportation of casualty to appropriate hospitals for further treatment is the final step in the T.H.R.E.A.T. acronym. This can be via ground transport ambulances or air medical services. Definitive care hospitals will depend upon the nature of the victim’s injuries.

3. Method of Transfer

The method of transporting a casualty to a medical facility will often depend on the resources available, the specific situation, and the identity and condition of the casualty.

a. Cruiser Transport

Law enforcement officers should follow their department policy when deciding whether to use a police vehicle to transport a casualty. Officers should consider the following:

- The severity of the casualty’s injuries;
- The police vehicle’s capabilities (depending on terrain); and
- The distance to the hospital or trauma center.

b. Ground or Air Ambulance Transport

First responders may request transport assistance from ground or air ambulance services when handling a casualty. Law enforcement officers should consider that many EMS protocols prohibit EMS and Fire personnel from entering an active and dangerous scene. Law enforcement command and supervisory staff should develop protocols and working relationships with their local and/or neighboring EMS and Fire/Rescue personnel. In some cases, an officer may need to accompany an individual in custody or an injured officer.

c. Special Vehicle Rescue

It may be necessary, depending on the situation, terrain, etc., to extract or transport a casualty away from an active tactical incident. These vehicles could include but are not limited to ATV, armored vehicle, boat, etc.
4. Destination Determination and Notification

Patient destination decisions are often made by medical professionals or by standing state protocols. If a law enforcement agency permits the use of police vehicle to transport a casualty if tactically necessary, hospital protocols must be followed.

Officers must be able to notify hospitals that they are transporting a casualty and their condition. Time saved in transport by using LE vehicles is wasted if the appropriate people at the hospital are not alerted ahead of your arrival.

5. Care in Custody

Officers may be faced with decisions to provide for their own care, the care of injured victims or bystanders, and injured subjects.

Officers should follow their departmental policies regarding the care of suspects in custody.

a. Priority of Care

Unlike the priority of life scale, this scale addresses the priority of care given to individuals injured in a violent encounter. The primary role of a law enforcement officer in a violent encounter is to stop the threatening action.

Officers must maintain their ability to address and defeat threats during all phases of casualty care. This mission cannot be successfully completed if an officer’s injuries prohibit them from acting effectively.

Therefore, in order to effectively counter threats, it is imperative that officers quickly and effectively treat their own life-threatening injuries or assist their partners in treating their injuries.

The priority of care for a law enforcement officer should be:

- Self-care

Once the immediate threat has been mitigated (Indirect Threat Phase), officers can provide:

- Partner care
- Victim / Bystander care
- Subject care

The priority of care must be balanced by the seriousness of the injuries and the tactical realities present at the scene.