The Capitol Region
Metropolitan Medical Response System
Hartford, Connecticut

DELIVERABLE # 4

Capitol Region MMRS Plan for Responding
To the Release of a Biological Agent

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Submitted on behalf of the Capitol Region Council of Governments
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Introduction

The Capitol Region MMRS Plan for Responding to the Release of a Biological Agent (MMRS Deliverable #4) is a component of the strategic Capitol Region MMRS Response Plan developed under contract with the U.S. Department of Homeland Security, Office of Domestic Preparedness. The Capitol Region Council of Governments administers the MMRS program. The Plan is intended always to be a dynamic, working document subject to change on short notice so as to ensure the flexibility of the Plan to meet the needs of the community.

This document details the planned response of the 41 communities comprising the Capitol Region of Connecticut to a naturally occurring or terrorist incident resulting from the release of a biological agent leading to illness, death, and massive economic and social upheaval. The plan is intended to maximize the resources of the region while identifying, and respecting, the rights and obligations of the 41 communities participating in the Capitol Region Emergency Planning Committee (CREPC).

The Capitol Region MMRS Plan for Responding to the Release of a Biological Agent provides a strategic framework for the detection and management of any biological threat, and links regional policies and actions to existing or developing state and federal response systems. As the state of Connecticut has not completed its final version of a bioterrorism response plan at the time of this writing, plans for resource allocation and command and control in a regional event, when state authorities and agencies become involved, are subject to revision.

Assumptions

1. The scope of the incident and the number of casualties are of such a magnitude that the Capitol Region requires the assistance of the State of Connecticut as well as applicable federal agencies in order to manage the incident.
2. The Capitol Region Regional Emergency Disaster (RED) Plan has been activated by a responsible local official or the Incident Commander through notification of the Regional Incident Coordination System (RICS) at 860-832-3477
3. The Capitol Region Emergency Planning Committee (CREPC) has activated at least one “Resource Coordination Center” (RCC) to manage all logistical requirements within or out of the Capitol Region.
4. It is further anticipated that at minimum the following Regional Emergency Support Functions are required to be present at the CR-RCC:
   - ESF1 - Transportation
   - ESF2 - Communications
   - ESF4 - Fire Service
   - ESF5 - Information and Planning
   - ESF6 - Mass Care
   - ESF8 - Health and Medical Services
   - ESF13 - Law Enforcement
   - ESF14 - Media
Overview of a Bioterrorism Incident

The *covert* dissemination of a biological agent presents specific problems not normally associated with community emergencies. There may be no immediate evidence of an agent release due to a prolonged delay from the time of the release until the first symptoms appear in the population. In this scenario, initial identification of a problem is likely to come from those health providers who first notice the symptoms and can recognize the unusual nature of what they have seen.

By the time there are a significant number of cases within the community to warrant an alarm, the disease likely will be well established and widely disseminated. Furthermore, because of the delay in diagnosis, most assuredly the disease will have been spread far beyond the boundaries of our own communities. The call to action following the initial determination must be swift and comprehensive.

By any definition, this type of incident is first and foremost a threat to the public health, so that leadership in the development of an effective response strategy must come from the health providers in our communities. The responsibilities for such a comprehensive approach to disease management must be shared among the local and regional public health agencies, hospitals, fire and police services, EMS and, ultimately, state and federal planners and responders.

Public health planning must include methods of early recognition, early warning, epidemiological investigation, inter-agency command and control, effective logistical management, appropriate medical triage and treatment, timely prophylaxis and separation of the population based on symptoms, public education, and environmental surety.

Due to these complexities, the appropriate time to develop this coordination of response is long before an incident occurs. Early detection and response to a biological agent is crucial if we hope to avoid overwhelming our regional capacities to manage an incident and to avoid massive casualties. If the biological agent is released as the result of a terrorism incident, there will be additional special challenges that will require superb, informed coordination of our resources if we are to minimize the disaster. Truly, the best defense against the release of a natural or man-made biological agent into our communities is to mount a good offense: a viable, practical medical surveillance and response system that is the product of a total community effort.

Indications of a Bioterrorism Event Using a Biological Agent

- Large numbers of cases of unexplained diseases or deaths
- Any outbreak of a disease
- Young patients with rapidly progressive respiratory illness
- Young patients with encephalitic symptoms
- Unidentified fever and rash illness
• Severe disease with high mortality
• Severe disease refractory to treatment
• Unknown disease with respiratory manifestations
• Infectious disease with unusual clinical presentation
• Higher morbidity and mortality in association with a common disease or syndrome, or failure of such patients to respond to usual therapy
• Many ill persons seeking treatment at about the same time
• Clusters of patients arriving from a common location
• Illness associated with a ventilation system
• A disease that is unusual for a given geographic area, occurs outside the normal transmission season, or occurs in the absence of the normal vector for transmission
• Multiple simultaneous epidemics of different diseases
• Illness that is unusual (or atypical) for a given population or age group
• Unusual patterns of death or illness among animals that precedes or accompanies illness or death in humans

Biological Agents

Biological agents generally fall into three categories:

A. **Bacteria** produce disease in humans and animals either by penetrating and invading tissue or by releasing toxins into the tissue, or both. Some bacteria can transform themselves into spores, a dormant form much more resistant to cold, heat, drying, chemical applications, and radiation, that can be reactivated when conditions become more favorable.
   a. Examples: B. anthracis (anthrax); F. tularensis (tularemia); Y. pestis (plague)

B. **Viruses** are simpler organisms that rely on a host to multiply and usually act quickly to produce host cell destruction. Both bacteria and viruses can have an effect not proportional to their quantity due to replication within the host.
   a. Examples: Variola (smallpox); Yellow Fever Virus; Equine Encephalitis viruses

C. **Toxins** are poisonous substances that can be produced by an animal, plant or microbe. Unlike bacteria and viruses, toxins are chemicals and do not reproduce. The speed of reaction to the presence of a toxin is directly proportional to the concentration of the toxin in the host.
   a. Examples: Ricin; Clostridium botulinum; Staphylococcus enterotoxins
Biological Agents of Concern to MMRS

The Capitol Region MMRS biological agent response plan is modeled to respond to five organisms that represent the most likely agents of a bioterrorism weapon:

<table>
<thead>
<tr>
<th>Agents Disease</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smallpox (Variola virus)</td>
<td>Person-to-Person Transmission (Transmitted by aerosols from infected victims)</td>
</tr>
<tr>
<td>Plague (Yersinia pestis)</td>
<td>Pneumonic form - Person-to-Person Transmission (Transmitted by aerosols within 6 feet of victim) Bubonic form – No Person-to-Person Transmission</td>
</tr>
<tr>
<td>Anthrax (Bacillus anthracis)</td>
<td>No Person-to-Person Transmission High Morbidity / High Mortality</td>
</tr>
<tr>
<td>Tularemia (Francisella tularensis)</td>
<td>No Person-to-Person Transmission High Morbidity / Low Mortality</td>
</tr>
<tr>
<td>Viral Hemorrhagic Fevers (VHF)</td>
<td>Person-to-Person Transmission High Morbidity / High Mortality</td>
</tr>
</tbody>
</table>

Bioweapons Scenarios

There is general agreement that it is more difficult to disseminate efficiently a biological agent than to manufacture it. Methods of delivery depend on the target. However, there is a clear advantage in choosing a biological agent as a weapon because of the difficulty in detecting a release in its early stages.

Methods of releasing a biological agent include tampering with foodstuffs, medicines or liquids, or using aerosol dispersal devices, to release pathogens into an enclosed environment. Another source of vulnerability could result from the introduction of pathogens into the contained water supply of a facility, although most water utilities are considered to have less of an exposure because of the greater volumes of water held in reservoirs. Potentially such attacks may be capable of killing tens of thousands of people.

Smallpox and plague are two biological agents that present an extreme threat to our communities, as both are transmitted readily through airborne droplet transmission from one individual to another. Furthermore, both agents are capable of being weaponized to enhance their effectiveness and their resistance to the environment. The result could be a self-perpetuating epidemic with the loss of thousands of lives.

Anthrax, tularemia and brucellosis are examples of three biological agents that are not contagious but would require a massive effort at containment and mitigation. An incident resulting from the release of one of these agents
probably would be self-contained and confined to the area immediately surrounding the release. However, the impact on our regional health resources may be overwhelming to the point of needing assistance from state and federal agencies.

In either case, rapid implementation of public health containment measures and the proper use of personal protective equipment by first responders and healthcare providers are critical elements in any plan to prevent a massive disaster reaching well beyond our recognized geographic boundaries.

Guidelines for Capitol Region MMRS Planning

Release of a biological agent in the Capitol Region, especially if the release is an act of terrorism, shall result in a rapid, comprehensive response by all components of the emergency planning agencies: fire, police, EMS, public health and hospitals.

Coordination of responders and resources shall be accomplished first on a local level and then expand rapidly, through the Capitol Region Emergency Planning Committee Regional Emergency Disaster (RED) Plan, to include regional, state and federal resources as required to control and mitigate the event and its consequences.

If massive casualties result from the incident, non-traditional healthcare facilities and personnel may play a large role in providing medical care to the afflicted population. Therefore, the Capitol Region MMRS plan of action includes guidelines for the strategic and tactical use of non-traditional healthcare resources. Planning strategies shall include:

- A plan to expand into regions beyond our local communities, and defined methods to expand resources rapidly.
- A community-wide assessment of available public health resources, including emergency department capacities in local hospitals, number of beds by specialty, availability of medical personnel by specialty, morgue capacity, and availability of specialized equipment to manage a mass casualty incident (pharmaceuticals, ventilators, etc.)
- Completion of a community-wide assessment of alternate sites for medical services, including nursing homes, schools, daycare centers, and community meeting places.
- Assess the capacity of each site to support basic medical services (backup power source, ventilation, refrigeration, parking, etc.). Identify especially those items that may limit the usefulness of that facility when expanding regional medical capacity.
- Identify sources of equipment and supplies to support medical care efforts in non-traditional settings, and provide these supplies in advance in sufficient quantity to ensure that an adequate, rapid response to a medical disaster can be implemented.
• Conduct an inventory of medical personnel in the Capitol Region, including current and retired physicians, nurses, dentists, veterinarians, EMTs, and medical technicians. Define the extent of care each can provide by law, and develop a plan to acquire their services in the event of a mass casualty incident. Define a plan to expand provider resources if local manpower is overwhelmed.
• Coordinate medical manpower resources through the Capitol Region Medical Reserve Corps to ensure federal recognition and uniformity of purpose
• Ensure that volunteer healthcare providers are assured of adequate liability protection when providing care in a non-traditional setting
• Update these assessments frequently and ensure that results are transmitted to all responsible parties in a timely and efficient manner through multiple means (redundant communications).
• Compile the information from each of these assessments to allow the development of a comprehensive local plan for the involvement of each of these agencies and professions to expand the regional capacity to provide medical care. Identify within the plan the trigger mechanisms to activate the plan.
• Educate every healthcare provider on early diagnosis, triage, treatment and transport procedures when dealing with biological agents
• Coordinate Capitol Region plans with state and federal planning efforts to maximize resources and to ensure a rapid and efficient response to the release of a biological agent

Currently, all of these strategies have been at least partially accomplished, and efforts continue to ensure a coordinated process among regional, state and federal agencies.
Operational Concepts

I. Stages of Severity

This plan is intended to address three stages of severity of a bioterrorism event. The levels are defined as:

Stage I: Developing Public Health Crisis
0 to 100 patients

Stage II: Public Health Disaster
101 to 1,000 patients

Stage III: Catastrophic Public Health Event
1,001 to 10,000 or more patients

The patient numbers associated with each stage are to be considered guidelines since the release of a highly contagious agent may require Stage III procedures even if the number of patients is far less than 1,001.

II. Strategies and Actions

Each stage of severity requires a different strategic response. This response is implemented through a general action plan suitable for each stage. The following is a list of strategies and general actions for each stage of severity:

Stage I: Developing Public Health Crisis: 0 to 100 patients
Strategy: Assess local needs
General Action: Utilize existing local response structure

Stage II: Public Health Disaster: 101 to 1,000 patients
Strategy: Establish regional response structure
General Action: Augment resources within the region

Stage III: Catastrophic Public Health Event: 1,001 to 10,000 or more patients
Strategy: Utilize all available state and federal resources
General Action: Integrate state and federal resources into regional response structure
III. Functional Organization

The Capitol Region MMRS Plan organizes the responsibilities to implement the general action plan into the following eight functional areas:

- Command and Control
- Early Recognition and Threat Assessment
- Initial Actions
- Medical Care
- Mass Prevention/Prophylaxis
- Logistics
- Fatality Management
- Environmental Clean-Up

Actions are undertaken in each of these functional areas at every stage of an incident. Specific details, tasks, and responsibilities for the eight functional areas are presented in the operational sections describing each function. The actions described therein do not necessarily follow one another in succession.

The following Plan Matrix shows the strategies and actions of the plan in general terms across functional areas:
<table>
<thead>
<tr>
<th>Early Recognition &amp; Threat Assessment</th>
<th>Medical Care (Mass Care /Treatment)</th>
<th>Prevention Prophylaxis/Vaccination</th>
<th>Logistics</th>
<th>Fatality Management</th>
<th>Environmental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification of expanded epidemiological surveillance&lt;br&gt;Identify Biological Agent</td>
<td>Identify hot zone&lt;br&gt;Rescue, and isolate&lt;br&gt;Transport samples to lab&lt;br&gt;Transport patients</td>
<td>Medical Command assesses need for activation of disaster plan and monitors status of hospital capacity&lt;br&gt;Assess need for prophylaxis&lt;br&gt;Issue public health recommendations for public and address media&lt;br&gt;Consider need for forward movement of SNS stockpile</td>
<td>Assess need for internal staffing increase&lt;br&gt;Assess security needs</td>
<td>Assess need for temporary morgue facilities</td>
<td>Identify environmental hazards and assess ability to clean up with local resources</td>
</tr>
<tr>
<td>Establish epidemiological investigation&lt;br&gt;Crime scene investigation&lt;br&gt;Laboratory Identification</td>
<td>Hospital disaster plans activated through CMED&lt;br&gt;Triage established outside of healthcare facilities and at Neighborhood Acute Care Centers&lt;br&gt;Targeted population prophylaxis if indicated&lt;br&gt;SNS Stockpile requested if indicated&lt;br&gt;Manage worried well&lt;br&gt;Control Measures: Identify Target Population Issue Airborne Precautions Quarantine or isolate as indicated</td>
<td>Increased staffing through regional call-up&lt;br&gt;Consider widespread security needs&lt;br&gt;Alternate transportation resources</td>
<td>Establish temporary morgue facilities</td>
<td>Residual hazard assessment and mitigation</td>
<td></td>
</tr>
</tbody>
</table>
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IV. Decision Points

Emergency managers must anticipate if and when a bioterrorism event will progress from one stage of severity to the next level, so that additional resources can be redirected or can be requested in a timely, progressive manner. When any trigger point is reached, leaders must look at initiating actions suitable for managing the next higher stage of severity. The following Decision Points are critical in managing each stage of the developing emergency:

Stage I: Developing Public Health Crisis: 0 to 100 patients

Strategy: Assess needs
General Action: Utilize existing response structure
Decision Points:

- More than 100 patients appears probable
- Hospitals are approaching maximum capacity
- Hospital triage is approaching maximum capacity

Epidemiology: Augmented and tied into Law Enforcement
Mass Care: No augmentation necessary
Prophylaxis: No prophylaxis campaign
Public Education: Public information and education campaign
Security: No augmentation beyond local resources
Stage II: Public Health Disaster: 101 to 1,000 patients

Strategy: Establish regional response structure

General Action: Augment resources within the region

Decision Points:

- More than 1,000 patients appears probable
- Cohort hospital system is approaching maximum capacity
- Casualty Collection Points approaching capacity
- Logistics is fully utilizing all regional staff, security, and other medical resources

Specific Treatment Model Stage II

Patient load: 100 - 1,000

Prophylaxis: Begin prophylaxis if indicated

Epidemiology: Augmented investigation tied into Law Enforcement investigation

Public Education: Widespread public education campaign

Security: Security needs augmented by local law enforcement

Hospitals will internally augment by transferring existing patients to Acute Care Centers (ACC).
Stage III: Catastrophic Public Health Event: 1,001 - 10,000 or more patients

Strategy: Utilize all available federal and state resources

General Action: Integrate federal resources into response

Decision Points:
- Alternate Care Facilities at maximum capacity
- Federal resources delayed for 24 hours or more

Specific Treatment Model Stage III
Patient load: 1,000+

Prophylaxis: Mass prophylaxis campaign if indicated

Epidemiology: Significantly augmented by federal assets

Public Education: Widespread public education campaign

Security: Security augmented by local law enforcement
V. Command and Control

Overview

The Capitol Region Emergency Planning Committee (CREPC) has adopted a standardized Incident Management System that remains constant but flexible no matter what the nature of the emergency, including acts of terrorism. This system, which is described in the CREPC Regional Emergency Disaster (RED) Plan, organizes the Capitol Region’s response to all hazards. The CREPC Incident Management System complies with the provisions of the National Incident Management System (NIMS) and the National Response Plan.

Whenever a local community’s first response capacity and resources are challenged, most communities will activate their existing mutual aid plans with surrounding communities. As the scope of the emergency expands, the 41 communities participating in CREPC can obtain immediate regional assistance with a simple request to CMED/RICS to activate the CREPC RED Plan. Activation of the RED Plan, which includes the Capitol Region MMRS Response Plan, sets into motion a series of decisions and events that are designed to respond efficiently to the emergency by mobilizing regional, state and federal resources as indicated by the nature of the incident.

Local emergency operations involve three levels of activity:

1. *Field Operations* refers to the first level of response that would be dispatched to any incident scene. This first response is aimed at dealing with rescue and life safety, the containment of threatening conditions, and ultimately the removal of all risks to people, property and the environment.
   - The local Incident Commander assumes command for all field operations, which may involve assets from one or more departments as well as outside support organizations.
   - If an incident becomes multi-jurisdictional or inter-jurisdictional in scope, a Unified Command shall be established in which incident objectives and strategies are collaboratively devised into a multi-functional incident action plan.
   - Department heads and agency leaders serve as subject matter experts and assist the local Incident Commander in the performance of his duties.

2. *Municipal department operations centers* refers to the coordination of municipal departments and agencies in order to provide the first line of technical support to field units by coordinating requests for assistance referred to them by departmental field operations supervisors.
   - Occasionally, the urgency of the incident or the need for extraordinary measures may exceed the normal authority of departmental controls. In these extreme situations or for purposes of expediency, the *municipal Emergency Operations Center (EOC)*
may be activated at the direction of the chief elected or operating official of the community.

- The local EOC serves as a community’s executive command center. Its mission is to help solve emergency requirements that exceed the capacity of city departments to handle on their own. The EOC is also responsible for making public policy decisions, interfacing with elected officials of other jurisdictions and levels of government, and for centrally managing emergency public information.

3. **Acquisition of outside resources**
   When the local Emergency Operations Center decides that local resources have been or are anticipated to be overwhelmed, the local Emergency Operations Center can request additional resources by calling RICS at 860-832-3477 to activate the CREPC RED Plan.

**Detail and Responsibilities of Command**

**Initial Local Command Considerations for Covert Threat**

1. In the event of a biological terrorism threat against a community within the Capitol Region Emergency Planning Committee (CREPC) area, under Presidential Decision Directive 39, *United States Policy on Counter-terrorism*, and Public Law 104-201, *Defense Against Weapons of Mass Destruction Act of 1996*, the FBI is charged with the responsibility to investigate and interdict persons or groups plotting to commit acts of terrorism in the United States or its territories.

2. An essential part of this mandate is the collection and analysis of intelligence information that could result in the issuance of a credible threat warning. Should the Capitol Region be the target of a credible threat, the FBI shall forward an alert to the local police departments. In turn, local police departments shall forward threat information to the local emergency planning authority and to the chief elected officials of the involved communities.

3. Depending upon existing circumstances, the chief elected official of each community may activate its Emergency Operations Center (EOC) to oversee and support local field operations, including the public health response. Activation of a local EOC would result in the activation of at least one of the CREPC Regional Coordination Centers (RCC) to ensure that local, state and federal resources are effectively integrated in support of the mission. The activation of these RCC’s may result in the concurrent activation of the Connecticut State EOC and the FBI Headquarters Strategic Information and Operations Center (SIOC).
Initial Local Command Considerations for Overt Attack

1. An overt biological agent incident might result in a flood of calls to the local 9-1-1 Dispatch Center, and local police or fire officers may be dispatched to investigate the complaint. Officers responding to the scene shall follow departmental procedures that state if there is reason to suspect a hazardous material, officers are to withdraw from the area, and to isolate and secure the immediate area without exposing themselves to the contaminant.

2. At this level of response, the senior fire or police officer would serve as the initial Incident Commander, awaiting the arrival of supporting units before transferring command. If the primary hazard on-scene is determined to be a biological or chemical contaminant, command would be transferred to the senior responding officer from the Fire Department.

3. Once an on-scene size-up (problem identification and assessment) is made, the Incident Commander shall oversee the initial notifications, the development of an action plan, and the requests for additional resources.

Regional Response Considerations

1. Any suspected biological or chemical agent release has the capacity to create enormous numbers of casualties in the community. To expedite the public health response, it is appropriate for the chief elected official of the community to declare a state of emergency in the community and to open the local EOC. The senior local public health official or a designee shall be located at the municipal EOC to facilitate the public health response.

2. It is imperative that the CREPC RED Plan shall be activated simultaneously with the local EOC activation in order to begin the process of coordinating regional, state and federal resources to support the local mission. The CREPC response shall include activation of the Capitol Region MMRS Response Plan to assist in the acquisition of medical assets, including activation of the National Disaster Medical System.

3. At any point, based on information obtained from local on-scene commanders, the Governor of the State of Connecticut, in consultation with the Commissioner of the CT Department of Public Health (CT Department of Public Health) and the Commissioner of the CT Department of Emergency Management and Homeland Security (DEMHS), may declare a statewide emergency and request FEMA assistance in managing the incident.
Public Information Protocols

One of the most important responsibilities of the command structure is to provide accurate, timely and relevant information to the public. People need to know what has happened, what may happen to them, and what they are expected to do. Controlling the release of important information through a single, informed source ensures accuracy and consistency of information that, in turn, will help to control panic and provide concise direction to the public.

1. It is essential that communities identify pro-actively the Public Information Officers of record, and then ensure that these individuals are properly trained and, in the event of an emergency incident, are kept fully informed of events and response actions.

2. Once an EOC has been activated, the designated Public Information Officer, located at the EOC, is charged with implementing a comprehensive public information effort to provide critical information to the public in a timely manner.

3. Since it can be presumed that a terrorist incident would attract immediate and widespread media attention, the local Director of Emergency Management may order the establishment of a Joint Information Center (JIC), which will place the Public Information Officers (PIO’s) from all departments including Public Health together, functioning as a Public Information Office team under the leadership of the Mayor’s Director of Communications. The city’s PIO Team would:
   a. Devise and articulate the city’s strategy for keeping the media and public informed
   b. Collaborate on the development of uniform messages so the city is speaking with one voice
   c. Ensure there are smooth working relations with other Joint Information Centers (JIC’s) that may be concurrently established by regional, state or federal agencies

4. The primary method for conveying information to the public shall be through the broadcast media. The two paramount goals, giving people instructions to protect their own health and preventing panic, both depend on the effectiveness of the public information plan.
   a. Use of the CT Health Alert Network (CT HAN) emergency alert system, blast fax, internet websites, telephone hotlines, public service announcements and highway message boards are some of the alternate technologies available.

5. In most cases, warning messages will result from findings and recommendations received from the medical community. Such messages shall receive the approval of the local Director of Health and the Chief Elected Official, and be transmitted to the media by the designated Public Information Officer.
6. If other information centers have been activated, local media releases should be coordinated with those centers in order to ensure that conflicting information is not released to the public.

**Communications**

Communications systems in the event of a biological incident will expand to include the most sophisticated technology available. But it is essential to ensure that the Incident Command structure managing the event is equipped with basic, proven equipment that they use everyday. Reliance on equipment used only occasionally will lead to confusion and failure of the communications networks among responders.

Planners must ensure that there are functional and redundant communications systems that include all responding agencies and communities, and that first responders are trained in their use. Regional resources are available through CREPC ESF 2 as described in the CREPC RED Plan to ensure that local responders can communicate effectively with other communities and responders.

**Training and Exercises**

A well-written, comprehensive plan to respond to a biological agent incident is useless if it sits in a drawer. The 41 communities participating in the CREPC RED Plan shall accept their responsibility to ensure that responders and planners receive the necessary training to fulfill their responsibilities, and to provide municipal support to regional drills and exercises that are designed to explore the weaknesses of the plan before it is needed.

Both CREPC and the Capitol Region MMRS conduct drills and exercises on a regular basis to ensure the effectiveness of regional planning efforts.
Early Recognition and Threat Assessment

A. Overview

Effective response to a bioterrorism event depends upon early recognition that a biological agent has been released, followed by a rapid and effective deployment of resources to meet the threat.

Early Recognition

Early recognition presents the greatest challenge to the response community since the release of a biological agent may be silent, and the first signs may be similar to those of non-specific, influenza-like illnesses. Early recognition of the incident is essential because it allows responders the time for resources to be mobilized, prophylactic measures to be taken, and non-survivors to be addressed in a deliberate, organized manner.

The State of Connecticut is fortunate to have a disease surveillance system as a statutory requirement and as a regulated activity. The Commissioner of CTDPH is required to declare an annual list of reportable diseases, and to conduct an annual evaluation of the reportable diseases under surveillance in Connecticut. The CT disease reporting system is based upon a dual reporting mechanism that requires reporting by physicians and laboratories located in Connecticut. The reportable diseases are listed in two categories to ensure timely notification to CTPDH and to local public health officials:

- **Category 1 Reportable Diseases** are required to be reported immediately by telephone on the day of recognition or strong suspicion of disease to CTDPH and to the local health department. Additionally a Confidential Disease Report (form PD-23) or a more disease-specific form must be mailed to CTPDH and to the local health department within 12 hours.

  Category 1 Reportable Diseases include those that are possible indicators of bioterrorism. These diseases are highlighted to ensure the disease surveillance system in Connecticut is immediately notified and activated. Additionally, the CTDPH Division of Epidemiology has the demonstrated capacity to implement syndromic surveillance for persons being admitted to Connecticut hospitals. CTDPH is developing electronic, wireless and radio communication systems with the 32 Connecticut hospitals and with local health departments to quickly activate syndromic surveillance.

- **Category 2 Reportable Diseases** require a Confidential Disease Report (form PD-23) to be mailed within 12 hours of recognition or strong suspicion to both CTPDH and to the local health department.
Each report is required to include the full name and address of the person reporting, the attending physician, the disease being reported, and the full name, race/ethnicity, sex and occupation of the person affected. Each report is considered confidential.

Early Response

The Capitol Region MMRS Response Plan involves a combination of actions and strategies that shall be used to meet the early response challenge. These initial actions include:

I. Public Health Initial Response

a. A public health investigation utilizing local, regional and state resources shall be initiated upon receipt of credible information of a possible biological agent release from any source identified by traditional or non-traditional surveillance information.

b. The goal of the investigation is to collect epidemiological information from healthcare providers and patients to be used for characterizing the event and for further decision-making. Collected information is intended to track distribution of cases by person, place and time.

c. The information obtained through the initial and subsequent epidemiological investigations is used to define the population at risk, map victim locations, and identify the source, mode and cause of the disease transmission. Such information is crucial in determining if the illness is a natural outbreak or a BT event.

II. Preliminary Investigation by Public Health Agencies:

The local health departments (LHD) in the affected communities shall join with the epidemiological section of the CT Department of Public Health to initiate and perform a preliminary investigation of any cluster of patients presenting with the following characteristics:

a. Large numbers of ill persons with similar disease or syndrome

b. Large numbers of unexplained disease, syndrome or deaths

c. Unusual illness in a selected population (e.g. outbreak of severe rash illness affecting adults)

d. Higher morbidity and mortality associated with usual disease or syndrome

e. Endemic disease with unexplained increased incidence (e.g. tularemia, plague)

III. Rapid Full investigation By Public Health Agencies

Local and state health departments shall combine their resources to perform a rapid full investigation if the preliminary investigation reveals:
1. A cluster of patients exhibiting essentially similar signs and symptoms that is unexplained after the preliminary investigation
2. One or more cases of disease in a community in which the disease does not normally occur (e.g., tularemia in New York City, or plague in North Carolina)
3. A cluster of patients presenting with the following unusual characteristics:
   - Endemic disease in a non-endemic area, or in an area without a vector/host for zoonotic disease (e.g., tularemia, plague)
   - Multiple disease entities in the same patient
   - Illness in an unusual geographic distribution (e.g., ‘downwind’ in an aerosol release)
   - Simultaneous clusters of similar illness in non-geographic areas, domestic or foreign
   - Unusual, atypical, or antiquated strain of agent (including antibiotic resistance pattern)

Additionally, the CTDPH may request assistance from the Centers For Disease Control (CDC) in Atlanta to expedite the process of rapid identification of the suspected biological agent, and to acquire additional personnel and other assets to conduct a timely and effective investigation.

B. Detail and Responsibilities

I. Law Enforcement Activities in Early Response

When a biological terrorism threat against a community in the Capitol Region is suspected, defining whether the threat is credible will guide the response.

a. The FBI shall be the lead federal agency for defining a credible threat and for crisis management.

b. The Local Police Department (LPD) shall be the lead local law-enforcement agency and shall work closely with the FBI to interdict the terrorists and to prevent the release of any biological materials.

II. Receipt of a Credible Threat

a. The FBI is primarily responsible for determining the credibility of a threat to use a weapon of mass destruction, including a biological agent, against a community in the Capitol Region.

b. A low-credibility threat shall be treated similarly to a telephoned bomb threat. Initially, there is no obvious physical evidence to substantiate the threat. However, once the credibility and nature of the threat has been established, the FBI shall notify the local police department, the local fire department and the local Director of Emergency Management.

c. The local Director of Emergency Management shall coordinate the community’s efforts to prepare for and mitigate the consequences of such an attack.

d. Realizing that local response protocols vary for this type of incident, it is recommended that there be a coordinated response of both Crisis
Management and Consequence Management in evaluating the threat, and if necessary to implement initial hazardous materials scene protocols (isolate, deny entry, and call for assistance).

e. Local dispatchers will consult with field units via cell phone or landline to provide dispatch details.

f. When a determination is made that a credible threat exists (prior intelligence information, or a device, a suspect package or physical evidence is found, or a release of an unknown substance has occurred) the incident shall be treated as a crime scene involving hazardous materials.

g. A credible-threat incident requires the deployment of a local or regional Hazardous Materials Response Team in addition to police and FBI resources.

III. Discovery of Suspected Materials

a. The discovery of biological material, or the receipt of a package suspected of containing a biological agent, requires the use of both field assays and sampling of the material for analysis at laboratories.

b. The local fire department (LFD) shall provide Incident Command and resources for the purposes of assaying, sampling, and containing the material, for patient care, and for decontamination at the scene of a biological incident.

c. The local police department, in coordination with the FBI, shall be the lead local law enforcement agency for managing crime scene operations.

d. In the event of a suspected release of a biological agent, the local incident commander shall notify RICS via Intercity 154.625 MHz PL 107.2, or by phone at 860-832-3477, that an activation of the CREPC RED Plan is required to meet the emergency.

e. The Capitol Region RED (Regional Emergency Disaster) Plan shall be activated and a Capitol Region Regional Coordination Center (RCC) shall be opened and staffed with the appropriate CREPC Emergency Support Functions.

f. The FBI, LPD, LFD, local and state departments of health, and the appropriate local elected or administrative officials shall gather to form an Interagency Task Force (ITF) to define the nature and the extent of the threat.

g. The ITF shall be organized according to the principles of the National Incident Management System (NIMS) and, using the strategies below, shall determine the appropriate level of resource mobilization needed to respond to the threat by recommending any of the following actions:

- Access the National Threat Assessment Group through the FBI
- Activate the local/state Emergency Operations Centers and/or declare a local/state State of Emergency
- Local police departments may be tasked with enhancing security at hospitals and other facilities
- Enhance public health surveillance and recognition activities throughout the Capitol Region and the state
- Request assistance from CT DPH and/or CDC for lab testing
CR-MMRS may be requested to alert the National Disaster Medical System (NDMS) in order to prepare for relocating patients from the Capitol Region

- Request activation of CT-1 DMAT through the CT Department of Public Health
- The CT National Guard may be asked to mobilize personnel and equipment, especially those units specializing in logistical operations
- Request deployment or pre-positioning of Department of Defense (DoD) or other federal assets such as the Marine Corps' Chemical/Biological Incident Response Force (CBIRF), or the U.S. Army's Technical Escort Unit
- Direct hospitals to activate their disaster plans
- Determine priorities for pharmaceutical distribution, and prepare to open Points of Distribution (PODs) for the distribution of medications according to Strategic National Stockpile protocols
- Prepare to open alternate care facilities, (i.e. hospital parking lots, community centers, etc.)
- Contact and notify the CT Office of the Chief Medical Examiner to prepare to open alternate morgue sites
- Task the local and state health departments to:
  - Alert hospitals and health providers to the possibility of patients presenting with diseases caused by rare and potentially dangerous pathogens
  - Request CDC epidemiological assistance and staff support
  - Closely observe call volume and call types for any suspicious changes suggesting the release of a biological agent

**IV. Crime Scene Handling and Investigation**

- The role of the local police department shall include establishing and maintaining perimeter security from the designated cold zone boundary to protect against unauthorized entry.
- It is then the responsibility of the technical team assembled by the FBI to handle all processing of the crime scene, and to collect and secure evidence. The technical team may include members of the CREPC Regional Hazardous Materials Team.
  - The CREPC Regional Hazmat Team members are trained to recognize potential evidence. They also are trained in evidence collection procedures to ensure they do not inadvertently disturb, destroy or spoil potential evidence or interfere with the FBI’s ability to establish a clean chain of custody
- Once evidence has been collected, it shall be determined by the FBI where is to be sent for laboratory examination.
INITIAL ACTIONS DURING A BIOLOGICAL INCIDENT

Overview

a. An incident involving a bomb threat, suspicious package, or actual device is a law enforcement event that requires an appropriate response from the local Police Department (LPD).

b. Regardless of the cause of the incident, however, the local senior fire officer shall serve as the Incident Commander during such an incident.

c. The fire Incident Commander shall establish a Unified Command that includes the local police Incident Commander, any other regional or state agency responding commanders, and the FBI when called to the scene.

d. Incident Command at the scene shall remain a Unified Command for the duration of the incident.

e. A suspected biological release shall initiate a 911 Dispatch response locally.

f. Additionally, the CREPC RED Plan shall be activated by the local Incident Commander via one telephone call to RICS at 860-832-3477.

g. First units on-scene shall assess the situation in the field, isolate the area, and follow standard hazardous materials operating procedures for management of an exposed population.

h. The criminal investigation shall commence under the direction of the local police Operations Commander and the FBI representative.

Detail and Responsibilities

I. Field Operations

A. Identification of the Response Zones

   o When local fire first responders reach the scene of a suspected biological agent, they shall perform an evaluation to define the “hot, warm and cold zones”, and to determine the potential number of exposed individuals. A local or regional Hazmat team may be called at the instigation of the local Incident Commander to assist in the identification of the agent.

   o These types of incidents shall be considered, and managed, as Weapons of Mass Destruction (WMD) incidents until proven otherwise.

   o The safety of first responders is of paramount importance. Local incident commanders shall not dispatch responders into a hot zone without proper protective equipment.

B. Evacuation

   o The local fire department (LFD) shall determine the necessity for, and extent of, an evacuation. The local police department (LPD) shall assist in evacuations in cooperation with the LFD.

   o Evacuation procedures shall be directed and implemented by local fire department personnel.
If mutual aid is required, local policies regarding requests for mutual aid shall be carried out at the direction of the local Incident Commander. Consideration must also be given to establishing shelter operations at or near the scene of the incident.

Evacuation procedures shall be carried out in compliance with the CREPC RED Plan and with the CT Statewide Evacuation Plan.

Transportation for the evacuation of non-infectious victims of a biological incident shall be coordinated by RICS according to the detailed plan specified in CR-MMRS Deliverable 7 Forward Movement of Patients, up to and including the activation of the National Disaster Medical System (NDMS).

C. Decontamination of Potentially Exposed Individuals

- The need for mass decontamination and prophylaxis depends on the suspected exposure and may not be necessary in all cases. The goal of decontamination after exposure to a bioterrorism agent is to reduce the extent of external contamination of patients, and to prevent further spread of the contaminant.
- Decontamination procedures detailed in the CR-MMRS Rapid Action Mass Decontamination Protocol provide a system of response to decontamination in the field. Local fire departments shall use the standard hazardous materials decontamination procedures specified in that Protocol in order to ensure a uniform regional response mechanism.
- The local fire department shall make provision for field decontamination of contaminated individuals and all entry team members.
- The local fire department shall be responsible for the medical clearance and evaluation of entry team members.

D. Crowd Control and Protection of Treatment Facilities

- The local police department is responsible for crowd control in public areas during an incident.
- In a mass casualty incident, local police resources may be overwhelmed, requiring activation of mutual aid protocols. Should mutual aid be insufficient to manage the incident, the local police incident commander shall request activation of the CREPC RED Plan by calling RICS at 860-832-3477 and requesting activation of ESF 13 (Law Enforcement) to assist in the acquisition of regional, state or federal law enforcement assets.
- Protection of hospitals and other treatment facilities and their personnel is primarily a function of the facilities’ security services. Should an individual facility’s resources be overwhelmed, the facility shall contact 911 Dispatch and request additional resources.
- Depending on the stated needs of the facility, local emergency management officials may request additional law enforcement personnel by calling RICS at 860-832-3477 and requesting activation of the CREPC RED Plan and mobilization of ESF 13.
E. Establishment of a Crime Scene and Initiation of a Criminal Investigation

- The Local Police Department, as the first arriving law enforcement agency, shall establish and control any crime scene and begin a preliminary criminal investigation.
- This includes establishing and maintaining a security perimeter from the designated cold zone boundary to protect against unauthorized entry.
- Local police shall assist any technical experts responding to the scene and collaborate with appropriate state and federal law enforcement agencies.
MEDICAL CARE

Overview

The severity of a bioterrorism attack can be measured by the number of people exposed to the biological agent and the number of victims requiring care. This section details the steps necessary to provide medical care and mass prophylaxis to a large population affected by a bioterrorism event. Usually, events involving less than 100 victims may be handled by response procedures, health care facilities, and pharmaceutical distribution systems currently in place. The primary challenge facing the response community at this level of severity is preventing a surge of concerned but unexposed citizens from overwhelming the local response system, and care must be taken to provide timely and accurate information to the public.

Direct patient care initially shall be provided by the hospitals. As the size of an event increases, a cohort hospital system may be implemented through CREPC ESF 8 (Health and Medical). These steps are implemented using resources that currently exist in the Capitol Region, and may require assistance from state and federal agencies. For the largest events, in-home self-care may become the primary care option available to the command structure. Implementation of extreme measures, such as quarantine and martial law, may need to be considered in order to effectively manage such an emergency according to the following model:

The following schematic describes the utilization of medical resources as an incident escalates from a small, locally manageable event into a catastrophic mass casualty incident:
I. Stage I: Developing Public Health Crisis, 0 to 100 patients

Strategy: Assess needs
General Action: Utilize existing response structure

Medical Care Actions:
   A. Utilize existing hospital capacity
   B. Monitor hospital capacity and determine need to initiate Stage II procedures
   C. Develop public information advisories

A. Hospital Capacity

The local hospital and clinic system shall be the primary care provider at the onset of an incident. The hospital healthcare system within the Capitol Region consists of 14 hospitals with 2150 licensed adult beds and 200 licensed pediatric beds. North Central CT CMED is responsible for determining bed availability and for casualty distribution during an incident.

At the start of an incident, hospitals will become increasingly busy as victims become symptomatic, or seek immunization. This increase in facility utilization is referred to as the Initial Surge and may be compounded by the “worried well,” those non-symptomatic or even unaffected members of the population who converge on hospitals seeking treatment or assistance.

B. Hospital Augmentation

1. Internal Augmentation
   As initial surge capacity is exceeded, space usage within all hospitals may be modified. Large internal spaces such as auditoriums may be converted to ward areas and patient rooms modified to accept more beds.

2. Admission restrictions
   When the hospitals are at predetermined maximum capacity, hospitals may be forced to initiate “lock down” procedures. Security personnel shall monitor the arrival of new patients to ensure that only patients meeting strict criteria are admitted. Local law enforcement agencies may be called to enforce security measures.

C. Public Information Advisories

   o The local public health Incident Commander shall have the primary responsibility to submit public information advisories to the appropriate local or regional agency for timely distribution to the public.
   o These advisories shall include signs and symptoms of exposure, prevention measures, and location(s) of hospitals designated as treatment facilities.
Dissemination of this information shall be accomplished by the Public Information Officer appointed by the chief elected official of the community or a designee.

II. Stage II: Public Health Disaster 101 to 1,000 patients

Strategy: Establish alternate response structure

General Action: Augment resources within the region

Medical Care Actions:
A. Activate Hospital Disaster Plans
B. Initiate the Cohort Hospital System
C. Establish Casualty Collection Points
D. Hospice Care

A. Activate Hospital Disaster Plans

An incident that generates up to 1,000 patients can stress the regional hospital system beyond its breaking point. Therefore, regional hospitals shall activate their disaster plans and open their emergency operations centers upon notification that an event of this magnitude has occurred.

B. Cohort Hospitals

As patient numbers increase, infected patients may be transported and placed into pre-identified cohort medical facilities. Shifting victim care to these cohort hospitals allows centralized patient care and consolidation of institutional and community resources. Studies show that centralized care models reduce treatment variations and patient misclassification, both critical in successfully managing an epidemic.

In addition, clustering of patients has been proven to be an effective model of care in managing previous infectious epidemics where resources were limited and the infection had generated a high degree of public fear (e.g., tuberculosis hospital, polio wards, HIV wards, cholera hospitals).

The ideal cohort institutions share some common attributes: they are geographically close to one another, have controllable access points, and can be isolated and secured should conditions warrant.

Once the regional biological agent response plan has been activated and has moved into a Stage Two response level, these cohort hospitals may begin transferring their stable medical/surgical patients to outlying community hospitals. In turn, community hospitals may be transferring suspect patients back to these cohort facilities. Informal surveys suggest that regional bed capacity may be increased by up to 40% using the cohort option.
The following schematic shows the process for the implementation of a cohort hospital model:

**C. Casualty Collection Points for Triage**

Once an affected population has been identified, the next step is to establish a casualty triage process. Effective triage directs individuals to an appropriate level of care according to their diagnoses, and controls the flow of patients into the management system to ensure that limited resources are used in the most efficient manner possible.

Initially, these triage centers shall be staffed by personnel assigned by the EMS Medical Control Officer. As the incident expands, EMS resources shall be supplemented by the activation and dispatch of response teams from the Capitol Region Medical Reserve Corps, or through the activation of specialized triage teams such as the CREPC Burn Incident Response Teams.

If indicated, the regional response may be supplemented through the activation and deployment of the CT-1 DMAT and/or the activation of the National Disaster Medical System (see the Capitol Region MMRS Forward Movement of Patients Plan for a description of the activation procedure).

The most logical locations for casualty collection points may be immediately adjacent to the cohort hospitals. Patients arriving at the
Triage centers shall have their needs evaluated based on the probability and timing of exposure, and the presence and severity of associated symptoms. Once evaluated, patients may be directed to their homes, to health care facilities, or to other points of distribution to be immunized or otherwise medicated.

Events such as the Tokyo subway sarin gas release in 1994 demonstrate that the majority of people who converge on the healthcare system in a bioterrorism event are the “worried well,” or those who have not been exposed, but who are nonetheless concerned about their safety. National research has shown that the ratio of worried well to affected patients may be as high as 15:1. The impact of these individuals on health care resources would be significant. The population of worried well represents a substantial impact on the healthcare system, and an enormous drain of health and medical personnel from other duties. Each person, though perhaps unexposed or not at risk, still requires individual attention, reassurance, and direction.

III. Stage III: Catastrophic Public Health Event 1,001 to 10,000 +

**Strategy:** Utilize all available federal and state resources

**General Action:** Integrate state and federal resources into response structure

**Medical Care Actions:**
A. Establish Alternate Care Facilities
B. In-Home Care Considerations

A. Establish Alternate Care Facilities

Regional hospital capacity may be exceeded as the scope of the event increases. Provisions must therefore be made to establish Alternate Care Facilities (ACF). Alternate Care Facilities are improvised medical facilities that can provide basic medical functions until facilities for more definitive care can be established.

As soon as the ACF’s are operational, the triage centers shall direct symptomatic victims to the ACF’s. This option is more time-critical for highly infectious diseases, as there is an increased need to isolate these individuals from both the general population and patients hospitalized for other reasons.

Staffing and supplies for the ACF’s initially shall rely on existing agreements between local hospitals, nursing homes, community clinics, and other provider facilities. Additional resources shall be acquired and deployed through the activation of the CREPC RED Plan’s ESF 6 (Mass Care), and through activation of the Capitol Region MMRS Memorandum of Understanding for Mutual Aid among CREPC Hospitals.
B. In-Home Care

The strategy of referring patients back to their own homes for self-care may be preferable in three types of situations.

First, in smaller scale events, patients who are asymptomatic and with a low probability of exposure may be directed to remain in their homes in order to reduce the burden on health care resources.

Second, the self-care strategy may be used for large-scale events that threaten to overwhelm the region’s ability to establish adequate Alternate Care Facilities.
   - In this situation, the mass care strategy shall shift from providing direct patient care to providing enough public information to allow the affected population to care for themselves.
   - The success of this strategy is dependent upon a well-coordinated public information campaign and adequate infrastructure control to prevent people from overwhelming the health care system in spite of directives to stay home.

Third, the self-care strategy may be used in an infectious disease scenario. Restricting the population to their homes limits their exposure to infected individuals and greatly enhances the ability to manage the spread of the disease.
MASS IMMUNIZATION AND PROPHYLAXIS

Overview

Timely use of preventative measures including immunization and prophylaxis can reduce the need for institutional care, and can forestall the possibility of communicating illness to those who are not initially exposed. As the scope of a biological agent event increases, separate resources may be used to provide medications to affected populations in order to reduce the burden on the traditional model for dispensation that is based on hospital distribution.

In Connecticut, the CT Department of Public Health (CTDPH) has identified forty-four regional immunization center locations, eleven of which are located in the jurisdiction served by the Capitol Region Metropolitan Medical Response System (CR-MMRS). The local health directors of the Capitol Region have been assigned the responsibility to design, implement and to staff these facilities according to templates provided by CTDPH. Details of the region's plans for mass immunization facilities have been developed by the assigned health departments in the Capitol Region, and currently are undergoing a comprehensive review for effectiveness by CREPC.

In general, the following schematic describes the decisions and deployment of resources at each stage of a developing incident in which mass immunization may be indicated:

I. Stage I: Developing Health Crisis, 0 to 100 patients
   Strategy: Assess needs
   General Action: Utilize existing response structure
   Mass Prevention and Prophylaxis Actions
   A. Determine need for prophylaxis or immunization
   B. Deliver medications
   C. Consider forward movement of CDC stockpile
   D.

A. Determine Need

The consideration of need focuses not only on those people directly exposed to an agent, but also those at risk of contracting a disease through secondary exposure. For highly contagious agents, this could include anyone who comes in contact with an exposed individual, including health care workers caring for them.

B. Delivery of Medications for Prophylaxis or Immunization

Some biological agents respond to prophylaxis utilizing approved pharmaceuticals. Localized incidents involving first responders may require the activation, deployment and dispensation of therapeutic agents contained in the pharmaceutical stockpile owned and
maintained by the Capitol Region MMRS for the use of the Capitol Region’s first responder workforce and their families. Activation procedures and criteria for distribution are contained in the CR-MMRS Deliverable 2A.

Currently, the Connecticut Department of Public Health (CTDPH), the CT Office of Emergency Management and Homeland Security (DEMHS), and the CT acute care hospital system are developing plans to create additional biological antidote stockpiles at each of the state’s 32 acute care hospitals to provide immediate access to medications for the general population. Also, a number of CT hospitals are preparing to receive chemical agent antidote stockpiles known as Chempacks, which should be in place by January 2007.

C. CDC Strategic National Stockpile

A biological agent release may require a massive campaign to immunize or prophylax all of CT’s citizens. In that event, the CREPC RED Plan and the Capitol Region MMRS Plan shall provide assistance in the implementation of the state immunization plan by providing resources and staffing as appropriate, particularly in support of the Capitol Region’s mass immunization clinics and first responders. The CT statewide immunization plan is under development at the CTDPH, and is integrated into the CDC’s Strategic National Stockpile system for acquisition and dispensation of appropriate medications.

II. Stage II: Public Health Disaster, 101 to 1,000 patients

Strategy: Establish alternate response structure
General Action: Augment resources within the region
Prevention/prophylaxis Action:
   A. CDC Stockpile Requested
   B. Prophylaxis of Targeted Population
   C. Regional Points of Distribution (POD’s) Established

Note:
Implementation of the elements of the second stage of response in the Capitol Region shall be coordinated with the CT state plan for mass immunization, and may overlap with those procedures described below for a response to a Stage III event.
III. Stage III: Catastrophic Public Health Event, 1,001 to 10,000+

Strategy: Utilize all available state and federal resources

General Action: Integrate state and federal resources into regional response structure

Mass Prevention/Prophylaxis Actions

A. Direct Delivery of Medications to the Public

Direct delivery of medication to an affected population may be considered in two circumstances:

- Identification of and delivery to home-bound individuals
- Presence of highly contagious agents

1. Home-bound individuals

The POD concept relies on the ability of the affected population to reach a POD. This may not be practical for homebound or physically challenged individuals. The Capitol Region RED Plan has established ESF 19 (Special Needs) to identify and implement plans and procedures to assure timely distribution of medications to these patients. These plans currently are in draft form.

2. Presence of a highly contagious agent

In the case of a disease that is highly communicable, the best course of action may be to isolate individuals from one another and to avoid mass gatherings. In order to prevent person-to-person spread of the disease, officials may choose to order people to remain at home, a choice that may require the distribution of medications by teams sent to every residence in the affected area. The ability to carry out such a plan in public emergency conditions is speculative at best, and untested.

B. Quarantine

In the absence of a Governor’s declared emergency in CT, quarantine or isolation procedures may be implemented only upon the order of a local public health director. Evacuation may be necessary to implement a quarantine plan.

The CT Department of Emergency Management and Homeland Security, and the CT Department of Public Health are working with local and regional planners to develop an effective evacuation plan.
Additionally, a statewide taskforce to consider quarantine and isolation issues is completing its draft plan and has submitted its recommendations to the appropriate state authorities for comment.

As a matter of practicality, it is the policy of the Capitol Region Emergency Planning Committee (CREPC) and the Capitol Region MMRS to first employ a policy of sheltering-in-place to meet the needs for isolation and separation. Only in extreme cases will the Capitol Region response include the movement of large segments of the population.

Quarantine and isolation would require massive security resources even for a small-scale incident, since persons may resist quarantine orders and family members may attempt to circumvent the order to contact loved ones. A quarantine scenario likely will require declaration of martial law, curfews, and other types of movement restriction. This type of action would require federal government assistance and shall be considered only under extreme circumstances.

IV. Record Keeping

Record keeping is a vital adjunct of successful medical care and immunization/prophylaxis operations. It is the principal means by which the at-risk population can be identified, followed up and tracked.

Patients who enter field triage centers or hospitals shall be triaged using the appropriate emergency medical triage tags and locally operated data management systems.

Regional systems to coordinate on-scene patient identification with hospital databases, and with state and federal information tracking systems, have not been established.
LOGISTICS

Overview

The determining factor for the successful management of logistics in a mass casualty incident lies in the ability of the local Incident Command to access and to deploy regional response assets quickly and efficiently.

A local Incident Commander in the Capitol Region, realizing or anticipating that his own resources are about to be overwhelmed, has access to the Capitol Region’s responder assets through the CREPC Regional Emergency Disaster Plan. With one telephone call to RICS at 860-832-3477, the RED Plan can be activated and logistical support can be coordinated through CREPC ESF 5.

By utilizing this tested and proven regional support mechanism, the capacity of local or regional Incident Command is greatly enhanced, and allows effective incident management to occur prior to the arrival of state or federal resources.

Detail and Responsibilities

Staffing Requirements
Planning for mass immunization and prophylaxis operations in the Capitol Region is being completed by the nineteen local health directors (LHD’s) included in the CREPC region, in conjunction with the CT Department of Public Health (CTDPH). Planning follows the guidelines issued to the LHD’s by CTDPH, and complies with the stipulations of the CDC. Planning includes provision for the pre-event identification and training of volunteer health and support professionals.

CTDPH has identified 44 separate geographic areas in which mass care clinic plans must be completed, and has given the responsibility for completion of those plans to the local health directors. All regional planning for mass immunization/prophylaxis operations is integrated into the developing CT statewide Strategic National Stockpile (SNS) Plan, and is in compliance with CDC and FEMA standards. Staffing issues regarding identification, training and deployment of qualified personnel continue to be challenging statewide.

Credentialing

A statewide plan for the credentialing of volunteer health professionals has been completed under the auspices of the CT Department of Public Health. In the Capitol Region, the Capitol Region Medical Reserve Corps has been assigned the task to develop a best practices concept for regional credentialing.

Furthermore, preliminary discussions are taking place with the five New England MMRS jurisdictions outside of the Capitol Region to encourage a New England-wide credentialing system.
**Pharmaceutical Stockpile**

The Capitol Region MMRS maintains a pharmaceutical stockpile with adequate supplies of antibiotics to prophylax the Capitol Region’s first responder population and their families during the first 48 hours of a biological incident. The CR-MMRS stockpile plan for activation and distribution of the pharmaceutical stockpile (see CR-MMRS Deliverable 2A) has been shared with the CTDPH officials responsible for the development of the CT Strategic National Stockpile Plan to assure compliance and coordination of the Capitol Region plan with both state and federal directives. The CT SNS plan is in final draft form and we have been assured that we are in compliance in the Capitol Region planning jurisdiction.

**Personal Protective Equipment**

An essential component of any plan for mass immunization is the provision of adequate personal protective equipment (PPE) to ensure the safety of responding professionals. At present, the logistics planning for PPE and other supplies to the local immunization clinical facilities is unclear and incomplete. The responsibility for the completion of this portion of the planning, as well as the purchase of supplies for local consumption, lies with the local health directors charged with the development of facilities plans.

**Surge Capacity in the Capitol Region**

Details of the Capitol Region MMRS Plan for the Forward Movement of Patients may be found in CR-MMRS Deliverable 7. The CR-MMRS FMOP plan details the activation and implementation procedures approved by the 41 communities participating in the Capitol Region Emergency Planning Committee to expand healthcare capacity in the event of a sudden surge in demand. The plan also describes the procedures for evolution of the region’s capacities during a surge event from a local incident to an interstate event involving federal resources. Elements of the FMOP plan have been tested and drilled, and have been proven effective.

**Security and Law Enforcement**

Transportation corridors and essential public services must be secured during a bioterrorism event in order for the mass care and prevention strategies to be successful. Security needs will depend upon the size of an incident. Public safety may require that the scene of a small release be secured, that entry into hospitals be restricted, that roadway arteries be closed to general traffic, or that more extreme measures be imposed to limit citizen movement and the spread of disease.

Pre-event identification and planning for the early security of vital transportation arteries is essential to assure quick distribution of medicines to POD’s and efficient movement of an affected population to triage centers and healthcare facilities. For large-scale events, local law enforcement agencies may require assistance from regional, state, and federal law enforcement personnel to achieve acceptable levels of security. Local Incident Commanders may access additional law enforcement assets by calling RICS.
at 860-832-3477 to activate the CREPC RED Plan. ESF 13 (Law Enforcement) shall identify and coordinate the deployment of security resources as requested by Incident Command. Deployed resources on-scene remain under the command of the local Incident Commander.
FATALITY MANAGEMENT

Overview

A biological terrorism event may result in large numbers of fatalities. Initially, mass fatalities may be managed through the establishment of temporary morgue facilities. These facilities must be prepared to store the bodies of non-survivors for extended periods prior to final disposition. In addition, these facilities may also need isolation capability in cases where infection may be transmitted by exposure to corpses.

The CT Office of the Chief Medical Examiner (CTCTOCME), in conjunction with the Connecticut Department of Public Health (CTDPH), shall make the determination as to what type of morgue facilities are the most suitable to control the possible spread of diseases.

Identities of non-survivors shall be tracked, and personal effects shall be organized for distribution to survivors or for disposal, depending on the nature of the biological agent. Final disposition of the deceased shall not occur until death certificates have been issued.

The method of disposition shall depend upon the nature of the agent used, and the public health concerns associated with large numbers of corpses. The options for final disposition will include normal burials, mass burials, normal cremations, and mass cremations. Social and religious concerns shall be considered and respected during final disposition.

Detail and Responsibilities

The Office of the State’s Chief Medical Examiner (CTOCME) is responsible for establishing causes of death when the cause is:
- Unknown or obscure
- By violence

The CTOCME shall be the lead agency responsible for managing fatalities during a bioterrorism event. Due to the challenge of managing a mass fatality incident, CTOCME may require immediate state and federal assistance through the State’s Assistant Medical Examiners, the CT State Funeral Directors Association, U.S. Public Health Disaster Mortuary Teams (DMORTS), DMATS, Armed Forces Institute of Pathology Teams and other available resources, including the Coroners Association District Coordinators, the Connecticut National Guard, and DoD Decontamination Teams.

Disaster Mortuary Response Teams (DMORT) can provide support in disaster recovery, evacuation and identification of remains, sanitation and preparation of remains, and family grief counseling.
Fatalities that occur during a biological terrorism event will be placed in the following categories:

- **Accepted Cases**
  
  Deaths that are suspicious and not related to the biological incident shall be transported to CTOCME for standard investigation.

- **Non-CTOCME Cases**
  
  Deaths that are not accepted for investigation will be held at area mortuaries. Those deaths that are determined to be due to natural causes shall be released to a designated funeral home.

- **Bioterrorism Cases**
  
  The corpses of these victims shall be held by CTCTOCME in order to ensure that each fatality is properly documented, and that none are released until a safe and proper disposition has been determined. In order to hold victims of a bioterrorism event, temporary morgue facilities shall be established using one or more of the following options:

  **I. Temporary Morgue Facilities**

  A. **Refrigerator Trucks/Containers**
     
     Lease agreements with refrigerated truck providers shall be needed for this type of event. If necessary, trucks may be dispatched to individual facilities to remove large numbers of fatalities.

  B. **Alternative Morgue Facilities**
     
     Large open areas and enclosed structures may be converted into Alternate Morgue Facilities (AMF’s). CTOCME shall locate appropriate storage facilities. If necessary, trailer-mounted air-conditioning units shall be employed to maintain appropriate temperatures.

  C. **Hospitals with Large Numbers of Non-Survivors**
     
     Capitol Region Acute Care Hospitals have an internal morgue capacity usually ranging from four (4) to twelve (12). As this capacity is exceeded, the hospitals may request access to additional facilities by request through RICS at 860-832-3477.

  **II. Final Disposition**

  Identity tracking and issuance of death certificates at the morgues may be accomplished by Mortuary Response Teams under the direction of CTOCME.

  The CTOCME shall establish a uniform cause of death and may require that the attending physician certify the cause of death. All deaths shall be reported to the CTOCME at its office and these statistics shall be relayed to the CT Department of Public Health.

  In no case may a hospital release corpses to families or next of kin without CTOCME approval.
CTOCME shall determine final disposition procedures using the following alternatives:

A. **Burial**
   If burial can be done in a timely fashion and there is no threat to public health, people shall be free to bury deceased family members.

B. **Mass Burial**
   If there are large numbers of victims, it may be necessary to inter the victims at mass burial sites.

C. **Cremation**
   For incidents involving certain biological agents (e.g. anthrax) with a limited number of victims, cremation may be the safest method of permanent disposition.

D. **Mass Cremation**
   With certain biological agents, cremation may be the preferred method of disposition for all victims. Cremation of mass fatalities poses a challenge for the Capitol Region as there may be limited availability of crematoria. The U.S. Environmental Protection Agency operates portable incinerators for use at toxic waste sites that may be requested for assistance in mass cremation.

III. **Victim Decontamination Policy and Procedures**

   CTOCME, in conjunction with the CTDPH, shall establish policy or procedures regarding care, safe handling, storage, decontamination, and final disposition (cremation, burial, etc) of fatalities. CTOCME and CTDPH shall establish policy or procedures for the safe handling (i.e., double bagging, etc.), decontamination, destruction, or final disposition of the victims' effects.

IV. **Identification/Investigation**

   An identification and tracking system is needed to properly manage a large number of fatalities that may result from a biological terrorism event. CTOCME and CTDPH shall maintain the database to assure accuracy.
Overview

The first step in an effective environmental clean-up strategy is to identify the health risks associated with a particular site. This step is accomplished by obtaining environmental samples, transporting samples to appropriate testing facilities, and analyzing the samples to determine the nature and level of contamination.

Once the nature and level of contamination are established, appropriate action shall be taken to decontaminate the site(s) by cleaning the area, or by removal and disposal of possible infection vectors such as animals. Re-entry to an area will be allowed only after decontamination is complete.

Detail and Responsibilities

Local authorities recognize that a chemical, biological, or other terrorist act falls under federal jurisdiction, and shall cooperate with local and federal law enforcement in investigating and prosecuting any related criminal case.

Any assembled regional Environmental Management Team shall consult with state and federal agencies for additional expert advice on identification and mitigation of environmental hazards.

The Connecticut Department of Environmental Protection (CTDEP), in conjunction with the CTDPH, is responsible for identifying the environmental hazards, for developing a decontamination plan, and for establishing criteria for re-entry into an area or building.

CTDEP shall coordinate decontamination of an area and make a recommendation to the Local Health Director and to CTDPH regarding whether or not a building or area can be re-occupied, and under what conditions.

The final decision to allow re-entry to a facility or area shall be made by the Local Health Director. Until that decision is made, local and regional law enforcement agencies shall be responsible for the security of the building or area to preclude entry or property damage.
## APPENDIX A:
### TERRORISM CHECKLISTS: OVERT EVENT

#### BIOLOGICAL TERRORISM CHECKLIST-ANNOUNCED EVENT INITIAL RESPONSE

<table>
<thead>
<tr>
<th>HOSPITAL/MEDICAL SYSTEM</th>
<th>PUBLIC HEALTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Determine number of patients:</td>
<td></td>
</tr>
<tr>
<td>- Acute care</td>
<td></td>
</tr>
<tr>
<td>- Symptomatic but not acute</td>
<td></td>
</tr>
<tr>
<td>- Worried well</td>
<td></td>
</tr>
<tr>
<td>- Ascertain available staff, beds, pharmaceuticals, equipment</td>
<td></td>
</tr>
<tr>
<td>- Distribute and track patients among hospitals</td>
<td></td>
</tr>
<tr>
<td>- Halt non-critical, elective admissions</td>
<td></td>
</tr>
<tr>
<td>- Divert patients when hospital is at capacity</td>
<td></td>
</tr>
<tr>
<td>- Activate Alternate Care Facilities (ACF)?</td>
<td></td>
</tr>
<tr>
<td>- Share diagnostic, lab, symptom, epidemiological, and infectious disease information with other hospitals, clinics, CTDPH, CDC</td>
<td></td>
</tr>
<tr>
<td>- Activate NDMS if appropriate through RED Plan</td>
<td></td>
</tr>
<tr>
<td>- Initiate mass fatality management</td>
<td></td>
</tr>
<tr>
<td>- Initiate and Monitor surveillance</td>
<td></td>
</tr>
<tr>
<td>- Poll emergency departments, clinics, physicians, veterinary clinics</td>
<td></td>
</tr>
<tr>
<td>- Monitor sales of OTC cough &amp; cold medicines</td>
<td></td>
</tr>
<tr>
<td>- Conduct epidemiological investigation</td>
<td></td>
</tr>
<tr>
<td>- Identify alpha case and interview patients and families; define commonalities</td>
<td></td>
</tr>
<tr>
<td>- Identify source and transmission mode</td>
<td></td>
</tr>
<tr>
<td>- Track distribution pattern</td>
<td></td>
</tr>
<tr>
<td>- Define population at-risk</td>
<td></td>
</tr>
<tr>
<td>- Coordinate with law enforcement investigation</td>
<td></td>
</tr>
<tr>
<td>- Determine if mass prophylaxis is appropriate</td>
<td></td>
</tr>
<tr>
<td>- Determine if quarantine is appropriate</td>
<td></td>
</tr>
<tr>
<td>- Support joint public information center</td>
<td></td>
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</tbody>
</table>
**FIELD OPERATIONS FOR EMS, LAW ENFORCEMENT, PUBLIC HEALTH, EMERGENCY MANAGEMENT, FIRE, MEDICAL EXAMINER**

- This is a cascading medical event
- Establish Incident Command (OSHA 29CFR1910.120)
- Identify Hot, Warm, Cold Zones for scene
- Search for secondary devices
- Activate CREPC RED Plan
- Conduct evacuations/shelter-in-place if appropriate
- **Decontamination will only be considered in instances of gross contamination where the biological agent is externally adhered to the exposed population.**
- Determine protective measures for responders
- EMS and Fire Rescue: decon, triage, treat, transport victims as appropriate while preserving crime scene and evidence
- EMS notify CMED
- Health Department determines exposure, prophylaxis, counseling, care of patients
- Establish staging
- Law enforcement process area is crime scene; conduct criminal investigation
- CTDEP gathers samples of product for analysis
- Identify product
- EMS, Fire support staffing needs of hospitals
- Law enforcement: manage crowd control at scene and/or hospitals
- Activate Emergency Operations Center, Regional Coordination Center if appropriate
- Advise Local CEOs on declaration of emergency
- CTOCME initiates mass fatality operations

**PUBLIC INFORMATION**

- Provide warning if appropriate
- Reassure public
- Establish Joint Information Center with departmental PIO’s
- Provide information to media
- Who, what, when, where, how, why, so what?
- What is being done
- Any protective actions public should take, especially if contagious
- Any actions public should NOT take
- Mass prophylaxis information if appropriate
- Provide information to the public through Media outlets
- EAS system
- NOAA Weather Radio civil emergency message
- City internet site
- Government access television channel
- Provide subject matter experts to media for news shows
## APPENDIX B

### TERRORISM CHECKLISTS: COVERT EVENT

#### BIOLOGICAL TERRORISM CHECKLIST-COVERT EVENT

<table>
<thead>
<tr>
<th>HOSPITAL/MEDICAL SYSTEM</th>
<th>PUBLIC HEALTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Cascading number of patients</td>
<td></td>
</tr>
<tr>
<td>- Acute care</td>
<td></td>
</tr>
<tr>
<td>- Symptomatic but not acute</td>
<td></td>
</tr>
<tr>
<td>- Sick to Worried Well ratio up to 20:1</td>
<td></td>
</tr>
<tr>
<td>- Ascertained available staff, beds, pharmaceuticals, equipment</td>
<td></td>
</tr>
<tr>
<td>- Distribute and track patients among hospitals</td>
<td></td>
</tr>
<tr>
<td>- Halt non-critical, elective admissions</td>
<td></td>
</tr>
<tr>
<td>- Divert patients when hospital is at capacity</td>
<td></td>
</tr>
<tr>
<td>- Activate Cohort hospitals if appropriate</td>
<td></td>
</tr>
<tr>
<td>- Acute Care Centers (ACC)</td>
<td></td>
</tr>
<tr>
<td>- Share diagnostic, lab, symptom, epidemiological, and infectious disease information with other hospitals, clinics, CT-DPH, CDC</td>
<td></td>
</tr>
<tr>
<td>- Activate NDMS if appropriate</td>
<td></td>
</tr>
<tr>
<td>- Manage fatalities</td>
<td></td>
</tr>
<tr>
<td>- Monitoring, surveillance</td>
<td></td>
</tr>
<tr>
<td>- Poll emergency departments, clinics, physicians, veterinary clinics</td>
<td></td>
</tr>
<tr>
<td>- Monitor sales of OTC cough &amp; cold medicines</td>
<td></td>
</tr>
<tr>
<td>- Conduct epidemiological investigation</td>
<td></td>
</tr>
<tr>
<td>- Identify alpha case</td>
<td></td>
</tr>
<tr>
<td>- Interview patients and families</td>
<td></td>
</tr>
<tr>
<td>- Identify source and transmission mode</td>
<td></td>
</tr>
<tr>
<td>- Define commonalities</td>
<td></td>
</tr>
<tr>
<td>- Track distribution pattern</td>
<td></td>
</tr>
<tr>
<td>- Define population at-risk</td>
<td></td>
</tr>
<tr>
<td>- Coordinate with law enforcement investigation</td>
<td></td>
</tr>
<tr>
<td>- Determine if mass prophylaxis is appropriate</td>
<td></td>
</tr>
<tr>
<td>- Determine if quarantine is appropriate and define</td>
<td></td>
</tr>
<tr>
<td>- Assist in diagnosis and treatment recommendations</td>
<td></td>
</tr>
<tr>
<td>- Support joint public information center</td>
<td></td>
</tr>
<tr>
<td>- Advise Local CEOs and response agencies on declaration of emergency</td>
<td></td>
</tr>
<tr>
<td>FIELD OPERATIONS FOR EMS, LAW ENFORCEMENT, PUBLIC HEALTH, EMERGENCY MANAGEMENT, FIRE, MEDICAL EXAMINER</td>
<td>PUBLIC INFORMATION</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>- EMA monitoring surveillance</td>
<td>- Establish joint information with department PIO’s</td>
</tr>
<tr>
<td>- EMS monitors transport run load</td>
<td>- Provide information to media</td>
</tr>
<tr>
<td>- CTOCME reports unusual death cases</td>
<td>- Who, what, when, where, how, why, so what?</td>
</tr>
<tr>
<td>- Activate RED Plan</td>
<td>- What is being done</td>
</tr>
<tr>
<td>- Law Enforcement conducts concurrent criminal investigation coordinated with Health Department</td>
<td>- Any protective actions public should take, especially if contagious</td>
</tr>
<tr>
<td>- Fire and EMS supports staffing needs of hospitals, ACF’s</td>
<td>- Any actions public should NOT take</td>
</tr>
<tr>
<td>- Law enforcement manages crowd control at hospitals, ACF’s</td>
<td>- Mass prophylaxis information if appropriate</td>
</tr>
<tr>
<td>- CTOEM Activates Emergency Operations Center</td>
<td>- Reassure public</td>
</tr>
<tr>
<td>- CR-MMRS may request Strategic National Stockpile</td>
<td>- Provide information to the public through Media outlets</td>
</tr>
<tr>
<td>- CR-MMRS receives and distributes pharmaceuticals in coordination with local and state Health Departments</td>
<td>- EAS system</td>
</tr>
<tr>
<td>- CR-MMRS may request USPHS CCRF, DMORT, DMRT response</td>
<td>- NOAA Weather Radio civil emergency message</td>
</tr>
<tr>
<td>- CTCTOCME initiates mass fatality management</td>
<td>- City internet site</td>
</tr>
<tr>
<td>- Examination, identification of remains</td>
<td>- Government access television channel</td>
</tr>
<tr>
<td>- Mass storage, burial, incineration</td>
<td>- Provide subject matter experts to media for news shows</td>
</tr>
</tbody>
</table>
Appendix C: First Responder Decision Matrix
Suspicious Package with Biological Threat
Source Document: International Association of Fire Chiefs
January 2004

Assessment

No Threat
- Notify Local Law Enforcement
- Jointly determine how to remove or dispose of package
- Seal & double bag
- Wash hands and/or affected area

Threat
Suspected or confirmed
- Establish Hot, Warm, & Cold Zones; Determine appropriate level of PPE
- Shut down HVAC and any mail processing machinery
- Isolate exposed individuals
- Deny entry and preserve evidence

Take Initial Actions
- Joint assessment or consequence consultancy

Request Assistance
- Joint assessment or consequence consultancy

Establish Unified Command

Field Screening

Transport Package to Laboratory for testing
- Decontaminate and transport exposed individuals as needed

Law Enforcement (local, state, FBI WMD Coordinator, US Postal Inspector)
- Additional Fire Service resources (Haz Mat Teams, EMS Providers)
- Public Health Department (Local, State)