Stop the Bleed

VALOR THRIVE Webcast Transcript

David F.: Well, hello and good day, everyone, and thank you for joining us for this THRIVE webcast. I'm retired Police Chief David Flory and lead instructor with the Bureau of Justice Assistance VALOR Program. Today's episode focuses on the importance of being prepared to provide casualty care in the field. We are so fortunate to have with us today Officer Taylor Brandt of the Washington, DC, Metro Police Department, along with tactical paramedic David Dunafan of the Irving, Texas, Police and Fire Department. Taylor's with us here today to discuss her experience with providing casualty care. And David, as an experienced tactical paramedic, is here to help answer some questions about the concept of tactical emergency casualty care and maybe even some of his experiences. John Bouthillette with the VALOR Program is also along with us in the background today to monitor the YouTube chat and share experiences, so you can share experiences with us. We highly encourage you to use the chat feature in YouTube. It will certainly help us, and you, along the way. I'd also like to recognize Deborah Meader, our VALOR policy advisor with the Bureau of Justice Assistance. Deborah is a former police officer herself, so she has been there—been here and has our back in the VALOR Program. And certainly, as a former law enforcement officer herself and a policy advisor for us with BJA, she epitomizes the stance that BJA takes with having your back in law enforcement. Trust me, I've had an opportunity to work with Deborah for a number of years in this program, and they truly, truly do have your back when it comes to supporting law enforcement, especially in the endeavor of providing quality training in the areas of tactical safety and wellness and resiliency. So, with that, Deborah, I'd like to open it up to you just to give a few opening remarks. Good morning. Good to see you again.

Deborah M.: Good morning. Thank you so much, Chief Flory, for those kind words. As the chief mentioned, my name is Deborah Meader, and I am a policy advisor at the Bureau of Justice Assistance. I'm also a former Montgomery County, Maryland, police officer. So, as he mentioned, I

do understand the challenges that you all face as you go out and protect our communities and our nation. So, I want to first off say thank you for all that you do, all of the sacrifices that you make, and the sacrifices that your friends and families make as well, because it really is—the families, our law enforcement families, they serve as well. So, thank you so much. We really are pleased to bring you today's event. We have brought amazing speakers so that you can really, hopefully, get really useful information to help you as you continue to perform your duties. The profession of law enforcement and first responders is one that is challenging. It's stressful, it's dangerous, and you all continue to do it in, honorably, day-in and day-out, to protect our communities and the citizens within our communities. And that means being Jack and Jill of all trades. That means going to scenes and responding to, and assisting people who are experiencing mental health crisis, or responding to a scene that has injuries. And you have to be the ones to provide that first care. And so with that, we wanted to bring you some information that can help you, because BJA, our mission, and the mission under our VALOR Initiative—which is what this is being brought to you under, the VALOR Program is a part of our VALOR Officer Safety and Wellness Initiative—the mission of the VALOR Initiative is to make sure that we support you in any way possible to help strengthen and increase your safety and your wellness. So, we hope that the information you receive today is useful. We are here to help you. We are here to help to make you safer and well. So please, I encourage you to visit BJA's website at bja.gov, and if you put into the little search bar "VALOR," the VALOR Initiative will pull up. You can see the amount of free training, technical assistance, resources, tools, skills that we have available to you and your agencies. All you need to do is just pick up the phone or tap out an email and request assistance, and we will see what we can do to support you and your agency. I want to thank the Institute for Intergovernmental Research, our VALOR program manager. We are so pleased to be working in partnership with IIR. And again, thank our amazing speakers. I'm sure that you will find today's event really, really interesting and hopefully walk away with some really useful skills and tools to help you. So, with that, I just want to finish up by saying thank you again for everything that you do, for all of the sacrifices that you make. BJA and the Department of Justice sees you and

appreciates everything that you do. So, thank you very much. Please stay safe, and please stay well. Thank you.

David F.: Thanks, Deborah. It's always such a pleasure to know that you're always here on these webcasts for us and always have very inspirational words, and just can't thank you and the BJA enough for providing this valuable training. And I must say, this training is completely cost covered for all law enforcement. Everything we do in the VALOR Initiative is cost covered through a grant through the BJA, and we can't thank them enough for supporting local law enforcement, local, and federal, state, tribal. So, boy, let's get to the topic. So, Taylor, wow, great to see you. Good to see you again. Your story is absolutely amazing. Nine saves of civilians in 14 months of you being on the job at the Washington, DC, Metro Police Department. That's got to be an all-time record. I can tell you that your training in tactical emergency casualty care obviously has made a difference in probably more than just nine lives that you have saved. We at the VALOR Program certainly are proud of you, because we see that this training that we've been providing around the country has come to fruition in a positive way. I know that your supervisors and your staff at Washington, DC, Metro are proud of you. I know your parents are proud of you, and I'm sure you are proud of yourself. I just can't thank you enough for what you've done and how you represent law enforcement in such a positive way. You epitomize everything that we believe in, in this program and professional law enforcement. And it doesn't make any difference who you are, who someone is that you come in contact with. We in law enforcement have an opportunity to make a difference in somebody's life every single day if we just look for those opportunities, and you have made a difference in the lives of many people in Washington, DC, in your short, 14-month career. So welcome, and so thank you very, very much for you being here. David Dunafan, it's good to see you again. For the listeners out there, David Dunafan and I have known each other for a number of years. He's a tactical paramedic with the City of Irving, Texas, which is a very, very large suburb right next to Dallas. I spent a lot of my law enforcement career right next to Irving. He and I are both paramedics, him with much more experience than me. He's saved a lot of lives as a paramedic with the Irving Fire Department and part of that Oklahoma City. And so, David, thank you for being here. You bring the expertise

to the floor this morning to provide some great answers to many questions that we may have from some of the listeners about tactical medicine and about how it can be applied. So, we're gonna have a conversation with Taylor today about her experience, her training, her background, where her passion for other people come from, and how that's made such a difference. So, Taylor, I'm gonna turn it over to you really quick. Kinda give us a little bit of background about yourself, how you got started with the Washington, DC, Metro, and then talk about some of the training that you went through that have made a difference in some of these people's lives. And we want to get more into, as we go along, maybe some particulars about some of the saves that you've had and then some of the nomenclature on tactical emergency casualty care, what the training meant to you, equipment, et cetera. So, I'm gonna turn it over to you real quick. Give us a little bit brief background about yourself.

Taylor B.: Great. Thanks, David. So, I grew up in Arlington, Virginia, just on the other side of the river from the district. I was always interested in policing ever since high school, finally took the plunge in 2019, started on the street in August of 2020, and just always really loved policing and kind of found my niche in the medical response. So, here I am.

David F.: Well, awesome. Awesome. Hey, Dave, real quick, give us a little bit of background about yourself so people can have an understanding of who you are and what you bring to the table for us today.

David D.: I've been in public safety 28 years now, starting in Oklahoma City in the 90s, been with Irving the last 20. The last 14 of that, I've been on the tactical operations team—dual role between the police department tactical team and then on the fire side as well. So, and then I've been with VALOR, I think, five years now.

David F.: Yeah, great. Well, it's good to see ya. I haven't seen you in person in quite a while, but good to see your face and really appreciate all the work you've done—and especially in the state of Texas, around the country, in the VALOR Program, and tactical medicine. So, Taylor, let's dig in. Let's talk about your training. I really wanna hear, wanna kinda keep this as casual as we can. We got a lot of people that are listening to us in the background over on the YouTube side. And they may

shoot us some questions that we'll try to answer, but let's start off with how you received your training in this concept, and then we'll kind of dig in to how that training kind of parlayed, if you will, into some of your saves you've had.

Taylor B.: Great. So, prior to this, I actually had no real medical response background, other than a babysitting course I took in middle school. So, nothing that really applied out here. MPD uses a great training program through—well, it was produced through Arlington County Fire and EMS. And it's a several-day course where you learn about how to apply tourniquets, how to do CPR, how to apply a chest seal. So, it was really great stuff, and I really took it to heart, and I personally use it all the time.

David F.: Sure, obviously, and I'm assuming you probably had some other colleagues at DC Metro. You work for a very, very large department, and as we've talked in the past, and I'm sure your listeners probably—it's no surprise, but DC, like a lot of large cities in the country, can have its share of violent crime. And I'm sure that in the district that you work in, you see quite a bit of violent crime. Is that right?

Taylor B.: Yeah, correct. So, I work in the northeast and a piece of the southeast, east of the Anacostia River, which is unfortunately known for having a lot of gun violence. So, in terms of my saves and rescues, the vast majority relate to gun violence.

David F.: Awesome. Awesome. So, your training was based on the tactical emergency casualty care program, which we know, and I think that's important for people to understand that, as we encourage people through this webcast to receive the training if they have not, certainly would like to make sure—and I don't know if David can back this up, we certainly want to make sure any training that's received on casualty care, we highly recommend that it be based on the official National Association of EMTs' Tactical Emergency Casualty Care Program, which was built upon the military's tactical combat casualty care program. And we learned how to civilianize that, because there's quite a bit of nuances and differences in civilian law enforcement rules of engagement, use of medical adjuncts, et cetera, et cetera. It's different than the military's model, although point of wounding care is point of

wounding care. And that's what's so important. So, let's talk a little bit about it, and then I'm gonna have to turn it over to Dave real quick to ask a few questions, but Taylor, talk to us about some of the equipment that was either issued to you, or I think maybe you have even purchased some on your own, but I know that your training consists of the issuance of tourniquets, and I want to talk about kind of what equipment you were issued, what you carry, what you have found works best for you, et cetera.

Taylor B.: Great. So typically, we're issued a TECC kit, which is basically a pre-ready, ready-to-go kit. And I've stocked it with a few other little extras from the fire department based on the need we have in the district. So, most used for me personally is the tourniquet. I have a preference for the CAT tourniquet, but we also do issue the MET tourniquet a little bit. My secondly most-used piece of equipment is the chest seal. And then, rounding up third, I've started using a little bit more of the ACE bandage, H&H bandage, and occlusive dressings. It just really depends on how much time I have on the scene and priority level of wounds, because obviously, limb wounds and extremity wounds, and then any kind of possible second chest wound are gonna come first compared to small grazes and minor injuries.

David F.: Sure, so seven tourniquet saves you've had, and two saves with chest seals. Talk to us again, with being respectful of anonymity and any victimology and those kinds of things—certainly don't want to violate any of those kinds of rules or HIPAA issues, but talk to us about maybe a couple of the saves that kind of stand out for you, whether it was the first one or maybe one that was more unusual or more dangerous, et cetera. Talk to us a little bit about some of the details.

Taylor B.: So, two—I will say two of the ones that stand out most to me, one was a call that initially came out as a robbery that ultimately ended up being a suicide attempt. There was a little bit of a, I guess you would call it a guilt issue. So, he didn't want to come forth with what originally had happened, and I was first on the scene. And when I pull up in the block, there was nothing but a man with his arm sliced open, like slightly below the elbow, just leaking blood out. And as soon as he sees me, he pretty much like collapses against a wall. And I'm by myself at that point, in my mind, thinking that there is a robber

somewhere within a good block distance of me, and here I am trying to apply a tourniquet to this man, while also just constantly swiveling around to make sure that no one approaches from behind. But thankfully, my backup was only a minute away in that case, and he ultimately did survive, but once they got to the hospital, they said if he had gone about another 30 seconds without a tourniquet application, he would not have survived.

David F.: So, you definitely made a difference in that person living. And that's an incredible testament to, again, to what I know, and I fully understand your passion for human life. And so, what gives you that passion, do you think, to put yourself in harm's way, knowing that you were called by some calling to provide care to anybody and everybody, regardless of dangers you may be putting yourself in?

Taylor B.: Yeah, so it's funny you mentioned that. I've always kind of been that way. I've seen people be inactive and not take action on scenes. I mean, before I even really considered joining MPD, me and my ex-boyfriend pulled a gentleman out of the James River and performed CPR on him, as he floated by groups of people under the water, we were the last group before he would have floated down river and hit the rapids and probably never be seen again. Just not seeing people take action makes me want to take action, so it's always been part of me.

David F.: That's awesome. Dave, I want to kick it over to you. I know you've probably got some questions and comments with your experience and our previous conversation with Taylor, so I'm gonna kick it to you, Dave.

David D.: Taylor, just out of curiosity, when you went to apply the first tourniquet in real life, how did that compare to the training that you had while you were in the academy? Do you feel like you were prepared, or did you have a moment of brief shock where you were trying to kind of gather your senses as to what actually was going on?

Taylor B.: Yeah, so my first tourniquet application was actually two tourniquet applications. We happened to—it was funny. The day before, on a block away, we had found a guy who crashed his car, overdosed, and,

you know, Narcan, everything. So, the next day, we pull up a block away. There is a gentleman laid out in the road, and we're thinking—the exact same situation. Again, someone's overdosed, he's crashed his car. His car is half up on the curb. And when we pull up and say, "Are you okay?" He said, "I've been shot." So, there's no call for service, nothing. You just kind of arrive on the scene. Here is this gentleman, you know, sprayed with bullets. Ultimately, he had one in one thigh, one blew out his opposite calf, and then he had two in the lower abdomen. So, that was my third week on the streets.

David F.: Oh, my God.

Taylor B.: So, I mean, you either—that is definitely your moment of like, you know, put up or shut up. You know, you've got to take action. This is what you've trained for, have at it. So, definitely a shock, but still, training worked clearly. I use it all the time.

David D.: When it came to training for the tourniquets in the academy, was it realistic in any stress added to it, or was it just kind of one of those things where they showed you in the classroom, you practiced a couple of times, and that was the end of the tourniquet training?

Taylor B.: So, for us, I was in the academy partially during COVID, so we were trying to keep contact to a minimum, but it was—we did both. We did various partner applications, and then we also did self-applications, dominant and nondominant hand. So, you do have practice, and I do recommend you keep up on it.

David D.: Absolutely.

Taylor B.: Pull that tourniquet out, and you're like, "Uh."

David D.: Yeah. One of the things that we have found over the years of doing this program is that officers are originally trained in the academy and then they have no refresher training. So, that skill is perishable, and they lose that context to be able to put that tourniquet on in a stressful situation. So, one of the things that we recommend to agencies is they, just like what you said, they practice on themselves, practice on a partner. And then we add it into range days, so when

they're on the range and doing qualifying, whatever, moving, shooting, we'll have an instructor come up and say, "Okay, you're hit in your arm," make him put the tourniquet on, and then get back in the fight, get back up on the line and re-engage with that situation to where they're just not stopping at the end of the tourniquet. One of the other things that we've done is we've added on our range days simulated blood, as well as using a water lubricant, such as KY, to makes it slick, to simulate how slick it actually is trying to put that tourniquet on when you have blood on your hands, and then handle your weapon with your nondominant hand as part of the training evolutions to help our officers better engage, putting the tourniquet on and then get back in a fight. And that's one of the things that TCCC recommends. And it's one of those things that we need to incorporate in our training for our agencies out there. And so, it sounds like you guys are doing a great job on doing that. And you brought up some valid points as far as making sure that we have that refresher training periodically, whether it's practicing on your own or every range day, and to any supervisors in the chat, I also recommend that every so often as part of your role call and daily briefings, you do a tourniquet check to see if your officers are carrying tourniquets. And that's one thing I would ask you, Taylor, is do you carry the tourniquet on your person? And if so, have you found a spot that's better than another location on your person to carry that tourniquet?

Taylor B.: So, yeah, depending on how many I have available and how often I've been to the equipment bureau, I have a personal one I carry on my right side, which for me is my nondominant side. So, I'm used to grabbing with my right hand as my nondominant side. I very much favor the left for everything else. So, I've tried to break that habit. If I have spares, I keep one in my vest pouch as well. And if I'm really lucky and I have a third, I keep it—we have a separate kit. I personally don't wear it, 'cause it's a little cumbersome for me since it's so full of stuff, but I keep that in the front seat next to me so it's ready to go.

David F.: Awesome. Hey, I'm seeing a chat in the chat box from Chief Bouthillette who's running the chat from behind us that says, I think we already answered this question, but one of the members, one of the students that's watching today mentions that he carries two tourniquets, and quite frankly, two of the most popular tourniquets

out there in the TECC world, and that's the CAT Tourniquet Gen 7, which we've talked about. And there is some differences between the Gen 7 CAT Tourniquet and previous iterations on the CAT Tourniquet, specifically, how many slots there are in the buckles, and that's a key, and we don't have really time to go into all that today, but make sure if you're watching this and you carry a CAT Tourniquet, there is a difference between CAT Gen 7s and previous iterations, previous generations. And then he also carries the SOFTT-Wide, which, again, is another Tactical Combat Casualty Care recommended tourniquet. And we always recommend that you carry a tourniquet that is recommended by the Committee on Tactical Combat Casualty Care. And the SOFTT-Wide tourniquet is different than the CAT in the sense that it has a quick disconnect buckle, which can be used differently. If people have entrapments, and you can't get the loop of the tourniquet over someone's arm or leg, you can unbuckle it and so forth. So, it really is a benefit. Taylor, you mentioned one thing that kinda really resonated with me back, just on, kind of, philosophy earlier. You mentioned that you have seen some people—and again, I don't want to be disrespectful or talk about anything confidential, if some of your fellow officers—we certainly see this in law enforcement across the country, but one of the things that we're real proud of in our program at VALOR is stressing peer accountability. In fact, we created a program called PALS, which stands for Peer Accountability and Law Enforcement Safety. In other words, we want officers to take a more robust responsibility in holding themselves accountable, but also allowing other officers that you work with to give you permission, if you will, to hold them, to hold you accountable. So, have you seen maybe a shift in your agency or any other law enforcement personnel that you know around the country in accountability and taking a more responsible role in saving civilians, or maybe even people who were involved in the justice system who may have just had force used against them? Have you seen a shift in that, maybe, in law enforcement?

Taylor B.: Yes, I was told prior to them issuing the whole TECC kit to every officer, that when officers were on scene, they just stood by and waited for the ambulance, that nothing was really done, because no one had any training and no one had any equipment. So, unless you were that paramedic or EMT in a prior life, not many people carried anything

medical-wise with them. And so, that's been a really big change, I would say, between pre-TECC-kit era and current TECC-kit era.

David F.: Yeah, and I think that's important. I think David and I can attest to that, as having both served as paramedics, both of us still working as paramedics. The delay in EMS response into those kinds of critical scenes is so delayed, not only because EMS personnel may have just a general delay in response because of traffic, being out of service, et cetera, but we also know as law enforcement officers as well that we're not gonna clear that EMS unit into the scene until it's safe. And we all know that people can die within those couple of two to three, four minutes of time that we have to wait for EMS to get in there, but on a more important scale, which you just mentioned, is we in law enforcement have to just recognize that it's the right thing to do for us to take responsibility. We have a moral and a ethical and, quite frankly, a legal obligation to make sure that we are treating everyone we can, regardless of what their status is. Civilian, bystander, law enforcement, again, someone involved in the justice system that we may have used force against. And we just have an obligation to do that. I'm so proud of you seeing that obligation. I'm so glad to say that you're seeing a shift in your organization. And we certainly are seeing that shift, generally speaking, in our program, as we teach police officers and law enforcement officers across the country. So, you talked about the need to have—and your practice, which I'm, again, so very proud of you, because we see sometimes law enforcement officers kind of miss this opportunity, if you will, to carry equipment on them. Have you ever seen anyone having to go a long distance to get their equipment 'cause maybe they're not carrying it with them, or is it a pretty common practice in your agency that they carry the equipment with them on their bodies?

Taylor B.: It's a mixed bag. I would say a good half plus carry a tourniquet immediately on their person, whether they wear the full TECC kit on their leg, whether their holster has a tourniquet slot on it, or they keep it, like, on their vest. But in the heat of the moment, sometimes you just forget that. I, on the 4th of July, had a shooting. And if you haven't been in DC when it's the 4th of July, it's like being overseas. It's just, you know, we probably have 2,000 different people setting off, let's say, noncommercial grade fireworks about every seven, you know,

five, seven, eight seconds all around you. One of my worst shootings was actually that day, a guy took a round to one leg, two to the chest and shoulder. And then, actually, last one we discovered was he took a round to the chin and it went up into his jaw, but we didn't even see it 'til he kept talking and it slowly kind of flowered open, and we're like, "Oh, you're done." And I actually left my TECC kit in my car that day. You know, I saw him sitting there just bleeding, and I just ran out, and sure enough, I'm sitting there putting my tourniquet on him. And I said, "Oh crap, where's the rest of it?" So, I mean, it happens, but someone else always has one. Thankfully, in my department, I never have to worry about being by myself, because my backup is coming down the road quickly.

David F.: Sure, yeah, we can recognize that for sure. David, what are questions you might have for Taylor?

David D.: So, you brought up a few good things about equipment carry and stuff. One of the things that we have found with a lot of agencies is they buy them all the equipment, active shooter kits, bug out bags, whatever you want to call it, but one of the things we've noticed is that the officers are never talked to or trained on when they should actually deploy those kits. So, I'll use my agency, for example. We bought active shooter kits years ago, but then what we found was the officers were never actually deploying them. And when they get up, as you said, you get up on a person, on a victim, if you don't have any equipment, you're just kind of stuck there. So, one of the things that we started looking at doing with agencies was going through their use of force policy and their threat continuum. If they transition to an active shooter scene, a long gun, then actually grabbing that active shooter kit and taking those supplies with them instead of leaving it in the trunk of the car. And as you stated, if the tourniquet is in the car and you need it, it's not doing you any good, because the majority of our job doesn't take place at the vehicle. It takes place, you know, either at the apartment, the house, or up on that traffic stop where we're not gonna be able to get back to that car within 30 seconds. I did also have a question. Have you ever had to—we've talked a lot about penetrating trauma, which you guys have a lot of. Has there been other cases where you've had to apply medical aid or tourniquets

that weren't actually a shooting, because a lot of the gear that you carry can be used for things other than just a shooting.

Taylor B.: So yeah, unfortunately, the vast majority of violent incidents is gun related. I have been on a couple of stabbings and the suicide attempt, but again, it's a lot easier to see someone coming at you at night from four feet away than when you catch a stray round. We had a lady two nights ago catch a stray round from a block away, and it hit her right in the chest.

David F.: I want to parlay on this, 'cause I think what the point Dave is making is really good, is because there are other kinds of injuries, car wreck victims, industrial accidents, all kinds of things that this kind of training and this kind of wound care can be applicable. And, for example, the last tourniquet I used a few months ago while I was working on an ambulance was an older gentleman who was attacked by three pit bulls, and the three pit bulls, all three latched onto one of his arms, and very, very gruesome scene that required the use of a tourniquet to stop the bleeding. And so, for those listeners out there, certainly, we want to make sure you understand that this is not just for penetrating trauma from gunshot wounds, stab wounds. It can be anything related to any kind of wound pattern that affects the arm or the leg in a significant way where we have significant bleeding that needs to be stopped before the person bleeds to death. And you having applied two chest seals, same thing. Penetrating trauma to the chest or the abdomen, to the back, anything that, as we say, kind of from the navel all the way to the neck, 360 degrees circumference generally is going to need some sort of occlusive dressing to prevent or mitigate some sort of sucking chest wound, tension thorax, as we say in medicine, anything that could allow air into a lung or the chest cavity, those really need a chest seal. And I know, Taylor, from talking to you, we've talked about the fact that I think you carry a commercially made chest seal, but for our listeners out there, chest seals can be really anything. We highly recommend commercially made ones. There's lots of them on the market. We're not pushing any particular product, but anything that will stop air from coming into the chest cavity. Now, that can be duct tape, quite frankly, can be Vaseline gauze, doesn't work very well. Certainly, I like, and I know David agrees, we like to push the use of expired external defibrillator

pads because they're free. They have hydrogel attached to the back of them. They're about the right size to cover a gunshot wound or penetrating trauma. They're really easily available from your EMS personnel, because they get thrown in the box in the fire station when they're expired. So, there's lots of different things that can be used for chest seals. Taylor, where do you think you see your career going? It looks like you're gonna be our biggest champion in that part of the world for the use of tactical emergency casualty care. Because as we say, affectionately, you are a—I don't want to say you're a black cloud. You're a white cloud, quite frankly, as we would say. Looks like there's a higher power that has placed you in the proper place to make a difference in people's lives. Where do you see yourself going with all this?

Taylor B.: That is the question I get asked a lot.

David F.: What's left for you?

Taylor B.: Yeah, so I definitely wanna work on improving the medical response that we have at MPD. I'm also in something called the Georgetown Police for Tomorrow Fellowship. And so, my big project, I want it to be how we improve both stocking equipment for officers, 'cause currently our process of getting—you know, you use your tourniquet, I've actually had this happen, you use some of your equipment during the night, and then an hour later, another shooting comes out, and you have no way of restocking in between those two shootings.

David F.: Sure. Exactly.

Taylor B.: So, my main thing is I would like to help improve MPD's medical response by fixing the equipment issues, and then also better utilizing our paramedic and EMTs and also selecting some more people like myself that would be more interested in getting more training, going and taking a full course, and actually having a whole medical patrol unit that can go out and respond to some of these scenes. 'Cause unfortunately, a lot of times, our shootings aren't single shootings. I've been on multiple double shootings, a quadruple shooting. The week I started, we had a mass shooting on Dubois Street, which involved 26 people injured. And that's a lot of TECC kits to have arrive on scene.

And I might only be equipped for one or two, but if we can have a medical team ready to go and treat 10 or 20, be a big difference. So, hopefully in the next few years, I can kind of help influence that a bit.

David F.: Yeah.

David D.: Taylor?

David F.: I'm sorry, go ahead.

David D.: Taylor, I do have a question about that. One of the things that is covered in TCCC is basically right medicine, wrong time, the legal and ethical, moral obligation. Have you ever found yourself in a situation where a person needed aid, but you couldn't render it yet because you were still worried about security of the scene, threats down range, et cetera? And, if so, how did you handle that?

Taylor B.: Yeah so, I believe it was my second shooting. This would have been back in April. We had significant amount of sounds of gunshots come out. We have a ShotSpotter application that detects fired rounds within the city. So, as we're heading over there, it comes out—oh, it's on one of the worst blocks in the sixth district, which is known for a very, very large apartment complex that's part of a housing project. And I told my partner, "When we show up, I'll do the medical, but I need you to stand right on my back, because it's gonna be a crowd." And when we pulled up, it's about 80 people, cameras out, surrounding this car, you know, screaming, "Why are the police here? We only want the ambulance." Not every citizen knows that the ambulance won't come until it's secure and having 80 people around the car is not secure.

David D.: And that brings up some points that have been brought up in the chat, as far as you have that moral and ethical obligation to render aid. But you still have to make sure that the scene is safe and doing the right medicine the wrong time can actually cause yourself to become a victim, your partner is a victim. So, you brought up an important principle, where basically you had somebody doing a security while you were providing the medical application. And that's something that we like to see. And for our officers out there on the chat, one of the

things that we need to remember is we're expected now to render aid. You brought up previously how we were never expected to render aid. We didn't even have the training for it. Now, we're expected to render aid. We're given the training. So, now we have to be able to document and protect ourselves as to why we didn't render aid in a hostile environment, because to the public, it looks like we're just sitting there doing nothing. And so, as an officer, you have to make sure that you're providing that security, and then render in aid as soon as feasible and safe to do. And you've hit on those points well, and I know we saw some questions in the chat about that, and I would say that it comes back to, "Can you articulate?" CYA for our officers out there, is, "Why did you leave this individual to bleed to death and not render aid?" You have to be able to articulate, "Well, scene security, et cetera, came first," or as soon as you got back up there, as you said, you dedicated one to scene security while you render aid, and those are all points that we need to do a better job of training our officers on. And so, those were some things that I liked the fact that you hit on.

David F.: Yeah, I like that too, for sure. And, you know, Taylor, you had mentioned about what your goal is. Man, I'm, again, so proud of how you want to take this to the next level, 'cause again, it's people like you in law enforcement that, certainly as a retired police chief, that just make my heart warm, if you will, to see people with your passion and with your energy to make the world better, especially to make the world of law enforcement better, more professional, better trained, but, you know, one thing—you mentioned a model about having embedded, if you will, embedded medicine within police officer ranks and so forth. I can think of a couple of places. One specific is near where David certainly works and lives now and where I used to be, and that's Fort Worth, Texas, which has a fairly robust, after a very tragic incident where a former police officer nearly lost his life in the shooting and was saved by a fellow police officer who had been trained. And they created a very robust medical response program within the ranks of the Fort Worth Police Department, which is a nearly 2,000-person agency, which brings me—really, really quick, David, we've only got about three minutes left, but as you being assigned as a tactical paramedic, as a full-time firefighter with Irving, but assigned over to the police department as an embedded medic within their

special response teams, spend just a minute or so talking about the value of that, which kind of takes the whole point of wounding care concept to the next level.

David D.: Like a lot of agencies, it's basically—officers may have a little bit of basic training in tourniquets. And if something happens, that team is on their own waiting for standardized civilian EMS that isn't coming in until the scene is safe, etc. So, our tactical medic program basically evolved because we had an officer-involved shooting in another city because our tactical team, we operate multiple jurisdictions across the DFW metroplex. And so, one of the things that we have learned is taking the military model and embedding our tactical medics with the team as far as full operations. So, anywhere our team goes, regardless of where they're at, we have a medical component to it. And we've also trained other officers up to speed on that team to where not only do we have at least one or two tactical paramedics, but everybody is trained in chest seals, tourniquets, and those type of things to where we always have a medical component required as part of our team deployment.

David F.: Yeah, I think that's just a great, great model. Again, it is literally taking from the battlefield medicine model that we have learned over the last, mainly over the last 20 years. And most specifically, after some of the issues that we found in the Battle of the Black Sea in Mogadishu, Somalia, where, made famous by the movie "Black Hawk Down," which most everyone that is listening has seen that. And that's really kind of the impetus and the birth of where we got robust battlefield medicine. And we have literally borrowed that from the military model, and, Taylor, you exemplify exactly what that model is. So, I'm gonna give you the last word before I close this out. Just give us some parting wisdom for those people that are watching you and listening to you about how they can make a difference, just like you have.

Taylor B.: Oh, goodness.

David F.: Gonna put you on the spot.

Taylor B.: I mean, one thing that even I still struggle with is you have to be able to delegate when you're on these scenes. If I'm not first on scene and I

have a couple of colleagues that are actual EMTs—I show up. If they have already got it, the first thing I say is, "What can I do to help?" You don't have to be—as much as I hate saying this, where you don't have to be the hero every time. You can put up crime scene tape. You can watch the crowd. You can interview witnesses. You can look for shell casings. You don't have to just be the medical person doing all the medical. On the last major scene, well, I won't say last, I guess two crime scenes ago, I was first on scene. And then, once everything finished, wrapped up, and he was on the ambulance, I stood with some shell casings. So, you don't always have to like be the hero, do the crazy stuff. Everyone's part of the team. And it's important that no matter when you show up, that you still are part of the team.

David F.: Wow, that is great wisdom. Taylor, I'm so proud of you. I can't wait to finally get a chance to meet you in person. We've certainly met over chat, phone, and Zoom many times, and it's been a pleasure to be with you today. So, I guess, everybody that's out there, thank you for joining us for this important and very, very necessary conversation. Taylor, David, you both shared a lot of useful information to help everyone that's watching this today to make sure they have the equipment, the confidence, and all the knowledge they need to respond to a medical situation if EMS, paramedics, and EMTs are not immediately available, as we know that's often the case. Taylor and David, thank you so much with being with us today. For our viewers, I highly, highly encourage you to reach out to us. If you have additional questions, comments, or requests for additional training from us through VALOR, our website is www.valorforblue.org. That's www.valorforblue.org, and for more information on this topic and other topics of officer safety and wellness, because we want to make sure you are healthy, safe, and well on this program. With that being said, thank you so much for joining us. Taylor, thank you so much for what you do. God bless you. You are my hero, and I know you're the hero of all the people who are listening today. Keep up the good work, stay safe, and to all of you that are watching, thank you so much for your time and commitment. Be safe, stay well.