

**Incident Annex 4
Catastrophic Annex**

LEAD: Department of Public Safety, Division of Emergency Management and Homeland Security

SUPPORT: All State departments and agencies (and other organizations) with assigned primary or supporting State Support Function (SSF) or Recovery Support Function (RSF) responsibilities

I. INTRODUCTION

A. PURPOSE

The Catastrophic Incident Annex to the State Emergency Operations Plan (SEOP) establishes the context and overarching strategy for implementing and coordinating an accelerated, proactive state-level response to a catastrophic incident.

B. SCOPE

A catastrophic incident, as defined by the National Response Framework (NRF), is any natural or manmade incident, including terrorism, which results in extraordinary levels of mass casualties, damage, or disruption severely affecting the population, infrastructure, environment, economy, national morale, and/or government functions.

A catastrophic incident could result in sustained State impacts over a prolonged period of time; almost immediately exceeds resources normally available to local, and private-sector authorities in the impacted area; and significantly interrupts governmental operations and emergency services to such an extent that public safety could be threatened. These factors drive the urgency for coordinated inter-agency, multi-level planning within the State to ensure maximum use of available resources as rapidly as possible and to identify and request as appropriate needed federal, regional mutual aid agreements or Emergency Management Assistance Compact (EMAC) or International Emergency Management Group (IEMG) resources.

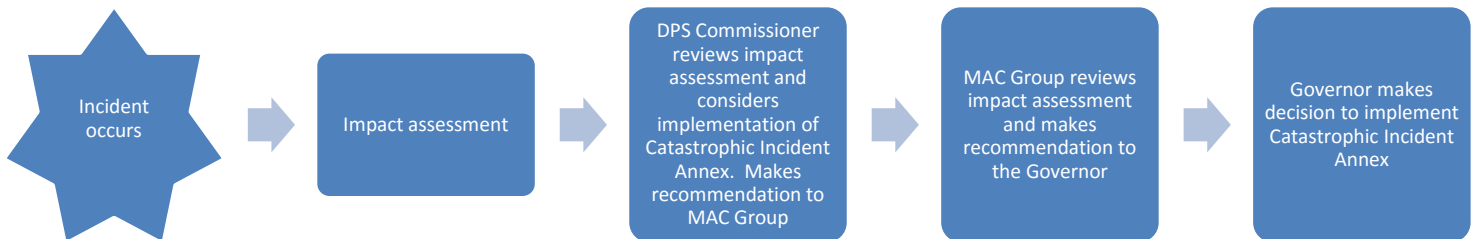
Recognizing that State resources are required to augment overwhelmed local response efforts, the VTEOP Catastrophic Incident Annex (CIA) establishes protocols to identify in advance and rapidly deploy key essential resources (mobile support units, National Guard units and special teams) that are expected to be urgently needed/required to save lives and contain incidents.

Accordingly, upon designation by the Commissioner of Public Safety of a catastrophic incident, a Declaration of Emergency by the Governor and the full use of State resources in accordance with the State Emergency Operations Plan and this annex in support of the affected local jurisdiction incident command structure, necessary federal resources will be requested. The Governor will also likely request an Emergency Declaration and a Presidential Major Disaster Declaration as soon as the incident is recognized as catastrophic.

C. POLICIES

The operational provisions of this annex are consistent with SEOP, National Incident Management System protocols and Incident Command System conventions.

Only the Governor, Commissioner of Public Safety or designee may initiate implementation of this annex.



Federal resources arriving at a Federal mobilization center or staging area remain there until requested by State/local incident command authorities, when they will be integrated into the incident response and response support effort.

Federal assets unilaterally deployed in accordance with the National Response Framework – Catastrophic Incident Annex (NRF-CIA) do not require a State cost-share. However, in accordance with the Stafford Act, State requests for use of deployed Federal assets, either as Direct Federal Assistance (DFA) or by Mission Assignment (MA) may require cost-sharing.

II. SITUATION AND ASSUMPTIONS

A. SITUATION

The initial response to a catastrophic incident starts on a local level with the local and mutual aid responders. However, there may be circumstances that exceed the capabilities of local authorities in which they are unable to initially establish or maintain a command structure for incident response. In these instances, accelerated state response and response support may be warranted, and the Department of Public Safety, Division of Emergency Management and Homeland Security (DEMHS) will coordinate response and response support activities until local authorities are capable or have re-established their incident command structure. In the interim, a Public Safety District or state-level area command may be established.

Following a catastrophic event, segments of State and local governments as well as Non-Governmental Organizations (NGOs) and the private sector may be severely compromised. The State Government and its partners must be prepared to implement Continuity of Operations (COOP) and Continuity of Government (COG) plans and procedures for their own entity and to fill potential gaps to ensure continuity of government and public and private sector operations. The

incident may cause significant disruption of the impacted area's Critical Infrastructure.

Normal procedures for certain SSFs, RSFs or other agencies may be expedited or streamlined to address the magnitude of urgent requirements of the incident. All SSFs and RSFs should maximize the implementation of their emergency authorities. SSFs and RSFs must explore economies of scale to maximize utilization and efficiency of scarce resources.

B. ASSUMPTIONS

1. The Planning Assumptions of the SEOP Base Plan apply for this annex.
2. SSF and RSF Lead and Support agencies will accomplish their responsibilities as outlined in their respective annexes.
3. There is a reasonable expectation that the state will need to manage resources entering the state, even if resources have not been requested.
4. Significant disruption of the affected area's infrastructure, particularly power, transportation, and communications systems, may occur. This will hinder the ability of responders to initiate and accomplish emergency, restoration, and recovery actions in a timely manner.
5. A catastrophic incident results in large numbers of casualties and/or displaced persons, possibly in the hundreds or thousands. During a catastrophic incident response, priority is given to human life-saving operations.
6. The Commissioner of Public Safety designates the event a catastrophic incident and directs implementation of this annex.
7. The nature and scope of a catastrophic incident may immediately overwhelm State and local response capabilities and may require immediate external resource support. The occurrence or threat of multiple catastrophic incidents may significantly reduce the size, speed, and depth of the State and Federal response. If deemed necessary or prudent, it is understood that the Federal Government may reduce the availability or allocation of finite resources when multiple venues are competing for the same resources, or hold certain resources in reserve in case of additional incidents.
8. A detailed, credible, and complete common operating picture may not be achievable for 24 to 48 hours (or longer) after the incident. As a result, response activities may have to begin without the benefit of a detailed or complete situation and critical needs assessment.

9. A catastrophic mass casualty/mass evacuation incident triggers a Declaration of Emergency by the Governor and a request for a Presidential Emergency and/or Major Disaster Declaration, immediately.
10. The nature and scope of the catastrophic incident may include chemical, biological, radiological, nuclear or high-yield explosive attacks, disease epidemics, and major natural or manmade hazards.
11. Multiple incidents may occur simultaneously or sequentially in contiguous and/or noncontiguous areas. Some incidents, such as a biological WMD attack or pandemic, may be dispersed over a large geographic area, and lack a defined incident site.
12. A catastrophic incident may occur with little or no warning. Some incidents, such as rapid disease outbreaks, may be well underway before detection.
13. The response capabilities and resources of the local jurisdiction (to include mutual aid from surrounding jurisdictions and response support from the State) will likely be insufficient and quickly overwhelmed. Local emergency personnel who normally respond to incidents may be among those affected and unable to perform their duties.
14. Extensive self-directed population evacuations may also occur with families and individuals traveling throughout the United States to stay with friends and relatives outside the affected area.
15. Large numbers of people may be left temporarily or permanently homeless and may require prolonged temporary housing.
16. A catastrophic incident may produce environmental impacts (e.g., persistent chemical, biological, or radiological contamination) that severely challenge the ability and capacity of governments and communities to achieve a timely recovery.
17. A catastrophic incident has unique dimensions/characteristics requiring that response plans/strategies be flexible enough to effectively address emerging needs and requirements.
18. Spontaneous volunteers and donations management will require significant attention immediately following the event. If not promptly and appropriately managed, attention to this activity will demand the diversion of resources away from service delivery.
19. A catastrophic incident may have significant international dimensions. These include potential impacts on the health and welfare of border community populations, cross-border trade, transit, law enforcement coordination, and other areas.

20. The Governor may declare a state of emergency prior to the occurrence of a catastrophic incident. This pre-event declaration would allow for staging of resources to include those of the National Guard.

III. MISSION

Guiding principles for a proactive State catastrophic incident response include the following:

The primary mission is to save lives, protect property and critical infrastructure, contain the incident, protect the environment and contribute to the protection of national security;

Standard procedures outlined in the SEOP regarding requests for assistance may be expedited or, under extreme circumstances, temporarily suspended in the immediate aftermath of an incident of catastrophic magnitude, pursuant to existing law (please see VSA Title 18 and 20);

Pre-identified State response resources are mobilized and deployed, and, if required, begin emergency operations to commence life-safety activities; and

Notification and full coordination with local jurisdictions occur, but the coordination process should not delay or impede the rapid mobilization and deployment of critical State resources.

Implementation of appropriate agency and department emergency authorities that supplement a Governor's Emergency Declaration.

Upon recognition that a catastrophic incident condition (e.g., involving mass casualties and/or mass evacuation) exists, the Commissioner of Public Safety in coordination with the Governor or designee immediately designates the event a Catastrophic Incident and begins, potentially in advance of a formal Emergency Declaration by the Governor, implementation of this annex. Upon notification from the State Emergency Operations Center (SEOC) that this annex has been implemented, State departments and agencies:

Take immediate actions to activate, mobilize, and deploy incident-specific resources in accordance with this annex;

Take immediate actions to protect life, critical infrastructure, property and the environment under their jurisdiction, and provide assistance within the affected area;

As needed, implement agency/organization COOP activities to maintain essential functions;

Immediately commence those hazard specific activities established under the appropriate and applicable SEOP Incident Annex(es), including this annex; and immediately commence functional activities and responsibilities established under the SEOP SSF Annexes and the Recovery and Restoration Support Annex.

IV. CONCEPT OF OPERATIONS

In accordance with SEOP provisions for proactive State response to catastrophic incidents, this annex employs an expedited approach to the provision of State resources to save lives and contain the incident and to identify the need for and request of Federal resources.

VTEOP Catastrophic Incident Annex actions that State Government takes in response to a catastrophic incident include:

- Initiation of action by all State departments and agencies to mobilize and deploy resources as planned for in this annex;
- Immediate implementation of responsibilities by all State departments, agencies, and organizations assigned primary or supporting SSF and/or RSF, as appropriate or when directed by the Governor;
- Activation of incident-specific resources and capabilities (e.g., medical teams, search and rescue teams, equipment, transportable shelters, preventive and therapeutic pharmaceutical caches, etc.) and preparation for deployment to a staging area near the incident site(s). The development of site-specific catastrophic incident response strategies that include the Pre-identification of incident-specific critical resource requirements and corresponding deployment/employment strategies accelerate the timely provision of critically skilled resources and capabilities;
- Activation of pre-identified facilities within appropriate Public Safety Districts (e.g., shelters, alternate care facilities, points of dispensing or distribution) are activated and prepared to accomplish their designated mission. The development of site-specific catastrophic incident response plans that include the Pre-identification of projected casualty and mass care support requirements and potentially available facilities expands the response architecture and accelerates the availability of such resources;
- Reprioritization of services by state facilities and operational locations are directed (in some cases reducing or postponing certain customary services) until life-saving activities are concluded. State departments and agencies may be asked to redirect efforts from their day-to-day responsibilities to other activities to support the response effort;
- Supplementary support agreements with the private sector are activated.

Local: Response operations and responsibilities are covered in the SEOP and Local Emergency Operations Plans (LEOPs).

State Response: Response operations and responsibilities are covered in the SEOP. This annex addresses the proactive State response to be taken in anticipation of or following a catastrophic incident to rapidly provide critical resources to assist and augment local response efforts and to be prepared to request Federal resources and capabilities.

Federal Response: The NRF-CIA addresses the proactive Federal response to be taken in anticipation of or following a catastrophic incident to rapidly provide critical resources to assist and augment State, local, and tribal response efforts.

V. SUPPORTING ACTIONS

In the case of catastrophic incident, it is expected that the State Government or other supporting entities provide expedited assistance in one or more of the following areas:

- A. Mass Evacuation and Transportation (SSF #1 – Transportation): While primarily a State and local responsibility, Federal support may be required for large-scale evacuations, organized or self-directed, that may occur. There may also be a need for evacuation of large numbers of people, including patients in local hospitals, nursing homes, and extended care facilities, as well as those with special needs, household pets, and service animals, out of the impacted area to safe areas within the State or in other States. Significant transportation and shelter coordination and resources may be required. There is likely to be significant shortage of response and casualty and/or evacuee reception capabilities throughout the impacted area.
- B. Mass Care, Emergency Assistance, Housing and Human Services (SSF #6 – Mass Care, Emergency Assistance, Housing and Human Services and the Housing RSF): The ability to provide temporary shelter, food, emergency first aid, clothing, and other essential life support to people may be complicated by contaminated resources or facilities.
- C. Search and Rescue (SSF #9 – Search and Rescue): Resources and personnel to perform operational activities (e.g., locating, extricating, and providing onsite medical treatment to victims trapped in collapsed structures) are limited. If search and rescue operations are required in areas of contamination, the limited availability of properly equipped resources supports or underscores the need for prompt request for Federal response that is beyond State capabilities.
- D. Decontamination (SSFs #8 – Health and Medical Services and #10 – Hazardous Materials; Infrastructure & Environmental Restoration RSF):
 1. Victim Decontamination: State and local officials retain primary responsibility for victim screening and decontamination operations. Given the potentially large numbers of casualties and evacuees, resulting decontamination requirements may quickly outstrip local and State capabilities resulting in the need for federal, EMAC or IEMAC resources.
 2. Environmental Assessment and Decontamination: Incidents involving a weapon of mass destruction (WMD) may require decontamination of casualties, evacuees, animals, equipment, buildings, critical infrastructure, and other areas. Given the potentially large numbers of casualties and evacuees, resulting decontamination requirements may quickly outstrip local and State capabilities resulting in the need for federal, EMAC or IEMAC resources.

- E. Health and Medical Services (SSF #8 – Health and Medical Services and Health and Medical Services RSF): There is a significant need for public health and medical support, including mental health services. Medical support is required not only at medical facilities, but at casualty collection points, evacuee reception centers and shelters, and at other locations to support field operations. In addition, any contamination requirement increases the requirement for technical assistance. Shortages of available supplies of preventive and therapeutic pharmaceuticals and qualified medical personnel to administer available prophylaxis are likely. Timely distribution of prophylaxis may forestall additional illnesses, and reduce the impact of disease among those already exposed. State and local capacity for casualty and fatality management is limited and may prompt and early request external resources (Federal, EMAC and IEMAC).
- F. Public Safety and Security (SSF #13 – Law Enforcement): External resources (NESPAC, Federal, EMAC and IEMG) may be required to augment State and local governments in protecting the public and securing the impacted area. Law enforcement and emergency management officials who normally respond to incidents may be among those affected and unable to perform their duties.
- G. Public Information (SSF #14 – Public Information): When State and local public communications channels are overwhelmed during a catastrophic incident, external resources (Federal, EMAC and IEMG) must immediately be requested to assist in delivering clear and coherent public information guidance and consistent messages to the affected areas.
- H. Private Sector Coordination: Private-sector organizations may be affected by direct or indirect consequences of the incident, including privately owned critical infrastructure, key resources and those main private-sector organizations that are significant to local, regional and national economic recovery from the incident. Examples of privately owned infrastructure include transportation, telecommunications, private utilities, financial institutions and hospitals.

Private-sector organizations support the SEOP (voluntarily or to comply with applicable laws and regulations) by sharing information with the government, identifying risks, performing vulnerability assessments, developing emergency response and business continuity plans, enhancing their overall readiness, implementing appropriate prevention and protection programs and donating or otherwise providing goods and services through contractual arrangement or government purchases to assist in response to and recovery from an incident.

Certain organizations are required by existing law and regulation to bear the cost of planning and response to incidents, regardless of cause. In the case of a catastrophic incident, these private-sector organizations are expected to mobilize and employ the resources necessary and available in accordance with their plans to address the consequences of incidents at their own facilities or incidents for which they are otherwise responsible.

- I. Logistics (Logistics Management Support Annex): The structure for SEOP logistics depends on logistics partners that provide resources to support incident-

related operations. Logistics support is provided for prevention, preparedness, response, and recovery actions during all phases of incident management. Effective logistics management contributes to mission success while ensuring all functions are executed in a unified manner to reduce costs, ensure appropriate support actions, and increase response capability.

- J. Critical Infrastructure and Key Resources [Vermont Infrastructure Protection Program (VIPP) Support Annex and Infrastructure & Environmental Restoration RSF]: VIPP include the assets, systems, networks, and functions that are vital to the American way of life. A terrorist attack on critical infrastructure or other natural or manmade disaster could significantly disrupt the functioning of government and business alike, and produce cascading effects far beyond the physical location of the incident.

VI. RESPONSIBILITIES

This section summarizes State department and agency responsibilities under this annex. For additional State department and agency responsibilities, refer to the individual SSF Annexes, the Recovery and Restoration Support Annex, Organizational Annexes and hazard-specific Incident Annexes in the SEOP.

Coordinating Agency: Department of Public Safety (DPS)

- Establish that a catastrophic incident has occurred and implement this annex.
- Notify all State departments and agencies to implement this annex.
- Upon implementation of this annex:
 - Fully activate the State Emergency Operations Center (SEOC) to coordinate the State Multi-Agency Coordination System (MACS).
 - Activate and deploy (or prepare to deploy) state-managed teams, equipment caches, and other resources in accordance with this annex;
 - Identify, prepare, and facilities critical to supporting the movement and reception of deploying State resources;
 - Activate additional facilities and capabilities in accordance with this annex and standard SEOP protocols;
 - Establish and maintain communications with incident command authorities to ensure a common and current operating picture regarding critical resource requirements. As specific resource requirements are identified, be prepared to satisfy those requirements with additional State resources or request specific Federal resources;

Cooperating Agencies

- When notified by the SEOC that the Commissioner of Public Safety, in coordination with the Governor, has implemented this annex, State departments and agencies:
- Activate and deploy (or prepare to deploy) agency- or SSF/RSF-managed teams, equipment caches, and other resources in accordance with this annex;
- Commence SSF/RSF or agency responsibilities as appropriate;
- Commence assessments of the probable consequences of the incident and projected resource requirements; and

- Commence development of shorter and longer term response and recovery strategies.

Departments and agencies assigned primary responsibility for one or more functional response areas are identified below.

- Mass Evacuation and Transportation: Agency of Transportation with support of the Vermont National Guard (See Tab A for more detailed responsibilities).
- Mass Care, Emergency Assistance, Housing and Human Services: Agency of Human Services with primary support from the American Red Cross and the Agency of Commerce & Community Development (See Tab B for more detailed responsibilities).
- Search and Rescue: Department of Public Safety, Vermont State Police and Division of Fire Safety (See Tab C for more detailed responsibilities).
- Decontamination: State Hazardous Materials Response Team and Department of Health in cooperation with the Agency of Natural Resources (See Tab D for more detailed responsibilities).
- Health and Medical Services: Department of Health (See Tab E for more detailed responsibilities).
- Public Safety and Security: Department of Public Safety, Vermont State Police (See Tab F for more detailed responsibilities).
- Public Information: Department of Public Safety and Department of Information & Innovation (See Tab G for more detailed responsibilities).
- Private-Sector Coordination: Department of Public Safety in cooperation with the Agency of Commerce and Community Development (See Tab H for more detailed responsibilities).
- Logistics: Department of Buildings & General Services (See Tab I for more detailed responsibilities).
- Critical Infrastructure/Key Resources: Department of Public Safety, Division of Emergency Management & Homeland Security and the Vermont Information Center (See Tab J for more detailed responsibilities).

VII. AUTHORITIES AND REFERENCES

- A. FEDERAL
- B. STATE

20 V.S.A. § 9. Emergency powers of governor

Subject to the provisions of this chapter, in the event of an all-hazards event in or directed upon the United States or Canada which causes or may cause substantial damage or injury to persons or property within the bounds of the state in any manner, the governor may proclaim a state of emergency within the entire state or any portion or portions of the state. Thereafter, the governor shall have and may exercise for as long as the governor determines the emergency to exist the following additional powers within such area or areas:

- (1) To enforce all laws, rules and regulations relating to emergency management and to assume direct operational control of all emergency management personnel and helpers in the affected area or areas.
- (2) To formulate and execute plans and regulations for the control of traffic and to coordinate the activities of the departments or agencies of the state

and of the political subdivisions thereof concerned directly or indirectly with public highways and streets, in a manner which will best effectuate such plans.

(3) To prescribe the maximum rates of speed at which motor vehicles may be operated on any road, highway or street in the state; prescribe the sizes and weights of such motor vehicles; suspend the application of any statute or regulation levying or assessing any license, insofar as such statute or regulation relates to the entry into or the privilege of operation in this state of any motor vehicle, including busses or house trailers, registered in any other state and with respect to which a valid and unexpired license has been issued by the other state.

(4) To employ such measures and give such directions to the state or local boards of health as may be reasonably necessary for the purpose of securing compliance with the provisions of this chapter.

(5) To utilize the services and facilities of existing officers, and agencies of the state and of the cities and towns thereof; and all such officers and agencies shall cooperate with and extend their services and facilities to the governor as he or she may request.

(6) To use and employ within the state, from time to time, and as he or she may deem expedient, any of the property, services and resources of the state, for the purposes set forth in this chapter.

(7) To establish agencies and offices and to appoint executive, technical, clerical, and other personnel as may be necessary to carry out the provisions of this chapter.

(8) Upon the declaration of an emergency as authorized in federal legislation which includes the state of Vermont, to cooperate with the president of the United States, the army, navy, and air force, with other federal departments, agencies and independent establishments, and other states in matters pertaining to emergency management; and in connection therewith to take such action, not inconsistent with the constitution and laws of the state which he or she may deem proper to carry into effect any request of the president, the secretary of defense, the secretary of homeland security, the secretary of health and human services, and the director of the federal emergency management agency.

(9) To order the evacuation of persons living or working within all or a portion of an area for which a state of emergency has been proclaimed.

(10) As provided in 30 V.S.A. § 248(l), in consultation with the chair of the public service board and the commissioner of the department of public service or their designees, to waive the prohibitions contained in 30 V.S.A. § 248 upon site preparation for or construction of an electric transmission facility or a generating facility necessary to assure the stability or reliability of the electric system or a natural gas facility. Waivers issued under this subdivision shall be subject to such conditions as are required by the governor and shall be valid for the duration of the declared emergency plus 180 days, or such lesser overall term as determined by the governor. Upon the expiration of a waiver under this subdivision, if a certificate of public good has not been issued by the public service board under 30 V.S.A. § 248, the board shall require the removal, relocation, or alteration of the facilities, subject to the waiver, as the board finds will best promote the general good of the state.

(11) In consultation with the secretary of the agency of natural resources or designee, to authorize the agency to issue temporary emergency permits, with appropriate conditions to minimize significant adverse environmental impacts, after limited or no opportunity for public comment, allowing site preparation for, construction of, or operation of an electric transmission facility or a generating facility necessary to assure the stability or reliability of the electric system or a natural gas facility. A permit issued under this subdivision shall be subject to such conditions as are required by the governor and shall be valid for the duration of the declared emergency plus 180 days, or such lesser overall term as determined by the governor. Upon the expiration of a temporary emergency permit under this subdivision, if any applicable permits have not been issued by the secretary or the commissioner of environmental conservation, the secretary may seek enforcement under applicable law. (Amended 1959, No. 23, § 2, eff. March 6, 1959; 1983, No. 115 (Adj. Sess.), § 1, eff. March 16, 1984; 1989, No. 252 (Adj. Sess.), § 11; 2003, No. 82 (Adj. Sess.), § 5; 2005, No. 209 (Adj. Sess.), § 10.)

20 V.S.A. § 11. Additional emergency powers

In the event of an all-hazards event, the governor may exercise any or all of the following additional powers:

(1) To authorize any department or agency of the state to lease or lend, on such terms and conditions and for such period as he or she may deem necessary to promote the public welfare and protect the interest of the state, any real or personal property of the state government or authorize the temporary transfer or employment of personnel of the state government to or by the army, navy, air force, or any other branch of the armed forces of the United States of America.

(2) To enter into a contract on behalf of the state for the lease or loan, on such terms and conditions and for such period as he or she may deem necessary to promote the public welfare and protect the interests of the state, of any real or personal property of the state government, or the temporary transfer or employment of personnel thereof to any town or city of the state. The chief executive or legislative branch of such town or city is hereby authorized for and in the name thereof to enter into said contract with the governor for the leasing or lending of such property and personnel, and the chief executive or legislative branch of such town or city may equip, maintain, utilize and operate such property except newspapers and other publications, radio stations, places of worship and assembly, and other facilities for the exercise of constitutional freedom, and employ necessary personnel therefor in accordance with the purposes for which such contract is executed; and may do all things and perform all acts which may be deemed necessary to effectuate the purpose for which such contract was entered into.

(3) To seize, take, or condemn property for the protection of the public or at the request of the president, or his or her authorized representatives including:

- (A) All means of transportation;
- (B) All stocks of fuel of whatever nature;
- (C) Food, clothing, equipment, materials, medicines, and all supplies;

(D) Facilities, including buildings and plants; provided that neither this nor any other authority in this chapter shall be deemed to authorize the eviction of a householder and his or her family from their own home.

(4) To sell, lend, give or distribute all or any such property among the inhabitants of the state and to account to the state treasurer for any funds received for such property.

(5) To make compensation for the property so seized, taken, or condemned on the following basis:

(A) In case property is taken for temporary use, the governor, at the time of the taking, shall fix the amount of compensation to be paid therefor; and in case such property shall be returned to the owner in a damaged condition or shall not be returned to the owner, the governor shall fix the amount of compensation to be paid for such damage or failure to return. Whenever the governor shall deem it advisable for the state to take title to property taken under this section, he shall forthwith cause the owner of such property to be notified thereof in writing by registered mail, postage prepaid, and forthwith cause to be filed a copy of said notice with the secretary of state.

(B) Any owner of property of which possession has been taken under the provisions of this chapter to whom no award has been made or who is dissatisfied with the amount awarded him or her by the governor, may file a petition in the superior court within the county wherein the property was situated at the time of taking to have the amount to which he or she is entitled by way of damages or compensation determined, and thereafter either the petitioner or the state shall have the right to have the amount of such damages or compensation fixed after hearing by three disinterested appraisers appointed by said court, and who shall operate under substantive and administrative procedure to be established by the superior judges. If the petitioner is dissatisfied with the award of the appraisers, he or she may file an appeal therefrom in said court and thereafter have a trial by jury to determine the amount of such damages or compensation in such manner as the court shall provide. The court costs of a proceeding brought under this section by the owner of the property shall be paid by the state; and the fees and expenses of any attorney for such owner shall also be paid by the state after allowances by the court wherein the petition is brought in such amount as the court in its discretion shall fix. The statute of limitations shall not apply to proceedings brought by such owners of property as above provided for and during the time that any court having jurisdiction of such proceedings shall be prevented from holding its usual and stated sessions due to conditions resulting from emergencies as herein referred to.

(6) To perform and exercise such other functions, powers and duties as may be deemed necessary to promote and secure the safety and protection of the civilian population. (Amended 1959, No. 23, § 3, eff. March 6, 1959; 1973, No. 193 (Adj. Sess.), § 3, eff. April 9, 1974; 1985, No. 4, eff. March 9, 1985; 2005, No. 209 (Adj. Sess.), § 12.)

20 V.S.A. § 184. Emergency interim successors for state offices

All state officers, subject to such exceptions and regulations as the governor (or other official authorized under the constitution and this chapter or other act to exercise the powers and discharge the duties of the office of, or to act as, governor) may issue, shall, within 60 days after the approval of

this chapter, and thereafter immediately after the date that they shall have been appointed and qualified, in addition to any deputy authorized pursuant to law, designate by title emergency interim successors and specify their order of succession. The officer shall, each year, review and shall revise, as necessary, designations made pursuant to this chapter to insure his or her current status. Forthwith after such designations are made and after a revision thereof the officer shall file copies in the offices of both the governor and the secretary of state. The officer shall designate a sufficient number of such emergency interim successors so that, including deputies, there will be not less than five emergency interim successors. In the event that any state officer (or his or her deputy) is unavailable, the said powers shall be exercised and said duties shall be discharged by his or her designated emergency interim successors in the order specified. Such emergency interim successors shall exercise said powers and discharge said duties only until such time as the governor (or other official authorized under the constitution and this chapter or other act to exercise the powers and discharge the duties of the office of, or to act as, governor) shall, where a vacancy exists, appoint a successor to fill the vacancy or until a successor is otherwise appointed, or elected and qualified as provided by law; or an officer (or his or her deputy or a preceding named emergency interim successor) becomes available to resume the exercise of the powers and discharge the duties of his or her office. (Added 1959, No. 13, § 5, eff. March 4, 1959; amended 2007, No. 47, § 19.)

20 V.S.A. § 601. When and by whom national guard called out

The commander in chief or, in his absence, the lieutenant governor, or, in the absence of both, the adjutant and inspector general, in case of riot, rebellion or insurrection within the state or in case of great opposition to the service of legal process, whether civil or criminal, or in case of invasion or imminent danger thereof, or in case of disaster, or emergency proclaimed by the governor, may call out the national guard, or such parts thereof as he or she deems necessary, and may order such force into camp for instruction and drill. Until discharged by order of the commander in chief such force shall be subject to his or her order and shall be governed by the regulations prescribed for the army of the United States; and the commander in chief may order the same into camp for instruction and drill when in his or her judgment the interests of the state require. (Amended 1969, No. 261 (Adj. Sess.), § 1, eff. April 7, 1970; 1973, No. 223 (Adj. Sess.), § 7, eff. April 4, 1974.)

20 V.S.A. § 641. When and by whom called out

Upon the requisition of the president of the United States, and in case of war or invasion, or to prevent insurrection or invasion, the commander in chief may call out from time to time, for the actual service, by draft or otherwise as many of the entire national guard as the necessity of the case requires. The enrolled national guard, when so ordered for preparation for actual service, shall be administered and trained according to the laws of this state and of the United States. On the termination of the emergency all persons discharged from the military service who were, upon draft into federal service, members of the national guard of Vermont shall resume their

membership in the national guard, and shall continue to serve in the national guard until the dates upon which their enlistments prior to their draft would have expired if uninterrupted. (Amended 1973, No. 223 (Adj. Sess.), § 9, eff. April 4, 1974.)

29 V.S.A. § 171. Responsibility for Security

e) Under this section, the Commissioner of Buildings and General Services is responsible for the protection of state facilities, the lands upon which the facilities are situated, and the occupants of those facilities, which is vital to sustaining the essential services of government in an emergency. The Commissioner shall develop plans for continuity of government and continuity of operations as an addendum to the state emergency operations plan maintained by the Department of Public Safety, Division of Emergency Management and referenced in 20 V.S.A. § 8(b)(2).

VIII. FEDERAL INTERFACE

- A. See appropriate SSF/RSF annexes or tabs of the Recovery and Restoration Annex

**TAB A to Incident Annex 4
Catastrophic Incident Annex
Mass Care**

LEAD: Agency of Human Services (AHS) with primary support from American Red Cross

I. Mission

Mass Care coordinates State, and local efforts to meet the mass care needs of survivors of a disaster. This includes delivery of shelter, feeding, and emergency first aid to disaster survivors; the establishment of systems to provide bulk distribution of emergency relief supplies to disaster victims; and the collection of information to operate a Disaster Welfare Information (DWI) system to report victim status and assist in family reunification.

II. Planning Assumptions (Unique to the Mass Care function)

Depending on the nature of the event, a catastrophic disaster will cause a substantial need for mass sheltering and feeding within, near, and beyond the disaster-affected area.

Populations likely to require mass care services include the following:

- A. Primary victims (with damaged or destroyed homes)
- B. Secondary and tertiary victims (denied access to homes)
- C. Transients (visitors and travelers within the affected area)
- D. Emergency workers (seeking feeding support, respite shelter(s), and lodging)

NOTE: There will also be a need for interpreters to provide assistance in communicating with non-English speaking populations.

In the initial phase (hours and days) of a catastrophic disaster, organized and spontaneous sheltering will occur simultaneously within and at the periphery of the affected area as people leave the area. Additional congregate sheltering may be required for those evacuating to adjacent population centers.

More people will initially flee and seek shelter from terrorist attacks involving chemical, biological, radiological, nuclear, or high-yield explosive (CBRNE) agents than for natural catastrophic disaster events. They will also exhibit a heightened concern for the health-related implications related to the disaster agent.

Public safety, health, and contamination monitoring expertise will be needed at shelters following CBRNE events. Measures to ensure food and water safety will be necessary following CBRNE events, and the general public will also need to be reassured concerning food and water safety.

Immediately following major CBRNE events, decontamination facilities may not be readily available in all locations during the early stages of self-directed population evacuations. Unaware contaminated persons therefore may seek entry to shelters. These facilities may, as a result, become contaminated, adversely affecting resident health and general public trust.

Public health and medical care in shelters will be a significant challenge as local Emergency Medical Services (EMS) resources and medical facilities will likely be overwhelmed quickly.

Significant numbers of special needs shelters will likely be required as nursing homes and other similar care facilities are rendered inoperable and are unable to execute their evacuation mutual aid plans and agreements with other local facilities.

DWI and family reunification will be a priority concern for family members throughout the United States.

Transient populations within the affected areas, such as tourists, students, and foreign visitors will require assistance.

Significant, additional logistical support and coordination and public information systems will be required whenever a “shelter in place” or a “quarantine” order is implemented.

III. Catastrophic Incident Response Strategy

A. Response Strategy: IMMEDIATE

1. Immediate response activities will focus on meeting urgent mass care needs of survivors in safe areas. There will be an increased emphasis on contamination, safety, and security issues for CBRNE events.
2. In coordination with State, Tribal, and local officials, determinations will be made on the scope of the event and need for additional resources to provide mass care services.
3. Local ARC chapters and other entities, which provide mass care services at the local level, will initiate shelter and feeding activities in or near the impacted area, depending on the nature of the event. (Sheltering will include organized sheltering efforts as well as “ad hoc” shelters formed by community organizations and groups and “spontaneous” shelters established by evacuating residents.)
4. Adjacent communities need to be prepared to deal with significant numbers of fleeing persons from the affected area. These “host” communities will also need significant mass care support.
5. ARC chapters will be immediately request augmentation (in the form of additional personnel, materials, and equipment deployed to the disaster area) from Red Cross Service Areas and national headquarters.
6. SSF#6 (Mass Care, Emergency Assistance, Housing, and Human Services) will establish contingency planning cells as part of the Incident Coordination Team (ICT) within the SEOC to facilitate the response and response support to and identify emerging Mass Care needs. Additionally, SSF #6 representatives will be prepared to coordinate with Federal Emergency Management Agency (FEMA) ESF #6 representatives for resource support to the disaster-affected area.

7. Contact and coordination will immediately proceed with VTVOAD, other voluntary organizations and NGOs. Available resources will be numerated and promptly applied to identified needs and requirements.

B. Response Strategy: FIRST 10 DAYS.

1. Determine and document the location and related information for all actual and potential shelters within each of the Public Safety Districts (PSDs) and communicate to appropriate authorities and the public.
2. Ensure logistical support is in place to meet the mass care needs of persons in all shelters, those sheltered in-place, and residents of quarantined quarters.
3. Conduct planning is under way with local, state and federal agencies regarding the temporary relocation of people beyond the affected area. This strategy will address the significant logistical requirements of potentially supporting large numbers of sheltered people in an otherwise difficult environment for prolonged periods of time. Relocation outside the affected area may also be required because of limited available local housing stock and the long-term decontamination of the disaster affected area.
4. Coordination is under way with the private sector desk to draw upon additional resources for mass care support.
5. DWI and family reunification services continue in accordance with established procedures and taking advantage of additional federal and private sector resources.

C. Response Strategy: TRANSITION and SUSTAINMENT

1. Transition Strategy
Within 2 weeks of the catastrophic incident, local, state and federal officials will begin the development of interim and long term housing solutions in accordance with the Recovery and Restoration Annex of the VTSEOP and the National Disaster Recovery Framework (NDRF).
2. Sustainment Strategy
 - a. Mass care services are provided as needed; ongoing collaboration and coordination continues with Federal, State, and local officials.
 - b. Efforts continue with FEMA to enable execution of interim, alternate long-term temporary and permanent housing strategies, and the provision of other Federal assistance.
 - c. Family resettlement actions and services will take on an increased momentum.

IV. Transportation and Logistical Requirements

- A. Material requirements will include but are not limited to:

The procurement and transportation of cots, blankets, and other feeding and shelter supplies beyond those available from Red Cross and other NGOs;

The procurement and transport of food, including USDA commodities; and bulk distribution of relief supplies from various vendors and points across the country. This will require the establishment of Commodity Points of Distribution (CPODs) at locations proximate to the incident site(s).

- B. Portable showers and sanitation units may be required at the individual shelter and feeding sites.
 - C. In the event of electrical power disruption, power generation support will be required for the shelters and particularly the food preparation, storage, and feeding sites.
 - D. Public safety and security personnel will be required at the larger shelters and to routinely patrol shelters, food preparation sites, and fixed feeding stations.
 - E. Each shelter will be expected to provide residents with access to telecommunication services.
- V. Agency Responsibilities

As outlined on the SSF #6 Annex of the VTSEOP, the Housing and Individuals and Families RSF of the VTSEOP Recovery and Restoration Annex of the VTSEOP.

**TAB B to Incident Annex 4
Catastrophic Incident Annex
Search and Rescue**

LEAD: Department of Public Safety

I. Mission

Search and Rescue provides personnel and equipment support to assist in the location and extraction of individuals, including structure collapses and water rescues.

II. Planning Assumptions (Specific to Search & Rescue)

- A. Terrorist employment of nuclear or high explosive weapons of mass destruction (WMD) will create catastrophic devastation of buildings and physical structures in densely populated urban areas. As a result, there will be a need to conduct Urban Search and Rescue (USAR) operations to locate survivors.
- B. Given that US&R is extremely time sensitive, initial operations will be undertaken by State and local responders and those volunteer personnel willing to assist in locating victims. If the catastrophic incident involves collapsed buildings, national USAR task force response assets will be requested by the State and immediately deploy. National USAR resources may be pre-positioned prior to a request by the State.
- C. FEMA will, in coordination with the Department of State (DOS), U.S. Agency for International Development (USAID), Office of Foreign Disaster Assistance, coordinate the use and employment of international search and rescue assets/resources if the level of response will overwhelm our national capability.
- D. The doctrine of “do no additional harm” will apply to all USAR operations. Search and rescue personnel will take into consideration the danger of contamination and unstable physical structures before entering into an area that may contain surviving victims and will take appropriate safety and protective measures before commencing operations. Catastrophic Incident Response Strategy

III. Catastrophic Response Strategy

A. Response Strategy: IMMEDIATE

The State USAR (SUSAR) capability is composed of a north and south task force (Type III). Either task force may be staged or deployed in sector based on the situation. If both task forces are deployed at the same time an assessment will be made regarding a request for national resources.

US&R task forces will address activities and operations within contaminated areas. This will include establishing perimeters and hot, warm, and cold zones, as well as ingress/egress and decontamination points. These actions/determinations will be coordinated with the local first responders/Incident Commander and other resources on site.

B. Response Strategy: FIRST 10 DAYS.

Additional task forces will be activated and deployed (based on anticipated/emerging requirements and/or as requested by Incident Command Authorities) to provide continuous operations, usually on a 5 to 7 day basis.

C. Response Strategy: SUSTAINMENT

For extended operations, additional task forces will be activated and rotated in to provide continuous operations, usually on a 5 to 7 day basis.

IV. Transportation and Logistical Requirements

A. US&R task forces will handle their own immediate transportation needs if required to move to the incident site by ground transportation. If necessary, SSF#9 will request air transportation support from SSF#1.

B. Task forces require minor to moderate logistical support at an incident site, and are self-sufficient for a minimum of 72 hours. Task forces requiring large forklift capability must request such support through local sources or SEOC Incident Coordination Team (ICT) Logistics Section or appropriate Regional Coordination Center logistics Section, if activated.

V. Agency Responsibilities

As outlined on the SSF #9 Annex of the VTSEOP and the Infrastructure & Environmental Restoration RSF of the VTSEOP Recovery and Restoration Annex of the VTSEOP.

**TAB C to Incident Annex 4
Catastrophic Incident Annex
Decontamination**

LEAD: Agency of Natural Resources

I. Mission

In the immediate aftermath of a catastrophic incident involving nuclear, radiological, biological, or chemical contamination, all appropriate State departments and agencies will provide resource and technical assistance to local governments regarding the decontamination of persons, first responder and medical treatment equipment and facilities, and animals in service. Assistance will include expert personnel and equipment, supplies, and systems to assist in the decontamination of buildings and equipment (especially those providing essential/critical services), and the environment. During the recovery phase, this assistance may include augmentation/replacement of first responder decontamination resources and capabilities.

II. Planning Assumptions (Specific to Decontamination)

- A. Overview. For catastrophic incidents depicted in the planning scenarios related to this plan, decontamination involves several related and sequential activities. Chief among these are:
1. immediate (or gross) decontamination of persons exposed to toxic/hazardous substances;
 2. continual decontamination of first responders so that they can perform their essential functions;
 3. decontamination of animals in service to first responders;
 4. continual decontamination of response equipment and vehicles;
 5. secondary, or definitive, decontamination of victims at medical treatment facilities to enable medical treatment and protect the facility environment;
 6. decontamination of facilities (public infrastructure, business and residential structures); and
 7. environmental (outdoor) decontamination supporting recovery and remediation.
- B. Decontamination of victims exposed to toxic/hazardous substances is primarily a State and local responsibility, since victim decontamination cannot be delayed pending the arrival of Federal support. However, the Federal Government will provide available decontamination support (coordinated primarily by ESF#8) to State and Local incident management authorities.
- C. The projected effects of contamination resulting from a catastrophic incident are generally based on an estimated population density of 2,000 people per square mile, but may increase for major urban areas. In addition, large-gathering situations (e.g., National Special Security Events (NSSEs), sporting events, conventions, etc.) create higher localized population densities.
- D. Following a nuclear/radiological or chemical incident, and in certain situations for biological agents, decontamination may be required for:
1. People (victims, including affected responders/workers who are decontaminating buildings and the environment will need their protective equipment decontaminated during response, recovery, and remediation; viable patients with injuries, exposure effects, and potential contamination; victims with no medically significant injuries or requiring only psychological support; and fatalities).
 2. Animals (working rescue and response service animals, companion animals, and livestock).

3. Equipment (equipment or apparatus required for or of potential use in response, equipment or apparatus required for or of potential use in recovery, and non-critical equipment or apparatus not meeting the first two criteria).
 4. Facilities (facilities and infrastructure required for or of potential use in response, facilities and infrastructure required for or of potential use in recovery, and non-critical facilities and infrastructure not meeting the first two criteria).
 5. Geographic outdoor areas requiring remediation.
- E. Decontamination priorities will be set using the following priorities, in order of importance: life safety, incident stabilization, and property protection or conservation.
- F. The following concerns must also be considered, as applicable:
1. For certain types of WMD releases (e.g., short-lived pathogens or volatile gas vapors), “exposure” to the contaminant may not require decontamination.
 2. Biological agents typically have delayed symptoms and lack easily recognizable signatures such as color or odor.
 3. Decontamination procedures may need to vary for different segments of the population.
 4. For example, preferred decontamination techniques for healthy adults may not be the same as for infants or the elderly, who require a heated environment.
 5. It is likely that a significant number of individuals exposed to a contaminant agent will flee the scene before first responders arrive. It may prove difficult to subsequently determine which of those individuals are contaminated and require decontamination, and ensure such individuals present themselves for gross decontamination (or conduct appropriate and effective self-decontamination, especially for persistent agents that have delayed effects, such as certain pathogens and the sulfur mustard blister agent).
 6. Gender separation during decontamination is recommended, whenever feasible, since undressing in front of the opposite sex can be a humiliating and degrading experience for some people.
 7. There will be a need to reduce the potential for secondary contamination (e.g., at shelters) by screening potentially contaminated individuals.
 8. It is very likely that a significant number of people exposed to a plume cloud will flee the scene before first responders arrive, and therefore will not be present for gross decontamination.
 9. Secondary contamination will be a major concern.
 10. The psychological dimensions of being exposed to a toxic chemical, biological, or radiological substance - and undergoing subsequent decontamination - may present social management challenges and concerns.
 11. The “worried-well” may represent a significant population (in the hundreds or thousands) that could overwhelm healthcare facilities. Monitoring and detection equipment can help reduce worried-well numbers by providing credible public reassurance.
 12. The absolute effectiveness of decontamination techniques (i.e., determining if a building or individual is “clean”) remains a major area of uncertainty.
 13. Internal contamination may pose a significant threat following a radiological or nuclear incident, as victims who have internalized significant amounts of radiological contaminants may themselves present a radiological threat to others.

III. Catastrophic Response Strategy

A. Response Strategy: IMMEDIATE

1. The SEOP and National Response Framework recognize that local governments retain the primary responsibility for initial response to catastrophic incidents. Accordingly, local responders will be responsible for implementing mass personnel decontamination protocols during the most crucial and chaotic period (and where minutes matter) of the incident response. Decontamination efforts will depend on the contaminant/agent and characteristics of the release. In cases involving short-lived infectious pathogens, the primary objective will be identification of infected persons for quarantine and medical treatment. For volatile toxic vapor releases, exposed individuals seeking medical assistance may require only limited or no decontamination. In such cases, precautionary removal of loose outer clothing can be employed to further ensure contaminant dissipation/devolatilization. In any situation where there exists the potential for direct agent liquid contact - or concern of high exposures to persistent contaminants - expeditious mass decontamination is critical. Removal of clothing and thorough washing with copious amounts of water is generally the most expeditious means of gross decontamination. Properly prepared individuals should begin initial mass victim decontamination actions, followed by mass decontamination procedures that are part of an organized local-level response. Where available, a Metropolitan Medical Response System (MMRS) team will immediately respond to the incident.
2. While specific decontamination protocols will depend on site and scenario characteristics, life safety and control/stabilization of contaminants will always remain key immediate response priorities. Generally, decontamination priorities will be as follows:
 - a. People known or highly suspected to be contaminated, including first responders engaged in the response.
 - b. First responder equipment and vehicles, medical treatment facilities, reception centers, and mass care shelters (should contamination prevention fail).
 - c. Working rescue and response animals supporting incident response operations. Decontamination of working animals may be routinely required during shift rotations to help prevent the spread of contamination.
 - d. Transportation vehicles needed to move casualties and evacuees (should contamination prevention fail).
 - e. Critical infrastructure (e.g., water and sewer systems, electric power, communications, banking, etc.).
 - f. Pets and livestock. Depending on the type of incident, livestock (including poultry) may need to be euthanized instead of decontaminated. Sheep, goats, and smaller animals will be dead within minutes if exposed to a nerve agent. Animals with dense fur are almost impossible to decontaminate, especially if they are exposed to a mustard agent. Decontamination of pets may be required prior to permitting evacuation with their owners. Removing as many animals as possible from the site during evacuation is preferable to dealing with those animals later in the hazardous zone.
3. State and local authorities will issue timely and accurate risk communications/emergency public information, via multiple means, regarding decontamination and protective actions regarding shelter-in-place or evacuation.
4. In the initial hours after a catastrophic incident, the State will request Federal assistance to provide reach-back technical advice/assistance to local responders and assess the effectiveness of decontamination as an element of situation awareness and assessment.

B. Response Strategy: FIRST 10 DAYS.

1. Decontamination of critical infrastructure will likely continue well through the first 10 days and into the sustained response phase, after decontamination of people, animals in service, critical

infrastructure, State and Federal facilities, and businesses that are critical to defense/security and the economy.

2. Medical monitoring of contaminated and potentially contaminated victims should be under way.
3. Federal resources in the incident area will focus on supporting State and local authorities with facility and environmental decontamination, contaminated debris removal, and monitoring and assessment in support of recovery and restoration.

C. Response Strategy: SUSTAINED

1. Continue decontamination of people, as needed.
2. Monitor and decontaminate buildings, facilities and equipment in support of restoration and recovery. Federal assistance will remain available as long as necessary.
3. Implement or continue contaminated debris removal. (Pre-identification and designation of contaminated debris sites by local authorities will significantly accelerate this activity.) Federal assistance will be available for contaminated debris removal, storage, and monitoring.
4. Local authorities (with technical support from Federal and State governments) will determine when buildings and other areas are safe for use, or should be condemned.

D. Additional Considerations

1. Federal resources, other than off-site technical experts, should not be expected for at least the first 4 hours following an incident. Significant quantities of Federal resources may not be available for at least 24 hours.
2. Insufficient resources to decontaminate people, animals, facilities, and equipment, or to contain contaminants and runoff, will result in the spread of some hazardous materials. The Environmental Protection Agency (EPA) makes saving lives a priority over protecting the environment from contaminated runoff, and has addressed this issue in a policy letter.
3. Decontamination requirements may quickly overwhelm State and local capabilities. Additional response assets may be available within several hours from internal State sources, as well as from neighboring States under the Emergency Management Assistance Compact (EMAC).
4. People and animals will not remain at a contaminated location. Public officials will direct contaminated victims to collection points, and direct self-decontamination where appropriate, expedient, and possible.
5. A crowd-control regimen should be instituted by law enforcement officials to prevent contaminated victims from departing to their homes or to medical treatment facilities. However, in a radiological or nuclear incident, it may be better to allow victims to leave the contaminated area to minimize their exposure to ionizing radiation.
6. Medical treatment facilities and mass care shelters are unusually vulnerable to secondary contamination, and typically lack the monitoring equipment necessary to ensure positive decontamination and prevent unauthorized entry by contaminated persons. Law enforcement support is critical to maintaining the public health integrity of medical treatment facilities and mass care shelters.
7. The Radiological Emergency Preparedness (REP) Program advocates a "reception center concept" that is employed in communities around commercial nuclear power plants. The reception center is where initial monitoring, decontamination, and registration occur, and is considered an intermediate victim processing step between gross decontamination and entry to a medical treatment facility, shelter, or return to home. This proven concept merits evaluation for integration into existing State and local catastrophic incident response strategies.
8. Medical treatment facilities and shelter managers must be able to readily identify people who have received gross decontamination, prior to allowing them entrance into clean

facilities. Some local governments already accomplish this using plastic wristbands and a data field on triage tags.

9. To effectively control and handle the maximum number of contaminated persons, local responders should position resources at hospitals and road network choke points.
10. Official public information and guidance on self-decontamination and shelter-in-place techniques should be distributed as soon as possible. While local responders generally provide this information, State and Federal officials may also issue guidance when appropriate.
11. Patient movement assets supporting the National Disaster Medical System (NDMS) will not accept contaminated victims for evacuation.
12. People who have self-decontaminated must identify themselves prior to decontamination processing. This will allow authorities to ensure those needing immediate treatment receive priority treatment.
13. The principal Federal interagency reference for mass personnel decontamination is "Best Practices and Guidelines for Mass Personnel Decontamination," published by the Technical Support Working Group in collaboration with the Chemical and Biological Defense Information Analysis Center and the Department of Health and Human Services (HHS).
14. Federal, State, and local efforts should focus on contaminant containment as soon as possible.

IV. Transportation and Logistical Requirements

- A. State level decontamination assets will use organic transportation resources or will request assistance from the SEOC Logistics Section.
- B. Follow-on Federal assets, including personnel and equipment assigned to support facility and environmental decontamination and removal of contaminated debris, will coordinate transportation and logistical requirements in accordance with standard NRF protocols.
- C. Resource Limitations and Unique Concerns:
 1. In general, at the venue level, there will be insufficient firefighter apparatus and personnel to conduct immediate gross decontamination due to incident impact on these resources, size of the contaminated population, competing tasks, and possible disruption to municipal water supply.
 2. In general, at the venue level, there will be insufficient quantities of detection and monitoring equipment for first responders, reception centers, mass care shelters, and medical treatment facilities.
 3. There may be inadequate, untimely, or competing plume modeling to support rapid decision-making regarding population protection measures—principally shelter-in-place or evacuation.
 4. Due to the site-specific nature of many cleanup issues (even for those contaminants for which there exist quantitative exposure reference values, such as for many chemical and radiological contaminants), a determination of "how clean is safe" for returning to residences and resumption of business is a risk management decision based on the selection and site-specific application of such values.
5. As such, cleanup levels will be determined on a site-by-site basis by local governments working in tandem with Federal and State technical experts in accordance with NRF/NIMS decision-making processes.

V. Capabilities/Responsibilities

A. Federal Capabilities

1. The National Response Center (NRC) is designated by Federal statute as the single mandatory notification point for HAZMAT spills. By interagency agreement, the NRC also provides a point of contact for members of the public and industry to report potential terrorist incidents. The NRC will notify other Federal agencies, as appropriate, and will

- assist the reporting party with referrals for technical assistance, including technical assistance for WMD incidents.
2. EPA and the U.S. Coast Guard (USCG) will respond to HAZMAT incidents, through the authorities, organization, and procedures contained in the “National Oil and Hazardous Substances Pollution Contingency Plan.”
 3. EPA is assembling a National Decontamination Team (specific to structures, infrastructure, and critical items; not people). This 15-person team will be located in Cincinnati, OH. This team will augment existing EPA response capabilities and will be dedicated to decontamination and the research and development of decontamination techniques and decontamination execution, technologies, and engineering for WMD.
 4. EPA provides Federal On-Scene Coordinators (OSCs) (approximately 250 individuals in 10 EPA Regions in 26 locations) to coordinate onsite HAZMAT activities, and maintains an Environmental Response Team (approximately 50 HAZMAT experts in three locations: New Jersey, Ohio, and Nevada), and Radiological Emergency Response Team (two locations: Alabama and Nevada). EPA has further reach-back capabilities with programs dealing with enforcement, air, water, research and development, and pesticides. EPA’s Radiological Emergency Response Team (RERT) members serve as part of the Federal Radiological Monitoring and Assessment Center (FRMAC) for radiological or nuclear incidents. For the intermediate and long-term phases of a radiological or nuclear incident, EPA takes over leadership of the FRMAC.
 5. The Department of Energy (DOE) will activate Radiological Assistance Program (RAP) Teams, the National Atmospheric Release Advisory Capability (NARAC), a FRMAC, and the Radiation Emergency Assistance Center/Training Site (REAC/TS), in accordance with the Nuclear/Radiological Incident Annex to the National Response Plan. RAP Teams respond to incidents involving radioactive materials and provide resources, including trained personnel and equipment, to evaluate, assess, advise, and assist in the mitigation of radiation hazards. NARAC provides real-time assessment advisories on nuclear, biological, or chemical (NBC) releases into the atmosphere. The FRMAC coordinates, through the primary agency, all Federal radiological monitoring and assessment activities during major radiological emergencies. REAC/TS provides medical consultation on the treatment of radiation exposure and contamination. DOE’s Aerial Measuring System (AMS) capability is an important asset that will allow the FRMAC to gather information about the site more quickly and safely than would be possible with only individuals performing monitoring.
 - a. RAP Teams: 27 teams in 8 DOE Regions, based at DOE facilities. RAP Teams are on a 2-hour call up (packed and in transit to the incident location within 2 hours) during working hours and on a 4-hour call up during non-working hours.
 - b. NARAC: Can provide initial dispersion plots, based on weather information, in as little as 15 minutes. NARAC continues to refine calculations and provide updated data until the release has been fully mapped and impacts assessed. NARAC activities and products will be coordinated with the Interagency Modeling and Atmospheric Assessment Center (IMAAC).
 - c. FRMAC: The Phase I Consequence Management Response Team (CMRT) keeps a readiness posture of “wheels-up” from Las Vegas in 4 hours, arriving on-scene in 6 to 10 hours for most of the continental United States (CONUS). Phase II CMRT, enabling round-the-clock operations, can be on-scene and running in 24 to 36 hours. The full FRMAC capability can be staffed with up to 500 people (including RAP elements) in a catastrophic incident, and use fixed and rotary-wing airborne assets for wide-area radiation monitoring. The full FRMAC capability is supported by DOE personnel and assets but is an interagency team of Federal and State technical experts.

- d. REAC/TS: Radiation experts with REAC/TS are on-call 24 hours a day to provide direct medical and radiological advice.
- 6. The following Federal teams/organizations provide (or are a source for) decontamination special assistance:
 - a. Agency for Toxic Substances and Disease Registry (ATSDR) Emergency Response Teams.
 - b. U.S. Marine Corps (USMC) Chemical Biological Incident Response Force (CBIRF).
 - c. DOE Nuclear Emergency Support Team (NEST).
 - d. EPA Environmental Response Team (ERT).
 - e. EPA RERT.
 - f. Federal Bureau of Investigation (FBI), Laboratory Division, Hazardous Materials Response Unit (HMRU).
 - g. USCG National Strike Force (NSF).
 - h. Occupational Safety and Health Administration (OSHA) Specialized Response Team.
 - i. U.S. Army Corps of Engineers (USACE) Rapid Response Program.
 - j. U.S. Department of Agriculture (USDA).
 - k. National Response Center (NRC).
 - l. Medical Emergency Radiological Response Team (MERRT).

B. HAZMAT Teams Deployment Time

Figure 5-1 reflects the number of hours before team is capable of departure from home unit or base. “HAZMAT Response Team” is defined as an organized group of individuals trained and equipped to perform work to control actual or potential leaks, spills, discharges, or releases of hazardous materials, requiring possible close approach to the material. The team/equipment may include external or contracted resources.

	Type I	Type II	Type III
CBIRF	1 Hour	1 Hour	1 Hour
EPA ERT	4 Hours	4 Hours	4 Hours
EPA Office of Enforcement Compliance, and Assurance (OECA)/National Counterterrorism Evidence Response Team (NCERT)	6 Hours	6 Hours	6 Hours
EPA RERT	6-8 Hours	6-8 Hours	6-8 Hours
USCG NSF	2 Hours	2 Hours	

NOTE: EPA OSCs are capable of departure from home unit or base within 1 hour.

C. Inventory of Other (Federally Accessible) Capabilities

- 1. National Medical Response Teams (NMRTs). NMRTs are private practitioners who are organized into teams and Federalized for activation and deployment. Teams deploy to and operate within a HAZMAT environment providing physician-supervised advanced level medical services, human decontamination services, agent detection, and/or assistance to response agencies.
 - a. All NMRT personnel are minimally trained to the OSHA HAZMAT operational level and some are at the technical level. All have specialized WMD medical training. The team is maintained in a state of readiness and is prepared to deploy within 4 hours of notification, 24 hours a day/7 days a week.

- b. The NMRT consists of 50 personnel as the standard deployed force, although specialized missions can require as few as 12 personnel. It is designed to deploy by ground or air and is self-contained (except for water for decontamination). Ground transportation may be needed at the receiving site for personnel and equipment.
 - c. The NMRT may be requested for planned events, after a WMD event has occurred, when a credible threat exists or to assist with technological disasters.
 2. Metropolitan Medical Response System (MMRS). The MMRS program assists highly populated jurisdictions organize immediate medical response resources, develop plans, conduct training and exercises, and acquire pharmaceuticals and PPE. It enables the jurisdiction to achieve an enhanced capability to respond - with their resources - to a mass casualty incident (regardless of cause) until significant external assistance can arrive. The MMRS approach requires coordination and operational linkages among first responders, medical treatment resources, public health, emergency management, volunteer organizations, and other local elements, to achieve an optimum capability to reduce the mortality and morbidity that would result from major terrorist acts. It also requires the integration of planning with neighboring jurisdictions and State and Federal agencies, as well as emphasizes enhanced mutual aid. As part of an immediate response strategy, MMRS can provide sufficient pharmaceuticals for at least 1,000 victims of a chemical incident, and for up to 10,000 victims of a biological event.
- D. Responsibilities of Coordinating and Support Agencies/Organizations
 1. When requested by the Coordinating Agency, DOE will:
 - a. Establish the FRMAC and coordinate monitoring and assessment of radioactive contamination, as outlined in the NRP Nuclear/Radiological Incident Annex.
 - b. Provide advisory assistance on radiological decontamination and monitoring techniques.
 - c. Assist in providing characterization of radiation deposition in affected areas.
 - d. Provide medical consultation on the treatment of persons injured by radioactive contamination or exposure and provide lists of all local medical personnel trained in the treatment of such injuries by the REAC/TS.
 2. EPA will assume primary Federal responsibility for coordinating structural and environmental decontamination in accordance with ESF#10 and/or the NRP Oil/Hazardous Materials Incident Annex, as appropriate.
 3. HHS/ATSDR will:
 - a. Perform specific functions concerning the effect on public health of hazardous substances in the environment. ATSDR primarily supports and advises EPA, and is also available to States or local entities on request.
 - b. Immediately initiate or support State/local initiation of a health registry for both victims and responders.

**TAB D to Incident Annex 4
Catastrophic Incident Annex
Public Health and Medical Support**

LEAD: Department of Health

I. Mission

To quickly augment the public health and medical support resources and capabilities of State, Tribal, and local governments responding to a catastrophic mass casualty/mass evacuation incident.

II. Planning Assumptions

- A. The Federal public health and medical response to a catastrophic incident will be coordinated by the HHS as outlined in ESF#8.
- B. During a catastrophic incident, medical support will be required not only at medical facilities, but in large numbers at casualty evacuation points, evacuee and refugee points, and shelters as well as to support field operations.
- C. Mass field triage will be required.
- D. Public anxiety regarding the catastrophic incident will require effective public information and risk communication and may also require appropriate mental health and substance abuse services.
- E. The Federal medical assets that can be brought to bear in a catastrophic incident are organized into four categories: Personnel (and their specific capabilities), Hospital Beds, Medical Countermeasures, and Equipment/Supplies. This appendix discusses personnel and hospital beds. Appendix 6 discusses equipment and medical supplies.
- F. Federal public health assets that can be brought to bear in are organized into five categories: Health Surveillance, Worker Health and Safety, Radiological/Chemical/Biological Hazards Consultation, Public Health Information, and Vector Control.
- G. Federal public health and medical assets are accessible through a wide number of components within the Federal Government, as well as from volunteer programs administered by the Federal Government. These assets may not always be available during the response to a catastrophic incident, depending on needs at their home institutions, family requirements, etc.
- H. The DHS National Disaster Medical System (NDMS) and HHS U.S. Public Health Service (PHS) Commissioned Corps assets will be the first Federal health and medical assets to arrive on the scene of a catastrophic event.
- I. Epidemiologic Intelligence Service (EIS) officers and other Centers for Disease Control and Prevention (CDC) emergency response assets (including the Agency for Toxic Substances and Disease Registry (ATSDR)) will be the first Federal public health assets to arrive on the scene of a catastrophic event.
- J. While civilian Federal employees cannot be ordered to respond to a catastrophic incident, it is anticipated that a sizable portion will volunteer to assist with the response.

- K. Because of disparate systems for counting personnel, numbers in this appendix are likely to overestimate the number of available personnel as a result of “double counting.”
- L. Additional teams are currently being developed, such as the National Nurse Response Team (NNRT) and the National Pharmacy Response Team (NPRT).
- M. A State-based Emergency System for Advanced Registration of Voluntary Healthcare Personnel (ESAR-VHP) is being developed.
- N. The assets identified in the response strategy may not be available at the time of a catastrophic incident due to needs at their home institutions, family requirements, and/or incapacitation as a result of the incident.

III. Catastrophic Incident Response Strategy

A. Response Strategy: IMMEDIATE

1. The personnel that can be brought to bear in response to a catastrophic incident come from various Federal Departments and Agencies and are coordinated through ESF#8 under the leadership of HHS. Figure 6-1 approximates the personnel available to deploy the first week of a catastrophic event. Each column represents the number of additional people who could be deployed.
2. In addition to the resources depicted in Figure 6-1:
 - a. The ARC will deploy local assets immediately following the incident. National ARC assets can be deployed within 72 hours. ARC assets include mental health and nursing personnel. These assets are under the ARC command structure, but will work in coordination with Federal, State, Tribal, and local efforts. Refer to Appendix 3 for more details.
 - b. Community Health Centers (CHCs) and Community Mental Health Centers (CMHCs) are available in all States and many jurisdictions. These centers are responsible for providing health and mental health services to their communities. While these centers typically receive the majority of their funding from State and local governments, they also receive substantial Federal funding. During a catastrophic incident, these centers could provide services to the injured and those needing mental health services. The use of CHCs and CMHCs should be coordinated with Federal, State, Tribal, and local authorities. The number of assets available will vary depending on local incident demands and pre-incident staffing levels. In Fiscal Year (FY) 2004, there were more than 3,650 CHC sites and 915 to 920 grantees across the country. In FY00 (the most recent year with available data) there were 2,075 CMHCs.
 - c. Agreements between individual Department of Defense (DoD) military treatment facility commanders and surrounding local authorities may allow provision of medical treatment facility (MTF) and/or personnel support for emergency care under immediate response authorities, or when requested by ESF#8 and approved for employment by the Secretary of Defense.
 - d. As provided for in local community emergency response plans, and as authorized under applicable authorities, Department of Veterans Affairs (VA) Directors may provide emergency medical care to victims in a catastrophic incident.

B. Response Strategy: FIRST 10 DAYS.

1. After the first week, there will be an additional 390 NDMS personnel (members of augmentation and developmental teams) that can serve as relief for NDMS personnel deployed during the initial response.
2. In addition to the PHS Commissioned Corps officers listed in Figure 6-1, there are more than 850 other PHS officers who could be deployed to support a catastrophic incident.

C. Response Strategy: SUSTAINED

A sustained Federal public health and medical response will be accomplished by continuous situation assessments, rotation of personnel assets, backfill of supplies and equipment and other actions according to the guidance and direction outlined in the ESF #8 annex of the NRF.

IV. Transportation and Logistical Requirements

A. Movement of personnel, equipment, and (potentially) patients will require transportation and logistics support. See Annex 2 (Transportation Support Schedule), Appendix 7 (Medical Equipment and Supplies Response Overview), and Appendix 8 (Patient Movement Response Overview) for additional information.

B. Response Limitations and Unique Concerns

1. There is no unified database to inventory the health and medical personnel employed in administrative and research jobs within the Federal Government. These personnel could be a valuable resource in a catastrophic incident.
2. Systems required to move personnel, patients, and equipment require extensive review and should be simultaneously exercised during national, State, and local exercises.
3. Federal planning efforts need to be tied more closely to the efforts of Regional, State, and local planners.
4. Plans need to be developed for rotating staff and incorporating volunteers.

V. Capabilities/Responsibilities

A. Capabilities

1. HHS Secretary's Operations Center (SOC). The SOC serves as an information and operations center providing a single focal point for the Federal health and medical response to a catastrophic incident, including information sharing, command and control (C2), communications, specialized technologies and information collection, assessment, analysis, and sharing. FEMA, VA, DoD, and relevant HHS Operating Divisions (OPDIVs) will send liaisons to the HHS SOC to facilitate coordination of the health and medical response to a catastrophic incident.
2. Secretary's Emergency Response Team (SERT). The ASPHEP, on behalf of the HHS Secretary, directs and coordinates HHS efforts to prevent, prepare for, respond to, and recover from the public health and medical consequences of a catastrophic incident. The SERT and/or SERT Advance element acts as the HHS Secretary's agent at incident sites. The SERT directs and coordinates the activities of all HHS personnel deployed to the incident site to assist State, Tribal, local and other Federal and Government agencies, as applicable.

3. DHS National Disaster Medical System (NDMS). NDMS medical response teams will be activated and deployed in response to a catastrophic incident. Current NDMS medical specialty force strength is reflected in Figure 6-2. NDMS teams include:
 - a. Management Support Team (MST). There is currently one MST. The MST serves as the operational interface between NDMS response teams and the local Incident Commander, as well as with State and local governments.
 - b. Disaster Medical Assistance Teams (DMATs). A DMAT is a group of professional and para-professional medical personnel (supported by a cadre of logistical and administrative staff) designed to provide medical care in response to a disaster or other incident. The DMAT mission is to rapidly deploy to a disaster site to provide primary and acute care; triage of mass casualties; initial resuscitation, stabilization, advanced life support; and preparation of sick or injured patients for evacuation. The DMAT structure includes specialized teams, such as the four National Medical Response Teams (NMRTs), five Burn Teams, two Pediatric Teams, one Crush Medicine Team, two Mental Health Teams, and one International Medical/Surgical Response Team (IMSuRT), with two additional IMSuRTs under development. The specific capabilities of the NMRT, IMSuRT, NNRT, and NPRT are described in succeeding paragraphs. Figure 6-3 shows the location of the MST and operational DMATs. Figure 6-4 shows the medical response teams under development.
 - c. DMAT Types and Strength:
 - i. Type-I (Fully Operational Teams) – 9 total teams. Type-I teams consist of required equipment caches and rostered personnel that have demonstrated the ability to pack their cache and report to the team's point of departure within 6 hours of activation (among other criteria).
 - ii. Type-II (Operational Teams) – 13 total teams. Type-II teams consist of required equipment caches and rostered personnel that have demonstrated the ability to pack their cache and report to the team's point of departure within 12 hours of activation (among other criteria).
 - iii. Type-III (Augmentation/Local Teams) – 16 total teams. Type-III teams may be used to supplement other deployed teams, or may be deployed by NDMS within their home State to assist a Type I deployed team. Personnel can be deployed 24 hours after activation by NDMS.
 - iv. Type-IV (Developmental Teams) – 17 total teams. Type-IV teams may be used to supplement other teams during deployments to allow the members an opportunity to gain the experience, training, and skills necessary to upgrade the team status. Team personnel can be deployed in 24+hours following activation by NDMS.
 - d. DMAT Capabilities:
 - i. Deploy to an incident site within 6 hours, for a 14-day period.
 - ii. Provide emergent care within 30 minutes of arrival at an incident site.
 - iii. Be fully operational within 6 hours of arrival at an incident site.
 - iv. Sustain 24-hour operations for 72 hours without external support.

- v. Provide initial resuscitative care to victims.
 - vi. For a 24-hour mission, provide out-of-hospital, acute care to 250 patients (including geriatric and pediatric patients).
 - vii. Provide sustained 24/7 care to 125 patients per day, including:
 - Limited laboratory and pharmaceutical services.
 - Immediate referral, transfer, or evacuation for 25 patients.
 - Stabilizing/holding a maximum of six patients for up to 10 hours.
 - Supporting two critical patients for up to 24 hours.
 - viii. Provide sustained hospital ward care for 30 medical/surgical (non-critical) inpatients.
 - ix. Provide primary response to a mass casualty incident resulting from a nonchemical, biological, radiological, nuclear, or high-yield explosive (CBRNE) event.
 - x. Triage and prepare 200 patients at a casualty collection point for evacuation or transport in a mass casualty incident.
 - xi. Provide patient staging for up to 100 patients at a Federal Coordinating Center
 - xii. (FCC) reception site.
 - xiii. Augment or assist at a mass drug distribution, immunization, or packaging center.
 - xiv. Staff or augment alternate care facilities.
- e. National Medical Response Teams (NMRTs). The four 50-person NMRTs are equipped and trained to perform the functions of a DMAT, but possess additional capabilities to respond to a CBRNE event, to include operating in Level "A" protective equipment. Each NMRT is equipped with its own chemical and biological monitors and detectors, used primarily for personnel and victim safety. Additionally, each team carries medical supplies and medications, including sufficient antidotes to manage 5,000 victims of a chemical incident. The team can deploy in 4 hours and can be fully operational within 30 minutes of arrival on the scene of a catastrophic incident. A NMRT can perform the following specific functions:
- i. Provide mass or standard decontamination.
 - ii. Collect samples for laboratory analysis.
 - iii. Provide medical care to contaminated victims.
 - iv. Provide technical assistance to local Emergency Medical Services (EMS).
 - v. Assist in CBRNE triage and treatment before and after decontamination.
 - vi. Provide technical assistance, decontamination, and medical care.
 - vii. Provide medical care to Federal responders on-site.
- f. International Medical Surgical Response Team (IMSuRT). There is currently one operational IMSuRT, which is located in Boston, MA. The mission of the IMSuRT is to assist in international disasters at the request of the Department of State (DOS) and to augment other U.S. disaster assets outside the continental United States (OCONUS). Each team is comprised of 25 medical and 5 logistic personnel. The medical personnel include trauma and general surgeons, physician's assistants, registered nurses (some with trauma expertise), anesthesiologists, and Emergency

Medical Technicians (EMTs)-paramedics. The IMSuRT provides triage and initial stabilization, definitive surgical care, critical care, and evacuation capacity. The team can deploy in 4 hours and is self-sustaining for 72 hours.

- g. Disaster Mortuary Operational Response Team (DMORT). There are currently 11 DMORTs. Each team is comprised of Funeral Directors, Medical Examiners, Coroners, Pathologists, Forensic Anthropologists, Medical Records Technicians and Transcribers, Fingerprint Specialists, Forensic Odontologists, Dental Assistants, X-Ray Technicians, Computer Professionals, Administrative Support staff, and Security and Investigative personnel. During an emergency response, DMORTs work under the guidance of local authorities by providing technical assistance and personnel to recover, identify, and process deceased victims. Capabilities include temporary morgue facilities; victim identification; forensic dental pathology; forensic anthropology; and processing, preparation, and disposition of remains. The DMORT program maintains two Disaster Portable Morgue Units (DPMUs) at FEMA Logistics Centers (one in Rockville, MD; the other in Sacramento, CA). The DPMU is a cache of equipment and supplies for deployment to an incident site. It contains a complete morgue, including workstations for each processing element and prepackaged equipment and supplies.
- h. NDMS Planning Assumptions and Timeline of Care
 - i. Transportation routes—ground and air—are available to move NDMS assets.
 - ii. Twenty-four hour post activation (day plus one (D+1)) teams will be in place, setup, and providing care within their region (East, Central, and West).
 - iii. If an incident occurs in one region (East or West), only one third of assets will be on site and providing care at D+1. All other activated teams could arrive and initiate care at D+2 to D+3.
 - iv. In the event of catastrophic incident, the “standard of care” will be minimal life support and patient holding for 2 to 3 days.
 - v. The NDMS timeline of care (Figure 6-6) is based on the following teams:
 - 12 DMATs
 - 3 NMRTs
 - 1 IMSuRT
 - 3 Base Support Teams (BSTs)
- i. PHS Commissioned Corps. The mission of the PHS Commissioned Corps is to provide highly trained and mobile health professionals to carry out programs to promote the health of the Nation. As one of the seven uniformed services of the United States, the PHS Commissioned Corps is designed to attract, develop, and retain health professionals who may be assigned to Federal, State, Tribal, or local agencies or international organizations to accomplish its mission. Figure 6-7 and Figure 6-8 illustrate the force strength and breadth of skill sets available among Commissioned Corps officers. Commissioned Corps officers can provide a wide variety of public health and medical services (both domestically and internationally), to include:

- i. Direct medical and dental care to disaster victims and/or responders.
- ii. Mental health and social work services to victims and/or responders.
- iii. Provision of occupational health support to responders, including personal protective equipment, environmental hazards, hygiene, food, water, and sanitation.
- iv. Providing general health educators to provide information to victims and their families.
- v. Environmental health and industrial hygiene officers to evaluate potable water, wastewater, and sanitation issues.
- vi. Environmental health, food safety, and dietician officers to evaluate food safety and security issues.
- vii. Epidemiologists to work with local public health departments to identify and evaluate morbidity and mortality issues.
- viii. Forensic dentists to support the local medical examiner in mass fatalities.
- ix. Information technology and medical records experts to improve the collection and communication of public health information.
- x. Veterinarians and epidemiologists to support animal health disasters and disease control, which may or may not transfer to humans. Roles include supporting the USDA and augmenting the VMATs.
- xi. Engineers, Environmental Health, Industrial Hygienists, and Safety Officers to evaluate buildings, roads, bridges, or water and sewer systems, as well as investigate and ameliorate environmental hazards and airborne materials in support of State and local jurisdictions and the SNS.
- xii. The PHS Commissioned Corps includes approximately 6,000 officers, divided among seven rosters, on-call on a rotating monthly basis. Officers are categorized according to the 26 deployment roles outlined in Figure 6-8. Once the mission requirements and the category/discipline/ specialty of members are determined, the Office of the Surgeon General (OSG) will match the requirement against the qualifications of officers on that month's rotational roster. Realistically, seventy percent of the on-call officers can be deployed within 24 hours (Figure 6-8). Within 72 hours, seventy percent of the people on the other six rotational rosters could be deployed.
- xiii. Fifty-five of the medical providers (e.g., physicians, nurses, dentists, nurse practitioners, and physician's assistants) listed in Figure 6-8 participate in the Health Resources and Services Administration's (HRSA's) Ready Responder program. These Officers annually receive 2 weeks of specialized training to respond to WMD events.
- xiv. CDC has more than 200 public health professionals that are trained in incident response and have been medically cleared and fit tested for respirators. In addition, it is estimated that additional CDC staff will volunteer to assist with the response to a catastrophic public health emergency. Specific capabilities include:

- Health Surveillance. Assistance in establishing surveillance systems to monitor the general population and special high-risk population segments, carry out field studies and investigations, monitor injury and disease patterns and potential disease outbreaks, and provide technical assistance and consultations on disease and injury prevention and precautions.
 - Radiological/Chemical/Biological Hazards Consultation. Assistance in assessing health and medical effects of radiological, chemical, and biological exposures on the general population and on high-risk population groups; conduct field investigations, including collection and analysis of relevant samples; advise on protective actions related to direct human and animal exposure, and on indirect exposure through radiologically, chemically, or biologically contaminated food, drugs, water supply, and other media; and provide technical assistance and consultation on medical treatment and decontamination of radiologically, chemically, or biologically injured/contaminated victims.
 - Public Health Information. Assistance by providing public health, disease, and injury prevention information that can be transmitted to members of the general public who are located in or near areas affected by a major disaster or emergency.
 - Vector Control. Assistance in assessing the threat of vector-borne diseases following a major disaster or emergency; conduct field investigations, including the collection and laboratory analysis of relevant samples; provide vector control equipment and supplies; provide technical assistance and consultation on protective actions regarding vector-borne diseases; and provide technical assistance and consultation on medical treatment of victims of vector-borne diseases.
- j. Medical Reserve Corps (MRC). The response to a catastrophic incident will begin locally. The local response will vary depending on the level of preparedness in the area of the incident. The MRC program is establishing teams of local medical and public health volunteers to enhance and support existing local capabilities on a regular basis and during emergencies. The MRC program is headquartered in the OSG. This program is part of a national initiative involving the U.S. Freedom Corps (sponsored by the White House) and Citizen Corps (sponsored by DHS). Joining the MRC ranks are over 30,000 volunteers from 237 communities (166 of the 237 units are funded by HHS/OSG as part of the MRC Demonstration Project). The number of volunteers is expected to double within the next 12 months. Figure 6-9 shows the locations of the 237 MRC units. Based on the interest in this program and the preliminary data from MRC units, the MRC program could be expanded to provide local staff for a catastrophic incident. Figure 6-9 – Medical Reserve Corps Communities

k. Department of Veterans Affairs (VA). The VA can ask available medical, surgical, mental health, and other health service support people to volunteer to assist the primary Federal agency in the response to a catastrophic incident. Refer to Figure 6-10 for a list of potentially available VA staff. In addition, local VA Medical Directors are authorized, under applicable authorities, to provide emergency medical care to victims of mass casualty events. Public Law requires that patients be billed for services provided.

Role Total Number
Physicians 14,529
Physician Extenders 4,262
Nurses 35,834
Pharmacists 5,159
Respiratory Therapists 98
Medical Support Staff 39,717
Mental Health Providers 8,625
Administrative Support 14,878
TOTAL 123,102

Figure 6-10 – Department of Veteran Affairs Staff

- l. Department of Defense (DoD). Under imminently serious conditions, when there is inadequate time to seek the approval of higher headquarters, the commanders of DoD installations near the incident may provide necessary assistance to save lives, prevent human suffering, or mitigate great property damage, under the authorities of immediate response without prior approval of the Secretary of Defense. Commanders will notify their higher headquarters at the earliest possible opportunity. Any continuation of assistance must be approved by the Secretary of Defense.
- m. Department of Labor/Occupational Safety and Health Administration (DOL/OSHA) The Occupational Safety and Health Administration provides technical assistance for responder safety, including the coordination of Federal Assets for occupational safety under the Worker Safety and Health Annex. OSHA has 89 Area Offices throughout the country, and coordinates with 26 State Occupational Safety and Health Programs. OSHA can deploy Specialized Response Teams which provide specific assistance for safety management involving Chemicals/Explosives, Biologicals, Radiation/Nuclear and collapsed structures. Along with assets from other Federal Agencies, including the Department of Health and Human Services, the Environmental Protection Agency, Army Corps of Engineers, and the Department of Homeland Security, these teams will provide assistance to safety officers for assessing safety and health risks to emergency workers, overseeing the development of a site safety and health plan, monitoring air contaminants and other hazards to determine personal protection equipment (PPE) and overseeing selection, use, fit testing, distribution and decontamination of PPE, and conducting safety monitoring.
- n. Hospital Beds. In the United States there are approximately 5,800 non-Federal hospitals with a staffed bed capacity of approximately 1 million. Of these non-Federal hospitals, over 1,600 have signed agreements with

NDMS agreeing to serve as receiving hospitals in an emergency. The NDMS system has designated FCCs that would determine the number of available beds among the NDMS hospitals in their region and coordinate patient movement to these facilities. The locations of the FCCs are shown in Figure 6-11. The FCCs and the potential hospital beds that would be available to receive patients in a mass casualty event are provided in Figure 6-12. These hospital beds may/may not be available due to existing circumstance in each facility. Thus real-time bed availability will be captured through a contingency bed report. Available hospital beds are defined as beds vacant for 24 hours prior to the day of the report and can immediately receive patients. They must be in a functioning medical or psychiatric treatment facility ready for all aspects of patient care. They must include supporting space, equipment, medical material, ancillary and support services, and staff to operate under normal circumstances. Excluded are transient patient beds, bassinets, incubators, and labor and recovery beds. FCCs will input the number of available hospital beds in their catchment area into the DoD U.S. Transportation Command C2 Evacuation System (TRACES2) database.

- i. If the number of casualties exceeds the available beds in non-Federal NDMS hospitals, non-Federal hospitals outside of the NDMS system will be contacted to determine their ability to accept patients. Furthermore, the VA has designated 65 hospitals as Primary Receiving Centers (PRCs) to receive, transport, and treat patients from DoD in time of war. DoD has Military Treatment Facilities (MTFs) that may - through local agreements and within the vicinity of the incident site – provide necessary assistance to save lives, prevent human suffering, or mitigate great property damage under the authorities of immediate response without prior approval by the Secretary of Defense. However, commanders will notify their higher headquarters at the earliest opportunity.
- ii. Tribal facilities may be called upon to assist in a catastrophic incident. Tribal facilities can be Federally owned and operated, Federally owned but Tribally operated, and Tribally owned and operated. These facilities can include hospitals and health centers. These facilities may or may not be available during a catastrophic incident, but they should be considered as part of planning efforts.
- iii. The HHS SOC maintains a hospital resource tracking system known as Hospital Asset Reporting and Tracking System (HARTS). This system can be used during a catastrophic incident to canvas American Hospital Association (AHA) hospitals in the area of the disaster to identify available beds. This data is entered through a secure Web site by the hospital. Using geographic information system capabilities, the HARTS can provide direction for movement of patients and resources to best support the medical needs during the response to a catastrophic incident.

**TAB E to Incident Annex 4
Catastrophic Incident Annex
Medical Equipment and Supplies**

LEAD: Department of Health

I. Mission

This appendix will consider medical assets for a Federal response to a catastrophic incident, irrespective of cause or hazard. These assets will include a description of various programs and their overall capabilities and are not limited to post-exposure prophylaxis.

II. Planning Assumptions

III. Catastrophic Incident Response Strategy

A. Response Strategy: IMMEDIATE

B. Response Strategy: FIRST 10 DAYS.

C. Response Strategy: TRANSITION and SUSTAINMENT

1. Transition Strategy

2. Sustainment Strategy

IV. Transportation and Logistical Requirements

A. Blood and Blood Products. In a catastrophic incident there will be a need for blood and blood products. Currently, blood reserves for national emergencies consist of 500 units of pretested, pre-positioned packed red cells held at two locations - 250 on the East Coast and 250 on the West Coast. Another 750 units are held in geographically dispersed private blood collection facilities. Blood can be ready for ground shipment within 4 to 6 hours. The responsibility for air shipment is dependent upon the situation.

1. The provision of blood/blood products will depend on the nature of the event; however, local blood collections, processing activities, and testing capabilities may be suspended.

2. Depending on the type of incident, blood collection centers and associated activity locations (i.e., processing, testing, and distribution) may require decontamination. These facilities should be given priority, as identified in Appendix 4.

B. Additional Equipment and Supplies. NDMS Teams have their own caches of equipment and supplies.

C. Response Limitations and Unique Concerns:

1. Regional and local healthcare facilities lack sufficient quantities of antibiotics, antidotes, and other pertinent pharmaceuticals and medical

countermeasures to effectively handle mass casualty incident requirements.

2. Since most healthcare systems use a “just in time” inventory system for supplies, “on hand” supplies could be depleted quickly during a large-scale event.

V. Capabilities/Responsibilities

A. Strategic National Stockpile (SNS) Program

1. 12-Hour Push Package. This is a 50-ton assortment of medical assets and pharmaceuticals from the SNS. The 12-hour Push Package provides a broad spectrum of countermeasures applicable to a broad array of threats. The dozen 12-hour Push Packages are identical, pre-packaged in specialized cargo containers, and stored for prompt access by SNS program transportation partners. The 12-hour Push Package is assured for delivery to any site in the United States or its Territories within 12 hours of a Federal order to deploy. Transportation methodology (via ground or air) is situationally determined by the SNS program.
2. Vendor-Managed Inventory (VMI). VMI comprises the majority of medical assets and pharmaceuticals in the SNS program (e.g., VMI can provide 12 million citizens with much of the 60 days of anthrax prophylaxis). Nearly the entire VMI is maintained by manufacturers who rotate various product lines to ensure current product dating. VMI is designed for a tailored response to provide specific pharmaceuticals or medical assets to a suspected or confirmed agent.
3. Department of Veterans Affairs (VA) National Acquisition Center (NAC). The SNS program selected the VA NAC as its procurement partner. VA NAC annually procures more than \$3.5 billion in medicines and medical material for the VA medical system and allows the SNS program to take advantage of economies of scale. The established relationship with the VA NAC also allows the SNS program to rapidly procure products not contained within the SNS formulary that are needed to respond to a specific event. The VA NAC also assists the SNS program in determining overall market availability and production capacity of pharmaceuticals and medical assets.
4. Treatment and Prophylaxis Capabilities of the SNS Program. The SNS formulary is designed for both pediatric and adult populations. The baseline capacity for children is based on the 2000 U.S. Census data and is applied to the SNS program requirements for prophylaxis or treatment for threat agents. The SNS capability against various threat agents will change over time as the formulary content is augmented, enhanced, or modified to respond to present or emerging threats. Therefore, the capabilities report will need to be continually updated.
5. SNS Formulary Content. A list detailing the specific formulary contents of the SNS is provided to State and local emergency planners through the SNS program consultant to that State. The list does not include quantities of the specific products available, as the SNS program considers this information to be sensitive in nature. The SNS formulary content changes over time as the formulary is modified, enhanced, or augmented to respond to present or emerging threats. The SNS formulary content may be divided in to various categories to include:
 - a. Airway management supplies (endotracheal tubes, manual resuscitators (ambu bags)) and intravenous (IV) supplies, including catheters and solutions (normal saline, lactated ringers).
 - b. Pharmaceuticals (antibiotics, analgesics, sedatives, chemical nerve agent antidotes, anti-epileptic drugs, anti-emetics and paralytics).

- c. Wound management supplies (bandages, ointments, laceration repair supplies).
 - d. Vaccines (smallpox, anthrax).
 - e. Antitoxin (botulism).
 - f. Ventilators.
6. Emergency Use Authorization (EUA). The National Defense Authorization Act was signed into law in November 2003. Section 1603 adds Section 564 to the Food, Drug, and Cosmetic Act (Authorization for Medical Products for Use in Emergencies), and states that the Department of Health and Human Services (HHS) Secretary may declare an emergency justifying the authorization, under this subsection, for a product (either an unapproved product or an unapproved use of an approved product) to be introduced into interstate commerce. The Secretary of HHS may make such an emergency declaration on the basis of the determination by the Secretary of Defense of a military emergency, or a significant potential for an emergency, involving a heightened risk to U.S. military forces from an attack with a specified biological, chemical, radiological, or nuclear agent(s). The Secretary of HHS may issue an authorization under this section with respect to emergency use of a product only if, after consultation with the Director of the National Institutes of Health (NIH) and the Director of the Centers for Disease Control and Prevention (CDC), the Secretary concludes that: (1) an agent specified above can cause a serious or life-threatening disease or condition; (2) it is reasonable to believe that the product may be effective in diagnosing, treating, or preventing such disease or condition; (3) the benefits or using a product outweigh the risks; and (4) there are no adequate, approved, and available alternatives. Under EUA, healthcare providers and patients are informed about the risk and benefits and alternative interventions. The SNS program is currently working with the Food and Drug Administration (FDA) to evaluate the impact of the EUA on pharmaceuticals currently requiring an Investigational New Drug (IND) for distribution and use as well as the overall impact on the SNS formulary.
7. SNS Transportation of Assets. The SNS program has transportation partnerships with the commercial sector. The SNS program will make the decision of whether to execute a Federal order to deploy a 12-hour Push Package or VMI by air or by ground based on such factors as the safety and physical condition of the closest airfield where it is possible to land a wide-body aircraft, weather and road conditions, the likelihood of continuing terrorist activity, or other perils that may threaten SNS material. In making this decision, the SNS program will invite input from State and local officials from the affected area; Federal health, homeland security, intelligence, meteorology, and law enforcement agencies; and the SNS program transportation partners who must carry out delivery.
8. SNS Delivery Goal. The SNS program delivery goal is 12 hours from notification and approval of request. Although the delivery time of SNS assets to hospitals or dispensing sites will vary from State to State and is situation dependent, it is expected that assets will be delivered to the end user within 24 hours of the approval for activation. In a mass casualty event, hospitals should plan to function with on-hand stocks and limited resupply for at least 24 hours.
9. State Roles in Distribution. It is the State's responsibility to formulate and implement a distribution and dispensing plan for SNS medical assets, including antibiotics for post-exposure prophylaxis. The resources required to implement each plan will vary by State and the organization of their SNS preparedness plan.

10. Cooperative Agreement Guidance. Sixty-two project areas receive funding to develop the necessary plans and infrastructure to receive and distribute the SNS assets. The project areas include 50 States, eight Territories, Commonwealth and Compact States, and four cities. Project areas obtain guidance from three sources:
 - a. The CDC. The CDC program announcement sets forth the broad expectations for using these funds and stresses the need for State-level infrastructure to help carry out SNS preparedness; a need to fund Regional and local SNS preparedness infrastructure development; and the need to develop these infrastructures based on CDC guidance.
 - b. SNS Program Preparedness Branch. The SNS Program Preparedness Branch offers technical assistance.
 - c. CDC Guidance Documentation. The CDC guidance document, "Receiving, Distributing, and Dispensing the Strategic National Stockpile: A Guide for Planners, Version 9" details the functions that State and local planners need to have in place in order for an affected area to effectively manage and use SNS assets in a deployment. This includes information and instructions on:
 - i. Requesting SNS assets.
 - ii. What State and local communities must do prior to arrival of the SNS.
 - iii. State and local responsibilities under C2 function.
 - iv. Receipt, storage, and staging of SNS assets.
 - v. Controlling SNS inventory.
 - v. Distributing SNS assets from staging warehouse to dispensing sites, treatment centers, or other distribution locations.
 - vi. Dispensing medications at emergency prophylaxis sites.
11. State Requirements to Request SNS Assets. The Governor of the State or his/her official designee is expected to initiate any request for Federal assets in an emergency. This request can be made to the President, to DHS (FEMA), or, in the case of requesting the SNS, to the Director of the CDC. There are no other requirements for a State to receive these assets. SNS assets can be deployed in the absence of Presidential or Public Health Emergency Declarations, and will be deployed when appropriate under the Catastrophic Incident Response Execution Schedule.
12. SNS Distribution and Dispensing Resources Available to States. States may use a variety of resources within their State to assist with the distribution and dispensing of medical assets and pharmaceuticals. These resources are not limited to State and local health professionals, law enforcement, Government workers outside of primary response agencies, and the National Guard, but can include volunteers from the community and professional organizations. The following U.S. Public Health Service (PHS) Commissioned Corps categories (and their proposed activities) are appropriate for assisting State and local personnel in the distribution of prophylaxis medications to an affected population:
 - a. General Health Educator: Assist with preparation and distribution of educational materials at distribution points.
 - b. Pharmacist: Assist with packaging/labeling of medications and distribution to affected population at community dispensing sites.
 - c. Dentist: Medical screening or counseling and assistance with dispensing of medications to affected populations.

- d. Emergency Medical Technician (EMT): Medical screening or counseling and assistance with dispensing of medications to affected populations.
 - e. General Nurse: Medical screening or counseling and assistance with distribution of medications to affected populations, including distributing SNS assets from staging warehouse to dispensing sites, treatment centers, or other distribution locations, as well as dispensing medications at emergency prophylaxis sites.
 - f. Physician Assistant: Medical screening or counseling and assistance with distribution of medications to affected populations.
 - g. Primary Care Nurse Practitioner. Supervision of Federal personnel assisting with overall medical screening and/or counseling activities and assist with distribution of medications to affected populations.
 - h. Primary Care Physician: Supervision of Federal personnel assisting with overall medical screening and/or counseling activities and assist with distribution of medications to affected populations.
- NOTE: Other PHS Commissioned Corps personnel categories may be required to assist with registration, information distribution, and other distribution site organization and support activities.

B. Department of Veterans Affairs (VA)

1. The VA maintains pharmaceutical caches at their medical centers to protect VA patients, staff, and visitors in the event of a terrorist attack. In a catastrophic incident, these caches could be employed as required to provide humanitarian medical assistance to non-veteran beneficiary populations although these caches are primarily intended to treat veterans, staff, and other victims that may present to a local VA medical center. These caches are designed to ensure short-term preservation of the VA healthcare infrastructure until other resources can be made available in the immediate area and to support the facility's involvement in the local community disaster plan. They contain limited stocks of pharmaceuticals, fluids, and other items needed for a terrorist attack. The VA pharmaceutical caches come in two different sizes. The small cache will support 1,000 casualties for 1 to 2 days while the large cache will support 2,000 casualties for 1 to 2 days. Each cache is color-coded to indicate its contents based on type of attack, with the exception of the color yellow, which indicates that the contents are supplies. Caches are available for the following incident types: Biological (B) - Blue; Chemical (C) - Green; Explosion and Burn (E) - Red; Radiological (R) - Orange; and Supplies (S) - Yellow.
2. Of the 143 current caches, 89 are large (1,500 square foot) and 54 are small (1,000 square foot) caches. All caches are on rollable carts secured by unbreakable, tamper-proof locks. The two exceptions are IV fluids, which are located on pallets in same area where the cache is stored, and all Class II and Class III items (controlled substances), which must be stored in a vault or safe in compliance with Drug Enforcement Agency (DEA) regulations. Should mobilization of the cache be necessary, operating procedures ensure that all Class II and Class III pharmaceuticals will be included with the cache.

**TAB F to Incident Annex 4
Catastrophic Incident Annex
Patient Movement**

LEAD: Department of Health

I. Mission

Coordinate the communication, transportation, and medical regulating system to evacuate seriously ill or injured patients from the disaster site to reception facilities where they may receive definitive medical care.

II. Planning Assumptions

- A. Casualties requiring medical care following a catastrophic incident are expected to present themselves or be taken to hospitals near the incident site for treatment. This includes hospitals not participating in the National Disaster Medical System (NDMS).
- B. Medical evacuation operations (through air, ground, or sea assets) that may occur in affected areas within the first 96 hours following a catastrophic incident are limited.
- C. State and/or local transportation assets, if available, will be used to transport casualties requiring medical care to the designated patient collection point before further movement to a shelter or to a hospital or other medical facility for care.
- D. There is no preferred method of patient movement. Air, ground, and rail resources will be used to support patient transportation.
- E. Periodic reports of estimated beds available in the NDMS, Department of Veterans Affairs (VA) Patient Reception Centers (PRCs), and Military Treatment Facilities (MTFs) represent the approximate definitive medical capability available to accomplish continental United States (CONUS) medical regulating and patient movement.
- F. The Department of Health and Human Services (HHS) can help identify hospitals that could potentially accept casualties.
- G. Various asset-tracking systems need to be coordinated.
- H. The Department of Defense (DoD) Global Patient Medical Regulating Center will serve as the single patient movement manager when moving patients on U.S. Transportation Command Assets or other Federal Departments' (e.g., Department of Transportation (DOT)) and Agencies' (e.g., General Services Administration (GSA)) transportation resources. Federal patient movement operations will be integrated into DoD's information technology (IT) system, TRAC2ES (U.S. Transportation Command Command and Control (C2) Evacuation System—the system of choice for casualty movement in response to a catastrophic incident) to ensure visibility of patient movement to hospital-definitive care by the Federal sector. Patients can be regulated to NDMS hospitals that have agreed to participate in NDMS.
- I. The movement of casualties on non-DoD Federal assets will require:
 - 1. Medical crews and specialists to support ambulatory and non-ambulatory patient movement.
 - 2. Patient regulating teams to enter data into TRACE2ES and associated hardware/software.
 - 3. Patient liaison teams to support patients placed in non-Federal, non-NDMS hospitals.

- J. NDMS hospitals are authorized to provide emergency care to casualties of a catastrophic mass casualty incident. If the number of casualties exceeds the available beds in NDMS hospitals, hospitals outside the NDMS system will be contacted to determine their ability to accept patients. VA PRCs and DoD MTFs are authorized to provide emergency care to casualties of a catastrophic mass casualty incident. DoD MTFs may, through local agreements and, if within the vicinity of the incident site, provide necessary assistance to save lives, prevent human suffering, or mitigate great property damage under immediate response authority without prior approval by the Secretary of Defense. Subject to ongoing DoD missions and approval by the Secretary of Defense, other MTFs may be available to assist during a domestic incident.

III. Catastrophic Incident Response Strategy

- A. FEMA will rapidly establish at least one Federal Mobilization Center (FMC), generally at military bases/airfields, near each incident site.
- B. State and local authorities will collect and transport patients to designated transportation hubs in coordination with FMCs for outbound and inbound patient movement operations.
- C. A Medical Inter-Agency Coordination Group (MIACG), consisting of representatives from DHS, HHS, DoD, and the VA will convene and assess national capabilities, including those of the NDMS, to accept casualties into definitive, hospital-based care.
- D. Patient care services at non-incident locations will generally be used only by specific affected metropolitan areas. Destination facilities identified as being used by one affected metropolitan area will not generally be considered for use by any other affected metropolitan area.
- E. Patients will generally not be transported to facilities located near threatened metropolitan areas.
- F. DoD's U.S. Transportation Command (TRANSCOM) will coordinate the movement of casualties/patients from patient collection points, such as Mobilization Centers, to airfields or other transporting sites, to hospitals for definitive care. This will be accomplished through DOT, GSA, and available DoD transportation assets (aircraft, rail, bus, ship), to NDMS hospitals. All Federal missions will be entered into DoD's TRAC2ES IT system. Once the casualties exceeds the available capacity in non-Federal NDMS hospitals, other non-Federal hospitals may be contacted to determine their ability to accept patients. VA hospitals and DoD MTFs within the vicinity of the incident site may be able to provide support, pursuant to ongoing missions and availability of resources. Subject to the approval by the Secretary Of Defense, other MTFs may be available to assist during a domestic incident.

IV. Transportation and Logistical Requirements

- A. Available beds are beds considered vacant as of 24 hours prior to the day of the report, and patients can be immediately transported to fill them. The beds must be in a functioning medical treatment facility set up and ready for all aspects of the care of a patient. It must include supporting space, equipment, medical material, ancillary and

support services, and staff to operate under normal circumstances. Excluded are transient patient beds, bassinets, incubators, and labor and recovery beds.

- B. Throughput is defined as the maximum number of patients (stable or stabilized) by category that can be received at the airport, staged, transported, and received at the proper hospital(s) within any 24-hour period (including DoD/VA/NDMS hospitals). This is an estimate, subjectively derived from considerations that include limitations on the reception site, local transportation, and personnel.
- C. Response Limitations and Unique Concerns. The Federal sector's capability to transport non-ambulatory patients requiring medical care during transit is limited. Additionally, resources to move contaminated and/or contagious patients are extremely limited and, for planning purposes, it should be assumed that this capability does not exist within the Federal sector.

V. Agency Responsibilities

- A. Coordinating Agency: HHS. When a catastrophic incident with significant numbers of victims occurs, HHS will:
 - 1. In collaboration with FEMA, through the VA Readiness Operations Center, and the DoD Office of the Assistant Secretary of Defense for Health Affairs and Homeland Defense, alert local NDMS Federal Coordinating Centers (FCCs) to obtain bed availability reports from the participating non-Federal NDMS hospitals and report bed status to Global Patient Medical Regulating Center (GPMRC).
 - 2. Through appropriate VA and Military Services command and control systems, alert local NDMS FCCs to obtain bed availability reports from the participating hospitals and report bed status to GPMRC.
 - 3. The concept of operation is for local authorities to operate Casualty Collection Points (CCPs) that will feed into State-operated Regional Evacuation Points (REPs). ESF#8 will coordinate the hand-off of patients from the REPs into the NDMS evacuation system.
- B. Supporting Agencies
 - 1. Department of Defense. DoD will provide health and medical services support as outlined in the NRP Public Health and Medical Services Annex (ESF#8).
 - 2. Department of Veterans Affairs. The VA is responsible for supporting in-hospital patient care services.

**TAB G to Incident Annex 4
Catastrophic Incident Annex
Mass Casualty and Fatality**

LEAD: Department of Health

- I. Mission

- II. Planning Assumptions
 - A. A catastrophic incident that produces mass fatalities will place extraordinary demands (including tremendous religious, cultural, and emotional burdens) on local jurisdictions and the families of victims. Accordingly, after a disaster, the timely, safe, and respectful disposition of the deceased is an essential component of an effective response. Accurate, sensitive, and timely public relations are crucial to this effort. A catastrophic incident involving mass fatalities will require Federal assistance to transport, recover, identify, process, and store deceased victims and support final disposition and Personal Effects (PE) processing. The actual work of search and recovery, identifying, and processing the victims can be lengthy and painstaking work, often complicated by the desires of families and the needs of investigative agencies. Most local jurisdictions are not equipped to handle a mass fatality event and will experience profound difficulties managing the disaster.

 - B. During a mass fatality incident, local jurisdictions will lack sufficient personnel, equipment, and storage capacity to handle significant numbers of deceased victims especially if remains are contaminated. Assistance from Federal, public, and private agencies will be required to assist in the, search and recovery, transportation, tracking, removal, processing, identification, PPE selection, and final disposition of victims and remains. Advanced methods of identification, to include but not limited to DNA typing and information management will be essential to effectively support mass fatality disasters.

 - C. In the event of a mass casualty event, mutual aid resources and Federal assets will be needed to support local medical examiner/coroner activities, as well as to coordinate public and private assistance to grieving families.

 - D. The mission of mass fatality management is to:
 1. Recover, transport, appropriately process, and protect all human remains;
 2. Establish victim identities and causes of death; preserve all property found on or adjacent to the bodies; and maintain legal evidence for criminal or civil court action.
 3. Determine identification of the victims, determine the cause of death and release remains promptly to the next of kin if possible.
 4. Prevent further risk to the health of the living for the sake of the dead (this includes staff and those coming to assist).
 5. Provide respect for those who have died and show compassion for their loved ones.
 6. Provide social and psychological assistance for family members and mortuary affairs

7. Assist in the pursuit of justice for the perpetrators.
- E. Catastrophic mass fatalities will present unique logistical challenges with cold storage space, human remains pouches, PPE, and related supplies..
- F. If the deceased have been contaminated with chemical, biological, radiological, and/or nuclear agents, mortuary personnel will need to use special precautions and PPE to protect themselves and to prevent cross-contamination.
- G. Stacking or piling of remains can cause unnatural bruising, discoloration and disfiguring of the remains and also slows down the cooling process, thereby increasing decomposition. Accordingly, the ability of the Federal Government to quickly secure long-term refrigerated storage will enable medical examiners/coroners time to identify, process, and “hold” remains until final disposition.
- H. Basic to a mass fatality response will be the identification and selection of a number of Casualty Collection Points (CCPs), using a combination of refrigerated trucks, portable preparation and storage sites (generally tents), the use of existing facilities such as vacant or unused National Guard/Reserve facilities, Department of Veterans Affairs (VA) facilities, and/or abandoned or under-used and convenient community structures. Collection sites will present significant challenges regarding access, traffic control, security, access to power, loading docks, air quality (related to diesel engines), and processes to handle the waste, affluent, and or contamination.
- I. Local medical examiners/coroners, State funeral associations, State and local emergency management agencies, local and interstate mutual aid, NGOs, local hospitals and hospitals councils, the ARC, FEMA, and DMORTs will immediately and actively respond to a mass fatality event. Additional Federal support will be coordinated in accordance with NRP and NIMS protocols, and may include support from the DoD, DOT, and the VA.

III. Catastrophic Incident Response Strategy

A. Response Strategy: IMMEDIATE.

NDMS DMORT and DMAT assets will commence activation and deployment actions in accordance with the Catastrophic Incident Response Execution Schedule (Annex 1). Based on subsequent situational assessment information and the judgment of local medical examiners/coroners, ESF#8 will:

1. Deploy additional DMORTs, DMATs, portable morgues, and such rental units that may be available.
2. Locate and establish reception and cold storage sites for human remains. Cold storage sites should be able to maintain a constant temperature of 37o F, and would include warehouses (or similar structures), aircraft hangars, and tents.
3. Secure human remains retrieval (search and recovery) staffing from US&R Teams, National Guard (Secretary of Defense approval is not required if deployed in State Active Duty status), Reserve elements (Secretary of Defense approval is required), ARC, and available volunteers from participating NGOs supporting various Federal, State, and local mutual aid resources.

4. Secure as many as 3,000 refrigerated trucks to both transport and (if necessary) store human remains. Utilizing trucks for storage creates additional potentially problematic logistics requirements (fuel, parking, maintenance personnel), so should be considered a last resort.
5. Provide information technology (IT)/DNA-typing support unit(s).
6. Establish a transportation coordination and development unit to address logistical issues and transportation requirements of human remains to and from local hospitals, reception sites, medical examiner/coroner offices, and local funeral parlors.
7. Provide, with support from NGOs, mental health and counseling services for families of victims.
8. Assign human remains retrieval (search and recovery) teams to the larger reception sites.
9. Establish an Emergency Family Assistance Center (EFAC) for immediate crisis intervention and sustained support to victims' families.
10. Deploy personnel qualified in critical incident stress management and crisis intervention strategies to sustain first responders engaged in fatality management operations.

B. Response Strategy: FIRST 10 DAYS.

During this period, decisions will be made regarding mass disposition strategies, storage, and processing at the reception sites and follow-on deployment of national DMORT assets. State and local emergency management agencies will quickly experience staffing/resource limitations as local funeral directors, the National Guard, and contractors begin exhausting existing inventories. Accordingly, the Federal Government will approach a variety of Federal, State, and local governmental—as well as private—entities to assist in the provision of additional personnel and equipment to search for, retrieve, transport, identify, categorize, and otherwise process potentially tens of thousands of human remains. Staffing and equipment augmentation will be sought from the following organizations:

1. Federal DMORTs
2. National US&R Teams
3. State Funeral Director's Associations
4. Local and Federally recognized mutual aid providers
5. National Guard
6. DoD
7. VA
8. DOT
9. Fully qualified mortuary affairs/emergency services contractors.
10. Local, State, and Federal resources for establishing and operating EFACs in conjunction with fatality management operations. EFAC services will include, but are not limited to: DNA collection, information updates on recovery operations, casualty assistance, death notifications to next of kin, reunification of family members, grief counseling, spiritual care, and memorial observances.

B. Response Strategy: SUSTAINED.

From Day 10 until the last victim has either been the subject of mass disposition or released by the local medical examiner/coroner to a local funeral parlor, the emphasis will shift from the location and retrieval of the remains to full functioning (staffing,

securing, and equipping) of the reception sites. FCCs will continue to work with the local medical examiner/coroner offices and State and local emergency management agencies, though restocking and rotation of personnel will continue to be heavily weighted as Federal assignments.

IV. Transportation and Logistical Requirements

- A. For the first 10 days following a catastrophic incident, the location, retrieval, transportation, identification, and processing of human remains will be the initial focus of mass fatality response efforts. Depending on the characteristics of the situation, mass disposition may be implemented. DMORTs are expected to play a major role in support of these initial response activities, to include acquiring several thousand refrigerator trucks, staffing massive human remains transportation initiatives, and securing tens of thousands of disaster pouches.
- B. During Days 10 to 20 the focus of mass fatality response efforts will broaden to include the staffing and equipping of 50 reception sites and the establishment of a transportation rotation between the various sites involved with processing and storing remains.
- C. From Day 20 forward, the response will focus on completing the staffing and equipping of reception sites and ensuring the proper disposition of all remains.
- D. Mass fatality-related transportation and logistics requirements may include:
 - 1. Deployment of additional DMORTs and two DPMUs and related assets, including portable morgues and associated equipment.
 - 2. Deployment of pathologists, funeral directors, and additional mortuary support
 - 3. Refrigerated trucks for transportation and (if necessary) storage of human remains. Includes personnel to load, drive, repair, and secure the trucks at reception sites.
 - 4. Disaster pouches for human remains.
 - 5. Reception sites with appropriate security, privacy, loading docks, power outlets, and dormitory facilities (for up to 5,000 personnel, based on a 12-hour shift schedule).
 - 6. Technical Information Specialists.
 - 7. Qualified personnel to augment DMORT DNA-typing resources.
 - 8. U.S. Public Health Service (PHS) Commissioned Corps personnel.
- E. Limitations
 - 1. All potential or requested assets and resources may not be available to respond to a catastrophic incident due to competing requirements at their home institutions (e.g., DOD assets may not be available due to primary mission priorities), because of family concerns at home, and/or competition with assets required for those still living.
 - 2. Logistics systems may be overwhelmed and unable to move, in a timely manner, the required volume of personnel, victims, and equipment.
 - 3. Protocols for processing (movement and identification) biologically and/or chemically contaminated remains.
 - 4. Lack of standards for decontaminated remains.
 - 5. Storage area where remains can be processed for family members to help identify the remains. Could be a large permanent structure; but would require refrigeration. Contracted refrigeration vans would suffice.

6. Storage area needed for personal effects; local procedures for inventorying personal effects may be incorporated into Federal inventory procedures.
7. Supplies and equipment (e.g., pouches and litters) may be needed for large numbers of deceased. In addition, limitations may include materials to build shelving units for cold storage, the equipment and technology to contain and remove contamination, and the expertise to establish a large cemetery facility for contaminated remains.
8. With very few exceptions, medical examiners and coroners do not have either the training or equipment to deal with contaminated remains.
9. Funeral home personnel and morticians often lack basic CBRN familiarization training, and are unfamiliar with the necessary precautions and requirements for dealing with contaminated or infected patients. As a result, funeral home personnel may not accept remains, creating a backlog of remains waiting final disposition.
10. A lack of dedicated remains retrieval (search and recovery) teams.
11. First responders are typically not trained in remains retrieval, and may not be available in a timely manner to assist in such operations.

V. Agency Responsibilities

- A. Coordinating Agency: HHS. As coordinating agency for ESF#8, HHS provides leadership in directing, coordinating, and integrating overall Federal efforts to provide mortuary assistance, equipment, and supplies in support of the incident response.
- B. Support Agencies
 1. U.S. Department of Homeland Security. DHS assists, principally through the NDMS, in providing victim identification and mortuary services (including DMORTs); temporary morgues; forensic dental and/or forensic pathology/anthropology; and support for processing, preparation, and disposition of remains.
 2. Department of Defense. DoD provides assistance in managing human remains, including victim identification and disposition. All DoD assets require approval by the Secretary of Defense.
 3. American Red Cross. ARC provides support counseling for family members of victims and provides personnel, if available, to assist with administrative duties for morgue operations.
- C. Inventory of Federal Capabilities
 1. Disaster Mortuary Operational Response Teams (DMORTs). There are currently 10 DMORTs; each comprised of funeral directors, medical examiners, coroners, forensic pathologists, forensic anthropologists, medical records technicians and transcribers, fingerprint specialists, forensic odontologists, dental assistants, x-ray technicians, computer professionals, administrative support staff, and security and investigative personnel. During an emergency response, DMORTs - working within the incident command and management structure established by local authorities - provide technical assistance and personnel to recover, identify, and process deceased victims.
 - a. DMORT capabilities include:
 - i. Temporary morgue facilities
 - ii. Victim identification

- iii. Forensic dental pathology
- iv. Forensic anthropology methods
- v. Processing, preparation, and disposition of remains
- b. DMORT support to the local Coroner/Medical Examiner includes:
 - i. Augmenting existing local resources.
 - ii. Providing specialized personnel.
 - iii. Providing mobile morgue facility(ies).
 - iv. Providing computer-based tools.
 - v. Providing family support.
- c. DMORT members are required to maintain appropriate certifications and licensure within their discipline. When members are activated, licensure and certification is recognized by all States.
- d. DMORTs work under the guidance of local authorities by providing technical assistance and personnel to recover, identify, and process deceased victims.
- e. In support of the DMORT program, FEMA maintains two Disaster Portable Morgue Units (DPMUs) at FEMA Logistics Centers; one in Rockville, MD, and the other in San Jose, CA. The DPMU contains a complete morgue with designated workstations for each processing element and prepackaged equipment and supplies. The DPMU core team travels with this equipment to assist in the set up, operation, packing and restocking of all DPMU equipment.
 - i. The DPMU requires a location that is completely secure and convenient to the incident scene, with easy access for vehicles.
 - ii. The DPMU requires 8,000 square feet of operating area, with ventilation, hot and cold water, adequate drainage, nonporous floors, some office space, rest and refreshment areas, and restrooms.
 - iii. Other support equipment required for mass fatality management operations includes refrigerated trucks, forklifts, fuel (diesel, propane etc.), and communications with the incident command post.
- f. The Family Assistance Act of 1996 created the Family Affairs Division within the National Transportation Safety Board (NTSB), and made them responsible (for major transportation accidents) to assist the local authorities in the coordination of victim identification and family assistance. The NTSB has agreements with FEMA and other national entities to assist them in fulfilling their duties under this law. An agreement between the NTSB and USPHS gives the NTSB the ability to request DMORT support for all transportation accidents involving multiple deaths.
- g. DMORTS do not perform search and recovery. Separate arrangements will be required to support search and recovery, to include transportation from the incident site to the DMORT facility.
- h. There is a single WMD DMORT. In addition to standard DMORT capabilities, WMD DMORT personnel are:
 - i. Able to respond and decontaminate human remains without the aid of a NMRT.Level A.

- ii. Trained to work in a hazardous environment using PPE, up to and including
- ii. All volunteers, due to the hazardous nature of the assignment.

2. DoD Mortuary Services

- a. DoD Mortuary Affairs Units can provide the following support to domestic catastrophic incident response and recovery operations, when authorized by the Secretary of Defense.
 - i. Search for remains. Setting up appropriate search methodology and preparing the necessary documentation for later research or use.
 - ii. Recover remains. Use any means available to recover all remains and portions of
 - iii. Provide tentative remains identification assistance to the local Medical Examiner or Coroner. (NOTE: The local Medical Examiner or Coroner is the office that provides positive identification of remains. DoD can only assist in this process).
 - iv. Set up a Personal Effects (PE) depot. A PE depot is structured into four main sections: receiving, administration, processing, and shipping. The primary functions for these sections are as follows.
 - Receiving Section: receive, account for, and store all PE.
 - Administrative Section: prepare and maintain all required reports and case files, and provide administrative assistance to the civilian mortuary affairs community.
 - Processing Section: Screen, clean, inventory, and package PE.
 - Shipping Section: Initiate required shipping documents, coordinate for transportation, and prepare packages for shipment.
 - v. Evacuate remains to a collection point. Evacuate remains, portions, and PE from the recovery site to a mortuary affairs facility. Transport remains in the most expedient manner to prevent the loss of identification media due to decomposition of remains. Operational requirements may dictate the use of all available covered transportation assets. However, use of medical and food-bearing vehicles is not encouraged.
 - vi. Perform DNA testing through the Armed Forces Medical Examiners Office to assist civilian authorities with positive identification. During mass-fatality incidents, the Dover Air Force Base (Delaware) military port mortuary can be activated to process remains. This processing can include autopsy and/or medical examination when supported by the Armed Forces Medical Examiners Office. Both the Armed Forces Medical Examiners Office and FBI also provide support for identification of remains, as required. The activation and use of Air Force Port Mortuary(s) is an option available to civilian authorities. Following a CBRNE mass casualty/fatality incident, which may occur without warning and is expected to produce considerable confusion and demand for personnel, there is likely to be insufficient personnel to handle the sensitive tasks of caring for the dead. Federal, State, and local governments may request DoD assistance in a mass fatality incident that does not involve mass military fatalities.

- b. Mortuary affairs facilities include collection points, military mortuaries, and interment sites, and can provide the following support:
 - a. Collection, inventory, storage, and processing of personal effects of deceased and missing personnel.
 - b. Operation of permanent port-of-entry mortuary facilities in the continental US for the preparation of remains and coordination of final disposition.
 - c. Preparation and coordination of shipment of remains for final disposition.
 - d. Response to mass-fatality incidents.
- c. DoD maintains the capability to provide technical assistance to civilian agencies. This technical assistance will be provided when requested by the appropriate civil authority.
- d. DoD has the capability to establish and operate a Mortuary Affairs Decontamination Collection Point (MADCP). The handling of contaminated remains at a MADCP is a three-phased process, as follows:
 - a. Recovery from the place of death to a MADCP, where decontamination and field verification occur.
 - b. Movement to a Quality Control Station, where a second verification check is made using specialized monitoring equipment.
 - c. Positive verification of decontamination is made prior to shipment of remains to a mortuary.
- e. Handling or working around decomposing remains requires strict enforcement of health and sanitation procedures. The potential for infection and the spread of contagious disease within such an environment is high; therefore, personnel should always be conscious of sanitation hazards, and keep themselves and their work areas clean. DoD Mortuary Affairs units can assist civil authorities with proper control point set-up.

**TAB H to Incident Annex 4
Catastrophic Incident Annex
Housing**

LEAD: Agency of Commerce & Community Development

I. Mission

This appendix outlines interim and long-term catastrophic incident housing requirements and strategy, using current capabilities.

II. Planning Assumptions

- A. A large number of people are homeless. Primary dwellings are destroyed, heavily damaged, unlivable, and/or inaccessible.
- B. There will be significant disruption of infrastructure that impacts residential area and endangers public health and safety.
- C. The ability to reenter and reoccupy primary dwellings will be dependent upon the incident hazard, event, and geography.
- D. Existing emergency shelter and temporary housing resources will not be sufficient to address the numbers of individuals in need.
- E. The Emergency Management Assistance Compact (EMAC) will be activated and neighboring States will be accepting disaster victims.
- F. There will be significant public health, law enforcement, and transportation issues.
- G. This housing strategy will be implemented in cooperation with the affected State, Tribal, and/or local governments(s).
- H. There will be other disaster events such as floods, tornadoes, or hurricanes elsewhere in the country during this response and recovery operation.
- I. Federal and voluntary agencies will be available under the NRP for primary and support functions.
- J. There will be significant impediments to the process of registering recipients for Federal assistance. Registration is necessary to provide continued assistance as victims become dispersed, to reunite families, and ensure program accountability. Using the standard teleregistration and inspection process will not be feasible in all areas. The field registration intake process will be concentrated in or near emergency shelters. Registrations will be taken in the field by caseworkers.
- K. Current means of disbursing and delivering disaster assistance will be inadequate to overcome disaster-related disruptions in banking and/or mail delivery services.

- L. Individuals will not have access to their homes, jobs, schools, stores, pharmacies, etc. There will be a lack of health and medical care, sanitation and hygiene, and food and water.
- M. There will be a lack of health and medical care, sanitation and hygiene, and food and water.
- N. Most individuals and families will be able to find shelter or temporary housing that is preferable to congregate shelters if they are given the financial means. This will require providing the victims money and, in some cases, transportation. Individuals and families will occupy individual dwellings such as apartments, hotels, motels, manufactured housing, or tents whenever possible.
- O. Normal methods of information dissemination will be significantly impaired due to the disruption of utility services.
- P. Management of the influx of incoming workers (e.g., Federal, State, and local response staff; insurance adjusters; and unsolicited volunteers and construction companies) is essential to prevent a second housing disaster from occurring. Planning for housing of these individuals is not included in this appendix.
- Q. Elevation of the Homeland Security Advisory System (HSAS) will impact transportation alternatives for victims seeking shelter or being transferred from shelters to temporary housing.

III. Catastrophic Incident Response Strategy

The core strategy for housing will be to provide people the financial and other assistance to move out of emergency shelters and into temporary and/or long-term housing as rapidly as possible. This will include encouraging people to temporarily leave the disaster area until local temporary housing becomes available.

A. Response Strategy: IMMEDIATE

1. In coordination with voluntary agencies, identify traditional and non-traditional shelter resources within the immediate vicinity of the impact area.
2. Identify traditional and non-traditional shelter resources within 250 miles of the impact area to shelter victims and recovery personnel.
3. Identify available housing resources within a 100-mile radius of the impact area, including potential sites for manufactured housing.
4. Deploy housing component of the Emergency Response Team to the area to establish an initial operating capability.
5. Activate contract employees to begin processing applications for disaster assistance and conducting residential damage inspections.
6. Disseminate public messages informing victims of what to do and the kind of disaster assistance to expect and the timeframes for delivery of services. Encourage people to temporarily relocate to outside the disaster area.
7. Initiate planning activities with Red Cross and DOT in order to relocate people out of shelters as quickly as possible.

B. Response Strategy: FIRST 10 DAYS.

1. Receive individuals and families into emergency shelters. Rapidly convert existing, structurally sound, accessible buildings for use as emergency shelters for meeting basic human needs. Structures in this category include commercially owned warehouses, manufacturing plants, vacant Federal facilities, stadiums, convention centers, and shopping malls.
2. Identify registration intake and damage inspection strategy.
3. Identify strategy for disbursing and delivering disaster assistance payments to displaced populations.
4. Consider private site use of tents and the use of larger tent cities (and prefabricated units) to house portions of the affected population.
5. Register individuals and families and conduct pre-placement interviews (PPIs).
6. Determine need and capabilities for expediting, postponing, or waiving residential damage inspections.
7. Identify housing resources within the disaster area and neighboring States.
8. Identify existing vacant manufactured housing sites (trailer parks) within 100 miles of the impact area.
9. Establish contracts with existing trailer parks and receive and position manufactured housing units there.
10. Identify undeveloped sites for manufactured housing units within 100 miles of the impact area.
11. Establish housing plan.
12. Establish and staff Disaster Recovery Centers (DRCs) in or near emergency shelters.
13. Disburse appropriate financial and other assistance to victims who want to temporarily leave the disaster area.
14. Refer individuals to available temporary housing such as apartments, hotels, motels, and manufactured housing, and provide them with appropriate financial and other assistance.
15. Deploy inspection and repair teams to identify and repair homes with minimal damage.
16. Identify neighborhoods with light damage that can be reoccupied if provided with water and sanitation services (e.g., portable toilets).
17. Deploy water and sanitation services to neighborhoods. (Mission would be tasked to the USACE by FEMA.)
18. Assemble ESF#14 to implement long-term recovery planning process.
19. Identify resources for the transport and relocation of individuals and families from shelters to temporary housing in areas of their choosing within 30 to 45 days.
20. Implement staff rotation plans for existing shelters.

C. Response Strategy: SUSTAINED

1. Integrate hardcopy registrations into the National Emergency Management Information System (NEMIS).
2. Continue to identify available housing.
3. Implement FEMA temporary housing strategy.
4. Continue to disburse financial and other assistance to victims and refer victims to temporary housing.
5. Continue repair of minimally damaged housing.
6. Coordinate procurement and delivery of temporary housing units.
7. Continue set up of manufactured housing and temporary shelter sites.
8. Place individuals and families in Federal or privately owned temporary housing.

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9. ESF#14 coordinates long-term recovery strategy.
10. Convert and remodel available, structurally sound buildings to make the structures suitable for longer term interim housing.
11. Remove debris and remediate sites as appropriate to allow for reoccupation and/or the building of temporary and permanent structures.

IV. Transportation and Logistical Requirements

- A. Victims from assembly points to emergency shelters.
- B. Recovery workers in and to the disaster area.
- C. Delivery of supplies to the DRCs.
- D. Delivery of housing units to the housing sites.
- E. Victims from shelters to temporary housing.
- F. Response Limitations and Unique Concerns:
 1. Individual assistance caseworkers and other trained staff.
 2. Existing shelter sites.
 3. Trained housing inspectors.
 4. Public/private partnerships.

V. Capabilities/Responsibilities

A. Federal Organic Capabilities:

1. Staff from:
 - a. FEMA National Processing Service Centers (trained).
 - b. Internal Revenue Service (IRS) (trained and not trained).
 - c. FEMA Headquarters (HQ) and Regions (trained and not trained).
 - d. Other Federal Agencies (not trained).
2. Materials:
 - a. DRC Go Kits from Logistics warehouses.
 - b. Temporary Housing Units stock and tent stock.
 - c. Federally owned housing (U.S. Department of Agriculture (USDA), Department of Housing and Urban Development (HUD), Department of the Interior (DOI), Department of Defense (DoD)).

B. Federal Non-Organic Capabilities:

1. Staff from:
 - a. FEMA inspections services contract.
 - b. USACE inspection, engineering, and construction contracts.
 - c. Federal local hires.
2. Materials:
 - a. Temporary Housing Units procurement contracts.
 - b. Temporary Housing Units hauling and installing contracts.
 - c. Standby disaster procurement contracts.

C. Coordinating Agency: DHS/FEMA

D. Support: ARC, DoD, Department of Labor (DOL), DOT, HHS, HUD, Small Business Administration (SBA), USACE, USDA, U.S. Postal Service (USPS), VA, and the Private Sector.

**TAB I to Incident Annex 4
Catastrophic Incident Annex
Public Information and Incident Communications**

LEAD: Department of Public Safety

I. Mission

This appendix outlines how information will be communicated to the public in support of a catastrophic incident response effort.

Interagency Coordination

The NRP Incident Communications Emergency Policy and Procedures (ICEPP) is the primary incident communications plan for use by the Federal interagency. It is used in conjunction with State and local authorities to manage incident communications and Public Affairs activities during domestic incidents. The NRP-ICEPP incorporates specific incident communications guidance on operations in support of WMD or catastrophic incident scenarios. This appendix will be used in conjunction with the NRP-ICEPP during such incidents. It provides detailed information on Departmental and Agency incident communications resources to support response contingency plans.

Each Department or Agency has respective emergency plans that are implemented as appropriate subject to respective missions, the nature of the incident, and tasks. These authorities support the NRP-ICEPP through implementation of their respective plans. These actions are incorporated in the overall interagency planning effort that is developed in the first hours of the incident. This effort uses the incident communications processes of control, coordination, and communications to unify and synchronize the interagency effort.

II. Planning Assumptions

A. National Incident Communications Planning Assumptions

1. Primary Communications Objectives. In all catastrophic and WMD incidents, direct communication from the Federal Government to the public will focus on lifesaving and life-sustaining information.
2. National Reassurance Objective. In all catastrophic and WMD incidents, reassuring and informing the public in areas not affected by the incident is critically important to the stability of communities and security of our population. Updated or available preparedness information must be reemphasized and aggressively pointed out to the non-affected public. Progress reports on the incident and the Government recovery plan must be provided to the public. Reassuring and informing the non-affected population is critical to the overall success of the recovery effort.
3. Pre-Incident Education. In all catastrophic and WMD incidents, public responsiveness will be significantly enhanced through increased pre-incident awareness of basic preparedness and response measures. Resources such as Ready.gov, media threat education, and pre-developed fact sheets all increase the ability of our citizens to better cope with or understand the nature of a threat and incident.
4. Scientific Support. In all catastrophic and WMD incidents, immediate and follow-on scientific support for Public Affairs and the public messaging effort is critical to

saving lives, mass movement of people, and emotional stability of our citizens in affected and non-affected areas. Public information must be correct and consistent with scientific recommendations.

5. **Panic and Rumors.** In all catastrophic and WMD incidents, it is possible that panic and rumors about an incident will occur and spread to non-affected areas of the Nation. The national incident communications effort must anticipate this possibility and ensure that measures are incorporated to mitigate or inhibit the spread of false information. Consistency among Federal, State, and local authorities in providing incident information beginning in the initial moments following the report of an incident is critical, as well as demonstrating that authorities do have plans and are working hard to implement them.
6. **Communications Infrastructure.** In all catastrophic and WMD incidents, the capability to immediately and effectively communicate to the population in affected or damaged regions may be destroyed or severely degraded. Rapid employment of the Emergency Alert System (EAS), National Oceanic and Atmospheric Administration (NOAA) Weather Radio, maximum use of battery-powered radios, non-traditional measures (two-way radios, HAM radios, etc.), and other alternatives will be essential to communicating our messages until power and normal utilities are restored. The ability of the Joint Information System (JIS)/Joint Information Center (JIC) to coordinate and communicate may be significantly limited or precluded. In situations with severe loss of utilities, a battery-powered radio kept by citizens provides a very effective means to receive timely public instructions and incident information.
7. **Control, Coordination, and Communication.** A catastrophic mass casualty/mass evacuation incident resulting from an act of terrorism may cause significant public concern, both in the incident area and nationally. State and local authorities will retain the lead responsibility for communicating positive, continuous, consistent, and timely public information and guidance to the affected population and those citizens potentially at risk. Federal, State, and local authorities must synchronize their efforts from the outset of an incident to reduce the development and spread of panic and rumors. The Federal Government will immediately coordinate with and support State and local public information efforts in the affected areas to ensure that communications at all levels are synchronized and consistent. The Federal Government will coordinate with other non-affected States and authorities to reassure citizens, and disseminate preparedness guidance and protective measures.

B. Federal Interagency Planning Assumptions

1. **Department of Veterans Affairs (VA)**
 - a. VA resources are distributed Nationwide and located in, or close to, major population centers. It may be assumed that should such an incident occur near a VA medical center without damaging or seriously diminishing its operational capacity, the facility will be a key asset in providing medical support and expertise to State and local emergency response agencies. This is in addition to maintaining all basic services to its constituent veteran population.
 - b. Because VA facilities are organized into Regional networks, personnel and material to support incident response activities would be directed through the network offices.
 - c. Public Affairs Officers (PAOs), many of whom serve in an additional duty status, are located throughout the VA's national networks in each of its three

administrations. In some cases these individuals provide support in overlapping geographic areas.

2. Department of Health and Human Services (HHS)
 - a. Ensuring that accurate medical and public health information and guidance is provided is of immediate paramount importance to protect and save lives of those who may be affected by the incident. This should be a top priority of Federal-wide incident communications.
 - b. HHS Public Affairs staff could be dispersed at the time of an event or could be directly affected by the event. HHS communication plans include the use of Public Affairs staff at its agencies in locations that would be unaffected directly.
 - c. HHS would rely on its family of agencies, in particular the CDC, to assist in public information activities and to provide subject matter expertise in all communications activities.
3. U.S. Department of Agriculture (USDA)
 - a. The safety of food and livestock may be jeopardized during an event.
 - b. Public information about the safety of the food supply should be a top priority.
4. Environmental Protection Agency (EPA)
 - a. Will provide support in accordance with the National Response Plan (NRP).
 - b. EPA Public Affairs will use its Crisis Communications Plan.
5. Department of Transportation (DOT)
 - a. Large numbers of people may be casualties. These could include Departmental Public Affairs staff and news media representatives.
 - b. When the incident occurs, offices will be evacuated and staff dispersed. If it occurs after working hours or on a weekend or holiday, staff will be dispersed.
 - c. Public Affairs staff and leadership will be unable to access normal logistical support, such as the Department's information technology (IT) and local area network (LAN). Computer networks and even personal computers will shut down.
 - d. Transportation in the area will stop. Roads will be jammed by people leaving the metropolitan area. In certain cases, cars, trucks, buses, subways, trains, aircraft, etc., will not operate because of electronic interference from the attack.
 - e. Demand for information about transportation facilities, roads, bridges, airports, etc., from news sources outside Washington, DC, will be great. New York, Chicago, Los Angeles, or other metropolitan areas will become news central.
6. American Red Cross (ARC)
 - a. The Public Affairs staff of the ARC will initiate communication strategies that support the response activities of the Red Cross.
 - b. The ARC will also mobilize its resources and capacities in coordination with Federal, State, and local governments, partner agencies, and other non-Governmental organizations (NGOs) to disseminate preparedness, safety, security, and calming messages to the affected communities and the general public.

III. Catastrophic Incident Response Strategy

The Federal interagency Public Affairs effort is detailed in the NRP-ICEPP. It is integrated with the NRP, NIMS, and IIMG Standard Operating Procedure (SOP). Incident communications is the primary Public Affairs concept of operations used by DHS to manage domestic incidents. This concept incorporates the following key processes and is used to immediately coordinate and execute an integrated interagency, State, and local incident communications plan.

- Control. What are the lead Departments and Agencies, authority, and authorities for release? Key non-Federal players?
- Coordination. How will the communications strategy be developed, coordinated, executed, and through what plans and protocols?
- Communication. What is known? What are the health risk concerns, preparedness advice, warning issues, incident information, information flow, message, and audience? Who will deliver, them? When? How? Where?

Execution. DHS Public Affairs will respond to and support the HSOC and IIMG as they coordinate the Nation's management of a domestic incident. To this end, DHS Public Affairs executes the following steps and measures:

1. Response Strategy: FIRST 10 TO 60 MINUTES.
 - a. HSOC notified of an incident.
 - b. HSOC initiates procedures for a nuclear/radiological/biological incident.
 - c. HSOC notifications to key DHS leadership.
 - d. DHS Public Affairs activates the supporting Incident Communications Emergency Plan (ICEP) of the NRP-ICEPP. This mobilizes the DHS Public Affairs response structure and provides staff support to the IIMG.
 - e. DHS Public Affairs initiates communications with the following:
 - i. White House Office of Communications.
 - ii. FBI
 - iii. Senior DHS IIMG/HSOC leadership.
 - iv. Incident site (including State/local) Public Affairs leadership.
 - v. Federal interagency Public Affairs team (via NICCL).
 - f. DHS Public Affairs requires immediate scientific support as facts and statements are collected and prepared for release. Nuclear and biological scientific and trend information is extremely critical to the development and deployment of an accurate and timely message to the public.
 - g. NRP-ICEPP execution follows with DHS Secretary public announcement within 1 hour, subject to known facts, security, and confirmation of threat.
 - h. Immediate health and safety advisories from DHS (with interagency concurrence) or State and local authorities may precede the announcement. This health and safety advisory may be the first announcement by Federal, State, or local authorities. Consideration should be given towards a basic statement of the best precaution or

protective measure until more refined information can be obtained, evaluated, and provided to the public. Specific examples could include:

- i. Immediate sheltering in place.
 - ii. Immediate evacuation or avoidance of a specific area (e.g., fallout).
 - iii. Basic facts (e.g., an anthrax attack has occurred, a nuclear blast, etc.).
- i. Splash Web page (a Web page that can be immediately created with emergency updates), posted on Ready.gov with basic precautionary guidance. DHS Web site also updated with the same information, which must be coordinated through the Interagency Incident Communications Team to ensure that other Cabinet and Agency Web pages post or contain the same emergency information and guidance.
 - j. NICCL brings key Federal interagency incident communications team together to develop coordinated communications plan and unified message. Key issues addressed include:
 - i. Incident situation.
 - ii. Control, leads, and authority for release.
 - iii. Coordination, plans in use, and key team for incident management.
 - iv. Communications, facts, information already released or known, plans for next official statements, and health or safety advisories.
 - v. Who will make the first releases and coordinate with State and local including synchronization of releases and role of spokespersons.
 - vi. Key Point: DHS takes national leadership role; State and local take lead for on-scene medical and messaging, if feasible.
 - k. First release by the DHS Secretary. Additional cabinet members or technical experts may accompany or support this formal announcement.

2. Response Strategy: FIRST 10 DAYS.

Sustaining messages coordinated by Federal, State, and local team: (see Note)

- a. Protection of population from fallout and contaminated areas.
- b. Evacuation guidance and support to State and local authorities.
- c. Sheltering guidance as necessary.
- d. Evacuation guidance as necessary.
- e. Medical guidance (treatment, antidotes, prophylaxis, etc.).
- f. Safety of food and water.
- g. Dangers and hazards.
- h. National situational and instructional communications to non-affected areas.
- i. Distribution of key instructions for print, Web, television, and radio programming.

NOTE: DHS will lead and coordinate the national messaging effort while the affected State and local incident communications authorities will lead and coordinate incident local public information.

3. Response Strategy: SUSTAINING ACTIONS

Sustaining actions by the Intergovernmental Incident Communications Team:

- a. JIC established to manage and coordinate incident site Public Affairs activities.
- b. DHS engages with non-affected States and initiates aggressive public preparedness and information communications effort. Emphasis on basic instructions, family plans, rationale for medical treatment, and distribution of appropriate medicines.
- c. DHS deploys PFO and supporting Public Affairs team.
- d. HHS and CDC may deploy Public Affairs teams to affected incident site to support State and local effort. Subject to incident and requests.
- e. FEMA establishes radio station to deliver incident and response activity.
- f. FEMA distributes battery-powered radios.
- g. FEMA initiates other incident site communications recovery efforts in support of normal ESF tasks.
- h. Ad Council national public service television advertisements are covering threat, public instructions, and preparedness measures.
- i. SMEs are briefed and available to support sustaining communications.

4. Department of Health and Human Services.

The HHS ASPA has developed an emergency operations plan for situations involving major public health emergencies. When HHS ASPA activates the plan, designated personnel will staff the teams as outlined in preceding paragraphs. The plan relies on the use of all HHS Public Affairs Office staff. If events continue for an extended period of time, the HHS Public Affairs Office would supplement/rotate staff from its Agency (CDC, NIH, FDA) Public Affairs Offices to prevent staff burnout.

5. U.S. Department of Agriculture.

The USDA has a “virtual war room” plan to access Public Affairs assets and resources throughout the Department and includes media response, information development, outreach, and coordination. This process will allow USDA to sustain an information center for a long period of time and was most recently used during the “mad cow disease” outbreak in 2004 in the United States. The plan includes daily briefings, regular written updates for distribution, and Web posting and recorded messages on mass casualty incident line. The USDA also has an incident command team capability through the U.S. Forest Service (USFS), which includes ground Public Affairs support functions.

6. Department of Veterans Affairs.

The VA immediate response strategy is to carry out essential communications functions in support of VA's primary mission and communicate emergency response and resource information to internal and external audiences in the affected incident area and across the VA system. Appropriate Public Affairs assets will be deployed as needed from closest available locations to assist with situational assessments and communications activities as directed by VA facility director or on-site authority. For the 10-day and sustained periods, additional resources would be deployed to the incident venue sufficient to provide necessary Public Affairs coverage and support with a 24/7 work schedule.

7. Environmental Protection Agency
 - a. Immediate. Implement the EPA Public Affairs Crisis Communications Plan; implement Public Affairs COOP Plan if needed; provide PIO to EPA EOC; support DHS ICEP including EPA staffing at a JIC.
 - b. First 10 Days. Support and follow DHS Public Affairs lead and continue to support; provide environmental and public health information to the media and public.
 - c. Sustained. Provide continued support to DHS Public Affairs.

8. Department of Transportation
 - a. Immediate. Three managers will disperse in the following manner: One with the Secretary of Transportation; another will go to another site in accordance with the COOP Plan; and the third will go to the DOT Crisis Management Center (CMC), also likely off-site. These managers will supervise and control the DOT Public Affairs response to the catastrophe.
 - b. First 10 Days. This configuration will continue for the first 10 days. Available local and, if needed, Regional Public Affairs staff will be called upon to execute the Department's response and messaging.
 - c. Sustained. Public Affairs managers, supervisors, and staff will be called to an appropriate central location where they will set up an office and function as a team.

9. American Red Cross.

ARC response actions to support first hour to sustaining actions are detailed below:

 - a. Staffing. Immediately deploy Public Affairs staff and officer to the incident site. Rapid Response Team members will also be sent to the area to provide an ARC response to national news media. Red Cross representatives will be dispatched to staff JICs and other messaging coordination centers.
 - b. Messaging. National HQ Public Affairs staff will begin collecting information and messages for dissemination. Talking points and frequently asked questions (FAQs) will be written for use by ARC

spokespersons. SMEs within the organization will be identified and recruited to speak when possible.

- c. Call Center/Hotline. Preparedness, safety, security, and calming messages and information will be provided to Call Center staff for use in responding to public inquires. When available, specific response information is also sent to the Call Center to respond to inquiries from the affected area.
- d. Internet Information. The Web team will receive information from the Public Affairs staff for posting to the public Web site. Web team members will also activate template pages of links to information pertinent to the specific emergency. Talking points and FAQs are also posted on the internal Web site for use by Red Cross State and local communicators, ensuring a coordinated message.
- e. Senior Leadership. Additional staff from the Communication and Marketing department will coordinate information, messaging, and media presence for the President/CEO of the American Red Cross, when necessary and appropriate.

IV. Transportation and Logistical Requirements

A. U.S. Department of Homeland Security

Transportation and logistical requirements will be assessed by the interagency during conference discussions and incident communications strategy planning. Additional issues are noted below:

1. Transportation. Transportation will be required to deploy the various surge personnel and response teams to the incident site or Regional area. The scope of the incident will determine this requirement. FEMA and USCG response teams have pre-established transportation plans and should be able to respond if the infrastructure has not been severely degraded.
2. Logistics. Logistics requirements will also be determined by the nature and scope of the incident and available surviving infrastructure. Logistical support and facilities for temporary Public Affairs operations may be available at Regional DHS component agency sites. This may also include afloat vessels or large aircraft that could deploy to affected areas and provide power and utilities to run incident communications recovery operations.

B. Department of Veterans Affairs.

Depending on distances to be covered, transportation for deploying or incident support Public Affairs personnel would be by personal vehicle or commercial carrier using existing Government credit cards or purchase agreements. Temporary lodging would be provided through commercial hotel facilities in or near the affected area or deployment location.

C. Environmental Protection Agency.

Transportation of EPA personnel to JIC site would be required if the catastrophic incident disrupts normal transportation. If the incident forces closing of hotels and other lodging facilities, lodging of EPA JIC staff would also be required.

- D. Department of Health and Human Services.
Upon activation of the HHS ASPA Public Affairs emergency operations plan, pre-designated HHS ASPA personnel will report to the CDC in Atlanta and also travel with the SERT to the incident jurisdiction.
- E. U.S. Department of Agriculture.
This is addressed through the USDA COOP Plan. If USDA is needed to support another agency, transportation will be required.
- F. American Red Cross.
Public Affairs staff responding to an emergency would work through existing channels and procedures within the Red Cross response plan to travel to the affected areas, and for housing need on site. In the event that common carriers are not available, the Red Cross would work with partner Government Departments and Agencies and private groups to facilitate alternate means of travel.
- G. Limitations
1. U.S. Department of Homeland Security.
DHS Public Affairs has assessed the potential limitations during a WMD or catastrophic incident. Specific limitations are contained in the initial planning assumptions in paragraph one of this appendix. Briefly, these limitations focus on the following components:
 - a. Developing the Message. The process to develop the interagency message has been refined and exercised. However, the nature of a catastrophic incident will likely inhibit or restrict the timeliness of this effort. This will be exacerbated if relocation or COOP by DHS or other Federal leadership has been initiated.
 - b. Delivering the Message. Delivering the message may be problematic for some audiences. Loss of power by the audience, the nature and threat of the incident, loss of media broadcast capabilities in and around the affected region, and other limitations will inhibit and restrict the delivery of the message. This will be more apparent in a nuclear incident where infrastructure and destruction or damage is widespread. Delivery of a message during a biological incident may be less problematic, but normal access and movement will limit communications opportunities and delivery.
 - c. Receiving the Message. The audience and the public, especially those who require evacuation or other guidance, must have the capability to receive the message. This may also be problematic if they do not have electrical power or battery-powered communications capability. These limitations and message options are addressed in the NRP-ICEPP and supporting annexes.
 - d. FEMA. The FEMA on-site Public Affairs response will be limited by how quickly teams could get to the affected area based on health and safety considerations. Other issues include:
 - i. Staffing. Considering the national and Regional teams that FEMA PAOs requires, Public Affairs leadership has few remaining incident communications resources. This will present a concern if multiple venues or incidents occur simultaneously.
 - ii. New Resources. A mobile broadcast unit would be useful for emergency broadcast capability in or near the incident locations.

2. Department of Veterans Affairs.
Given the distribution of resources across the country, it is reasonable to assume certain VA assets may be diminished or lost due to any significant manmade or natural disaster, or terrorist attack involving chemical, biological, radiological, nuclear, or high-yield explosive (CBRNE) WMD.
3. U.S. Department of Agriculture. Standby satellite facilities and time as well as communications equipment that would take precedence on airtime is always needed.
4. Department of Transportation. Transportation Public Affairs will be severely limited by the anticipated inability to communicate with both staff and news media. The demand for information about the safety and operation of transportation facilities will be great and urgent.

V. Capabilities/Responsibilities

A. Federal Public Affairs and Incident Communications Capabilities:

1. U.S. Department of Homeland Security (DHS)
 - a. Joint Information Centers (JICs). Following an incident of national significance or domestic incident, JICs are established to coordinate the Federal, State, Tribal, and local incident communications effort. A JIC is a central point for coordination of disaster information, Public Affairs activities, and media access to information about the latest developments.
 - i. National JIC. Initially, and at the national level, a virtual JIC led by DHS Public Affairs coordinates information among Federal Departments and Agencies. If necessary, a national JIC may be established at FEMA Headquarters (HQ) in Washington, DC, or another designated location. If established, Federal Departments and Agencies may be requested to provide representatives to the national JIC. A national JIC may be used when an incident of national significance is anticipated to have an extended duration (i.e., weeks or months).
 - ii. Incident JIC. The JIC is a physical location where incident communications professionals from organizations involved in the response work together to provide critical emergency information and Public Affairs response functions. The JIC serves as a focal point for the coordination and dissemination of information to the public and media concerning incident prevention, preparedness, response, recovery, and mitigation. The JIC may be established at an on-scene location in coordination with State, Tribal, and local agencies depending on the requirements of the incident. In most cases, the JIC is established at, or is virtually connected to, the JFO, under the coordination of DHS Public Affairs.
 - b. Staff Organization. DHS Public Affairs personnel are managed by the DHS Assistant Secretary for Public Affairs (ASPA). This centralized management of highly trained personnel is particularly effective during incident management situations where additional assets can be surged from one component to support another or the overall national effort. Moreover, these personnel assets are distributed around the United States and provide depth or deployable support to other locations.

- c. Staff Incident Management. During a domestic WMD or incident, DHS Public Affairs will support and manage the following elements:
 - i. Press Office. Performs primary media response and management of Departmental issues or queries, including changes to the Homeland Security Threat Status.
 - ii. Speechwriting. Performs drafting tasks in support of the Secretary DHS and other senior leadership. Prepares statements for use during major announcements.
 - iii. Interagency Incident Management Group (IIMG). DHS Public Affairs assigns a team of experienced incident management personnel to the IIMG. They coordinate and support the IIMG on Public Affairs issues and provide liaison with incident communications decision makers. They also assist in interagency coordination through the National Incident Communications Conference Line (NICCL).
 - iv. Principal Federal Official (PFO) PAO. The deploying DHS PFO(s) will be assigned a DHS Staff PAO to provide coordination between the JIC, incident site Public Affairs leadership, and PFO personal staff. The PFO PAO will stay in close consultation with the DHS Public Affairs staff while deployed for an incident.
 - v. Homeland Security Operations Center (HSOC). The DHS Public Affairs Duty Officer (PADO) will remain on watch in the HSOC and liaise with the Press Office, IIMG, and other components.
 - vi. Media Support. A media support staff assists the Press Office and interagency coordination efforts.
 - vii. Web Support. The DHS Public Affairs Web team maintains close contact with the Press Office and other key staff to ensure the Web site contains the most relevant incident information.

- 2. DHS Component Agencies.

DHS Public Affairs manages Public Affairs personnel in 22 component agencies throughout the United States. Additional specialized resources are noted below:

 - a. Federal Emergency Management Agency
 - i. Emergency Response Team (ERT). ERTs have a Public Affairs component (full-time and reserve disaster cadre).
 - ii. Mobile Emergency Response Support (MERS). The primary function of MERS is to provide mobile, self-sustaining telecommunications, logistics, operations, and administrative support required by Federal, State, and local responders in their efforts to save lives, protect property, and coordinate disaster operations. Assets include some 270 mobile units, from five detachments positioned throughout the United States that provide emergency telecommunications, logistics and operations support.
 - iii. National Emergency Response Team (ERT-N). The ERT-Ns are activated for large disasters only. When disaster hits multiple States, each State gets its own ERT (or ERT-N if needed) based on the severity and magnitude of the incident (for example, during Hurricane Isabel, only Virginia got an ERT-N; the other affected States received regular ERTs, made up mostly of Regional resources).

- iv. Community Relations (CR). The CR function provides the vital information link between FEMA, the State, local communities, and those affected by disasters. The information link is designed to ensure the citizens of disaster-affected communities are aware of available Federal disaster assistance programs and how to access them. The CR cadre includes 241 personnel who work during times of a Presidential declared disaster or emergency to provide information and assistance to disaster victims and their communities to increase understanding of disaster assistance and to increase FEMA's disaster response and recovery efforts. CR works in close coordination with Response and Recovery Divisions and the Regional Cadre Managers to ensure the CR Disaster Assistance Employees (DAEs) are trained to provide accurate and timely information to the Federal Coordinating Officer (FCO) and State Coordinating Officer (SCO), disaster victims as well as the State, local, and community leadership. CR DAEs also are trained to understand the communities and their disaster related issues. From this understanding, field reports are produced to reflect those concerns and a recommendation is produced to resolve the issue. The Federal and State Coordinating Officers and the Headquarters Cadre Manager also use these reports to ensure a clear understanding of how FEMA's disaster assistance programs assist the community analysis and victims of a disaster.
- v. Emergency Alert System (EAS). The EAS is activated for the President by FEMA and is managed in coordination with the FCC. It is also available within minutes to provide commercial broadcast resources to national, State, and local authorities in an emergency to transmit critical information to the public. The EAS is activated by the FEMA Operations Center (FOC) or the FEMA Alternate Operations Center (FAOC) to provide audio broadcasts at the direction of the President and DHS Secretary.
- vi. Broadcast Radio Teams. The Broadcast Radio Team and the Broadcast Television Team are the remote broadcast assets that FEMA deploys and is staffed by DAEs. These teams allow Federal response authorities and FEMA to set up an information broadcast in a community where normal media has been rendered incapable of broadcasting or operating.
- b. Border and Transportation Security (BTS). DHS/BTS Public Affairs retains a strong surge force of Public Affairs personnel through the many staffs and/organizations they support. This includes airports, seaports, border crossings, and other customs and immigration facilities.
- c. U.S. Coast Guard (USCG). The USCG has a similar range of Public Affairs personnel and offices arrayed around the Nation. While they are mainly located in coastal areas, they can be surged and deployed for contingency purposes to other incidents. Special response capability is provided by a Public Information Assist Team (PIAT). This is a deployable specialized Public Affairs team skilled in HAZMAT and environmental response, capable of supporting conventional, biological, and chemical incidents.

3. Department of Veterans Affairs (VA).
VA maintains a large force of field Public Affairs personnel to support the wide network of facilities around the Nation. Field PAOs are located at each VA medical center (162), Regional office (57), and cemetery (120). VA's Regional offices of Public Affairs are located in New York, Washington, DC, Atlanta, Chicago, Dallas, Denver, and Los Angeles (21), plus the VA's central office compliment of PAOs (20) brings the total to 380 people.
 - a. Field Capabilities. Each field location has, as a minimum, computer, telephone, and fax capabilities while approximately 20 VA medical centers possess some level of medical media support for documentary coverage capability.
 - b. Regional Offices. Five of the seven Regional offices of Public Affairs have digital cameras, two have 35mm cameras, and one owns a video camera.
 - c. VA Central Office. Operates a fully operational three-camera television studio with digital post-production editing capability and access to three satellite broadcast channels. A media services office provides a full range of audiovisual recording and still photography.

4. U.S. Department of Agriculture (USDA).
The USDA possesses the following Public Affairs resources:
 - a. Television and radio studio with satellite capabilities at the Washington, DC, HQ
 - b. Agency Public Information Officers (PIOs) in regions, States, and many counties.
 - c. Virtual War Room plan would be implemented to support public information efforts.
 - d. Remote computer database capability to access lists.
 - e. Food and agricultural experts in U.S. embassies.
 - f. Food and agricultural constituent outreach lists.
 - g. Webcast capabilities.

5. Department of Health and Human Services (HHS).
HHS ASPA maintains the following team structure to be ready to respond to a catastrophic incident:
 - a. HHS ASPA. Coordinates the overall HHS Public Affairs response, maintains close liaison with the Secretary, White House, DHS, CDC Director, NIH Director, Food and Drug Administration (FDA) Commissioner, Assistant Secretary for Public Health Emergency Preparedness (ASPHEP), and other principals. HHS ASPA also directs all HHS/CDC Public Affairs Team operations and meets regularly with team leaders.
 - b. Media and Message Team. This team handles media inquiries to include coordinating and fulfilling requests. The team also coordinates development of unified talking points for principals and Public Affairs staff to use when speaking to the media or in other public venues.
 - c. Materials Development and Writing Team. The team develops, writes, and produces documents necessary to communicate emergency response information. Materials include news releases, background papers, factsheets, question and answer papers, and secretarial speeches. The team maintains and ensures all information is accurate and up-to-date.

- d. Outreach Team. The team oversees outreach of communication materials and information to HHS partner organizations as well as all other interested organizations. This includes outreach to other governments, the private sector, not-for-profit organizations, minority groups, and other organizations affected by the crisis. The team will coordinate public information campaigns, public service announcements, and look for opportunities to partner with organizations to educate the public.
 - e. Go Team. The team is comprised of staff that deploy as Public Affairs representatives at various locations to assist HHS ASPA in liaison and communications activities. Upon activation, predesignated HHS ASPA personnel will report to the CDC in Atlanta, GA, the Secretary's Emergency Operations Center (EOC) and the ASPHEP. A Public Affairs representative will also travel with the Secretary's Emergency Response Team (SERT). Go Team members primary responsibilities are to prevent communications failures, misunderstandings, ensure coordination in the release of information and consult with HHS ASPA on all major media requests.
 - f. Web Team. The team oversees prompt posting of all Public Affairs materials to the HHS Web site. The team also assesses how the Internet can be best used to communicate with the public with information on the crisis.
 - g. Studio/Broadcast Team. The team ensures the HHS studio and auditorium are ready for use in an emergency situation. Their duties include setting up for news conferences, taping messages from the Secretary and other senior officials, establishing communications with CDC, handling teleconferences and documenting, via video and still photo, activities of the Secretary and key HHS response components during a crisis.
 - h. Support Team. The team handles all essential Public Affairs administrative and technical support. Their duties include procuring supplies, posting and distribution of news releases, handling incoming telephone calls, and maintaining and circulating news clips.
 - i. Preparedness and Health Information. HHS and its agencies maintain a wealth of medical and public health information on biological, chemical, nuclear, and radiological agents and hazards on their respective Web sites.
 - j. Emergency Web Support. HHS also maintains an emergency shell Web page that can be populated and posted quickly with information relevant to the event.
6. Environmental Protection Agency (EPA)
- a. EPA Headquarters. The EPA HQ Public Affairs staff consists of media relations; communications including Web posting on the EPA homepage; video and still photography, and public liaison.
 - b. EPA Regional Support. Public Affairs Offices in EPA's 10 Regional HQ and laboratories.
7. Nuclear Regulatory Commission (NRC).
- In the event of a nuclear or radiological emergency involving an NRC-licensed nuclear facility or materials, NRC would activate and fully staff its EOC at its HQ

in Rockville, MD, including Public Affairs, to issue press announcements and operate a news center for press briefings, as needed. Briefings would be Webcast live and archived for future viewing by the public.

- a. Regional Teams. Regional teams with Public Affairs staff would be deployed from one of four regions to the site of the emergency where they would support a pre-established joint information/news center provided by the facility operator. This facility accommodates Public Affairs staff of the facility operator, NRC, FEMA, possibly the FBI, and the affected State and counties. Members of the media would be briefed periodically at this facility on the status of the facility and the response.
 - b. Headquarters Staff. NRC Public Affairs staff at headquarters will handle incoming media calls and monitor news coverage.
 - c. Interagency Coordination. Coordination and communication with DHS and other Federal agency Public Affairs personnel would be achieved through the IIMG and the NICCL. Other communications would be coordinated with the JIC, affected States central news centers, and the plant operator's public information organization.
 - d. NRC Incident Response Plan. Procedures and participants for responding to a radiological emergency are identified in the NRC Incident Response Plan, which will be followed if an event becomes an emergency in accordance with predetermined emergency classification levels. The NRC would post all its press releases and other Public Affairs material relevant to the event to its home page on the Internet as well as providing it directly to DHS, the JIC and media.
8. Department of Transportation (DOT).
The Office of the Secretary's Public Affairs Office will coordinate the overall DOT response, maintaining close contact with DOT'S modal administrations public affairs personnel. DOT supports and will comply with the NRP ICEPP Plan.
9. American Red Cross.
The ARC maintains the following:
- a. Rapid Response Team. Fifty-member team of trained, national media spokespersons.
 - b. Disaster Responders. Six hundred responders around the Nation to work with State and local media.
 - c. Web Support. Internet group for Web coding of both internal and public Web sites.
 - d. Photographic Support. Staff photographers and video production experts.
 - e. Nationwide Chapters. More than 900 local Red Cross chapters throughout the country provide a tangible local presence in communities.
 - f. Information Hotline. The Red Cross maintains a 24/7 public information hotline.
 - g. National Disaster Education Coalition Partnership. The Red Cross has extensive preparedness and safety messaging and collateral materials available in both printed and electronic formats. Much of the material is readily available on the public Web site.
10. General Services Administration (GSA).

- a. GSA Headquarters.
- b. FirstGov.gov. The official gateway to all U.S. government information. This search engine connects to millions of web pages from government, local and tribal governments, U.S. territories and foreign nations.

B. Responsibilities of Coordinating and Support Agencies/Organizations

1. U.S. Department of Homeland Security. As stated in the Basic Plan to the ICEP, when operating in support of catastrophic incidents, the Secretary of Homeland Security will coordinate the Federal incident communications response effort. This will involve execution of the ICEP, higher authority guidance, interagency plan execution, incident updates, and delivery of a consistent and unified message to the public. Other Departments, Agencies, and authorities may, however, retain incident communications roles for respective tasks and speak for these areas. Coordinating agency issues will be assessed and identified during initial conference call discussions and as necessary throughout the incident. Notional lead assignments for incident communications may include the following:
 - a. Incident Management.
 - b. Law Enforcement.
 - c. Medical or Health.
 - d. Environmental.
 - e. Protective Measures.
 - f. Search and Rescue.
 - g. Preparedness.
 - h. Mass Care, Housing, and Food Safety.
 - i. Recovery Assistance.
2. Department of Health and Human Services.

In a public health emergency, the HHS Public Affairs Office assumes the lead in media response for public health, coordinated with and through the JIC. Depending on the nature of the event or incident, HHS Public Affairs may designate one of the HHS Agencies (e.g., CDC, NIH, FDA) to take the lead on Public Affairs activities with the responsibility of consulting with HHS Public Affairs as they move forward to manage the incident communications. In addition, HHS Public Affairs would rely on its Agency Public Affairs Offices to supplement the office with additional staff if events continue for an extended period of time. In the event of a terrorist incident, the FBI should be consulted before issuing sensitive media/press releases.
3. U.S. Department of Agriculture.

USDA would likely take the lead in animal and plant health related emergencies as well as food-related emergencies involving meat and poultry. Food-related activities would be coordinated with HHS. USDA and HHS have met to work through scenarios on food-related issues and the appropriate response. USDA has also drilled internally with Agencies to address food and animal-related activities and have several written plans in place for scenarios.

4. State and Local Authorities.

Since most domestic terrorist incidents will occur within the jurisdiction of State or local authorities, integration and teamwork between Federal and non-Federal players is absolutely critical. State and local authorities retain their leadership role in assuring the health and safety of their citizens. To this end, they may make statements or provide preparedness instructions to their citizens at the onset of an incident. DHS Public Affairs and the Federal IIMG will use the ICEP to engage with these authorities as soon as possible to synchronize the overall incident communications effort and to provide support and assistance where State and local capabilities have been destroyed or degraded. State and local incident communications authorities are requested to contact DHS Public Affairs as soon as possible following a domestic incident.

5. Environmental Protection Agency.

EPA Public Affairs would provide staff and other support to the overall Federal effort and environmental and public health information via the media and the Internet.

6. Department of Transportation.

Following an incident, the Department of Public Affairs will look to DHS as the lead agency in coordinating a message. The Transportation Public Affairs message will, in turn, be managed solely by the Transportation Director of Public Affairs in coordination with other appropriate Federal agencies.

7. American Red Cross.

Will work in cooperation with DHS in the coordination of public messaging following a major disaster incident. The Public Affairs team at the Red Cross would take the lead in crafting and disseminating messaging that relates to the specific relief activities conducted by ARC, including mass care sheltering, feeding, bulk distribution of supplies, recovery assistance, and disaster welfare inquires. The Red Cross will also coordinate messaging related to preparedness, recovery assistance, protective measures, and health and safety with other lead agencies.

8. Department of Veterans Affairs.

Public Affairs will follow the DHS lead in communicating the incident response message as well as supporting HHS regarding health and medical services as outlined in ESF#8 of the NRP. At the incident site(s), VA PAOs will assist in communicating appropriate medical and emergency response messages in coordination with local representatives of DHS, HHS, and State and local emergency response authorities whenever possible.

C. Inventory of Other (Federally Accessible) Capabilities

1. DHS and FEMA

- a. DHS Ready.gov Preparedness Program. Ready.gov is a specially developed package of preparedness measures for the public. The measures and presentation are crafted to be easily understood by the public, and are available on-line in English and Spanish.
 - b. DHS Subject Matter Experts (SMEs). DHS Public Affairs maintains a comprehensive listing of available SMEs covering medical, radiological, nuclear, chemical, and biological threats. These experts can be made available to the media for technical explanations and in support of incident response leadership.
 - c. DHS Public Affairs and Ad Council. DHS Public Affairs and the Ad Council have established a contingency program wherein the Ad Council will develop and air preparedness and emergency medical or health segments. This program can be activated and provide features on air within 24 hours.
 - d. Strategic Partnerships. As part of the planning process, DHS and FEMA are developing strategic partnerships with large media conglomerates (especially radio) that have access to major markets in the United States. This would be beneficial during emergencies and facilitate mass communications efforts.
 - e. FEMA Radio Survey Effort. As part of the catastrophic planning process, FEMA is identifying State and local radio frequencies that may be available for broadcast of disaster information.
2. Department of Health and Human Services.
HHS is the lead Federal Department for protecting and preserving the Nation's public health. Through its many Agencies, (CDC, NIH, FDA, HRSA, Substance Abuse and Mental Health Services Administration (SAMHSA), etc.), HHS has immediate access to a wide range of SMEs on virtually every medical and public health facet of any type of WMD incident. The Department's most senior and visible spokespersons—from the HHS Secretary and NIH leadership to CDC Director and the Surgeon General—will be needed to quickly address the Nation's health concerns. The HHS Public Affairs Office has significant experience in quickly providing the appropriate and needed SMEs to the media in any type of public health emergency, and would plan to do so in the event of any WMD incident.
3. Department of Commerce (DOC), National Oceanic and Atmospheric Administration (NOAA) Weather Radio.
NOAA Weather Radio broadcasts National Weather Service (NWS) warnings, watches, forecasts, and other non-weather related hazard information 24 hours a day. During an emergency, NWS forecasters interrupt routine weather programming and send out a special tone that activates weather radios in the listening area. Weather radios equipped with a special alarm tone feature can sound an alert and give immediate information about a life-threatening situation.

4. Environmental Protection Agency.
EPA maintains a contract with U.S. Newswire for electronic distribution of press releases.
5. Department of Transportation.
DOT maintains a contract for an Associated Press (AP) feed with eight stations.
6. Department of Veterans Affairs.
The VA maintains contracts for news monitoring, clipping services, and videotape and photo duplication services at the central office. Three Regional Public Affairs Offices have news clipping service contracts.
7. U.S. Department of Agriculture.
The USDA maintains mass casualty incident telephone support for 24/7 incident communications, as well as a satellite standby truck on call at Continuity of Operations (COOP) sites.
8. American Red Cross.
ARC can call upon cooperative relationships with the National Association of Broadcasters (NAB), the Public Relations Society of America (PRSA), and various corporate partners.

**TAB J to Incident Annex 4
Catastrophic Incident Annex
Private Sector Support**

LEAD: Agency of Commerce and Community Development

I. Mission

This appendix addresses how the private sector can assist and support a catastrophic response effort.

II. Planning Assumptions

A. Comprehensive response and recovery capabilities will be expanded and enhanced if private sector support is quickly coordinated.

B. Many firms and organizations within the private sector will work directly within existing volunteer organization structures to provide goods, services, building space, and trained personnel to assist in the response and recovery effort.

C. State and local governments will create and staff systems for donations receipt/prioritization and needs collection to ensure that needs and wants are coordinated and met.

D. Some portion of what the private sector will volunteer to provide will be made available without charge, and the balance will be available under varying compensation arrangements. Any discussions of compensation to private organizations, instead of disaster victims, will be reviewed first with the agency providing the funding.

III. Catastrophic Incident Response Strategy

A. Private Sector Response Support Strategy: GENERAL.

1. Emphasis will be placed on supporting existing donation management frameworks, such as FEMA, NRCC, and National Volunteer Organizations Active in Disasters (NVOAD), and linking potential donors (regardless of whether they are donating housing space, search and rescue assistance, or other assistance) with identified resource needs.
2. DHS will identify local donations coordination centers as soon as possible and recommend that the private sector work directly with the donations coordination centers to satisfy their needs.
3. DHS will establish and maintain an information sharing system to facilitate the submission of offers by private sector organizations and the transmittal of such information to those sector specific agencies or the donations centers. This will include a link/page on the Homeland Security Information System (HSIN) allowing ESF POCs to list specific needs (goods or services). The link/page will also advise companies or organizations to list information, including contact information, about the goods or services that the organizations are willing to donate and/or sell.

B. Private Sector Response Support Strategy: MASS CARE.

1. If a mass casualty incident occurs, the mass care response will look to non-Government entities - such as NVOAD, ARC, and other such groups - to augment Federal, State, and local efforts.
 2. The mass care response will require existing and temporary facilities of varying kinds, equipment, food, other consumables, and trained or quickly trainable personnel.
 3. DHS/PSO will coordinate with FEMA, ARC, NVOAD, the Citizens Corps, and other organizations to provide information about organizations engaged in the mass care response and facilitate donations or provision of needed goods and services.
- C. Private Sector Response Support Strategy: HOUSING.
If a mass casualty/mass destruction incident occurs, temporary housing will be required. Private sector assistance could be offered in addition to that identified in the Housing Response Overview Appendix. DHS/PSO will coordinate with FEMA, ARC, NVOAD, the Citizens Corps, and other organizations to rapidly communicate offers of help to the appropriate organizations.
- D. Private Sector Response Support Strategy: SEARCH AND RESCUE.
1. If a catastrophic incident occurs that includes a mass destruction component, search and rescue operations will be required. Several types of private sector organizations (e.g., mining and construction companies) may have employees with skills useful for such operations, and may be willing to volunteer their assistance. Other organizations may have useful heavy construction equipment or needed steel-working equipment that could be transported to the incident site.
 2. DHS/PSO will coordinate with ESF#9 (Urban Search and Rescue), FEMA, and other appropriate organizations to facilitate/coordinate donations or provision of needed goods and services, when such services are offered by the private sector.
- E. Private Sector Response Support Strategy: DECONTAMINATION.
1. If a catastrophic mass casualty/mass evacuation incident occurs involving a contamination component, decontamination of well, injured, and deceased individuals and facilities, equipment, and property will be required. Several types of private sector organizations (e.g., nuclear power companies, service companies to the nuclear power industry and chemical industry) that possess skills and experience in various decontamination situations may be willing to volunteer to assist in the decontamination effort.
 2. When services are volunteered by the private sector, DHS will coordinate with appropriate organizations to rapidly communicate the offers of help.
- F. Private Sector Response Support Strategy: MEDICAL SUPPORT.
1. If a catastrophic mass casualty/mass evacuation incident occurs, various private sector organizations (hospitals, large companies with in-house medical facilities, and other organizations) not already identified by the NDMS or other Governmental health organizations may offer assistance with response readiness, patient care, treatment, isolation, and recovery, to complement NDMS activities.
 2. Several types of private sector organizations have facilities, skills, and experience that would allow them to provide temporary care facilities in relative proximity the impacted area. Many factories, universities, schools, churches,

fraternal or social organizations, and other organizations have large facilities with both feeding capabilities and space that could be converted for patient use. It is anticipated such companies/facilities will want to assist in the medical response to a mass casualty event.

3. DHS/PSO will coordinate with ESF#8 (Public Health and Medical Services) and other appropriate organizations to facilitate donations or provision of needed goods and services.

G. Private Sector Response Support Strategy: MASS FATALITY.

1. If a catastrophic mass casualty/mass destruction incident occurs, assistance in recovering, identifying, and processing deceased victims will be required. Several sources of private sector assistance could volunteer to augment those capabilities identified in the Mass Fatality Response Overview Appendix.
2. DHS/PSO will coordinate with ESF#8 (Public Health and Medical Services) and other appropriate organizations to facilitate donations or provision of needed goods and services.

H. Private Sector Response Support Strategy: TRANSPORTATION.

1. The Department of Transportation (DOT) and its 10 major operating administrations maintain strong and historic relationships with the transportation industry. During periods of defense mobilization, DOT plays a vital coordinating role with private sector transportation providers and suppliers in order to meet emergency requirements. During a catastrophic mass casualty/mass evacuation incident requiring additional, extraordinary transportation resources, DOT, as the Coordinating Agency for ESF#1 (Transportation), will facilitate the rapid acquisition of additional specialized transportation-related resources in coordination with State and local counterparts. Requirements would likely extend beyond those resources described in the Transportation Support Schedule at Annex 2.
2. In response to a catastrophic incident, DOT would work closely with DHS/PSO to facilitate the identification of donated services. The transportation industry has a history of volunteer contributions to our nation during times of unprecedented need. It is imperative that any voluntary donation of transportation services be coordinated through ESF#1. This will ensure that donated services can be effectively organized to match nationally identified priorities; duplicative donations are reduced or minimized; and ensure that donated services and equipment are documented, tracked, and free from controversy. ESF#1 can quickly validate the need for specific transportation services and equipment.
3. In the event of multiple major incidents, and under the most extreme circumstances, DOT will use allocation or prioritization authority under the Defense Production Act (DPA). This authority is available if domestic emergency conditions required civil transportation materials, services, or facilities that are not available through the marketplace. For example, airlift, sealift, trains, or trucks may be needed to support the mass and sustained movement of personnel, casualties, equipment, or other resources into and away from the incident area. After identifying appropriate resources that could be used and confirming that they will not be provided voluntarily, DOT would seek a determination and concurrence from DHS. The DPA would only be used as a last resort.
4. Each of the Operating Administrations within DOT maintains extensive industry contact lists, which would be immediately accessible to DHS/PSO through

ESF#1. These contact lists would be used by DHS to reduce conflicting or duplicative communications between DHS and private sector organizations.

IV. Transportation and Logistical Requirements

V. Agency Responsibilities