

**COMMANDERS GUIDEBOOK:  
MTF PREPAREDNESS AND RESPONSE TO  
CHEMICAL WARFARE TERRORISM**



**Prepared by:**

**Bureau of Medicine and Surgery  
Chemical, Biological, Radiological, Nuclear, and High-Yield Explosives  
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**February 2002**

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## *PREFACE AND PURPOSE*

Preparing for the consequences of a chemical agent release in the local community is unpleasant. However, as recent events have shown us, dealing with these consequences in the absence of preparation is more unpleasant. This Commanders Guidebook: Preparedness and Response to Chemical Warfare Terrorism, a companion to similar guides on biologic, radiation and high explosive warfare, is intended to stimulate thought and provide a format for planning. Overall, a chemical event is the scenario for which we classically train. It represents a point-in-time mass casualty with the potential for devastating effects on force readiness and the ability of the medical community to respond.

Chemical warfare (CW) agents are readily available throughout the world. While the threat is traditionally conceived of as arising from foreign terrorists, the relative ease of access to these agents creates the possibility that the threat may arise domestically as well as on foreign shores.

This Guidebook is not a cookbook. It will not propose definitive answers. Unfamiliar chemical agents, mixed chemical agents, and combined biological-chemical agents present scenarios with so many permutations that definitive answers are impossible. However, there are things we do know, courses of action to contemplate, scenarios we can plan for, and painful decisions to consider. Hopefully this Guidebook will equip military treatment facilities (MTF) and base installation planners with basic background information, scenarios, treatment recommendations and references to produce an effective plan. [Appendix A](#) provides guidance on funding considerations.

This guide is a product of BUMED's Chemical, Biological, Radiological, Nuclear, and high-yield Explosives Integrated Product Team (CBRNE IPT), and Navy Medicine subject matter experts. It will be revised and updated annually or as events dictate. BUMED welcomes recommendations on how this Guidebook can be improved. Comments should be addressed to BUMED (Attn: MED-02 CBRNE Program Manager).

BUMED offers a 24 hour notification and consultation line in the event of a chemical agent release or chemical terrorism attack — the MED-27 Readiness Watch Officer at (202) 445-0500.

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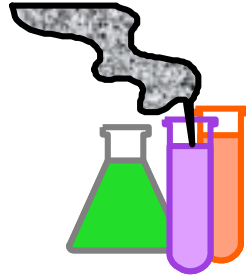
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## *CHAPTER 1: SCENARIO*



# *CHEMICAL TERRORISM: A SCENARIO*



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## *Incipient Stage (first 1-2 hours)*

*You are the Commanding Officer of a Military Treatment Facility in rural North Carolina. Early one weekday morning, the Emergency Dispatch Center receives an urgent call for assistance from the field. A battalion of Marines is in the field conducting live fire training exercises. The caller is panicked and the information incomplete, but it appears that the battalion was sprayed with an unknown liquid from an overhead aircraft. Almost immediately, the Marines collapsed with a multitude of symptoms including difficulty breathing, muscle twitching, blurred vision, sweating, nausea, vomiting, involuntary urination and defecation, profusely running noses, convulsions and coma. Some of them appear to be dead. The caller estimates 300 casualties. The dispatcher sends out two ambulance crews and notifies the Emergency Department of the situation. On arrival at the scene, the ambulance crew confirms a mass casualty situation and proceeds to immediately triage the patients. They have not donned personal protective gear and are quickly overcome by incapacitating symptoms. One crewmember manages to radio the Dispatch Center and requests further assistance. He is able to provide enough information for the Dispatch Center to realize the possibility of a chemical attack and dispatch two new ambulance crews, both equipped with personal protective gear. This takes time and more Marines succumb to their symptoms. A quick-thinking GySgt directs those who are able to disrobe and sets up the water buffalo as an emergency decontamination station. In view of the severity of symptoms and the numbers of victims, this provides limited relief. The two new ambulance teams arrive on the scene and immediately declare the limits of the "hot zone", inside which all rescuers must wear personal protective gear. They approach the scene from the uphill and upwind side. Victims who are able to walk are instructed to carefully disrobe and walk away from the area to the casualty receiving area. The corpsmen begin to inject the most seriously affected victims with atropine, but quickly run out of injectors. The ambulance is not equipped with either 2-PAM Cl or convulsive antidote for nerve agent (CANA). They radio for more injectors and for assistance from the military police to secure the area. An ambulance crewmember collects a sample of the unknown substance for analysis.*

## Sentinel Events

One of the great difficulties in timely response to a chemical incident is that there will frequently be massive numbers of victims, limited resources for treating the victims and very severe time constraints for effective action. In addition, the nature of the attack is usually unknown at first and with it, the potential to create more victims among the first responders who are facing an undefined threat

The key to successful management of a chemical incident lies in ensuring that all primary care providers, first responders, and other key staff personnel maintain a high index of suspicion for a chemical attack when large numbers of victims appear simultaneously. [Appendix B](#) gives a listing of available federal government, Navy, and other DoD courses in the medical management of CW agents. These courses may be available in variable formats including, on-line, VTC, CD-ROM and other distance learning options. Contact BUMED Code MED-05 (Education and Training) for further information (202) 762-3370. [Appendix C](#) and [Appendix D](#) are highly regarded references for background information on probable agents and management of chemical casualties.

*It is now two hours after the initial call for assistance was received. The sample of the unknown substance has been delivered to the hospital, but no one is able to identify it with the available resources. The substance is prepared for shipment to a more sophisticated lab. The corpsmen on the scene have established limited control of the situation. They have removed the ambulatory victims from the exposed area. The Marines have been able to secure additional water buffaloes and efforts at in-field decontamination are ongoing. In the confusion, not all personnel are wearing protective gear and new victims are appearing regularly. New supplies of atropine and 2-PAM Cl injectors have been delivered and the corpsmen continue to treat the most severely symptomatic victims. Because CANA is a controlled substance, there is confusion in the Pharmacy about how to issue this and it is not available. Field ambulances have been dispatched and victims are being collected for transport. The Emergency Department has notified the Commanding Officer of the military treatment facility (MTF) of the situation and a mass casualty has been declared. Crews are standing by outside the Emergency Department in appropriate Mission Oriented Protective Posture (MOPP) gear ready to receive and decontaminate the arriving victims. The head of the Pharmacy Department has placed an urgent call to the PRIME vendor source and additional supplies of atropine and 2-PAM Cl are on the way. The PRIME vendor has been notified of the need for future supplies of atropine for intravenous use and these are forthcoming, but will not be delivered until tomorrow. Calls have been placed to other hospitals in the area requesting that they provide any additional drug supplies that can be spared.*

## **Medical Surveillance**

“Red Flag” warnings for possible chemical warfare agent release may include:

- Groups of individuals becoming ill around the same time
- Any sudden increase in the following non-specific syndromes:
  - Sudden explained weakness in previously healthy individuals
  - Hypersecretion syndromes (like drooling, tearing and diarrhea)
  - Inhalation syndromes (eye, nose, throat, chest irritation; shortness of breath)
  - Burn-like skin syndromes (redness, blistering, itching, sloughing)

## **MTF Commander Actions, Incipient Stage:**

- Foster a high index of suspicion when large numbers of victims appear simultaneously. Time is of the essence in control and containment of chemical agent release. Personnel must be adequately trained to deal with creation of a “hot zone” to facilitate containment and exposure.
- Consider the events you are experiencing against the backdrop of current political tensions, world events, local circumstances and local threat condition.
- Know local emergency response resources and be prepared to quickly involve civilian law enforcement and medical personnel when mass casualties occur. Establishing a working relationship with civilian counterparts prior to any incident is critical. Civilian law enforcement and fire department officials may be needed to assist in evacuation of downwind facilities, especially when these facilities are outside the confines of the military jurisdiction.
- Be ready to quickly interact with local civilian authorities in a situation that overwhelms facility capabilities.
- Be aware of emergency back-up resources and the probable response times. Have a plan in place for distribution of pharmaceuticals, including those with restricted access. During the incident, there will be no time to create one.

Have a plan for appropriate decontamination and preposition the necessary resources. Be aware of the proper procedure for decontamination to avoid contaminating ambulances, the MTF or other personnel while treating victims. BUMED Instruction 3400.1, [Operational Concepts for Medical Support and Casualty Management in Chemical and Biological Warfare Environment](http://navymedicine.med.navy.mil/instructions/external/3400-1.pdf) (<http://navymedicine.med.navy.mil/instructions/external/3400-1.pdf>) provides explicit instructions.

## ***Early Suspicions (2-4 hours)***

*The Commanding Officer is in contact with her Responsible Line Commander (RLC). The most reliable estimates are that the battalion has sustained 100% loss of operational capability with 267 fatalities thus far. Assuming the worst case scenario, the RLC has notified his chain of command and the threat condition has been escalated to THREATCOM Delta. The RLC has also activated a casualty assistance program, but he has limited resources for handling a crisis of these proportions. Headquarters, Marine Corps has been notified and additional support is being mobilized.*

*The Federal Bureau of Investigation (FBI) has been notified of the incident, although it is not clear yet whether this is a terrorist attack or a chemical accident. Local law enforcement authorities have been cooperating with the military. They report no similar activity in the civilian community. There are no reports of increased potential for terrorist threat from any source.*

### **Notification and Consultation**

If the MTF commander suspects a CW incident, early notification of the base installation commander / Responsible Line Commander (RLC) is essential to allow control and containment of the situation. The RLC should notify the FBI to allow them to begin investigation of the incident. The RLC is also responsible for notification of other operational military units in order to prevent loss of operational capability. Consultation with BUMED and local community public health agencies is strongly recommended. This consultation is critical when it is clear that assistance from the civilian health care system is required.

### **Assistance**

MTF commanders can request direct consultation and assistance from BUMED activities with specialized CW detection and response team capabilities. These activities include the Navy Medical Research Center — (301) 319-7400/7100, Navy Environmental Health Center (NEHC) — (757) 462-5404 / 2178, and Navy Environmental Preventive Medicine Units (NEPMU) — see [Appendix B](#) for phone numbers.

In addition, specialized DoD response units including Chem/Bio Rapid Response teams (C/B-RRT), chemical casualty and medical management experts from U.S. Army Medical Research Institute of Chemical Defense (USAMRICD), U.S. Army Medical Research Institute of Infectious Diseases (USAMRIID), Navy Environmental Health Center (NEHC), and the Marine Corps Chem-Bio Incident Response Force (CBIRF) are

available for assistance. Assistance from any of these sources will not be immediate, however, and the MTF commander will be required to function independently for several hours before other resources can be mobilized.

For OCONUS MTF commanders, Crisis Response Teams (CRTs) may be able to provide interim assistance while these other resources are being activated.

### **Incident Investigation**

Local law enforcement agencies and the FBI should be notified and provided with resources as needed to assist with any criminal investigation efforts. Cooperation among military and civilian agencies is key to achieving a complete investigation and maintaining chain of custody for any evidence collected. If criminal prosecution is indicated, its success hinges on adhering to the standards defined for legal search and seizure and for preservation of chain of custody during evidence processing.

### **Laboratory Confirmation**

The rapid action of most chemical warfare agents means that laboratory confirmation of suspected chemical warfare agents would not be available in time to be of assistance during any incident. Treatment of the victims will be symptomatic based on the characteristics of the agent.

Chemical warfare agents can be grouped according to their actions:

- Nerve agents
- Mustard agents
- Hydrogen cyanide
- Tear gases
- Arsines
- Psychotomimetic agents
- Toxins

NAVMED P-5041, [Treatment of Chemical Agents Casualties and Conventional Military Chemical Injuries \(http://www.vnh.org/FM8285/about.html\)](http://www.vnh.org/FM8285/about.html) provides an overview of these agents including a discussion of the classes of agents and guides to recognition and treatment of victims of their use. Decontamination requirements and treatment options vary by the group and MTF's must insure that all providers are prepared to manage any contingency. [Appendix C](#) "Textbook of Military Medicine" and [Appendix D](#) "Medical Management of Chemical Casualties" are excellent references for use in planning. Protocols for decontamination must be established prior to any incident. The time-sensitive nature of these agents means that any response must

be automatic and efficient. This occurs only when plans have been established prior to the exposure.

If specimen collection is indicated, the specimens must be collected and handled consistent with standard protocols. If there is no individual on the scene with this expertise, the scene must be secured until someone adequately qualified can be contacted.

### **MTF Commander Immediate Actions:**

#### *MEDICAL Response Activities:*

- Isolate the area of exposure and establish a staging area away from the “hot zone”. Prepare to move the demarcation line if meteorological conditions dictate.
- Complete a hazard and risk assessment to determine if it is acceptable to commit responders to the site.
- Begin immediate removal of clothing, gross decontamination and definitive medical care of the most seriously affected victims.
- Move ambulatory patients away from the area of highest concentration.
- Confine all contaminated and exposed victims to a restricted/isolated area at the edge of the “hot zone” until decontamination can be completed.
- Obtain assistance from law enforcement agencies to secure the area.
- If a particular agent is known or suspected, institute efforts to obtain sufficient quantities of antidote.
- Notify hospitals, both military and civilian, of the anticipated arrival of contaminated victims. Establish gross decontamination facilities at the hospital.
- Request assistance from the Regional Response Team through the Federal Emergency Management Agency (FEMA).

Notification of the Base installation commander / RLC should be immediate. Early notification of the BUMED Readiness Division Watch Officer is also recommended (202) 445-0500. Alternative notification of BUMED can be made to the OOD/CDO cell phone at (202) 316-0932/3 and to the Navy Environmental Health Center (757) 462-5500.

MTF Commanders should be familiar with the precepts outlined in BUMEDINST 3400.1 [Operational Concept for Medical Support and Casualty Management in Chemical and Biological Warfare Environments](#) <http://navymedicine.med.navy.mil/instructions/external/3400-1.pdf> and NAVMED P-5041 [Treatment of Chemical Agents Casualties and Conventional Military Chemical Injuries](#) (<http://www.vnh.org/FM8285/about.html>).

## ***Consolidation 4-8 hours***

*The increased threat condition has restricted access to the base and word is already spreading in the community about the unusual activities that are occurring. Most of the information being spread is inflammatory and incorrect, but it has caused dozens of people to descend on both the base and local civilian emergency departments with complaints similar to those seen in the initial victims. None of the new patients can be confirmed as having been exposed but their large volumes have clogged emergency facilities. The civilian facilities are now reluctant to provide your MTF with further supplies of pharmaceuticals.*

*The base communication center is swamped with phone calls from concerned citizens, family members of the unit personnel and occasionally, with crank callers, adding further to the chaos. CNN now has a television crew outside the front gate of the base and is reporting on what limited information is known to them. Their reporters are demanding more information.*

### **Protection of Mission Capability**

First and foremost, MTF commanders need to maintain mission capability and protect the MTF staff and patients. Relevant considerations include universal protective precautions (gloves, gowns, masks, eye protection, etc.), individual protective equipment (IPE), facility protection, and security. Recommendations for specific actions vary with the chemical agent encountered, however an overview of IPE, collective protection, and decontamination can be found in [Chapter 2](#) and in NAVMED P-5041, [Treatment of Chemical Agents Casualties and Conventional Military Chemical Injuries](#) (<http://www.vnh.org/FM8285/about.html>).

### **Assistance**

MTF commanders should be prepared to function independent of state or federal response assistance agencies for at least the first 24 hours following discovery of a chemical event. Assistance from various DoD service component deployable platforms may be forthcoming, and considerations as to possible site locations, infrastructure support, supplies, and coordination with local civilian authorities should be undertaken in advance. Facility support for related functions (morgue overflow, decontamination stations, staging and reception areas) need advanced consideration. Issues for consideration and directed solutions are found in NAVMED P-5041, [Treatment of Chemical Agents Casualties and Conventional Military Chemical Injuries](#) (<http://www.vnh.org/FM8285/about.html>).

## **Pharmaceutical Prophylaxis**

In coordination with the State and Federal authorities, the RLC and MTF commander should notify the Emergency Support Operations Center (ESOC), Defense Supply Center Philadelphia (DSCP) of the developing CW event at 215-737-3965. This announcement will activate emergency actions at DSCP and will allow lead-time to source the expected high-volume requests for CBRNE medical items. See [Chapter 3](#) for information on the ESOC and transport of mass protection and treatment materiel provided in the discussion of lessons learned in the TOPOFF Exercise.

## **Communications**

Advance planning should define procedures for dealing with media and the release of public information. Clear, consistent, risk communication material should be provided via press briefings, MTF fact sheets or flyers disseminated to staff members, patients, families, visitors, media, and to the general public. Staying out front in the information campaign will assist in decreasing the risk of panic in the community. BUMED resources are available to assist MTFs in developing these risk communication materials.

MTF personnel can expect to be confronted by news media before, during, and after a CW related disaster. In addition, some MTF staff may feel compelled to “tell their story” about what is happening. A pre-established policy governing staff interaction with the media, release of information, avoidance of speculative or hypothetical questions and establishment of authorized spokespersons will minimize disruptions. Close cooperation with operational units is essential to insure that casualty notification procedures are followed. Consideration should be given to having a designated site located away from the MTF to hold regularly scheduled, and pre-announced media related news events.

## **MTF Commander Actions, Intermediate Stage:**

- Protect and preserve mission capability
- Ensure safety of facility, staff, and patients.
- Integrate whatever assistance may be forthcoming into unified effort.
- Control and sequester area of exposure. Prevent spread of contamination whenever possible.

- Implement MTF media and communications plan with designated single release point for information. Consider use of neutral, non-MTF site for media briefings at pre-announced times. Provide centralized information source for family and friends seeking patient status reports. Maintain close contact with Casualty Assistance Call Officers (CACO).
- Request consultation and assistance from BUMED activities with specialized CW response team capabilities (e.g. NMRC, NEHC, NEPMUs).

### ***Mass Casualty Management (9-48 hours)***

*The situation at the scene is now under control and patients are being transported in an orderly fashion to the Emergency Department for further care as needed.*

*One of the later responders calls the hospital to request advice on disposition of the deceased. He estimates more than 300 bodies are lying exposed on the field where the exercises were being conducted. Most of the remains have not been decontaminated and the parent unit does not have adequate supplies of body bags to accommodate all of the victims.*

*A working party is established with Marines from other units working side-by-side with corpsmen from the MTF. Remains of the deceased are decontaminated and placed in refrigerator cars that have been located in the civilian community. Mortuary teams have been requested and will be arriving tomorrow to assist in remains recovery and identification.*

#### **Hospital Emergency Incident Command System**

MTF commanders should have a complete understanding of the Hospital Emergency Incident Command System (HEICS) module and the Incident Command System (ICS) for improving their command and control during disasters and emergencies. ICS is a mandated requirement established by federal law for any CBRNE terrorism related response. Understanding the basic terminology and concepts of these two systems will greatly increase MTF effectiveness through improved cooperation and coordination with multiple response agencies at all levels. The Hospital Emergency Incident Command System (HEICS) may be downloaded from the following website: <http://www.emsa.cahwnet.gov/dms2/history.htm>. The Federal Emergency Management

Agency (FEMA) has produced a self-study course on the Incident Command Systems (ICS), obtainable at <http://www.fema.gov/emi/is195.htm>.

### **Facility Security**

Security and crowd control measures may become necessary at MTFs, emergency departments, fatality handling sites, and at other vital installation locations. A good MTF traffic management plan provides physical control of ingress and egress routes for essential personnel, equipment, food, water, for residents within the affected area, and for all travel to and from the reception and staging areas.

### **Protection of Staff**

MTF responders and healthcare staff should wear proper protective equipment when working with potentially contaminated material and victims. When and if a hazardous area is defined, proper protection should be available for not only first responders but also to those people living or otherwise located near these hazardous areas. Refer to [Chapter 2](#) for more information and [Appendix B](#) for website resources on individual protective equipment (IPE), collective protection, MTF decontamination, and universal precautions needed in any CBRNE environment.

Victims should be decontaminated prior to entrance into healthcare facilities. In such an event, EMS personnel would require experience in a rapid triaging system, such as the Simple Triage and Rapid Treatment (START) system. The START system, modified for contaminated casualties, is described in detail in [“Guidelines for Mass Casualty Decontamination During a Terrorist Chemical Agent Incident”](#) which can be found at [http://dp.sbcom.army.mil/fr/cwirp\\_guidelines\\_mass\\_casualty\\_decon.pdf](http://dp.sbcom.army.mil/fr/cwirp_guidelines_mass_casualty_decon.pdf).

Prior to any event, community leaders must be informed of the MTF distribution plan with its priority emphasis on protection of military mission capability and essential personnel. In implementing the distribution plan of protective gear or pharmaceuticals, MTF commanders should be prepared to field pointed questions from staff members, families, the media and the general public.

In the event that elevation to THREATCON Charlie or Delta is required, access to the military installation will be severely restricted. Personnel from off base and from civilian facilities who may be required to respond in the event of an emergency should be identified in advance and placed on rosters provided to base security. These rosters must be kept current to be of any utility.

Re-supply of CBRNE medical items may be facilitated 24 hours / day through the Emergency Support Operations Center ([ESOC](#)), Defense Supply Center, Philadelphia. See [Chapter 3](#) and [Appendix B](#) for more info on the ESOC. On-hand inventory distributions should consider that re-supply without assistance from the National Pharmaceutical Stockpiles (NPS “Push Packs”) and Vendor Managed Inventory of CDC / VA may be delayed. See [Chapter 3](#) for more information on the NPS Push Packs. Navy Medicine’s just-in-time inventory posture precludes the stockpile of most medical materiel and commodities, however MTF commanders will need to make individual decisions based on fiscal and operational needs regarding how much and what kind of CBRNE materiel is required at the local level. The 2000 Joint Warfighting Capability Assessment study conducted by Logistics Management Institute (LMI) for the combatant commanders proved that CBRNE medical defense pharmaceuticals are readily available from commercial sources at a 150 percent estimated dual multiple theater warfare demand and deliverable within 24-48 hours of notification. Transportation of supplies from depot stock, manufacturer, or distributor within CONUS, given our current capabilities, is achievable at 24-48 hour timeframe as well. However, OCONUS strategic and tactical transportation capabilities are still under study by LMI, therefore, it will be premature to assume 100 percent and 24-48 transportation coverage for these items.

### **The “Worried Well”**

Many patients may present for medical care both with and without symptoms consistent with exposure. After evaluation, they are found not to be casualties of the event and in retrospect, are dubbed the “worried well.” This is a diagnosis that can ONLY be made in retrospect and these patients will place demands on the healthcare system until their unaffected status is confirmed. The difficulty of this situation is that these “worried well” from a CW attack may exceed the number of exposed victims by 5 to 15 times according to some published reports. In the case of the Tokyo subway attack by the Aum Shinrikyo terrorists, the number of worried well was nearly 4500 of the approximate 5000 reported casualties.

MTFs should anticipate the potential for large volumes of patients who may ultimately be determined to be unaffected and establish procedures that accommodate the demands on space, staffing, equipment, consumables and transportation which these patients create. These patients cannot be assumed to be healthy and the MTF must also take care not to lose sight of the fact that many of these patients may have other medical problems unrelated to the incident or which are exacerbated by the incident and require attention.

## **Support Services**

MTF commanders can use the disaster relief and emergency services of the American Red Cross to provide information hotlines, assist with implementation of central coordination efforts involving various volunteer service groups and non-governmental organizations (NGOs), or provide food and shelter. The Red Cross should be included in MTF disaster planning and drills / exercises.

In a federally declared emergency, the American Red Cross serves as the Lead Federal Agency for Mass Care services under the Federal Response Plan (FRP). See [Appendix B](#) for information on the FRP.

NGOs, such as the Salvation Army, Latter Day Saints Charities, Catholic Medical Missions, United Methodist Relief Committee and others, can play a vital role in emergency relief. MTF commanders should consider establishing a volunteer skills / NGO database to catalog skills and professional services that can assist with victim and family support services (e.g. healthcare, shelter, food, water, language translation services, childcare, animal care, etc.).

There may be many individual volunteers, staff augmentees, NGOs, and others who will be present to assist the MTF during the CW event. The needs of these volunteer caregivers should also be considered. Victim and family support needs should also be included in MTF mutual assistance agreements with local community resource. The Emergency Services Division, Medical Services Branch of the Canadian Minister of Health and National Welfare produced the manual “Personal Services: Psychosocial Planning for Disasters.” a practical guide to planning, training, organizing, and implementing personal and family services in the wake of a disaster. This manual is available at [http://www.hc-sc.gc.ca/msb/emergency/pers\\_e.pdf](http://www.hc-sc.gc.ca/msb/emergency/pers_e.pdf).

## **Psychological Aspects of CW**

During a chemical terrorism event anxiety, fear, and panic can be expected from not only victims of the attack, but from MTF staff members and their families. MTF commanders can assist with the management of psychological needs by incorporating mental health scenarios and mental health professionals (including chaplains and local community clergy support) into CW drills and exercises. The National Center for Post-Traumatic Stress Disorders has produced a monograph on disaster counseling, entitled “[Disaster Response and Recovery: A Handbook for Mental Health Professionals](#)” which is available at <http://www.empowermentzone.com/disaster.txt>.

## **Mutual Aid Agreements**

The MTF should consider pre-established mutual aid agreements with neighboring communities and health agencies for sharing of resources across jurisdictional boundaries. Such agreements should consider: EMS, private ambulance services, first responder and other transportation services, sharing of local fixed site health care facilities, skilled nursing facilities, and residential homes, patient overflow and facility expansion sites, hospital supply centers for obtaining mechanical ventilators, local funeral home resources, and county medical examiner affiliation.

Mutual aid agreements should be coordinated with the nearest base installation to facilitate overall military response efforts and allow for improved communications between the installation commander and the MTF commander. Physical security needs, transportation requirements, and the possibility of access restrictions and / or quarantine order should be anticipated.

## **MTF Commanders Actions, Mass Casualty Phase:**

### *EMERGENCY MANAGEMENT Response Activities:*

- Activate MTF Emergency Operations Center (EOC)
  - Request local, state, federal representation to MTF EOC
  - Implement MTF Emergency Operations Plan (EOP)
- 
- Provide facility security in conjunction with base installation / law enforcement agencies at: MTF, ER, Ambulatory Care Centers, medical supply depots, PPE distribution sites, morgue, ingress and egress routes for essential personnel, equipment and residents.
  - Implement mass personal protective equipment distribution as per previously defined protocol. (Refer to Scenario and [Chapter 2](#) for considerations).
  - Refer to the section on the “worried well” for recommended response activities dealing with concerned, but unaffected patients.

*SUPPORT SERVICES – Response Activities:*

- Implement central coordination of NGOs / volunteer service organizations
- Conduct next of kin notification
- Provide families with non-medical, logistics, and transportation assistance
- Perform crisis, mental health, and grief counseling
- Provide translation services for non-English speakers
- Seek State Department liaison if disasters involves OCONUS MTFs / foreign victims
- Provide individual and family financial assistance, lodging assistance

*PSYCHOLOGICAL Response Activities:*

- Minimize panic by clearly communicating risks involved with a CW event
  - Develop informational items describing how MTF plans to protect its patients (e.g. use of media / press flyers, info / fact sheets, etc.)
  - Provide CW training and education opportunities for all staff - include frank discussions of potential risks
  - Include mental health participation in CW drills and exercises
  - Consider MOUs / MOAs for mental health services with local community
- 
- Establish liaison with local, regional and state assistance teams BEFORE their services are needed. Coordinate training exercises and drills with National Disaster Medical System (NDMS) sponsored Disaster Medical Assistance Teams (DMAT) teams and National Guard WMD Civil Support Teams. See [Appendix B](#) for more info on state based National Guard response teams.
  - Activate mutual aid agreements with local and regional community agencies and with the base installation.

## ***Consequence Management (48-96 + hours)***

***Disaster Mortuary Teams, the FBI and FEMA have all arrived on the scene. Decontamination, removal and identification of remains have been completed. Clean up of the contaminated area has begun. Investigation reveals that the toxic substance was an organophosphate compound commonly used as a pesticide in farming. The FBI is subsequently contacted by a crop-duster who reports that he had a malfunction while spraying on the day of the incident. He thinks he might be the source of the contamination. This is later confirmed. No evidence to support terrorist activity can be proven and the threat condition is returned to THREATCON Alpha.***

### **Lead Federal Agencies**

With an emergency declared by the President, two federal agencies, FBI and the FEMA, will assume lead federal agency roles and set up a Joint Operations Center (JOC) to provide immediate assistance to local and state authorities. Crisis and consequence management activities should work concurrently. FBI has overall control during crisis management, even on military property. FEMA can offer assistance on or off military installations and serves primarily in an advisory and support role to local and state authorities. FEMA has the lead agency role for domestic consequence management efforts and supports the FBI's role in accordance with Presidential Decision Directive (PDD39) ([Appendix B](#)).

In the event of a CW / terrorist attack at or near an OCONUS MTF, the State Department is the Lead Federal Agency and will coordinate the U.S. response to requests for relief to foreign governments affected by terrorist attacks against U. S. military / MTF targets.

### **CINCLANTFLT Role / OCONUS Navy Support by other CINCs**

Commander-in-Chief, Atlantic Fleet (CINCLANTFLT) is charged with planning all Navy support to DoD relief operations in support of federally declared relief efforts within CONUS, Puerto Rico, U. S. Virgin Islands. CINCLANTFLT also provides for foreign disaster relief operations OCONUS in support of U.S. government relief efforts for those nations located within the geographic areas of both CINC Joint Forces Command (JFCOM) and CINC Southern Command (SOUTHCOM). INCONUS deployments of DoD specialized response units under a federally declared emergency

are initially validated by a DoD Coordinating Officer, with DoD response units then being ultimately tasked to JFCOM and mobilized by the Joint Task Force - Civil Support (JTF-CS) office. JFCOM will be the supported theater commander for disaster relief operations and CINCLANTFLT will be a supporting component command.

Pacific region OCONUS emergencies are the responsibility of CINCPACFLT for PACOM, NAVEUR handles Europe for EUCOM, and NAVCENT is responsible for the CINCCENT geographic area.

### **DoD Specialized Response Units**

DoD response units may include Chem / Bio Rapid Response teams (C/B-RRT), biological casualty management experts from USAMRIID, NEHC, NMRC, and the Marine Corps Chem-Bio Incident Response Force (CBIRF). For OCONUS MTFs, Crisis Response Teams (CRTs) are proven emergency and disaster response assets already in place. CRTs may provide military assistance sooner while awaiting the arrival of the more specialized DoD response units. However, these response assets will not be immediately available to MTF commanders. MTFs need to be prepared to provide an immediate response on their own until the Federal Response Plan is activated and outside help arrives.

### **Military Support to Civil Authorities**

MTF commanders may be asked to provide direct medical assistance and support to the civilian community in the absence of a federally declared emergency. MTF commanders have authority to provide emergent response assistance to local and state governments under DoD Instruction 3025.1 Military Support to Civil Authorities ([Appendix B](#)). The “Immediate Response” authority of DoDINST 3025.1 may be exercised by MTF commanders when imminently serious conditions resulting from a civil emergency require immediate action to save lives, reduce suffering, or mitigate great property damage. Some examples of approved immediate response activities include, but are not limited to, rescue, evacuation, emergency medical treatment of casualties, maintenance or restoration of emergency medical capabilities, and safeguarding the public health.

Current capabilities and military mission requirements will dictate what MTF resources might be made available under the “Immediate Response” clause. In general, support of military operations will have mission priority over any civil operations, unless otherwise directed by the Secretary of Defense. Additionally, MTF commanders are cautioned DoDINST 3025.1 prohibits the MTF from developing plans or using its

resources strictly for the purpose of providing an immediate response to the civilian community.

### **Posse Comitatus Considerations**

Use of Navy medical personnel in the civilian community on an emergent basis does not violate the Posse Comitatus Act (18 USC 1385). The Act requires advance approval for the use of federal military forces to enforce federal, state, or local civil law. However, all MTF mutual aid agreements with civilian agencies should include a legal review. MTFs may consult with BUMED Legal at (202) 762-3091.

### **Mortuary Affairs**

With activation of the National Disaster Medical System (NDMS), specialized NDMS Disaster Mortuary Teams (DMORTs) will deploy to assist with fatality management efforts. Consideration should be given to establishing mutual assistance agreements for alternative storage sites such as refrigerated trucks, rail cars, and other cold storage facilities that can hold remains until final disposition. Additionally, assistance is available from state and federal disaster mortuary assistance teams as part of the National Disaster Medical System (NDMS). See [Appendix B](#) for more information on these NDMS disaster mortuary assistance teams.

MTF commanders may face difficult decisions concerning the final disposition of remains, especially when recommended procedures conflict with family member's preferences. Coordination with the chaplain community is encouraged.

Additional information may be found in JP 4-06 Joint Tactics, Techniques, and Procedures for Mortuary Affairs in Joint Operations, at [http://www.dtic.mil/doctrine/jel/new\\_pubs/jp4\\_06.pdf](http://www.dtic.mil/doctrine/jel/new_pubs/jp4_06.pdf); and in Appendix M-3 "Mass Fatalities" – Kentucky State Emergency Operations Plan at: <http://webservice.dma.state.ky.us/kyeop.htm>.

#### ***FATALITY MANAGEMENT – Response Activities:***

- Manage expected high volume of families seeking deceased relatives
- Use morgue as initial central processing site for fatalities
- Consider use of long-term fatality storage facility until final disposition
- Maintain mortuary registry of similar deaths
- Consider temporary and final disposition of fatalities
- Implement options for release of remains, as appropriate

## **Quarantine and Contamination**

Close and frequent communications via chain of command authority with BUMED, base installation commander / RLC, and with local, state, and federal authorities is essential to contain the spread of contamination. Contingency plans should address MTF continuity of operations, and provide policies and procedures for essential movement of first responders, other critical personnel, staff augmentation, food and water, and physical security in the event of a quarantine order.

The burden of requesting a quarantine order remains a public health decision at the local, regional, or state agency level. If authority to quarantine is requested by public health officials, the order will be issued to law enforcement officials beginning at the local community government level. Authority to issue such orders rests with the Governor of the State.

Quarantine imposes serious legal, logistics, enforcement, and other concerns and may seem harsh and cruel to those people affected. In addition, the extended viability of some chemical agents in the environment may extend the period of quarantine. State quarantine laws vary. MTF commanders should obtain military legal counsel on the full implications of a quarantine order in the local community.

## **Residual Hazard Assessment and Mitigation**

FEMA has overall responsibility for coordinating the clean up of environmental hazards after an incident, however residual hazard mitigation is the shared responsibility of the MTF along with local, state, and federal environmental and health agencies.

Assessment and mitigation efforts may include efforts of the MTF environmental health staff for sampling of air, water, soil, insect and animal screening for the CW agent.

### ***RESIDUAL HAZARD ASSESSMENT AND MITIGATION – Response Activities:***

- Request environmental health officer assistance for air, water, soil, and surface screens.
- Conduct local area control and decontamination

## **Criminal Investigations**

MTF Commanders may be asked to cooperate with local and federal law enforcement activities in their criminal investigations of the event.

### **MTF Commanders Actions, Consequence Management Phase:**

- Understand the Federal Response Plan (FRP), Joint Operations Center (JOC), and DoD emergency response units and their impact upon MTF command and control. Refer to [Appendix B](#) for specific resource information on the FRP, JOC, JTF-Civil Support office, NDMS, and National Guard Civil Support teams.
- Be aware of the restrictions outlined in DoD Instruction 3025.1 - Military Support to Civil Authorities (MSCA) especially the “Immediate Response” clause.
- Contact local and state public health agencies for CW plan coordination efforts See [Appendix B](#) for state agencies.

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## *CHAPTER 2*

# **Individual Protection, Collective Protection, Decontamination, Universal Precautions**

### **INDIVIDUAL PROTECTIVE EQUIPMENT (IPE)**

The level of individual protective equipment (IPE) needed by staff members who are treating and/or responding to a chemical incident will be determined by the specific chemical agent used and by the concentration level from the attack. The Incident Commander at the scene makes this decision for the level of protection. In a contaminated zone or decontamination environment, MTF commanders should allow for frequent staff rotation due to the physical strain and stress of wearing IPE.

The most important decontamination measure concerns the individual: the first responder or MTF staff member in need of immediate decontamination. If it is suspected that skin has been exposed to liquid CW agents, then it must be decontaminated immediately. The rule of thumb for decontamination is that it must be completed in one minute from exposure. All experience with CW agents confirms that the most important factor is time—the means used in decontamination is of lesser importance. Good results can be obtained with such widely differing means as talcum powder, flour, soap and water in addition to any special decontaminates used.

For complete decontamination, clothes and personal equipment must also be decontaminated. If clothes have been exposed to liquid contamination, then extreme care must be taken when undressing to avoid transferring CW agents to the skin. There may be particular problems when caring for the injured since it may be necessary to remove the victim's clothes by cutting them off. This must be done in such a way that the victim is not further injured through skin contact with CW agents. During subsequent treatment it is essential to ensure that the entire patient is decontaminated to avoid the risk of exposing the MTF medical staff to the CW agents.

For further guidance on IPE see <http://www.nap.edu/html/terrorism/ch3.html>.

## **COLLECTIVE PROTECTION**

The use of IPE is of limited value where greater numbers of medical personnel need to operate together for longer periods of time in a CBRNE environment. Collective Protection systems typically involve a fully functional CBRNE protected zone or unit supplied with both pressurized and filtered air. Use of Collective Protection allows delivery of medical care to continue in any CBRNE contaminated environment. Within a Collective Protective environment, the use of IPE is not required. Collective Protection systems are typically designed to be integral parts of the designated zone or unit's heating, ventilation, and air conditioning (HVAC) system. Work inside a Collective Protective System implies that the victim has been adequately decontaminated prior to placement in the system.

Collective Protection against CBRNE agents employs efficient filtration, systems integrity, and associated control mechanisms. Systems integrity involves use of efficient seals and pressure gradient airflow. Techniques for expedient collective protection are detailed at: <http://www.firefighting.com/default.asp?GoTo=namID938>.

## **MISSION ORIENTED PROTECTIVE POSTURES (MOPP) LEVELS**

MTF commanders should become familiar with the various levels of MOPP. The MOPP system is designed to be a flexible means of increasing or decreasing levels of personal protection based on an assessment of the actual CBRNE threat encountered.

MOPP levels should be increased when encountering known contamination or before entering an area believed to be contaminated. First responders and other healthcare personnel should always mask if they are in downwind / plume hazard areas, and if detection equipment has not yet been deployed. MOPP levels should not be increased solely on the basis of unconfirmed reports of a CW attack. Important Note: The use of IPE in higher MOPP levels for extended periods can cause dehydration, heat stress injury, and otherwise degrades the normal efficiency of medical personnel in performing routine tasks. Higher MOPP levels impair visibility, mobility, and communication. More information on MOPP levels can be found at:

<http://www.gulflink.osd.mil/mopp>

## **DECONTAMINATION**

Decontamination (decon) of patients affected by chemical agents is critical to treatment. Any decontamination required ideally would take place prior to entry into the MTF. See [Scenario, Consequence Management Phase](#) for more info on when decontamination of patients may be necessary. However, during a terrorist incident, ambulatory casualties may self-evacuate to the nearest medical facilities. Medical personnel who will be treating patients and who have not been decontaminated need to be wearing IPE.

Prior coordination of decontamination capabilities and response assets is needed with the Base installation or local fire department and with other local first responder agencies. MTF personnel should be prepared to perform patient decontamination if any pre-designated decontamination assets are delayed or unavailable. If patient decontamination is required, it should be performed in a pre-designated location, ideally outside the MTF but near the emergency department. Consideration for special decontamination arrangements may be needed if difficult weather / temperature conditions are present. BUMED Instruction 3400.1 provides details on decontamination of casualties under a variety of circumstances.

### **MOPP Level Local Decision**

The on scene commander determines the appropriate MOPP levels based on the local environment, threat analysis, personal vulnerability and working conditions.

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## CHAPTER 3

### *Observations from TOPOFF*

#### Executive Summary/Approach Findings

##### **TOPOFF Exercise**

The United States Congress, believing “that few of the *top officials* of agencies have ever fully participated” in domestic preparedness exercises has directed the Department of Justice to conduct an exercise “with the participation of all key personnel who would participate in the consequence management of [an actual chemical, biological, or cyber] terrorist event.” [Senate Report 105-233]

##### **TOPOFF Exercise Planning Conference**

The **TOPOFF Exercise Planning Conference** brought together over 100 state and local emergency response planners and practitioners from across the nation, to identify objectives to be used in designing the Top Official’s (TOPOFF) Exercise. Hosted by the Department of Justice and the Federal Emergency Management Agency, the Conference was held May 20-21, 1999 in Chantilly, VA.

Over the day and a half of the Conference, fire/HAZMAT, law enforcement, medical/EMS, and emergency management professional identified and prioritized consensus objectives reflecting each discipline and jurisdiction, large and small. As a result, the TOPOFF Exercise will directly address the concerns and issues of Stakeholders nationwide.

##### **The Process**

On the morning of the first day of the conference, participants were assigned to functional/professional working groups (law enforcement, fire/HAZMAT, medical/EMS, local emergency management, and state emergency management). These working groups were asked to identify and prioritize critical exercise objectives for a national exercise.

In the afternoon session, these exercise objectives were considered by five multidisciplinary groups, tasked with recommending consensus objectives for use by TOPOFF exercise planners. Their prioritized objectives reflect the crosscutting nature of the groups' makeup and provide the basis for the Conference's recommendations.

## **TOPOFF Conference Recommendations**

The following categories highlight the final objectives that were produced by the TOPOFF Conference participants.

### **Command and Control**

- Exercise an integrated Emergency Management Structure (Incident Command System, Unified Command System, etc.).
- Exercise Interagency and Intra-agency coordination.
- Demonstrate Federal, State, and local integration and cooperation.
- Show the integration of the medical community into the overall emergency response.
- Exercise the interaction between crisis to consequence management: FBI and FEMA roles.
- Exercise crime scene evidence preservation, criminal investigation, and chain of custody issues.
- Exercise communications degradation.
- Review and exercise procedures and mechanisms for reimbursement to local and State agencies for expenses and losses incurred due to a WMD incident.

### **Incident Timing/Scope**

- A no notice event
- Stage multiple events at multiple locations or jurisdictions on a local, State, and Federal level. Utilize contrasting cities (i.e. Nunn-Lugar-Domenici and non-Nunn-Lugar-Domenici cities) and involve rural participants.
- Exercise over multiple days.
- Conduct the event with "real time" deployment of assets and real resource limitations in handling mass fatalities and mass casualties.
- Address both crisis and consequence management issues simultaneously.
- Demonstrate the distinction between chemical and biological incidents, including an overt release, covert release or biological event. Have a combined event, (i.e. explosive and a biological agent).

## **Public Information**

- Exercise and evaluate public affairs plans and procedures for establishing and maintaining responsive and thoroughly coordinated public information programs at the local, State, and Federal levels.
- Prepare to handle disinformation and misinformation from overnight experts, media designated Subject Matter Experts, media use by the adversary, as well as public expectations and misunderstandings.

## **Medical/Public Health**

- Exercise the medical and public health infrastructure, response and resources, provision of health resources (prophylaxis), and mutual aid/support to handle mass casualties and mass fatalities on an immediate level. Assess the ability to provide extended care and extended resources. Examine the effectiveness and timeliness of the Federal government response to provide long-term support to jurisdictions.
- Demonstrate the ability to protect lives.
- Prevent injury at all levels through an assessment of the capability to deliver, distribute and administer medical supplies (antibiotics, antidotes, and vaccinations, ventilators, ICU capabilities) and personnel in a timely manner, and manage disposition of mass fatalities (the management of contaminated remains).
- Exercise surveillance, diagnosis, and identification capabilities.
- Show the ability to effectively integrate supplemental support.
- Determine the capabilities and resources to provide mental health care for victims, first responders, and the community at large.

## **Infrastructure**

- Test the ability to protect and/or respond to disruptions of critical infrastructure resulting from a catastrophic WMD attack.
- Test different types of infrastructure, public works, (water and wastewater), utilities, and transportation.
- Test quarantine challenges (transportation of victims and facilities to house them).
- Test technical capabilities of federal resources, including software and hardware.

## **Resource Management**

- Promote and broaden understanding of the assets available at all levels, how to call up these assets, and stress the most effective integration of federal assets in local, county, and State operations.
- Analyze the adequacy of current federal response systems and programs at meeting local, State and regional needs.
- Identify, manage, and move Federal, State, and local resources and mutual aid pacts, including local accommodation/reception support to augment federal assets.
- Demonstrate the prioritization of limited specialized Federal response assets to separate and simultaneous WMD incidents.
- Utilize a broad resource pool: contractors, the private sector, volunteers and Non-Governmental Organizations.
- Integrate the activation/call up of personnel, including Reserves and the National Guard.

## **Information Sharing**

- Demonstrate the value of information sharing between Federal, State, and local entities in preventing and/or mitigating the consequences of WMD.
- Exercise information sharing horizontally, vertically, up, down and across all levels.
- Reassess classification issues, who should be cleared?
- Conduct threat assessments and pre-event intelligence for jurisdictions.

## **Interoperable Communications**

- Expose suspected gaps in physical communications interoperability between functional and jurisdictional levels of government during a WMD incident.

## **Lessons Learned**

- Utilize a neutral party or observers to assist in the peer evaluation and capture of lessons learned.
- Disseminate After Action Reports on a timely and widespread basis.
- Ensure widespread dissemination and discussion of lessons learned.
- Maintain a comprehensive recording of incident play.
- Identify and evaluate the efficacy of deployed Federal and State assets and standing response plans utilized during the incident response.

## **Consensus Objectives/Guidance**

In plenary session on the morning of May 21, the Planning Conference participants received, discussed, and adopted the following consensus objectives for the TOPOFF Exercise:

### **1. Command and Control**

- 1.1. Exercise an integrated Emergency Management Structure (Incident Command System, Unified Command System, etc.).
- 1.2. Exercise Interagency and Intra-agency coordination.
- 1.3. Demonstrate Federal, State, and local integration and cooperation.
- 1.4. Show the integration of the medical community into the overall emergency response.
- 1.5. Exercise the interaction between crisis to consequence management: FBI and FEMA roles.
- 1.6. Exercise crime scene evidence preservation, criminal investigation, and chain of custody issues.
- 1.7. Exercise communications degradation.
- 1.8. Review and exercise procedures and mechanisms for reimbursement to local and State agencies for expenses and losses incurred due to a WMD incident.

### **2. Incident Timing/Scope**

- 2.1. A no notice event
- 2.2. Stage multiple events at multiple locations on a local, State, and Federal level. Utilize contrasting cities (i.e. Nunn-Lugar-Domenici and non-Nunn-Lugar-Domenici cities) and involve rural participants.
- 2.3. Exercise over multiple days.
- 2.4. Conduct the event with “real time” deployment of assets and real resource limitations in handling mass fatalities and mass casualties.
- 2.5. Address both crisis and consequence management issues simultaneously.
- 2.6. Demonstrate the distinction between chemical and biological incidents, including overt release, covert release, and hoax. Recognize, identify and predict consequences stemming from a chemical or biological event. Have a combined event, (i.e. explosive and a biological agent).

### **3. Public Information**

- 3.1. Exercise and evaluate public affairs plans and procedures for establishing and maintaining responsive and thoroughly coordinated public information programs at the local, State, and Federal levels.
- 3.2. Prepare to handle disinformation and misinformation from overnight experts, media designated Subject Matter Experts, media use by the adversary, as well as public expectations and misunderstandings.

### **4. Medical/Public Health**

- 4.1. Exercise the medical and public health infrastructure, response and resources, provision of health resources (prophylaxis), and mutual aid/support to handle mass casualties and mass fatalities on an immediate level. Assess the ability to provide extended care and extended resources. Examine the effectiveness and timeliness of the Federal government response to provide long-term support to jurisdictions.
- 4.2. Demonstrate the ability to protect lives.
- 4.3. Prevent injury at all levels through an assessment of the capability to deliver, distribute and administer medical supplies (antibiotics, antidotes, and vaccinations, ventilators, ICU capabilities) and personnel in a timely manner, and manage disposition of mass fatalities (the management of contaminated remains).
- 4.4. Exercise surveillance, diagnosis, and identification capabilities.
- 4.5. Show the ability to effectively integrate supplemental support.
- 4.6. Determine the capabilities and resources to provide mental health care for victims, first responders, and the community at large.

### **5. Infrastructure**

- 5.1. Test the ability to protect and/or respond to disruptions of critical infrastructure resulting from a catastrophic WMD attack.
- 5.2. Test different types of infrastructure, public works, (water and wastewater), utilities, and transportation.
- 5.3. Test quarantine challenges (transportation of victims and facilities to house them).
- 5.4. Test technical capabilities of federal resources, including software and hardware.

## **6. Resource Management**

- 6.1. Promote and broaden understanding of the assets available at all levels, how to call up these assets, and stress the most effective integration of federal assets in the local, county, and State operations.
- 6.2. Analyze the adequacy of current federal response systems and programs at meeting local, State, and regional needs.
- 6.3. Identify, manage, and move Federal, State, and local resources and mutual aid pacts, including local accommodation/reception support to augment federal assets.
- 6.4. Demonstrate the prioritization of limited specialized Federal response assets to separate and simultaneous WMD incidents.
- 6.5. Utilize a broad resource pool: contractors, the private sector, volunteers and Non-Governmental Organizations.
- 6.6. Integrate the activation/call up of personnel, including Reserves and the National Guard.

## **7. Information Sharing**

- 7.1. Demonstrate the value of information sharing between Federal, State, and local entities in preventing and/or mitigating the consequences of WMD.
- 7.2. Exercise information sharing horizontally, vertically, up, down and across all levels.
- 7.3. Reassess classification issues, who should be cleared?
- 7.4. Conduct threat assessments and pre-event intelligence for jurisdictions.

## **8. Interoperable Communication**

- 8.1. Expose suspected gaps in physical communications interoperability between functional and jurisdictional levels of government during a WMD incident.

## **9. Lessons Learned**

- 9.1. Utilize a neutral party or observers to assist in the peer evaluation and capture of lessons learned.
- 9.2. Disseminate After Action Reports on a timely and widespread basis.
- 9.3. Ensure widespread dissemination and discussion of lessons learned.
- 9.4. Maintain a comprehensive recording of incident play.

- 9.5. Identify and evaluate the efficacy of deployed Federal and State assets and standing response plans utilized during the incident response.

These objectives are intended for use by the designers of the exercise in developing the scenario and specific elements for TOPOFF. The Planning Conference participants recognized that it may not be possible to incorporate every objective into the exercise design. It was their consensus, however, that by addressing as many of the recommended items as possible, TOPOFF can provide maximum and substantial value to WMD terrorism responders at all levels of government.

Report from the Department of Justice.

### **National Pharmaceutical Stockpile**

*A decision to deploy the stockpile is based on the best epidemiologic, laboratory and public health information regarding the nature of the threat.*

- The mission of the CDC's National Pharmaceutical Stockpile program (NPS) is to ensure the availability of life saving pharmaceuticals, antibiotics, chemical interventions, as well as medical, surgical and patient support supplies, and equipment for prompt delivery to the site of a disaster, including a possible biological or chemical terrorist event anywhere in the United States.
- The NPS is available to supplement the initial response to an incident of biological or chemical terrorism. That response will come from the local and state emergency medical and public health personnel.
- A primary purpose of the NPS is to provide critical drugs and medical material that would otherwise be unavailable to local communities.
- CDC's NPS is a unique resource available to all United States public health departments.

## Contents of Stockpile

- CDC has established relationships with various national security agencies to facilitate continuous updates and analyses of threat agents and ensure that the NPS reflects current needs.
- Expert panels convened by CDC prioritized the following biologic agents: smallpox, anthrax, pneumonic plague, tularemia, botulinum toxin and viral hemorrhagic fevers.
- Because anthrax, plague and tularemia can be effectively treated with antibiotics that are immediately available, purchasing these products for the NPS formulary was given first priority.
- The NPS also has a cache of vaccine available to address smallpox threats.
- In addition to medications and supplies for intravenous administration, the NPS includes medical equipment that would be essential for treatment, including airway supplies, bandages and dressings, and other emergency medication. These are items that local clinicians may find in short supply in the event of a terrorism event.
- The National Pharmaceutical Stockpile (NPS) has two basic components. The first component consists of eight 12-hour Push Packages for immediate response. These 12-hour Push Packages are fully stocked, positioned in environmentally controlled and secured warehouses, and ready for immediate deployment to reach any affected area within 12 hours of the federal decision to release the assets.
- A 12-hour push package is a pre-assembled set of supplies, pharmaceuticals, and medical equipment ready for quick delivery to and use in the field. Each “package” consists of 50 tons of material intended to address a mass casualty incident. These packages will permit emergency medical staff to treat a variety of different agents, since the actual threat may not have been identified at the time of the stockpile deployment.
- The second component is comprised of Vendor Managed Inventory (VMI) material. If the incident requires a larger or multi-phased response, follow-on VMI packages will be shipped to arrive within 24 to 36 hours.

- The follow-on VMI packages are comprised of pharmaceuticals and supplies that can be “tailored” to provide pharmaceuticals, supplies and/or products specific for the suspected or confirmed agent or combination of agents.

From the Centers for Disease Control,

[http://www.bt.cdc.gov/DocumentsAPP/national\\_pharmaceutical\\_stockpile.pdf](http://www.bt.cdc.gov/DocumentsAPP/national_pharmaceutical_stockpile.pdf)

Important Note: Only State and Federal authorities can formally request NPS—such assistance cannot be requested directly by the MTF commander. Note also that technical assistance personnel accompany NPS Push packs only. NPS has no dedicated support personnel to help secure, distribute, transport, or apply the mass therapy.

## CHAPTER 4

# Toxidromes

## **Nerve Agents**

### *Signs and Symptoms:*

#### Vapor:

Small exposure: onset within seconds to minutes of miosis, rhinorrhea, mild difficulty breathing

Large exposure: onset within seconds to minutes of sudden loss of consciousness, convulsion, apnea, flaccid paralysis, copious secretions, miosis

#### Liquid on skin:

Small to moderate exposure: onset within minutes of localized sweating, nausea, vomiting, feeling of weakness

Large exposure: onset within minutes of sudden loss of consciousness, convulsions, apnea, flaccid paralysis, copious secretion

### *Detection:*

M256A1, CAM, M8 paper, M9 paper, M8A1 and M8 alarms

### *Decontamination:*

M291, M258A1, hypochlorite, large amounts of water

### *Immediate management:*

Administration of MARK I Kits (atropine and pralidoxime chloride); diazepam in addition if casualty is severe; ventilation and suction of airways for respiratory distress

## **Mustard Agents**

### *Signs and Symptoms:*

Asymptomatic latent period of hours followed by erythema and blisters on the skin, eye irritation, conjunctivitis, corneal opacity, mild to severe respiratory signs, gastrointestinal effects and bone marrow stem cell suppression

### *Detection:*

M256A1, M272 water testing kit, MINICAMS, the ICAD, M18A2, M21 remote sensing alarm, M90, M93A1 Fox, Bubbler, CAM and DAAMS (not the M8A1 automatic chemical agent alarm), M8 paper, or M9 paper

### *Decontamination:*

0.5% hypochlorite, M291 kit and water in large amounts

### *Management:*

Decontamination immediately after exposure is the only way to prevent damage. Supportive care of affected patients. There is no specific therapy.

## **Hydrogen Cyanide**

### *Signs and Symptoms:*

Few. After exposure to high concentration, seizures, respiratory and cardiac arrest. Death occurs in six to eight minutes after inhalation.

### *Detection:*

M256A1 detector ticket detects hydrogen cyanide as a gas or vapor in the air. The M272 kit detects cyanide in water. The ICAD, M18A2 and M90 also detect hydrogen cyanide. The CAM, M8A1 automatic chemical alarm and M8 and M9 paper do NOT detect cyanide.

### *Decontamination:*

Skin decontamination is usually not necessary because the agent is highly volatile. Wet, contaminated clothing should be removed and the underlying skin decontaminated with water or other standard decontaminates.

### *Management:*

Immediate intravenous sodium nitrite and sodium thiosulfate. Support with oxygen and correct acidosis.

## **Tear Gases**

### *Signs and Symptoms:*

Burning and pain on exposed mucous membranes and skin, eye pain and tearing, burning in the nostrils, respiratory discomfort, tingling of the exposed skin.

### *Detection:*

None.

### *Decontamination:*

**Eyes:** thoroughly flush with water, saline or similar substance. **Skin:** flush with copious amounts of water, alkaline soap and water, or mildly alkaline solution (sodium bicarbonate or sodium carbonate). Generally decontamination is not needed if the wind is brisk. Hypochlorite exacerbates the skin lesion and should NOT be used.

### *Immediate management:*

Usually none is necessary. The effects are self-limiting.

## **Arsines**

### *Signs and Symptoms:*

Onset hours (up to 24 hours) after exposure with headache, lightheadedness, malaise, weakness, thirst, muscle cramping, abdominal pain, flank pain, nausea, vomiting and possible hypotension from intravascular hemolysis. Excretion of dark red urine six to eight hours after exposure frequently develops.

### *Detection:*

Nonirritating, colorless, heavier-than-air gas with odor of garlic.

### *Decontamination:*

Skin decontamination after removal of wet, contaminated clothing.

### *Management:*

Observation of asymptomatic patients for four to six hours. Alkalinization of urine with sodium bicarbonate for symptomatic patients. Transfusion, exchange transfusion and hemodialysis for severely affected patients.

## **Psychotomimetic Agents**

### *Signs and Symptoms:*

Onset of hallucinations minutes to hours after exposure. May also have associated abdominal pain, nystagmus, pinpoint pupils, sensory anesthesia, hyperpyrexia, hypertension, seizures or coma depending on the agent ingested.

### *Detection:*

None.

### *Decontamination:*

Consider gastric decontamination on a case by case basis.

### *Management:*

Differentiate psychotomimetic ingestion from other causes of symptoms (hypoglycemia, hyperthermia, impending delirium tremens, salicylate toxicity, anticholinergic toxicity, tricyclic antidepressant overdose or thyrotoxicosis) and treat symptomatically.

## **Toxins**

### *Signs and Symptoms:*

**Botulinum:** onset within 12-72 hours of visual disturbance, skeletal muscle weakness and/or paralysis of oropharyngeal muscles.

**Staphylococcal enterotoxin B:** onset within hours of headaches, muscle aches, cough, chest pain, difficulty breathing, nausea, vomiting, and diarrhea depending on the route of exposure.

**Ricin:** rapid onset of respiratory distress after aerosol exposure

### *Detection:*

None.

### *Decontamination:*

Standard skin decontamination is prudent but likely to have limited effect after aerosol attack.

### *Management:*

Symptomatic treatment only.

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## *Chemical Agents (Warfare to Toxic Industrial Agents)*

### Nerve Agents

Ethyl NN-dimethylphosphoramidocyanidate (**tabun** or **GA**)  
O-isopropyl methylphosphonofluoridate (**sarin** or **GB**)  
O-1,2,2-trimethylpropyl methylphosphonofluoridate (**soman** or **GD**)  
O-cyclohexyl methylphosphonofluoridate (**cyclosarin** or **GF**)  
O-ethyl S-2-diisopropylaminoethyl methylphosphonothiolate (**VX**)

### Blood Agents

Hydrogen cyanide  
Cyanogen chloride

### Blister Agents

2-chlorovinylchloroarsine (**lewisite**)  
bis(2-chloroethyl) sulfide (**mustard gas**)  
tris(2-chloroethyl)amine (**a nitrogen mustard**)  
**phosgene**

### Heavy Metals

Arsenic  
Lead  
Mercury

### Volatile Toxins

Benzene  
Chloroform  
Trihalomethanes

### Pulmonary Agents

Phosgene  
Chlorine  
Vinyl agents

### Incapacitating Agents

3-quinuclidinyl benzilate (**BZ**)

### Pesticides, Persistent and Nonpersistent

**Dioxins, Furan and Polychlorinated Biphenyls (PCB's)**  
**Explosive Nitro Compounds and Oxidizers**

Ammonium nitrate combined with fuel oil

**Flammable Industrial Gases and Liquids**

Gasoline

Propane

**Poison Industrial Gases, Liquids and Solids**

Cyanides

Nitrites

**Corrosive Industrial Acids and Bases**

Nitric acid

Sulfuric acid

From “Biological and Chemical Terrorism: Strategic Plan for Preparedness and Response. Recommendations of the CDC Strategic Planning Workgroup, April 21, 2000” <http://www.cdc.gov/mmwr/PDF/RR/RR4904.pdf>

## **EMERGENCY ROOM PROCEDURES IN CHEMICAL HAZARD** **EMERGENCIES: A JOB AID**

### **Preparations**

1. Try to determine agent identity.
2. Break our personal protective equipment, decon supplies, antidotes, etc.
3. Is chemical hazard certain or very likely?  
  
    **YES:**
  - Don personal protective equipment
  - Set up hot line
4. Clear and secure all areas which could become contaminated.
5. Prepare to or secure hospital entrances and grounds.
6. Notify Civil Defense authorities if needed.
7. If chemical is a military agent and Army has not been informed, call them.
8. If an organophosphate is involved, notify hospital pharmacy that large amounts of atropine and 2-PAM may be needed.

### **When victim arrives**

(Note: A contaminated patient may present at an emergency room without prior warning.)

9. Does chemical hazard exist?
  - Known release/exposure (including late notification)
  - Liquid on victim's skin or clothing
  - Symptoms in victim, EMTs, others
  - Odor (H, L, phosgene, chlorine)
  - M-8 paper, if appropriate

**YES:** Go to 10.

**NO:** Handle victim routinely.

10. Hold victim outside until preparations are completed (don personal protective equipment to assist EMT's as necessary).
11. If patient is grossly contaminated (liquid on skin, positive M-8 paper) OR if there is any suspicion of contamination, decontaminate before entry into building.

### **Initial Treatment and Identification of the Chemical Agent**

1. Establish airway if necessary.
2. Give artificial respiration if not breathing.
3. Control bleeding if hemorrhaging.
4. Symptoms of cholinesterase poisoning?
  - Pinpoint pupils
  - Difficulty breathing (wheezing, gasping, etc.)
  - Local or generalized sweating
  - Fasciculations
  - Copious secretions
  - Nausea, vomiting, diarrhea
  - Convulsions
  - Coma

**YES:** Go to nerve agent protocol.

5. History of chlorine poisoning?

**YES:** Go to chlorine protocol.

6. Burns that began within minutes of poisoning?

**YES:** Go to 7.

**NO:** Go to 8.

7. Thermal burn?

**YES:** Go to 9.

**NO:** Go to lewisite protocol.

8. Burns or eye irritation beginning 2-12 hours after exposure?

**YES:** Go to mustard protocol.

**NO:** Go to 9.

9. Is phosgene exposure possible?

- Known exposure to phosgene
- Known exposure to hot chlorinated hydrocarbons
- Respiratory discomfort beginning a few hours after exposure

**YES:** Go to phosgene protocol.

10. Check other possible chemical exposures:

- Known exposure
- Decreased level of consciousness without head trauma
- Odor on clothes or breath
- Specific signs or symptoms

<b>Phosgene Protocol</b>	<b>Mustard Protocol</b>
<p>1. Restrict fluids, chest x-ray, blood gases</p> <p>Results consistent with phosgene poisoning? <b>YES: GO to #4.</b></p> <p>2. Dyspnea?</p> <p><b>YES: OXYGEN</b>, positive end-expiratory pressure</p> <p>3. Observe closely for at least 6 hours.</p> <ul style="list-style-type: none"> <li>• IF SEVERE DYSPNEA develops, go to 4.</li> <li>• IF MILD DYSPNEA develops after several hours, go to 1.</li> </ul> <p>4. Severe dyspnea develops or x-ray or blood gases consistent with phosgene poisoning:</p> <ul style="list-style-type: none"> <li>• Admit</li> <li>• Oxygen under positive end-expiratory pressure</li> <li>• Restrict fluids</li> <li>• Chest x-ray</li> <li>• Blood gases</li> <li>• Seriously ill list</li> </ul>	<p>1. Airway obstruction?</p> <p><b>YES: tracheostomy</b></p> <p>2. If there are large burns:</p> <ul style="list-style-type: none"> <li>• Establish IV line-do not push fluids as for thermal burns.</li> <li>• Drain vesicle-unroof large blisters and irrigate area with topical antibiotics.</li> </ul> <p>3. Treat other symptoms appropriately:</p> <ul style="list-style-type: none"> <li>• Antibiotic eye ointment</li> <li>• Sterile precautions prn</li> <li>• Morphine prn (generally not needed in emergency treatment; might be appropriate for inpatient treatment.)</li> </ul>

<b>Lewisite Protocol</b>	<b>Chlorine Protocol</b>
<ol style="list-style-type: none"> <li>1. Survey extent of injury.</li> <li>2. Treat affected skin with British Anti-Lewisite (BAL) ointment (if available).</li> <li>3. Treat affected eyes with BAL ophthalmic ointment (if available).</li> <li>4. Treat pulmonary/sever effects: <ul style="list-style-type: none"> <li>• BAL in oil, 0.5 ml/25 lbs body wt. Deep IM to max of 4.0 ml. Repeat q 4 h x 3 (at 0, 4, 8, and 12 hours).</li> <li>• Morphine prn</li> </ul> </li> <li>5. Severe poisoning? <p><b>YES:</b> Shorten interval for BAL injections to q 2 h.</p> </li> </ol>	<ol style="list-style-type: none"> <li>1. Dyspnea? <ul style="list-style-type: none"> <li>• Try bronchodilators</li> <li>• Admit</li> <li>• Oxygen by mask</li> <li>• Chest x-ray</li> </ul> </li> <li>2. Treat other problems and reevaluate (consider phosgene)</li> <li>3. Respiratory system OK? <p><b>YES:</b> Go to 5.</p> </li> <li>4. Is phosgene poisoning possible? <p><b>YES:</b> Go to <u>phosgene protocol</u>.</p> </li> <li>5. Give supportive therapy; treat other problems or discharge.</li> </ol>

<b>Nerve Agent Protocol</b>	
<p>1. Severe respiratory distress:</p> <p><b>YES:</b></p> <ul style="list-style-type: none"> <li>• Intubate and ventilate</li> <li>• ATROPINE Adults: 6 mg IM or IV Inf/Ped: 15-25 mcg/kg</li> <li>• 2-PAM Cl Adults: 600-1000 mg IM or slow IV Inf/Ped: 15 mg/kg</li> </ul> <p>2. Major secondary symptoms?</p> <p><b>NO:</b> Go to 6.</p> <p><b>YES:</b></p> <ul style="list-style-type: none"> <li>• ATROPINE Adults: 4 mg IM or IV Inf/Ped: 15-25 mcg/kg</li> <li>• 2-PAM Cl Adults: 600-1000 mg IM or slow IV Inf/Ped: 15 mg/kg</li> <li>• OPEN IV LINE</li> </ul>	<p>3. Repeat atropine as needed</p> <p>Adults: 2 mg IV or IM Inf/Ped: 15-25 mcg/kg</p> <p>4. Repeat 2-PAM as needed</p> <p>Adults: 1.0 gm IV over 20-30 min Inf/Ped: 15 mg/kg</p> <p>5. Convulsions?</p> <p><b>NO:</b> Go to 6.</p> <p><b>YES:</b> DIAZEPAM 10 mg slowly IV</p> <p>6. Reevaluate q 3-5 min. IF SIGNS WORSEN, repeat from 3.</p> <p>Note: Warn the hospital pharmacy that unusual amounts of atropine and 2-PAM may be needed.</p>

From Centers for Disease Control. <http://www.cdc.gov/nceh/demil/articles/initialtreat.htm>

## *APPENDIX A*

### **Funding Considerations: CW Preparedness and Response**

In recent years, the trend in Navy medicine has been to move away from holding large amounts of supplies in the MTF to relying on “just in time” delivery. The time required for this “just in time” delivery varies with the geographic location of the MTF, the amount of materiel required and ease of access to other resources in the community.

In this era of increased threat from asymmetric warfare, the notion of “just in time delivery” requires re-evaluation. What is “just in time” in a peacetime environment may be “just missed” in time of crisis. If casualties are to be reduced and losses prevented, commanders may well be served by moving to a posture of “just in case” stockpiling.

There are no absolute answers for what constitutes adequate stockpiling for preparedness. It will be impossible to prepare for all possible contingencies. Furthermore, what is acceptable for a large MTF in a high-risk metropolitan region with access to other civilian resources will not be the same as what is acceptable for a small MTF in a low risk rural area but which is also constrained by limited access to civilian resources.

In assessing what constitutes appropriate preparedness, the MTF commander must consider the likelihood of attack, the nature of the possible attack, the scale of the mission which must be protected, the rapidity with which other resources can be tapped and the amount of money available to fund this preparedness. Decisions on how much to rely on “just in time” or how much to shift to a “just in case” posture should be individualized to fit the situation and should be based on an evidence-based analysis of the appropriate medical response and the MTF fiscal constraints. When that decision is made, the following information provides guidance on obtaining funding.

There are three ways for MTF commanders to obtain funding for CW preparedness and response activities:

- **Program Objective Memorandum (POM) cycle**
- **Business Case Analysis (BCA)**
- **Mid Year Review Process**

**POM cycle:**

MTF Commanders can plan and program for long-term CBRNE preparedness and response activities at their facilities using the Program Objective Memorandum (POM) cycle process. Individual MTF activity issues related to CBRNE preparedness and response need to be submitted in the December / January timeframe each year to meet POM cycle requirements. Contact BUMED (either MED-01 or the MED-02 CBRNE Program Manager) for a sample of a CBRNE disaster preparedness POM item.

**BCA:**

MTF planning efforts to acquire resources for CBRNE medical disaster preparedness and response prior to the next POM cycle may also take place through the BCA process. BCA is intended to provide an avenue for medical activities to justify resources for a new unbudgeted initiative, with actions (if not assets) under local control, when that initiative has documented and quantifiable benefits (cost avoidance, savings, efficiencies) or a “return on investment” in future years. Contact BUMED (MED-01) to reach the POCs responsible for the BCA review process. These POCs can assist MTFs with the preparation and submittal requirements for a BCA package.

**Mid Year Review:**

Finally, MTF Commanders have the mid-year review process to request current year resources or unfunded items. A mid-year review item may be submitted either “before the fact” or “after the fact.” In the first case, the MTF is faced with an emergent, additional requirement for disaster preparedness, or a response to an external threat. In the second case, the disaster has already happened, and the MTF documents the actual, fact-of-life costs that were expended in response to it. The MTF’s true unfunded category then becomes those resources that had to be diverted in order to pay for the disaster. Mid-year review guidance will be issued to all MTFs through their Healthcare Support Offices by MED-01. To obtain a sample of a mid-year review submitted for an unfunded item, contact Mr. Charles Martin (MED-11) at 202-762-3588.

## APPENDIX B

### CW Resource List and Recent Publications

#### DoD / Federal Emergency Response Agencies:

Emergency Support Operations Center, DSCP (215) 737-2112 (24 hrs)  
CDC - Emergency Response Office (770) 488-7100 or (800) 311-3435 (24 hrs).  
USAMRIID Emergency Response Line (888) 872-7443 (24 hrs)  
National Response Center (800) 424-8802 (24 hrs)  
Edgewood Operations Center - Aberdeen, MD. (410) 436-4484 (24 hrs)  
FBI (contact nearest [field office](#) to MTF).  
For OCONUS, call U.S. Embassy / Consulate (U.S. Dept of State is Lead Agency)  
Domestic Preparedness Helpline: 1-800-368-6498 (24 hrs)  
NEPMU-2 Norfolk, VA: Phone (757) 444-7671; FAX (757) 444-1191;  
    DSN prefix 564-; e-mail [nepmu2@nepmu2.med.navy.mil](mailto:nepmu2@nepmu2.med.navy.mil)  
NEPMU-5 San Diego, CA: Phone (619) 556-7070; FAX (619) 556-7071;  
    DSN prefix 526-; e-mail [nepmu5@nepmu5.med.navy.mil](mailto:nepmu5@nepmu5.med.navy.mil)  
NEPMU-6 Pearl Harbor, HI: Phone (808) 473-0555; FAX (808) 473-2754;  
    DSN prefix 473-; e-mail [nepmu6@nepmu6.med.navy.mil](mailto:nepmu6@nepmu6.med.navy.mil)  
NEPMU-7 Sigonella, Italy: Phone 001-39-095-56-4101; FAX 001-39-095-56-4100;  
    DSN prefix 624-; e-mail [nepmu7@nepmu7.sicily.navy.mil](mailto:nepmu7@nepmu7.sicily.navy.mil)

#### Military Response Assets, Presidential Directives, DoD Instructions:

##### **Emergency Support Operations Center, Defense Supply Center Philadelphia.**

- After initial notification is made, the ESOC offers a 24-48 hour reach back capability for transportation of CBRNE prophylaxis and supplies. The ESOC website is at: <http://www.dmmonline.com/dmmonline/index.asp>

**Chemical Emergency Preparedness and Prevention Office (CEPPO)** website is at: <http://www.epa.gov/ceppo>.

- CEPPO provides help for development of emergency plans that can address deliberate chemical releases and provides suggestions for rapid response to CW.

**U.S. Army Medical Research Institute of Chemical Defense (USAMRICD)** website is at: <http://ccc.apgea.army.mil/>.

- The USAMRICD “Redbook” details specific information dealing with medical management of any CW casualty or event. Gives chemical agent identification and recognition signs/symptoms, IPE/PPE, collective protection, and decontamination requirements ([Appendix D](#) [http://ccc.apgea.army.mil/reference\\_materials/handbooks/mmccthirdeditionjul2000.pdf](http://ccc.apgea.army.mil/reference_materials/handbooks/mmccthirdeditionjul2000.pdf))

**U.S. Army Soldier & Biological Chemical Command (SBCCOM)** website is at: <http://www.sbccom.army.mil>. Information concerning treatment options, protective equipment and other valuable information.

- Good source for preparedness and planning for CBRNE events.

**Presidential Decision Directive 39 (PDD 39).** White House. June 1995. The PDD 39 website is found at: <http://www.fas.org/irp/offdocs/pdd39.htm>

- Gives U.S. Policy on Counter-Terrorism and outlines Lead Federal Agency roles for crisis management and consequence management efforts during a declared emergency.

**Military Support To Civil Authorities (MSCA).** DODD 3025.1. This and other DoD Directives and Instructions are available at <http://web7.whs.osd.mil/>.

- Provides MTF Commanders with authority to provide “Immediate Response” actions

**National Guard WMD Civil Support Teams.** National Guard WMD Civil Support Teams article: “Defense Leaders Commentary: The facts on WMD Civil Support Teams” Armed Forces Press Service. Charles Cragin, Principal Deputy, ASD Reserve Affairs. April 6, 2000.

- Provides a description of mission and current listing (August 2000) of the 27 National Guard WMD CSTs located in the following states: Alaska; Arizona; Arkansas; California (2); Colorado; Florida; Georgia; Hawaii; Illinois; Idaho; Iowa; Kentucky; Louisiana; Maine; Massachusetts; Minnesota; Missouri; New Mexico; New York; Ohio; Oklahoma; Pennsylvania; South Carolina; Texas; Virginia; and Washington. (5 more teams were added in 2001 for a total of 32, 9 of which are certified).
- **Important Note:** These state National Guard WMD CSTs are deployed only after a declaration of emergency assistance and specific request by the state governor – MTF commanders cannot directly request the support of these unique state response teams.

## **Other Federal Emergency Response Agencies and Information:**

**National Domestic Preparedness Office** website: <http://www.ndpo.gov>

- Source for BW response template used for medical surveillance

**Federal Response Plan (FRP)** at: (<http://www.fema.gov/r-n-r/frp/frpbpln.htm>)

**Federal Emergency Management Agency (FEMA)** website at: <http://www.fema.gov>

- Identifies FEMA as Lead Federal Agency for Consequence Management. Provides information on implementation of the FRP and its potential impact on the MTF during a CBRNE event. Gives the responsibilities of the Emergency Support Functions (ESF) listed by each federal agency as outlined in the FRP.

**Environmental Protection Agency (EPA)** website: <http://epa.gov>

- Provides information on EPA response capabilities

**Centers for Disease Control and Prevention (CDC)** website: <http://www.cdc.gov/>

- Provides information on BW agent identification and critical protocols
- The Laboratory Response Network (LRN) website: <http://www.bt.cdc.gov/>

**National Disaster Medical System (NDMS)**. Disaster and emergency response capabilities of NDMS are found at: <http://www.ndms.dhhs.gov>

- Explains the roles of various NDMS response teams (e.g., teams for medical response, mortuary assistance, etc.) and the oversight role of NDMS from the Office of Emergency Preparedness (OEP) and U.S. Public Health Service

### **BUMED information:**

BUMED and NEHC subject matter experts developed a WMD preparedness and response resource tool available on CD-ROM. The CD covers an exhaustive listing of Disaster Preparedness, Terrorism and WMD resources current as of April 2001. The listed resources on CD are also available on the BUMED (MED-27) homepage at: <https://bumed.med.navy.mil/MED27/>

- The CD was first developed for the Surgeon General's Flag Day Bioterrorism Wargame "Attack on Onslow" (August 2000). The CD and MED-27 homepage link was updated in May 2001.

BUMEDINST 3440.4 Activity Disaster Preparedness Plans and Material for Disaster Preparedness Teams at:

<http://navymedicine.med.navy.mil/instructions/external/external.htm>

- Outlines basic requirements for disaster and emergency preparedness activities at MTFs (This instruction is being completely revised and updated.)

### **State and Local Information:**

State and Local Guide for All-Hazards Emergency Operations Planning. FEMA. Emmitsburg, MD. 1996. Available at: <http://www.fema.gov/library/allhzpln.htm>.

- Most comprehensive FEMA guide available covering entire spectrum of preparedness and response for all CBRNE events

Statewide Disaster Medical Standards Development Project: Final Report. California Emergency Medical Services Authority. August 2000. Available at:

<http://www.mvemsa.com/Final%20DMS%20Report.htm>.

- Important look at how California provides disaster response

Homeland Defense: Biological Weapons Improved Response Program (BW IRP) 17 Sept 2001, available at: or <http://www2.sbcom.army.mil:80/hld/bwirp/index.htm>

Homeland Defense: Interim Planning Guide: Improving Local and State Agency Response to Terrorist Incidents Involving Biological Weapons September 12, 2000 is available at:

[http://www2.sbcom.army.mil/hld/bwirp/bwirp\\_interim\\_planning\\_guide\\_download.htm](http://www2.sbcom.army.mil/hld/bwirp/bwirp_interim_planning_guide_download.htm)

- Excellent source for preparedness and planning for CBRNE events

### **Joint Commission on Accreditation of Healthcare Organizations:**

New JCAHO Standards for 2001: EC 1.6. Emergency Management website:

[http://www.jcaho.org/standards\\_frm.html](http://www.jcaho.org/standards_frm.html)

- Effective 01 Jan 2001, JCAHO establishes new standards for emergency management (Environment of Care - EC standards)

### **American Hospital Association (AHA):**

AHA, with support of Office of Emergency Preparedness (OEP) and Dept of Health and Human Services (DHHS) produced the document "Hospital Preparedness for Mass Casualties - Final Report August 2000".

- Provides AHA recommendations for mass casualty events at hospitals

**Individual Protective Equipment (IPE), Collective Protection, Decontamination, Mission Oriented Protective Posture (MOPP), and Universal Precautions websites:**

IPE in a bioterrorist environment is at: <http://www.nap.edu/html/terrorism/ch3.html>.

- Provides excellent overview of the OSHA requirements used in civilian environment. Explains the differences between OSHA levels of protection and military IPE protection

Techniques for expedient collective protection, personal protection, and evacuation at: <http://www.firefighting.com/default.asp?GoTo=namID938>.

- Offers good overview of collective protection requirements, including options for evacuation, shelter-in place, and protective shelter in any CBRNE environment

The USAMRIID “Bluebook” at:

<http://www.usamriid.army.mil/education/bluebook.html>

- Best military source for IPE, collective protection, and decon requirements

The USAMRICD “Redbook” at:

<http://ccc.apgea.army.mil/Douments/RedHandbook/001TitlePage.htm>

- Best source for information on management of chemical casualties

Chemical agent fact sheets at:

<http://ccc.apgea.army.mil> (Click on “Training” then select “Download Materials”)

- Good source for information sheets which can be used as handouts

Universal precautions from CDC at:

<http://www.cdc.gov/ncidod/HIP/blood/universa.htm>

- CDC specific recommendations for universal precautions

Hospital planning for contaminated casualties:

<http://jama.ama-assn.org/issues/v282n2/ffull.jsc90100.html>

- JAMA special communication on effective planning for health care facilities

Preparedness for WMD events:

<http://jama.ama-asn.org/issues/v283n2/ffull/jed90095.html>

- JAMA editorial on domestic preparedness for WMD events

Mission Oriented Protective Posture (MOPP) at:

<http://www.gulflink.osd.mil/mopp>

- Explains the military MOPP levels for use in any CBRNE environment

## **CW/BW EDUCATION / TRAINING INFORMATION**

Note: For a comprehensive listing of CBRNE training / education courses available from various federal government sources go to the following website:

<http://www.ndpo.gov/compenium.pdf>

### **USAMRIID / CDC / Office of the Army Surgeon General:**

*Biological Warfare and Terrorism – The Medical and Public Health Response.*  
 (401)436-2230  
*Medical Management of Biological Casualties.*

### **USAMRICD (410) 436-2230:**

*Field Management of Chemical and Biological Casualties.*

### **US Army Chemical School (573) 563-7257:**

*Chemical / Biological Countermeasures Training (CBCT).*

### **National Interagency Civil-Military Institute (805) 782-6739**

*Community Response Emergency Simulation Training (CREST).*  
*Preparing for and Managing Consequences of Terrorism.*

### **SBCCOM (800) 368-6498:**

*NBC Domestic Preparedness - Basic Awareness.*  
*NBC Domestic Preparedness - Incident Command.*  
*NBC Domestic Preparedness - Senior Officers / Officials.*

### **FEMA / Emergency Management Institute / National Fire Academy:**

*Emergency Management Information System (EMIS). (800) 238-3358*  
*Emergency Planners Companion (CD-ROMs). (202) 646-2734*  
*Personal Protective Equipment (video). (202) 646-2734*  
*Incident Command System / Emergency Operations Center (ICS / EOP). (301) 447-1249*  
*Integrated Emergency Management: Consequences of Terrorism. (501) 447-1249*  
*Mass Fatalities Incident. (301)447-1249*  
*Emergency Response to Terrorism: Self-Study. (301) 447-1060*

**DoD Emergency Preparedness Course.** *Further information available at FEMA's website: [http://fema.gov/emi/iemc\\_01.htm](http://fema.gov/emi/iemc_01.htm)*

**NEHC / NEPMUs.** Currently offer 1 and 3 day courses in BW/CW. Call NEHC at (757) 462-5404 / 2178 or call the nearest NEPMU:

NEPMU-2 Norfolk, VA	(757) 444-7671 X 306, DSN: 564
NEPMU-5 San Diego, CA	(619) 556-7070, DSN: 526
NEPMU-6 Pearl Harbor, HI	(808) 473-0555, DSN: 473
NEPMU-7 Sigonella, IT	011- 39-095-56-3783



### **Other Services/Publications/Software on Chemical Terrorism:**

- Emergency Response Guidebook, U.S. Department of Transportation
- Emergency Care for HazMat Exposure, Bronstein & Currence, C. V. Mosby Co.
- Hazardous Materials Injuries, Stutz, et al. Bradford Communications Corp.
- Pocket Guide to Chemical Hazards (NIOSH/OSHA)
- Fire Protection Guide to Hazardous Materials, Fire Protection Assn.

- Toxicologic Emergencies, Rumack, et al., Robert J. Brady Co.
- First Aid Manual, Chemical Accidents, Lefevre, et al. Dowden, and Ross, Inc.
- TOMES + CD Database. HazMat-Medical Information System, Micromedex Inc.
- Chemtox Database Software System, Resource Consultants, Inc.
- Emergency Response Guide Software, Labelmaster, Inc.
- CAMEO Incident Planning & Command, EPA, National Safety Council
- Agency for Toxic Substances and Disease Registry (ATSDR)
- National Institutes of Health (NIH). “Med-Line,” “Hazard-Line,” and “Tox-line”

## *Federal Bureau of Investigation Field Offices*

<b>FIELD OFFICE</b>	<b>STREET ADDRESS</b>	<b>ZIP CODE</b>	<b>TELEPHONE No.</b>
Albany, NY	200 McCarty Avenue	12209	518/465-7551
Albuquerque, NM	415 Silver Avenue, SW, Suite 300	87102	505/224-2000
Anchorage, AK	101 E. 6 <sup>th</sup> Avenue	99501	907/258-5322
Atlanta, GA	2635 Century Parkway, NE, Suite 400	30345	404/679-9000
Baltimore, MD	7142 Ambassador Road	21244	410/265-8080
Birmingham, AL	2121 8 <sup>th</sup> Avenue, N., Room 1400	35203	205/326-6166
Boston, MA	One Center Plaza, Suite 600	02108	617/742-5533
Buffalo, NY	One FBI Plaza	14202	716/856-7800
Charlotte, NC	400 S. Tryon Street, Suite 900, Wachovia Blvd.	28285	704/377-9200
Chicago, IL	219 S. Dearborn Street, Room 905	60604	312/431-1333
Cincinnati, OH	550 Main Street, Room 9000	45202	513/421-4310
Cleveland, OH	1240 East 9 <sup>th</sup> Street, Room 3005	44199	216/522-1400
Columbia, SC	151 Westpark Blvd.	29210	803/551-1200
Dallas, TX	1801 N. Lamar, Suite 300	75202	214/720-2200
Denver, CO	1961 Stout Street, Room 1823, FOB	80294	303/629-7171
Detroit, MI	477 Michigan Avenue, P.V. McNamara FOB, 26 <sup>th</sup> Floor	48226	313/965-2323
El Paso, TX	Suite 3000, 660 South Mesa Hills Drive	79912	915/832-5000
Honolulu, HI	300 Ala Moana Blvd., Room 4-230, Kalaniana'ole FOB	96850	808/521-1411
Houston, TX	2500 East T.C. Jester	77008	713/693-5000
Indianapolis, IN	575 N. Pennsylvania St., Room 679, FOB	46204	317/639-3301
Jackson, MS	100 W. Capitol Street, Suite 1553, FOB	39269	601/948-5000
Jacksonville, FL	7829 Arlington Expy. Suite 200	32211	904/721-1211
Kansas City, MO	1300 Summit Street	64105	816/221-6100
Knoxville, TN	710 Locust Street, Suite 600	37902	423/544-0751
Las Vegas, NV	John Lawrence Bailey Bldg., 700 E. Charleston Blvd.	89104	702/385-1281
Little Rock, AR	10825 Financial Center Pkwy., Suite 200	72211	501/221-9100
Los Angeles, CA	11000 Wilshire Blvd., Suite 1700 FOB	90024	310/477-6565
Louisville, KY	600 Martin Luther King Jr. Pl., Room 500	40202	502/583-3941
Memphis, TN	225 North Humphries Blvd., Suite 3000, Eagle Crest Bldg.	38120	901/747-4300
Miami, FL	16320 NW 2 <sup>nd</sup> Avenue, N. Miami Beach	33169	305/944-9101
Milwaukee, WI	330 E. Kilbourne Avenue, Suite 600	53202	414/276-4684
Minneapolis, MN	111 Washington Avenue South, Suite 1100	55401	612/376-3200

Mobile, AL	One St. Louis Street, 3 <sup>rd</sup> Floor, One St. Louis Centre	36602	334/438-3674
New Haven, CT	150 Court Street, Room 535 FOB	06510	203/777-6311
New Orleans, LA	1250 Poydras Street, Suite 2200	70113	504/522-4671
New York City, NY	26 Federal Plaza, 23 <sup>rd</sup> Floor	10278	212/384-1000
Newark, NJ	One Gateway Center	07102	973/622-5613
Norfolk, VA	150 Corporate Blvd.	23502	757/455-0100
Oklahoma City, OK	50 Penn Place, Suite 1600	73118	405/290-7770
Omaha, NE	10755 Burt Street	68114	402/493-8688
Philadelphia, PA	600 Arch Street, 8 <sup>th</sup> Floor, William J. Green, Jr., FOB	19106	215/418-4000
Phoenix, AZ	201 E. Indianola Avenue, Suite 400	85012	602/279-5511
Pittsburgh, PA	700 Grant Street, Suite 300 USPO	15219	412/471-2000
Portland, OR	1500 S. W. 1 <sup>st</sup> Avenue, Suite 400; Crown Plaza Bldg.	97201	503/224-4181
Richmond, VA	111 Greencourt Road	23228	804/261-1044
Sacramento, CA	4500 Orange Grove Avenue	95841	916/481-9110
Salt Lake City, UT	257 East 200 South, Suite 1200	84111	801/579-1400
San Antonio, TX	615 E. Houston Street, Suite 200; US Post Office & Courthouse Bldg.	78205	210/225-6741
San Diego, CA	9797 Aero Drive	92123	619/565-1255
San Francisco, CA	450 Golden Gate Avenue, 13 <sup>th</sup> Floor	94102	415/553-7400
San Juan, PR	150 Carloa Chardon, Room 526; U. S. Federal Building, Hato Roy, PR	00918	787/754-6000
Seattle, WA	915 Second Avenue, Room 710	98174	206/622-0460
Springfield, IL	400 W. Monroe Street, Suite 400	62704	217/522-9675
St. Louis, MO	2222 Market Street	63103	314/231-4324
Tampa, FL	500 E. Zack Street, Suite 610 FOB	33602	813/273-4566
Washington D. C.	601 4 <sup>th</sup> Street, N. W.	20535	202/278-2000

## STATE / TERRITORIAL PUBLIC HEALTH AGENCIES

### **Alabama**

Alabama Department of Public Health  
State Health Officer  
Phone No. (334) 206-5200  
Fax No. (334) 206-2008

### **Alaska**

Division of Public Health  
Alaska Department of Health and Social Svcs  
Director  
Phone No. (907) 465-3090  
Fax No. (907) 586-1877

### **American Samoa**

Department of Health  
American Samoa Government  
Director  
Phone No. (684) 633-4606  
Fax No. (684) 633-5379

### **Arizona**

Arizona Department of Health Services  
Director  
Phone No. (602) 542-1025 / (800) 411-2336 (24 hrs)  
Fax No. (602) 542-1062

### **Arkansas**

Arkansas Department of Health  
Director  
Phone No. (501) 661-2417  
Fax No. (501) 671-1450

### **California**

California Department of Health Services  
State Health Officer  
Phone No. (916) 657-1493 / (916) 262-1621 (24 hrs)  
Fax No. (916) 657-3089

### **Colorado**

Colorado Department of Public Health & Environment  
Executive Director  
Phone No. (303) 692-2011  
Fax No. (303) 691-7702

### **Connecticut**

Connecticut Department of Public Health  
Commissioner  
Phone No. (860) 509-7101 / (860) 566-3180 (24 hrs)  
Fax No. (860) 509-7111

### **Delaware**

Division of Public Health  
Delaware Department of Health and Social Services  
Director  
Phone No. (302) 739-4700  
Fax No. (302) 739-6659

### **District of Columbia**

DC Department of Health  
Acting Director  
Phone No. (202) 645-5556  
Fax No. (202) 645-0526

### **Florida**

Florida Department of Health  
Secretary and State Health Officer  
Phone No. (850) 487-2945 / (800) 320-0519 (24 hrs)  
Fax No. (850) 487-3729

### **Georgia**

Division of Public Health  
Georgia Department of Human Resources  
Director  
Phone No. (404) 657-2700 / (800) 879-4362 (24 hrs)  
Fax No. (404) 657-2715

### **Guam**

Department of Public Health & Social Services  
Government of Guam  
Director of Health  
Phone No. (671) 735-7102  
Fax No. (671) 734-5910

### **Hawaii**

Hawaii Department of Health  
Director  
Phone No. (808) 586-4410  
Fax No. (808) 586-4444

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## **Idaho**

Division of Health  
Idaho Department of Health and Welfare  
Administrator  
Phone No. (208) 334-5945  
Fax No. (208) 334-6581

## **Illinois**

Illinois Department of Public Health  
Director of Public Health  
Phone No. (217) 782-4977 / (800) 782-7860 (24 hrs)  
Fax No. (217) 782-3987

## **Indiana**

Indiana State Department of Health  
State Health Commissioner  
Phone No. (317) 233-7400  
Fax No. (317) 233-7387

## **Iowa**

Iowa Department of Public Health  
Director of Public Health  
Phone No. (515) 281-5605  
Fax No. (515) 281-4958

## **Kansas**

Kansas Department of Health and Environment  
Director of Health  
Phone No. (785) 296-1343  
Fax No. (785) 296-1562

## **Kentucky**

Kentucky Department for Public Health  
Commissioner  
Phone No. (502) 564-3970  
Fax No. (502) 564-6533

## **Louisiana**

Louisiana Department of Health and Hospitals  
Asst Secretary and State Health Officer  
Phone No. (504) 342-8093 / (225) 342-5470 (24 hrs)  
Fax No. (504) 342-8098

## **Maine**

Maine Bureau of Health  
Maine Department of Human Services  
Director  
Phone No. (207) 287-3201 / (800) 452-4664 (24 hrs)  
Fax No. (207) 287-4631

## **Mariana Islands**

Department of Public Health & Environmental Services  
Commonwealth of the Northern Mariana Islands  
Secretary of Health and Environmental Services  
Phone No. (670) 234-8950  
Fax No. (670) 234-8930

## **Marshall Islands**

Republic of the Marshall Islands  
Majuro Hospital  
Minister of Health & Environmental Services  
Phone No. (692) 625-3355  
Fax No. (692) 625-3432

## **Maryland**

Maryland Dept of Health and Mental Hygiene  
Secretary  
Phone No. (410) 767-6505 / (877) 463-3464 (24 hrs)  
Fax No. (410) 767-6489

## **Massachusetts**

Massachusetts Department of Public Health  
Commissioner  
Phone No. (617) 624-5200  
Fax No. (617) 624-5206

## **Michigan**

Community Public Health Agency  
Michigan Department of Community Health  
Chief Executive and Medical Officer  
Phone No. (517) 335-8024  
Fax No. (517) 335-9476

## **Micronesia**

Department of Health Services  
FSM National Government  
Secretary of Health  
Phone No. (691) 320-2619  
Fax No. (691) 320-5263

## **Minnesota**

Minnesota Department of Health  
Commissioner of Health  
Phone No. (651) 296-8401  
Fax No. (651) 215-5801

## **Mississippi**

Mississippi State Department of Health  
State Health Officer and Chief Executive  
Phone No. (601) 576-7634 / (601) 576-7400 (24 hrs)  
Fax No. (601) 960-7931

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## **Missouri**

Missouri Department of Health  
Director  
Phone No. (573) 751-6001  
Fax No. (573) 751-6041

## **Montana**

Montana Department of Public Health & Human  
Services  
Director  
Phone No. (406) 444-5622  
Fax No. (406) 444-1970

## **Nebraska**

Nebraska Health and Human Services System  
Chief Medical Officer  
Phone No. (402) 471-8399  
Fax No. (402) 471-9449

## **Nevada**

Division of Health  
Nevada State Department of Human Resources  
State Health Officer  
Phone No. (702) 687-3786  
Fax No. (702) 687-3859

## **New Hampshire**

New Hampshire Department of Health & Human  
Services  
Medical Director  
Phone No. (603) 271-8560 / (603) 271-3636 (24  
hrs)  
Fax No. (603) 271-4827

## **New Jersey**

New Jersey Department of Health & Senior  
Services  
Commissioner of Health  
Phone No. (609) 292-7837  
Fax No. (609) 292-0053

## **New Mexico**

New Mexico Department of Health  
Secretary  
Phone No. (505) 827-2613  
Fax No. (505) 827-2530

## **New York**

New York State Department of Health  
ESP-Corning Tower, 14th Floor  
Albany, NY 12237  
Commissioner of Health  
Phone No. (518) 474-2011  
Fax No. (518) 474-5450

## **North Carolina**

NC Department of Health and Human Services  
State Health Director  
Phone No. (919) 733-4392 / (800) 858-0368 (24  
hrs)  
Fax No. (919) 715-4645

## **North Dakota**

North Dakota Department of Health  
State Health Officer  
Phone No. (701) 328-2372  
Fax No. (701) 328-4727

## **Ohio**

Ohio Department of Health  
Director of Health  
Phone No. (614) 466-2253  
Fax No. (614) 644-0085

## **Oklahoma**

Oklahoma State Department of Health  
Commissioner of Health  
Phone No. (405) 271-4200  
Fax No. (405) 271-3431

## **Oregon**

Oregon Health Division  
Oregon Department of Human Resources  
Administrator  
Phone No. (503) 731-4000  
Fax No. (503) 731-4078

## **Palau, Republic of**

Ministry of Health  
Republic of Palau  
Minister of Health  
Phone No. (680) 488-2813  
Fax No. (680) 488-1211

## **Pennsylvania**

Pennsylvania Department of Health  
Secretary of Health  
Phone No. (717) 787-6436  
Fax No. (717) 787-0191

## **Puerto Rico**

Puerto Rico Department of Health  
Secretary of Health  
Phone No. (787) 274-7602  
Fax No. (787) 250-6547

## **Rhode Island**

Rhode Island Department of Health  
Director of Health  
Phone No. (401) 277-2231  
Fax No. (401) 277-6548

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## **South Carolina**

SC Department of Health and Environmental  
Control  
Commissioner  
Phone No. (803) 734-4880  
Fax No. (803) 734-4620

## **South Dakota**

South Dakota State Department of Health  
Secretary of Health  
Phone No. (605) 773-3361  
Fax No. (605) 773-5683

## **Tennessee**

Tennessee Department of Health  
State Health Officer  
Phone No. (615) 741-3111  
Fax No. (615) 741-2491

## **Texas**

Texas Department of Health  
Commissioner of Health  
Phone No. (512) 458-7375  
Fax No. (512) 458-7477

## **Utah**

Utah Department of Health  
Director  
Phone No. (801) 538-6111  
Fax No. (801) 538-6306

## **Vermont**

Vermont Department of Health  
Commissioner  
Phone No. (802) 863-7280  
Fax No. (802) 865-7754

## **Virgin Islands**

Virgin Islands Department of Health  
Commissioner of Health  
Phone No. (340) 774-0117; Fax No. (340) 777-  
4001

## **Virginia**

Virginia Department of Health  
State Health Commissioner  
Phone No. (800) 523-6019 / (800) 523-6019 / (804)  
674-2400 (24 hrs)  
Fax No. (804) 786-4616

## **Washington**

Washington State Department of Health  
Acting Secretary of Health  
Phone No. (360) 753-5871  
Fax No. (360) 586-7424

## **West Virginia**

Bureau for Public Health  
WV Department of Health & Human Resources  
Commissioner of Health  
Phone No. (304) 558-2971  
Fax No. (304) 558-1035

## **Wisconsin**

Division of Health  
Wisconsin Department of Health and Family  
Services  
Administrator  
Phone No. (608) 266-1511  
Fax No. (608) 267-2832

## **Wyoming**

Wyoming Department of Health  
Director  
Phone No. (307) 777-7656  
Fax No. (307) 777-7439