Catastrophic Incident Supplement

to the National Response Plan

April 2005

Homeland Security

FOR OFFICIAL USE ONLY

FINAL DRAFT

National Response Plan – Catastrophic Incident Supplement

Implementation Instructions

This *Catastrophic Incident Supplement* provides the operational framework for implementing the strategy contained in the *National Response Plan Catastrophic Incident Annex,* and is effective upon issuance.

Departments and Agencies with designated responsibilities under this *Catastrophic Incident Supplement* (to include those specific response actions listed in the Catastrophic Incident Response Execution Schedule) are authorized 120 days to establish and institutionalize processes and procedures necessary to effectively execute those responsibilities, should the provisions of this Supplement be implemented. Departments and Agencies will notify the Secretary of Homeland Security, in writing, when the necessary processes and procedures are in place.

Should conditions warrant, the Secretary of Homeland Security may implement the provisions contained within the Supplement prior to the expiration of the 120-day process institutionalization period.

Within 1 year of its effective date, the Secretary of Homeland Security will conduct an interagency review to assess the effectiveness of the *National Response Plan Catastrophic Incident Supplement*, identify improvements, and provide modification and reissuance recommendations, as required.

The Department of Homeland Security will establish an operational review cycle to ensure regular revalidation of the actions and capabilities listed herein.

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Basic Plan

1. Purpose

The purpose of the *Catastrophic Incident Supplement to the National Response Plan* (henceforth, NRP-CIS) is to establish a coordinated strategy for accelerating the delivery and application of Federal and Federally accessible resources and capabilities in support of a jurisdictional response to a no-notice or short-notice catastrophic mass victim/mass evacuation incident. Such an incident may result from a technological or natural disaster, or terrorist attack involving chemical, biological, radiological, nuclear, or high-yield explosive (CBRNE) weapons of mass destruction (WMD). The NRP-CIS provides the operational strategy summarized in the *National Response Plan Catastrophic Incident Annex* (*NRP-CIA*).

2. Design

A. The NRP-CIS is designed to address a no-notice or short-notice incident of catastrophic magnitude, where the need for Federal assistance is obvious and immediate, and where anticipatory planning and resource prepositioning were precluded. The NRP-CIS and, in particular, the Execution Schedule (**Annex 1**), are not designed to address incidents that evolve or mature into an incident of catastrophic magnitude, such as an initially localized infectious biological release that, over time, matures into a large-scale catastrophe. For evolving events, the response strategy will be determined and applied in accordance with standard National Response Plan procedures, as guided by the appropriate Incident Annex (e.g., Biological Incident Annex).

B. The NRP-CIS outlines an aggressive concept of operations, establishes an execution schedule and implementation strategy, and, in the supporting appendices, provides functional capability overviews and outlines key responsibilities of Departments and Agencies. It is organized around a basic plan, two operational annexes, and thirteen referential appendices.

(1) The Basic Plan provides a general strategic overview and outlines the tactical concept of operations at Local, State, and Federal levels of government, to include detailed Federal logistical and transportation support actions and responsibilities.

(2) The operational annexes contain the Catastrophic Incident Response Execution Schedule (CIRES) and a supporting CIRES Transportation Support Schedule.

(3) The referential appendices include general planning assumptions, an inventory of Federal teams, abbreviations and acronyms, and additional information about unique functional area planning assumptions, response strategies, transportation and logistics requirements, capabilities, responsibilities, and concerns.

3. Overview

A. An urban or metropolitan area, or more expansive geographical area encompassing a large aggregate population, suffers a sudden, catastrophic incident resulting (either immediately or over time) in tens of thousands of casualties (dead, dying, and injured) and producing tens of thousands of evacuees and/or affected-in-place. The response capabilities and resources of the local jurisdiction (to include mutual aid from surrounding jurisdictions and response support from the State) will be profoundly

insufficient and quickly, if not immediately, overwhelmed. In addition, characteristics of the precipitating event, such as severe damage to critical and public infrastructure and contamination concerns or other public health implications, will severely aggravate the response strategy and further tax the capabilities and resources available to the venue. Life saving support from outside the area will be required, and time is of the essence. A catastrophic incident is also likely to have long-term impacts within the incident area as well as, to a lesser extent, on the Nation. It is expected that venue capabilities will be exceeded in one or more of the following areas:

(1) **Mass Care.** The ability of State and local first responders to adequately manage and provide mass care (food and shelter) to a large, displaced, and potentially contaminated evacuee population numbering in the tens of thousands will be quickly exceeded.

(2) **Search and Rescue.** If the incident involves collapsed structures, organic and mutual aid, search and rescue resources are likely to be extremely limited. If the search and rescue operations are required in areas of contamination, the availability of properly trained and equipped resources will be further reduced.

(3) **Decontamination.** A WMD incident may involve contamination, and will require State and local first responders and reception center receivers to organize, support, and conduct mass decontamination of casualties (including animals), evacuees, vehicles, and facilities. In addition, it will require the commencement of site characterization as well as monitoring of both air quality and for contamination among members of the public. Given the potentially immense numbers of casualties, evacuees, vehicles, and facilities resulting from such an incident, decontamination requirements will immediately overwhelm State and local capabilities.

(4) **Public Health and Medical Support.** There will be significant issues relating to environmental health and public health needs, including mental health services and, potentially, isolation and quarantine requirements. Medical support will be required not only at medical facilities, but in large numbers at victim collection and evacuation points, evacuee and refugee points and shelters, and to support field operations and emergency responders. In addition, any contamination dimension will increase the requirement for technical assistance. The situation will quickly tax the organic public health and medical infrastructure.

(5) **Medical Equipment and Supplies.** Depending on the nature of the incident, organically available supplies of preventive and therapeutic pharmaceuticals and treatments will be insufficient or unavailable to meet the demand, both real and perceived. Additionally, there will be insufficient numbers of qualified medical personnel to administer available treatment to both the affected and adjacent populations. Timely provision of treatment may be able to forestall additional people becoming ill and reduce the impact of disease among those already exposed.

(6) **Victim and Fatality Management and Transportation.** The number of dead, injured, and exposed may number in the tens of thousands and immediately overwhelm State and local transportation capabilities and infrastructure. In addition, the immense numbers of casualties are likely to overwhelm the bed capacities of State and local medical facilities.

(7) **Public Information.** A catastrophic mass victim/mass evacuation incident resulting from an act of terrorism may terrify the population, both in the incident area and nationally. If the State and local Government are overwhelmed by the scope and dimensions of the event and unable to provide quick, positive, continuous, consistent, and clear public information and guidance to the affected population, mass confusion and panic may ensue. On a national scale, the Federal Government must be prepared to immediately provide clear and coherent guidance and direction.

B. Recognizing that Federal and/or Federally accessible resources **will** be required to support State and local response efforts in some or all of the preceding areas, the Federal Government has pre-identified resources (e.g., medical teams, transportable shelters, preventive and therapeutic pharmaceutical caches, Federal medical facilities, cargo and passenger aircraft, etc.) that are expected to be needed/required to support the state and local incident response. Upon NRP-CIS implementation, the Federal Government will act immediately and "push" these predesignated resources to a federal mobilization center or staging area near the incident area, as well as "push" certain actions (e.g., activate or make available Federal facilities, such as hospitals). Upon arrival, these resources will be redeployed to the incident area and integrated into the response operation when requested and approved by - and in collaboration with – appropriate state or local incident command authorities, in accordance with the NRP and NIMS. All "pushed" assets and resources will be 100% federally funded through initial deployment to the Federal mobilization center or staging area. (Note: some Federal departments/agencies may deploy predesignated resources directly to the incident scene under separate statutory incident response authority and direction. In such cases, the department/agency must notify the National Response Coordination Center (NRCC) of the deployment and destination.)

(1) The NRP-CIS recognizes that State and local authorities may or may not ultimately require all of the resources that are initially "pushed" or made available to an incident venue in support of response operations and in anticipation of projected needs. Nevertheless, to assure their timely availability to provide critical and life-saving support, these pre-designated resources will be deployed as rapidly as possible. Additional resources will be deployed (if available) as more precise requirements are subsequently identified through post-incident needs assessments. To ensure that logistical support capabilities are not overwhelmed, Federal resources NOT listed on the Execution Schedule will NOT be deployed without special mission assignment approval.

(2) The development of venue-specific plans that fully integrate and leverage the resources and capabilities of all levels of Government and the private sector into a coordinated incident-specific advance response strategy will further accelerate the delivery and application of support and reduce the ratio of unneeded resources and capabilities within the pre-established Execution Schedule.

3. Concept of Operations

A. Local Response

(1) Responsibility for immediate response to an incident typically rests with local authorities and first responders, as augmented by inter-jurisdictional mutual aid and, when requested, the State. Accordingly, immediately following an incident, local authorities will:

(a) Establish an Incident Command System (ICS) response and management authority and structure (e.g., identify an Incident Commander, establish an inter-jurisdictional Unified Command and, if necessary, Area Command) and initiate whatever response actions they are capable of taking with organic and inter-jurisdictional mutual aid resources. All resources and assistance provided to support the response (regardless of source) will be integrated within and employed through this incident command structure.

(b) Commence assessment activities to determine critical support requirements that cannot be met by local government and non-government resources or through mutual aid, and that will require support and augmentation from the Federal Government. These requirements will be communicated to inter-jurisdictional, State, Tribal, and Federal authorities through the incident command structure, in accordance with the National Incident Management System (NIMS).

(c) In accordance with the NIMS, the lowest level of government capable of managing the incident response remains in charge at the incident site.

(2) The Federal Government recognizes that each State and major urban area possesses varying levels of capability, organic resources, and mutual aid availability, as well as unique physical and social characteristics that will influence a tactical response strategy. However, regardless of local and state capabilities, it is anticipated that the scope of a catastrophic incident, as defined herein, will require federal support. Accordingly, to facilitate the rapid, coordinated, and seamless integration of Federal and Federally accessible resources into a localized immediate response effort, States and jurisdictions should, as part of a comprehensive pre-event planning strategy:

(a) Revise existing State and jurisdiction response plans to reflect a coordinated advance strategy for receiving, deploying, and integrating the pre-identified resources reflected in the Catastrophic Incident Response Execution Schedule.

(b) Identify Mobilization Centers, staging areas, receiving and distribution sites, victim collection points, temporary housing sites, and other key operational support facilities and necessary staffing.

(c) Exercise their revised response plans to identify projected priority support requirements that will not be met by the Catastrophic Incident Response Execution Schedule or through existing local, mutual aid, and State resources and capabilities.

(d) Collaborate with FEMA Regions to develop, where appropriate, modifications to the Execution Schedule tailored to the unique requirements of the at-risk venue.

B. State Response

(1) The State will fully activate its incident management/response support architecture and coordinate, through the incident command structure overseeing the response, the provision of additional resources to the extent that State capabilities permit.

(2) The ability of the State to quickly and effectively augment local response operations will be enhanced by ensuring incident-specific response plans address a coordinated strategy for receiving, deploying, and integrating pre-identified Federal resources.

C. Federal Response

(1) The NRP-CIS assumes that a catastrophic mass victim/mass evacuation incident will trigger a Presidential disaster declaration. Accordingly, the NRP-CIS will be implemented under and carried out within the framework, operating principles, and authorities of:

(a) The National Response Plan.

(b) The National Incident Management System.

(c) Homeland Security Presidential Directive (HSPD) -5, Domestic Incident Management.

(d) HSPD-10, Biodefense for the 21st Century.

(e) The Robert T. Stafford Disaster Relief and Assistance Act (henceforth, the Stafford Act).

(f) National Preparedness for Bioterrorism and other Public Health Emergencies, 42 United States Code (U.S.C.) Sections 300hh and 300hh-11.

(2) Federal support under the NRP is normally provided on an expressed-need basis; i.e., upon a threat or following an event, incident response authorities, through their State emergency management authorities and in accordance with the ICS, identify life and property-saving requirements that cannot be met by organic and mutual aid resources, and request Federal assistance. Typically, the State identifies specific Federal support requirements and requests a Presidential major disaster or emergency declaration. (Federal support may also be provided when the threat or event is declared an Incident of National Significance by the Secretary of Homeland Security.) However, the NRP recognizes that a more proactive and aggressive Federal response strategy is required for no-notice catastrophic incidents, where the need for Federal assistance is obvious, overwhelming, and immediate, and cannot wait for absolute situational clarity. Accordingly, immediately upon recognition that a domestic jurisdiction or region has suffered a catastrophic mass victim/mass evacuation incident, the Secretary of Homeland Security will declare an Incident of National Significance, direct implementation of the NRP-CIS, and direct initiation of the automatic response actions reflected in the Execution Schedule (**Annex 1**). Those actions (both standard NRP and unique to this NRP-CIS) include, but are not limited to:

(a) Designating and deploying a Principal Federal Official (PFO) and support staff to directly represent the Secretary of Homeland Security. Until the designated PFO arrives in the area of response, the U.S. Department of Homeland Security (DHS)/Federal Emergency Management Agency (FEMA) Regional Director will assume the role of and function as Interim PFO.

(b) Designating and deploying a Federal Coordinating Officer (FCO) and activating and deploying a Federal Incident Response Support Team (FIRST) and National Emergency Response Team (ERT-N) to the State Emergency Operations Center (EOC) and/or incident venue. The FIRST and ERT-N will coordinate Federal support, through the State and incident command structure, to local authorities.

(c) Identifying and rapidly establishing necessary support facilities (Mobilization Centers, Joint Field Offices (JFOs), etc.) proximal to the incident venue.

(d) Immediately activating and mobilizing incident-specific resources and capabilities (e.g., pharmaceutical caches, search and rescue teams, medical teams and equipment, shelters, etc.) for deployment to the incident venue.

(e) Activating national and Regional-level operations centers and field support centers (e.g., teleregistration centers).

(f) Activating and deploying reserve personnel to augment and support organic State/local response capabilities and requirements in critical skills areas.

(g) Activating and preparing Federal facilities (e.g., hospitals) to receive and treat casualties from the incident area. Tribal hospitals and clinics in the area of the incident need to be considered.

(h) Issuing timely public announcements to inform and assure the Nation about the incident and actions being undertaken to respond. If the venue and/or State infrastructure are incapable of providing timely incident information, warning, and guidance to the public in and around the affected area, the Federal Government will provide the necessary communications.

(i) Activating supplementary support agreements with the private sector.

NOTE: *The advance retooling of State and local response plans to specifically address and include the pre-identification of projected victim and mass care support requirements, regionally available private sector capabilities, critical skill and resource augmentation requirements, and corresponding deployment/employment strategies, will accelerate the availability, delivery, and integration of such resources.*

4. Federal Execution Strategy

A. General.

(1) The NRP-CIS will be implemented when the Secretary of Homeland Security determines that an incident has resulted or will result in a mass victim/mass evacuation situation. Upon an implementation decision, relayed by the Homeland Security Operations Center (HSOC):

(a) All Federal Departments and Agencies (including the American Red Cross (ARC)) identified to initiate specific actions in the Execution Schedule (refer to **Annex 1**) will implement those assigned actions within the directed timeframe(s). Transportation of resources will be in accordance with the procedures beginning at paragraph C, below.

(b) All Federal Departments and Agencies (including the ARC) assigned primary or supporting Emergency Support Function (ESF) responsibilities under the NRP will immediately implement those responsibilities. Refer to the NRP for a description of individual ESF responsibilities.

(c) The incident command structure/organization managing the response at the incident venue will prepare to receive and direct the integration of deploying/activated Federal resources into the response.

(2) Resource mobilization actions directed in the Execution Schedule will be initiated no later than their corresponding initiation times. Deployment timing for mobilized resources will depend on the availability of air and surface transportation and the availability of adequate reception capabilities at the programmed destination.

B. Transportation.

(1) Upon activation of the NRP-CIS, the Department of Transportation (DOT), ESF#1 primary agency, will:

(a) Fully mobilize the Crisis Management Center (CMC) at DOT HQ. This team will immediately begin an assessment of the transportation system and infrastructure providing reports to the DHS Homeland Security Operations Center (HSOC) and NRCC.

(b) Activate the ESF#1 Emergency Transportation Center (ETC).

(c) Dispatch DOT Regional Emergency Transportation Representatives (RETREPs) to appropriate Regional Response Coordination Centers (RRCCs) and, when established, the JFO and Mobilization Center(s). If multiple incidents occur, DOT will support each incident in the same manner. DOT has Regional Emergency Transportation Coordinators (RETCOs) and RETREPS in nine FEMA Regions and Alaska. (One RETCO serves FEMA Regions 1 and 2.)

(d) Coordinate with the NRCC the issuance of a Mission Assignment that authorizes the deployment of DOT personnel and funds transportation of all appropriate Execution Schedule assets in **Annex 2.**

(e) Activate the Movement Coordination Center (MCC) at, and in support of, the NRCC.

(2) The Transportation response will be provided in two broad categories. The first is the immediate movement of pre-identified teams, equipment, and personnel to Mobilization Center(s). The second category involves the movement of specifically requested assets into or from the affected area. Transportation services will continue until the affected infrastructure returns to self-sufficiency or Federal assistance is no longer needed.

(a) Immediate – Push Items *(Dispatched during first 48 hours of incident):* Assets that will be transported automatically without any request from State or local authorities. These include emergency response teams, equipment, and other supplies. Movement of these assets will be sequenced to arrive at the incident Mobilization Center(s) in an appropriate order and quantity. These assets are summarized in **Annex 2**. DOT maintains a separate listing of all assets in **Annex 2** that provide detailed coordination, locality, cargo, and contact information to facilitate the movement of these assets.

(b) Mid-Term – Pull Items *(Dispatched within first 10 days).* Assets that are likely to be needed at the incident site, but will not be transported until requested by appropriate authority at the FEMA Region, Joint Field Office (JFO) (local response cell), or FEMA Headquarters. A DOT transportation representative will be present at each of these locations.

(c) Long-Term Operations. Transportation services will be sustained as long as necessary, until normal infrastructure is self-sustaining, and there is no longer a need for ESF#1 to support Federal, State, or local efforts.

(3) Requests for transportation services will be made through the NRCC. The RRCC and/or JFO, when established, can originate requests as well. DOT representatives are present at each of these locations. Transportation of the asset(s) at the origination site will normally occur within 6 hours of receipt of the request. ERTs with their own vehicles must notify the ESF#1 watch at the NRCC to facilitate coordination at the receiving location. Assets transported outside of DOT will not automatically benefit from the unique capabilities offered through the DOT-shipped program. Assets in transit will not be centrally tracked and rerouted around damaged infrastructure, and special waivers and clearances must be obtained individually. There will be no in-transit tracking of these movements.

(4) Consistent with their functional responsibilities under the NRP, ESF#1 will coordinate the movement of assets for which it is tasked to provide transportation support. The primary source of transportation services is the industry itself, administered through contracts. Other supporting Federal organizations and agencies are available as required.

(a) DOT will activate a 24/7 Emergency Transportation Center (ETC) that coordinates the movement of supplies and resources via air, sea, and land transport. Movement of these

materials includes special handling of unique and unusually large size and quantities of equipment and commodities.

(b) Shipments will be contracted with a wide range of commercial transportation operators based on the most cost efficient, effective, and productive mode and carrier. Other Departments and Agencies possess their own transportation capabilities to meet their own transportation needs or supplement the DOT-provided service as alternate resources. DOT will augment response agency/activity capabilities, when and where necessary:

(5) Assets will be picked up, in accordance with the Execution Schedule, at any location within the mainland United States within 6 hours (if possible). Times will vary for operations outside the continental United States (OCONUS) and for international movements.

C. Logistics.

(1) Response efforts will require at least one Mobilization Center. Upon implementation of the NRP-CIS, Mobilization Center(s) will be designated as required. FEMA Regions, in collaboration with their respective States, have identified tentative Mobilization Center sites. Military bases may be available for use and, in most cases, possess adequate material handling facilities. However, the types of incidents envisioned by the NRP-CIS may create conditions that preclude the use of a nearby military installation as the Mobilization Center. Pre-identification of acceptable Mobilization Center sites in each State will result in speedier and more organized response and logistical support activities.

(2) Designated resources will begin flowing in accordance with the Execution Schedule upon implementation of the NRP-CIS. Resource flow will be from the resource starting point/home station to the Mobilization Center location identified by the NRCC, unless notified to proceed to an Assembly Point. An Assembly Point can be a formal site set up and staffed by logistics personnel, or an informal location, such as a rest area along the route. The function of an Assembly Point is to provide, as required, an intermediate, alternate deployment location in support of an organized, coordinated, and efficient Mobilization Center reception operation. Federal resources arriving at the Mobilization Center will be processed, but not released for employment until requested by state/local incident management authorities and directed by the FCO or appropriate ESF. Resources stopped at an Assembly Point will proceed to the Mobilization Center or incident area, as appropriate, when directed by the MCC.

(3) **Figure 1** reflects, in general terms, resource flow following NRP-CIS activation. Under this strategy:

(a) Resources will deploy in accordance with the Execution Schedule.

(b) Deployment will be to the Mobilization Center unless the resource is redirected by the MCC to an Assembly Point.

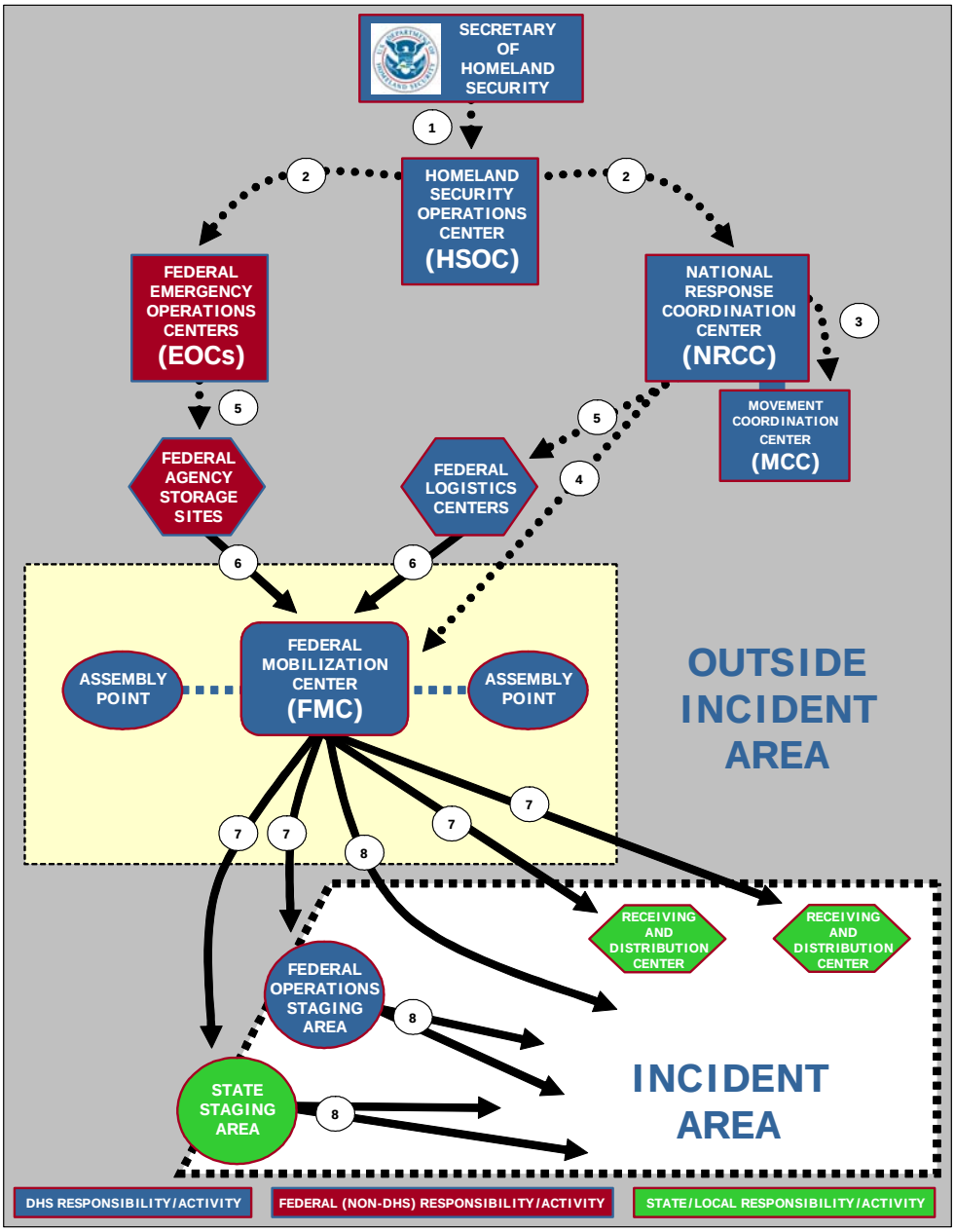
(c) For resources directed to an Assembly Point, the MCC will provide notification on when to move to a Mobilization Center or other location, such as a Federal Operations Staging Area.

(d) If the resource is at the Mobilization Center, the MCC will notify that resource when and where to stage in direct support of the incident response.

(e) Upon arrival, resources will be redeployed to the incident area and integrated into the response operation when requested/approved by and in collaboration with state/local incident command authorities, in accordance with the NRP and NIMS.

Figure 1 – NRP-CIS Resource Flow Concept of Operations

Note: The following graphic represents a generalized flow, and does not necessarily reflect every participating or engaged entity. Variations may occur based on situational requirements.



1. DHS Secretary designates an incident of catastrophic magnitude and notifies HSOC.

2. HSOC notifies NRCC and federal EOCs of NRP-CIS implementation and I-Hour.

3. NRCC activates MCC.

4. NRCC designates FMC and dispatches FMC management team.

5. NRCC and Federal EOCs direct Federal Agency Storage Sites and Federal Logistics Centers to implement NRP-CIS Execution Schedule.

6. Federal Agency Storage Sites and Federal Logistics Centers deploy resources to FMC, unless directed otherwise by the NRCC.

7. Commodities are sent from the FMC to Federal Operations Staging Areas, State Staging Areas, or Local Receiving and Distribution Centers, as directed by the RRCC.

8. Resources (commodities, teams, equipment, personnel) are sent from the FMC and Staging Areas into the incident area in support of state/local incident command authorities.

(4) The Mobilization Center, including Assembly Points and Federal Operations Staging Areas, is integral to the NRP-CIS concept of accelerated operations. FEMA Logistics maintains and exercises overall responsibility for Mobilization Center operations, to include providing guidance and direction regarding establishment, operations, and demobilization. ESF#7 (Resource Support and Logistics Management) has the primary role for providing logistical team support and will mission-assign necessary resources from supporting agencies (e.g., Incident Management Teams (IMTs) from the U.S. Forest Service (USFS)). However, in accordance with the Execution Schedule, USFS will activate and deploy IMTs to the designated Mobilization Center in advance of a direct mission assignment.

(5) The Mobilization Center Management Team (MCMT) provides the organizational management structure for a Mobilization Center. Responsibilities include mission planning and direction, coordination and liaison, external relations, safety planning and operations, and security planning and operations. Upon NRP-CIS implementation, a MCMT will immediately activate and deploy (in accordance with the Execution Schedule) to the designated Mobilization Center to bring it to operational readiness as soon as possible.

(6) The Mobilization Center Group is a component of the MCMT; its organizational structure (including associated Federal Operations Staging Areas) will support the complexities and accelerated response requirements of a catastrophic incident response, as outlined in the NRP-CIS. A "heavy" Mobilization Center (with areas of responsibility assigned to the General Services Administration (GSA), U.S. Army Corps of Engineers (USACE), and USFS) will be established at full staffing levels, with additional staffing for Assembly Points and Federal Operations Staging Areas. If necessary, an Assembly Point or Federal Operations Staging Area site can be expanded into a Mobilization Center.

(7) Standard resource flow (generalized) is depicted in **Figure 1.** The MCC will identify and utilize assessment points to make operational course adjustments to deploying resources. The ability to execute flow adjustments at designated points during deployment will ensure a smooth, organized Mobilization Center reception operation and ensure proper support of arriving resources. Resource flow steps are listed below.

(a) The NRCC, through the MCC, will notify Federal Logistics Centers to begin deploying resources in accordance with the NRP-CIS Execution Schedule. The NRCC, in coordination with Regional, State, and local officials will quickly determine the Mobilization Center location.

(b) The MCC will notify the NRCC of the location of Mobilization Center(s). The NRCC will notify the HSOC, which will immediately notify Federal emergency operations centers (EOCs), who will in turn notify resource storage sites under their control. Resources will subsequently be deployed to Mobilization Center(s) in accordance with the Execution Schedule.

(c) The NRCC and MCC will continually monitor and assess resource flow conditions to facilitate the safe, effective, and efficient movement of resources.

(d) Personnel, teams, equipment, and other resources will be deployed from starting locations with instructions to proceed to the Mobilization Center, unless directed elsewhere. During this movement, the MCC will decide whether conditions require a change in instructions. The MCC may also contact the resource with instructions to proceed to an Assembly Point.

(e) Resources arriving at the Mobilization Center will be processed and prepared for continued movement into the incident area. Resources arriving at an Assembly Point will await further instructions from the MCC.

(f) Assembly Points will be set up at primary points of arrival (e.g., specified airports for resources traveling by air; primary ground transportation route sites to process resources traveling overland). Transportation from both types of Assembly Points will be provided to the Mobilization Center.

(g) Assembly Points will be established at primary ports of entry and primary transportation route node, whether air, land, or maritime, to handle incoming resources such as teams and equipment. There is currently no formal structure for an Assembly Point; the only requirement is communication with the MCC. Once at an Assembly Point, the resource will not leave until authorized by the MCC.

(h) MCC operational and logistical control will be transferred to the JFO upon readiness to assume the mission.

(8) As primary agency for ESF#1, DOT will assist in the assessment of transportation requirements and provide transportation resources and authorities necessary to ensure the effective movement of resources (refer to **Annex 2**).

5. Catastrophic Response Inhibitors

A. The occurrence or threat of multiple catastrophic mass victim/mass care incidents may significantly reduce the size, speed, and depth of the Federal response. If deemed necessary or prudent, the Federal Government may:

(1) Reduce the availability and control the allocation of certain resources when they are the subject of competition by multiple incidents.

(2) Withhold certain otherwise available resources in reserve in anticipation of additional incidents.

B. Major disruptions to the transportation infrastructure, either at or near the incident venue or occurring nationally, may significantly impede the timely deployment of Federal and Federally accessible resources.

C. Large-scale civil (or other types of) disruptions, either at or near the incident venue or occurring nationally, may significantly impede the timely deployment of Federal and Federally accessible resources.

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National Response Plan – Catastrophic Incident Supplement

Annex 1 – Execution Schedule

Upon implementation of the National Response Plan Catastrophic Incident Supplement (NRP-CIS) by the Secretary of Homeland Security, responsible organizations will, unless specifically directed otherwise, initiate the actions in the following schedules - appropriate to the Incident Type - no later than the time indicated (see Figure X-1 below)

A. Unless indicated otherwise under the "Action" verbiage, the action reflects the time the action will be initiated, not completed.

B. **Bold** actions reflect resources that will deploy to or activate within or near the incident area.

C. The term "ALL" when used under the "Responsible Agency" column refers to all Federal Departments and Agencies *to which the action applies.*

D. Where multiple but specific agencies are listed under the "Responsible Agency" column, the corresponding Action Identifier is "M."

E. Action Identification numbers are provided to facilitate quick reference.

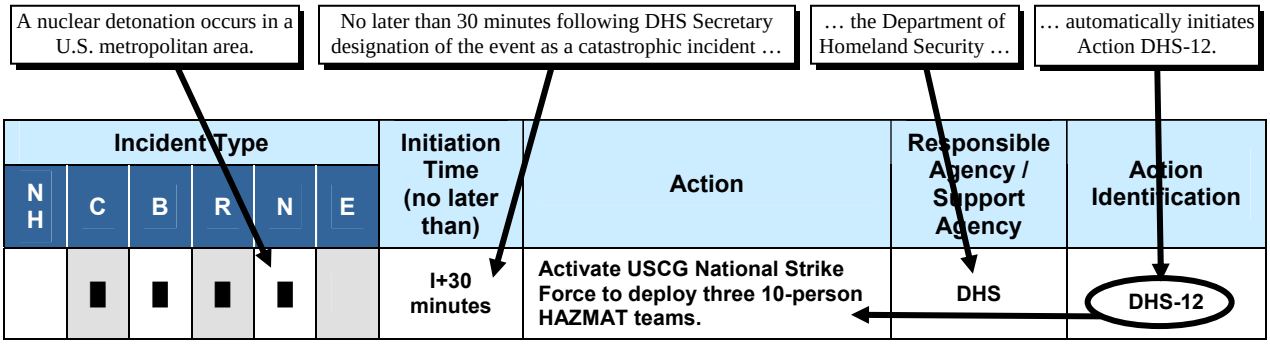
F. The term "initiate deployment actions," when used under the "Action" column, means to mobilize resources for immediate pickup at the designated air/ground departure point.

G. Incident Types are as follows:

NH = Natural Hazards (Earthquake, Hurricane, Tsunami, Volcano, *et al*)
C = Chemical Incident
B = Biological Incident
R = Radiological Incident
N = Nuclear Incident
E = High-Explosive Incident

H. This annex contains two Execution Schedules. Schedule 1 is organized by time and provides a sequential, chronological schedule of required actions. Schedule 2 is organized by Responsible Agency.

Figure X-1 – Execution Schedule Explanation



1. Schedule 1

Execution Schedule - Organized by Initiation Time

NH = Natural Hazards (Earthquake, Hurricane, Tsunami, Volcano, *et al*)
C = Chemical Incident, B = Biological Incident, R = Radiological Incident, N = Nuclear Incident, E = High-Explosive Incident

Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
			■	■		I+10 minutes	Activate Emergency Alert System (EAS).	DHS	DHS-1
■	■	■	■	■	■	I+10 minutes	Activate Incident Communications Emergency Plan (ICEP).	DHS	DHS-2
■	■	■	■	■	■	I+10 minutes	Activate National Incident Communications Conference Line (NICCL).	DHS	DHS-3
			■	■		I+10 minutes	Coordinate first release of information to public.	DHS	DHS-4
■	■	■	■	■	■	I+10 minutes	Establish and maintain lines of communication with State authorities for incident venues.	DHS	DHS-5
■	■	■	■	■	■	I+15 minutes	Designate Federal Mobilization Center site(s) and notify NRP-CIS action agencies.	DHS	DHS-6
■	■	■	■	■	■	**I+15 minutes**	**Activate and initiate deployment actions for the FEMA Mobilization Center Team and equipment cache.**	**DHS**	**DHS-7**
■	■	■	■	■	■	**I+15 minutes**	**Initiate deployment actions for an ERT-A (including Rapid Needs Assessment Team), the on-alert Federal Initial Response Support Team (FIRST) and the on-alert National Emergency Response Team (ERT-N). Place all remaining FIRSTs and ERT-Ns on full alert.**	**DHS**	**DHS-8**
■	■	■	■	■	■	I+15 minutes	Activate, at full staffing levels, the IIMG, NRCC (including MCC), and Regional Response Coordination Centers (RRCCs) with incident oversight. Activate all other RRCCs at watch staff levels.	DHS	DHS-9
■	■	■	■	■	■	I+15 minutes	Activate all NRP Emergency Support Functions (ESFs) at full staffing levels.	ALL	A-1
			■	■		I+15 minutes	Implement protective actions that correspond to a "SEVERE" condition under the Homeland Security Advisory System (HSAS).	ALL	A-2
■	■	■	■	■	■	I+15 minutes	Activate the HHS Secretary's Emergency Response Team (SERT).	HHS	HHS-1

Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
	■	■	■	■		I+15 minutes	Initiate actions to deploy and deliver appropriate Strategic National Stockpile (SNS) initial push-packages to a Federal Mobilization Center or other designated reception location.	HHS	HHS-2
■	■	■	■	■	■	I+30 minutes	Activate Mobile Emergency Response Support (MERS) and deploy Life Support Vehicles and MERS Emergency Operations Vehicle to the affected area to establish a temporary operating location for the Principal Federal Official (PFO) and support staff. MERS deployment elements to carry JFO set-up equipment (100-person JFO kit and two DISC Packs).	DHS	DHS-10
■				■	■	I+30 minutes	If the incident involves collapsed structures, activate and initiate deployment actions for all on-alert, weapons of mass destruction (WMD)-equipped National US&R Task Forces, Incident Support Teams (ISTs), and caches. Activate and fully mobilize all other WMD-equipped National US&R assets in place. Place all remaining National US&R Task Forces and ISTs on full alert. Deployment into the incident area will be as directed by the National Response Coordination Center (NRCC).	DHS	DHS-11
■	■	■	■	■	■	I+30 minutes	Initiate deployment actions for appropriate ESF#8 Regional resources (such as the Regional Health Administrator) to the Regional and State Operations Centers.	HHS	HHS-3
			■	■		I+30 minutes	Close airspace in affected area (via Temporary Flight Restrictions (TFRs) and Notices to Airmen (NOTAMs)). Coordinate ground stops as necessary.	DOT	DOT-1
■	■	■	■	■	■	I+30 minutes	Activate on call roster of U.S Public Health Service (PHS) Commissioned Corps.	HHS	HHS-4
	■	■	■	■		I+30 minutes	Activate USCG National Strike Force to deploy three 10-person HAZMAT teams.	DHS	DHS-12
■			■	■		I+30 minutes	Initiate actions to immediately deploy 4800 cots.	DHS	DHS-13
■			■	■		I+30 minutes	Initiate actions to immediately deploy 9600 blankets.	DHS	DHS-14
■			■	■		I+30 minutes	Initiate actions to immediately deploy 30,000 emergency heater meals.	DHS	DHS-15

Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
■			■	■		**I+30 minutes**	**Initiate actions to immediately deploy 1500 personal toilets with privacy tents.**	**DHS**	**DHS-16**
■			■	■		**I+30 minutes**	**Initiate actions to immediately deploy 6600 daily restroom kits.**	**DHS**	**DHS-17**
■			■	■		**I+30 minutes**	**Initiate actions to immediately deploy 1500 personal wash kits.**	**DHS**	**DHS-18**
■			■	■		**I+30 minutes**	**Initiate actions to immediately deploy 900 sleeping bags.**	**DHS**	**DHS-19**
■			■	■		**I+30 minutes**	**Initiate actions to immediately deploy 300 tents (6-8 person).**	**DHS**	**DHS-20**
■						**I+30 minutes**	**Initiate actions to immediately deploy 1740 rolls of plastic sheeting (20x100).**	**DHS**	**DHS-21**
■			■	■		**I+30 minutes**	**Initiate actions to immediately deploy 30,000 gallons of bottled water.**	**DHS**	**DHS-22**
■			■	■		**I+30 minutes**	**Initiate actions to immediately deploy 48 mid-range generators.**	**DHS**	**DHS-23**
■			■	■		**I+30 minutes**	**Initiate actions to immediately deploy 1 million MREs (via 46 trailers).**	**DHS**	**DHS-24**
■			■	■		**I+30 minutes**	**Initiate actions to immediately deploy 200,000 gallons of water (via 40 trailers) and source 400,000 lbs of ice (10 trailers).**	**DHS**	**DHS-25**
■			■	■		**I+30 minutes**	**Initiate actions to immediately deploy ten 250-person Pre-Positioned Disaster Supply containers.**	**DHS**	**DHS-26**
■			■	■	■	**I+30 minutes**	**Initiate actions to immediately deploy nine 500-person Pre-Positioned Disaster Supply containers.**	**DHS**	**DHS-27**
■	■	■	■	■	■	I+40 minutes	Conduct interagency conference call and develop initial communications strategy and plan.	DHS	DHS-28
■	■	■	■	■	■	I+45 minutes	Activate the American Association of Blood Banks Interorganizational Task Force on Domestic Disasters and Acts of Terrorism (AABB Task Force) to assess current blood supply levels throughout the country.	HHS	HHS-5
■	■	■	■	■	■	**I+1 hour**	**Designate a PFO, who will assemble a support staff and deploy to the affected area as soon as possible.**	**DHS**	**DHS-29**
■	■	■	■	■	■	I+1 hour	Designate Federal staging areas inside incident area (forward of Federal Mobilization Center)..	DHS	DHS-30

Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
■	■	■	■	■	■	**I+1 hour**	**Initiate deployment actions for one (1) NDMS Management Support Team (MST) and equipment cache.**	**DHS**	**DHS-31**
■	■	■	■	■	■	**I+1 hour**	**Activate Rapid Response Victim Registry.**	**HHS**	**HHS-6**
			■	■		I+1 hour	Activate Department of Energy (DOE) Nuclear Incident Team (NIT) at DOE Emergency Operations Center (EOC).	DOE	DOE-1
■	■	■	■	■	■	I+1 hour	Activate the National Disaster Medical System (NDMS).	DHS	DHS-32
■	■		■	■	■	I+1 hour	Activate the patient movement portion of the NDMS.	DHS HHS VA DoD DOT	M-1
■	■	■	■	■		I+1 hour	Coordinate stoppage of all non-critical cargo and passenger rail, maritime, and highway transportation into incident area.	DOT	DOT-2
■	■	■	■	■		I+1 hour	Provide initial HHS-coordinated public service announcement. Coordinate and issue follow-on announcements at frequent and regular intervals.	DHS	DHS-33
■	■	■	■	■	■	I+1 hour	DHS Secretary makes first senior Federal announcement of incident and response effort.	DHS	DHS-34
■	■	■	■	■	■	I+1 hour	Activate Hospital Asset Reporting and Tracking System (HARTS).	HHS	HHS-7
■	■	■	■	■	■	I+1 hour	Activate a National Joint Information Center (JIC) to coordinate all response-related press and media affairs.	DHS	DHS-35
			■	■		I+1 hour	Release updated nuclear/ radiological incident advice to general public.	DHS	DHS-36
	■	■	■	■		I+1 hour	Activate Public Affairs surge plans.	DHS	DHS-37
■	■	■	■	■	■	**I+1½ hours**	**Initiate establishment of a Joint Information Center (JIC) at incident site.**	**DHS**	**DHS-38**
■	■	■	■	■	■	I+1½ hours	Release updated incident and information statement to general public.	DHS	DHS-39
■	■	■	■	■	■	**I+2 hours**	**Commence transportation of Execution Schedule Assets (refer to Annex 2, Table 2-1).**	**DOT**	**DOT-3**
			■	■		**I+2 hours**	**Deploy Radiological Assistance Program (RAP) Teams.**	**DOE**	**DOE-2**

Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
■	■	■	■	■	■	**I+2 hours**	**Activate and initiate deployment actions for (coordinated through the NRCC) Incident Management Team(s) (IMTs) to support each designated Federal Mobilization Center.**	**USDA**	**USDA-1**
■	■	■	■	■	■	I+2 hours	Activate all Red Cross disaster response functions.	ARC	ARC-1
■	■	■	■	■		I+2 hours	Inventory existing available shelter space within a radius of 250 miles. Inventory national ARC food supply stockpiles and their locations.	ARC	ARC-2
■	■	■	■	■	■	**I+2 hours**	**Dispatch the Red Cross (Internal) Critical Response Team (CRT) to safe area near affected area(s) to assist with initial national response efforts.**	**ARC**	**ARC-3**
■	■	■	■	■	■	I+2 hours	Assess mass care actions initiated by local response entities and determine additional resources needed to provide necessary services.	ARC	ARC-4
■	■	■	■	■	■	I+2 hours	Activate WMD Response Guidelines for all national HQ units, to include Biomedical Services Operations Center for blood coordination.	ARC	ARC-5
■	■	■	■	■	■	I+2 hours	Place 100 Red Cross Emergency Response Vehicles (ERVs) on standby for deployment to provide mobile feeding.	ARC	ARC-6
■	■	■	■	■		**I+2 hours**	**Coordinate with Red Cross Disaster Field Supply Centers to begin movement of 50,000 cots and 100,000 blankets to affected area(s).**	**ARC**	**ARC-7**
■	■	■	■	■	■	I+2 hours	Coordinate with national voluntary organizations and non-Governmental organization (NGO) partners to provide personnel and equipment to support response activities.	ARC	ARC-8
■	■	■	■	■	■	**I+2 hours**	**Deploy Red Cross kitchens and other mobile feeding units to Staging Areas, once identified in safe area.**	**ARC**	**ARC-9**
■	■	■	■	■	■	**I+2 hours**	**Activate and deploy Pre-positioned Equipment Program Teams.**	**DHS**	**DHS-40**
■	■	■	■	■	■	**I+2 hours**	**Initiate deployment actions for ERT-N Joint Field Office (JFO) equipment and support kits.**	**DHS**	**DHS-41**
						I+2 hours	**Initiate deployment actions for Emergency Housing Support Team.**	**DHS**	**DHS-42**

Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
■	■	■	■	■	■	**I+2 hours**	**Initiate deployment actions for Emergency Temporary Housing units into affected area.**	**DHS**	**DHS-43**
	■		■	■	■	I+2 hours	Determine if decontamination technical assistance resources have been requested and are engaged.	DHS	DHS-44
	■	■	■	■	■	I+2 hours	Obtain preliminary estimate of the number of victims exposed to toxic/ hazardous substance(s), preliminary material identification, and source containment.	DHS	DHS-45
■	■	■	■	■	■	I+2 hours	Coordinate with the AABB Task Force to identify supply levels at the supporting medical facilities for the incident. Activate supply distribution plans for affected region(s).	HHS	HHS-8
■	■	■	■	■	■	I+2 hours	Activate links to the private sector (e.g., secure CEO COMLINK) and request them, as appropriate, to inventory and identify available transportation assets, potential mass shelter facilities, and medical facilities, personnel, equipment, and supplies.	DHS	DHS-46
				■		I+2 hours	Activate Continuity of Operations (COOP) Plans.	ALL	A-3
■	■	■	■	■	■	**I+2 hours**	**Initiate deployment actions for Defense Coordinating Officer (DCO) and supporting Defense Coordinating Element (DCE) to JFO or Initial Operating Facility (IOF).**	**DoD**	**DoD-1**
	■		■	■	■	I+3 hours	Determine zones and boundaries of contamination and advise all response entities.	DHS	DHS-47
■	■	■	■	■		I+3 hours	Convene the NDMS Interagency Planning Group and Medical Inter-Agency Coordination Group (MIACG).	DHS HHS VA DoD	M-2
■	■	■	■	■	■	I+3 hours	Send qualified representatives to staff the IIMG at DHS HQ and/or other interagency EOCs (e.g., Strategic Information and Operations Center, NRCC, etc.), as rostered or directed.	ALL	A-4
■	■	■	■	■	■	I+3 hours	Review all cargo and passenger aviation activities within the Agency's operational control. Inventory and make available cargo and passenger aviation assets. Report availability to the MCC in the NRCC.	ALL	A-5

Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
■	■	■	■	■		I+3 hours	Provide assessment of transportation system and infrastructure to HSOC and NRCC.	DOT	DOT-4
■	■	■	■	■	■	**I+3 hours**	**Alert and initiate deployment actions for ESF#3 teams and assets (water, power, debris, housing, ice, deployable tactical operations system).**	**USACE**	**USACE-1**
			■	■		**I+4 hours**	**Deploy Aerial Measurements System (AMS).**	**DOE**	**DOE-3**
			■	■		**I+4 hours**	**Initiate deployment actions for Nuclear Radiological Advisory Team (NRAT).**	**DOE**	**DOE-4**
			■	■		**I+4 hours**	**Activate FRMAC and deploy Consequence Management Response Team.**	**DOE**	**DOE-5**
	■	■	■	■	■	**I+4 hours**	**Initiate deployment actions for National Medical Response Team (NMRT).**	**DHS**	**DHS-48**
■					■	**I+4 hours**	**Activate and initiate deployment actions for field survey support team and remote sensing aircraft to incident area.**	**DOC**	**DOC-1**
■	■	■	■	■	■	I+4 hours	Obtain Assistant Secretary for Health (ASH) approval for the AABB Task Force coordinated public information announcement regarding the adequacy and safety of the Nation's blood supply.	HHS	HHS-9
	■	■	■	■	■	**I+4 hours**	**Alert HQ Joint Task Force – Civil Support (JTF-CS) and designated Initial Entry Forces (IEFs). Deploy Command Assessment Element (CAE) to provide rapid mission assessment in coordination with Federal authorities. Identify key IEF capabilities as required based on assessment and coordination with DHS.**	**DoD**	**DoD-2**
■	■	■	■	■	■	I+4 hours	Initiate/expedite actions to establish a JFO. NRCC and RRCC coordinate JFO size and develop requirements.	DHS	DHS-49
■	■	■	■	■	■	I+4 hours	Assess requirements for facility/ environmental decontamination.	EPA	EPA-1
■	■	■	■	■	■	**I+4 hours**	**Initiate deployment actions for the HHS SERT.**	**HHS**	**HHS-10**
	■	■	■	■	■	**I+6 hours**	**Initiate deployment actions for three (3) NDMS Disaster Medical Assistance Teams (DMATs).**	**DHS**	**DHS-50**
	■	■	■	■	■	**I+6 hours**	**Initiate deployment actions for three (3) NDMS DMAT equipment caches.**	**DHS**	**DHS-51**

Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
		■				**I+6 hours**	**Initiate deployment actions for EIS officers and other staff to support epidemiological investigations.**	**HHS**	**HHS-11**
■	■	■	■	■		**I+6 hours**	**Initiate deployment actions for food safety inspectors.**	**HHS**	**HHS-12**
	■	■	■	■	■	I+6 hours	Update estimates/actual reporting of number of victims.	HHS	HHS-13
■	■	■	■	■	■	I+6 hours	Initiate action planning for facility/ environmental decontamination.	EPA	EPA-2
■	■	■	■	■		I+6 hours	Update status of transportation system and provide emergency transportation management recommendations to DHS. Continue updates as necessary.	DOT	DOT-5
	■		■	■	■	I+6 hours	Ascertain extent of success of initial/gross decontamination and containment activities.	DHS	DHS-52
■	■		■	■		I+6 hours	Inventory and identify (to ESF-7) all large-space facilities/structures within 250 miles of the incident venue(s) that could be made available as temporary shelters, temporary morgues, or to support mass casualty medical operations.	ALL	A-6
	■		■	■	■	I+6 hours	Ascertain extent of contaminated victim access to medical treatment facilities and impact on operational status.	DHS HHS	M-3
	■		■	■		I+6 hours	Assess local emergency public information activities regarding victim decontamination and engage consultation if adjustments appear necessary.	DHS	DHS-53
■	■	■	■	■	■	I+6 hours	Verify need for additional monitoring equipment at medical treatment facilities and shelters and ensure necessary logistics actions are initiated.	DHS	DHS-54
	■	■	■	■		**I+30 minutes**	**Initiate actions to deploy and deliver appropriate Strategic National Stockpile (SNS) initial push-packages to a Federal Mobilization Center or other designated reception location.**	**HHS**	**HHS-14**
■	■	■	■	■	■	**I+12 hours**	**Initiate deployment actions for on-call roster of PHS Commissioned Corps.**	**HHS**	**HHS-15**
	■	■				I+12 hours	Identify laboratories that could be used to support diagnostic activity for agent of concern.	ALL	A-7

Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
■	■	■	■	■	■	I+12 hours	Inventory and report on (to the NRCC) the availability and functionality status of all Plan-supporting teams and resources. Identify any deficiencies or limiting factors in planned capability.	ALL	A-8
■	■	■	■	■	■	I+12 hours	Activate all PHS Commissioned Corps rosters.	HHS	HHS-16
■	■	■	■	■	■	I+12 hours	All NDMS medical facilities inventory and report bed availability to Federal Coordinating Facilities.	DHS HHS VA DoD	M-4
	■	■	■	■	■	**I+12 hours**	**Initiate deployment actions for two (2) NDMS NMRTs.**	**DHS**	**DHS-55**
	■	■	■	■	■	**I+12 hours**	**Initiate deployment actions for two (2) NDMS NMRT equipment caches.**	**DHS**	**DHS-56**
■	■	■	■	■	■	**I+12 hours**	**Initiate deployment actions for two (2) NDMS Veterinary Medical Assistance Teams (VMATs).**	**DHS**	**DHS-57**
■	■	■	■	■	■	I+16 hours	Locate owners of, and available apartments in Federally funded multifamily housing to provide shelter to emergency response personnel proximal to the incident venue. Report to HUD.	ALL	A-9
■	■	■	■	■	■	I+18 hours	NDMS hospitals prepare to begin receiving evacuated patients from affected areas.	DHS HHS VA DoD	M-5
■	■	■	■	■	■	**I+18 hours**	**Initiate deployment actions for Specialized Response Team provide technical assistance to incident safety officer.**	**DOL**	**DOL-1**
■	■	■	■	■	■	**I+24 hours**	**Initiate deployment actions for eleven (11) NDMS DMATs.**	**DHS**	**DHS-58**
■	■	■	■	■	■	**I+24 hours**	**Initiate actions to deploy two (2) NDMS DMORTs.**	**DHS HHS**	**M-6**
■	■	■	■	■	■	**I+24 hours**	**Activate and initiate deployment actions for eleven (11) NDMS DMAT equipment caches.**	**DHS**	**DHS-59**
	■	■	■	■	■	**I+24 hours**	**Activate and initiate deployment actions for two (2) NDMS DMORT deployable morgue units.**	**DHS**	**DHS-60**
■	■	■	■	■	■	**I+24 hours**	**Activate and initiate deployment actions for one (1) full NDMS MST equipment cache.**	**DHS**	**DHS-61**
■	■	■	■	■	■	**I+24 hours**	**Initiate deployment actions for a medical regulating team.**	**DoD**	**DoD-3**
■	■	■	■	■	■	I+24 hours	Release public messages providing information on how to apply for individual assistance.	DHS	DHS-62

Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
■	■	■	■	■	■	I+24 hours	Primary Receiving Centers (PRCs) within 500 miles of an incident venue prepare to terminate non-critical medical services and redirect available resources for receipt of patients at VA medical facilities.	VA	VA-1
■	■	■	■	■	■	I+24 hours	Assess short-term medical treatment needs of incident area population and evacuees.	HHS DHS	M-7
■			■	■		**I+24 hours**	**Initiate actions to immediately deploy 4800 cots.**	**DHS**	**DHS-63**
■			■	■		**I+24 hours**	**Initiate actions to immediately deploy 9600 blankets.**	**DHS**	**DHS-64**
■			■	■		**I+24 hours**	**Initiate actions to immediately deploy 30,000 emergency heater meals.**	**DHS**	**DHS-65**
■			■	■		**I+24 hours**	**Initiate actions to immediately deploy 1500 personal toilets with privacy tents.**	**DHS**	**DHS-66**
■			■	■		**I+24 hours**	**Initiate actions to immediately deploy 6600 daily restroom kits.**	**DHS**	**DHS-67**
■			■	■		**I+24 hours**	**Initiate actions to immediately deploy 1500 personal wash kits.**	**DHS**	**DHS-68**
■			■	■		**I+24 hours**	**Initiate actions to immediately deploy 900 sleeping bags.**	**DHS**	**DHS-69**
■			■	■		**I+24 hours**	**Initiate actions to immediately deploy 300 tents (6-8 person).**	**DHS**	**DHS-70**
■						**I+24 hours**	**Initiate actions to immediately deploy 1740 rolls of plastic sheeting (20x100).**	**DHS**	**DHS-71**
■			■	■		**I+24 hours**	**Initiate actions to immediately deploy 30,000 gallons of bottled water.**	**DHS**	**DHS-72**
■			■	■		**I+24 hours**	**Initiate actions to immediately deploy 48 mid-range generators.**	**DHS**	**DHS-73**
■			■	■		**I+24 hours**	**Initiate actions to immediately deploy 1 million MREs (via 46 trailers).**	**DHS**	**DHS-74**
■			■	■		**I+24 hours**	**Initiate actions to immediately deploy 200,000 gallons of water (via 40 trailers) and source 400,000 lbs of ice (10 trailers).**	**DHS**	**DHS-75**
■			■	■		**I+24 hours**	**Initiate actions to immediately deploy ten 250-person Pre-Positioned Disaster Supply containers.**	**DHS**	**DHS-76**
■			■	■		**I+24 hours**	**Initiate actions to immediately deploy nine 500-person Pre-Positioned Disaster Supply containers.**	**DHS**	**DHS-77**

Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
■	■	■	■	■	■	I+36 hours	Initiate patient evacuation. Establish Federal patient movement through DoD TRACES2 system.	DHS HHS DoD GSA DOT	M-8
	■	■	■	■	■	I+36 hours	Begin backfill of medical support packages from Strategic National Stockpile.	HHS	HHS-17
■	■	■	■	■		I+36 hours	Devise a national animal, plant, and health surveillance plan.	USDA	USDA-2
■	■	■	■	■	■	**I+48 hours**	**Initiate deployment actions for veterinary team to evaluate situation.**	**USDA**	**USDA-3**
■	■	■	■	■	■	I+48 hours	Determine animal/livestock disposal options.	USDA	USDA-4
■			■	■		**I+48 hours**	**Initiate actions to immediately deploy 4800 cots.**	**DHS**	**DHS-78**
■			■	■		**I+48 hours**	**Initiate actions to immediately deploy 9600 blankets.**	**DHS**	**DHS-79**
■			■	■		**I+48 hours**	**Initiate actions to immediately deploy 30,000 emergency heater meals.**	**DHS**	**DHS-80**
■			■	■		**I+48 hours**	**Initiate actions to immediately deploy 1500 personal toilets with privacy tents.**	**DHS**	**DHS-81**
■			■	■		**I+48 hours**	**Initiate actions to immediately deploy 6600 daily restroom kits.**	**DHS**	**DHS-82**
■			■	■		**I+48 hours**	**Initiate actions to immediately deploy 1500 personal wash kits.**	**DHS**	**DHS-83**
■			■	■		**I+48 hours**	**Initiate actions to immediately deploy 900 sleeping bags.**	**DHS**	**DHS-84**
■			■	■		**I+48 hours**	**Initiate actions to immediately deploy 300 tents (6-8 person).**	**DHS**	**DHS-85**
■						**I+48 hours**	**Initiate actions to immediately deploy 1740 rolls of plastic sheeting (20x100).**	**DHS**	**DHS-86**
■			■	■		**I+48 hours**	**Initiate actions to immediately deploy 30,000 gallons of bottled water.**	**DHS**	**DHS-87**
■			■	■		**I+48 hours**	**Initiate actions to immediately deploy 48 mid-range generators.**	**DHS**	**DHS-88**
■			■	■		**I+48 hours**	**Initiate actions to immediately deploy 1 million MREs (via 46 trailers).**	**DHS**	**DHS-89**
■			■	■		**I+48 hours**	**Initiate actions to immediately deploy 200,000 gallons of water (via 40 trailers) and source 400,000 lbs of ice (10 trailers).**	**DHS**	**DHS-90**

Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
■			■	■		**I+48 hours**	**Initiate actions to immediately deploy ten 250-person Pre-Positioned Disaster Supply containers.**	**DHS**	**DHS-91**
■			■	■		**I+48 hours**	**Initiate actions to immediately deploy nine 500-person Pre-Positioned Disaster Supply containers.**	**DHS**	**DHS-92**
■	■	■	■	■	■	**I+72 hours**	**Initiate deployment actions for all PHS Commissioned Corps rosters.**	**HHS**	**HHS-18**
	■	■	■	■	■	**I+72 hours**	**Begin backfill of Pre-Positioned Disaster Supplies (PPDS) containers.**	**DHS**	**DHS-93**
■	■	■	■	■	■	I+72 hours	Activate all PHS Commissioned Corps deployable assets.	HHS	HHS-19
■	■	■	■	■	■	I+72 hours	Develop crisis-counseling plan.	DHS	DHS-94
■	■	■	■	■	■	I+72 hours	Assess and quantify projected housing needs.	DHS	DHS-95
■	■	■	■	■		I+96 hours	Determine animal/livestock treatment.	USDA	USDA-5
■	■	■	■	■	■	I+96 hours	Develop preliminary temporary housing plan.	DHS	DHS-96
■	■	■	■	■	■	I+96 hours	Develop donations strategy and voluntary agency plan.	DHS	DHS-97

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2. Schedule 2

Execution Schedule - Organized by Responsible Agency

NH = Natural Hazards (Earthquake, Hurricane, Tsunami, Volcano, *et al*)
C = Chemical Incident, B = Biological Incident, R = Radiological Incident, N = Nuclear Incident, E = High-Explosive Incident

All Agencies									
Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
■	■	■	■	■	■	I+15 minutes	Activate all NRP Emergency Support Functions (ESFs) at full staffing levels.	ALL	A-1
			■	■		I+15 minutes	Implement protective actions that correspond to a "SEVERE" condition under the Homeland Security Advisory System (HSAS).	ALL	A-2
				■		I+2 hours	Activate Continuity of Operations (COOP) Plans.	ALL	A-3
■	■	■	■	■	■	I+3 hours	Send qualified representatives to staff the IIMG at DHS HQ and/or other interagency EOCs (e.g., Strategic Information and Operations Center, NRCC, etc.), as rostered or directed.	ALL	A-4
■	■	■	■	■	■	I+3 hours	Review all cargo and passenger aviation activities within the Agency's operational control. Inventory and make available cargo and passenger aviation assets. Report availability to the MCC in the NRCC.	ALL	A-5
■	■		■	■		I+6 hours	Inventory and identify (to ESF-7) all large-space facilities/structures within 250 miles of the incident venue(s) that could be made available as temporary shelters, temporary morgues, or to support mass casualty medical operations.	ALL	A-6
	■	■				I+12 hours	Identify laboratories that could be used to support diagnostic activity for agent of concern.	ALL	A-7
■	■	■	■	■	■	I+12 hours	Inventory and report on (to the NRCC) the availability and functionality status of all Plan-supporting teams and resources. Identify any deficiencies or limiting factors in planned capability.	ALL	A-8
■	■	■	■	■	■	I+16 hours	Locate owners of, and available apartments in Federally funded multifamily housing to provide shelter to emergency response personnel proximal to the incident venue. Report to HUD.	ALL	A-9

Multiple Responsible Agencies

Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
■	■		■	■	■	I+1 hour	Activate the patient movement portion of the NDMS.	DHS HHS VA DoD DOT	M-1
■	■	■	■	■		I+3 hours	Convene the NDMS Interagency Planning Group and Medical Inter-Agency Coordination Group (MIACG).	DHS HHS VA DoD	M-2
	■		■	■	■	I+6 hours	Ascertain extent of contaminated victim access to medical treatment facilities and impact on operational status.	DHS HHS	M-3
■	■	■	■	■	■	I+12 hours	All NDMS medical facilities inventory and report bed availability to Federal Coordinating Facilities.	DHS HHS VA DoD	M-4
■	■	■	■	■	■	I+18 hours	NDMS hospitals prepare to begin receiving evacuated patients from affected areas.	DHS HHS VA DoD	M-5
■	■	■	■	■	■	**I+24 hours**	**Initiate actions to deploy two (2) NDMS DMORTs.**	**DHS HHS**	**M-6**
■	■	■	■	■	■	I+24 hours	Assess short-term medical treatment needs of incident area population and evacuees.	HHS DHS	M-7
■	■	■	■	■	■	I+36 hours	Initiate patient evacuation. Establish Federal patient movement through DoD TRACES2 system.	DHS HHS DoD GSA DOT	M-8

American Red Cross

Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
■	■	■	■	■	■	I+2 hours	Activate all Red Cross disaster response functions.	ARC	ARC-1
■	■	■	■	■		I+2 hours	Inventory existing available shelter space within a radius of 250 miles. Inventory national ARC food supply stockpiles and their locations.	ARC	ARC-2
■	■	■	■	■	■	**I+2 hours**	**Dispatch the Red Cross (Internal) Critical Response Team (CRT) to safe area near affected area(s) to assist with initial national response efforts.**	**ARC**	**ARC-3**

American Red Cross

Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
■	■	■	■	■	■	I+2 hours	Assess mass care actions initiated by local response entities and determine additional resources needed to provide necessary services.	ARC	ARC-4
■	■	■	■	■	■	I+2 hours	Activate WMD Response Guidelines for all national HQ units, to include Biomedical Services Operations Center for blood coordination.	ARC	ARC-5
■	■	■	■	■	■	I+2 hours	Place 100 Red Cross Emergency Response Vehicles (ERVs) on standby for deployment to provide mobile feeding.	ARC	ARC-6
■	■	■	■	■		**I+2 hours**	**Coordinate with Red Cross Disaster Field Supply Centers to begin movement of 50,000 cots and 100,000 blankets to affected area(s).**	**ARC**	**ARC-7**
■	■	■	■	■	■	I+2 hours	Coordinate with national voluntary organizations and non-Governmental organization (NGO) partners to provide personnel and equipment to support response activities.	ARC	ARC-8
■	■	■	■	■	■	**I+2 hours**	**Deploy Red Cross kitchens and other mobile feeding units to Staging Areas, once identified in safe area.**	**ARC**	**ARC-9**

Department of Agriculture

Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
■	■	■	■	■	■	**I+2 hours**	**Activate and initiate deployment actions for (coordinated through the NRCC) Incident Management Team(s) (IMTs) to support each designated Federal Mobilization Center.**	**USDA**	**USDA-1**
■	■	■	■	■		I+36 hours	Devise a national animal, plant, and health surveillance plan.	USDA	USDA-2
■	■	■	■	■	■	**I+48 hours**	**Initiate deployment actions for veterinary team to evaluate situation.**	**USDA**	**USDA-3**
■	■	■	■	■	■	I+48 hours	Determine animal/livestock disposal options.	USDA	USDA-4
■	■	■	■	■		I+96 hours	Determine animal/livestock treatment.	USDA	USDA-5

Department of Commerce

Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
■					■	I+4 hours	Activate and initiate deployment actions for field survey support team and remote sensing aircraft to incident area.	DOC	DOC-1

Department of Defense

Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
■	■	■	■	■	■	I+2 hours	Initiate deployment actions for Defense Coordinating Officer (DCO) and supporting Defense Coordinating Element (DCE) to JFO or Initial Operating Facility (IOF).	DoD	DoD-1
	■	■	■	■	■	I+4 hours	Alert HQ Joint Task Force – Civil Support (JTF-CS) and designated Initial Entry Forces (IEFs). Deploy Command Assessment Element (CAE) to provide rapid mission assessment in coordination with Federal authorities. Identify key IEF capabilities as required based on assessment and coordination with DHS.	DoD	DoD-2
■	■	■	■	■	■	I+24 hours	Initiate deployment actions for a medical regulating team.	DoD	DoD-3

Department of Energy

Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
			■	■		I+1 hour	Activate DOE Nuclear Incident Team (NIT) at DOE Emergency Operations Center (EOC).	DOE	DOE-1
			■	■		I+2 hours	Deploy Radiological Assistance Program (RAP) Teams.	DOE	DOE-2
			■	■		I+4 hours	Deploy Aerial Measurements System (AMS).	DOE	DOE-3
			■	■		I+4 hours	Initiate deployment actions for Nuclear Radiological Advisory Team (NRAT).	DOE	DOE-4
			■	■		I+4 hours	Activate FRMAC and deploy Consequence Management Response Team.	DOE	DOE-5

Department of Health and Human Services								
Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
■	■	■	■	■	■	I+15 minutes	Activate the HHS Secretary's Emergency Response Team (SERT).	HHS	HHS-1
	■	■	■	■		**I+15 minutes**	**Initiate actions to deploy and deliver appropriate Strategic National Stockpile (SNS) initial push-packages to a Federal Mobilization Center or other designated reception location.**	**HHS**	**HHS-2**
■	■	■	■	■	■	**I+30 minutes**	**Initiate deployment actions for appropriate ESF#8 Regional resources (such as the Regional Health Administrator) to the Regional and State Operations Centers.**	**HHS**	**HHS-3**
■	■	■	■	■	■	I+30 minutes	Activate on call roster of U.S Public Health Service (PHS) Commissioned Corps.	HHS	HHS-4
■	■	■	■	■	■	I+45 minutes	Activate the American Association of Blood Banks Interorganizational Task Force on Domestic Disasters and Acts of Terrorism (AABB Task Force) to assess current blood supply levels throughout the country.	HHS	HHS-5
■	■	■	■	■	■	**I+1 hour**	**Activate Rapid Response Victim Registry.**	**HHS**	**HHS-6**
■	■	■	■	■	■	I+1 hour	Activate Hospital Asset Reporting and Tracking System (HARTS).	HHS	HHS-7
■	■	■	■	■	■	I+2 hours	Coordinate with the AABB Task Force to identify supply levels at the supporting medical facilities for the incident. Activate supply distribution plans for affected region(s).	HHS	HHS-8
■	■	■	■	■	■	I+4 hours	Obtain Assistant Secretary for Health (ASH) approval for the AABB Task Force coordinated public information announcement regarding the adequacy and safety of the Nation's blood supply.	HHS	HHS-9
■	■	■	■	■	■	**I+4 hours**	**Initiate deployment actions for the HHS SERT.**	**HHS**	**HHS-10**
		■				**I+6 hours**	**Initiate deployment actions for EIS officers and other staff to support epidemiological investigations.**	**HHS**	**HHS-11**
■	■	■	■	■		**I+6 hours**	**Initiate deployment actions for food safety inspectors.**	**HHS**	**HHS-12**
	■	■	■	■	■	I+6 hours	Update estimates/actual reporting of number of victims.	HHS	HHS-13

Department of Health and Human Services

Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
	■	■	■	■		**I+12 hours**	**Deploy and deliver appropriate Strategic National Stockpile (SNS) initial push-packages to a Federal Mobilization Center or other designated reception location.**	**HHS**	**HHS-14**
■	■	■	■	■	■	**I+12 hours**	**Initiate deployment actions for on-call roster of PHS Commissioned Corps.**	**HHS**	**HHS-15**
■	■	■	■	■	■	I+12 hours	Activate all PHS Commissioned Corps rosters.	HHS	HHS-16
	■	■	■	■	■	I+36 hours	Begin backfill of medical support packages from Strategic National Stockpile.	HHS	HHS-17
■	■	■	■	■	■	**I+72 hours**	**Initiate deployment actions for all PHS Commissioned Corps rosters.**	**HHS**	**HHS-18**
■	■	■	■	■	■	I+72 hours	Activate all PHS Commissioned Corps deployable assets.	HHS	HHS-19

Department of Homeland Security

Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
			■	■		I+10 minutes	Activate Emergency Alert System (EAS).	DHS	DHS-1
■	■	■	■	■	■	I+10 minutes	Activate Incident Communications Emergency Plan (ICEP).	DHS	DHS-2
■	■	■	■	■	■	I+10 minutes	Activate National Incident Communications Conference Line (NICCL).	DHS	DHS-3
			■	■		I+10 minutes	Coordinate first release of information to public.	DHS	DHS-4
■	■	■	■	■	■	I+10 minutes	Establish and maintain lines of communication with State authorities for incident venues.	DHS	DHS-5
■	■	■	■	■	■	I+15 minutes	Designate Federal Mobilization Center site(s) and notify NRP-CIS action agencies.	DHS	DHS-6
■	■	■	■	■	■	**I+15 minutes**	**Activate and initiate deployment actions for the FEMA Mobilization Center Team and equipment cache.**	**DHS**	**DHS-7**

Department of Homeland Security								
Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
■	■	■	■	■	■	**I+15 minutes**	**Initiate deployment actions for an ERT-A (including Rapid Needs Assessment Team), the on-alert Federal Initial Response Support Team (FIRST), and the on-alert National Emergency Response Team (ERT-N). Place all remaining FIRSTs and ERT-Ns on full alert.**	**DHS**	**DHS-8**
■	■	■	■	■	■	I+15 minutes	Activate, at full staffing levels, the IIMG, NRCC (including MCC), and Regional Response Coordination Centers (RRCCs) with incident oversight. Activate all other RRCCs at watch staff levels.	DHS	DHS-9
■	■	■	■	■	■	**I+30 minutes**	**Activate Mobile Emergency Response Support (MERS) and deploy Life Support Vehicles and MERS Emergency Operations Vehicle to the affected area to establish a temporary operating location for the Principal Federal Official (PFO) and support staff. MERS deployment elements to carry JFO set-up equipment (100-person JFO kit and two DISC Packs).**	**DHS**	**DHS-10**
■				■	■	**I+30 minutes**	**If the incident involves collapsed structures, activate and initiate deployment actions for all on-alert, weapons of mass destruction (WMD)-equipped National US&R Task Forces, Incident Support Teams (ISTs), and caches. Activate and fully mobilize all other WMD-equipped National US&R assets in place. Place all remaining National US&R Task Forces and ISTs on full alert. Deployment into the incident area will be as directed by the National Response Coordination Center (NRCC).**	**DHS**	**DHS-11**
	■	■	■	■		**I+30 minutes**	**Activate USCG National Strike Force to deploy three 10-person HAZMAT teams.**	**DHS**	**DHS-12**
■			■	■		**I+30 minutes**	**Initiate actions to immediately deploy 4800 cots.**	**DHS**	**DHS-13**
■			■	■		**I+30 minutes**	**Initiate actions to immediately deploy 9600 blankets.**	**DHS**	**DHS-14**
■			■	■		**I+30 minutes**	**Initiate actions to immediately deploy 30,000 emergency heater meals.**	**DHS**	**DHS-15**
■			■	■		**I+30 minutes**	**Initiate actions to immediately deploy 1500 personal toilets with privacy tents.**	**DHS**	**DHS-16**

Department of Homeland Security								
Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
■			■	■		**I+30 minutes**	**Initiate actions to immediately deploy 6600 daily restroom kits.**	**DHS**	**DHS-17**
■			■	■		**I+30 minutes**	**Initiate actions to immediately deploy 1500 personal wash kits.**	**DHS**	**DHS-18**
■			■	■		**I+30 minutes**	**Initiate actions to immediately deploy 900 sleeping bags.**	**DHS**	**DHS-19**
■			■	■		**I+30 minutes**	**Initiate actions to immediately deploy 300 tents (6-8 person).**	**DHS**	**DHS-20**
■						**I+30 minutes**	**Initiate actions to immediately deploy 1740 rolls of plastic sheeting (20x100).**	**DHS**	**DHS-21**
■			■	■		**I+30 minutes**	**Initiate actions to immediately deploy 30,000 gallons of bottled water.**	**DHS**	**DHS-22**
■			■	■		**I+30 minutes**	**Initiate actions to immediately deploy 48 mid-range generators.**	**DHS**	**DHS-23**
■			■	■		**I+30 minutes**	**Initiate actions to immediately deploy 1 million MREs (via 46 trailers).**	**DHS**	**DHS-24**
■			■	■		**I+30 minutes**	**Initiate actions to immediately deploy 200,000 gallons of water (via 40 trailers) and source 400,000 lbs of ice (10 trailers).**	**DHS**	**DHS-25**
■			■	■		**I+30 minutes**	**Initiate actions to immediately deploy ten 250-person Pre-Positioned Disaster Supply containers.**	**DHS**	**DHS-26**
■			■	■	■	**I+30 minutes**	**Initiate actions to immediately deploy nine 500-person Pre-Positioned Disaster Supply containers.**	**DHS**	**DHS-27**
■	■	■	■	■	■	I+40 minutes	Conduct interagency conference call and develop initial communications strategy and plan.	DHS	DHS-28
■	■	■	■	■	■	**I+1 hour**	**Designate a PFO, who will assemble a support staff and deploy to the affected area as soon as possible.**	**DHS**	**DHS-29**
■	■	■	■	■	■	I+1 hour	Designate Federal staging areas inside incident area (forward of Federal Mobilization Center)..	DHS	DHS-30
■	■	■	■	■	■	**I+1 hour**	**Initiate deployment actions for one (1) NDMS Management Support Team (MST) and equipment cache.**	**DHS**	**DHS-31**
■	■	■	■	■	■	I+1 hour	Activate the National Disaster Medical System (NDMS).	DHS	DHS-32

Department of Homeland Security								
Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
■	■	■	■	■		I+1 hour	Provide initial HHS-coordinated public service announcement. Coordinate and issue follow-on announcements at frequent and regular intervals.	DHS	DHS-33
■	■	■	■	■	■	I+1 hour	DHS Secretary makes first senior Federal announcement of incident and response effort.	DHS	DHS-34
■	■	■	■	■	■	I+1 hour	Activate a National Joint Information Center (JIC) to coordinate all response-related press and media affairs.	DHS	DHS-35
			■	■		I+1 hour	Release updated nuclear/ radiological incident advice to general public.	DHS	DHS-36
	■	■	■	■		I+1 hour	Activate Public Affairs surge plans.	DHS	DHS-37
■	■	■	■	■	■	**I+1½ hours**	**Initiate establishment of a Joint Information Center (JIC) at incident site.**	**DHS**	**DHS-38**
■	■	■	■	■	■	I+1½ hours	Release updated incident and information statement to general public.	DHS	DHS-39
■	■	■	■	■	■	**I+2 hours**	**Activate and deploy Pre-positioned Equipment Program Teams.**	**DHS**	**DHS-40**
■	■	■	■	■	■	**I+2 hours**	**Initiate deployment actions for ERT-N Joint Field Office (JFO) equipment and support kits.**	**DHS**	**DHS-41**
						I+2 hours	**Initiate deployment actions for Emergency Housing Support Team.**	**DHS**	**DHS-42**
■	■	■	■	■	■	**I+2 hours**	**Initiate deployment actions for Emergency Temporary Housing units into affected area.**	**DHS**	**DHS-43**
	■		■	■	■	I+2 hours	Determine if decontamination technical assistance resources have been requested and are engaged.	DHS	DHS-44
	■	■	■	■	■	I+2 hours	Obtain preliminary estimate of the number of victims exposed to toxic/ hazardous substance(s), preliminary material identification, and source containment.	DHS	DHS-45
■	■	■	■	■	■	I+2 hours	Activate links to the private sector (e.g., secure CEO COMLINK) and request them, as appropriate, to inventory and identify available transportation assets, potential mass shelter facilities, and medical facilities, personnel, equipment, and supplies.	DHS	DHS-46

Department of Homeland Security								
Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
	■		■	■	■	I+3 hours	Determine zones and boundaries of contamination and advise all response entities.	DHS	DHS-47
	■	■	■	■	■	**I+4 hours**	**Initiate deployment actions for National Medical Response Team (NMRT).**	**DHS**	**DHS-48**
■	■	■	■	■	■	I+4 hours	Initiate/expedite actions to establish a JFO. NRCC and RRCC coordinate JFO size and develop requirements.	DHS	DHS-49
	■	■	■	■	■	**I+6 hours**	**Initiate deployment actions for three (3) NDMS Disaster Medical Assistance Teams (DMATs).**	**DHS**	**DHS-50**
	■	■	■	■	■	**I+6 hours**	**Initiate deployment actions for three (3) NDMS DMAT equipment caches.**	**DHS**	**DHS-51**
	■		■	■	■	I+6 hours	Ascertain extent of success of initial/gross decontamination and containment activities.	DHS	DHS-52
	■		■	■		I+6 hours	Assess local emergency public information activities regarding victim decontamination and engage consultation if adjustments appear necessary.	DHS	DHS-53
■	■	■	■	■	■	I+6 hours	Verify need for additional monitoring equipment at medical treatment facilities and shelters and ensure necessary logistics actions are initiated.	DHS	DHS-54
	■	■	■	■	■	**I+12 hours**	**Initiate deployment actions for two (2) NDMS NMRTs.**	**DHS**	**DHS-55**
	■	■	■	■	■	**I+12 hours**	**Initiate deployment actions for two (2) NDMS NMRT equipment caches.**	**DHS**	**DHS-56**
■	■	■	■	■	■	**I+12 hours**	**Initiate deployment actions for two (2) NDMS Veterinary Medical Assistance Teams (VMATs).**	**DHS**	**DHS-57**
■	■	■	■	■	■	**I+24 hours**	**Initiate deployment actions for eleven (11) NDMS DMATs.**	**DHS**	**DHS-58**
■	■	■	■	■	■	**I+24 hours**	**Activate and initiate deployment actions for eleven (11) NDMS DMAT equipment caches.**	**DHS**	**DHS-59**
	■	■	■	■	■	**I+24 hours**	**Activate and initiate deployment actions for two (2) NDMS DMORT deployable morgue units.**	**DHS**	**DHS-60**
■	■	■	■	■	■	**I+24 hours**	**Activate and initiate deployment actions for one (1) full NDMS MST equipment cache.**	**DHS**	**DHS-61**
■	■	■	■	■	■	I+24 hours	Release public messages providing information on how to apply for individual assistance.	DHS	DHS-62

Department of Homeland Security								
Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
■			■	■		I+24 hours	Initiate actions to immediately deploy 4800 cots.	DHS	DHS-63
■			■	■		I+24 hours	Initiate actions to immediately deploy 9600 blankets.	DHS	DHS-64
■			■	■		I+24 hours	Initiate actions to immediately deploy 30,000 emergency heater meals.	DHS	DHS-65
■			■	■		I+24 hours	Initiate actions to immediately deploy 1500 personal toilets with privacy tents.	DHS	DHS-66
■			■	■		I+24 hours	Initiate actions to immediately deploy 6600 daily restroom kits.	DHS	DHS-67
■			■	■		I+24 hours	Initiate actions to immediately deploy 1500 personal wash kits.	DHS	DHS-68
■			■	■		I+24 hours	Initiate actions to immediately deploy 900 sleeping bags.	DHS	DHS-69
■			■	■		I+24 hours	Initiate actions to immediately deploy 300 tents (6-8 person).	DHS	DHS-70
■						I+24 hours	Initiate actions to immediately deploy 1740 rolls of plastic sheeting (20x100).	DHS	DHS-71
■			■	■		I+24 hours	Initiate actions to immediately deploy 30,000 gallons of bottled water.	DHS	DHS-72
■			■	■		I+24 hours	Initiate actions to immediately deploy 48 mid-range generators.	DHS	DHS-73
■			■	■		I+24 hours	Initiate actions to immediately deploy 1 million MREs (via 46 trailers).	DHS	DHS-74
■			■	■		I+24 hours	Initiate actions to immediately deploy 200,000 gallons of water (via 40 trailers) and source 400,000 lbs of ice (10 trailers).	DHS	DHS-75
■			■	■		I+24 hours	Initiate actions to immediately deploy ten 250-person Pre-Positioned Disaster Supply containers.	DHS	DHS-76
■			■	■		I+24 hours	Initiate actions to immediately deploy nine 500-person Pre-Positioned Disaster Supply containers.	DHS	DHS-77
■			■	■		I+48 hours	Initiate actions to immediately deploy 4800 cots.	DHS	DHS-78
■			■	■		I+48 hours	Initiate actions to immediately deploy 9600 blankets.	DHS	DHS-79
■			■	■		I+48 hours	Initiate actions to immediately deploy 30,000 emergency heater meals.	DHS	DHS-80

Department of Homeland Security								
Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
■			■	■		I+48 hours	**Initiate actions to immediately deploy 1500 personal toilets with privacy tents.**	**DHS**	**DHS-81**
■			■	■		I+48 hours	**Initiate actions to immediately deploy 6600 daily restroom kits.**	**DHS**	**DHS-82**
■			■	■		I+48 hours	**Initiate actions to immediately deploy 1500 personal wash kits.**	**DHS**	**DHS-83**
■			■	■		I+48 hours	**Initiate actions to immediately deploy 900 sleeping bags.**	**DHS**	**DHS-84**
■			■	■		I+48 hours	**Initiate actions to immediately deploy 300 tents (6-8 person).**	**DHS**	**DHS-85**
■						I+48 hours	**Initiate actions to immediately deploy 1740 rolls of plastic sheeting (20x100).**	**DHS**	**DHS-86**
■			■	■		I+48 hours	**Initiate actions to immediately deploy 30,000 gallons of bottled water.**	**DHS**	**DHS-87**
■			■	■		I+48 hours	**Initiate actions to immediately deploy 48 mid-range generators.**	**DHS**	**DHS-88**
■			■	■		I+48 hours	**Initiate actions to immediately deploy 1 million MREs (via 46 trailers).**	**DHS**	**DHS-89**
■			■	■		I+48 hours	**Initiate actions to immediately deploy 200,000 gallons of water (via 40 trailers) and source 400,000 lbs of ice (10 trailers).**	**DHS**	**DHS-90**
■			■	■		I+48 hours	**Initiate actions to immediately deploy ten 250-person Pre-Positioned Disaster Supply containers.**	**DHS**	**DHS-91**
■			■	■		I+48 hours	**Initiate actions to immediately deploy nine 500-person Pre-Positioned Disaster Supply containers.**	**DHS**	**DHS-92**
	■	■	■	■	■	I+72 hours	**Begin backfill of Pre-Positioned Disaster Supplies (PPDS) containers.**	**DHS**	**DHS-93**
■	■	■	■	■	■	I+72 hours	Develop crisis-counseling plan.	DHS	DHS-94
■	■	■	■	■	■	I+72 hours	Assess and quantify projected housing needs.	DHS	DHS-95
■	■	■	■	■	■	I+96 hours	Develop preliminary temporary housing plan.	DHS	DHS-96
■	■	■	■	■	■	I+96 hours	Develop donations strategy and voluntary agency plan.	DHS	DHS-97

Department of Labor

Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
■	■	■	■	■	■	**I+18 hours**	**Initiate deployment actions for Specialized Response Team.**	**DOL**	**DOL-1**

Department of Transportation

Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
			■	■		I+30 minutes	Close airspace in affected area (via Temporary Flight Restrictions (TFRs) and Notices to Airmen (NOTAMs)). Coordinate ground stops as necessary.	DOT	DOT-1
■	■	■	■	■		I+1 hour	Coordinate stoppage of all non-critical cargo and passenger rail, maritime, and highway transportation into incident area.	DOT	DOT-2
■	■	■	■	■	■	**I+2 hours**	**Commence transportation of Execution Schedule Assets (refer to Annex 2, Table 2-1).**	**DOT**	**DOT-3**
■	■	■	■	■		I+3 hours	Provide assessment of transportation system and infrastructure to HSOC and NRCC.	DOT	DOT-4
■	■	■	■	■		I+6 hours	Update status of transportation system and provide emergency transportation management recommendations to DHS. Continue updates as necessary.	DOT	DOT-5

Department of Veterans Affairs

Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
■	■	■	■	■	■	I+24 hours	Primary Receiving Centers (PRCs) within 500 miles of an incident venue prepare to terminate non-critical medical services and redirect available resources for receipt of patients at VA medical facilities.	VA	VA-1

Environmental Protection Agency									
Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
■	■	■	■	■	■	I+4 hours	Assess requirements for facility/ environmental decontamination.	EPA	EPA-1
■	■	■	■	■	■	I+6 hours	Initiate action planning for facility/ environmental decontamination.	EPA	EPA-2

United States Army Corps of Engineers (DoD)									
Incident Type						Initiation Time (no later than)	Action	Responsible Agency / Support Agency	Action Identification
NH	C	B	R	N	E				
■	■	■	■	■	■	**I+3 hours**	**Alert and initiate deployment actions for ESF#3 teams and assets (water, power, debris, housing, ice, structural assessment, deployable tactical operations system).**	**USACE**	**USACE-1**

National Response Plan – Catastrophic Incident Supplement

Annex 2 – Transportation Support Schedule

1. The transportation response strategy will be provided in two phases. The first phase will be the automatic movement of pre-identified teams, equipment, and personnel to Federal Mobilization Center(s) or other designated reception points. The second phase will support the movement of specifically requested assets into or out of the affected area. These phases may overlap, depending on how quickly incident command authorities are able to seize up the situation and determine specific support requirements. Regardless, Federal transportation support and services will continue until the affected infrastructure returns to self-sufficiency.

A. **NRP-CIS Phase.** Designated Execution Schedule assets will be transported automatically, without any request from Federal, State or local authorities. These include various emergency response teams, equipment, and other supplies. Movement of these assets will be sequenced to arrive at Federal Mobilization Center(s) in an appropriate order and quantity. These assets are summarized in **Table 2-1.** DOT maintains a separate listing of all assets in **Table 2-1** that provide detailed coordination, locality, cargo, and contact information to facilitate the movement of these assets.

B. **Standard Transportation Phase.** As incident command authorities begin to establish a credible common operating picture and determine specific critical support requirements, the transportation response strategy will transition to begin supporting emerging resource transportation requests. This phase represents and will be implemented in accordance with standard NRP transportation support procedures and protocols.

2. ESF#1 (Transportation) is responsible for coordinating all transportation support, in collaboration with the NRCC, appropriate RRCC, or JFO.

Table 2-1 – Execution Schedule Transportation Support Summary

Assets will be automatically transported to Federal Mobilization Center(s)

Catastrophic Incident Supplement to the National Response Plan

Transportation Planning Summary

Team/Support Cache	Response Time	Unit Size	Incident Type						Agency	Transportation	
Name of Team or List of Equipment or Supplies	Ready to Deploy Hours following Notification (e.g. N+X)	Number of personnel/ team or equipment/ unit	Natural Hazard	Chemical	Biological	Radiological	Nuclear	Explosive (High Yield)	Parent Agency	Primary Shipper	Secondary Shipper
Management Support Team (MST)	N+2	43 people per team	2	2	2	2	2	2	FEMA	DOT	NA
Management Support Team (MST) cache	N+2	Medical equipment and supplies	2	2	2	2	2	2	FEMA	DOT	NA
Management Support Team (MST) Advanced Element	N+2	5 people per team		1		1	1	1	FEMA	DOT	NA
National Medical Response Team (NMRT)	N+6	50 people per team		3		3	3	3	FEMA	DOT	NA
National Medical Response Team (NMRT) cache	N+6	Medical equipment and supplies		3		3	3	3	FEMA	DOT	NA
Disaster Medical Assistance Team (DMAT)	N+6	35 people per team		14		14	14	14	FEMA	DOT	NA
Disaster Medical Assistance Team (DMAT) cache	N+6	Medical equipment and supplies		14		14	14	14	FEMA	DOT	NA
Deployable Mortuary Operational Response Team (DMORT)	N+24	35 people per team		2		2	2	2	FEMA	DOT	NA
Deployable Mortuary Portable Unit (DPMU) cache	N+24	Medical equipment and supplies		2		2	2	2	FEMA	DOT	NA
Deployable Mortuary Operational Response Team-Weapons of Mass Destruction (DMORT-WMD)	N+24	50 people per team	1				1	1	FEMA	DOT	NA
Deployable Mortuary Operational Response Team-Weapons of Mass Destruction (DMORT-WMD) cache	N+24	Medical equipment and supplies	1				1	1	FEMA	DOT	NA
Veterinary Medical Assistance Team (VMAT)	N+48	22 people per team	2	2	2	2	2	2	FEMA	DOT	NA
Urban Search and Rescue Task Force (USAR)	N+6	70 people per team							FEMA	DOT	NA
Type I Hotshot Crew (94 Crews Nationally)	N+2	20 people per crew	15	15	15	15	15	15	USFS	USFS	DOT

Table 2-1 – Execution Schedule Transportation Support Summary (Continued)

Catastrophic Incident Supplement to the National Response Plan

Transportation Planning Summary

Team/Support Cache	Response Time	Unit Size	Incident Type						Agency	Transportation	
Name of Team or List of Equipment or Supplies	Ready to Deploy Hours following Notification (e.g. N+X)	Number of personnel/ team or equipment/ unit	Natural Hazard	Chemical	Biological	Radiological	Nuclear	Explosive (High Yield)	Parent Agency	Primary Shipper	Secondary Shipper
Type II Incident Management Teams (30 Crews Nationally)	N+12	50 people per Team	5 Teams	5 Teams	5 Teams	5 Teams	5 Teams	5 Teams	USFS	USFS	DOT
Type I Incident Management Teams (16 Crews Nationally)	N+6	50 people per Team	3 Teams	2 Teams	2 Teams	2 Teams	2 Teams	3 Teams	USFS	USFS	DOT
Epidemiologists	N+6	Epidemiologists-100			1				HHS/CDC	Commercial	DOT
Occupational Safety Officers	N+6	Occupational Safety Officers-3	1	1	1	1	1	1	HHS/CDC	Commercial	DOT
Commissioned Corp Readiness Force (CCRF)	N+24	Various Specialities-2503	7	7	7	7	7	7	HHS	Commercial	DOT
HHS Secretary's Emergency Response Team	N+6	15-30	1	1	1	1	1	1	HHS	Commercial	DOT
Food Safety Inspectors	N+6	Varies	1	1	1	1	1	1	HHS/FDA	Commercial	DOT
Rapid Response Team	N+6	1-9 person team	1	1	1	1	1	1	HHS/FDA	Commercial	DOT
Incident Support Team	N+6	1-3person team	1	1	1	1	1	1	HHS/CDC	Commercial	DOT
Emergency Response Team	N+6	200 persons	1	1	1	1	1	1	HHS/CDC ATSDR	Commercial	DOT
Debris Planning and Response Team (PRT)	N+6	3	1	1	1	1	1	1	USACE	DOT	NA
Ice Planning and Response Team (PRT)	N+6	5	1	1	1	1	1	1	USACE	DOT	NA
Logistics Planning and Response Team (PRT)	N+6	16	1 per Mob Site	1 per Mob Site	1 per Mob Site	1 per Mob Site	1 per Mob Site	1 per Mob Site	USACE	DOT	NA
Power Planning and Response Team (PRT)	N+6	6	1	1	1	1	1	1	USACE	DOT	NA
Roofing Planning and Response Team (PRT)	N+6	3	0	0	0	0	0	0	USACE	DOT	NA
Structural Safety Planning and Response Team (PRT)	N+6	4	1	1	1	1	1	1	USACE	DOT	NA
Temporary Housing Planning and Response Team (PRT)	N+6	3	1	1	1	1	1	1	USACE	DOT	NA
Water Planning and Response Team (PRT)	N+6	5	1	1	1	1	1	1	USACE	DOT	NA
Emergency Access Response Team (PRT)	N+6	3	1	1	1	1	1	1	USACE	DOT	NA

Table 2-1 – Execution Schedule Transportation Support Summary (Continued)

Catastrophic Incident Response Annex to the National Response Plan

Transportation Planning Summary

Team/Support Cache	Response Time	Unit Size	Incident Type						Agency	Transportation	
Name of Team or List of Equipment or Supplies	Ready to Deploy Hours following Notification (e.g. N+X)	Number of personnel/ team or equipment/ unit	Natural Hazard	Chemical	Biological	Radiological	Nuclear	Explosive (High Yield)	Parent Agency	Primary Shipper	Secondary Shipper
Accident Response Group	N+4-8	242				1	1		DOE/NNSA	NNSA Aircraft	Military
Aerial Measuring System (AMS)	N+4	Up to 4 Aircraft				1	1		DOE/NNSA	NNSA Aircraft	
Atmospheric Release Advisory Capability (ARAC)	N+0.25	N/A				1	1		DOE/NNSA		
Consequence Management Planning Team	N+4	8				1	1		DOE/NNSA	NNSA Aircraft	Commercial
Consequence Management Response Team	N+4-6	63				1	1		DOE/NNSA	Military	
Federal Radiological Monitoring and Assessment Center (FRMAC)	N+4-36	15-200				1	1		DOE/NNSA	Military	
Search Response Team (SRT) and Search Augmentation Team (SAT)	N+2	31				1	1		DOE/NNSA	Commercial	
Nuclear Radiological Advisory Team (NRAT)	N+6	8				1	1		DOE/NNSA	Military	Commercial
Radiological Emergency Assistance Center/Training Site (REAC/TS)	TBD	6, may bring additional resources from other sites				1	1		DOE/NNSA	Commercial	
Radiological Assistance Program (RAP) Teams	N+2 (duty hours) N+4 (otherwise)	3 to 27				1	1		DOE/NNSA	Commercial	Military
Critical Response Team (CRT)	N+4	48 people per team	1	1	1	1	1	1	Red Cross	Red Cross	DOT
RERT - Las Vegas, NV	N+6	2 people per team				5	5		EPA	DOT	USAF
RERT - Montgomery, AL	N+6	2 people per team				3	3		EPA	DOT	USAF
EPA Emergency Response Program (OSC & ERT)	N+2	10 teams (25 people per team plus equipment)	1	1	1	1	1	1	EPA	EPA	DOT
Medical Emergency Radiological Response Team (MERRT)	N+6	21 people per team				1	1		VA	DOT	VA
Pharmaceutical Cache (143 locations)	N+1	11-18 pallets, 6-11 wheeled carts	1	1	1	1	1	1	VA	DOT	VA
Disaster Medical Assistance Team-VISN #8/ Bay Pines	N+6	60	1	1	1	1	1	1	VA	DOT	VA

National Response Plan – Catastrophic Incident Supplement

Appendix 1 – Basic Planning Assumptions

1. A catastrophic event or attack may occur with little or no warning. Some incidents, such as rapid disease outbreaks, may be well underway before detection.

2. A catastrophic incident may include chemical, biological, radiological, nuclear or high-yield explosive attacks, disease epidemics, and major natural or manmade hazards.

3. A catastrophic incident may result in large numbers of casualties and/or displaced persons, possibly in the tens to hundreds of thousands.

4. The nature and scope of a catastrophic incident will immediately overwhelm State and Local response capabilities and require immediate Federal support.

5. Federal support actions must commence immediately in order to save lives, prevent human suffering, and mitigate severe damage. This will require the mobilization and deployment of Federal assets before they are requested via normal NRP protocols.

6. A detailed and credible common operating picture reflecting critical, urgent needs and requirements may not be achievable for 24 to 48 hours (or longer) after the incident. Accordingly, Federal response support activities must begin without the benefit of a detailed or complete situation and critical needs assessment.

7. The Secretary of Homeland Security will immediately designate the event an Incident of National Significance and direct implementation of the NRP-CIA and NRP-CIS.

8. A catastrophic incident will trigger a Presidential disaster declaration, immediately or otherwise.

9. Multiple incidents may occur simultaneously or sequentially in contiguous and/or noncontiguous areas. Some incidents, such as a biological WMD attack, may be dispersed over a large geographic area, and lack a defined incident site.

10. The majority of deployment-dependent Federal response resources are not likely to provide significant lifesaving or life-sustaining capabilities until 18 to 36 hours after the event. However, Regional Federal capabilities (hospitals, specialists, etc.) can begin providing critical support almost immediately.

11. Movement of casualties throughout the area of operations will pose a significant challenge.

12. The incident may result in significant to massive disruption of the area's critical infrastructure, such as energy, transportation, telecommunications, and public health and medical systems.

13. Large-scale evacuations, organized or self-directed, may occur. More people initially are likely to flee and seek shelter for attacks involving chemical, biological, radiological, or nuclear agents than for natural events. The health-related implications of an incident may aggravate or impair attempts to implement a coordinated evacuation management strategy.

14. There will be a significant shortage of response and casualty/evacuee reception capabilities, equipment, and pharmaceuticals.

15. Adequate water supplies (both potable and non-potable to drive air conditioning systems) may be compromised. Similarly, loss of city power will be only partially met by auxiliary power sources.

16. Depletion of medical supplies and pharmaceuticals may significantly stress the Nation's industrial base and ability to rapidly meet national resource requirements.

17. Large numbers of people (potentially numbering in the hundreds of thousands) may be left temporarily or permanently homeless and will require prolonged temporary housing.

18. Blood supplies will be severely taxed and significant regional shortages could materialize quickly following a catastrophic incident. Blood manufacturing, infectious disease-testing, and distribution of tested blood will be problematic.

19. Due to potentially unforeseen delays in the identification of a non-naturally occurring epidemiological event, detection of disease outbreaks may not occur until large numbers of victims are affected, particularly when the agent has a long incubation period.

20. The response capabilities and resources of the local jurisdiction (to include mutual aid from surrounding jurisdictions and response support from the State) may be insufficient and quickly overwhelmed. Local emergency personnel who normally respond to incidents may be among those affected and unable to perform their duties.

21. Isolation and quarantine (voluntarily or compelled) strategies may be implemented by public health officials to contain the spread of a contagion.

22. Patient transportation to and from airheads and medical treatment facilities (MTFs) will be problematic due to excessive congestion on local roads and limited patient movement alternatives (e.g., rotary wing lift).

23. Emergency protective actions recommendations to the public will likely lack detailed assessment data.

24. 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.

25. There will be significant issues regarding environmental health (e.g., air quality and food safety) and public health (e.g., sanitation, housing, animal health) needs, including mental health services.

26. Public anxiety related to the catastrophic incident will require effective risk communication and may require mental health and substance abuse services.

27. A non-detected/recognized biological release spares the physical infrastructure but results in a uniformly exposed population that is likely to create an overwhelming demand on medical resources. However, the physical infrastructure may require decontamination.

28. A nuclear detonation will significantly degrade and potentially destroy initial local emergency response management, medical, and public health capabilities.

29. Non-Federal hospitals of the NDMS, as well as VA Primary Receiving Centers (PRCs) and DoD MTFs are authorized to provide definitive care to casualties of a catastrophic mass casualty incident.

30. The assets identified in the response strategy may not be available at the time of a catastrophic event due to needs at their home institutions, family requirements, etc.

31. Neighboring States/jurisdictions may resist accepting patients that are contaminated or infectious.

32. 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.

33. If the catastrophic incident results from terrorism, the Homeland Security Advisory System (HSAS) level will likely be raised regionally, and perhaps nationally. Elevation of the HSAS level requires additional local, State, and Federal security enhancements that may affect the availability of certain response resources.

34. A catastrophic incident will present a dynamic response and recovery environment requiring that response plans and strategies be flexible enough to effectively address emerging or transforming needs and requirements.

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National Response Plan – Catastrophic Incident Supplement

Appendix 2 – Inventory of Federal Response Teams

Team Name	Team Mission Description	Agency	Point of Contact	Applicable Incident Type						Other (List)
				NH	C	B	R	N	E	
Critical Response Team (CRT)	American Red Cross (ARC) national Headquarters (HQs) trained team assesses local needs; quickly initiates ARC national relief operation.	ARC	Disaster Operations Center (202) 303-5555 Ask for manager on call	X	X	X	X	X	X	Agricultural, food-borne, aviation and other transportation disasters
Border Patrol Search, Trauma, and Rescue Team (BORSTAR)	Provides tactical search and rescue capabilities with special expertise in rough terrain operations. It is fully supported by Bureau of Customs and Border Protection (CBP) air and marine assets.	DHS/BTS CBP	CBP Operations Center (202) 344-3910	X						
Border Patrol Tactical Unit (BORTAC)	Provides tactical law enforcement teams and is fully supported by CBP air and marine assets.	DHS/BTS CBP	CBP Operations Center (202) 344-3910	X						
Laboratory and Scientific Services (LSS) Weapons of Mass Destruction (WMD) Response Teams	Provides Level "A" hazardous material (HAZMAT) technical response capabilities.	DHS/BTS CBP	CBP Operations Center (202) 344-3910		X	X	X			
Crush Medical Assistance	Provide specialized medical assistance to victims of crush injuries due to collapsed structures.	DHS FEMA NDMS	NDMS Operations Support Center (OSC) (202) 646-4580	X				X	X	
Disaster Medical Assistance Team (DMAT)	Provide primary and acute care, triage of mass casualties, initial resuscitation, stabilization, advanced life support, and preparation of sick or injured patients for evacuation.	DHS FEMA NDMS	NDMS OSC (202) 646-4580	X	X	X	X	X	X	

Team Name	Team Mission Description	Agency	Point of Contact	Applicable Incident Type						Other (List)
				NH	C	B	R	N	E	
Disaster Mortuary Operational Response Team (DMORT)	Provide temporary morgue facilities; victim identification; forensic dental pathology; forensic anthropology; and processing, preparation, and disposition of remains.	DHS FEMA NDMS	NDMS OSC (202) 646-4580	X	X	X	X	X	X	
Disaster Mortuary Operational Response Team – WMD	Provide for decontamination of remains.	DHS FEMA NDMS	NDMS OSC (202) 646-4580	X	X	X	X	X	X	
Disaster Response Team	Provides emergency tele-communications and local area network/wide area network (LAN/WAN) support for all-hazard missions.	DHS FEMA	Enterprise Operations National Helpdesk (540) 542-4000	X	X	X	X	X	X	Oil, agricultural, food-borne, terrorism
Domestic Emergency Support Team (DEST)	A rapidly deployable, interagency team responsible for providing expert advice and support concerning the Federal Government's capabilities in resolving a terrorist threat or incident.	DHS FEMA	(202) 646-3685	X	X	X	X	X	X	Food-borne
Federal Incident Response Support Team (FIRST)	A forward component of the ERT-A that provides on-scene support to the local Incident Command or Area Command structure in order to facilitate an integrated interjurisdictional response.	DHS FEMA	FEMA NRCC (202) 646-2470	X	X	X	X	X	X	As required
Hurricane Liaison Team (HLT)	The Hurricane Liaison Team supports effective hurricane response by providing capability to facilitate information exchange between emergency managers and the National Hurricane Center.	DHS FEMA	FEMA NRCC (202) 646-2470	X						

Team Name	Team Mission Description	Agency	Point of Contact	Applicable Incident Type						Other (List)
				NH	C	B	R	N	E	
International Medical Surgical Response Team (IMSuRT)	The IMSuRT provides triage and initial stabilization, definitive surgical care, critical care and evacuation capacity.	DHS FEMA	NDMS OSC (301) 443-1167, ext 2	X	X	X	X	X	X	Food-borne
Mobile Air Transportable Telecomm System (MATTS) (1 Team)	The MATTS Team deploys to support initial communications and command and control missions in support of FEMA's all-hazard response missions.	DHS FEMA	MERS Operations Center (800) 792-6196	X	X	X	X	X	X	
Mobile Emergency Response Support (MERS) Detachment	Functioning as an extension of FEMA's Command and Control System, the MERS is the focal point for State and local governments and coordinates emergency responses of assigned resources.	DHS FEMA	Operations Center (229) 225-4756	X	X	X	X	X	X	
Mobilization Center Management Team (MCMT)	Unified Management Group set up by FEMA HQ and deployed to set up and operate a Mobilization Center in the field.	DHS FEMA	FEMA NRCC (202) 646-2828	X	X	X	X	X	X	Agricultural, food-borne
Emergency Response Team (ERT)	An interagency team organized at each of the 10 FEMA Regions that coordinates the Regional response operations within an impacted State. The Regional Director activates the Emergency Response Team (ERT).	DHS FEMA	FEMA NRCC (202) 646-2828	X	X	X	X	X	X	Agricultural, food-borne
National Emergency Response Teams (ERT-N)	One of three nationally organized ERTs staffed by agency experts and deployed at the direction of the Under Secretary to high visibility or catastrophic incidents.	DHS FEMA	FEMA NRCC (202) 646-2828	X	X	X	X	X	X	Agricultural, food-borne

Team Name	Team Mission Description	Agency	Point of Contact	Applicable Incident Type						Other (List)
				NH	C	B	R	N	E	
National Response Coordination Center (NRCC)	An interagency team that operates at FEMA HQ during national level disasters and emergencies to coordinate national level response operations.	DHS FEMA	FEMA NRCC (202) 646-2828	X	X	X	X	X	X	Agricultural, food-borne
National Medical Response Team (NMRT)	The four 50-person NMRTs are equipped and trained to perform the functions of a DMAT, but possess additional capabilities to respond to a chemical, biological, radiological, nuclear, or high-yield explosive (CBRNE) event, to include operating in Level "A" protective equipment.	DHS FEMA NDMS	NDMS OSC (301) 443-1167, ext 2	X	X	X	X	X	X	Food-borne
Rapid Needs Assessment Team	The Rapid Needs Assessment Team is a small and self-sufficient team that collects and provides information on disasters to determine requirements for critical resources. The team operates as a component of an Advanced ERT.	DHS FEMA	FEMA NRCC (202) 646-2828	X	X	X	X	X	X	Oil
Urban Search and Rescue (US&R) Task Forces	70-person multi-disciplinary task force for the extrication, rescue, and medical stabilization of victims trapped in collapsed structures.	DHS FEMA	NDMS/US&R Operations Center (800) 872-6367	X	X		X	X	X	Oil, transportation accidents
Veterinary Medical Response Team (VMAT)	Teams of veterinary specialists.	DHS FEMA	NDMS OSC (301) 443-1167, ext 2	X	X	X	X	X	X	Food-borne
Correctional Special Response Team (SRT)	Located nationwide, multiple teams to respond to disturbances and other high-risk activities within Detention and Correctional facilities.	DHS/ICE	ICE Operations Center (866) 514-2423	X						Correctional institution response

Team Name	Team Mission Description	Agency	Point of Contact	Applicable Incident Type						Other (List)
				NH	C	B	R	N	E	
Special Response Teams (SRT)	Located nationwide, multiple teams to respond to high-risk and other specialized law enforcement activities.	DHS/ICE	ICE Operations Center (866) 514-2423	X						Support of law enforcement operations and other special events
Hazardous Response Program	Located nationwide, multiple teams to respond to CBRNE threats and incidents to protect Federal workers and property. Investigation, HAZMAT assessment, occupant evacuation and shelter in place assistance.	DHS/ICE	ICE Operations Center (866) 514-2423	X	X	X	X	X	X	
Explosive Detection Dog (EDD) Teams	Located in major cities, multiple law enforcement teams perform explosive searches of buildings, vehicles, materials, and persons.	DHS/ICE	ICE Operations Center (866) 514-2423						X	
Explosives Division	Expert, rapidly deployable Explosive Ordnance Disposal (EOD) personnel stationed nationwide, skilled in CBRNE response.	DHS/ICE	ICE Operations Center (866) 514-2423		X	X	X	X	X	Post-blast analysis, explosive scenario experts
Interagency Modeling and Atmospheric Analysis Center (IMAAC)	The IMAAC is responsible for production, coordination, and dissemination of consequence predictions for an airborne HAZMAT release.	DHS/S&T	Emergency Hotline (925) 422-9100		X	X	X	X	X	
Science and Technology Advisory and Response Teams (STARTs)	Provide rapid scientific and technical support through virtual links and deployed elements.	DHS/S&T	S&T Watch Desk (202) 282-8125	X	X	X	X	X	X	

Team Name	Team Mission Description	Agency	Point of Contact	Applicable Incident Type						Other (List)
				NH	C	B	R	N	E	
National Screening Force	Provides screening support to all airports in times of emergency, or under other special circumstances that require a greater number of screeners than regularly available	DHS/TSA	(571) 227-1505							
Explosives Detection Canine Teams	These teams search areas in response to bomb threats associated with airport terminals and aircraft, luggage, cargo, and vehicles.	DHS/TSA	(571) 227-1269						X	
National Strike Force/Teams	The National Strike Force provides personnel and equipment to facilitate preparedness and response to oil and hazardous substance pollution incidents. This consists of 3 regionally based Strike Teams and a Public Information Assist Team (PIAT).	DHS/USCG	USCG HQ Crisis Action Center (202) 267-2100	X	X	X	X	X	X	
Marine Safety and Security Team (MSST)	Provides specialized law enforcement and security expertise and capabilities.	DHS/USCG	USCG HQ Crisis Action Center (202) 267-2100	X	X	X	X	X	X	
National Construction Safety Team	Investigative team formed on an as needed basis from technical experts from the Federal community and private sector to assess building performance and emergency response and evacuation procedures in the wake of any building failure that has resulted in substantial loss of life or that posed the potential for substantial loss of life.	DOC NIST	NIST Emergency Communications Center (NIST Police) (301) 975-2805	X					X	Building fire and safety

Team Name	Team Mission Description	Agency	Point of Contact	Applicable Incident Type						Other (List)
				NH	C	B	R	N	E	
Atmospheric Dispersion Team	Supports analysis of atmospheric agents.	DOC NOAA	DOC EOC (202) 482-5100	X	X		X	X		Forest fires, volcanoes
Navigation Response Teams	Emergency hydrographic surveys, submerged object/ obstruction detection to assist in safe vessel movement. Provide rapid chart revisions; create situation-specific charts to U.S. Coast Guard for marine operation in event of an emergency.	DOC NOAA	DOC EOC (202) 482-5100	X					X	
Law Enforcement Team	Federal maritime enforcement agency with the ability to provide a broad range of law enforcement response and support services on a 24/7 basis to emergencies throughout the United States and its Territories.	DOC NOAA	DOC EOC (202) 482-5100	X	X	X	X	X	X	
National Geodetic Survey (NGS) Field Operations Response Team	Field survey team capable of providing a variety of positional and geospatial support.	DOC NOAA	DOC EOC (202) 482-5100	X					X	
NGS Remote Sensing Response Team	Provides end-to-end acquisition and processing of remote sensing data (both aircraft and satellite) including digital imagery and LIDAR.	DOC NOAA	DOC EOC (202) 482-5100	X					X	
HAZMAT Scientific Support Team	Provides scientific expertise of responses to marine releases of oil and hazardous materials.	DOC NOAA	DOC EOC (202) 482-5100							

Team Name	Team Mission Description	Agency	Point of Contact	Applicable Incident Type						Other (List)
				NH	C	B	R	N	E	
National Weather Service (NWS) Incident Meteorologist (IMET)	NWS IMETs provide onsite meteorological support with site-specific weather forecasts.	DOC NOAA	DOC EOC (202) 482-5100	X	X	X	X	X	X	Wildfires
Aerial Measuring System (AMS)	Aerial survey for detection, measurement, and tracking of radioactive material.	DOE	DOE Emergency Response Officer (202) 586-8100				X	X		
National Atmospheric Release Advisory Center (NARAC)	Creates predictive plots of radioactive contamination after a release using computer models.	DOE	DOE Emergency Response Officer (202) 586-8100				X	X		
Radiation Emergency Assistance Center/Training Site (REAC/TS)	Treatment and medical consultation for injuries resulting from radiation exposure.	DOE	DOE Emergency Response Officer (202) 586-8100				X	X		
Radiological Assistance Program (RAP)	First responder program for assessing and characterizing radiological hazards.	DOE	DOE Emergency Response Officer (202) 586-8100				X	X		
Accident Response Emergency Weapon Group (ARG)	Responds to accidents and emergencies involving U.S. nuclear weapons.	DOE	DOE U.S. Nuclear Response Officer (202) 586-8100				X	X		
Federal Radiological Monitoring and Assessment Center (FRMAC)	Coordinates Federal radiological monitoring and assessment activities with those of State and local agencies.	DOE	DOE Emergency Response Officer (202) 586-8100				X	X		
Nuclear Emergency Support Team (NEST)	Specialized technical expertise in search, identification, and resolution of nuclear/ radiological terrorist incidents.	DOE	DOE Emergency Response Officer (202) 586-8100				X	X		

Team Name	Team Mission Description	Agency	Point of Contact	Applicable Incident Type						Other (List)
				NH	C	B	R	N	E	
Earthquake Response Team	Disseminates the location, size and, where possible, impacts of destructive earthquakes worldwide, delivering this information immediately to concerned national and international agencies; after a major event, U.S. Geological Survey (USGS) can deploy a team of seismologists to conduct post-earthquake investigations and provide aftershock warnings.	DOI USGS	National Earthquake Information Center (NEIC) (303) 273-8500	X						
Volcano Disaster Action Team	USGS rapidly responds to developing volcanic crises by deploying a team of scientists with a state-of-the-art portable cache of monitoring equipment to determine the nature and possible consequences of volcanic unrest and communicate eruption forecasts and hazard-mitigation information to local authorities.	DOI USGS	Volcano Hazards Program Coordinator CONUS and Hawaii (703) 648-6711 Alaska (907) 786-7497	X						
National Response Team	These teams assist federal, state, and local investigators in meeting the challenges faced at the scenes of significant arson and explosives incidents. The teams work alongside state and local officers in reconstructing the scene, identifying the site of the blast or origin of the fire, conducting interviews, and sifting through debris to obtain evidence related to the incident.	DOJ/ATF	ATF National Response Coordination Center (NRCC) (202) 927-7777		X	X	X		X	

Team Name	Team Mission Description	Agency	Point of Contact	Applicable Incident Type						Other (List)
				NH	C	B	R	N	E	
Special Response Teams	Teams trained in special weapons and tactics.	DOJ/ATF	ATF NRCC (202) 927-7777							Execution of high threat law enforcement actions; crowd control, provides a reactionary team at special events
Emergency Medical Response Team	A rapid response medical team that can be deployed quickly for trauma situations or natural disasters.	DOS	(202) 663-1611	X	X	X			X	
Evacuation Liaison Team	Facilitates the sharing of timely and accurate evacuation traffic information among Federal and state emergency management and public safety officials during multi-state hurricane threats.	DOT	(404) 305-5471	X	X	X	X	X	X	Can provide evacuation facilitation for other incident types, as required.
Emergency Communications and Outreach Team (ECOT)	A support team of 30 communicators who have the expertise to function as the Public Information Officer (PIO) during an emergency response.	EPA	EPA EOC (202) 564-3850	X	X	X	X	X	X	Oil, HAZMAT, all EPA and FEMA-related incidents
Emergency Response Peer Support and Critical Incident Stress Management (CISM)	Provides stress management and trauma prevention assistance to EPA's emergency responders.	EPA	EPA EOC (202) 564-3850	X	X	X	X	X	X	Agricultural, food-borne
Environmental Response Team	Provides specialized technical assistance to the On-Scene Coordinator (OSC). Areas include health and safety, environmental sampling, ecological assessment, toxicology, air monitoring, waste treatment, and site decontamination and cleanup.	EPA	Duty Officer (732) 321-6660	X	X	X	X	X	X	Agricultural, food-borne

Team Name	Team Mission Description	Agency	Point of Contact	Applicable Incident Type						Other (List)
				NH	C	B	R	N	E	
Environmental Protection Agency (EPA) National Decontamination Team	Provides technical assistance in decontaminating nonliving infrastructure (buildings, airports, stadiums, shopping malls, etc.).	EPA	EPA EOC (202) 564-3850	X	X	X	X	X	X	
EPA Diving Team	Provides expertise for operations involving contaminated water diving, hazardous response, criminal enforcement, and national disaster response.	EPA	EPA EOC (202) 564-3850	X	X	X	X			Agricultural, food-borne
Ocean Survey Vessel	Provides off-shore monitoring and assessment of coastal waters in Gulf of Mexico, Caribbean, and along the east coast.	EPA	EPA EOC (202) 564-3850	X	X	X	X			Agricultural, food-borne
Office of Enforcement, Compliance, and Assurance (OCEA) and National Counterterrorism Evidence Response Team (NCERT)	Provides technical, safety, hazardous evidence collection, and other forensic support to law enforcement in the event of a WMD terrorist attack or environmental catastrophe.	EPA	EPA EOC (202) 564-3850	X	X	X	X	X	X	Agricultural, food-borne
Radiological Emergency Response Team (RERT)	Provides expertise in radiological monitoring and sampling, and analytical capabilities.	EPA	EPA EOC (202) 564-3850				X	X		
Regional Response Teams	Plan, prepare, and coordinate response activities on regular intervals at an interagency Regional level.	EPA	EPA EOC (202) 564-3850	X	X	X	X	X	X	Agricultural, food-borne
National Response Team (NRT)	Provides technical assistance and planning, preparedness, and policy guidance in preparation for and in response to oil and hazmat incidents.	EPA USCG	EPA EOC (202) 564-3850	X	X	X	X	X	X	Agricultural, food-borne

Team Name	Team Mission Description	Agency	Point of Contact	Applicable Incident Type						Other (List)
				NH	C	B	R	N	E	
Liquefied Natural Gas (LNG) Emergency Response Team	Rapid response to an accident involving jurisdictional LNG plant or vessel.	FERC	EOC (202) 498-2207		X					Oil, LNG terminal or tanker accident
Pipeline Reconstruction Team	Appropriate response to an accident involving jurisdictional pipeline facilities.	FERC	EOC (202) 498-2207		X					Oil, natural gas, pipeline accident or attack
U.S. Public Health Service (PHS) Commissioned Corps	A cadre of highly trained and mobile health professionals.	HHS	SOC (202) 619-7800	X	X	X	X	X	X	
Secretary's Emergency Response Team (SERT)	The SERT is deployed to the vicinity of an incident and directs and coordinates the activities of all HHS personnel deployed to the incident site(s).	HHS	SOC (202) 619-7800	X	X	X	X	X	X	
Food and Drug Administration (FDA) Rapid Response Team	Collect samples of FDA regulated products of an unknown or known hazardous containment.	HHS FDA	FDA/OCM EOC (301) 443-1240	X	X	X		X	X	Oil, agricultural, food-borne
Technical Advisory Response Unit	This team is comprised of pharmacists, emergency responders, and logistics experts that will advise local authorities on receiving, distributing, dispensing, replenishing, and recovering SNS materiel.	HHS CDC	(404) 687-6523	X	X	X	X	X	X	Support the Strategic National Stockpile (SNS)
Incident Support Team (IST)	Provides on-site logistics, administration, and reach-back communications support for CDC's emergency response personnel.	HHS CDC	CDC Director's EOC (770) 488-7100	X	X	X	X	X	X	
Regional Based Team (Base Team)	Supports both the Executive and Site Teams.	NRC	NRC HQ Operations Center (301) 816-5100				X			Incident at NRC regulated facility or involving radioactive materials licensed by NRC

Team Name	Team Mission Description	Agency	Point of Contact	Applicable Incident Type						Other (List)
				NH	C	B	R	N	E	
Site Team	Implements Nuclear Regulatory Commission (NRC) on-scene primary Federal agency role.	NRC	NRC HQ Operations Center (301) 816-5100				X			Incident at NRC regulated facility or involving radioactive materials licensed by NRC
Safety Board "Go Team"	Conduct investigation of a major aviation, rail, highway, marine or pipeline accident at the scene, as quickly as possible.	National Transportation Safety Board (NTSB)	(202) 314-6421	X					X	Transportation-related accident
Transportation Disaster Assistance Team	Teams provide family/victim support coordination, Family Assistance Centers, forensic services, communicating with foreign governments, and inter-agency coordination following major transportation accidents.	NTSB	(202) 314-6421	X					X	Transportation-related accident
National Type-I Incident Management Team	All risk incident management using Incident Command System (ICS).	USDA USFS	USFS Disaster and Emergency Operations (202) 205-1500	X	X	X	X	X	X	Wildfires, agricultural, food-borne
Geographical Type-II Incident Management Team	All risk incident management using ICS.	USDA USFS	USFS Disaster and Emergency Operations (202) 205-1500	X	X	X	X	X	X	Wildfires, agricultural, food-borne
National Area Command Team	All risk incident management using ICS.	USDA USFS	USFS Disaster and Emergency Operations (202) 205-1500	X	X	X	X	X	X	Wildfires, agricultural, food-borne
Incident Complexity Analysis Group	Characterizes human, physical and financial resource needs for response to a foreign animal disease outbreak.	USDA/ Animal and Plant Health Inspection Service (APHIS)	APHIS EOC (301) 436-3110	X	X	X	X	X	X	Livestock, production agriculture, food-borne, all-hazards affecting livestock

Team Name	Team Mission Description	Agency	Point of Contact	Applicable Incident Type						Other (List)
				NH	C	B	R	N	E	
Veterinary Diagnostic Teams	Conducts epidemiological investigation and economic impact assessment in response to the diagnosis of an unusual domestic livestock disease incident.	USDA/ APHIS	APHIS EOC (301) 436-3110		X	X				Livestock, agriculture
Animal Emergency Response Organization	Provides operational and support infrastructure for a State to respond to all-hazards emergencies.	USDA/ APHIS	APHIS EOC (301) 436-3110	X	X	X	X	X	X	Livestock, production agriculture, food-borne, all-hazards affecting livestock
Incident Management Team	Provides short-term response capability during a foreign animal disease outbreak.	USDA/ APHIS	APHIS EOC (301) 436-3110	X	X	X	X	X	X	Livestock, production agriculture, food-borne, all-hazards affecting livestock
National Animal Health Emergency Response Corps	Enrolled human resources that are federalized to provide operational and support capability in response to a foreign animal disease outbreak.	USDA/ APHIS	APHIS EOC (301) 436-3110	X	X	X	X	X	X	Livestock, production agriculture, food-borne, all-hazards affecting livestock
Medical Emergency Radiological Response Team (MERRT)	The MERRT responds to any radiological disaster (including nuclear power plant accidents or terrorist activity) that requires medical support and/or decontamination. Once deployed, the team provides radiological decontamination, medical support and consultation, and radiation training/consultation to hospital or others during an emergency.	VA	VA Readiness Operations Center (RRCC) (202) 273-5510	X			X	X		

National Response Plan – Catastrophic Incident Supplement

Appendix 3 – Mass Care Response Overview

1. Mission

Mass Care coordinates Federal assistance in support of Regional, State, and local efforts to meet the mass care needs of victims of a disaster. This Federal assistance will support the delivery of mass care services of shelter, feeding, and emergency first aid to disaster victims; 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.

2. Planning Assumptions

A. The American Red Cross (ARC) is designated a primary agency for Emergency Support Function (ESF) #6 (Mass Care, Housing, and Human Services) with the lead for mass care. In this role, the ARC mission is to coordinate Federal mass care assistance and support when a disaster event exceeds the resources and capacity of State and local responders.

B. ARC also independently provides mass care services to disaster victims as part of a broad program of disaster relief, and as outlined in charter provisions enacted by Congress – Act of January 1905 (36 United States Code (U.S.C.) Section 3001, *et seq.*). The responsibilities assigned to ARC as the co-primary agency for ESF#6 at no time will supersede those responsibilities assigned to the ARC by its congressional charter.

C. The ARC is assigned support agency responsibilities for ESF#8 (Public Health and Medical Services) by the National Response Plan (NRP). These responsibilities center on augmenting certain health and medical service response activities as requested by the primary ESF#8 agency, the Department of Health and Human Services (HHS). HHS also provides support to ARC for the mass care portion of ESF#6.

D. 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.

E. The U.S. Department of Homeland Security (DHS) will likely raise the Homeland Security Advisory System (HSAS) to "red" status immediately following a terrorist attack for designated areas, if not the entire Nation. Depending on the location, scope, and magnitude of the event, this elevated status can prompt actions limiting the availability of air transportation within the United States. Such travel limitations can negatively impact the timely convergence, at the disaster-affected area, of needed personnel and material resources.

F. As a result of the incident, many local emergency personnel—paid and volunteer—that normally respond to disasters may be dead, injured, involved with family concerns, or otherwise unable to reach their assigned posts.

G. 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.

H. State and local resources will immediately be overwhelmed; therefore, Federal assistance will be needed immediately.

I. 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.

J. Populations likely to require mass care services include the following:

(1) Primary victims (with damaged or destroyed homes)

(2) Secondary and tertiary victims (denied access to homes)

(3) Transients (visitors and travelers within the affected area)

(4) 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.*

K. 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.

L. The wide dispersal of disaster victims will complicate Federal Government assistance eligibility and delivery processes for extended temporary housing, tracking, and need for registering the diseased, ill, injured, and exposed.

M. 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.

N. Long-term sheltering, interim housing, and the mass relocation of affected populations may be required for incidents with significant residential damage and/or contamination. (Refer to Appendix 10 for information on catastrophic housing.)

O. Substantial numbers of trained mass care specialists and managers will be required for an extended period of time to augment local responders and to sustain mass care sheltering and feeding activities.

P. Timely logistical support to shelters and feeding sites will be essential and required for a sustained period of time. Food supplies from the U.S. Department of Agriculture (USDA) positioned at various locations across the country will need to be accessed and transported to the affected area in a timely manner.

Q. Close liaison and coordination with numerous voluntary and non-Governmental organizations (NGOs) will be necessary on the national, Regional, State, and local levels.

R. Service delivery to affected populations by voluntary agencies and NGOs will occur in locations deemed safe by appropriate Government officials.

S. 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.

T. 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.

U. 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. The deployment of public health and medical personnel and equipment to support medical needs in shelters will need to be immediate and sustained by HHS. (Refer to Appendix 6 for information on medical support activities.)

V. Shelters will likely experience large numbers of elderly with specific medication requirements and other evacuees on critical home medical care maintenance regimens. (Refer to Appendix 6 for information on medical support activities.)

W. 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. ARC will coordinate with HHS in these situations.

X. DWI may be a priority concern for family members throughout the United States.

Y. Family reunification within the affected area will be an immediate and significant concern as many family members may be separated at the time of the event.

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

AA. There will be an immediate and sustained need for the bulk distribution of relief supplies. Requirements will depend on the nature of and human needs produced by the incident.

BB. Criteria for identifying and validating priority needs will need to be established immediately.

CC. Populations with the resources to help themselves will be encouraged to take independent action.

DD. 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.

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

FF. Coordinated, accurate, timely public information will be required immediately to inform the public of appropriate protective and self-care actions. ARC will support activities at Joint Information Centers (JICs).

GG. Accurate and timely information over time must be distributed to the affected populations to control rumors and assuage anxiety related to the event. This activity will be particularly important following CBRNE-related events.

HH. Mental health services will be sought by victims and responders in and near the affected area, as well as (on a lesser scale) throughout the Nation. ARC will coordinate activities with HHS.

II. If decontamination is ongoing during the early stages of a catastrophic incident, persons undergoing decontamination will have logistical, medical, and mental health needs that will need to be addressed quickly.

JJ. Red Cross staff will have access to needed medications/vaccinations made available to other response personnel providing services.

3. Catastrophic Response Strategy

A. **Response Strategy: IMMEDIATE.**

(1) **Assumptions**

(a) Immediate response activities will focus on meeting urgent mass care needs of victims in safe areas. There will be an increased emphasis on contamination, safety, and security issues for CBRNE events.

(b) 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.

(c) 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.)

(d) 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.

(e) ARC chapters will be immediately augmented (in the form of additional personnel, materials, and equipment deployed to the disaster area) by Red Cross Service Areas and national headquarters. (Refer to Annex 1 – Execution Schedule.)

(f) ESF#6 (Mass Care, Housing, and Human Services) operational cells will be established at the Federal Emergency Management Agency (FEMA) Regional Response Coordination Center(s) (RRCC) and FEMA’s National Response Coordination Center (NRCC). Assessments for resource support to the disaster-affected area will be promptly conducted. The receipt of Federal Government support in the form of personnel, material, and equipment will be in accordance with the NRP.

(g) Contact and coordination will immediately proceed with other voluntary organizations and NGOs. Available resources will be numerated and promptly applied to identified needs and requirements.

(h) HHS will ensure the provision of blood/blood products and public messaging blood supply safety through coordination with the American Association of Blood Banks Task Force on Domestic Disasters and Acts of Terrorism (AABB Inter-Organizational Task Force).

B. **Response Strategy: FIRST 10 DAYS.**

(1) **Assumptions**

(a) Mass care services are at peak activity and in coordination with other voluntary organizations, NGOs, ESF#6 support Federal agencies, and State and local governments. The location and related information for all actual and potential shelters within a 250-mile radius is determined (as well as can be established) and communicated to appropriate authorities and the public. Additionally, 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.

(b) Full coordination with DHS and other Federal Departments/Agencies related to mass care services. Information flows uninterrupted between agencies at the Federal level. Problem area and resolution action information is exchanged promptly and routinely.

(c) Planning is under way with FEMA, Department of Transportation, and other agencies regarding the prompt relocation of people beyond the affected area. This strategy will address the significant logistical requirements of supporting thousands of sheltered people in an otherwise difficult environment for prolonged periods of time. This will also allow the affected area's infrastructure to be repaired and rebuilt without placing additional strain on severely stressed resources. 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.

(d) Ongoing work with HHS and other Federal Agencies will continue to ensure that public health and medical care personnel and equipment are on site where needed.

(e) Liaison and coordination continues at the national level with DHS, HHS, DOT, DoD, and others as needed.

(f) Coordination is under way with the DHS Private Sector desk to draw upon additional resources for mass care support from the private sector. (Refer to Appendix 12 for information on private sector activities.)

(g) Public information is provided via the ARC National Call Center, ARC public Web site, and local chapters across the Nation. Health information is coordinated closely with the Centers for Disease Control and Prevention (CDC), HHS, and other agencies as appropriate.

(h) The Coordinated Assistance Network (CAN) client information sharing system is initiated by non-Governmental relief organizations to support relief activities. This system will enable sharing of client information among identified participating relief agencies, but only under the strictest standards of confidentiality and only with appropriate client approval.

(i) DWI and family reunification services continue; collaboration proceeds with HHS and the National Disaster Medical System (NDMS) regarding casualty and patient information for the DWI system.

(j) Support efforts for ESF#8 activities are underway, as required.

(2) **Primary Areas of Concern**

(a) **Shelter**

i. Additional sheltering capability at levels beyond which currently exists within the Red Cross system will need to be identified immediately if information is not readily available from partners and Government entities.

ii. The safety and integrity of shelters is of paramount importance in order to ensure that victims will use shelters. If decontamination is required for an incident, Federal, State, and local assets must work with the Red Cross and other entities providing shelter to ensure that persons entering shelters are free from contamination. Additionally, persons must be free from communicable diseases and not exhibiting symptoms of an agent-related sickness.

(b) **Food**

i. Distribution of food within the affected area will require a substantial logistical effort and may be complicated by the disruption of transportation systems within the affected area and/or raising the HSAS to red.

ii. Special dietary considerations will need to be integrated into meal planning at shelters as soon as possible.

(c) **Other Human Needs**

i. Human needs will need to be met on a significant scale in a catastrophic disaster. These include such items as showers, toiletry items, bedding, diapers, and clothing.

ii. The ability to obtain large quantities of these items may be affected by "just-in-time" supply strategies of major manufacturers and the nature of the event.

(d) **Medical**

i. Persons in shelters requiring medical care must receive appropriate medical assistance from appropriate medical entities as soon as possible.

ii. Special needs persons will be a significant challenge during a catastrophic disaster.

(3) **Strategies**

(a) **Shelter.** To ensure all victims are sheltered quickly and safely in the immediate aftermath of a catastrophic event, the Red Cross will use all sheltering capability in its jurisdiction to meet initial needs, as well as work with partner agencies to ensure all sheltering needs are met.

i. Experience indicates that many persons fleeing an affected area will seek shelter with relatives or stay in a hotel/motel, depending on their financial situation. However, a significant number of persons will seek shelter in traditional shelter facilities.

ii. Ad hoc or spontaneous shelters may be established in the immediate aftermath of the catastrophic incident and will need to be integrated into the official mass care response activities as soon as possible.

iii. Depending on the nature of the event, the safety and integrity of shelters may come into play. If decontamination is required for an incident, Federal, State, and local assets must work to ensure that persons entering shelters are free from contamination prior to entry. Additionally, persons entering shelters must be free from communicable diseases and not exhibiting symptoms of an agent-related sickness.

iv. The Red Cross will work with Federal partners to ensure that as many persons as possible are moved from shelters to interim housing situations within 30 to 45 days of an event. It is likely, however, that many shelters will not be able to close for up to 90 days (or longer) after the event. Since all shelters are not necessarily suitable to be used for long-term sheltering, this may prove a significant problem.

(b) **Food.** The Red Cross will use significant internal assets, as well as work with partner agencies under existing Memorandums of Understanding (MOUs), to meet the significant feeding requirements a catastrophic incident will entail. This includes reliance on feeding equipment, such as large kitchens, being brought into or near the affected area by such organizations as the Southern Baptists and Salvation Army. Additionally, work with the USDA and private sector vendors, under existing Standard Operating Procedures (SOPs) and MOUs at the national, State, and local level, is anticipated on a significant scale. Finally, special dietary considerations will need to be rapidly integrated into meal planning at shelters.

(c) **Other Human Needs.** Meeting the human needs of significant numbers of people will necessitate close, timely, and sustained collaboration with private sector vendors during the recovery phase.

i. Bulk distribution of items will need to be accomplished quickly at central locations. Needed items will include shower accessories such as towels, washcloths, toiletry items, bedding, diapers, and clothing. The management of donated goods will be coordinated with the DHS Private Sector desk.

ii. Management of people's expectations will need to be quickly addressed, and include timely and frequent dissemination of accurate information about what is happening. Family reunification issues and Disaster Welfare Inquiries will also need to be quickly dealt with.

(d) **Medical.** Ensure that persons requiring medical care receive appropriate medical assistance as soon as possible to include evaluating requirements and developing strategies for coping with special needs evacuees and providing medical support to emergency shelters. The Red Cross will work closely with local EMS and Federal partners through HHS to address these needs and ensure that proper medical care is given as soon as possible.

C. **Response Strategy: SUSTAINED and TRANSITION.**

(1) **Sustained 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. (Refer to Appendix 10 for housing strategy.)

(c) Family resettlement actions and services will take on an increased momentum.

(2) **Transition Strategy.** Within 2 weeks of the catastrophic incident, the Red Cross and FEMA will jointly develop a plan for transportation of persons in shelters out of the affected area and into interim housing situations. This will require close coordination with the Department of Transportation (DOT). Shelterees requiring medical attention, or special needs shelter(s) populations, will be given priority in leaving the area. This will involve close coordination with HHS.

4. Transportation and Logistical Requirements

A. Transportation needs include the ability to move mobile feeding units into and near the affected area quickly. These units include Red Cross Emergency Response Vehicles (ERVs), large kitchens, and feeding units from other voluntary organizations and NGOs. Additionally, communications vehicles and logistical support trucks must be moved in a rapid manner.

B. The transportation of needed mass care and support workers from around the country must be accomplished quickly and sustained over time.

C. 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 venders and points across the country.

D. Procurement and distribution of potable water and ice to support the individual shelters and feeding sites. Potable water and ice distribution will also be required for individuals who are able to continue residing in their homes, but are without safe drinking water.

E. Portable showers and sanitation units at the individual shelter and feeding sites.

F. Possible transportation of residents requiring relocation beyond the affected area.

G. 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.

H. Portable food containers will be required at the food preparation and feeding sites.

I. Public safety and security personnel will be required at the larger shelters and to routinely patrol shelters, food preparation sites, and fixed feeding stations. The Red Cross may augment with private security, if needed.

J. Transportation and allied logistics systems will need to be established within the incident area. Moreover, linkages would be required, outside the affected area, with adjacent staging and marshalling sites.

K. Information on venders, products, and services will need to be available on a real-time basis.

L. Transportation and other linkages need to be established with in-kind donation sites and warehouses and mass care facilities within and near the incident area.

M. Each shelter will need to provide residents with access to telecommunication services.

5. Response Limitations and Unique Concerns

A. Refer to planning assumptions in Section 2 of this appendix.

B. The lack of a real-time national database reflecting all potential shelters for geographic areas around major metropolitan areas poses a significant problem for mass care response activities during a catastrophic incident.

C. Many metropolitan areas view mass care activities, especially sheltering, as a short-term problem and have not developed plans for potential long-term shelter situations or coordinated plans across geographic areas. This will pose significant challenges for mass care response activities at the time of a catastrophic incident.

D. Lack of significant numbers of trained mass care specialists and managers will hinder effective mass care response activities, as it is estimated that 30,000 mass care staff will be needed to provide services for 300,000 displaced persons over extended periods of time.

6. Response Capabilities

A. **Organic.** In accordance with its assigned responsibilities as the primary agency for ESF#6 (Mass Care, Housing, and Human Services), the ARC has an organizational structure to support mass care activities, which includes:

(1) Formal liaison and coordination with Federal, Regional, State, Tribal, and local authorities for disaster planning preparedness and response.

(2) Ongoing planning, collaboration, and operational relationships with the following Federal Agencies and private sector organizations: DHS, Interagency Incident Management Group (IIMG) and NRCC; HHS, including the CDC; and the American Association of Blood Banks (AABB). The ARC also supports FEMA RRCCs.

(3) Nearly 900 chapters responsible for implementing initial disaster response activities in collaboration and cooperation with their local Government disaster response counterparts.

(4) Regional Red Cross Service Areas that provide technical guidance and resource support to disaster affected chapters in coordination with Red Cross national headquarters.

(5) The 24/7 Disaster Operations Center (DOC) at the ARC national headquarters in Washington, DC, routinely initiates major relief operations in support of field units, and coordinates

related ARC activities with Federal Departments and Agencies. The DOC directs the nationwide movement of personnel, materials, and equipment to major disaster affected areas. This includes:

(a) Critical Response Team (CRT). Specialized all-hazards trained teams of ARC personnel who deploy immediately to major disaster affected areas. These teams support and enhance the efforts of affected ARC chapters and integrate the introduction and application of external personnel, material, and equipment resources.

(b) Disaster Services Human Resources (DSHR). Over 26,000 trained disaster response personnel, resident nationwide, who can assist with major disaster relief operations and support initial local chapter response activities.

(c) Logistics Support Network. Features a fleet of more than 300 ERVs pre-positioned nationwide to provide mobile feeding; two large mobile kitchens; ten mobile satellite (voice and data) communications vehicles; five Local Area Network (LAN)-based field deployable automated systems, ten Disaster Field Supply Centers (warehouses) with more than 50,000 stored cots and blankets, feeding equipment, disaster victim hygiene kits, and home cleanup kits.

(d) The ability to activate Statements of Understanding (SOUs) between ARC with 43 national organizations that have signed SOUs and MOUs with ARC to support disaster relief activities.

(6) The Biomedical Services Operations Center (BSOC) in Washington, DC, coordinates Red Cross Blood Services operations, handling approximately half the Nation's blood supply. The BSOC coordinates with the AABB Inter-Organizational Task Force and HHS concerning blood availability and public messaging regarding the safety and availability of the Nation's blood supply.

B. **Non-Organic (Collaborative).** Includes voluntary organizations, NGOs, and private sector entities with which ARC has written MOUs/SOUs to provide assistance at the time of a disaster. Certain organizations may provide services in more than one area. For example, the Teamsters assist with finding facilities and also provide volunteers to work in shelters. The list of current MOU/SOU partners includes but is not limited to the following:

(1) **Food and Shelter Assistance**

(a) North American Mission Board of Southern Baptists
(b) The Salvation Army
(c) America's Second Harvest
(d) Church of Jesus Christ of Latter Day Saints
(e) Woodmen of the World Insurance Society
(f) National Restaurant Association
(g) American School Food Service Association

(2) **Additional Mass Care Volunteer Assistance**

(a) Corporation of National and Community Service (CNCS)
(b) National Urban League
(c) Faith-based partners, such as Catholic Charities and Church World Service
(d) U.S. Jaycees

(3) **Transportation Assistance**

(a) Civil Air Patrol
(b) Amtrak
(c) Federal Express (FedEx)

(4) **Child Care Assistance.** Church of the Brethren

(5) **Mental Health Assistance**

(a) American Psychological Association
(b) National Mental Health Association
(c) American Counseling Association
(d) American Psychiatric Association
(e) Various Associations for Chaplains of varying denominations
(f) National Association of Social Workers
(g) Association of Marriage and Family Therapists

(6) **Facilities Procurement**

(a) International Brotherhood of Teamsters
(b) International Brotherhood of Painters and Allied Trades
(c) Faith-based partners

(7) **Technical Assistance**

(a) American Radio Relay League
(b) Humane Society of the United States
(c) American Veterinary Medical Foundation
(d) National Funeral Directors Association
(e) National Foundation for Mortuary Care
(f) American Society of Civil Engineers
(g) National Voluntary Organizations Active in Disaster (NVOAD)

7. Responsibilities

A. ARC Responsibilities as Coordinating Agency for ESF#6 (Mass Care, Housing, and Human Services)

(1) **Shelter.** Provide temporary congregate shelters to displaced individuals or persons denied access to their homes by the disaster incident. This will involve the use of the pre-identified facilities and facilities secured during and immediately following the incident. Sheltering will occur both within and outside the disaster-affected area.

(2) **Feeding.** Provide prepared meals and food items to the disaster-affected area residents in need. This may include a combination of fixed feeding sites, mobile feeding units, and the bulk distribution of food. While the feeding and other logistical support for emergency workers is the responsibility of their employing agency or organization, emergency workers will have access to feeding sites within the disaster-affected area.

(3) **Emergency First Aid.** Provided to victims and workers at mass care facilities and at designated sites within or around the incident area. This service will be supplemental to the emergency health and medical care services established and managed by Government and medical authorities. This service consists of basic first aid review and referral to appropriate medical personnel and facilities. The ARC will not provide direct medical care to victims/workers. Direct medical care is addressed under Medical Support in Appendix 6.

(4) **Disaster Welfare Information.** Information on well-being will be collected from individuals residing within the affected area and provided, with their approval, to immediate family members located outside the affected area. The DWI system, managed by the ARC, will also be used to aid in reunification of family members separated at the time of the incident. A "reverse DWI" system will also be deployed. It will allow affected area residents in shelters to directly contact immediate family members outside the affected area using a telephone.

(5) **Bulk Distribution of Emergency Relief Items.** Sites will be established within or near the incident area for the general distribution of relief items to meet urgent disaster victim needs.

B. Support Agency Responsibilities to ESF#6 (Mass Care, Housing, and Human Services)

(1) **U.S. Department of Homeland Security (DHS).** FEMA will identify temporary housing, and provide NDMS assets to help assist with medical care in shelters. The Red Cross will also work with the DHS Private Sector desk, State and local desk, Public Affairs desk, and others as appropriate.

(2) **Department of Health and Human Services (HHS).** Specifically, U.S. Public Health Service (PHS) Commissioned Corps deployable assets to provide medical care in shelters.

(3) **Department of Defense (DoD).** Provide requested logistical support, as approved by the Secretary of Defense.

(4) **U.S. Department of Agriculture (USDA).** Coordinate food stockpile locations and identify for movement to incident areas.

(5) **Department of Housing and Urban Development (HUD).** Coordinate temporary shelter and long-term housing assistance.

(6) **Department of Veterans Affairs (VA).** Provide food preparation and storage in its facilities nationwide; provide medical supplies, mental health practitioners, and other personnel to shelters; and offer facilities as possible shelter sites. Provide professional mental health staff to augment local and Red Cross resources.

(7) **U.S. Army Corps of Engineers (USACE).** Provide, via contract, potable water and ice to incident area(s) in need; also, inspect shelters for structural suitability and provide assistance in constructing temporary shelters, if necessary.

(8) **General Services Administration (GSA).** Provide procurement and contracting services and assistance based on defined mass care requirements. Also provide communications links between the Disaster Welfare Inquiry Center (DWIC) and incident area.

(9) **U.S. Postal Service (USPS).** Provide change of address cards for victims who are relocating, as well as provide an electronic file of address change information.

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Appendix 4 – Search and Rescue Response Overview

1. Mission

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

2. Planning Assumptions

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 (US&R) operations to locate surviving victims.

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 US&R task force response assets will immediately deploy in accordance with the Catastrophic Incident Response Execution Schedule (Annex 1). The goal will be to have full task forces on the scene and operational within 24 hours of occurrence.

C. Federal US&R assets are under the control of FEMA and will be activated and deployed to support the US&R mission. This will include activation of an overhead US&R Incident Support Team (IST) to assist with the integration and coordination of national US&R task forces with the local incident command system. Federal US&R assets possess organic supplies and equipment to conduct the US&R mission, to include conducting limited defensive operations and victim decontamination in a CBRNE environment.

D. 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.

E. The doctrine of "do no additional harm" will apply to all US&R 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.

3. Catastrophic Response Strategy

A. **Response Strategy: IMMEDIATE.** The National US&R Response System uses a defined Activation Rotation Model (maintained by FEMA) for the selection and activation of US&R task forces. The first three task forces used - in accordance with the timing established in the Catastrophic Incident Response Execution Schedule in Annex 1 - will be the three geographically closest, operationally ready task forces.

(1) If more than three task forces are or will be required, the Program Office will refer to the annual Task Force Rotation Model for resources using the following protocols:

(a) Assuming that the three closest selected task forces have been activated, the strategy will be to move to the "1st Rotation" column and select the next closest task force in that column for activation.

(b) All of the task forces in the "1st Rotation" column will be activated before moving to the "2nd Rotation" column. This process is repetitive.

(c) Absent a compelling reason otherwise, the process will not involve horizontal movement on the rotation model to find an operational task force. (This protocol balances the immediate needs of the victims - by activating the closest task forces first - with the need to maintain a fair system of activations that will include all task forces.)

(2) It is estimated that one IST and three Type-I task forces would be able to address initial and moderate scale incidents. For a catastrophic incident involving widespread collapses, a far larger IST and task force response will be required and initiated. (A Type-I US&R task force has an estimated useful operational period of 5 to 7 days, based on prior experiences.)

(3) 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 Federal 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 or ISTs) to provide continuous operations, usually on a 5 to 7 day basis.

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

4. 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. Parent organizations will arrange transportation for their personnel and supporting equipment to the point of departure (airport/airbase) if transportation is by air. If necessary, ESF#9 will request air transportation support from ESF#1.

B. IST personnel are activated directly by the US&R Program Office at FEMA Headquarters and are responsible for coordinating their own transportation reservations.

C. 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 from the IST through local sources or the Incident Command Logistics Branch.

D. ISTs have supporting administrative and on-site support equipment caches and will coordinate through FEMA to have one or more of these transported to the incident site.

5. Response Limitations and Unique Concerns

A. The US&R program is limited to the 28 task forces in the national system. While this resource size has been adequate to successfully respond to major terrorist incidents to date, the system could be overwhelmed by a single, extremely large catastrophic incident (or multiple concurrent incidents) involving many collapsed structures.

B. The WMD task forces in the national system are capable of only limited/defensive hazardous material (HAZMAT) operations.

6. Response Capabilities

A. **Organic Federal Response Assets.**

(1) Twenty-eight Type-I task forces, each comprised of a 70-person, WMD-capable task force and full equipment cache (see **Figure 4-1** for a system overview). Each task force is fully self-sufficient for the first 72 hours of operation. A Type-I task force has an internal HAZMAT component staffed by two HAZMAT managers and eight HAZMAT specialists. A Type-I task force is capable of addressing limited, defensive HAZMAT operations in a contaminated environment to enable the rescue of trapped victims or rescuers. In addition, WMD cache enhancements have been added to the traditional equipment cache and include atmospheric monitors, personnel protective equipment (PPE), and decontamination equipment for approximately 60 ambulatory or 20 non-ambulatory patients per hour.

(2) Three 21-person ISTs, which are activated concurrently with US&R task forces in support of the mission response . The IST provides command, control, and coordination (C^3) with the local Incident Commander and first responders.

(3) Three National Disaster Medical System (NDMS) National Medical Response Teams (NMRTs) for mass decontamination.

(4) U.S. Coast Guard (USCG) personnel and assets for assistance and movement of US&R task force personnel, either by fixed or rotor wing, and/or boat operations in areas of still or open water or areas of inundation.

B. **Non-Organic Federal.** Approximately 12 to 15 International Search and Rescue Teams of varying sizes/configurations are potentially available through the USAID/U.S. Office of Foreign Disaster Assistance and the International Search and Rescue Advisory Group (INSARAG).

Figure 4-1 – National Urban Search and Rescue Response System

7. Responsibilities of Coordinating and Support Agencies/Organizations

A. **Coordinating Agency – FEMA** will:

(1) Serve as national-level ESF#9 coordinator.

(2) Establish, maintain, and manage the National US&R Response System. This responsibility includes predisaster activities such as training, equipment purchase, and evaluation of operational readiness.

(3) Dispatch ISTs and task forces to the affected area(s) upon implementation of and when directed by the Catastrophic Incident Response Execution Schedule.

(4) Manage US&R task force deployment to, employment in, and redeployment from the affected area.

(5) Coordinate logistical support for US&R assets during field operations.

(6) Develop policies and procedures for the effective use and coordination of US&R assets.

(7) Provide status reports on US&R operations throughout the affected area.

(8) Under the NDMS:

(a) Provide administrative support to US&R task force medical teams to:

i. Ensure medical team personnel who are not Federal employees have appropriate and valid licenses to practice in their States and they are provided Federal tort claims liability coverage for the practice of medicine.

ii. Develop an appropriate pay scale for US&R task force medical team personnel.

iii. Register medical teams of each National US&R Response System task force as specialized teams under the NDMS.

(b) Provide operational support to US&R task force medical teams and IST from ESF#8 (Public Health and Medical Services), as requested by DHS, to provide liaisons; medical supplies, equipment, and pharmaceuticals; supporting personnel; and veterinary support.

(c) Provide NDMS patient evacuation and continuing care after trapped victims are removed from collapsed structures by US&R task force personnel.

B. **Support Agencies**

(1) **U.S. Department of Agriculture (USDA), U.S. Forest Service (USFS)**

(a) Develop standby agreements with US&R task forces to provide equipment and supplies from the National Interagency Cache System at the time of deployment.

(b) Develop contingency plans for use of National Interagency Fire Center contract aircraft by ESF#9 during disasters.

(2) **Department of Health and Human Services (HHS).** Provide operational support to US&R task force medical teams and IST from ESF#8, as requested by DHS.

(3) **Department of Defense (DoD).** DoD will provide support as requested if it does not interfere with its primary role to protect the nation.

(a) Serve as primary source for the following assistance:

i. Fixed-wing transportation of US&R task forces and ISTs from base locations to Mobilization Centers or Base Support Installations (BSIs). Target timeframe for airlift missions is 6 hours from the time of task force activation.

ii. Rotary-wing transportation of US&R task forces and ISTs to and from isolated, surface inaccessible, or other limited access locations.

iii. Through the U.S. Army Corps of Engineers (USACE), provide trained structures specialists and System to Locate Survivors (STOLS) teams to supplement resources of US&R task forces and ISTs.

iv. Through the USACE, provide pre-disaster training for US&R task force and IST structures specialists.

(b) Serve as secondary source for the following assistance:

i. Ground transportation for US&R task forces and ISTs within the affected area.

ii. Mobile feeding units for US&R task forces and IST personnel.

iii. Portable shelter (i.e., tents) for use by US&R task force and IST personnel for eating, sleeping, and working.

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Appendix 5 – Decontamination Response Overview

1. Mission

In the immediate aftermath of a catastrophic incident involving nuclear, radiological, biological, or chemical contamination, all appropriate Federal departments and agencies will provide technical advice and assistance to State and local governments regarding the decontamination of persons, first responders 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.

2. Planning Assumptions

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. The primary Federal roles in the immediate aftermath of a catastrophic incident are:

(1) Providing technical advice and assistance for local personnel managing victim decontamination activities.

(2) Obtaining status and assessment information regarding the extent and effectiveness of local decontamination activities in order to analyze their implications for ongoing medical treatment and population protection.

(3) Ensuring that requirements for additional Federal equipment and/or personnel to support local victim decontamination activities are expeditiously obtained and acted upon, *to the extent such Federal resources are available.*

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 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. In such cases, decontamination priorities should carefully consider and focus on those persons and items most likely contaminated, to minimize the logistical and psychological burden of mass decontamination. However, unless it can be clearly and unambiguously established that decontamination is not required, err on the side of caution and commence potentially life-saving personnel decontamination. For facilities, equipment, and materials that do not pose an immediate life-saving or public health threat, time and weathering (followed by sampling and analyses) may be used to minimize overall decontamination needs.

(2) Biological agents typically have delayed symptoms and lack easily recognizable signatures such as color or odor. There will rarely be an on-site incident to respond to when a biological agent is released unless there is a dissemination warning, a claimed or suspected dissemination device is found, or a perpetrator is caught in the act of disseminating the agent. Healthcare facilities are the most likely locations for managing a biological agent incident. If a biological agent is suspected, care must be taken to protect current patients, staff, and faculty from infection. If there is an on-site response to a biological incident, decontamination is necessary to reduce the risk of additional contamination. When biological decontamination is performed, thoroughness is more important than speed.

(3) Decontamination procedures may need to vary for different segments of the population. For example, preferred decontamination techniques for healthy adults may not be the same as for infants or the elderly, who require a heated environment.

(4) 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.

(5) 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. Accordingly, efforts to preserve gender privacy (draping by tarpaulins, etc.) is a recommended practice, as is the provision of expedient clothing, such as blankets, sweat suits, and large plastic bags.

(6) Reduce the potential for secondary contamination (e.g., at shelters) by screening potentially contaminated individuals. Portal monitors and handheld detection instrumentation are crucial components of an effective and comprehensive decontamination strategy.

(7) 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. This reinforces the requirement for effective risk communications and emergency public information, as well as the need for monitoring and detection capability at medical treatment facilities, first responder facilities, reception centers, and mass care shelters.

(8) Secondary contamination will be a major concern. Hospital emergency rooms may close if contaminated victims are admitted without proper decontamination, as occurred during the Tokyo subway sarin incident. Other secondary contamination issues of note include control of runoff of fluids used in decontamination, and the handling of contaminated remains such as clothing and personal effects. It is important to plan for the secondary contamination of first responders, even those wearing personal protective equipment (PPE). Such contamination can occur during the removal of a patient from a hazardous area, during the performance of basic life support functions, or when initial responders are unaware that a hazardous material (HAZMAT) is involved.

(9) The lack of hospital preparedness for handling contaminated patients or performing decontamination operations is a major decontamination shortfall. Although many hospitals have decontamination plans in place, few possess the necessary support facilities. Further, those with facilities are capable of processing only a limited number of patients at a time. Critical to this hospital preparedness issue is the availability and use of appropriate PPE. While many hospitals are now receiving (and training in how to don, work in, and safely remove) PPE, there remains a significant need for further education on PPE and decontamination at the hospital level.

(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. For example, epidemic hysteria has been associated with perceived exposure to toxic substances among adolescent groups. Additionally, an accident may trigger psychological stress-induced symptoms resembling actual exposure, provoking people exhibiting such false symptoms to seek medical treatment. However, of greatest concern are the short and long-term psychological consequences resulting from actual exposure to chemical, biological, or radiological substances, and which subsequently produce negative health effects. Short-term stress symptoms may be a prelude to long-term, debilitating, post-traumatic stress disorder (PTSD).

(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. This is generally less problematic for buildings and equipment, where time may allow for multiple and/or phased decontamination actions and extensive testing, depending on the intended use of the buildings/equipment and the nature of the contaminant. It must be noted that decontaminating an area to "clean" may not always be possible. For example, following a nuclear incident, an area may be so contaminated that restricting access is a more realistic and feasible option than decontamination. Most problematic is determining if individuals are "clean" following a decontamination protocol, largely due to a limited ability to test for and verify levels of residual contamination following decontamination procedures.

(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. Accordingly, catastrophic incident planning at the state and local level must ensure that local first responder, medical provider, public health, emergency management, business, and volunteer organization leaders address relevant pre-incident decontamination preparedness issues, to include:

(a) Development and implementation of a modular approach to medical treatment facilities, first responder facilities, and reception centers/mass care shelters, to include the designation of such facilities and the tasking of elements/units and required equipment and supplies to provide portal and point monitoring and detection, human and animal decontamination, and physical security. The operational viability of each of these locations must be maintained in order to achieve a minimally successful incident response.

(b) Development and implementation of a robust and redundant risk communications and emergency public information capability to deliver timely and accurate information, on an ongoing basis, throughout the response phase. The information must address the nature and extent of the incident; actions to reduce the risk of WMD agent contamination; how to obtain personal and facility decontamination support and/or how to conduct self-help decontamination; shelter-in-place or evacuation procedures; establishment of exclusion/isolation/quarantine zones; and related matters regarding human and animal health with respect to WMD agent dispersal.

(c) Provision of personal, family, workplace, and institutional setting information, as well as guidance on personal, animal, and facility decontamination.

3. Catastrophic Response Strategy

A. **Response Strategy: IMMEDIATE.**

(1) The National Response Plan recognizes 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/devolitalization. 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) 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 priority Federal roles will be 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.

4. Transportation and Logistical Requirements

A. The Execution Schedule does not contain any Federal decontamination support assets, other than DOE teams, which provide their own transportation and logistics support.

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 NRP protocols.

5. Resource Limitations and Unique Concerns

A. 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.

B. 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.

C. There may be inadequate, untimely, or competing plume modeling to support rapid decision-making regarding population protection measures—principally shelter-in-place or evacuation.

D. 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. 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 NRP/NIMS decision-making processes.

6. Response Capabilities

A. **Organic Federal**

(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.*

Figure 5-1 – HAZMAT Team Response Times

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.

7. Responsibilities of Coordinating and Support Agencies/Organizations

A. When requested by the Coordinating Agency, DOE will:

(1) Establish the FRMAC and coordinate monitoring and assessment of radioactive contamination, as outlined in the NRP Nuclear/Radiological Incident Annex.

(2) Provide advisory assistance on radiological decontamination and monitoring techniques.

(3) Assist in providing characterization of radiation deposition in affected areas.

(4) 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.

B. 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.

C. HHS/ATSDR will:

(1) 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.

(2) Immediately initiate or support State/local initiation of a health registry for both victims and responders.

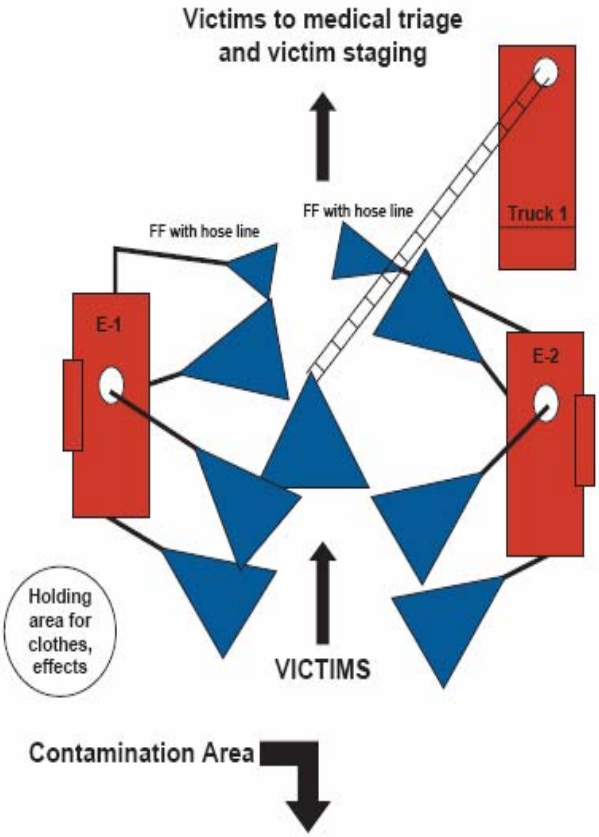
8. Graphic Illustrations of Decontamination Operations

A. **Figure 5-2** depicts the "Ladder Pipe" method of emergency decontamination. It requires minimal resources, is quick to establish, and can process a large number of patients.

B. **Figure 5-3** depicts an example personnel decontamination station configuration.

C. **Figure 5-4** depicts the "Emergency Decontamination Corridor" method of emergency decontamination. It takes additional time to establish and does not have the same throughput as the Ladder Pipe method but provides some patient privacy and protection from the weather.

D. **Figure 5-5** depicts a sample decontamination decision tree (the example is for a chemical incident).



LDS

- Advantages
  - Rapid set up time
  - Provides large capacity high volume low pressure shower
  - Rapid hands free mass decontamination
- Disadvantages
  - No privacy
  - Increased chance of hypothermia from exposure to elements
- Comprised of:
  - Ladder pipe/Truck
  - 2 engines
  - Hand held hose lines
- Set up:
  - Engines placed approximately 20 feet apart
  - 2 ½ fog nozzles set at wide fog pattern attached to pump discharges
  - Truck with fog nozzle placed on ladder pipe to provide downward fog pattern
- Firefighters can be positioned at either or both ends of shower area to apply additional decontamination wash

The information presented in this reference card was derived from several technical studies and reports that were produced by the U.S. Army Research, Development and Engineering Command, Edgewood Chemical Biological Center (ECBC) Improved Response Program. These reports can be obtained from the ECBC Homeland Defense Web site at http:/www.ecbc.army.mil/hld and should be referenced in order to fully understand the full extent of responding to a chemical or biological WMD incident.

Figure 5-2 – Ladder Pipe Decontamination System

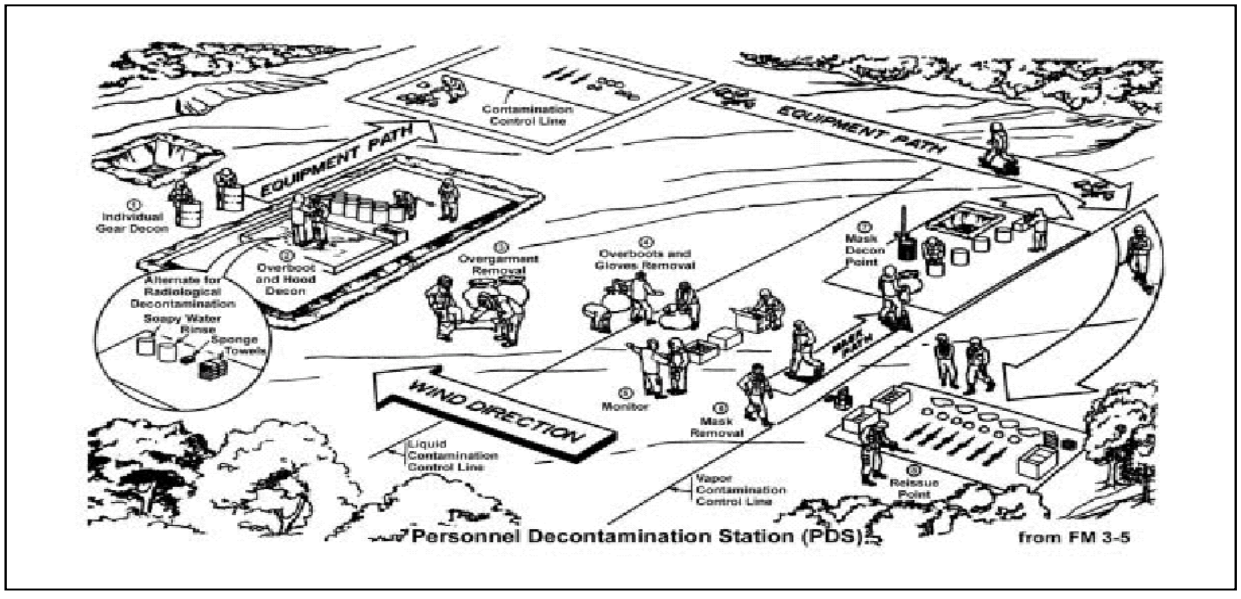
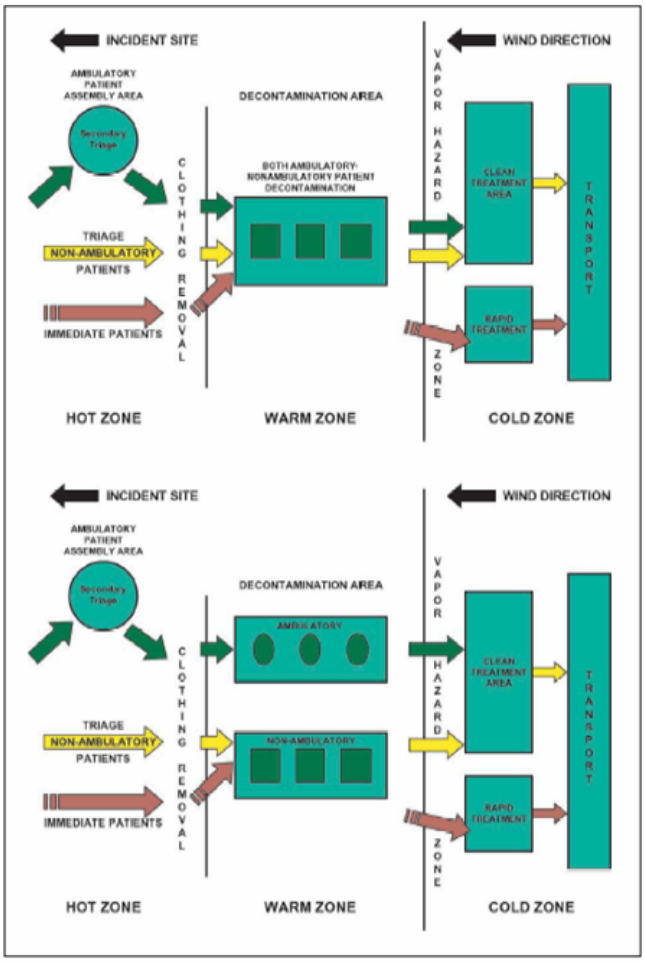


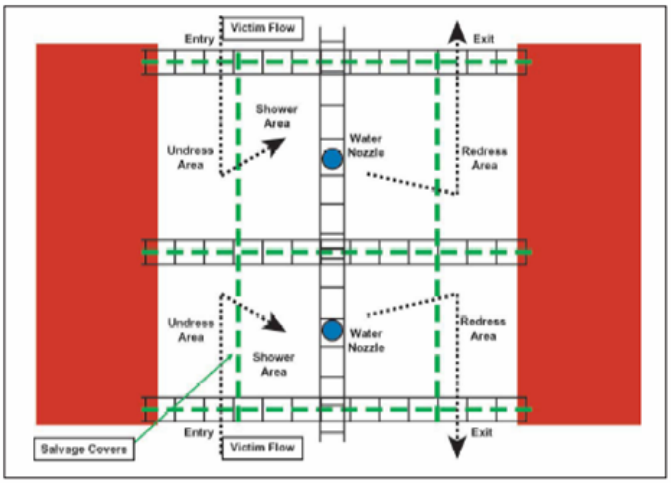
Figure 5-3 – Personnel Decontamination Station (PDS)



EDCS Layouts

EDCS

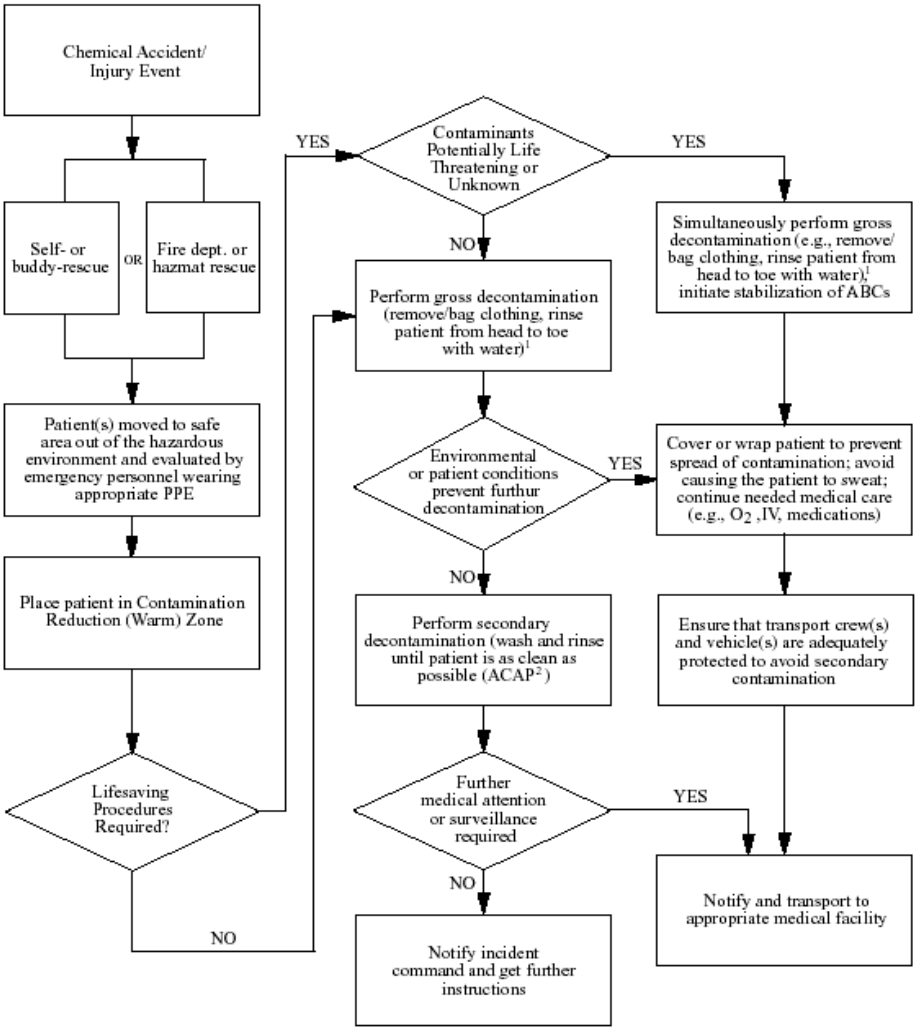
- Advantages
  - Privacy for victims
  - Separate male/female corridors
  - Shower area can be heated using portable heaters
- Disadvantages
  - Slower set up time than LDS
  - Casualty processing slower
  - Requires more manpower to set up
- Comprised of:
  - 2 Engines
  - Salvage covers
- Set up:
  - 2 engines positioned approximately 20 feet apart
  - 3 ladders placed across and secured to top of engines
  - 4th ladder centered atop the other three ladders and secured
  - 2 nozzles secured to 4th ladder hanging down into shower area
    Salvage covers draped over ladders to create corridors



EDCS Decontamination Area Setup

Figure 5-4 – Emergency Decontamination Corridor System (EDCS)

Sample EMS Decision Tree for Chemical Incidents



[1] No patient should be transported without a minimum of gross decontamination performed.

[2] Contamination reduced to a level that is no longer a threat to patient or responder (once achieved, move patient to the Support [Cold] Zone).

Figure 5-5 – Decontamination Decision Tree Example

National Response Plan – Catastrophic Incident Supplement

Appendix 6 – Public Health and Medical Support Response Overview

1. 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.

2. 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.

3. Catastrophic 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.

	Deployment Time to Mobilization Center/Incident Site			
Personnel Expertise	**24 Hours**	**48 Hours**	**72 Hours**	**Total**
Physician	48	39	240	327
Nurse Practitioner/Physician Assistant	37	26	188	251
Nurse	120	146	515	781
Paramedic	39	118	64	221
Pharmacist/Technician	74	25	432	531
Administrative Support	99	117	445	661
Mental Health	23	13	125	161
Respiratory Therapist	0	0	0	0
Medical Staff Support	219	0	1,331	1,550
Total	**659**	**484**	**3,340**	**4,483**
	3 DMATs, 1 NMRT and 70 percent of 1 PHS Roster	11 DMATs and 2 NMRTs	8 DMATs and 70 percent of 6 PHS Rosters	

Figure 6-1 – Available Health/Medical Personnel Deployment Projections

(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 NRP.

4. Transportation and Logistical Requirements

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.

5. Response Limitations and Unique Concerns

A. 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.

B. Systems required to move personnel, patients, and equipment require extensive review and should be simultaneously exercised during national, State, and local exercises.

C. Federal planning efforts need to be tied more closely to the efforts of Regional, State, and local planners.

D. Plans need to be developed for rotating staff and incorporating volunteers.

6. Response Capabilities

A. **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 (C^2), 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.

B. **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.

C. **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:

(1) **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.

Role	Number
Physician	574
Nurse Practitioner/Physician's Assistant	234
Registered Nurse	1,159
Emergency Medical Technician (EMT)/Paramedic	738
Pharmacist	158
Mortician	235
Veterinarians	100
Mental Health Professionals	48

Figure 6-2 – NDMS Medical Specialty Force Strength

(2) **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.

(3) **DMAT Types and Strength**

(a) **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).

(b) **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).

(c) **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.

(d) **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.

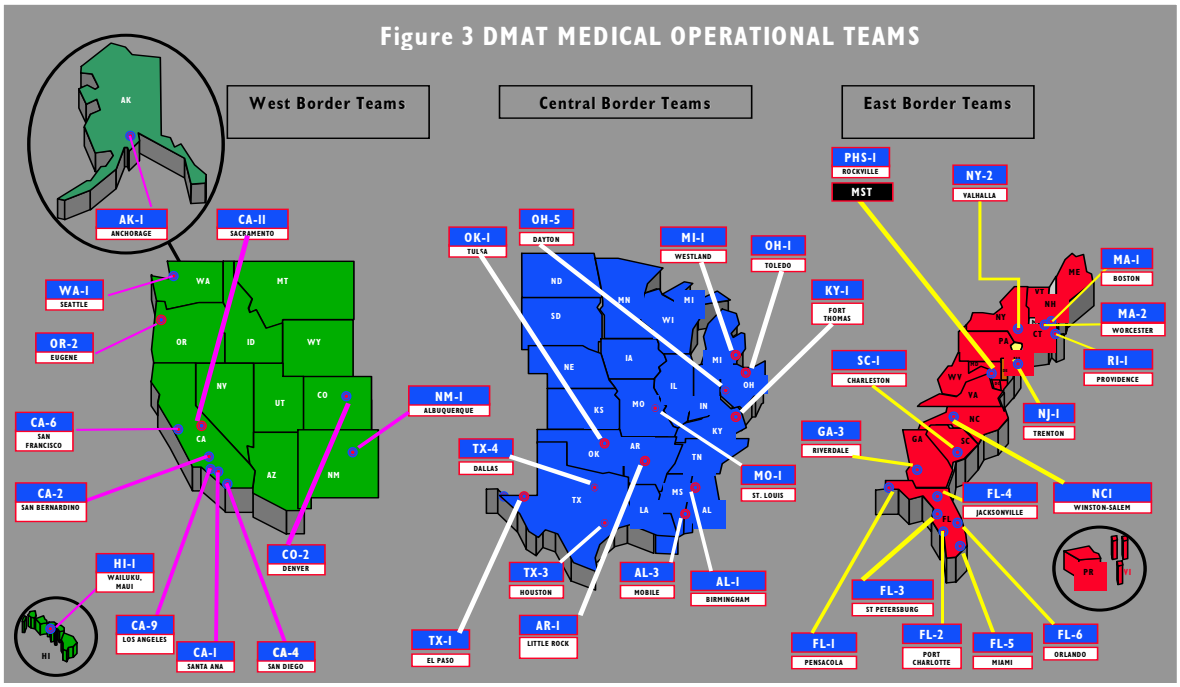


Figure 6-3 – Operational (Type-I) Disaster Medical Assistance Teams and Management Support Team

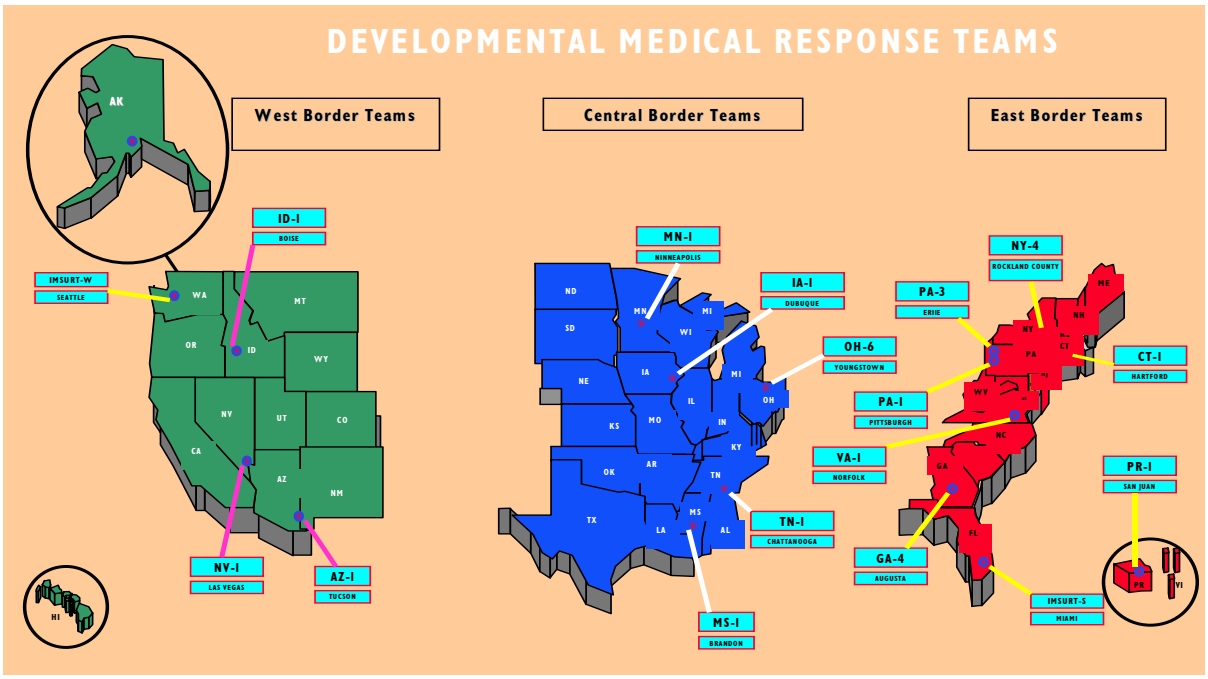


Figure 6-4 – Medical Response Teams Under Development

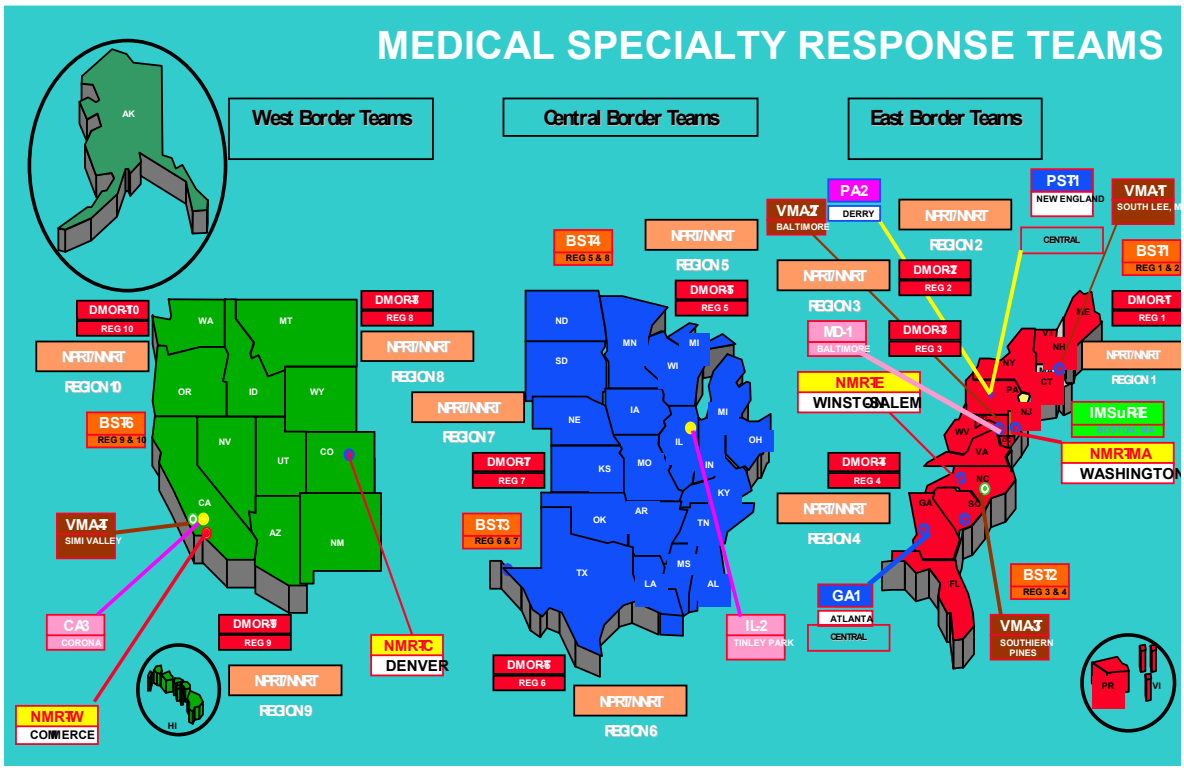


Figure 6-5 – Medical Specialty Response Teams

(4) **DMAT Capabilities**

(a) Deploy to an incident site within 6 hours, for a 14-day period.

(b) Provide emergent care within 30 minutes of arrival at an incident site.

(c) Be fully operational within 6 hours of arrival at an incident site.

(d) Sustain 24-hour operations for 72 hours without external support.

(e) Provide initial resuscitative care to victims.

(f) For a 24-hour mission, provide out-of-hospital, acute care to 250 patients (including geriatric and pediatric patients).

(g) Provide sustained 24/7 care to 125 patients per day, including:

i. Limited laboratory and pharmaceutical services.
ii. Immediate referral, transfer, or evacuation for 25 patients.
iii. Stabilizing/holding a maximum of six patients for up to 10 hours.
iv. Supporting two critical patients for up to 24 hours.

(h) Provide sustained hospital ward care for 30 medical/surgical (non-critical) inpatients.

(i) Provide primary response to a mass casualty incident resulting from a non-chemical, biological, radiological, nuclear, or high-yield explosive (CBRNE) event.

(j) Triage and prepare 200 patients at a casualty collection point for evacuation or transport in a mass casualty incident.

(k) Provide patient staging for up to 100 patients at a Federal Coordinating Center (FCC) reception site.

(l) Augment or assist at a mass drug distribution, immunization, or packaging center.

(m) Staff or augment alternate care facilities.

(5) **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:

(a) Provide mass or standard decontamination.

(b) Collect samples for laboratory analysis.

(c) Provide medical care to contaminated victims.

(d) Provide technical assistance to local Emergency Medical Services (EMS).

(e) Assist in CBRNE triage and treatment before and after decontamination.

(f) Provide technical assistance, decontamination, and medical care.

(g) Provide medical care to Federal responders on-site.

(6) **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.

(7) **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.

(8) **NDMS Planning Assumptions and Timeline of Care**

(a) Transportation routes—ground and air—are available to move NDMS assets.

(b) 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).

(c) 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.

(d) In the event of catastrophic incident, the "standard of care" will be minimal life support and patient holding for 2 to 3 days.

(e) The NDMS timeline of care (**Figure 6-6**) is based on the following teams:

i. 12 DMATs
ii. 3 NMRTs
iii. 1 IMSuRT
iv. 3 Base Support Teams (BSTs)

Care Provided	NDMS Patient Volume Capability		
	Single Team (D+0) 35 Personnel	**14 Teams (D+1)** 660 Personnel	**Entire NDMS System (D+3)** 1,080 Personnel
Treat and Release (Outpatient Facility)	250 patients per day	2,500 patients per day	5,000 patients per day
Treat and Limited Holding (Alternate Care Facility)	160 outpatients per day 8 inpatients	2,250 outpatients per day 112 inpatients	4,500 outpatients per day 224 inpatients
Standard Medical Holding Facility (Hospital Ward)	50 patients	700 patients	1,400 patients
Mass Casualty Incident (Holding Collection Facility)	150 patients	2,100 patients	4,200 patients

Figure 6-6 – National Disaster Medical System Timeline of Care

(9) **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:

(a) Direct medical and dental care to disaster victims and/or responders.

(b) Mental health and social work services to victims and/or responders.

(c) Provision of occupational health support to responders, including personal protective equipment, environmental hazards, hygiene, food, water, and sanitation.

(d) Providing general health educators to provide information to victims and their families.

(e) Environmental health and industrial hygiene officers to evaluate potable water, wastewater, and sanitation issues.

(f) Environmental health, food safety, and dietician officers to evaluate food safety and security issues.

Role	Number
Physicians	1,210
Dentists	502
Nurses	1,224
Engineers	415
Science	269
Environmental Health	375
Veterinarian	97
Pharmacists	877
Dieticians	82
Therapists	117
Health Services	831
TOTAL	**5,999**

Figure 6-7 – U.S. Public Health Service Commissioned Corps Force Strength

(g) Epidemiologists to work with local public health departments to identify and evaluate morbidity and mortality issues.

(h) Forensic dentists to support the local medical examiner in mass fatalities.

(i) Information technology and medical records experts to improve the collection and communication of public health information.

Medical Position/Role	Number Available to		
	Deploy to Destination Within 24 Hours	Deploy to Destination Within 72 Hours	Totals
Clinical Dietitian	5	32	**37**
Clinical Veterinarian	5	31	**36**
Communications Officer	6	40	**46**
Dentist	36	226	**262**
Emergency Coordinator Augmentee	12	70	**82**
Emergency Medical Technician	1	4	**5**
Epidemiologist	48	288	**336**
Food Safety	9	51	**60**
General Environmental Health Officer	46	279	**325**
General Health Educator	38	232	**270**
General Nurse	72	435	**507**
Hazardous Waste/Materials	5	32	**37**
Liaison Officer	29	159	**188**
Medical Records Administrator	3	21	**24**
Medical Technologist (Laboratory Technician)	6	36	**42**
Mental Health Provider	19	117	**136**
Occupational Health/Industrial Hygiene	9	56	**65**
Optometrist	8	46	**54**
Pharmacist (General)	65	391	**456**
Pharmacist (Strategic National Stockpile)	5	33	**38**
Physical Therapist	8	50	**58**
Physician Assistant	11	63	**74**
Primary Care Nurse Practitioner	18	109	**127**
Primary Care Physician	36	216	**252**
Safety Officer	6	38	**44**
Strategic National Stockpile Officer	2	13	**15**
TOTALS	**508**	**3,068**	**3,576**
70 percent	**356**	**2,148**	**2,503**

Figure 6-8 – Active U.S. Public Health Service Commissioned Corps Force Roster

NOTE: *In response to a catastrophic incident, all officers are potentially deployable. However, at any given time, 50 percent of officers are fulfilling mission-critical roles and will not be deployable.*

(j) 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.

(k) 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.

(l) 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.

(m) 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.

(n) 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:

i. **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.

ii. **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.

iii. **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.

iv. **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.

(10) **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.

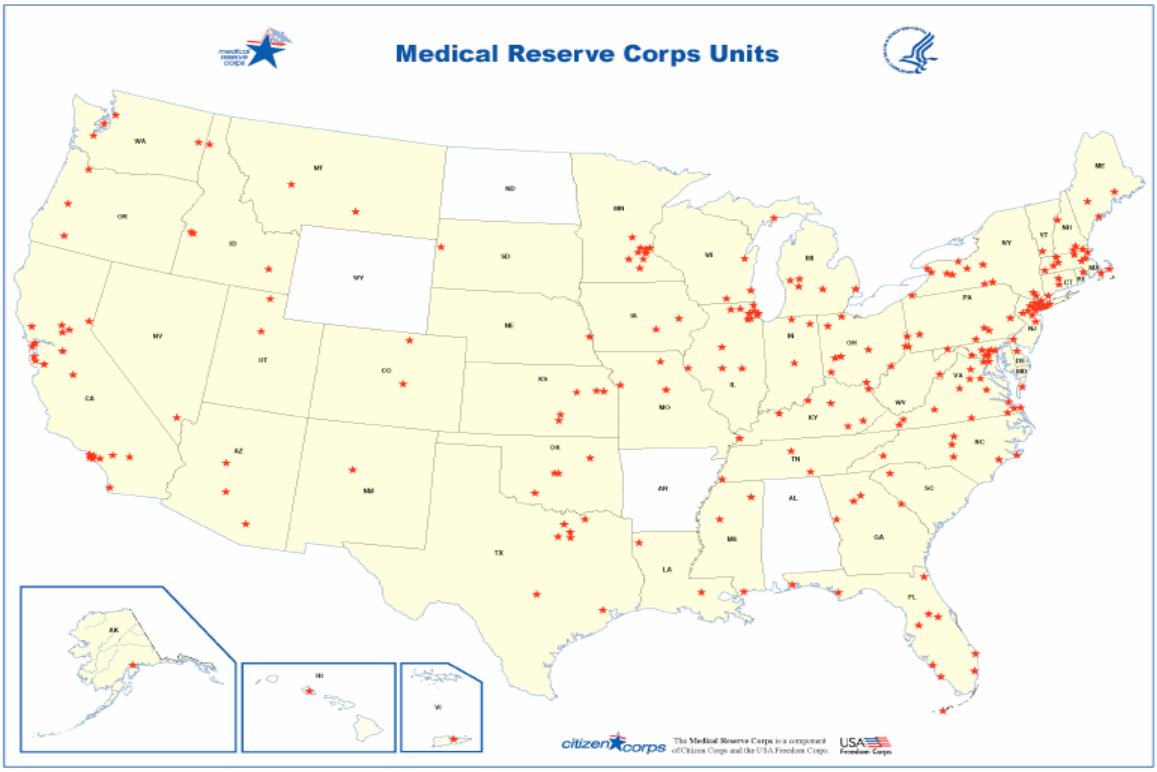


Figure 6-9 – Medical Reserve Corps Communities

(11) **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

(12) **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.

(13) **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.

(14) **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 C^2 Evacuation System (TRACES2) database.

(a) 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.

(b) 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.

(c) 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.

Figure 6-11 – Federal Coordinating Center Locations

Figure 6-12 – Potential National Disaster Medical System Beds Available Through Federal Coordinating Centers

Federal Coordinating Center (FCC) Name/Identification	State	Number of NDMS Hospitals	Minimum Beds	Maximum Beds
Birmingham/Montgomery	AL	17	516	819
Mobile (Keesler Air Force Base – Alabama)	AL	6	396	707
Phoenix (Luke Air Force Base)	AZ	25	664	1,444
Tucson	AZ	10	145	379
Little Rock	AR	14	183	417
Long Beach/Greater Los Angeles Area	CA	21	421	1,538
Oakland/San Francisco	CA	15	825	1,573
Orange County (Camp Pendleton Naval Base)	CA	28	290	1,048
Sacramento/Travis (Travis Air Force Base)	CA	15	130	961
San Diego (San Diego Naval Base)	CA	17	319	945
Denver/Boulder (Fort Carson Army Base)	CO	20	720	1,316
New Haven/Hartford (Groton Naval Base)	CT	31	502	2,304
Washington, DC/Maryland (Bethesda)	DC	6	163	260
Wilmington/Dover (Dover Air Force Base)	DE	7	126	475
Jacksonville (Jacksonville Naval Base)	FL	11	106	269
Miami/Fort Lauderdale/Tampa/Orlando	FL			
Miami		35	681	1,403
Tampa		35	372	1,229
Bay Pines		6	166	375
Pensacola/Gulfport (Keesler Air Force Base – Florida)	FL	7	182	322
Atlanta	GA	32	567	1,100
Augusta (Fort Gordon Army Base)	GA	8	144	751
Chicago/Gary/Hammond (Great Lakes Naval Base)	IL	24	863	1,793
Indianapolis	IN	17	372	807
Des Moines	IA	8	145	500
Wichita	KS	5	240	595
Louisville/Lexington	KY			
Lexington		11	98	383
Louisville		16	127	355
New Orleans/Baton Rouge/Shreveport	LA			
New Orleans		23	595	1,433
Shreveport		8	154	428
Baltimore (Walter Reed Army Base)	MD	32	676	1,729
Boston/Eastern MA/Northampton/Central & Western MA	MA			
Bedford		60	1,157	3,803
Northampton		22	254	779
Detroit/Flint/Ann Arbor/Grand Rapids	MI	36	1,151	2,747
Minneapolis/St. Paul	MN	26	569	1,338
Biloxi/Gulfport/Mobile, AL (Keesler Air Force Base – Mississippi)	MS	9	185	435
Jackson/Vicksburg	MS	12	221	452
Kansas City, MO/Kansas City, KS	MO	9	380	700
St. Louis (Scott Air Force Base)	MO	20	377	1,229
Omaha/Lincoln (Offutt Air Force Base)	NE	17	219	578
Newark/Northern/Central (Lyons)	NJ	71	2,090	3,758

Figure 6-12 (continued) – Potential National Disaster Medical System Beds Available Through Federal Coordinating Centers

Federal Coordinating Center (FCC) Name/Identification	State	Number of NDMS Hospitals	Minimum Beds	Maximum Beds
Albuquerque/Santa Fe	NM	10	216	403
Nassau/Suffolk/Brooklyn/Queens/Manhattan/Staten Island	NY			
Long Island		25	659	1,132
Brooklyn		18	189	463
New York		19	584	1,120
Rochester/Buffalo/Western NY/Syracuse	NY			
Albany		19	500	850
Buffalo		28	648	1,307
Syracuse		25	613	1,102
Southern Tier/Mid-Hudson/New York Northern Metropolitan/Bronx	NY	42	705	1,447
North Carolina	NC	80	2,085	4,584
Cincinnati/Columbus/Dayton/Toledo (Wright Patterson Air Force Base)	OH			
Cincinnati		22	265	485
Toledo		6	75	155
Dayton		13	130	265
Columbus		8	120	225
Cleveland/Akron	OH	38	927	2,070
Oklahoma City/Tulsa	OK	12	340	801
Portland/Vancouver, WA	OR	16	511	1,142
Philadelphia/Southern New Jersey	PA	75	1,236	2,837
Pittsburgh/Northern West Virginia	PA	51	953	3,260
Puerto Rico and Virgin Islands	PR	19	193	378
Providence (Newport Naval Base)	RI	18	123	544
Charleston (Charleston Naval Base)	SC	5	55	125
Columbia/Greenville/Spartanburg (Fort Jackson Army Base)	SC	22	341	632
Nashville/Knoxville	TN			
Nashville		31	811	1,823
Memphis as Patient Reporting Activity (PRA) Pending				
Dallas/Fort Worth	TX	50	1,082	2,459
El Paso/Las Cruces, NM (William Beaumont Army Base)	TX	9	216	503
Houston	TX	59	1,215	2,530
San Antonio	TX	33	472	1,293
Salt Lake City	UT	23	294	839
Norfolk/Virginia Beach (Portsmouth Naval Base)	VA	16	395	726
Northern Virginia Suburbs (Andrews Air Force Base)	VA	7	184	353
Richmond/Central/Western Virginia	VA	21	758	1,301
Seattle/Everett/Tacoma (Madigan Army Base)	WA	27	767	2,173
Milwaukee	WI	17	358	756
TOTAL		**1,656**	**35,511**	**83,560**

National Response Plan – Catastrophic Incident Supplement

Appendix 7 – Medical Equipment and Supplies Response Overview

1. 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.

2. Response Capabilities

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 C^2 function.

iv. Receipt, storage, and staging of SNS assets.

v. Controlling SNS inventory.

vi. Distributing SNS assets from staging warehouse to dispensing sites, treatment centers, or other distribution locations.

vii. 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.

C. **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.

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

3. Response Limitations and Unique Concerns

A. 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.

B. 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.

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Appendix 8 – Patient Movement Response Overview

1. 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.

2. 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 (C^2) 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.

3. Catastrophic 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.

4. 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.

5. 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.

6. Responsibilities of Coordinating and Support Agencies/Organizations

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.

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Appendix 9 – Mass Fatality Response Overview

1. 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 personnel.

(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.

2. Inventory of Federal Capabilities

A. **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.

(1) DMORT capabilities include:

(a) Temporary morgue facilities

(b) Victim identification

(c) Forensic dental pathology

(d) Forensic anthropology methods

(e) Processing, preparation, and disposition of remains

(2) DMORT support to the local Coroner/Medical Examiner includes:

(a) Augmenting existing local resources.

(b) Providing specialized personnel.

(c) Providing mobile morgue facility(ies).

(d) Providing computer-based tools.

(e) Providing family support.

(3) 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.

(4) DMORTs work under the guidance of local authorities by providing technical assistance and personnel to recover, identify, and process deceased victims.

(5) 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.

(a) The DPMU requires a location that is completely secure and convenient to the incident scene, with easy access for vehicles.

(b) 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.

(c) Other support equipment required for mass fatality management operations includes refrigerated trucks, forklifts, fuel (diesel, propane etc.), and communications with the incident command post.

(6) 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.

(7) 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.

(8) There is a single WMD DMORT**.** In addition to standard DMORT capabilities, WMD DMORT personnel are**:**

(a) Able to respond and decontaminate human remains without the aid of a NMRT.

(b) Trained to work in a hazardous environment using PPE, up to and including Level A.

(c) All volunteers, due to the hazardous nature of the assignment.

B. **DoD Mortuary Services**

(1) DoD Mortuary Affairs Units can provide the following support to domestic catastrophic incident response and recovery operations, when authorized by the Secretary of Defense.

(a) Search for remains. Setting up appropriate search methodology and preparing the necessary documentation for later research or use.

(b) Recover remains. Use any means available to recover all remains and portions of remains.

(c) 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.).*

(d) 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.

i. Receiving Section: receive, account for, and store all PE.

ii. Administrative Section: prepare and maintain all required reports and case files, and provide administrative assistance to the civilian mortuary affairs community.

ii. Processing Section: Screen, clean, inventory, and package PE.

iv. Shipping Section: Initiate required shipping documents, coordinate for transportation, and prepare packages for shipment.

(e) 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.

(f) 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.

(2) 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.

(3) DoD maintains the capability to provide technical assistance to civilian agencies. This technical assistance will be provided when requested by the appropriate civil authority.

(4) 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.

(5) 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.

3. Response Strategy

A. **Response Strategy: IMMEDIATE.**

(1) 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:

(a) Deploy additional DMORTs, DMATs, portable morgues, and such rental units that may be available.

(b) Locate and establish reception and cold storage sites for human remains. Cold storage sites should be able to maintain a constant temperature of 37° F, and would include warehouses (or similar structures), aircraft hangars, and tents.

(c) 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.

(d) 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.

(e) Provide information technology (IT)/DNA-typing support unit(s).

(f) 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.

(g) Provide, with support from NGOs, mental health and counseling services for families of victims.

(h) Assign human remains retrieval (search and recovery) teams to the larger reception sites.

(i) Establish an Emergency Family Assistance Center (EFAC) for immediate crisis intervention and sustained support to victims' families.

(j) 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.**

(1) 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 humans remains. Staffing and equipment augmentation will be sought from the following organizations:

(a) Federal DMORTs

(b) National US&R Teams

(c) State Funeral Director's Associations

(d) Local and Federally recognized mutual aid providers

(e) National Guard

(f) DoD

(g) VA

(h) DOT

(i) Fully qualified mortuary affairs/emergency services contractors.

(j) 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.

C. **Response Strategy: SUSTAINED.**

(1) 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.

4. Transportation and Logistics 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 personnel.

(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.

(6) 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).

(7) Technical Information Specialists.

(8) Qualified personnel to augment DMORT DNA-typing resources.

(9) U.S. Public Health Service (PHS) Commissioned Corps personnel.

5. Limitations

A. 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.

B. Logistics systems may be overwhelmed and unable to move, in a timely manner, the required volume of personnel, victims, and equipment.

C. Protocols for processing (movement and identification) biologically and/or chemically contaminated remains.

D. Lack of standards for decontaminated remains.

E. 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.

F. Storage area needed for personal effects; local procedures for inventorying personal effects may be incorporated into Federal inventory procedures.

G. 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.

H. With very few exceptions, medical examiners and coroners do not have either the training or equipment to deal with contaminated remains.

I. 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.

J. A lack of dedicated remains retrieval (search and recovery) teams.

K. First responders are typically not trained in remains retrieval, and may not be available in a timely manner to assist in such operations.

6. Responsibilities of Coordinating and Support Agencies/Organizations

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.

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Appendix 10 – Housing Response Overview

1. Mission

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

2. 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. 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.

N. Normal methods of information dissemination will be significantly impaired due to the disruption of utility services.

O. 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.

P. Elevation of the Homeland Security Advisory System (HSAS) will impact transportation alternatives for victims seeking shelter or being transferred from shelters to temporary housing.

3. Catastrophic 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.

(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.

4. 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.

5. Response Limitations and Unique Concerns

A. Individual assistance caseworkers and other trained staff.

B. Existing shelter sites.

C. Trained housing inspectors.

D. Public/private partnerships.

6. Response Capabilities

A. **Organic Federal**

(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. **Non-Organic Federal**

(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.

7. Coordinating and Support Agencies/Organizations

A. **Coordinating Agency:** DHS/FEMA.

B. **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.

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National Response Plan – Catastrophic Incident Supplement

Appendix 11 – Public Information and Incident Communications Response Overview

1. 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.

2. 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.

3. Federal Public Affairs and Incident Communications Capabilities

A. U.S. Department of Homeland Security (DHS)

(1) **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.

(a) **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).

(b) **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.

(2) **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.

(3) **Staff Incident Management.** During a domestic WMD or incident, DHS Public Affairs will support and manage the following elements:

(a) **Press Office.** Performs primary media response and management of Departmental issues or queries, including changes to the Homeland Security Threat Status.

(b) **Speechwriting.** Performs drafting tasks in support of the Secretary DHS and other senior leadership. Prepares statements for use during major announcements.

(c) **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 decisionmakers. They also assist in interagency coordination through the National Incident Communications Conference Line (NICCL).

(d) **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.

(e) **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.

(f) **Media Support.** A media support staff assists the Press Office and interagency coordination efforts.

(g) **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.

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

(1) **Federal Emergency Management Agency**

(a) **Emergency Response Team (ERT).** ERTs have a Public Affairs component (full-time and reserve disaster cadre).

(b) **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.

(c) **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).

(d) **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.

(e) **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.

(f) **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.

(2) **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.

(3) **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.

C. **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.

(1) **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.

(2) **Regional Offices.** Five of the seven Regional offices of Public Affairs have digital cameras, two have 35mm cameras, and one owns a video camera.

(3) **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.

D. **U.S. Department of Agriculture (USDA).** The USDA possesses the following Public Affairs resources:

(1) Television and radio studio with satellite capabilities at the Washington, DC, HQ Building.

(2) Agency Public Information Officers (PIOs) in regions, States, and many counties.

(3) Virtual War Room plan would be implemented to support public information efforts.

(4) Remote computer database capability to access lists.

(5) Food and agricultural experts in U.S. embassies.

(6) Food and agricultural constituent outreach lists.

(7) Webcast capabilities.

E. **Department of Health and Human Services (HHS).** HHS ASPA maintains the following team structure to be ready to respond to a catastrophic incident:

(1) **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.

(2) **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.

(3) **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.

(4) **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.

(5) **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.

(6) **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.

(7) **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.

(8) **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.

(9) **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.

(10) **Emergency Web Support.** HHS also maintains an emergency shell Web page that can be populated and posted quickly with information relevant to the event.

F. **Environmental Protection Agency (EPA)**

(1) **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.

(2) **EPA Regional Support.** Public Affairs Offices in EPA's 10 Regional HQ and laboratories.

G. **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.

(1) **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.

(2) **Headquarters Staff.** NRC Public Affairs staff at headquarters will handle incoming media calls and monitor news coverage.

(3) **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.

(4) **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.

H. **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.

I. **American Red Cross.** The ARC maintains the following:

(1) **Rapid Response Team.** Fifty-member team of trained, national media spokespersons.

(2) **Disaster Responders.** Six hundred responders around the Nation to work with State and local media.

(3) **Web Support.** Internet group for Web coding of both internal and public Web sites.

(4) **Photographic Support.** Staff photographers and video production experts.

(5) **Nationwide Chapters.** More than 900 local Red Cross chapters throughout the country provide a tangible local presence in communities.

(6) **Information Hotline.** The Red Cross maintains a 24/7 public information hotline.

(7) **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.

J. **General Services Administration (GSA).**

(1) **GSA Headquarters.**

(2) **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.

4. Inventory of Other (Federally Accessible) Capabilities

A. **DHS and FEMA**

(1) **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.

(2) **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.

(3) **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.

(4) **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.

(5) **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.

B. **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.

C. **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.

D. **Environmental Protection Agency.** EPA maintains a contract with U.S. Newswire for electronic distribution of press releases.

E. **Department of Transportation.** DOT maintains a contract for an Associated Press (AP) feed with eight stations.

F. **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.

G. **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.

H. **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.

5. 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?

A. **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

i1i. Senior DHS IIMG/HSOC leadership.

iv. Incident site (including State/local) Public Affairs leadership.

v. Federal interagency Public Affairs team (via NICCL).

vi. Media contact through pre-established emergency contact line.

(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.**

(a) Sustaining actions by the Intergovernmental Incident Communications Team:

i. JIC established to manage and coordinate incident site Public Affairs activities.

ii. 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.

iii. DHS deploys PFO and supporting Public Affairs team.

iv. HHS and CDC may deploy Public Affairs teams to affected incident site to support State and local effort. Subject to incident and requests.

v. FEMA establishes radio station to deliver incident and response activity.

vi. FEMA distributes battery-powered radios.

viii. FEMA initiates other incident site communications recovery efforts in support of normal ESF tasks.

ix. Ad Council national public service television advertisements are covering threat, public instructions, and preparedness measures.

x. SMEs are briefed and available to support sustaining communications.

B. **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.

C. **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.

D. **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.

E. **Environmental Protection Agency**

(1) **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.

(2) **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.

(3) **Sustained.** Provide continued support to DHS Public Affairs.

F. **Department of Transportation**

(1) **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.

(2) **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.

(3) **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.

G. **American Red Cross.** ARC response actions to support first hour to sustaining actions are detailed below:

(1) **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.

(2) **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.

(3) **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.

(4) **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.

(5) **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.

6. 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.

7. Limitations

A. **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:

(1) **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.

(2) **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.

(3) **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.

(4) **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:

(a) **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.

(b) **New Resources.** A mobile broadcast unit would be useful for emergency broadcast capability in or near the incident locations.

B. **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.

C. **U.S. Department of Agriculture.** Standby satellite facilities and time as well as communications equipment that would take precedence on airtime is always needed.

D. **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.

8. Responsibilities of Coordinating and Support Agencies/Organizations

A. **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:

(1) Incident Management.

(2) Law Enforcement.

(3) Medical or Health.

(4) Environmental.

(5) Protective Measures.

(6) Search and Rescue.

(7) Preparedness.

(8) Mass Care, Housing, and Food Safety.

(9) Recovery Assistance.

B. **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.

C. **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.

D. **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.

E. **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.

F. **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.

G. **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.

H. **Deparatment 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.

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Appendix 12 — Private Sector Support Overview

1. Mission

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

2. 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.

3. Catastrophic 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.

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Appendix 13 – Acronyms, Abbreviations, and Terms

1. Departments and Agencies

APHIS	Animal and Plant Health Inspection Service (USDA)
ARC	American Red Cross
ASPA	Assistant Secretary for Public Affairs (DHS & HHS)
ASPHEP	Assistant Secretary for Public Health Emergency Preparedness (HHS)
ATF	Bureau of Alcohol Tobacco and Firearms
ATSDR	Agency for Toxic Substances and Disease Registry (HHS)
BOR	Bureau of Reclamation
BTS	Border and Transportation Security (DHS)
CBP	Customs and Border Control (DHS)
CDC	Centers for Disease Control
CMC	Crisis Management Center
DHS	Department of Homeland Security
DOC	Department of Commerce
DoD	Department of Defense
DOE	Department of Energy
DOI	Department of the Interior
DOJ	Department of Justice
DOS	Department of State
DOT	Department of Transportation
DS/OFM	Diplomatic Security Office of Foreign Missions (DOS)
EPA	Environmental Protection Agency
FBI	Federal Bureau of Investigation
FCC	Federal Communications Commission
FDA	Food and Drug Administration
FEMA	Federal Emergency Management Agency (DHS)
FERC	Federal Energy Regulatory Commission
GSA	General Services Administration
HHS	Department of Health and Human Services
HUD	Department of Housing and Urban Development
ICE	Immigration and Customs Enforcement (DHS)
IRS	Internal Revenue Service
JS	Joint Staff (Office of the Chairman of the Joint Chiefs of Staff, DoD)
NASA	National Aeronautics and Space Administration

NIH	National Institute of Health
NIST	National Institute of Standards and Technology
NNSA	National Nuclear Security Administration
NOAA	National Oceanic and Atmospheric Administration
NORTHCOM	U.S. Northern Command
NRC	Nuclear Regulatory Commission
NWS	National Weather Service
OASD(HA)	Office of the Assistant Secretary of Defense for Health Affairs
OASD(HD)	Office of the Assistant Secretary of Defense for Homeland Defense
OSHA	Occupational Safety and Health Administration
S&T	Science and Technology
TRANSCOM	U.S. Transportation Command
TREAS	Department of Treasury
USACE	U.S. Army Corps of Engineers
USAID	United States Agency for International Development
USCG	U.S. Coast Guard
USDA	U.S. Department of Agriculture
USFS	U.S. Forest Service
USGS	U.S. Geological Survey
USPS	U.S. Postal Service
VA	Department of Veterans Affairs

2. Key Acronyms and Terms

AABB	American Association of Blood Banks
AHA	American Hospital Association
ARF	Action Request Form
ASH	Assistant Secretary of Health
BSOC	Biomedical Services Operations Center
CAE	Command Assessment Element (DoD)
CBIRF	Chemical Biological Incident Response Force (USMC)
CBRNE	Chemical, Biological, Radiological, Nuclear, or High-Yield Explosive
CCP	Casualty Collection Point
CCRF	Commissioned Corps Readiness Force
CHC	Combined Health Center
CIS	Community Information System
CMC	Crisis Management Center
CMHC	Community Mental Health Centers
CONOP	Concept of Operations
CONUS	Continental United States
COOP	Continuity of Operations
CRT	Critical Response Team
DCE	Defense Coordinating Element

DCO	Defense Coordinating Officer
DEMPS	Disaster Emergency Medical Personnel System
DEST	Domestic Emergency Support Team
DMAT	Disaster Medical Assistance Team
DMORT	Disaster Mortuary Operational Response Team
DOC	Disaster Operations Center
DPMU	Disaster Portable Morgue Units
DRC	Disaster Recovery Center
DSHR	Disaster Services Human Resources
DWI	Disaster Welfare Information
EAS	Emergency Alert System
EDCS	Emergency Decontamination Corridor System
EFAC	Emergency Family Assistance Center
EIS	Epidemiologic Intelligence Service
EMAC	Emergency Management Assistance Compact
EOC	Emergency Operations Center
ERT	Emergency Response Team (FEMA)
ERT	Environmental Response Team (EPA)
ERT-N	National Emergency Response Team
ESAR-VHP	Emergency System for Advanced Registration of Voluntary Healthcare Personnel
ESF	Emergency Support Function
EST	Emergency Support Team
ETC	Emergency Transportation Center
FCC	Federal Coordinating Center
FCO	Federal Coordinating Officer
FIRST	Federal Incident Response Support Team (FEMA)
FRMAC	Federal Radiation Monitoring and Assessment Center
GIS	Geographic Information System
GPMRC	Global Patient Movements Requirement Center
HARTS	Hospital Asset Resource Tracking System
HMRU	Hazardous Materials Response Unit
HRSA	Health Resources and Services Administration
HRT	Health Response Team
HSAS	Homeland Security Advisory System
HSOC	Homeland Security Operations Center
HSPD	Homeland Security Presidential Directive
ICEP	Incident Communications Emergency Plan
ICEPP	Incident Communications Emergency Policy and Procedures
IEF	Initial Entry Forces (DoD)
IIMG	Interagency Incident Management Group
IMAAC	Interagency Modeling and Atmospheric Assessment Center
INRP	Initial National Response Plan
INSARAG	International Search and Rescue Advisory Group
IOF	Interim Operating Facility
IRR	Individual Response Resource

IST	Incident Support Team
JFO	Joint Field Office
JIC	Joint Information Center
JTF-CS	Joint Task Force – Civil Support
LIDAR	Light Detection and Ranging (System)
LNG	Liquefied Natural Gas
MATTS	Mobile Air Transportable Telecommunications System
MCC	Movement Coordination Center
MCMT	Mobilization Center Management Team
MERS	Mobile Emergency Response Support
MIACG	Medical Interagency Coordination Group
MMRS	Metropolitan Medical Response System
MOU	Memorandum of Understanding
MRC	Medical Reserve Corps
MSST	Marine Safety and Security Team
MST	Management Support Team
MTF	Military Treatment Facility
NARAC	National Atmospheric Release Advisory Capability
NCP	National Disaster Medical System
NEIC	National Earthquake Information Center
NEMIS	National Emergency Management Information System
NEST	Nuclear Emergency Support Team
NGO	Non-Governmental Organization
NGS	National Geodetic Survey
NH	Natural Hazard
NICCL	National Incident Communications Conference Line
NIMS	National Incident Management System
NIT	Nuclear Incident Team (DOE)
NLT	No Later Than
NMRT	National Medical Response Team
NOTAM	Notice to Airmen
NRAT	Nuclear Radiological Assessment Team
NRC	National Response Center
NRCC	National Response Coordination Center
NRP	National Response Plan
NRP-CIA	National Response Plan – Catastrophic Incident Annex
NRP-CIS	National Response Plan – Catastrophic Incident Supplement
NSF	National Strike Force (USCG)
OPDIV	Operating Division
PADO	Public Affairs Duty Officer
PAO	Public Affairs Office (or Officer)
PFO	Principal Federal Official
PHS	Public Health Service
PIAT	Public Information Assistance Team
POE	Point of Embarkation

PPDS	Pre-Positioned Disaster Supplies
PPI	Pre-Placement Interviews
PRC	Primary Receiving Center
PSO	Private Sector Office
RAP	Radiological Assistance Program
REAC/TS	Radiation Emergency Assistance Center/Training Site
REP	Regional Evacuation Point
RERT	Radiological Emergency Response Team
RETCO	Regional Emergency Transportation Coordinator
RETREP	Regional Emergency Transportation Representative
RHS	Rural Housing Service
RNA	Rapid Needs Assessment
RRCC	Regional Response Coordination Center
SAR	Search and Rescue
SOC	Secretary's Operations Center (HHS)
SCO	State Coordinating Officer
SERT	Secretary's Emergency Response Team (HHS)
SME	Subject-Matter Expert
SNS	Strategic National Stockpile
SOP	Standard Operating Procedure
SOU	Statement of Understanding
STOLS	System To Locate Survivors
TLC	Territorial Logistics Center
TRAC2ES	TRANSCOM Command and Control (C2) Evacuation System
TRF	Temporary Flight Restriction
US&R	Urban Search and Rescue
VA NAC	Veterans Affairs National Acquisition Center
VMAT	Veterinary Medical Assistance Team
VMI	Vendor-Managed Inventory
WMD	Weapon(s) of Mass Destruction

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