Scene to Subpoena: What Gunshot Wound Documentation Really Means

In EMS, we train for GSWs like they're rare. But if you work in our system, you know better.

Gunshot wounds are not once-a-career events—they're weekend-normal. And the way we document them doesn't just impact the trauma team. It can affect a criminal investigation, a patient's legal outcome, and your own credibility on the stand.

This blog is your deep dive into the clinical reality, legal implications, and documentation standards for gunshot wounds in the prehospital setting, based on our latest Life and Sirens podcast episode: Scene to Subpoena.

Why GSW Documentation Matters in Our System

In the communities many of us serve, GSWs aren't theoretical. We run them regularly—sometimes multiple times in a shift. They come with:

- Underserved populations
- High-crime neighborhoods
- Frequent law enforcement overlap
- Increased courtroom relevance

We're often first on scene—before crime scene tape, detectives, or forensics. That means our chart may be the first legal document tied to that case.

The Clinical Side: PHTLS Doesn't Skip Documentation

According to PHTLS 10th Edition, your focus should be on:

- Airway and hemorrhage control first
- Platinum 10: <10 minutes on scene for critical patients
- Life threats via MARCH or XABCDE

But clinical care is documentation. We're not just treating the wound—we're also translating that care into words someone else can understand.

PHTLS Clinical Pearls

- Document entry and exit wounds with anatomical landmarks.
- Differentiate junctional vs. extremity bleeding—and what was done.
- Trend vitals. Track changes in GCS and perfusion.

DCHART: Your Legal Lifeline

Let's stop writing "GSW to leg" and calling it a day.

Your DCHART is the legal map of what happened. It should include:

- **Dispatch:** Was it an "unknown problem" or "gunshots heard"?
- **Chief Complaint:** Use exact quotes: "I got shot in the alley."
- **History:** Who was there? What did the patient say? What didn't they say?
- **Assessment:** Single, penetrating approximately 2 cm above R knee. No soot. Tender, pulsatile bleeding.
- **Treatment:** Hemostatic gauze applied. 18g IV. TXA if indicated.
- **Transport:** Emergent? Stable? Reassessed?

Common Mistakes to Avoid:

- Writing "appeared intoxicated" instead of "slurred speech, alcohol odor"
- Leaving out tourniquet times
- No wound locations, no descriptions, no mechanism

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BEHIND AND ON THE SCENE

Two Narratives. Two Outcomes.

"Bad" GSW Narrative

[Dispatch / General Impression]
- Medic 1 responded immediately, emergency traffic to the dispatched location for a reported gunshot wound.
- On EMS arrival to the scene the patient was found lying on the sidewalk, alert, in mild distress, skin pink, warm, and dry.
- Fire was on scene with the patient prior to EMS arrival.

[Chief Complaint]
- "I got shot in the leg."

[History of Present Injury / Illness]
- Patient explained that he was walking home when someone "came out of nowhere" and shot him. No further details provided.
- Patient has a history of hypertension.
- NKA.
- PATIENT'S LIVING CONDITIONS: Patient lives alone.
- IMPLANTED MEDICAL DEVICES: None
- CODE STATUS: Full Code

[Assessment]
- Patient was fully assessed en route to the ER.1 cm wound noted to lateral left thigh, no obvious exit. Minimal bleeding controlled with gauze prior to arrival.
- Lung sounds clear bilaterally.
- PMS intact. No abnormalities noted to head, chest, or abdomen.
- Cap refill <2 seconds.
- Vitals monitored. GCS 15.
- *[FOR FULL DETAILS SEE VITALS, FORMS, FLOWCHART, AND ASSESSMENT TABS]*

[Airway and Oxygenation Interventions]
- Patient airway remained patent without needing intervention.
- Patient maintained SPO2 >94% without oxygen.

[Cardiac Monitor / Electrical Interventions]
- Placed on monitor due to trauma mechanism.
- Sinus rhythm, no ectopy. 12-lead unremarkable.

[Changes in Patient Condition]
- No significant changes during transport.

[Other Interventions]
- IV established. No medications given.
- *[FOR FULL DETAILS SEE FLOWCHART TAB]*

[Transport and Patient Movement / Positioning]
- Patient assisted to cot, secured with all rails and straps, transported non-emergency.

[Transfer of Care]
- Report given, care transferred to trauma team.

"Good" GSW Narrative

[Dispatch / General Impression]
- Medic 1 responded immediately, emergency traffic to the dispatched location for a 911 call reporting a male shot in a suspected robbery.
- On EMS arrival, patient was found supine on the sidewalk outside a convenience store. Patient was alert but in visible distress, pale, with rapid, shallow breathing.
- Fire was on scene applying initial bleeding control measures.

[Chief Complaint]
- "I was shot in the stomach—help me."

[History of Present Injury / Illness]
- Patient stated he was approached by an unknown male who attempted to rob him. He reports
- hearing a gunshot and feeling immediate pain in the abdomen.
- Patient has no significant past medical history.
- No known drug allergies.
- PATIENT'S LIVING CONDITIONS: Patient lives with mother, independent in daily activities.
- IMPLANTED MEDICAL DEVICES: None
- CODE STATUS: Full Code

[Assessment]
- Primary assessment revealed a single, penetrating wound approximately 3 inches left of the umbilicus. No wounds noted.
- Bleeding was moderate with signs of early shock (BP 92/64, HR 122). Abdomen rigid and tender on palpation.
- Lung sounds clear bilaterally.
- No JVD or tracheal deviation.
- PMS intact. Capillary refill less than 2 seconds.
- GCS 15 on scene.
- Secondary survey revealed no other injuries.
- *[FOR FULL DETAILS SEE VITALS, FORMS, FLOWCHART, AND ASSESSMENT TABS]*

[Airway and Oxygenation Interventions]
- Patient maintained a patent airway.
- O2 via NRB at 15L/min administered for suspected internal hemorrhage and perfusion support. SPO2 improved from 91% to 97%.

[Cardiac Monitor / Electrical Interventions]
- Placed on monitor for trauma protocol.
- Sinus tachycardia, no ectopy.
- 12-lead performed and transmitted to receiving facility—no ST changes noted.

[Changes in Patient Condition]
- Patient remained alert, though tachycardic throughout transport. BP stable after fluid bolus.

[Other Interventions]
- 18g IV established in right AC. 500 mL NS bolus given.
- Hemostatic gauze applied with pressure, reinforced by trauma dressing.
- *[FOR FULL DETAILS SEE FLOWCHART TAB]*

[Transport and Patient Movement / Positioning]
- Patient was log-rolled onto the cot by a 3-person crew, placed supine, and secured with straps and all side rails up.
- Emergency transport initiated. En route, trauma center pre-alerted.

[Transfer of Care]
- Patient delivered directly to trauma bay. Full report given to trauma team including scene observations, wound location, and interventions. Signature obtained.

The Legal Reality

At what point does your chart become evidence?

Immediately. From the second you touch a patient in a potential crime scene, everything you do (or don't document) matters.

Legal Tips:

- Avoid editorializing. Stick to what you saw, heard, and did.
- Maintain chain of custody when cutting clothes, moving items, or transferring personal effects.
- Don't let PD dictate your chart. You're not there to build a case—you're there to record facts.

This Is Why We're Qualified to Talk About It

At Life and Sirens, we serve areas where GSWs are frequent, fast, and high-risk. We've seen firsthand how poor documentation delays justice—or costs it. We've also seen how one solid narrative can clear up a cloudy timeline or protect a provider from legal fallout.

We've run the calls. We've watched the courtroom fallout. We've lived it.

Final Takeaways

- GSW documentation is both clinical and legal.
- Use DCHART like your job depends on it—because it might.
- Stay neutral, be accurate, and document everything.

Resources

- NAEMSP documentation guidelines
- PHTLS 10th Edition updates