Texas Commission on Law Enforcement
Officer Standard and Education

Texas Tactical Police Officer’s Association
Instructor Lesson Plan

Subject: Self-Aid/Buddy-Aid for Law Enforcement
Instructor (train the trainer)

TCLEOSE#: 
PPD#: 

Instructors: Add specific instructor's names here
Phone: Add instructor(s) contact phone number here

Time Allotted: 16 hours

Instructor Aids: Laptop Computer; Projector with screen; Power Point; Medical Kit Contents; Skills break-out sessions; outcome based training scenarios

Student Materials: Handouts with note taking space, pen, full duty/tactical rig, NO WEAPONS

Prerequisite Experience of the Learners: Full-time or reserve local, state or federal law enforcement, active duty military; No prior medical knowledge/training necessary

GOAL (PURPOSE OF COURSE): For students to be able to provide immediate Life Saving Skills in the Law Enforcement Environment

Date Prepared: March 2010
Prepared By: David Flory
Brian Lankford

Date Revised:
Revised By:
Instructors’ Profile

Insert bio of specific instructor(s) here..............................

Course Schedule

16 Hours (dates/times to be determined by host agency/instructor)

Introduction to the course:

As a law enforcement officer you will likely be exposed to high-risk situations throughout your career that have a potential for creating injuries and illness to you, your fellow officers, and civilians. Being able to provide medical aid to those in need can reduce the effects of the injury and increase the chance of the victims’ survival. Remember, the life you may be saving could be that of your own.

This is an instructor course whereby students will learn how to teach the SABA concept consisting of the history of Self-Aid/Buddy-Aid, the TCCC concept and history, use of tourniquets, pressure dressings, etc. Throughout the course, instructor-students will learn how to motivate students and exercise “teach back” techniques in order to ensure that end-user students are absorbing the material.

Instructor’s Lesson Plan

Subject: Self-Aid/Buddy-Aid for Law Enforcement Instructor (train the trainer) Program
Self-Aid/Buddy-Aid (SABA) Programs: Need, History and Concepts

TERMINAL OBJECTIVE
Upon completion of this module, the participant (student) will recognize the need for Self-Aid/Buddy-Aid (SABA) training, the history and development of SABA concepts and its importance on American law enforcement

ENABLING OBJECTIVES
The participant (student) will be able to:

- Illustrate the need for SABA programs.
- Understand how SABA programs can be a life saving tool for law enforcement
- Explain the history of SABA Programs and cite National events that have helped create the need for SABA programs
- Explain how the military model of Tactical Combat Casualty Care (TCCC) has influenced the development of civilian law enforcement SABA concepts and programs
- Define Self-Aid, Buddy Aid and Medic Aid and be able to differentiate each from the other
- Compare the strengths and vulnerabilities of these different types of aid

I. PREPARATION (Student Motivation/Opening Statement)

INTRODUCTION
Law enforcement is safer today than it was even as little as a decade ago. With strides in equipment, body armor, vehicle design and safety tactics to name a few, we’ve improved our ability to minimize officer’s injuries and deaths. However, as the families of more than 100 of our colleagues who died in the line of duty during 2009 will attest, we’ve not eliminated these risks altogether therefore, it is imperative we equip our officers with the knowledge and tools to mitigate and minimize the consequences of
injuries when they occur. We can no longer afford to bury our heads and just strive for zero injuries. Until we get there, we must prepare, and to prepare, we must teach lifesaving skills to all our officers. What has been limited historically to the tactical team medic or delegated to the civilian fire/rescue or EMS agency now must be delivered to the hands of each officer who has the potential for hostile contact. Hence, we present the “Self-Aid/Buddy-Aid (SABA) program and concept.

In order for this information to be passed on to those officers that need to know it, qualified instructors must understand the concepts behind the SABA and TCCC and must be able to impart that knowledge to students.

II. PRESENTATION

1.1 The goal of the Self-Aid/Buddy-Aid for Law Enforcement Class is to provide each Law Enforcement Officer the knowledge, skills set and tools necessary to survive or save a fellow officer’s life in time of crisis. All models of this class are based upon the basic principles of the Tactical Combat Casualty Care (TCCC) adopted by the military. This class IS NOT a basic First Aid Class. The students attending this class will learn ways to stop life-threatening hemorrhage through the utilization of Tourniquet application, hemostatic agents and pressure dressings. Students will learn that sometimes the best medicine on the battle field is being able to locate, isolate and eliminate a current threat. Students by the end of class will also learn the importance of first extracting and officer from the area of wounding takes priority over performing a medical intervention at the wrong time. Students will also learn how to recognize and treat severe chest injuries as well as how to place a victim in the recovery position while waiting on EMS or extraction to a more safe/secure location.
Read disclaimer verbatim to students and emphasize that because this is a medical class, students are encouraged to check with their agencies medical director for approval of techniques and adjuncts. Explain that this program was developed under the direction of Dr. Alex Eastman, MD who is the Medical Director for TTPOA and any deviation from the information provided must be approved in writing by Dr. Eastman.

Emphasize that although our research supports that the adjuncts that we will be issuing to the students are of a certain make/model, etc. TTPOA does not endorse one over the other, except those that are recommended by the US military Committee on Tactical Combat Casualty Care (Tccc) nor does TTPOA receive compensation or benefit from any manufacturer of products discussed in this program.

Motivating Statement #1 ………..Stress to the students that this is why they are here. It is important for them to know that this is a life-saving technique school; maybe their life, maybe their fellow officer’s life.
Motivating Statement #2...........Explain that this is why this particular training is important. In the event of a severe injury, there might not be time to wait on EMS to arrive before treatment is started.

Officers must have a basic understanding and knowledge of how to provide medical aid/interventions to themselves and or their fellow officers.

Motivating Statement #3............Except for those trained in Tactical Medicine, most EMS personnel are not trained nor properly equipped (ballistic vests/helmets/weapons) to enter a scene that is still "active" and are required by policy to wait (stage) until the scene is safe.

As Paramedics, you understand the “Golden Hour,” your students may not understand this concept. You may want to explain how long it takes to bleed out from an arterial bleed or how long before a person dies from hypoxia.

In the event of severe injury, medical intervention must be initiated immediately. Being able to start this medical treatment prior to EMS arrival may help sustain the victim until he/she can reach definitive care.

A reiteration of the requirement for Fire/EMS personnel to stage until the “scene is safe” This delay in medical attention could result in death to an officer.

If not staged, a delay in response can be due to traffic, lack of EMS units available, etc.

This is a slide that you should reference as to what is killing officers in the U.S. It is taken from the time period 1997-2007 as provided by the FBI. It shows the kinds of events that officers died in. It does not address what the injuries were that caused the death but is a good visual slide that can serve as an attention grabber for police officers. This is just the tip of the iceberg; We know that some of the officers’ lives could have been saved with proper SABA care. Also, point out the graph on the right that shows over 500,000 that were injured in assaults.

As an aside note, in calendar year 2009 there was an increase of 63% of officers killed by handguns. That statistic alone should hammer home to your students the need for understanding the need for SABA training. Additionally, you might cite the recent (2009) rash of ambush assaults against U.S. police officers around the county.
Although there are a number of events nationally where officers were treated by the use of SABA skills, two of these three occurred in Texas and were highly publicized.

Details:
On August 30, 2006 Dallas Police Patrol Officer, Jeremy Borchardt answered a disturbance call at a Dallas hotel. A male suspect, who was assaulting a female inside the room (the nature of the original disturbance) shot through the door of the hotel room striking Borchardt in the upper leg, nicking his femoral artery. Officer Borchardt’s assist officer had been through Dallas PD’s SABA training as part of their patrol-rifle program and performed a drag to evacuate Borchardt from the opposite side of the suspects’ hotel room door. Dallas FD medics who were also on scene had to leave their equipment which had also been staged on the opposite side of the door. Borchardt’s assist and Medics loaded the wounded officer into the back of the MICU without a stretcher, applied direct-pressure and a make-shift tourniquet and drove to the hospital. The tourniquet saved Borchardt’s life.

On July 11, 2008, Wichita, Kansas patrol officer Derek Purcell was shot twice, once in each leg, by 26 year old Francisco Aguilar. Purcell had been dispatched to an intersection on a report that Aguilar was “acting suspiciously”…....a call that occurs in most American cities, everyday.

Purcell found Aguilar walking down the sidewalk of a neighborhood street. Purcell got out of his patrol car and approached Aguilar to question him. As he called for Aguilar to stop, Aguilar spun around and for no reason fired twice at Purcell striking him twice; once in each upper leg. Purcell returned fire but missed with four shots.

One of the responding officers had been an Army medic. He applied direct pressure with his own uniform shirt and a make-shift tourniquet from Purcell’s inner belt. This is a great example SABA

The Fort Hood shooting was a mass shooting that took place on November 5, 2009, at Fort Hood, Texas, the most populous US military base in the world, located just outside Killeen, Texas—killing 13 people and wounding 30 others. The accused perpetrator is Nidal Malik Hasan, a U.S. Army major serving as a psychiatrist. He was shot by civilian police officers, and is now paralyzed from the waist down.

At approximately 1:34 p.m. local time Hasan entered his workplace, the Soldier Readiness Center, where personnel receive routine medical treatment immediately prior to and on return from deployment. According to eyewitnesses, he took a seat at an empty table, bowed his head for several seconds and then stood up and opened fire. Initially, Hasan reportedly jumped onto a desk and shouted: "Allah!", before firing more than 100 rounds at soldiers processing through cubicles in the center, and on a crowd gathered for a college graduation ceremony scheduled for 2 p.m. in a nearby theater. Witnesses reported that Hasan appeared to focus on soldiers in uniform. He had two handguns: an FN Five-seven semi-automatic pistol, which he had purchased at a civilian gun store and a .357 Magnum revolver which he may not have fired. A medic who treated Hasan said his combat fatigues pockets were full of
pistol magazines.

Unarmed army reserve Captain John Gaffaney attempted to stop Hasan, either by charging the shooter or throwing a chair at him, but was mortally wounded in the process. Base civilian police Sergeant Kimberly Munley, who had arrived on the scene in response to the report of an emergency at the center, encountered Hasan exiting the building in pursuit of a wounded soldier. Hasan shot Munley, while witnesses claim Munley also fired at Hasan. Munley was hit three times: twice through her left leg and once in her right wrist, knocking her to the ground. Munley was treated by a fellow soldier who had been trained in the military TCCC buddy aid concept. This aid included the application of a tourniquet to stop bleeding from a femoral wound.

The incident, which lasted about 10 minutes, resulted in 30 people wounded, and 13 killed — 12 soldiers and 1 civilian; 11 died at the scene, and 2 died later in a hospital.

Slide 10

SABA-HISTORY

SABA is not a novel concept, it is simply a program designed to train police officers in simple, lifesaving techniques that have been proven to be effective. The delivery of training in life-saving techniques to nonmedical providers and fighters is not new. First believed to be attributed to Napoleon’s army, it is clear that even early descriptions of Self-Aid/Buddy Aid (SABA) programs exist. SABA, as a general concept, involves placing lifesaving skills and tools in the hands of people most likely to suffer injury. In short, it essentially involves taking trauma center concepts out of the hospital and moving them to the point of injury. These programs are a theoretical offshoot from the fact than when people are injured, the earlier care begins the better the outcome. While these concepts are indeed those that were born in trauma centers and field hospitals, the effectiveness of SABA programs is based on the simplicity and profound effectiveness of the basic techniques. It has been clearly proven that these techniques can be easily taught to police officers, soldiers, or anyone engaged in high-risk occupations (Butler, 2003).

The origins of EMS date back to the days of Napoleon, when the French army utilized horse drawn “ambulances” to transport the injured soldier from the battlefield. Its more recent incarnation can be traced back to 1869, when Dr. Edward L. Dalton at Bellevue Hospital, then known as the Free Hospital of New York, in New York City started a basic transportation service for the sick and injured. The component of care on scene began in 1928, when
Julien Stanley Wise started the Roanoke Life Saving Crew, the first rescue squad in the nation. Over the years EMS continued to evolve into much more than a “ride to the hospital.”

In particular in the US state of California and in King County, Washington state, projects began to include paramedics in the EMS responses in the late 1960s. Despite opposition from firefighters and doctors, the program eventually gained acceptance as its effectiveness became obvious. Furthermore, such programs became widely popularized around North America in the 1970s with the television series, *Emergency* which in part followed the adventures of two Los Angeles County Fire Department paramedics as they responded to various types of medical emergency. The popularity of this series encouraged other communities to establish their own equivalent services.

In a return to the military roots of EMS, the United States Army has developed the combat lifesaver program to instruct soldiers in advanced first aid and limited paramedic skills including intubation. The combat lifesaver is intended to bridge the gap between self-aid / buddy-aid and the platoon medic on the 21st century decentralized battlefield.
Tactical Combat Casualty Care (TCCC): The science behind the Self-Aid/Buddy-Aid Concept

TERMINAL OBJECTIVE
Upon completion of this module, the student will be able to understand the history and development of Tactical Combat Casualty Care (TCCC) and its influence on the Self-Aid/Buddy-Aid concept.

ENABLING OBJECTIVES
The participant will be able to:
- Explain that the science behind SABA is based upon the military model of TCCC
- Define (TCCC or TC3)
- Explain the history and evolution of TCCC and its impact on America’s Military Personnel
- Understand and explain the impact of TCCC on American Law Enforcement to include:
  - FBI Law Enforcement Officer Killed and Assaulted (LEOKA) Program
    - IACP SafeShield Program and new data collection program
  - Limitations to
- Recognize and fully define the main goals of TCCC and how those concepts apply to Law Enforcement SABA Programs
- List, define and explain each of the three phases of TCCC and how they apply to SABA
No group has learned more about the care of the injured over the last decade than our nation’s armed forces. It is said that one of the few good things that comes from war are a number of improvements in the care of the injured warrior. Now more than ever, those improvements learned overseas and paid for with American blood are being rushed into the civilian trauma care environment. While a number of advances have revolutionized the care of the injured, none has served as a greater “force multiplier” from a medical standpoint than the delivery of lifesaving training and tools not just to the military medic, but to the warriors themselves. In reviewing the Joint Trauma Theater System that has saved so many lives during OEF/OIF, Col. Brian Eastridge, JTTS Director, has identified the delivery of SABA training and tools as the critical first link in the chain of survival (Eastridge BJ, Jenkins D, Flaherty S, et al., 2006).

The SABA Program and its techniques are based on sound science and the proven techniques known collectively as Tactical Combat Casualty Care. Originally designed to address the profound failure of military medical doctrine in Mogadishu, Somalia in 1993, the US military started the Tactical Combat Casualty Care (TCCC) project ultimately developing a set of tactically appropriate battlefield trauma care guidelines. Much of the content of these guidelines were geared towards those interventions that could be taught to the troops, hence multiplying the available number of “medics”.

Since the first course in 1996, TCCC is now standardized from the war-fighter/operator to the physician. Many civilian medical organizations including the American College of Surgeons Committee on Trauma (ACS-COT) and the Pre-Hospital Trauma Life Support Program (PHTLS), as well as law enforcement and EMS agencies, including the National Tactical Officer’s Association (NTOA) and the National Association of EMT’s (NAEMT) have adopted these guidelines for conducting operations in environments where the risk from penetrating trauma is a reality. With the DoD implementation of TCCC guidelines, US forces have achieved the lowest percentage of Killed in Action and Case Fatality Rate in recent recordable history (1945-present) (Eastridge, et al., Dec 2009). The TCCC recommendations were “somewhat at odds” with civilian pre-hospital guidelines.
being taught at that time, but the advantages of having battlefield trauma guidelines customized for the tactical environment was quickly acknowledged.

It is a common misconception from the civilian sector that the TCCC guidelines are only applicable in a 360° military battle space similar to that seen in *Blackhawk Down*, or in the middle of the streets of Iraq or Afghanistan. However, nothing could be farther from the truth. The reality is that TCCC addresses optimal casualty care within a hostile environment when there is an unknown or variable evacuation time or potential delay in casualty transport. The average transport time to a medical treatment facility (MTF) in Iraq can be less than one hour, which is not unlike situations that may be encountered here in the United States. Weather, traffic, rural response, mass casualty, and ongoing tactical operations against active threats can contribute to longer transport times to definitive care in the civilian environment. Many also question the relevance of these guidelines due to the epidemiology of “battlefield” injuries compared to injuries likely to be encountered during civilian tactical operations. While military forces face a higher incidence of explosion and fragmentation injuries, penetrating trauma remains the predominant cause of injury and death. A gunshot wound that severs a police officer’s femoral artery is just as likely to cause death from blood loss as a shrapnel wound that severs a soldier’s femoral artery, and both are equally amenable to immediate life-saving treatment.

**HISTORY OF THE BATTLE OF BLACK SEA**

In 1992, the United States sent Marines to Somalia as part of a United Nations peacekeeping force (Operation Restore Hope) providing food to millions of starving people. Due to a civil war that had cost the lives of more than 300,000 people, international intervention was more than warranted.

After the conflict quieted down and U.S. Marines departed, local warlords battling for control of Somalia soon raided UN food distribution sites and killed UN personnel. The warlords controlled the country by starving their people. No matter that the rest of the world was supplying vast amounts of aid to relief organizations, the people were starving to death by the thousands.

Following the slaughter of UN peacekeeping forces, the United States responded with a show of force. Task Force Ranger was sent to Somalia with the primary mission of arresting warlord Mohamed Farah Aidid and his fellow clansmen for crimes against humanity.

On 3 October 1993 members of the Delta Forces and Rangers were engaged in a pitched battle against rebel forces on the streets of Mogadishu, Somalia. The mission had been to extricate rebel leaders from a known meeting place and should have been completed within an hour. Having met heavy rebel opposition, the 18 hour battle
resulted in the loss of 18 soldiers, with scores of injured. The command had requested armored vehicles and AC-130 gunships as support for Task Force operations. Those requests had been denied by the Clinton administration, so Task Force Ranger did the best they could with the equipment they had.

The men who fought this battle did so in a noble and courageous manner. Two soldiers were awarded the Medal of Honor (posthumously). Other members of the group were awarded the Silver Star, Bronze Star, and Purple Heart, with the "V" device to signify valor under fire.

Although the Rangers and Delta Forces sustained heavy casualties, they had accomplished their objective, having taken important rebel leaders prisoner. Critics of the military and this mission argue that the daylight raid was a failure. They had completed their mission, but four Black Hawk helicopters were shot down during the raid. A secondary mission became necessary. Protecting the lives of their fellow soldiers according to the Ranger Creed gained greater importance.

The Delta Forces and Rangers stood their ground and rescued as many of their men (including the dead and wounded) as was possible given the circumstances. One of the Black Hawk pilots having been shot down in the area of operation was captured and held prisoner for eleven days.

This pilot would not have survived had it not been for the two Delta snipers who gave their lives (subsequently earning the Medal of Honor) in defense of the pilot and his downed aircraft.

The United States woke on 4 October 1993 to see images on the news of dead Rangers and Delta Forces personnel being mutilated and dragged through the streets of Mogadishu. The bodies were later recovered and each was buried with appropriate military honors.

The battle was sensationalized by the movie "Black Hawk Down."

Instructor Notes

Show Blackhawk Down video as an example of what TCCC looks like from the military perspective.
Introductory slide for motivating students about what is coming next; a closer, more in-depth look at TCCC.

“So let’s, take a closer look at TCCC.”

Although TCCC is a concept that is borrowed from the military the fact that American law enforcement officers are subject to similar (i.e., gunshots, blast injuries, etc.) makes this concept one that makes sense to utilize.

When explaining the TCCC concept to students it might be helpful to understand that there is very little data to show that a significant number American police officers have died as the result of the failure to utilize TCCC concepts and/or adjuncts because of a lack data drawn upon from the FBI’s Law Enforcement Officers Killed and Assaulted (LEOKA) as LEOKA data does not capture “saves” of officers that had SABA type treatment applied to them. Therefore, it is hard to empirically substantiate the value of SABA programs for Law Enforcement.

**Read article taken from the 2010 winter addition of the NTOA’s Tactical Edge written by Dr. Mathew D. Sztajnkrycer, MD which is in your resources section in order to understand the correlation between military TCCC concepts and America LE self-aid/buddy-aid concepts.***

Here is the bottom line as taken from a quote from Dr. Sztajnkrycer’s article: “……Despite strong evidence to support the use of TCCC in combat, no studies have examined the appropriateness of TCC for American Law Enforcement medical care. Unlike the military, the law enforcement community has not performed studies examining the types of lethal injuries suffered by officers during felonious assault, nor possible interventions to prevent death or disability. “

“Finally, it must be noted that the LEOKA data set is limited. It does not capture every line-of-duty death in LE. LEOKA does not capture information on circumstances in which officers were critically injured yet survived wounds (“near misses”).

In an effort to better track officer injuries where there is no fatality, the IACP (International Association of Chiefs of Police) has begun a pilot study whereby
agencies across the U.S. will begin a new reporting system whereby ALL injuries to officers will be reported and the statistics will be tracked. Three agencies in Texas have been selected for a one year study:

Dallas, Bedford and Woodway PD’s each representing a large, medium and small agency. It is our hope that this study may be a springboard for more collection of data that may be valuable in assessing SABA concepts in the mitigation of injuries.

Additionally, the IACP SafeShield Committee, a committee that studies safety issues for American police officers has agreed to endorse the SABA concept from a national level and has created a sub-committee to promote the program they are calling: “Save Our Own.” Dr. Eastman and Chief Flory are members of the sub-committee and will update the instructional cadre as information is available.

Here is a slide provided by Col. Ron Bellamy, member of the Committee on TCCC. It shows the kinds of injuries that historically been killing U.S. solders in a variety of war theaters. Stress to students that the key statistics are those showing KIA- Exsanguination (9%) from extremity wounds and 1% from Airway Obstruction. If statistics are similar to L.E., that is potentially 10% off American Officers whose lives could be saved by SABA techniques.

Emphasize these 3 important goals of TCCC
Suggested comments:
“Look guys, we are going to try and make this concept pretty simple; the three main goals of TCCC are:
• Prevent Further Casualties
  - Get off of the X and get your buddy off of the X
  - Take cover/find concealment
  - Eliminate the threat (lead down range)
  - Mission success
    ▪ Finish the original mission if possible
• Treat the Casualty
  - This means, you have got to give fast, proper and adequate first aid care to yourself and/or your fellow officer. TREAT, means just that…….not wait for an ambulance!”
Introductory slide as motivator for student(s) having an understanding of the 3 critical phases of TCCC.

**Suggested comments:**
"Okay, let’s get into the actual phases of TCCC. They are:
- Care Under Fire
- Tactical Field Care
- Tactical Evacuation

This is the actual definition of what Care Under Fire is…

It is important to stress to your students that this is a critical point in this entire concept of SABA. It may be necessary to treat yourself and or a buddy in order to stay in the fight and live to see the next fight.

We will cover what to carry and how, later in the program.

**Details of incident:** Maricopa County, Arizona (Phoenix) Sergeant Glen Powe was part of a SWAT operation serving a high risk search warrant on October 5, 2006. The suspect was lying in wait with an automatic AR15 rifle and fired at Glen as soon as he entered the door. The first two rounds hit him on the lower back, missing his spine. Glen turned to engage the suspect with his rifle and took a round to his “EO tech” sight. The round sent shrapnel into his left hand (he’s left handed), slicing off his thumb and severely mangling his hand which caused him to drop his rifle. At that point he took 14 additional rounds to his steel trauma plate which sent shrapnel into his biceps but did not cause any significant damage. Glen went to the ground and was rescued when the suspect's attention was diverted by a flash bang deployment to the rear bedroom. Glen took 9 months to recover. The suspect was a 60 year old Vietnam Vet who is now spending life in prison.

In the video you can hear the operators yell “failed breach” before pulling the door off. The narrator says they did not return fire because of the family. This is not true. Glen did not return fire because his left hand was mangled. The other officer who tried to enter the doorway to engage the suspect retreated when he was shot in the leg. As soon as they were able to rescue Glen, the team treated the incident as a barricade.
Glen suffered significant damage to his intestines and his left hand but is otherwise fine. He is still working for the Sheriff’s Department and giving seminars around the country about his experience.

SUGGESTED BREAK HERE
TERMINALE OBJECTIVE
Upon completion of this module, the participant/student will be able to define, explain and demonstrate the management plans for each of the three phases of the TCCC concept.

ENABLING OBJECTIVE:
The participant/student will be able to:

- Define each of the 3 management plans under the umbrella of TCCC
  - Care under fire (CUF)
  - Tactical Field Care (TFC)
  - Tactical Evacuation (TACEVAC)
- Demonstrate knowledge of the components of each management plan to include:
  - Reasoning behind each plan
  - Implementation of each plan
  - Steps of each plan
- Demonstrate (hands-on) the proper use of each adjunct associated with each management plan
- Explain the when, why, where and how for each adjunct
- Explain how to recognize the success and/or failure of the effects of each adjunct
This is the nuts and bolts slide that gives detailed description of what CUF is. This is an important slide and concept that needs to be hammered home with students. Spend significant time with this slide and emphasize each bullet point.

1. Stress to students that they MUST get it in their head to remember to return fire if possible and if justified. Accuracy counts.....remind them to keep their head and be precise.

2. Stress to students that this is not a medical class; this is a gun-fighter class with extra tools in an officer’s tool box if they get injured.

3. The right medical intervention at the wrong time will get you or your fellow officer killed

4. If treating in a Buddy-Aid mode, expect/encourage partner to continue firing if possible and if justified

5. Give clear and concise instructions to partner to moved to cover/concealment if possible and treat himself

6. Reduce the possibility of additionally wounding

7. **GET OFF OF THE “X”**

8. Treat the wounds (how to treat is coming next)

A good “hammer home” **summary** for the core concepts of CUF........talk this one up......

I think the important message here is that just because we are teaching you guys the basic “concepts” of TCCC doesn’t mean that the tactical situation will necessarily let you to accomplish CUF in the order that we are showing you. The situation itself will dictate if you “Get someone off the X” first, or if “lead and copper downrange” comes first or maybe even both simultaneously etc. I also think it’s important for us to stress that we can very easily go from the CUF phase to the TFC phase and then back to the CUF phase in a matter of seconds. It’s kind of like the use of force continuum in the “slice of pie” model vs. the old triangle example. Officers will understand their use of force policy and know that you don’t have to utilize officer presence, verbal, hands on, less lethal, then deadly force in THAT order during a combat situation where there are casualties.

A truthful slide that ends with a slight joke......”all bleeding stops eventually”............meant to imply that if you do nothing or don’t adequately treat yourself or your buddy, you’re going to die!
An introductory slide announcing that the next topic is TFC

Definition bullet points explaining what TFC is. Emphasize that this phase is **ONLY** after the threat has been eliminated or you are behind cover. Stress to students that TFC **MUST** not be done while still under fire. If they are still under fire they must return fire and get off the X before self aid.

- This is a skill that will be practiced later in the program but make sure to stress that downed officers will need to be disarmed due to a potential altered mental status.
- When disarming, remember to unload and secure the weapon but DON’T leave an unarmed officer alone and unprotected!
- Explain why “head to toe” is done in this manner/sequence
- Stress **EFFECTIVENESS** is the key

Give the students the provided IFAK kit. Keep this procedure controlled so students don’t open something that is sterile. Talk about each piece of equipment as they come in the presentation. So, for purpose of this break-out session, only have them unpack their tourniquet. This may be a good point to remind them about the fact that this equipment is what is recommended by CoTccc.
Slide 30

An introductory slide for the SOF-T Tourniquet. This is what their tourniquet should look like.

Have students remove the Tourniquet from its packaging and let them play with it for a minute or two. They tell them that the next video will give a good explanation on how to use it.

Slide 31

An introductory slide that shows the Sof T Tourniquet application. The next slide (video) shows its application in depth.

This slide’s purpose is only a visual eye-catcher as a lead in for the next video that goes over the use of the SOF-T.

Instructor Notes

Show SOF Tactical Tourniquet video here.

Slide 32

This photo is an example of someone dying as the result of wound exsanguination.

Although a photo taken of one of U.S. military, it is an injury that a police officer could encounter in a blast injury, vehicle crash, etc.

Slide 33
Conversely, just as bad (or worse) of a wound where this soldier lived as the result of the application of multiple tourniquets.

Another example of the use of tourniquets.

Point out to your students that these are "make-shift" tourniquets (see the paint brush). Stress to students that anything can work in a pinch.

Again, make-shift, multiple tourniquets

In the previous slide where we introduced Tactical Field Care (#28), we talked about the need to perform a head-to-toe assessment of a victim officer. Before showing this video, explain to the student that this is what a "wound sweep" head-to-toe exam should look like.
An introductory slide for Quickclot Combat Gauze. A stair-step approach to revealing all of the contents of the IFAK.

Have students remove their package of Combat Gauze from IFAK but DON’T open it as it is a sterile dressing. Use the Combat Gauze trainer packages for demonstration purposes and hands-on training.

EXPLAIN THAT THE REASON THAT TTPOA HAS ADOPTED THIS PRODUCT AS THE HEMOSTATIC AGENT THAT WE SUGGEST IS BECAUSE THE COMMITTEE ON TCCC (CoTCCC) HAS DONE STUDIES ON ALL HEMOSTATIC AGENTS AND THIS IS THE ONLY ONE THAT THEY RECOMMEND. IF THIS CHANGES, TTPOA WILL UPDATE OUR RECOMMENDATION.

(NOTE: AS TTPOA INSTRUCTORS, DR EASTMAN MAY BE CONSULTED IF YOU WISH TO DISCUSS THIS TOPIC FURTHER AS HE HAS PERSONAL EXPERIENCE WITH POWDER HEMOSTATIC AGENTS IN THE SURGICAL SUITE)

Tell your students that QuikClot Combat Gauze is a 3-inch x 4-yard roll of sterile Hemostatic Gauze that is impregnated with “Kaolin”. Kaolin is an advanced hemostatic agent that controls blood loss by rapidly promoting coagulation
- Explain what “Hemostatic” agent means and a brief explanation of coagulation

A slide that introduces the concept of using direct pressure along with combat gauze. Introduce to your students the concept of using pressure “proximal” (tell them what this means) to the wound along with combat gauze.
A slide that explains how hemostatic Combat Gauze works to clot the blood. No need to go into great detail of the coagulation cascade theory that it simply clots the blood by its chemical make-up.

It is safe to leave in the wound and won’t burn the skin unlike some other hemostatic (powder) agents.

A slide that shows the proper use of Combat Gauze. Stress to students to pack the gauze tightly into the wound and DIRECTLY onto the source.

Self explanatory……..read verbatim if necessary

Self explanatory….read verbatim if necessary
Break out session can consist of one of the following:

1. Build and utilize TTPOA designed wound packing device (equipment list and instructions included in resource pack)
2. Utilize pork loin/pork shoulder device (equipment list and instructions included in resource pack)

OLAES got its name from United States Army Staff Sergeant and Special Forces Medic Tony Olaes who was killed on September 20, 2004 in Afghanistan. The name of the bandage was given as an honor to Olaes by Ross Johnson of Tactical Medical Solutions, the manufacturer of the OLAES.

After showing video, demonstrate how to use the OLAES Bandage
Somewhat self explanatory but use your knowledge to explain the concepts about how to apply direct pressure.

When performing OLAES break-out session, take the time to first explain the concept of pressure dressing’s and how they work. Be sure to include in your discussions the value of elevation of the injured sight to further mitigate bleeding.

Instructors need to stress to students that this is a basic class and airway management needs to be addressed from a basic perspective. There is really only one airway remedy that we need to look at when someone determines that a victim is not breathing.

1. Head-tilt/Chin-tilt

A slide to use when showing how to perform the Head-tilt/Chin-lift method. If you have access to an airway head mannequin, feel free to use it for demonstration purposes or find a student in the audience that will volunteer to have this procedure demonstrated on them.
A slide to use when showing how to perform the recovery position. If you have access to a mannequin, feel free to use it for demonstration purposes.

Explain what purpose that the “Recovery Position” serves.

The “Recovery Position” allows the victim/patient to maintain their own airway. Explain what happens with the tongue when a victim is on their back.

Explain to students what causes a sucking chest wound and that any kind of penetrating trauma (gunshot, knife wound, etc.) can cause this.

This is how most gunshot wounds will present. Minimal bleeding...from a non-medically trained police officer perspective, this might not look too bad. Stress to students that even though this might not look “too bad” it most likely is a sucking wound or will turn into a tension pneumothorax.
Emphasize the “navel to neck” (front or back) concept.

An introductory slide with a visual example of the different types of chest seals (Asherman, Bolin, Vaseline, etc.) A further step-by-step reveal of the adjuncts contained with the IFAK.

TTPOA currently recommends and will issue a Vaseline gauze chest seal. If we decide to recommend/issue a different one, we will put that information out to all instructors. Stress to students that in a pinch, there are a number of things that can serve as a chest seal such as: a plastic baggie, a piece of plastic newspaper bag, a small piece of trash bag, etc.

This slide is just intended for you, the instructor to mention what a Tension Pneumothorax, how it develops and how it is treated. We only what you to mention it here as a point of information and to stress that this is why the concept of TEMS and having Paramedics attached to SWAT team is important.

As a side note, some agencies are electing to teach their SWAT officers in how to perform this intervention. If non-medically trained police officers are to be taught this concept and adjunct, it would need to be handled on a local level under control of a Medical Director.
Opening slide for the introduction of TACTICAL EVACUATION (TACEVAC)

An introductory slide that gives a definition of TACEVAC

An explanatory slide for what kinds of remedies there are for EVAC.....

Special Instructions

Stress to students that the main issue is to GET OFF OF THE “X”

An introductory slide that introduces the casualty extraction concepts of “Drags, Pulls and Carries.”
This slide and the next one show examples of the kinds of drags, pulls and carries mentioned in the previous slide. There are other extrication techniques that students may bring to your attention. Feel free, if time permits, to allow those to be talked about, describe and/or demonstrated but at least show these basic skills and make sure everyone is able to perform them.

**Special Instructions**

Show Tactical Rescue Myths video here. The only purpose of showing this slide is that it is a good example of what does/does not work well.

Define Hypothermia for your students as a body temperature significantly low enough to cause poor mentation, etc.

Preventing shock is a key reason to understand hypothermia

Stress the need to keep the victim warm despite the ambient

Carry options is a topic that should be left to the individual officer and/or their department. We suggest that officers have easy access to their IFAK and may consider incorporating it into an active-shooter style “go bag” such as those pictured next.
Break here and go to scenario break-out sessions.
TERMINAL OBJECTIVE
Upon completion of this module, the instructor-participant will be able to evaluate the student-participant’s understanding of SABA training according to TTPOA standards.

ENABLING OBJECTIVES
Instructor-participants will be able to:

- Value the TTPOA philosophy for the training of law enforcement officers in the SABA concept and express support for the concepts contained in the SABA training program to include:
  - The purpose behind verbalizing and explaining the TTPOA disclaimer
  - The reason for listing, verbalizing and explaining in detail each of the course learning objectives
  - The value of supporting the Medical Director’s role in the SABA training program
  - The value of the TCCC concept as the science behind SABA
  - The value and purpose behind hands-on training as a reinforcement tool to the didactic model of training
  - The reasoning behind the emphasis of continues training/re-training of the SABA concepts

1.1 The student will be able to understand and re-teach TTPOA’s concept on certain aspects of training:

1.1.1 Verbalizing the disclaimer
1.1.2 Verbalizing all learning objectives

1.2 The student will be able understand the structure of the TTPOA’s TEMS Program to include the SABA Program and the role of the Medical Director

1.3 The student will demonstrate various instructor techniques in a classroom setting to the satisfaction of the instructor(s)
The TTPOA is a non-profit organization run by volunteer police officers and has been in existence for nearly 20 years. The association is run by a President, Vice-President, Director of Operations, Secretary, Treasurer, Training Coordinator, 8 geographical Regional Directors as well as other personnel. Per bylaws, no one is allowed to take a salary. The TEMS Cadre/Staff is supervised by a Medical Director, Dr. Alex Eastman, a Program Manager, David Flory. It is staffed by several career Paramedics, RN’s and other physicians. Each member of the TEMS cadre/staff are all either currently or have operated in the tactical environment as either a Physician, Medic and/or operator.

It is the goal of the TTPOA Self-Aid/Buddy-Aid Program to provide each and every police officer within the State of Texas with the basic knowledge, training and tools necessary to provide potentially life-saving aid to themselves and/or fellow police officers. Many of the concepts of this training are not inherently natural for officers and may provide challenges for the instructors trying to impart these ideals. As a Paramedic (or other trained medical provider) serving as an Adjunct Instructor for the TTPOA SABA program it is imperative that you are mentally and physically prepared when teaching this program.

Further, it is the belief of the TEMS Cadre/training staff that we must train our brothers and sisters in the spirit of the Warrior. This, we believe, has been lacking for some time now in our Professional Police Model and must be brought back. Additionally, as a medical provider you must be willing to teach the first tenant of medicine: DO NO HARM.

As an instructor for the TTPOA’s SABA Program, you were hand-picked based upon several criteria. This does not give you permission to think of yourself as “special” and show your ego to students. Your previous medical training, your experience and expertise, your ability to teach among other things, is what brought you here. If you show an ego to your students you will run the risk of destroying your own credibility and the credibility of this program. TEACH WITH HUMILITY AND PATIENCE; REMEMBER, YOU TARGET AUDIENCE LIKELY HAS NO MEDICAL TRAINING WHATSOEVER.
WHAT DO WE EXPECT OF YOU?

• The same commitment that we have to the program
• A professional representation of the EMS and Tactical EMS profession
• A respect for the process and program development
• A respect for your law enforcement brothers/sisters/students

WHAT SHOULD YOU EXPECT OF US?

• Similar respect on all similar points
• Program, curriculum and logistics support
• A willingness for new ideas and change to the program
• Support from the TTPOA Regional Directors that will coordinate the class you will teach
• Research information and supporting documents
• Support from Dr’s Eastman and Metzger for issues related to medical debate concerning certain adjuncts, etc.

GOAL AND PURPOSE OF THE TTPOA

• Provide quality, cost-effective to police officers and medical providers in the State of Texas and beyond
• Save the lives of Police Officers, Civilians and Suspects
• Be recognized as a leader in the arena in law enforcement training on a national level
• Follow all training rules and regulations as established by TCEOSE
• Follow the program protocols as established by the TTPOA Medical Director, Dr. Alex Eastman and the TEMS Cadre
• Teach the SABA Program based upon the TCCC guidelines
• Use Didactic and hands-on teaching methods
• Emphasize the importance of training / re-training of officers that receive SABA training.
• Stress and practice SAFETY, SAFETY, SAFETY

ATTRIBUTES OF THE TTPOA SABA INSTRUCTOR

• No egos are allowed!
  – We are a team of trainers and are expected to act as a team, not individuals
  – Teach with a passion for the subject
  – Teach with patience and respect for students
  – Express your desire to help police officers save their own lives and the lives of others with training in SABA techniques
TTPOA’S PHILOSOPHY AND METHODOLOGY

• The TTPOA’s philosophy is to teach the concept:
  – Train like you fight, fight like you train”
• Stress inoculation must be included in most L.E. training in order to fulfill this fighting philosophy
• Safety, Safety, Safety

Teaching is about imparting knowledge that you have to those that need the same knowledge. Students learn in different ways but few learn by intimidation or being “talked down to.”

The “Parent-Child relationship gives a visual of someone standing over someone else and intimidating them….not allowing feedback……and a concept of domination.

The Parent-Parent relationship gives the visual of a calm, professional relationship and conversation allowing for feedback and mutual respect. This is the visual we want of our instructors when they are teaching this program. Talk to your students in a “parent-parent” style relationship or, “adult to adult.” Don’t criticize when a student is not grasping a concept or a technique

Remember your audience in this program; Non medically trained police officers. As a Paramedic, each of you has a tremendous amount of medical knowledge compared to the target audience. Don’t use “paramedic” terms; use everyday terms. In other words: “Dumb it down for the Cops.”

This curriculum was specifically developed under the supervision of Dr. Alex Eastman, TTPOA Medical Director, David Flory, TTPOA TEMS Program Manager, and the TEMS cadre of instructors and with the approval of the TTPOA Executive Board to include the TTPOA President, Paul Hershey.

DO NOT deviate from the curriculum without the express written approval from Dr. Eastman. We realize that there is multiple way of delivering the same message but it is our desire that because of the sensitive nature of teaching a “medical” course that we all teach from the same page. In an effort to keep current, we encourage ALL instructors to forward in writing any questions, concerns or suggestions for curriculum changes or, for suggestions on the type and/or style of Power Point slides, etc. The Cadre, along with Dr. Eastman will review TCCC guidelines periodically and will update this presentation as needed.

The Committee on TCCC updates often based on current research and trends. The CADRE will monitor the committee’s publications and will update our curriculum based on their updates.
f any instructor has suggestions about the curriculum send to the list serve for feedback. The Cadre will review and make changes as appropriate.

CLASS LOGISTICS
- Classes will be scheduled by geographic regional directors on an as-needed basis
  - Requests from agencies, etc.
- RD’s will work with each instructor in their region to coordinate scheduling, number of students, student/instructor ratios, adequate classroom space, dates, day of week, times, etc.
- RD's are responsible for all posting of classes on website, TCLOSE reporting requirements, certificates, collection of SS, etc.
- Instructors are responsible for
  - Being prepared
  - Proper coordination with RD for above
  - Media needs, etc.

CLASS LOGISTICS cont...
- Classes must be 8 hours in length with a meal break
- Can be any day of week, any time of day as long as coordinated with RD and fits the desires of students
- Didactic vs. hands-on is intended for 4-4
- Your payment is $500.00 per class taught plus travel expenses (mileage is ?? per mile) to include hotel if necessary
- Payment will be submitted by RD to Treasurer and check will be sent to instructor
- You may be required to fill out an expense report

HANDLING STUDENT ISSUES
- Make contact with agency host/contact
- Address any “problem” students with contact or RD
- Students must complete all 8 hours of class to get credit
- Students must be physically able to complete all drills, hands-on portions to include drags, carries and scenarios
- Students must pass all skills
  - Complete skills check-off sheets and forward to RD
- Give ample time during breaks for students to ask questions, address issues that they don’t understand

HANDLING STUDENT ISSUES cont.
- Allow input for change to the program/curriculum
  - Document reasonable suggestions and forward to D. Flory and B. Lankford for distribution to the Cadre for consideration
  - Encourage instructor evaluations
  - Use provided forms and forward to RD with other paperwork and run copies and send to D. Flory for distribution to the Cadre
DRILLS/BREAK-OUT SESSIONS

- Only conduct drills/break-out sessions when skills have been discussed/taught and corresponding adjunct has been covered
  - Once covered, use drills as often as time will permit
  - Skills

BREAK-OUT SESSIONS

- Tourniquet station

- Combat Gauze station

TOURNIQUET STATION

COMBAT GAUZE STATION
SCENARIOS/SKILLS TESTING

• Use prepared scenarios
  – May add any others that are reasonable
  • If others are used, send copy for file and consideration of distribution to other instructors

• Skills testing
  • Use testing sheets to score pass/fail and forward to RD with all other paperwork
IFAK CARRY OPTIONS

- IFAK’s come as ordered
- TTPOA is not making official recommendations of any particular brand, manufacturer, design, etc.
- Only recommendation is to have equipment as assessable to officer as possible
Operational Emergency Medical Skills Course Manual, LTC (Ret) J. Hagmann, M.D., 2004

Tactical Combat Casualty Care, Committee on Tactical Combat Casualty Care, Government Printing Agency, Feb 2003

Tactical Combat Casualty Care in Special Operations, CPT Frank Butler, Jr., MC, USN; LTC John Hagmann, MC, USA; ENS George Butler, MC, USN, Military Medicine, Vol. 161, Supp 1, 1996

Texas Tactical Police Officer’s Association Basic Tactical Medic Training Program Curriculum