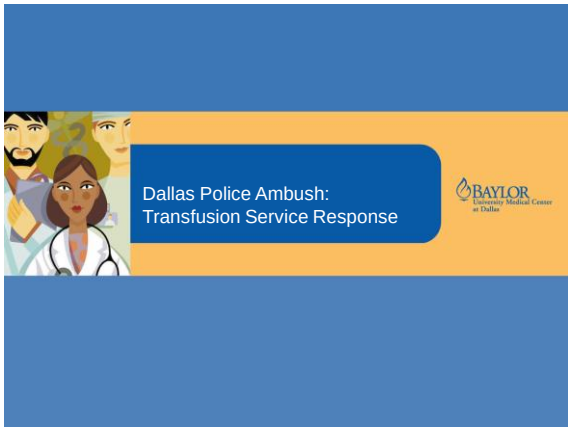
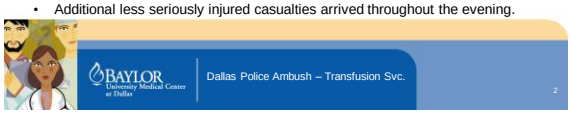


Thursday, July 7, 2016, approximately 2100

- First casualties arrived without notice to the ED ambulance bay.
  - *Officers drove 2 critically wounded officers from the scene:*
    - *In their police vehicle*
      - *Bullet-riddled doors*
      - *On their tire rims.*
- Trauma pager did not go off for the team until the casualties had already arrived.
- Massive transfusion protocol (MTP) – nickname "Trauma Tray" activated
  - *One officer expired in the trauma bay*
  - *One officer quickly went to the OR for the next 6 hours – 1 MTP to the ED>OR*
  - *Chief of trauma requested 3 MTP coolers (O neg red cells/AB plasma) on stand-by in the ED, with a BB employee present.*
- Additional less seriously injured casualties arrived throughout the evening.

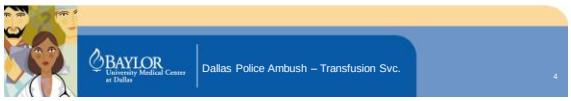


As the Event Developed…

- Told to expect 9 victims.
- Ordered products from both primary and secondary supplier.
  - *Blood Centers rose to the occasion to help us.*
  - *Multiple deliveries throughout the evening and night.*
- OR initially too busy to provide blood samples on seriously wounded officer.
  - *For first several MTP coolers, had to stay on O pos red cells/AB or A plasma.*
  - *Manager went to OR to insist on samples. Needed to protect O red cell supply.*
  - *Officer was A positive.*
- OR brought in enough staff to have 4 OR suites dedicated to the event.

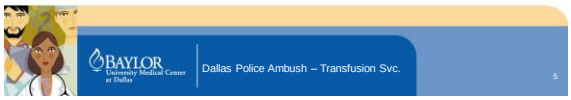
Primary Blood User

- The primary blood user was a severely injured police officer. "Shot everywhere"
- OR team ordered MTPs 3 at a time and "stay 2 ahead."
- Team of OR runners took the filled coolers from us and delivered them to the OR.
- Same runners brought back the emptied coolers to be filled again.
- This was repeated throughout the surgery.
  - *Surgery lasted about 6 hours.*
  - *Prepared to go to ICU post-op but never able to leave the OR.*
- Used 165 blood products, 91 cellular.



Staffing…

- Manager saw ambush on cable network. Immediately called in, and then came in.
- Manager notified Medical Director, who arrived shortly after manager did.
  - *Key to have MD present for decision-making/planned deviations from SOP.*
- Timing of event – Both evening and night shift were present. Value in having overlapping shifts.
- Half of staff matched/prepared/tagged/signed out products and filled coolers.
- Half of staff entered arriving products into inventory and confirmed red cell types.
- No one went home until the shooting stopped and the scene was secure.
- Some off duty staff members called in, but were not needed.

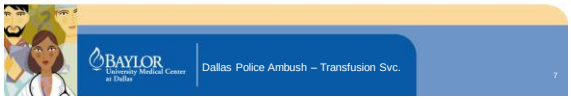


Communication…

- Medical director made several trips to the ED to check in with trauma surgeons.
- Chief of trauma surgery stopped by frequently with updates from the scene and from the OR. He was in direct communication with the incident commander from DPD. He also provided his cell phone number.
- Chief of Pathology was communicating with medical director with information from TV reports, etc.
- BUMC public relations deferred all requests for information to the DPD public relations department. Hospital revealed nothing.

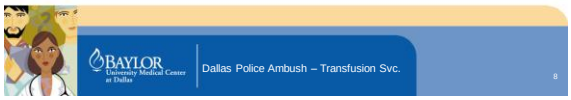
Challenges…

- Did not really know how many casualties to expect; therefore, did not know how many products might be needed.
- Was not getting information about the scene, was/were the shooter(s) contained? "Was it over?"
- Police officers from every level came to the hospital to be with their brotherhood.
  - *ED was crowded with the police.*
  - *Difficult for other activities.*
- After disaster code was called, the ED was on lock-down, so BB badges did not work for product delivery.
- Parkland shut down their ED to other, non-event related trauma, so Baylor received all other Level 1 trauma cases.
- After event was over, tried to find food for the BB staff within the medical center.
  - *Most had been placed in ED breakrooms, meeting rooms, and OR waiting rooms for the police officers.*
  - *Tried to order pizza, but open restaurants were afraid to send delivery staff to the area.*



Days following the incident…

- Several additional planned protests, some with opposing groups.
- BUMC declared Disaster Codes (lower level) for these protests
  - *Brought in extra staff and blood supplies.*
- Many blood drives were conducted across the Metroplex.
- Calls to BUMC on how to set up the blood drives.
  - *Referred callers to blood centers*
- Support messages/banners received at BUMC from Orlando
- Support messages/banners sent by BUMC to DPD and to DART police
- Transfusion service recognized for above and beyond efforts

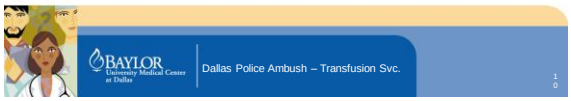


After the event analysis…After Action Report (AAR)

- Ran out of thawed plasma. Needed more thawing capacity.
- Runners returning empty coolers from OR on occasion brought back external packs with platelets in them.
  - Redelivered the platelets to the OR.
  - On the spot retraining of runners by anesthesiology.
- Need better understanding of why early blood samples are needed
  - Preserve O red cells.
  - Enable use of electronic crossmatch
- Patients given own names instead of "no id" names, i.e., Omega, Six; Alpha, Seven, etc.
  - "No id" names are quicker
  - Confirmation of true name can happen later.
- Other work for the other patients has to continue.
  - Need a plan for who will cover those patients, those phone calls.
- Police officers and others called the operator wanting to donate blood.
  - Operator directed those calls to blood bank.
  - Blood bank informed operator not to route any donation calls to blood bank.

Future Mass Casualty Incidents (MCI)

- Planning is in place for future incidents.
- Such incidents appear to be inevitable in today's world
- Baylor Emergency Management has made a trip to Orlando to learn from that MCI
- Transfusion service project to better utilize LIS to create generic MTP coolers without completing paper forms.
- Seeking protocols from other large trauma centers who have had these experiences.
- Have created a texting group for those willing to be called in for an MCI.



Questions/Discussion