

**BY ORDER OF
THE SECRETARY OF THE AIR FORCE**

**AIR FORCE TACTICS, TECHNIQUES, AND
PROCEDURES 3-42.32
20 APRIL 2004**



Tactical Doctrine

**HOME STATION MEDICAL RESPONSE TO CHEMICAL,
BIOLOGICAL, RADIOLOGICAL, NUCLEAR, OR
HIGH-YIELD EXPLOSIVE (CBRNE) EVENTS**

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Pages: 47/Distribution: F

PURPOSE: The Air Force Tactics, Techniques, and Procedures (AFTTP) 3-42 series of publications is the primary reference for medical combat support capability. This document, AFTTP 3-42.32, provides tactics, techniques and procedures for home station medical commanders to plan, prepare, and employ their assigned assets to respond to chemical, biological, radiological, nuclear, and/or high-yield explosives (CBRNE) events including Weapons of Mass Destruction (WMD) events.

APPLICATION: This publication applies to all Air Force military and civilian personnel (including Air Force Reserve Command [AFRC] and Air National Guard [ANG] units and members). It is understood that some facilities such as ANG and AFRC installations may not possess the inherent capabilities to provide the response outlined in this publication. The doctrine in this document is authoritative but not directive.

SCOPE: This Tactics, Techniques, and Procedures (TTP) provides the essential guidance for Air Force Medical Service personnel's initial response to a CBRNE/WMD event. The ability to respond appropriately will be critical in mitigating the consequences of CBRNE/WMD events. Medical commanders must be aware of the necessary steps to ensure maximum survivability and to safeguard mission capabilities.

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Chapter 1

INTRODUCTION

1.1. Overview. Chemical, Biological, Radiological, Nuclear, and/or High Yield Explosive (CBRNE) and Weapons of Mass Destruction (WMD) events can quickly overwhelm Air Force (AF) Medical Treatment Facilities (MTF) and can pose significant threats to all airbases worldwide. This TTP provides *initial response* guidance for medical commanders to plan, prepare, and employ their assigned assets to initially respond to CBRNE/WMD events at home stations (i.e. fixed-site airbases).

1.2. Terms.

1.2.1. “Initial Response” is considered the first 24 hours after a CBRNE/WMD event has occurred and/or has been detected. Initial response includes crisis and consequence management. Beyond this time frame additional federal (e.g., Department of Defense [DOD] or other), state, host nation, and local assets are assumed to have arrived at the location of the incident and become functional.

1.2.2. WMD are weapons capable of a high order of destruction and/or being used in such a manner as to destroy large numbers of people (JP 1-02). CBRNE is a broader term that includes WMD events but also includes non-hostile events. For example, an accidental chemical spill would be a CBRNE event, but not a WMD event. In this TTP, the procedures for WMD and CBRNE events are basically the same except that WMD events initiate force protection and criminal investigation measures that may be unnecessary in other events.

1.3. Guidance. First response to a home station CBRNE/WMD event is governed by AFI 10-212, *Air Base Operability*; AFI 10-245 *Antiterrorism*; AFI 10-2501, *Full Spectrum Threat Response (FSTR) Planning and Operations*; AFH 10-2502, *USAF Weapons of Mass Destruction (WMD) Threat Planning and Response Handbook*; AFI 31-210, *Antiterrorism/Force Protection*; AFI 32-4001, *Disaster Preparedness Planning and Operations*; AFI 41-106, *Medical Readiness Planning and Training*; AFDP10-26 *Counter-Nuclear, Biological and Chemical Operational Preparedness*.

1.3.1. Locally, the base response to a CBRNE/WMD event is deliberately planned for in the base disaster response plan. Each base must identify its threats, vulnerabilities, response capabilities and plan accordingly. Full protection is unobtainable commanders will manage risk based on available information and resources. The intent of this TTP is to provide the planning and organizing framework for the Medical Contingency Response Plan (MCRP) Annex N, “Terrorist and Weapons of Mass Destruction Threats” and, as applicable, the other annexes (refer to AFI 41-106, *Medical Readiness Planning and Training*). It also forms the framework for the medical requirements of the base FSTR Plan 10-1 WMD appendix. Additionally, it establishes a manning and equipment framework to guide resource allocation. CBRNE/WMD responses in deployed

environments are governed by AF operational and tactical doctrine (AFTTP 3-42.3, *Health Service Support in Nuclear, Biological, and Chemical Environments*). Refer to the Bioterrorism Event Readiness and Response Planning Guide at <https://www.afms.mil/aetcs/pol-letters/policy.htm> (SGPM - Public Health policy letter section, 22 Apr 03 publication) for detailed MCRP disaster team checklists addressing bioterrorism response.

1.3.2. The CBRNE/WMD Threat.

1.3.2.1. CBRNE /WMD can cause catastrophic damage and loss of lives. These weapons, however, should be considered as much a psychological as a physical weapon. The threat of a CBRNE/WMD event can cause anxiety even panic that can threaten mission effectiveness. Medical personnel and planners must address these psychological concerns along with medical issues for planning, prevention and crisis management.

1.3.2.2. Biological warfare (BW) agents can be employed by a terrorist to produce mass casualties, disrupt air operations, or to create fear and confusion. These actions have the potential to significantly burden or even overwhelm medical assets. Widespread and sporadic BW attacks would force a protective posture, thereby degrading United States operational effectiveness. For example, the limited anthrax “attacks” through the US Postal Service in October and November 2001 caused widespread uncertainty and drained sampling, analysis and identification resources. Food, water, and other means of agent delivery must be considered in threat and vulnerability analyses. BW agents are highly versatile and adaptive. For example, spraying a salad bar with salmonella could render an organization incapable of performing their mission. Food and water contamination remain the highest risk means of delivering a biological attack. Food and water supplies are one of the most vulnerable vehicles for a biological attack.

1.3.2.3. Chemical agents are grouped into four types: nerve, cyanide, vesicants, and pulmonary agents. For homeland security purposes, the planner must consider all hazardous materials that can be used. Heavy industry located off base, hazardous cargo transported near the base, and hazardous materials stored on base should all be considered as potential threats. The MTF Nuclear Biological and Chemical (NBC) Medical Defense Officer (MDO) (normally a Bioenvironmental Engineer (BEE)) working with the Civil Engineering (CEX) readiness planners must assess and analyze these non-traditional vulnerabilities. They should also consider that terrorists might attack or use these areas to create a catastrophic event.

New technology and coordinated response plans deployed since the anthrax "attacks" of 2001 have dramatically improved response time. In mid-March 2003, local authorities were notified by US Marshals of the eminent arrival of two suspicious envelopes addressed to a Bomb Wing Commander. The envelopes arrived and one envelope was emitting a fine white powder. The first responder team, a Disaster Control Group team of bioenvironmental and fire department staff, deployed to the local post office. The team followed plan guidelines to evacuate and barricade the area in the post office with the envelopes.

In only one and a half hours the response team was able to determine with 99% confidence that the white powder substance was non-diary creamer. The commanding officer, then declared the scene safe. There was no impact on the intended target (the Bomb Wing) and minimal disruption of the local post office. The incident demonstrates the remarkable improvements that can be achieved with a planned response and appropriate resources.

1.3.2.4. Nuclear Weapons/Radiological Dispersal Devices range greatly in size and energy yield and can be employed by a variety of means. Radiological Dispersal Devices (RDD), often termed "dirty bombs," contain explosives and radioactive material. The device is intended to disperse radioactive material and does not require the use of sophisticated nuclear components. Deployment of an RDD could result in radiation injuries without the blast or heat effects that accompany a nuclear weapon. Non-lethal RDDs could produce widespread panic. An example of how a terrorist might create a RDD by crashing an aircraft into a nuclear power plant. The base Radiation Safety Officer (RSO) should have information on radioactive isotopes stored on the installation along with detection devices.

1.3.2.5. Historically, high-yield explosives pose the most likely threat to home stations. Various vulnerability assessment processes are established in AF policy (reference AFI 31-210, *The Air Force Antiterrorism/Force Protection [AT/FP] Program Standards*). High-yield explosions will likely cause massive casualties, particularly crush and burn victims.

1.3.2.6. For all the threats discussed in this TTP, the MTF commander and staff must understand the assessed vulnerabilities and anticipated consequences for casualties in order to plan and prepare for the medical response.

1.4. Medical CBRNE/WMD Capabilities. Air Force Medical Service (AFMS) personnel must be ready for a CBRNE/WMD incident on their home stations. MTFs vary greatly in size, scope of medical treatment capability, and their proximity to civilian medical facilities. Therefore, MTFs will have varying degrees of response capabilities. However,

some common principles and operational parameters are established for all MTFs in AFI 41-106, *Medical Readiness Planning and Training*, Annex N. Each MTF must plan for the provision of the following based on their organic capability and/or Memorandum of Agreements (MOA)/contracts:

- 1.4.1. Conduct disease surveillance to identify covert biological attacks or endemic disease outbreaks.
- 1.4.2. Obtain and disseminate at appropriate level applicable CBRNE/WMD vulnerability assessments and intelligence.
- 1.4.3. Identify local limiting factors affecting ability to execute Annex N, MCRP as directed in AFI 41-106 *Medical Readiness Planning and Training*.
- 1.4.4. Maintain in ready status the equipment and supplies required for initial response to a CBRNE/WMD event.
- 1.4.5. Secure and protect the MTF and its personnel from CBRNE contamination and effects.
- 1.4.6. Perform health risk assessment of situation; conduct risk education/communication.
- 1.4.7. Triage CBRNE casualties.
- 1.4.8. Recognize, detect, and identify CBRNE agents.
- 1.4.9. Decontaminate casualties that present at the MTF.
- 1.4.10. Diagnose and treat CBRNE casualties.
- 1.4.11. Restrict movement and/or quarantine contagious patients as appropriate.
- 1.4.12. Integrate initial effort with follow-on response teams to include federal, state, and local responders.
- 1.4.13. Plan for coordinating with other agencies including public affairs, local and national media, and local and state governments.
 - 1.4.13.1. Communicate accurate and timely information to these organizations to lessen panic among the civilian and base population.
 - 1.4.13.2. Coordinate public responses with the State Department and American Embassy/Consulate if based in overseas location .

1.5. Organizing and Equipping. Organizing and equipping to respond to a WMD event and manage the consequence at a home station MTF requires a combination of Line of the Air Force (LAF) and Defense Health Program (DHP) resourcing. Materiel solely required to support a WMD crisis and consequent response will be supported through LAF programs. Other materiel that normally supports the provision of peacetime health care at the MTF but will be utilized in a WMD response will be provided through the DHP.

1.5.1. All MTFs should be able to protect their personnel and facility, provide medical surveillance, identify pathogens and support home station WMD detection and hazard evaluation. These capabilities are designed in existing disaster teams. These disaster team responsibilities are outlined in each MTF's MCRP. In order to provide a seamless response to a CBRNE/WMD incident, disaster teams should use this TTP and determine additional procedures and resources needed to respond to a CBRNE/WMD incident. The equipment for these disaster teams will be provided as in-place Allowance Standards (AS). For example, detection equipment is used on a daily basis by Bioenvironmental Engineering (BE). The AS for the disaster teams will be provided by Air Combat Command (ACC) as Manpower/Equipment Force Packaging (MEFPAK) for the WMD 1st Responder Program.

1.5.1.1. BEE and Public Health (PH) disaster teams conduct medical surveillance, CBRNE/WMD detection, preventive medicine, CBRNE/WMD risk assessment and hazard communication.

1.5.1.2. All MTFs must provide for pathogen identification, using the testing resources of Homeland Defense Laboratory Response Teams (HLD LRT), Laboratory Response Network (LRN) and host nation, as appropriate. Testing capability at each MTF will vary, depending on equipment, microbiology expertise, and safety considerations. It is important that each MTF assess the in-house testing capability provided by HLD LRT and LRN resources, and plan for additional testing as needed within the local or state community. Overseas home stations should use regionally or country specified referral networks pre-established by MOAs for OCONUS. HLD LRTs are two-man in-place response teams equipped with the Ruggedized Advanced Pathogen Identification Device (RAPID™), designed to provide presumptive (initial screening) identification of potential BW agents using DNA-based technology. This asset is placed to support medical treatment facilities and the Wing Commander's Installation Force Protection program. The LRN is a national BW testing network in which the Centers for Disease Control and Prevention, the Association of Public Health Laboratories, and DOD are partnered (AF/SG memo to ALMAJCOM/SG, 1 May 01). Most AF laboratories can provide presumptive testing for select BW organisms using conventional microbiology techniques (Level A labs). Currently, four AF laboratories can provide confirmatory testing for select biological agents (Level B labs). Further guidance on the HLD LRT and LRN is slated for publication in AFMC CONOPS, [Draft], Homeland Defense Laboratory Response Team (HLD LRT).

1.5.1.3. All MTFs must provide an In-Place Patient Decontamination Capability (IPPDC). Refer to the AF CONOPS In-Place Patient Decontamination Capability Plan

(Sep 02) for details or if within USAFE, refer to the USAFE In-Place Patient Decontamination Capability.

1.5.1.4. Allocation of these AS resources will be prioritized based on base threats, vulnerabilities, capabilities, and mission criticality.

1.5.2. MTF casualty treatment capabilities vary considerably and are inherently dependent on the business model of each MTF. For instance, medical response (treatment) to CBRNE/WMD scenarios may or may not have available organic ambulance services, 24/7 emergency medicine, and surgical services because peacetime healthcare requirements dictate level of care and service at the MTFs. Therefore, each MTF's response plan must be tailored to their local capability, MOA, local jurisdiction, state, regional, other military response capabilities, and contracts.

1.5.3. BW/CW countermeasures should support vaccination and treatment of any first responders (and other workers who could be exposed during a response) and initial treatment of casualties. Home stations within the United States will coordinate planning efforts with local civilian agencies so they can assume access to the National Pharmaceutical Stockpile. Home stations in foreign countries will plan based on materiel in the War Reserve Material (WRM) and Host Nation (HN) support.

1.5.4. Medical CBRNE/WMD response materiel will be resourced via a combination of DHP and LAF monies. The DHP resources the routine business case of the MTF, and non-CBRNE/WMD emergency medical requirements are predicated on this practice. The MTF will manage peacetime operating stocks of expendables and equipment considering their planned CBRNE/WMD response in MCRP Annex N, MOAs and contracts. Materiel unique to CBRNE/WMD response and materiel supporting home station allowance standards will be procured with LAF monies.

1.5.5. Education, training and exercises will be conducted as required by AFI 32-4001, *Disaster Preparedness Planning and Operations*; AFI 41-106, *Medical Readiness Planning and Training*; MAJCOM policy; and local directives. The Readiness Skills Verification Program (RSVP) should contain the skill sets required to respond to a CBRNE/WMD incident.

Chapter 2

CASUALTY PREVENTION

2.1. Introduction.

2.1.1. Casualty Prevention is an integral element of Force Health Protection in a CBRNE environment (AFTTP 3-42.2, *Casualty Prevention in Expeditionary Operations*). Casualty prevention operations are further characterized under the passive defense operations of contamination avoidance, contamination protection, and contamination control. The scope includes force health protection measures, a process that encompasses pre-incident, incident, and post incident phases of a WMD attack.

2.1.2. Casualty prevention seeks to provide the installation commander the best available health-based risk assessment of an incident. Historically, well-trained medical providers have been the first to identify biological and chemical induced outbreaks—well before other surveillance systems.

2.2. Pre-Incident Planning. CBRNE/WMD agents may be disseminated on an installation overtly or covertly. Overt events generally produce a signature that alerts personnel of the incident but a covert release may not be detected until casualties present at the MTF. MTF WMD First Responder Response Plans must address both overt and covert WMD incidents. Casualty prevention planning for terrorist WMD threat response must begin long before an incident occurs and plans will need to be continuously updated and disseminated. Planning and preparation will prove to be essential elements of a successful, timely response. Medical pre-incident planning includes the following:

2.2.1. Conduct disease surveillance for early identification of covert biological attacks or endemic disease outbreaks. PH will conduct disease and syndromic surveillance on a daily basis. The single most effective tool for identifying and targeting health hazards is a robust health surveillance and Disease Non-Battle Injuries (DNBI) monitoring and reporting system. PH must educate all providers on the importance of accurate reporting and follow-up. PH should work with Population Health to monitor trends based on coding data in ambulatory data module of Composite Health Care System (CHCS). In order for monitoring to be effective, clinicians must code each day's work daily. Other indicators may be revealed through ancillary support functions such as pharmacy, laboratory, and radiology. Monitoring these data sources is critical to health risk assessment and may produce the first indication of biological agent attack. Examples of surveillance software include Global Expeditionary Medical System (GEMS) and Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE). Guidelines for smallpox surveillance, *Smallpox Response Plan and Guidelines, Version 3.0*, can be accessed at <http://www.bt.cdc.gov/agent/smallpox/response-plan/index.asp>.

2.2.2. Health surveillance may give the first indication of a biological warfare attack. Ensuring that medical providers are well-trained in symptomology of biological and chemical outbreaks facilitates the early identification of biological or chemical attacks.

2.2.3. Obtain and disseminate at appropriate level applicable CBRNE vulnerability assessments and intelligence. Preventative medicine and facility medical personnel should participate in the Antiterrorism/Force Protection (AT/FP) Working Group.

2.2.3.1. Food and Water Vulnerability. PH and BE should assess the threat of intentional contamination to food and water using available intelligence sources (i.e., Air Force Office of Special Investigators [AFOSI] data, Federal Bureau of Investigation [FBI], Secret Internet Protocol Router Network [SIPRNET], Defense Intelligence Agency's Armed Forces Medical Intelligence Center). These assessments should be a part of a focused analysis of the installation vulnerability and potential mitigation measures. Food and water surveillance should be increased with the associated force protection levels. Food/Water vulnerability assessments should be coordinated with other applicable agencies and updated/reviewed annually by the force protection-working group. The following references will be useful in conducting the vulnerability analysis: AFI 10-245, *Air Force Antiterrorism (AT) Standards*; AFI 31-210, *The Air Force Antiterrorism/Force Protection [AT/FP] Program Standards*; and *Water Vulnerability and Risk Assessments for DOD Potable Water Assets (FOUO) (Draft)*.

2.2.3.2. Hazardous Material (HAZMAT) Vulnerability. BE and CE will assist the AT/FP Working Group on a HAZMAT vulnerability assessment for the installation and surrounding community. The intentional or unintentional release of HAZMAT may adversely impact the base. The assessment should be a coordinated effort with the base force-protection working group, updated and reviewed by the group annually. This information may also be available through local emergency planning offices and state environmental regulatory agencies. The BEE should provide HAZMAT health consequences based on the vulnerability assessment to the medical providers as input for preparation of treatment protocols.

2.2.3.3. Intelligence. BE (NBC MDO) and PH (Medical Intelligence Officer [MIO]) should receive periodic intelligence briefs from AFOSI and Intelligence Office to identify potential threats. These threats should be addressed in all vulnerability assessments. Other sources of WMD intelligence are available on the SIPRNET. Historically, some BEs and PHs have had difficulty accessing SIPRNET capabilities. These representatives should advocate for ready access to SIPRNET and other intelligence sources.

2.2.4. Secure and protect the MTF and its personnel from CBRNE contamination and effects.

2.2.4.1. Physical/Environmental Security. The MTF should take measures to secure its infrastructure from potential contamination such as locking doors, posting guards, restricting traffic flow around the facility, and controlling ventilation of the facility.

2.2.4.2. Individual Protection. Each MTF will provide appropriate Personal Protective Equipment (PPE), based on threat level, for all responding personnel. The intent is for each medic who may ride on an ambulance, or respond to the site, to have access to this equipment as identified by the base BEE. The following items should be considered:

2.2.4.2.1. Respiratory Protection. For respiratory protection, a loose-fitting Powered Air Purifying Respirator (PAPR) provides useful capabilities (such as a 3M Breath-Easy or equivalent). Three replacement AP3 (or equivalent) PAPR cartridges must be supplied with these respirators. The BEE is the authority on selection, use, fit testing, limitations, and maintenance of respirators. All respirator wearers must be enrolled in the Respirator Protection Program, receiving medical evaluations and annual training as a minimum.

2.2.4.2.2. Contact Protection. The following are protective equipment recommended items but should be tailored to the MTF's requirements: Tyvek "Tychem" SL suits (large or extra-large) or equivalent; pairs of butyl rubber chemical warfare gloves w/liners; silver shield chemical protective gloves for short-term tasks requiring dexterity; and overboots.

2.2.4.3. Pre-Exposure Training (PEP). PEP training is a proactive approach to help individuals prepare for and cope with potentially traumatic events. It can be useful for everyone facing exposure to a potentially traumatic event and promotes optimal performance. First responders should attempt to get this training prior to exposure to a traumatic event. This training can also be done "just-in-time" (JIT).

2.2.5. Recognize, Detect, and Identify CBRNE Agents. One of the BEE's core operational competencies is detection and surveillance. This is required prior to performing the health risk assessment. BEE must perform detection and surveillance in order to obtain a valid health risk assessment. To accomplish this, the BEE must be equipped with the proper mix of detection/monitoring equipment (886H Allowance Standard). Other responders, such as CE Readiness, Explosive Ordnance Disposal (EOD), and the Fire Department may possess complementary capabilities. As the health risk Office of Primary Responsibility (OPR) and sampling expert, BEE should inventory available response capabilities and coordinate an effective response, including periodic, integrated exercises and training. Specifically, in preparation for an incident, the BEE should exercise and train with other responders on a periodic basis—at least once a year.

2.2.5.1. Laboratory Capability. USAF biomedical laboratory officers, government or civilian contract medical technologists, and technicians will form a team in-place to operate an equipment set comprised of routine in-house microbiology testing procedures, to include Centers for Disease Control and Prevention Laboratory

Response Network (CDC LRN) protocols. If available, they will use a specialized Homeland Defense equipment package which contains the RAPID™, a Polymerase Chain Reaction (PCR) device that serves as an on-base sample processing and testing sites for unknown or suspect samples. However, HLD LRT testing using the RAPID is not a confirmatory method. All samples tested by the HLD LRT must also be processed using CDC LRN protocols. The HLD LRT CONOPS (Draft) provides further instruction on the procedures used for rapid, specific pathogen identification. Refer to Air Force Institute for Environmental Risk Analysis's sampling guidance. (Note: MTFs without in house microbiology capability will have a plan and a procedure identifying where properly collected samples will be sent for processing).

2.2.5.1.1. The CDC LRN is a partnership system between the Centers for Disease Control and Prevention (CDC), Association of Public Health Laboratories (APHL), DOD and FBI. The LRN uses CDC's established standardized protocols for sample collection, processing, testing, referral, and results reporting. In addition to participating in the community LRN, the AF/SG directed the HLD LRT parallel network to directly support rapid biological response for AF installation commanders using military approved technology.

2.2.5.1.2. Samples tested in house. All samples tested in house with LRN Level A protocols must be transferred to a Level B laboratory for confirmation, and all samples tested with LRN Level B protocols must undergo final confirmation at a Level C laboratory. The MTF must arrange with the nearest Level B/C laboratory (as appropriate) for follow-on testing. In addition, the laboratory should confirm the notification procedure required by the local public health community in cases of presumptive/confirmed positive results.

2.2.5.1.3. The laboratory must ensure that responders, commanders, and the MTF Director of Clinical Services understand the constraints of presumptive testing and the limitations of DNA-based (polymerase chain reaction such as the RAPID™ device) testing. In addition, the laboratory should make clear the reasonable expected result times for each methodology. For example, analyzing three samples on the RAPID™ does not just take 30 minutes for the actual DNA amplification and analysis - all involved must understand that preparing the samples for analysis adds at least 60-90 minutes to the process, depending on sample type and processing method. Add to that additional time to complete chain-of-custody paperwork and sample accessioning, and realistically a presumptive PCR result can take several hours to attain.

2.2.5.2. Sample collection:

2.2.5.2.1. The BE, the laboratory, and providers must plan the sample types and collection strategies to be employed when collecting environmental and clinical samples. This plan should be formalized in a MTF or Wing operation instruction. Guidance for environmental sampling is available on the CDC web site at

<http://www.bt.cdc.gov/Agent/anthrax/environmental-sampling-apr2002.asp> and in “Guidelines for the Prevention and Management of Suspected Anthrax and Other Biological Agent Incidents in the Air Force”, 9 Nov 2001 (USAF/SG). Clinical sample guidelines are outlined in LRN Level A protocols, available at <http://www.bt.cdc.gov/labissues/index.asp> and the CDC’s interim smallpox response plan, available at <http://www.bt.cdc.gov/labissues/index.asp>.

2.2.5.2.2. Chain-of-custody must be started at the origin of sampling. The CDC, in coordination with the FBI, has published LRN chain-of-custody forms, which are preferred for BW sampling. The forms are available at <https://www.afms.mil/bsclab> from the LRN link.

2.2.5.3. Sample transportation:

2.2.5.3.1. Samples collected on base should be transported by law enforcement (i.e., Security Forces, Office of Special Investigations [OSI]), first-responders, etc. Key consideration is that chain-of-custody and security procedures are followed. While transportation by law enforcement is preferred, manpower restrictions may dictate that the responder collecting the sample will transport it to the laboratory. Analogous transportation plans must be devised for samples collected within the MTF (i.e., clinical samples from patients). Chain-of-custody is an important consideration for the prosecution of perpetrators of WMD attacks. In the midst of disaster, it may be easy to forget about these steps, but the successful apprehension and prosecution of these perpetrators may depend upon it.

2.2.5.3.2. Some installations have plans to support testing of samples obtained from off base. Plans must address access to the base by transporters with these samples especially in Force Protection Conditions CHARLIE and DELTA.

2.2.5.3.3. Samples tested in AF laboratories that require further confirmatory testing must be transported to the nearest Level B/C laboratory. Plans must address how the sample will be transferred and by whom. Again, chain-of-custody and security are key considerations. Transportation by base OSI or the local FBI WMD Coordinator is preferred. For planning purposes, consult both agencies to discuss their requirements before exploring alternate options. The Army’s Technical Escort Unit may also be a transportation resource for CONUS and OCONUS bases (see <http://teu.sbcom.army.mil> for further information).

2.2.5.4. Communication:

2.2.5.4.1. The HLD LRT reports directly to the Chief, Laboratory Services. LRN testing is also under the control of the Chief, Laboratory Services. Each laboratory director will keep his/her medical chain of command informed of sample status and test results in addition to communicating with the appropriate local and regional public health laboratories, to include other military laboratories, for referral testing.

2.2.5.4.2. The HLD LRT/LRN laboratory team requires inter-team communications and two-way communication with other medical and non-medical functions/teams, such as, Infection Control, PH, BEE, Emergency Room, Medical Control Center, and BEE Disaster Team for consultation. As such, plans should establish 24-hour contact information for all response entities and minimal communication pathways.

2.2.5.4.3. Due to the sensitive nature of a positive finding for a BW threat agent, plans must account for COMSEC and OPSEC, and should include guidelines on information classification. The HLD LRT/LRN laboratory must have ready access to secured communications, to include Secure Telephone Unit and SIPRNET capabilities. Information concerning samples and results should be protected as “For Official Use Only” as a minimum.

2.2.5.5. Result Reporting

2.2.5.5.1. The chain of command will be followed when reporting presumptive positive samples for biological warfare agents. HLD LRT and LRN Level A presumptive results will be reported to the Chief, Laboratory Services, who in turn will brief the on-site medical commander and the submitting provider (if reporting on a clinical sample) of the presumptive results. Presumptive cases resulting from BW agents should also be reported to the Disaster Control Group and/or other base agencies. Plans must outline the desired notification scheme for samples collected both on- and off-base, and will include local/regional authorities, as appropriate. Staff should assure the presumptive nature of the results is reflected in reports, as confirmation is required prior to Presidential and Secretary of Defense decision-making. Presumptive PCR results cannot be released as “LRN” results. The preliminary nature of the early results requires plans that assure communication controls to prevent release of unconfirmed positive results beyond the team.

2.2.5.5.2. After the organism’s identification has been confirmed, plans must outline the chain of command and notification scheme desired for samples collected both on- and off-base, as stated in the previously. Patient treatment decisions and public release of information can occur only after an organism’s identification has been confirmed using LRN protocols. Exceptions to this include cases where informed consent is obtained or if a Presidential waiver is granted during a national emergency.

2.2.5.5.3. BE, PH, Flight Medicine, and Life Skills should be involved as soon as possible in determining the content and presentation of positive sample results to the base and civilian population.

2.2.5.6. Sample disposal: Plans should include instructions for disposing of or archiving samples after testing is complete. Consider all scenarios, to include disposing

of low-risk negative samples in biohazard waste, submitting original and microbiological samples to the next LRN Level laboratory, and/or returning negative samples (i.e., suspicious packages) to the OSI, FBI, or host nation authorities, as appropriate.

2.2.6. Perform health risk assessment of situation; conduct risk communication. The BEE is primarily responsible for performing the health risk assessment. In planning for a WMD incident, the BEE must possess a variety of references, equipment, and experience with these assets. In the planning stage, the BEE, Public Health Officer (PHO), and Flight Surgeon (FS) work together with PA to develop risk communication tools such as press releases to communicate risks. Life Skills officers can also aid in risk communication.

2.3. Incident Response. The MTF first responder should plan, train, organize and equip to execute a medical WMD response. The minimum medical response is to detect, assess, contain and recover patients in the event of a terrorist WMD incident. Casualty Prevention Incident Response capability includes proper personal protection for responders, minimizing the spread of contamination, WMD detection and identification, toxic cordon management, operational risk management advice to the On-Scene Commander (OSC), and exposure determination for personal health records.

2.3.1. Overt Incidents. Overt CBRNE/WMD incidents are those that are done openly, without concealment. The Incident Command System will be in effect for the initial response to a CBRNE/WMD incident, in the same manner as all other installation responses in support of OPLAN 32-1 (FSTR Plan 10-2). First responders may or may not know they are dealing with a CBRNE/WMD incident when the call comes into the dispatch center. The Senior Fire Officer (SFO) is in charge of the scene under the Incident Command System, and is responsible for establishing the hot, warm, and cold zones.

2.3.1.1. Installation Command and Control. Ambulance and BE teams will activate upon direction from the Fire Dispatch Center and/or upon formation of the Disaster Control Group and report to the SFO or OSC as appropriate. An additional medical representative is also sent to the Disaster Control Group (DCG) to facilitate communications between the DCG and the Medical Control Center (MCC). When teams enter the hot and warm zones they are under the command and control of the SFO or OSC. Otherwise, medical teams are under the command and control of the MCC.

2.3.1.2. CBRNE Detection and Identification. When the use of CBRNE/WMD is suspected, the BEE will monitor for the presence of radiological, chemical, and biological contaminants. Following a positive detection, the BEE will attempt to identify the specific material used in the attack to enable appropriate medical treatment and risk management. Identification of materials may require the collection of field samples that will be taken to appropriate laboratories for analysis. In that case, suspect biological agents will be transported to the designated National Laboratory Response

Network lab for analysis by standardized methods. This task will require the BEE team to be properly protected against the potential threat.

2.3.1.3. Cordon Management. The BEE will work with CE readiness to develop a toxic cordon plume model. BEE will advise the OSC on appropriate modifications to the basic cordon established by Security Forces and fire department based on the physical characteristics and toxicology of the material identified, meteorological conditions, and the outcome of appropriate toxic cordon plume models (when available). The BEE will also advise the OSC on appropriate actions to take within the established corridor to include shelter in place and/or evacuation.

2.3.1.4. Operational Risk Management Advice to OSC. The BEE will advise the OSC on appropriate measures to protect response personnel and to avoid additional casualties within the base populace. Specific actions required are:

2.3.1.4.1. Health Risk Assessment. The BEE will determine the health risk to all personnel exposed to the CBRNE/WMD material based on the toxicity of the material, potential routes of exposure, and likely doses received and communicate this risk to the SFO and OSC. PH will contribute to the assessment in the response action. Aerospace Medicine Specialists or Flight Surgeons have extensive toxicology training. They can also be involved in developing risk communication strategies for MCC, public affairs, and the media. Exposure documentation procedures for patients and other personnel must also be accomplished.

2.3.1.4.2. Personal Protective Equipment. Based on the health risk assessment, the BEE will recommend appropriate personal protective equipment for response personnel to the OSC IAW AFI 32-4004, paragraph 1.2.8, *Emergency Response Operations*. These recommendations should take into consideration both the protection required and the operational need of the situation. Overly conservative requirements can be just as dangerous to the response as ineffective controls.

2.3.1.4.3. Risk Communication. The BEE will advise all response personnel including the OSC, DCG commander, and MCC commander on the health risks identified and the appropriate controls. Additionally, the BEE will work with the PHO, a Life Skills officer and the Base Public Affairs Office. Each profession brings background and experience that must be coordinated and blended to produce the optimal outcome.

2.3.1.4.4. Contamination Control. The BEE will work with Civil Engineering to develop methods to reduce the spread of contamination from the incident to other areas on base. Techniques employed may be decontamination of personnel and equipment, marking contaminated areas, and the application of water or other suppressants to plumes.

2.3.1.4.5. Security/Facility Team. The MTF security team will secure the MTF and the area immediately around the MTF. This will be accomplished by (1) locking down the facility and limiting access for staff and patients to a predetermined point of entry; (2) blockading vehicle access to parts of the MTF except for a predetermined arrival path for ambulances and vehicles; (3) if necessary, closing the ventilation intake louvers to prevent contaminants from entering the ventilation system; and (4) posting guards and maintaining general security throughout the MTF. Based on the risk to personnel, the security team may need PPE when working outside the MTF. Security Force augmentation may be needed to protect the MTF, assist with crowd control, and assist with other security needs.

2.3.2. Covert Incident. Covert incidents involve deliberate CBRNE/WMD attacks that may not be overtly and/or immediately recognized. For example, injecting *cryptosporidium* (protozoan parasite) into the water supply is a covert incident. A covert incident may not become evident until patients report to the medical facility. The link between their illness and an intentional CBRNE/WMD release may not be readily apparent. Patients may present in mass from a common source exposure or trickle in due to a propagated outbreak, as might be the case with exposure to a BW agent such as smallpox. The first line of defense in the MTF is a well-trained medical staff that recognizes the syndromes related to CBRNE/WMD. The second line of defense is a disease/syndromic surveillance system that tracks the incidence of selected diseases and syndromes on a daily basis. Surveillance systems currently in place include ESSENCE. ESSENCE monitors MTF Ambulatory Data System patient diagnoses on a daily basis and reports clusters or incidence rates that exceed historical averages to the MTF Public Health Office. Public Health investigates the clusters to determine if indeed an outbreak is occurring, using standard epidemiological outbreak investigation methods. Public Health requests support from the BEE if the investigation links it to suspected CBRNE/WMD activity or food and water contamination. If the BEE suspects a CBRNE/WMD event, he/she will notify the medical chain of command in the most expeditious manner. The MTF/CC will direct the required MTF response and recommend activation of the CAT/DCG/battle staff to the wing commander as appropriate. Other medical response actions remain similar to an overt attack.

2.4. Post-Incident Recovery Actions. Following a WMD incident, the MTF must accomplish several tasks to assist the Wing in reestablishing normal operations and to ensure the health of the base populace. Casualty Prevention activities during the post-incident recovery include risk communication, expanded medical surveillance of exposed personnel, Critical Incident Stress Management (CISM) actions, and WMD contamination avoidance and control.

2.4.1. Risk Communication. Risk communication will be vital to ensure responders operate in a safe environment by minimizing their risk of exposure. Medical personnel must communicate risks of response personnel to commanders. This will assist commanders in their ORM-based decisions. Clear, consistent, understandable information should be provided to patients, visitors, medical group staff, and the general public.

Tailored risk communication efforts will be required prior to re-occupancy of facilities affected by the WMD incident.

2.4.2. Expanded Medical Surveillance. Critical to casualty prevention post-incident response is a highly focused medical surveillance program. Continuous disease/syndromic surveillance enables the MTF to quickly identify and treat new cases related to the WMD incident. The surveillance process will help identify potential exposures and implement casualty management practices such as immediate prophylaxis. For contagious agents, surveillance efforts will drive quarantine requirements to prevent further exposures. Finally, surveillance will identify exposed members to protect responders and other health care staff from spreading contamination and contracting disease.

2.4.3. Critical Incident Stress Management (CISM). The MTF will provide an appropriate team to conduct CISM. This team may consist of providers from Life Skills or other clinical entities as appropriate, to include assistance from deployed CISM teams. The CISM provides both casualty prevention and management functions. Under casualty prevention, the CISM will support mental health needs of responders so that responders can continue the response effort with minimal adverse psychological effects.

2.4.4. CBRNE Contamination Avoidance and Control. Part of the restoration of operations is determining the extent of contamination. Next, the responders must decide whether to manage contamination through avoidance or control. Contamination avoidance is supported by detection and surveillance efforts. Contamination control is supported through barriers and decontamination. Responders will decide which contaminated assets will be decontaminated and which will be discarded. The BEE and PHO will assist the installation commander in making this risk-based decision. When decontamination is chosen, the BEE will develop: a decontamination plan in conjunction with Civil Engineering; a health and safety plan for personnel involved in the operation; and a sampling, analysis, and monitoring plan to determine the efficacy of the decontamination effort. Ultimately, casualty prevention and control are achieved through both avoidance and control.

Chapter 3

CASUALTY MANAGEMENT

3.1. Introduction. Responses to CBRNE/WMD events will closely follow established guidelines for mass casualty response. The involvement of CBRNE/WMD materials will drive additional taskings and create unique problems. Casualty care operations include patient decontamination, triage, clinical care of CBRNE casualties, patient movement on the airbase, restriction of movement/quarantine, and aeromedical evacuation (AFDD 2-4.2, *Air Force Doctrine on Health Service Support*; AFTTP 3-42.3, *Health Service Support in Nuclear, Biological, and Chemical (NBC) Environments*). This chapter addresses specific actions MTFs must take to effectively prepare, respond, and recover from CBRNE/WMD events.

3.2. Pre-Incident Preparation and Planning: In accordance with AFI 41-106, *Medical Readiness Planning and Training*, all MTFs will develop a MCRP to address the threat of CBRNE/WMD taking into consideration local threat, mission, capabilities of facilities, and community resources. Mutual Aid Contracts and Memorandum of Agreements (MOAs) will be developed to cover contingencies and services not provided by the MTF. The plan must be reviewed/approved by the Medical NBC Defense Officer.

3.2.1. In preparation for a CBRNE/WMD event, the MTF must plan for:

3.2.1.1. Medical operations at the scene (to include surveillance, triage, life saving actions, and transport).

3.2.1.2. Medical operations at the MTF (to include decontamination, triage, treatment).

3.2.1.3. Patients that present at the MTF without on-scene treatment and may be contaminated. They either bypassed the scene control, or none was established.

3.2.1.4. A flood of patients that may or may not have had contact with the contaminant. In particular, MTFs may be inundated with unexposed, anxious patients (i.e. “worried well”).

3.2.1.5. Providing chemical and biological agent countermeasures and/or prophylaxes to first responders and incident casualties.

3.2.1.6. Requirement to have visibility on all pharmaceuticals – know what you have, where it is (peacetime pharmacy and WRM CBRNE/WMD).

3.2.1.7. Immediate implementation-distribution of countermeasures and rapid administration of prophylaxes for the effects of WMD agents.

3.2.1.8. Plan for the strong possibility of public anxiety and panic and the need to provide public information and advice.

3.2.2. The potential magnitude of a CBRNE/WMD event, and limited staffing resources at our MTFs due to AEF rotations, and down-sizing over the past years, requires establishment of cooperative relationships with local community emergency response agencies (Hospitals, ambulance services, and other emergency management organizations). Memorandums of Understanding and Memorandums of Agreement (MOUs/MOAs) are the tools used to establish agreements between these agencies, but often times after development they are placed in binders and quickly become outdated. In order to ensure our agreements do not become ineffective, MTFs are encouraged to implement the following recommendations:

3.2.2.1. Assign a member of the staff (Provider, or senior Nurse) to represent the MTF on local hospital emergency planning committee, or Medical Operations Center. If no such organization exists, assist other community hospitals, and emergency management organizations to develop one.

3.2.2.2. Regularly attend local hospital emergency planning committee meetings to keep abreast of changes in response capabilities within the community.

3.2.2.3. Develop/update comprehensive MOUs/MOAs with local hospitals, and other emergency response agencies.

3.2.2.4. Whenever possible, participate in, and/or invite local emergency response agencies to participate in CBRNE/WMD exercises.

3.3. Pre-Incident Planning Considerations

3.3.1. Preparing for a large influx of patients.

3.3.1.1. Executive management will be required to make early decisions regarding existing plans for providing health care. When the number of patients exceeds the number of available beds and staffing, decisions must be made as to whether alternative, off-site facilities will be opened; who will staff these facilities; and how they will be supplied. At the MTF level, major decisions will have to be made and implemented quickly. Plans should be IAW local, state and national plans.

3.3.1.2. Below are some recommendations to assist management in prioritizing requirements and networking patient needs with local facilities.

3.3.1.2.1. Decisions may have to be made as to whether one hospital in the city or county will be designated as a WMD MTF or if all hospitals will share equally in the influx of patients.

3.3.1.2.2. Implement the hospital emergency management plan (i.e., the MCRP) and WMD response plan.

3.3.1.2.3. Cancel non-emergency surgeries, and other elective procedures; terminate outpatient care.

3.3.1.2.4. Develop discharge instructions for non-contagious patients.

3.3.1.2.5. Discharge patients to other acute care facilities out of the affected geographical area, to long-term care, or to home care.

3.3.1.2.6. Determine the availability and sources of additional medical equipment such as ventilators, IV pumps, and other equipment.

3.3.1.2.7. Brief the OSC and develop plans for incident status report.

3.3.1.2.8. Establish liaison with civilian counterparts in planning disaster, emergency medical services (EMS), and WMD response.

3.3.1.2.9. Coordinate with appropriate base agencies to develop plans for isolation/quarantine of affected/infected personnel as needed.

3.3.1.2.10. Communicate information through a designated medical public affairs officer to staff, visitors, current patients, and the media (consider development of educational handouts, etc).

3.3.1.2.11. Discharge patients with communicable diseases, when appropriate. Develop specific discharge instructions that include recommendations for caregiver protection, hand washing, disinfection of the environment, and post-mortem care.

3.3.1.2.12. Coordinate with local (civilian) Public Health resources for pre-incident surveillance reporting as well as post-incident exposure and effect tracking.

3.3.1.2.13. Provide pre-exposure training IAW AFI 44-153, *Critical Incident Stress Management*, if possible.

3.3.2. Ambulance Considerations.

3.3.2.1. Ambulance crews commonly configure their response equipment and supplies based on local policies. This TTP does not alter that practice. However, it is required that local MTFs, in the course of their response training, clearly identify which medical care equipment items will be taken with the medics responding to the incident. Some examples may include airway management bag, oxygen delivery system, trauma bag, and Advanced Life Support (ALS) medication bag.

3.3.2.2. Individual MTFs may consider configuring a “WMD Response Bag” with patient care items that can be stored in a dedicated ambulance compartment, perhaps with the individual “mini-C-Bags” of the ambulance crews.

- 3.3.2.3. Each ambulance must also have patient covers and blankets for ambulatory and litter patients after the decontamination process. The ambulance must have markers and sturdy plastic bags for contaminated clothing and infectious waste bags to contain items contaminated with blood/body fluids.
- 3.3.2.4. Decontamination of vehicles may be necessary before returning to normal services. Patients arriving at the MTF with suspected contamination will be directed/transported to the MTF's patient decontamination site.
- 3.3.2.5. MOAs must include local EMS access to the base during increased FORCECONS. MTF commanders should discuss ways to expedite EMS access during these events so that patients can receive prompt medical attention without compromising base security.
- 3.3.2.6. MTFs with contract ambulance services must ensure that CBRNE/WMD planning actions required of the EMS are included in contract statements of work.
- 3.3.3. Evidence Collection. In some cases, the OSI may require collection of exposed clothing and other potential evidence. The MTFs will establish policies and procedures for evidence preservation and labeling/inventory of patient's effects. Procedures should include how weapons brought in by patients (e.g., guns, knives, and syringes) will be retrieved, secured and handed over to law enforcement officials. Evidence from BW attacks may also be biological specimens collected (blood, urine, etc.) from casualties and may need to be treated as evidence under certain circumstances. Strict chain-of-custody protocols must be established and followed for any materials given to outside agencies.
- 3.3.4. Management of Human Remains. Management of human remains is primarily a USAF Services responsibility. The MTF, in conjunction with Services, and the local community must determine how remains will be transported from the scene and by whom. Additional concerns include when and where a provider will certify death in a mass casualty response situation and other issues such as decontamination of the MTF after removal of remains, morgue capacity and alternate facilities determinations. The MTF in coordination with BE and PH will advise Services personnel on the type of contamination, health hazards, and prevention of spread of disease and contamination. Local initial decontamination and contaminated remains collection points may need to be established. (Reference JP 4-06, *JTTP for Mortuary Affairs in Joint Operations*.)
- 3.3.5. Personal Protection.
- 3.3.5.1. Each MTF will provide appropriate PPE, based on threat level, for all responding medical personnel. The intent is for each medic who may ride on an ambulance, or respond to the site, to have access to this equipment as identified by the BE.

3.3.5.2. The purpose of this equipment is to provide basic protection against the vast majority of chemical and radiological agents, and provide a limited individual-level detection and decontamination capability.

3.3.6. Medical Public Affairs and the Media.

3.3.6.1. CBRNE/WMD events will draw media attention. It is critical that MTF respond appropriately measuring the public's need/right to know information against security needs and patients' rights.

3.3.6.2. Medical Public Affairs should be part of the MCC. Their primary task is to keep the medical staff informed on the incident, its progress and any other items of interest. In a chaotic situation the medical staff may be insulated from the response effort as they treat in-coming patients. To avoid rumors and other distractions that may adversely affect the morale and ability of medical staff to perform, the medical public affairs officer will provide updates to the staff.

3.3.6.3. The second Medical Public Affairs task is to provide medically related information on the response, medical effects and countermeasures, etc. to the wing public affairs office for release to the media. The media may want to interview a health care provider or representative from the hospital; this should be coordinated through the medical public affairs officer.

3.3.6.4. BE, PH, Aerospace Medicine, and Life Skills can be invaluable in preparing press releases and public statements. Their expertise can help identify people who need to report for medical evaluation and calm the concerns of those who do not.

3.4. Medical Operations at the Scene. The Incident Command System will be in effect for the initial response to a WMD incident, in the same manner as all other responses.

3.4.1. First responders may or may not know they are dealing with a WMD incident when the call comes into the dispatch center. The SFO is in charge of the scene under the Incident Command System, and is responsible for establishing the Hot, Warm and Cold zones. (See AFMAN 32-4004, *Emergency Response Operations*, for additional details.) Medical responders will initially stage at the Entry Control Point (ECP) and initiate communication with the Incident Commander. Every attempt will be made to keep ambulances from entering the Warm or Hot Zones. If an ambulance enters these areas, either intentionally or unintentionally, it must remain there until otherwise directed by the incident commander in consultation with the BEE.

3.4.2. Initial Response. All Air Force MTFs providing ambulance service are required to accomplish the following medical actions on-scene:

3.4.2.1. Obtain all available information concerning the nature of the event (location of ECP, HAZMAT potential, wind direction, etc.).

3.4.2.2. Medical first responders will report to on-scene commanders at the entry control point. Medical personnel will not enter the Warm or Hot zone.

3.4.2.3. Call the MCC for additional resources as needed, and request notification of other local (military or civilian) MTFs of potential activation of mutual aid agreement and Facility Security Plan.

3.4.2.4. The fire department performs gross decontamination of all contaminated personnel at the scene (See AFH 10-2502, *WMD Threat Planning and Response Handbook*.) If questions arise on how to decontaminate a severely injured individual the fire department will question the on-scene first responder flight surgeon via radio before decontaminating this individual.

3.4.2.5. Triage and Treat. The following are information resources available to guide triage and treatment b type of injury/casualty.

3.4.2.5.1. Triage and Provide Emergency Medical Treatment for Chemical Casualties IAW AFJMAN 44-149 “Treatment of Chemical Agent Casualties and Conventional Military Injuries or USAMRICD’s (United States Army Medical Research Institute of Chemical Defense) ‘Field Management of Chemical Casualties’ or ‘Medical Management of Chemical Casualties’ (Refer to the Chemical Casualty Care Division, USAMRICD <http://ccc.apgea.army.mil/products/handbooks/Books.htm#fmcc>).

3.4.2.5.2. Triage and Provide Emergency Medical Treatment for Biological Casualties IAW USAMRIID’s (United States Army Medical Research Institute of Infectious Diseases) ‘Medical Management of Biological Casualties’.

3.4.2.5.3. Triage and Provide Emergency Medical Treatment for Radiological Casualties IAW AFRRI’s ‘Medical Management of Radiological Casualties’ (<http://www.afri.usuhs.mil/www/outreach/pdf/radiologicalhandbooksp99-2.pdf>)

3.4.2.5.4. Triage and Provide Emergency Medical Treatment IAW Field Management of Chemical Casualties Handbook. (Refer to the Chemical Casualty Care Division, <http://chemdef.apgea.army.mil>, for more detailed information on agents of concern). For Toxic Industrial Chemicals/Materials (TICs/TIMs), consult the Toxicology Occupational Medicines and Environmental Sciences Meditext function, the Medical Services Delivery System (MSDS) and the Department of Transportation (DOT) Emergency Response Guide. Consult the BEE/Fire Department Resource Officer for assistance.

3.4.2.6. Implement patient identification and tracking mechanism. This tracking mechanism must be pre-planned with all possible responding medical facilities in the local area and fulfill Department of Health and Human Services (DHHS) and FBI requirements since these agencies will be assuming the lead role in the response. A patient administration team will be responsible for tracking patients; they may be deployed on-scene to track transported patients, their ambulance, and their destination. This information will be needed for notifying family members. Additionally, the patient administration team manages bed space and coordinates with local hospitals for patient care.

3.4.2.7. Transport casualties.

3.4.2.8. Medical OSC working through the MCC will direct patients to either a military or civilian MTF, based on patient acuity, contagiousness, suspected contamination, and capabilities of local treatment facilities as appropriate.

3.5. Medical Operations at the MTF. Smaller MTFs may not be the primary receiving location for patients arriving from the scene, particularly if the incident occurred off base in the nearby community. However, all Air Force MTFs must be capable of handling patients to the extent of their capacity. A patient could present at the “front door” of the facility whether it is big or small. Even if scene control is established, MTFs must be prepared to receive the type and amount of casualties specified in their Medical Contingency Response Plans (MCRPs) (Reference AFI 41-106, *Medical Readiness Planning and Training*), and activate local disaster response/mutual aid agreements as appropriate.

3.5.1. Patients arrive at the MTF after triage, gross decontamination, and initial treatment at the scene.

3.5.1.1. Execute plan to receive patients at the MTF.

3.5.1.2. Initiate patient tracking mechanism(s).

3.5.1.3. Deliver patients to medical decontamination site.

3.5.1.4. Re-triage and provide appropriate immediate care.

3.5.1.5. Monitor and medically decontaminate as necessary. IAW USAF CONOPS In-Place Peacetime Patient Decontamination Capability (See <https://www.sg.langley.af.mil/> follow links to Flight Medicine section) or within USAFE, IAW USAFE In-Place Patient Decontamination Capability.

3.5.1.6. Deliver patient(s) to appropriate treatment team(s). IAW AFJMAN 44-149, *Treatment of Chemical Agent Casualties and Conventional Military Chemical Injuries*; AFMAN (I) 44-156 *Treatment of Biological Warfare Agent Casualties*; AFMAN 44-161 (I), *Treatment of Nuclear and Radiological Casualties, Medical Management of*

Biological Casualties Handbook, 3rd Ed.; AFJMAN 44-151 *NATO Handbook on the Medical Aspects of NBC Defensive Operations*; US Army Medical Research Institute of Chemical Defense (USAMRICD) <http://chemdef.apgea.army.mil/>; *Medical Management of Chemical Casualties Handbook*.

3.5.2. Patients might also arrive at the MTF without on-scene treatment. Other patients might arrive that may or may not have had any contact with the contaminant, but may be experiencing symptoms.

3.5.2.1. Implement local plans to activate triage team per MCRP. The triage team could be split into two sub-teams: primary (field) triage team and secondary triage team. The primary triage team will don needed PPE after receiving confirmation and establish a triage staging area outside the MTF for receiving and triaging patients. This triage will be based on injury, contamination, available resources, and transport/evacuation priority. The primary triage team is tasked with providing immediate, stabilizing care and prioritizing casualties for decontamination and ultimately entry into the MTF.

3.5.2.2. Identify contaminated patient and immediately isolate.

3.5.2.3. Monitor and medically decontaminate as necessary IAW USAF In-place Peacetime Patient Decontamination Capability CONOPS (<https://www.langley.af.mil/> follow links to Flight Medicine section.)

3.5.2.4. After decontamination, patients will be provided with a gown and escorted into the MTF. An inside staging area will be established for secondary triage. The secondary triage team can now triage patients based on their injury and available resources. After secondary triage, the patients are delivered to their appropriate treatment team(s) [Minimal, Delayed, Immediate, or Critical Incident Stress Management (CISM) teams] and medical care facility as needed.

3.6. Additional MCC responsibilities during WMD include:

3.6.1. Execute existing checklists to include:

3.6.1.1. Activation of Facility Security Plan.

3.6.1.1.1. Activate facility shutdown of H-VAC as needed.

3.6.1.1.2. Lock down facility as appropriate.

3.6.1.1.3. Establish facility entry location(s).

3.6.1.2. Activation of MOUs and MOAs for additional medical support.

3.6.1.3. Communicate with staff and patients to prevent panic.

3.6.1.4. Direction of WMD assets for immediate use.

3.6.1.5. Activation of MTF response/recall to include field response, treatment, CISM, and decontamination teams as appropriate.

3.6.2. During normal duty hours the MTF commander has availability of all MTF assets and can deploy them as needed.

3.6.3. After normal duty hours the MTF will respond with available resources; the MTF commander or designee will evaluate need for additional staff. Realistic timelines will be established for staff response.

3.7. Provision of Nuclear, Chemical and Biological Countermeasures.

3.7.1. Nuclear/Radiological WMD. Implementation of supportive measures per MTF capabilities. Refer to USACHPPM Tech Guide 244, Medical NBC Battlebook UFRRI's Medical Management of Radiological Casualties, and the Nuclear Weapons Accident Response Procedure (NARP) manual.

3.7.2. Biological WMD. Implementation of antibiotic treatment per Medical Management of Biological Casualties Handbook (3rd ed) and current CDC guidelines. MTF will know availability and location of WMD supplies (antibiotics and vaccines) to include accessing CDC National Pharmaceutical Stockpile per pre-arranged local (National Disaster Medical System [NDMS]).

3.7.3. Chemical WMD. Implement care procedures for chemical exposed patients IAW AFJMAN 44-149, Treatment of Chemical Agent Casualties and Conventional Military Chemical Injuries, Medical Management of Chemical Casualties Handbook, Chemical Casualty Care Division, USAMRICD and Field Management of Chemical Casualties Handbook, Chemical Casualty Care Division, USAMRICD for more detailed information on agents of concern. MTFs will have sufficient Atropine, 2-PAM chloride, and Diazepam immediately available/accessible to treat anticipated number of casualties.

3.8. Post-Incident Recovery Actions. Following a CBRNE/WMD incident, the MTF must accomplish several tasks to assist the installation in reestablishing normal operations and to ensure the health of the base populace. These activities are risk communication, expanded medical surveillance of exposed personnel, and critical incident stress management. Many of these activities are seamless with casualty prevention efforts. Below are the casualty management aspects of these actions.

3.8.1. Risk Communication. It is apparent that any CBRNE/WMD incident will affect the base populace and the local community. Risk communication will be vital to reduce public fears. Clear, consistent, understandable information should be provided to patients,

visitors, and the general public. To minimize the anticipated response of fear, confusion, and anger, MTFs should develop a risk communication fact sheet and coordinate its distribution through the public affairs office as soon as possible. Tailored risk communication efforts will be required prior to re-occupancy of facilities affected by the CBRNE/WMD incident. Failure to provide a public forum for information exchange may increase fear among individuals who could attribute non-specific symptoms to the incident. Ultimately, these risk communication efforts are targeted to managing existing casualties, while those of casualty prevention are focused on the continuing response efforts and response personnel.

3.8.2. Expanded Medical Surveillance. Critical to casualty prevention post-incident is a highly focused medical surveillance program. Disease/syndromic surveillance continues to enable the MTF to quickly identify and treat new cases related to the WMD incident. A detailed accounting of all potentially exposed personnel is essential to ensure all are treated and receive proper follow-up. A post-exposure questionnaire must be developed in cooperation with the lead agency and administered to all potentially exposed individuals to assess their exposure and symptomology history. Documentation of the CBRNE/WMD exposure and treatment into the patient's longitudinal medical record is required by Presidential Review Directive 5.

3.8.3. Critical Incident Stress Management. The Base/Wing will provide an appropriate team to conduct CISM. This team is composed of representatives from Life Skills, Chapel, Family Support, Medical and Personnel. External CISM staff may also be available for assistance. CISM should be prepared to provide post-incident intervention to both staff and patients as deemed necessary. Quick intervention is critical to restoring responders and quelling patient anxiety and stress.

Chapter 4

LOGISTICS

4.1. Purpose and Objective. The Medical Logistics Flight provides logistical support to include custodian/team leader training, procurement, receipt, and issue of the supplies and equipment deemed necessary for all WMD response teams and the HLD LRT to accomplish their missions.

4.2. Pre-Incident Procedures.

4.2.1. Allowance Standards (AS). All CBRNE/WMD and HLD LRT projects will be managed using the processes defined in AFI 41-209, Chapter 13. These processes provide a systematic method to develop, change, and review medical AS to ensure they are kept functional and current. CBRNE/WMD and HLD LRT AS are a maximum authorization for a given module, unlike WRM AS that are a standard list of items and quantities (basis of issue) that cannot be modified locally. Not all items on a CBRNE/WMD AS will be required by every facility assigned that module. Local threat and capability assessments will drive the basis of issue for a given MTF. Documentation to support local basis of issue determinations must be approved by the Medical Readiness Staff Function (MRSF) and revalidated annually. Requirements that exceed the AS cannot be procured. Disaster team leaders should identify AS shortfalls using the procedures outlined in AFI 41-206, Chapter 13. Allowance Standards are published on the AFMLO Web Site at <https://afml.ft-detrick.af.mil/afmlo/Readiness/as/asmgr.cfm>.

4.2.2. Peacetime Operating Stock (POS). POS may be used to reduce CBRNE/WMD and HLD LRT requirements, but only when there is reasonable expectation that POS will be consistently available. Documentation to support POS decisions must be approved by the MRSF and revalidated annually. Procedures for WRM POS outlined in AFI 41-209, Chapter 13 will be followed to calculate and document POS for CBRNE/WMD and HLD LRT.

4.2.3. Cost Centers. Cost centers must be established using the following Responsibility Center/Cost Center (RC/CC) codes:

XB5888	Immediate Medical Response Module
XD5888	In-patient Support Module
XE5888	Pharmaceutical Support Module
XF5888	In-Place Patient Decontamination Capability
XG5888	Bioenvironmental Engineering Detection

NOTE: Fund code 30/3400/O&M funds in PEC 28038F should be used. DHP dollars cannot be used to procure supplies and equipment for these accounts.

4.2.4. **Accountability.** All Home Station Response assets will be managed and accounted for by IAW the policies and procedures outlined in AFI 41-209, Chapters 3, 5, 7, 9, 11, and 13. Each team lead will appoint a property custodian for their account (RC/CC), per AFI 41-209, Chapter 7. The property custodian is responsible for initiating all requests for materiel and is accountable for all property on the Receipt/Locator List. Sites using Defense Medical Logistics Standard Support (DMLSS) 3.0X will use the Assemblage Management module to manage their projects.

4.2.5. **Procurement.** Medical Logistics will procure, receive and issue all required materiel identified by the team property custodian based on the local basis of issue determination referenced in Para 4.2.1. Some equipment (i.e., BEE AS) may be purchased centrally by the MAJCOMs to achieve economies of scale, validate the requirements, and to alleviate some of the logistics burden at base level. Normal peacetime procedures for procurement, receipt and issue will be utilized to accomplish these tasks.

4.2.6. **Storage.** If CBRNE/WMD materiel is stored in Medical Logistics warehouses, it must not be commingled with Air Force Working Capital Fund (AFWCF) inventories. CBRNE/WMD assets must be clearly marked and segregated from peacetime and WRM inventories.

4.2.7. **Visibility.** Status of CBRNE/WMD and HLD LRT projects will be visible in Medical Readiness Decision Support System (MRDSS). DMLSS version 3.04 will provide that update automatically. Property custodians will conduct inventories and replenish their module using the DMLSS 3.04 Assemblage Management module. Sites not yet on DMLSS 3.04 will utilize the MRDSS UIM module to manually provide project status. Team Leaders are responsible for accomplishing monthly inventories of their CBRNE/WMD and HLD LRT project assets and providing the results to the Medical Readiness Flight. Medical Readiness personnel will make the appropriate changes to the UIM materiel screen when they update project personnel and training status.

4.3. Incident Procedures. The Medical Logistics Flight Commander will activate the Medical Logistics, Facility Management, and Transportation Teams as directed by the MCC. Specific team composition and responsibilities should be outlined in Annexes G (Medical Logistics), J (Facility Management), and O (Transportation) in the local MCRP.

4.4. Post-Incident Procedures. The disaster team leaders will complete an inventory of their modules and identify materiel shortfalls or equipment maintenance requirements to the property custodian. If funds are available, the property custodian will initiate replenishment actions using the procedures outlined in paragraph 4.2.5.

Chapter 5

TRAINING AND EXERCISES

5.1. Introduction. The education and training recommended in this TTP should impart a working knowledge of the concepts, principles, and procedures of operating in the CBRNE environment. This education and training addresses the individual, collective, unit, and leadership skills needed to support home station CBRNE/WMD response requirements.

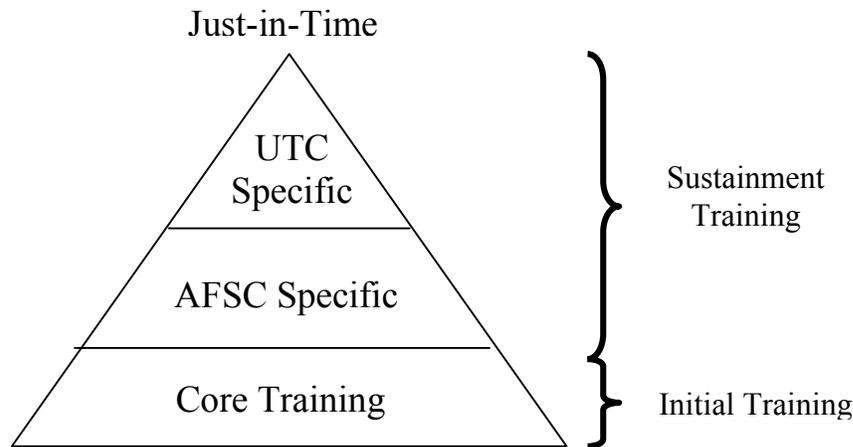
5.2. Training.

5.2.1. Education, training, and exercises will be conducted as required by AFI 10-2501, *Full Spectrum Threat Response Operations*; AFI 41-106, *Medical Readiness Planning and Training*; MAJCOM policy; and local directives. The Readiness Skills Verification Program (RSVP) should contain the skill sets required for each team member assigned to respond to a CBRNE incident.

5.2.2. Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Environment of Care (EC) standard EC.1.4 requires hospital, ambulatory care, behavioral health, home care, and long term care organizations to *develop* a management plan that ensures effective response to emergencies affecting the environment of care. Standard EC.2.4 requires these organizations to *implement* the emergency management plan. Standard EC.2.9.1 requires them to *execute* the plan by conducting emergency management drills. Although not required by JCAHO standards, it would be prudent for other types of health care organizations to plan for disasters given today's environment. It is clear that there is a core set of skill requirements that apply to every medic, regardless of specialty. However, the level of expertise brought to bear on the CBRNE/WMD event will determine the breadth and depth of understanding and level of proficiency. Training requirements will be established based on CBRNE/WMD first-responder capabilities.

5.2.3. Training shall be based on the duties and functions to be performed by each member of the first responder team. It is understood that medical personnel responding to the scene will be properly trained and equipped to protect themselves from exposure. Responding personnel will at a minimum receive Incident Command System awareness training. All ER/triage and field response teams must comply with the training requirements outlined in AFI 10-2501, *Full Spectrum Threat Response (FSTR) Planning and Operations*.

5.3. Requirements. The combination of core skill requirements and mission specific or (Unit Type Code) UTC specific requirements represent the full-spectrum requisite CBRNE/WMD training. The education and training building blocks for AF medical personnel begins at initial training received upon entry into the service and continues with periodic refresher training throughout the lifecycle of the service member. The pieces of the blocks can best be described in three phases: initial training, sustainment training, and just-in-time (JIT) training. (See Figure 5.3).

Figure 5.3. Training Building Blocks.

5.3.1. Initial NBC Defense training will occur at the accession/entry-level courses. NBC Defense training is described in AFI 10-2501, *Full Spectrum Threat Response (FSTR) Planning and Operations*. Personnel, who do not receive NBC Defense training through accession/entry-level programs, must be trained at the unit level. AFI 10-2501 outlines when this training must be accomplished. Additional training may be necessary on subjects such as personnel protective equipment or incident command as outlined in 29 CFR 1910120, *OSHA, Hazardous Waste Operations and Emergency Response*.

5.3.2. Sustainment training is required at a specified frequency to maintain or enhance the proficiency of individual readiness, clinical, and unit/platform skills. The level of proficiency needed to maintain currency in CBRNE/WMD related skills, and the criticality of the skill will determine the frequency of training. Sustainment training will focus on Air Force Specialty Code (AFSC)-specific and UTC-specific requirements.

5.3.2.1. Several venues for sustainment training that address AFSC-specific and UTC-specific requirements are available to medical personnel. Formal courses provide an opportunity for a standardized approach to training. Additionally, maximum utilization of distance learning capabilities will be integral in reducing TDY costs and time away from home station. Reference materials (e.g., NBC Toolkit, CD-ROM training, etc.) should be incorporated as needed to augment initial/sustainment training.

5.3.2.2. Although JIT training is a component of education and training, it is not the optimal or desired method of training. It may not be of value for home station CBRNE/WMD response as there is no spin-up time afforded from the terrorist. However, there may be circumstances where it is applicable and its goal is immediate re-enforcement of critical NBC skills only (e.g., wear of the gas mask, proper inspection of the PPE, use of auto-injectors, etc.).

5.4. Field Exercises. Field exercises are training conducted outside the classroom, normally employing unit equipment, and operating under simulated CBRNE/WMD conditions. An example of a field exercise is a circumstance in which a unit focuses on setting up its medical equipment and simulates all aspects of the deployment phase of a CBRNE/WMD operation. Essential elements of the exercise should include aspects of triage, decontamination, treatment, and transportation of casualties. MTF commanders should exploit every opportunity to participate in base-wide CBRNE/WMD exercises as well as demonstrate the ability to conduct in-house training to ensure functional capabilities. Exercise scenarios should include all areas of the MTF that are involved in a CBRNE/WMD event and include the sampling, risk assessment and risk communication task as well as the tasks outlined in Chapter 2. For example, a full-spectrum scenario involving a credible BW agent should be employed to test laboratory capabilities and interactions with local, state, and federal agencies.

DAVID F. MacGHEE, Major General, USAF
Commander, Air Force Doctrine Center

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

*References*Air Force Doctrine and Publications*AFDD 2, Organization and Employment of Aerospace Power**AFDD 2-1.8, Counter Nuclear, Biological, and Chemical Operations**AFDD 2-4.2, Health Services**AFTTP 3-42.2, [Draft], AFTTP 3-42.2, [Draft], Casualty Prevention in Expeditionary Operations**AFTTP 3-42.8, Medical Logistics and the Blood Program**AFI 10-212, Air Base Operability Program**AFMAN 10-100, Airman's Manual**AFI 10-206, Operational Reporting**AFI 10-211, Civil Engineer Contingency Response Planning**AFPAM 10-219, Vol 1, Contingency and Disaster Planning**AFPAM 10-219, Vol 2, Pre-attack and Pre-disaster Planning**AFPAM 10-219, Vol 3, Post-attack and Post-disaster Procedures**AFI 10-801, Assistance to Civilian Law Enforcement Agencies**AFI 10-802, Military Support to Civil Authorities**AFPAM 10-219, Vol 5, Bare Base Conceptual Planning Guide**AFI 10-404, Base Support and Expeditionary Site Planning**AFI 10-2501, Full Spectrum Threat Response Operations**AFH 10-2502, WMD Threat Planning and Response Handbook**AFI 10-2601 [Draft], Counter – Nuclear, Biological, and Chemical Passive Defense Operations**AFMAN 10-2602 [Draft], Nuclear, Biological, Chemical, and Conventional (NBCC) Defense Operations and Standards**AFPAM 10-2603 [Draft], Counter – Nuclear, Biological, and Chemical Passive Defense Commander's Guide**AFMAN 23-110, Vol 5, Chapter 15, USAF Supply Manual, Medical Logistics**AFCSM 31-230, Vol 2, Medical Logistics System (MEDLOG): 1008/AJ, User Manual**AFI 32-4001, Disaster Preparedness Planning and Operations**AFMAN 32-4002, Hazardous Materials Emergency Planning and Response Program**AFMAN 32-4004, Emergency Response Operations**AFMAN 32-4005, Personnel Protection and Attack Actions**AFMAN 32-4007, Camouflage, Concealment, and Deception**AFVA 32-4010, USAF Standardized Alarm Signals for the US, Its Territories, and Possessions**AFVA 32-4011, USAF Standardized Alarm Signals for Areas Subject to NBCC Attack**AFMAN 32-4013, Hazardous Material Emergency Planning and Response Guide**AFH 32-4014, Vol 1, USAF Operations in a Chemical and Biological (CB) Warfare Environment, CB Planning and Analysis**AFH 32-4014, Vol 2, USAF Operations in a Chemical and Biological (CB) Warfare*

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 AFH 32-4014, Vol 3, *USAF Operations in a Chemical and Biological (CB) Warfare Environment, Defense Equipment*
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 AFPAM 32-4019, *Chemical-Biological Warfare Commander's Guide*
 AFRD 34-5, *Mortuary Affairs*
 AFI 41-106, *Medical Readiness Planning and Training*
 AFI 41-209, *Medical Logistics Support*
 AFD 41-317, *Compendium of Aeromedical Evacuation Terminology*
 AFJMAN 44-149, *Treatment of Chemical Agent Casualties and Conventional Military Chemical Injuries*
 AFJMAN 44-151, *NATO Handbook on the Medical Aspects of NBC Defensive Operations*
 AFMAN (I) 44-156, *Treatment of Biological Warfare Agent Casualties*
 AFMAN (I) 44-161, *Treatment of Nuclear and Radiological Casualties*
 AFJI 48-110, *Immunizations and Chemoprophylaxis*
 AFPAM 91-216, *USAF Safety Deployment and Contingency Pamphlet*
 AFMS CONOPS, *Wartime Medical Decontamination Team*

Joint Doctrine and Policy

CJCS Memo, MCM 251-98, *Deployment Health Surveillance and Readiness*
 CJCS Memo MCM 0006-02, *Updated Procedures for Deployment Health Surveillance and Readiness*
 Joint Policy Memo, *Deployed Occupational Health and Environmental Health Surveillance*
 JP 3-07.2, *Joint Tactics, Techniques, and Procedures for Antiterrorism*
 JP 3-11, *Joint Doctrine for Operations in Nuclear, Biological, and Chemical (NBC) Environments*
 JP 4-02, *Doctrine for Health Service Support in Joint Operations*
 JP 4-06, *JTTP for Mortuary Affairs in Joint Operations*

Other Service Publications

US Army FM 8-9, *NATO Handbook on the Medical Aspects of NBC Defensive Operations*
 US Army FM 8-10-7, *Health Service Support in NBC Environments*
 US Army FM 8-33/NAVMED P-5038, *Control of Communicable Diseases Manual*
 US Army FM 8-285, *Chemical Agent Casualties*
 US Army FM 21-10, *Field Hygiene and Sanitation*
 US Army Medical Research Institute of Chemical Defense (USAMRICD), *Medical Management of Chemical Casualties Handbook*
 US Army Medical Research Institute of Infectious Diseases (USAMRIID), *Medical Management of Biological Casualties Handbook*
 USACHPPM Tech Guide 244, *The Medical NBC Battlebook*
 Tri-service textbook series: *Textbook of Military Medicine (TMM), Volumes 1 and 8*

Armed Forces Radiology Research Institute (AFRRI), *Medical Management of Radiological Casualties*

Other Guidance and Sources

DODD 2000.12, *Combating Terrorism Program*

DODD 6205.3, *DOD Immunization Program for Biological Warfare Defense*

Force Protection Battlelab, *Commanders Guide to Food and Water Systems Force Protection*

National Institute for Occupational Safety and Health, *Pocket Guide to Chemical Hazards*

US Department of Transportation, *North American Emergency Response Guidebook (ERG)*

Institute for Defense Analyses, Grotte and Yang, *Report of the Workshop on Chemical Agent Toxicity for Acute Effects*

Abbreviations and Acronyms

ADM-300	RADIAC Meter Manufactured by REMRAD™
AFMAN	Air Force Manual
AFMLO	Air Force Medical Logistics Office
AFSC	Air Force Specialty Code
AFWCF	Air Force Working Capital Fund
ALS	Advanced Life Support
AS	Allowance Standard
ATH	Air Transportable Hospital
BDO	Battle Dress Overgarment
BDU	Battle Dress Uniform
BE	Bio-Environmental Engineering
BEE	Bio-Environmental Engineer
BIDS	Biological Integrated Detection System
BOS	Base Operating Support
BW	Biological Warfare
CAM	Chemical Agent Monitor
CBRNE	Chemical, Biological, Radiological, Nuclear, and High-Yield Explosive
CCA	Contamination Control Area
CE	Civil Engineering
CFMN	Craftsman
CHATH	Chemically Hardened Air Transportable Hospital
CISM	Critical Stress Incident Management
CONOPS	Concept of Operations
CONPLAN	Contingency Plan
CPM	Counts per Minute
CPOG	Chemical Protective over Garment
CW	Chemical Warfare
DCG	Disaster Control Group
DECON	Decontaminate/Decontamination
DECON Team	Wartime Medical Decontamination Team
DOC	Designed Operation Capability

DMLSS	Defense Medical Logistics Standard Support
DP	Disaster Preparedness Office
DNBI	Disease and Non Battle Injury
DHP	Defense Health Program
DRF	Disaster Response Force
EC	Environment of Care
ECP	Entry Control Point
EET	Exercise Evaluation Team
EMS	Emergency Medical Services
EOD	Explosive Ordnance Disposal
FFGLA	UTC for the Wartime Medical Decontamination Team Equipment Package
FFGLB	UTC for the Wartime Medical Decontamination Team Personnel
GCE	Ground Crew Ensemble
GEMS	Global Expeditionary Medical System
HAZMAT	Hazardous Material
HLD	Homeland Defense
HQ AFMOA	Headquarters Air Force Medical Operations Agency
IPPDC	In-Place Patient Decontamination Capability
IPPDT	In-Place Patient Decontamination Team
IRF	Incident Response Force
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JNMN	Journeyman
JIT	Just in Time
LAF	Line of the Air Force
LHA	Liquid Hazard Area
LRN	Laboratory Response Network
LRT	Laboratory Response Team
MCC	Medical Control Center
MCRP	Medical Contingency Response Plan
MEFPAK	Manpower/Equipment Force Packaging
MERIT	Medical Evaluation of Readiness in Individual Training
MIO	Medical Intelligence Officer
MOA	Memorandum of Agreement
MOPP	Mission Oriented Protective Posture
MRDSS	Medical Readiness Decision Support System
MRSF	Medical Readiness Staff Function
MTF	Medical Treatment Facility
NAIC	National Air Intelligence Center
NARP	Nuclear Weapon Accident Procedures
NATO	North Atlantic Treaty Organization
NBC	Nuclear/Biological/Chemical
NIOSH	National Institute of Occupational Safety and Health
NPS	National Pharmaceutical Stockpile
O&M	Operations and Maintenance
OPLAN	Operational Plan

OPR	Office of Primary Responsibility
OSC	On Scene Commander
OSI	Office of Special Investigations
PA	Public Affairs Office
PAPR	Powered Air Purifying Respirator
PEC	Program Element Code
PH	Public Health
PHO	Public Health Officer
PMCS	Preventive Maintenance Checks for Systems
PMEL	Precision Measurement Equipment Laboratory
POS	Peacetime Operating Stock
PPE	Personal Protection Equipment
PPM	Parts Per Million
RAM	Radio Active Material
RAPID™	Ruggedized Advanced Pathogen Identification Device
RC/CC	Responsibility Center/Cost Center
RDD	Radiological Dispersal Devices
RDIC	Resuscitation Device, Individual Chemical
RSO	Radiation Safety Officer
RSVP	Readiness Skills Verification Program
SCBA	Self Contained Breathing Apparatus
SFO	Senior Fire Officer
TAP	Toxicological Agent Protective Apron
TEMPER	Tent, Expandable, Modular, Personnel
TIC	Toxic Industrial Chemical
TIM	Toxic Industrial Material
TTP	Tactics, Techniques and Procedures
UIM	Unit Input Module
USAFE	United States Air Forces in Europe
USAMRICD	United States Army Medical Research Institute of Chemical Defense
USAMRIID	United States Army Medical Research Institute of Infectious Diseases
UTC	Unit Type Code
VHA	Vapor Hazard Area
WMD	Weapons of Mass Destruction
WMP-1	War Mobilization Plan
WRM	War Reserve Materiel

Terms

allowance standard-Air Force publication that prescribes items and quantities (basis of issue) of equipment normally required by Air Force organizations and individuals in the accomplishment of assigned missions, functions, and duties.

basis of issue-Items and quantities of equipment and supplies on Air Force Allowance Standards.

cold zone-The zone encompassing the warm and hot zone and is used to carry out all other support functions of the incident. Workers in the cold zone are not required to wear personal protective clothing because the zone is considered safe. The mobile command post, DCG, staging area, and the triage/treatment area are located within the cold zone.

hazardous material (HAZMAT)-All hazardous substances, petroleum, natural gas, synthetic gas, acutely toxic chemicals, and other toxic chemicals including hazardous waste.

hot zone-The area immediately surrounding a hazardous materials incident, which extends far enough to prevent adverse effects from HAZMAT releases to personnel outside the zone.

warm zone-An area established up wind from the "Hot Zone" near the entry control point, where decontamination of personnel, patients, and equipment is accomplished prior to moving them into the clear zone.

Attachment 2**NBC REFERENCES FOR HEALTHCARE PROVIDERS****NBC:**

FM 8-9 NATO Handbook on the Medical Aspects of NBC Defensive Operations. 1996
The Medical NBC Battlebook (Aug 02); USACHPPM Tech Guide #244. 2000.
The NBCT Event CD-ROM, Nuclear, Biological, Chemical, Terrorism, Center of Excellence
in Disaster Management and Humanitarian Assistance. 1998.

Nuclear:

The Nuclear Weapons Accident Response Procedure (NARP) Manual.
Textbook of Military Medicine, Medical Consequences of Nuclear Warfare, Office of the
Surgeon General 1989.
UFRRI Medical Management of Radiological Casualties, and the Nuclear Weapons Accident
Response Procedure (NARP) Manual.

Biological:

USAMRIID'S Medical Management of Biological Casualties Handbook; US Army Medical
Research Institute of Infectious Diseases.
Textbook of Military Medicine: "Medical Aspects of Chemical and Biological Warfare" US
Army Office of the Surgeon General. 2001.

Chemical:

USAMRICD'S Management of Chemical Warfare Agent Casualties, A Handbook for
Emergency Medical Service
USAMRICD'S Medical Management of Chemical Casualties Handbook; US Army Medical
Research Institute of Chemical Defense
USAMRICD'S Medical Management of Chemical Casualties, NCO Handbook
Management of Chemical Warfare Injuries CD-ROM# DN804039, Naval School of Health
Sciences. August 1996
DECON: Decontamination of Casualties by the Wartime Medical Decontamination Team, CD-
ROM, USAF Medical Service Version 1.0. 2001

Courses:

Contingency/Counter-Terrorism Casualty Decontamination #B3AZYDECON-000, USAF
School of Aerospace Medicine, Brooks AFB
Contingency Operations Course (CONOPS) # B3OZYCONOP-001; USAF School of
Aerospace Medicine, Brooks AFB
Counterproliferation Awareness Course (CPAC) #J5OZD32E1D-001; Defense Threat
Reduction Agency, Kirtland AFB
Expeditionary Medical Support; EMEDS Basic Course # B3OZYEMEDS-0006; USAF School
of Aerospace Medicine, Brooks AFB
Field Management of Chemical and Biological Casualties Course; USAMRIID/USAMRICD

Medical Management of Chemical and Biological Casualties Course;
USAMRIID/USAMRICD
Medical Effects of Ionizing Radiation Course; Armed Forces Radiology Research Institute,
Kirtland AFB; J5OZD32E1D
Satellite Training, Biological and Chemical Warfare and Terrorism: Medical Issues and
Response; USAMRIID
Satellite Training, Medical Response to Chemical Warfare and Terrorism; USAMRICD

INTERNET Resources

www.usamriid.army.mil
biomedtraining.org
www.nbc-med.org
chemdef.apgea.army.mil
ccc.apgea.army.mil
chppm-www.apgea.army.mil

Attachment 3

ANTI-TERRORISM AWARENESS TRAINING

A3.1. Level I Anti-Terrorism Awareness Training shall be required for all individuals in basic training and all initial entry courses. Annually, all CONUS –based DOD personnel who are eligible for OCONUS deployment shall receive Level I training. A program of instruction shall be delivered by a qualified trainer or any approved computer based training program. The program of instruction shall include a reference review, service-specific modules, and training in the methods available to obtain area of operation specific data to which the individual or unit will deploy. In addition individuals shall view Service-selected personal awareness videos and receive two documents: the Joint Staff Guide 5260, “Service Member’s Personal Protection Guide, A Self-Help Handbook to Combating Terrorism,” and “Antiterrorism Individual Protective Measures” card.

A3.2. Level II training will be completed at an established service school or by use of core course material from other programs such as the Special Warfare Center, U.S. Army, Dynamics in International Terrorism, Hurlburt Field and Nellis Air Force Base Level II certification. Each program qualifies individuals to provide Level I training to their units and certifies them as installation AT Officers.

A3.3. Level III training shall be conducted at the O-5 and O-6 level by the Services in conjunction with pre-command training. The focus of this training shall be on the responsibilities discussed in the pertinent DOD 2000 series publications, Service publications, and associated Joint Doctrine. Level III training will include audiovisual materials featuring Secretary of Defense/Chairman Joint Chiefs of Staff comments on Antiterrorism and Force Protection.

A3.4. Level IV training will be conducted as executive level seminars or other forms of instruction suitable for O-6 to O-8 personnel. The focus of this training shall be on AT program planning, development, evaluation, and implementation. The training shall include but not be limited to AT simulations and war games.

Attachment 4

TRAINING STANDARDS

A4.1. Each military active duty, guard, reserve unit and deploying organizations outside the fifty United States must have an AT Officer assigned in writing. The AT Officer shall be responsible for ensuring that each person within the unit is trained and fully aware of terrorist attack potential and methods to reduce the risk and mitigate effects should an attack occur.

Figure A4.1. Level of Training Target Audience Minimum Training Standard.

<p>Level I Awareness Training annually to all DOD personnel eligible for official OCONUS travel on government orders or if the Threat level within the Continental United States or its territories or possessions is promulgated above LOW. Level I may be delivered by a qualified instructor or an approved computer based training program.</p>	<p>Military, DOD Civilians, and their family members, (14 years and older) when traveling on government orders, and DOD employed Contractors</p>	<ol style="list-style-type: none"> 1. Viewing the Service-selected personal awareness video and/or DOD sponsored computer-based instruction 2. Issuance of JS Guide 5260 “Service Member’s Personal Protection Guide: A Self-Help Handbook to Combating Terrorism” and “Antiterrorism Individual Protective Measures” folding card. (Local reproduction of both is authorized) <p>Service standardized POI including as a minimum:</p> <ol style="list-style-type: none"> a) Introduction to Terrorism b) Terrorist Operation c) Individual Protection Measures d) Terrorist Surveillance Techniques e) Improvised Explosive Device Attacks f) Kidnapping & Hostage Survival g) Explanation of Threat Levels and THREATCON System <ol style="list-style-type: none"> 4. Receive AOR updates three months prior to travel to include current threat brief and AOR specific requirements as provided by CINC.
<p>Level II AT Training Officer</p>	<p>AT Officer/Non-Commissioned officers or equivalent, who are then qualified to provide Level I Instruction</p>	<p>Service provided instruction (resident or MTT).</p> <ol style="list-style-type: none"> 1. POI based on core curriculum of the JFKSWCS Antiterrorism Instructor Qualification Course:

		<p>Understanding FP Roles and Responsibilities</p> <ul style="list-style-type: none"> a) Understanding Policy & Standards b) Access Reference Source c) Organize for AT d) Command/Staff Relations e) FP Working Groups f) Assess Vulnerabilities g) Baseline Unit FP Posture h) Conduct Assessment (PE) i) Intel/CI Integration j) Information OPS k) Prepare AT plan l) Template & Planning Tools m) How to Develop and Write Plans n) WMD Considerations o) Use of RAM to protect the Installation p) AT Resource Management q) Requirements Generation & Prioritization r) CbT RIF s) Conduct AT Training t) Oversee AT Level I Training u) Exercise Unit FP Plans v) Create and Execute AT Programs w) Use of Threat Levels/THREATCONS x) Unit/Installation Protective Measures Mitigating Vulnerabilities y) Engagement Methods/Procedures for local Liaison z) Use of Local Intel Resources aa) Methods of Sharpening Understanding of Local Threat Picture bb) Coordination with Civil Authorities and Security Forces
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		<p>cc) Use of Counterintelligence Resources</p> <p>2. Review of applicable AT Reference publications</p> <p>3. Methods available for obtaining AOR specific updates for deployment/travel area</p> <p>4. Service-directed modules on other aspects of AT such as physical security requirements, technology updates, etc. Graduates will have basic understanding and materials to provide Level I instruction and support their Commanders in the conduct of unit's AT program and related issues.</p>
Level III	O-5/O-6 Commanders	<p>Resident instruction provided by Services through pre-command pipelines.</p> <p>1. POI based on the following core curriculum and learning objectives:</p> <ul style="list-style-type: none"> a) Understand AT Responsibilities b) Understanding Policy Assessments c) Off-Installation Housing d) Ensure Preparation of AT Plans e) Baseline FP Posture f) Mitigating WMD Attack g) MOU/MOA's h) Ensure Conduct of AT Planning i) AT Plans & Training j) Level Training k) Organize for AT l) Understanding the Local Threat Picture m) Fusion of Intelligence n) Building a Sustainable AT Program o) Threat Levels p) Executing Resource Responsibilities q) AT

		<ul style="list-style-type: none"> r) Resource Programs s) MILCON t) Standards u) Understanding Use of Force and ROE Engagement v) Methods/Procedures for Local Liaison w) Use of Local Intel Resources x) Methods of Sharpening y) Understanding of Local Threat Picture z) Coordination with Civil Authorities and Security Forces aa) Use of Counterintelligence Resources <p>2. Include viewing SECDEF/CJCS AT video, directive/reference review, and issuance of CDR's Handbook (Joint Pub 5260)</p>
<p>Level IV Executive AT Seminar</p>	<p>Executive AT Seminar O-6 to O-8 Commanders/ personnel, selected by Service/ CINC/DOD Agency who are responsible for AT programs or involved in AT policy, planning and execution</p>	<p>Executive-level seminar providing pertinent current updates, briefings, panel discussion topics. Seminar should conclude with a tabletop AT wargame aimed at facilitating interaction and discussion among the participants.</p>