



TRACIE
HEALTHCARE EMERGENCY PREPAREDNESS
INFORMATION GATEWAY

MASS SHOOTINGS AND RURAL AREAS



On November 5, 2017, a gunman opened fire in the First Baptist Church of Sutherland Springs (TX), killing 26 and injuring 20. While most of the wounded were taken by helicopter or ambulance to the closest Level 1 trauma center in San Antonio, some were brought to Connally Memorial Medical Center in Floresville first. Mandi Sralla was the director of this facility's emergency department (ED) at the time of the shooting and shared her experiences with ASPR TRACIE.

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■ John Hick (JH)

Please tell us about your facility and your role on the day of the shooting at the First Baptist Church.

■ Mandi Sralla (MS)

Connally Memorial Medical Center is a 44 bed licensed facility. We have four beds in the intensive care unit, and our ED has 10 beds with one major trauma bay. The other 9 rooms are centrally monitored rooms or OB/GYN rooms. Our average daily census is 8-10 patients per day; this increases to between 18 and 20 patients in the wintertime. In the ER, we average 35 visits a day, with higher peak times (up to 60 visits) in the wintertime. Our ER is a "one-doc shop." While some used to work 24 hour shifts, most now work 12 hour shifts.

I moved here from Houston when I was 15. I've been at Connally for 15 years. I started as an ER technician, then served as a registered nurse (RN). I was asked to move to management, and I've been the ED director for eight years—this is the position I held on the day of the incident. Running a rural ER has been a rewarding experience for me.

■ JH

How close are you to a major trauma center?

■ MS

Sutherland Springs is a very small community made up of a few hundred residents. It is about 15-20 miles east of Floresville, the county seat, which

has a population close to 8,000. The closest Level 1 is 45 minutes away by ground with no traffic. We're about the same distance to both of the Level 1 trauma centers in San Antonio.

■ JH

What ambulance services do you have in your area?

■ MS

We have three ambulance services in Wilson County and all three systems were dispatched to the incident.

■ JH

Because this happened on a Sunday, I'm curious if staffing was a challenge. Can you share how your staffing is set up during the week versus on weekends?

MS

It's standard for us to have 2 RNs on duty in the ER at all times during the day and night shifts. During the day, we have two midshift staff working (LVN or RN) from 8:00 a.m. till 8:00 p.m. and from 1:00 p.m. till 1:00 a.m. We have one technician and a clerk who work the 11:00 a.m. to 11:00 p.m. shift. We never have fewer than two nurses and no more than four working at a time. We also have a laboratory and blood bank in house.

■ JH

Please walk us through how you first found out about the incident.

■ MS

At about 11:30 that morning I was getting gas at the station right next to the hospital. My charge nurse called me and said there had been a "tone out" on the radio for a possible shooting in Sutherland Springs, and she asked if I was available. We still have police scanners here, so we can hear what is going on in the county, and this gives us a heads up, often before we are notified of a transport. I said yes, and told her I would call her back in a few minutes. When I called her back about five minutes later, her voice had dramatically changed, and she said there had been a shooting at a church and there had been multiple victims.

In this [article](#) and [related video](#), Dr. Kingdon (a physician working in Connally's ER on the day of the shooting) shares his thoughts about the patients and the incident in general.



Wilson County first responders and Airlife staff. Photo courtesy of Mandi Sralla.

I was so fortunate to have Dr. Kingdon working with us that day; he's an experienced military trauma surgeon who managed to keep everyone calm and follow the process in the few minutes we had before we received patients. Furthermore, my tech that day was a retired Army veteran who did 18 years as a flight medic. He started gathering supplies (e.g., tourniquets, QuikClot®, gowns, and extra blankets) to prepare for patients' arrival.

To top that off, University Hospital was having a trauma surgeon conference on the day of the incident. So not only did we have our own excellent in-house resources, but they had 10 extra trauma surgeons who pitched in to help with the patients received from the field and those we transferred.

When I walked in, I was greeted by some nurses whose children and/or spouses had been at church with family members during the time of the shooting. They didn't know which church had been affected at the time, so they were frantically trying to figure that out. Within a few minutes of my arrival, it was confirmed by EMS on the scene that this would be a multiple fatality incident. They asked for all available units in the county, including air services to be launched to the scene.

Overview of Events

11:15 a.m.	Incident Command requested all mass casualty resources.
12:00 p.m.	Incident Command came back over the air and reported that there were more than 20 wounded, including children. We had the benefit of hearing this over the radio before patients arrived, giving us time to prepare.
12:15 p.m.	The first call came from EMS stating they were inbound with a small child with multiple GSW. This patient ended up being the most severely injured we received. Injuries included multiple suspected entrance and exit wounds, a shattered pelvis and femur, and we could see the back of the patient's spine. The patient was bleeding profusely, so the first things Dr. Kingdon and our tech did were pack the wounds with QuikClot® and administer blood. We called the aircraft for a transfer. The IC and mass triage at the scene had already isolated who needed to go by air or by ground and who was deceased. They were able to divert one of the aircraft coming from San Antonio to us to pick up this young patient. During a subsequent hot wash, we found out that the reason this pediatric patient lived is because we stopped the bleeding. This child is now back at school and doing well physically.
12:25 p.m.	EMS pulled up with three patients in the back. These patients had GSW to the extremities and abdomen, and were varying levels of critical.
12:35 p.m.	MEDCOM called us back and said they would auto accept all trauma transfers; we just needed to have the doctor call and provide a full patient report.
12:50 p.m.	Received three adult patients.
12:53 p.m.	Received two more patients. After that, some patients came in their own cars, primarily with ricochet injuries. The church is very small and there was only one exit door. People were trying to escape, but they were crushing each other in the process; this led to additional injuries.
1:50 p.m.	We transferred our last patient to a Level 1 facility. One was transferred by helicopter, three went by ground. MEDCOM did help arrange the ambulances and air transport. Only one patient was admitted to our hospital.

Dr. Kingdon immediately called the STRAC (the Southwest Texas Regional Advisory Council). Within the STRAC is MEDCOM, the trauma dispatching system we use. If an incident meets the MEDCOM criteria, we call them, explain the situation, and ask for transfers to nearby Level 1 trauma centers. After we called STRAC, we called the South Texas Blood and Tissue Center in San Antonio to let them know what was going on. Then we activated our phone tree system. Our general surgeon, our orthopedic surgeon and our general medical director were en route, too, so we knew help was coming.

■ JH

Are most of your ER physicians local?

■ MS

No—they all work for Victoria Emergency Associates. Some are from the San Antonio area (e.g., Dr. Kingdon), others are from the Austin area. Some also come from the coast to work a few shifts per month, then go back home

■ JH

What did you have to deal with once the patients were transferred?

■ MS

Many of the clergy and church members from surrounding houses of worship started reporting to the hospital and asking what they could do to help. The scary part is we all knew each other. A few nurses took them by the hand and led them to pray with the patients' loved ones. These people were separated from their loved ones—either they didn't know if they'd been killed, or they saw them killed before their own eyes. In such a chaotic scene, our healthcare providers didn't have the time to stop and be sympathetic with loved ones, so that's what the clergy did. In a sense, this was very eerie. So many patients were so calm—not frightened or panicked. I think the clergy helped with that, too.

There was just a lot of raw emotion in some of the rooms. What could we say to the one lady who had just lost all five of her family members? But community members and clergy helped so much. While our medical mindsets were to get everyone stable, knowing we had people providing emotional care for patients' loved ones was so helpful.

There were games and tournaments taking place in the community that day, and they all stopped. In some cases, parents were cooking for the tournament and brought food and water to the hospital instead.

We immediately began receiving calls from media from all over the world. They would call our general line and press one for the ED—we quickly became inundated by the calls. There we were, trying to use the phone to arrange patient transfers, and our lines were tied up. We quickly arranged for some marketing personnel to go to an office and take the media calls to enable us to keep working.

Another challenge was that it took over 24 hours for authorities to positively identify most of the bodies in the church, so we had a lot of

The [entire press conference](#), featuring Dr. Kingdon, Mandi Sralla, and Dr. Preston Morehead is available via Facebook.

Access Mandi's presentation "[When It's Not a Drill](#)" to learn more about the hospital's response to this no-notice incident.

family members calling and coming to the hospital because they wanted information on their loved ones. Dealing with that secondary wave of emotions—where we had to tell people that their loved ones hadn't come to our facility for care—was another challenge.

■ JH

Was there a transition to a community-based center to relieve pressure on the hospital?

■ MS

Yes, and our CEO did a good job managing this. We held one press conference. The media presence at the actual scene was outrageous—responders had to work hard to block cameras as they extricated casualties.

We were able to use a different church as a "healing center." This is where investigators released the names of the deceased, and there were counselors and clergy available to meet with loved ones. While this process took a little more than a day, every minute was like hours to them, waiting to hear if their loved one's body was still in the church.

My hospital's stroke coordinator and her husband are also the pastors of the church that became the healing center. She recently resigned from the hospital, because the demand for mental health services is still so great. They are still providing equine therapy and other types of assistance to residents.

■ JH

How have hospital staff done as far as mental health goes?

■ MS

I think they've done really well overall. We prepared and tried to plan for these incidents, but you never think it's going to happen in your community. I think at first they were overwhelmed, but our community helped us out so much and continue to do so. We've had the opportunity to talk and vent to them and to each other to share our feelings and experiences. Our staff have all been pretty resilient. I think that the first responders who had to work the scene and see the deceased have had a harder time managing the negative emotional effects of seeing so many young victims. A lot of them are younger—the Incident Commander was 24. And hearing from the patients—some of them experiencing survivor guilt—was very hard for the responders. The shooter was tormenting people as he went through the church. Those stories hit our staff and responders the hardest. You simply can't fathom this type of scenario. Two quit altogether, another took an extended leave of absence, and another has been taking part in long-term counseling.

■ JH

Are there any other lessons learned you would like to share?

We recently revamped our phone tree process, as it was initially geared towards disaster response (e.g., tornado). But in a mass casualty incident, you need more people and faster. People didn't follow the phone tree process and we had a large number of staff reporting, making the scene a bit more chaotic for us. We also learned that we needed to prepare to work with the media.

As far as physical resources, we had what we needed, but since the incident, we've increased the number of tourniquets we have and we have increased our levels of "Stop the Bleed" teaching to the community and law enforcement. We also make sure all ambulances have QuikClot® on board. A physician at University Hospital recently wrote a grant that will help provide us with whole blood for the helicopters and hospitals.

The biggest key to success is having clear, effective communication from the scene. Establish who your Incident Commanders are, and who is in charge at the hospital. Setting up Incident Command at the hospital and making sure people are following established procedures will also help the response be as smooth as possible. Had our incident lasted longer, we would have set up an actual room where this could take place.

Education and training are just so important and should be a priority. It is worth the extra dollars, and there are available resources out there. You can never know enough. In a sense, this changed our exercise approach—everyone knows how to stabilize a patient, how to transfer, and the like, but making sure each department is on the same playing field and communication with the county is working well needs to be exercised, too.

Rural Mass Violence Considerations

Unfortunately, mass violence incidents are not confined to urban areas, and in rural settings, there are often substantial differences in terms of resources, response, and recovery. Some key considerations drawn from incidents in rural areas (such as the 2005 Red Lake (MN) Reservation shooting, where 10 people died [including the shooter] and 5 were injured at the high school) include:

- Law enforcement response times are longer, and fewer officers may be available to initiate "task force" responses with EMS and fire personnel.
- The local hospital may have limited staffing and capability to handle multiple critical trauma patients. For example, Red Lake IHS Hospital is licensed for 12 beds and is located half a mile from the high school. While rapid call-in resulted in adequate staffing after the shooting, in many rural communities, there simply may not be enough physicians and nurses available.
- Hospitals and first responders in all communities can be targets of primary or secondary attacks.
- While rural facilities may have better entrance controls than larger facilities, they often lack security staff. Local law enforcement should be familiar with the hospital's emergency management plan and need for support.

ASPR TRACIE's [Select Disaster Behavioral Health Resources](#) page and [Rural Disaster Health Topic Collection](#) include links to helpful resources.

- Alternative communication mechanisms should exist for requesting support when hospital phone lines are not working (after an incident, they will be jammed and cell service unavailable).
- Local EMS resources may be overwhelmed and mutual aid minimal; surrounding communities may only be able to spare a single ambulance to assist and travel distances may be long. Hospitals should collaborate with surrounding EMS agencies to ensure that mutual aid planning for inter-facility transfers is a priority (including identifying landing areas for multiple helicopters).
- Incoming EMS assets (both ground and air) could also be used to deliver additional personnel or supplies (e.g., blood, chest tubes). This should be part of local and regional mass casualty plans.
- In some cases, EMS personnel responding to conduct secondary transport to another healthcare facility may be needed to assist with immediate patient care at the originating hospital prior to initiating that transport.
- Smaller hospitals may have limited resources and space to deal with the influx of loved ones, phone calls, and media after an incident. Community planning for family assistance (including a location in which to provide it) is vital. Hospitals should also have pre-drafted messages to share via traditional and social media and plans for a variety of incidents.
- In smaller communities, responders and hospital staff are more likely to know patients and their loved ones, which could affect triage and treatment decisions as well as profoundly increase stress on providers during and after the event.
- Events occurring on tribal lands create specific challenges relative to sovereignty. Entrance to the reservation may be restricted or closed, and the tribe may govern themselves for the most part, but may directly engage federal resources in some cases. Understanding the unique local and regional differences and incorporating them into emergency management planning are key to successful response and recovery.



Connally ER staff pose with a banner sent from Sunrise hospitals in Las Vegas. Photo courtesy of Mandi Salla.