



## **Written Testimony of Lieutenant Alexander L. Eastman, MD, MPH, FACS**

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Commissioner Ramsey, Chairwoman Robinson, members of the President's Task Force: Thank you for the invitation and opportunity to present my perspective on Law Enforcement Officer Safety in 2015. I hope that you'll find it to be a relatively unique perspective given my particular background.

## **Background**

Currently, I serve as a Dallas Police Department lieutenant, assigned to our SWAT Unit as its lead medical officer and the Deputy Medical Director for the entire Dallas Police Department. In this role, I am not only an operational law enforcement officer but also responsible for the many aspects of the operation of a major, urban law enforcement agency that have a health or medical component. My office includes a wide variety of programs from all of our operational medicine providers to advising Chief David O. Brown on a number of issues from law enforcement officer (LEO) suicide prevention to guiding parts of our most recent Ebola response. In addition to our work with the Dallas Police Department, we provide both operational and consultative support to the Office of The Director of Police at The University of Texas System Police (UTSP). The UTSP provides law enforcement and campus safety support for the sixteen campuses that encompass The University of Texas System.

In addition, I am also a practicing trauma surgeon; board certified in general surgery with added qualifications in surgical critical care. I serve as the Chief of Trauma Surgery at The Trauma Center at Parkland and Assistant Professor of Surgery at The University of Texas Southwestern Medical Center. In this role I perform direct patient care, teach, do research and lead the more than 1,000 Parkland employees who in some way touch the trauma patient service line.

For the last decade, my professional (and sometimes very personal) life has been focused on exploiting this unique interface of trauma surgery, public health and law enforcement to make not only the job of being a U.S. LEO more safe but also improving the overall safety of our communities as well.

## **Hemorrhage Control Training and Equipment for LEOs**

Despite improvements in equipment, tactics and trauma care, law enforcement remains one of our country's most dangerous occupations. Over the last decade or so, there has been increasing efforts and interest in teaching law enforcement officers some of the techniques pioneered by the U.S. armed forces with regards to the care of the injured. These techniques, known collectively as the Tactical Combat Casualty Care program (TCCC), have helped lower the battlefield fatality rates to the lowest levels in the history of warfare[1]. Many of these improvements were, and remain, the results of a vigorous review of injuries sustained and care provided on the battlefield in recent conflicts. Recognizing that LEOs are in no way at war, some of the medical techniques pioneered on the battlefield translate very well into helping our nation's LEOs "Save Our Own" during those times when serious injury occurs. And from a community

policing perspective, there's no finer example of a police department engaged in the community when the LEO applies his own equipment to save the life of a civilian. In November 2013, the Dallas Police Department conducted department-wide deployment of a Downed Officer Kit (DOK) and its associated training. Since the deployment of the DOKs, which contain a Special Operations Forces Tourniquet—Wide tourniquet (SOFT-W), an Olaes modular bandage and a roll of QuikClot Combat Gauze, twelve lives have been saved with two of them being our own officers. These techniques are safe to use in nearly all policing settings. In fact, the University of Texas System Police has made DOK deployment and training mandatory for all officers.

For the most part, successful programs have focused on training and equipping the LEO with advanced hemorrhage control capabilities. While this may sound complicated and scientific, the investment lies at around \$50.00 per officer and maybe a half day or so of training. Imagine that for a relatively small cost, police departments could provide their LEOs with the ultimate insurance policy—one that would ensure that they would have the knowledge, skills and equipment to intervene upon what we believe to be the most common cause of preventable death. In addition, this is the best kind of training as it is not only applicable to the injured law enforcement officer but also to the officer responding to the active shooter or other intentional mass casualty event.

## **The Hartford Consensus**

Immediately following the Sandy Hook Elementary School shooting and ultimately driven by the response to the Boston Marathon Bombing, the American College of Surgeons (ACS) and the Federal Bureau of Investigation (FBI) convened a consensus committee of experts designed to improve survivability from active shooter / intentional mass casualty events. In addition to the ACS and FBI, representatives from the Major Cities Chiefs Association (MCCA), the United States Department of Homeland Security, the American College of Emergency Physicians (ACEP) and the 17th Surgeon General of the United States met and developed what would come to become known as The Hartford Consensus[2]. While a detailed discussion is beyond the scope of this testimony, The Hartford Consensus has encouraged law enforcement agencies to embrace hemorrhage control as a core law enforcement skill and to move this skill and associated integration with fire/rescue/emergency medical services agencies to the forefront of community-wide active shooter preparedness and training. Time is critical in these situations and in order to maximize lives saved, patients cannot wait until conditions for medical providers to respond are ideal.

As an original and continuing participant in the Hartford Consensus, the members of the MCCA have led the way in implementation of LE-based hemorrhage control programs. In a late 2014 survey of MCCA Chiefs of Police, 42 of 70 member agencies had implemented some sort of hemorrhage control training program. These 42 programs have trained and equipped nearly 200,000 LEOs that now provide this hemorrhage control coverage to more than 65 million Americans. The application of LE-based

hemorrhage control programs, originally an officer safety initiative to “Save Our Own” now makes communities all across our nation much more safe places to live. In the eyes of many, this is the ultimate community policing program.

### **The Need for Scientific Data**

As a trauma surgeon at an academic, level I trauma center, part of the quest to further the scientific mission of improving the care of the injured involves the analysis of vast amounts of data with regards to injuries, care of the injured, the processes involved and in the many ways to improve all of the above. Presently, there is no system to track law enforcement officer injuries in The United States. While many point to the FBI’s Law Enforcement Officers Killed and Assaulted (LEOKA) database, the information contained there is relevant to many of the law enforcement specific aspects of these incidents but does not contain the granular, medical detail from which improvements in medical care for injured officers or improvements in officer safety can be gleaned. In order to make the job of policing more safe, a nationwide repository for LEO injuries sustained is desperately needed. A robust database of this nature, analyzed by medical providers and scientists involved in law enforcement, would allow for recommendations in tactics, training, equipment, medical care and even policies/procedures that are grounded in that interface between scientific evidence, best medical practice and sound policing.

### **Peer Review in Law Enforcement**

When errors are made in medicine, patients often pay the ultimate price. In surgery, these can be unforgiving and can even result in death. Yet, each week, in Departments of Surgery around the world, these errors are discussed openly. They are brought to light and lessons learned delivered to every surgeon who will listen in order not to repeat those mistakes. This process is called “peer review” and it has been credited in large part with making the practice of medicine much safer. The peer review model has been applied to commercial aviation and several other high risk sectors with great success. Because the process is protected from legal discovery in the medical profession, it allows for a frank, honest, open and candid discussion to facilitate improvements in patient care. In the book [American Policing in 2022: Essays on the Future of the Profession](#), the idea of peer review for law enforcement agencies was discussed in some detail[3]. Arising from this publication, a national “near-miss” database and reporting system is currently being deployed by The Police Foundation in Washington, DC. Improving officer safety and changing the practices that continue to place us at risk can only be fueled by a sound review process that is protected from legal discovery. We must take a hard look at and learn from those times when things do not go exactly as we plan.

## **Recommendations**

In summary, I would offer The President's Task Force on 21st Century Policing the following recommendations:

- 1) Ensure that hemorrhage control training and the provision of hemorrhage control equipment is required at every U.S. law enforcement agency.
- 2) Embrace recommendations of Hartford Consensus as national policy.
- 3) Develop and implement a national, comprehensive database for law enforcement officer injuries and treatment.
- 4) Facilitate legislative protections and national policy to develop a robust peer review/ error management program in U.S. law enforcement.

## **Conclusions**

It is a pleasure and a calling to serve both as a law enforcement officer and a caregiver of law enforcement officers. I am humbled and honored to have been given this opportunity to represent both groups today. The interface between medicine, public health and law enforcement has great potential not just as the source for many novel officer safety programs but also to harness those programs and transform them into true community resources. My most sincere thanks to the Task Force, Commissioner Ramsey, Chairwoman Robinson and the President for the opportunity to speak to you this morning.

## **References**

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