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THE HARTFORD CONSENSUS ON ACTIVE SHOOTERS: IMPLEMENTING THE CONTINUUM OF PREHOSPITAL TRAUMA RESPONSE

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☐ **Abstract—Background: Active shooter incidents have led to the recognition that the traditional response paradigm of sequential response and scene entry by law enforcement, first responders, and emergency medical service (EMS) personnel produced delays in care and suboptimal victim outcomes. The Hartford Consensus Group developed recommendations to improve the response to and outcomes from active shooter events and urged that a continuum of care be implemented that incorporates not only EMS response, but also the initiation of care by law enforcement officers and potentially by lay bystanders. Objective: To develop and implement tiered educational programs designed to teach police officers and lay bystanders the principles of initial trauma care and bleeding control using as a foundation the U.S. military's Tactical Combat Casualty Care course and the guidelines of the Committee on Tactical Emergency Casualty Care. Discussion: The Tactical Casualty Care for Law Enforcement and First Responders course is a 1-day program combining didactic lecture, hands-on skills stations, and clinical scenarios designed primarily for police officers. The Bleeding Control for the Injured is a 2- to 3-h program for the potential citizen responder in the skills of hemorrhage control. In addition, we document the application of these skills by law enforcement officers and first responders in several real-life incidents involving major hemorrhage. Conclusions: Developing and implementing tiered educational programs for hemorrhage control will improve response by police officers and the lay public. Educating law enforcement officers in these skills has been demonstrated to improve trauma victim survival.** © 2015 Elsevier Inc.

☐ **Keywords—Hartford Consensus; active shooter; tourniquets; law enforcement; prehospital trauma care; extremity hemorrhage; external hemorrhage; tactical care; casualty care; tactical casualty care; tactical emergency casualty care; EMS**

INTRODUCTION

Beginning with the mass shooting at Columbine High School in Littleton, Colorado in 1999 and continuing with the many subsequent active shooter and active assailant events since came the growing realization that maximizing victim survival from these types of incidents required a change in the emergency response paradigm of all public safety agencies. This paradigm shift is perhaps best summarized by the several documents published after the multiple agency working group meetings held in Hartford, Connecticut, which

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have been come to be known as the Hartford Consensus statements (1–3).

This article describes the implementation of the Hartford Consensus recommendations and its effect on prehospital care provided to victims of trauma.

OVERVIEW OF THE HARTFORD CONSENSUS

The Hartford Consensus group met to develop strategies that would ultimately lead to policies aimed at improving survival from active shooter/active assailant events. The working group consisted of representatives from the American College of Surgeons (ACS) Committee on Trauma, the Federal Bureau of Investigation, the Prehospital Trauma Life Support (PHTLS) Committee of the National Association of Emergency Medical Technicians (NAEMT), the Major Cities Chiefs Association, the International Association of Fire Chiefs, the Committee on Tactical Combat Casualty Care (CoTCCC), and the American College of Emergency Physicians.

The participants of the Hartford meetings developed a number of recommendations and conclusions, including:

1. hemorrhage control should be an integral part of law enforcement response;
2. care of wounded victims is a shared responsibility involving law enforcement, fire/rescue personnel, and emergency medical services (EMS); and
3. the response to an active shooter/active assailant incident requires a continuum of medical care involving all public safety responders to minimize the loss of life (1,2).

This continuum of response and care involves a number of important considerations that were further defined and developed in the subsequent Hartford Consensus Call to Action article (3). Specifically:

1. the integrated medical response should begin with the uninjured or minimally injured public who should be educated to provide basic hemorrhage control;
2. law enforcement officers should be taught hemorrhage control techniques to include tourniquet placement and the application of direct pressure and hemostatic dressings, as well as identification of victims at risk of internal hemorrhage;
3. fire/rescue and EMS personnel must work with law enforcement agencies to enter these scenes earlier than has been traditionally performed, intervene promptly to stop ongoing external hemorrhage, and incorporate basic concepts of tactical combat casualty care/tactical emergency casualty care into their education, training, and practice; and
4. educational programs must be developed and disseminated to provide this education and skill set to all groups, beginning with the lay public, in order to expand the pool of initial responders to these events.

As a direct result of the lessons learned in past active shooter events, as well as these concepts and recommendations from the Hartford Consensus Group, a number of important changes have been occurring in the public safety response to active assailant events. The prior paradigm that EMS does not enter a hazardous scene until law enforcement declares that it has been secured and safe to access is changing. This change is in marked contrast to the traditional approach of sequential response wherein street patrol officers secure the scene perimeter; SWAT (special weapons and tactics) teams are notified and activated to respond, enter the scene, and neutralize the threat; and medical responders stage at a safe location, which, in some cases, was several blocks away from an incident until safe entry is assured by law enforcement. As stated by W. Craig Fugate, Administrator of the Federal Emergency Management Agency, at the annual meeting of the International Association of EMS Chiefs held in Washington, DC in December 2014, the new paradigm is evolving from one of “no risk entry” to one of “managed risk” entry. This is a direct result of medical responders of all levels working in concert with their law enforcement counterparts to clear and secure “rescue corridors” within an active shooter scene that allow fire/rescue emergency medical responders and EMS emergency medical technicians (EMTs) and paramedics to enter a location with reduced risk in order to provide immediate medical care to and perform extraction of victims to expedite their treatment and transport.

One potential added benefit, unstated in the original articles, to implementing the Hartford Consensus Group recommendations relates to the likely application of hemorrhage control interventions in situations other than active assailant incidents. Educating law enforcement officers that techniques such as tourniquet placement for life-threatening extremity bleeding apply not only to active shooter scenarios but also to any other trauma situation that may be encountered as part of their daily response duties and may well provide life-saving benefit beyond the original intent of the recommendations.

THE CONTINUUM OF EDUCATIONAL PROGRAMS

The second important change that is occurring relates to the growing availability of educational programs designed to help implement the Hartford Consensus Group recommendations and to teach all of the target audiences