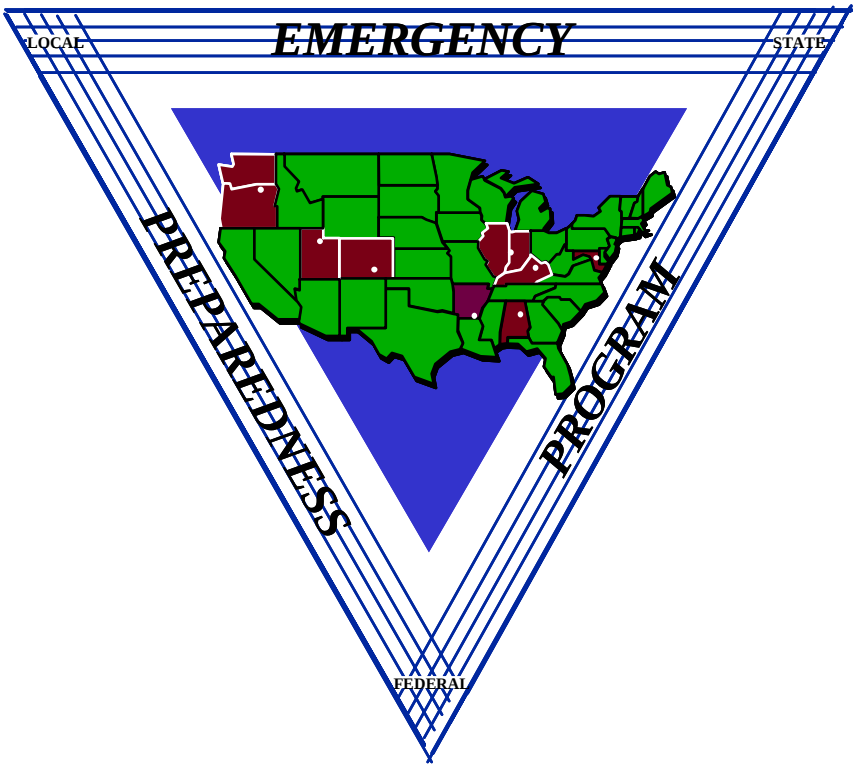
NEWPORT COMMUNITY CSEPP EXERCISE 2003
(NECD CSEPP EX 03)

FEMA

July 23, 2003

CHEMICAL STOCKPILE



ADDENDUM TO THE EXERCISE REPORT

JUNE 22, 2004

NEWPORT COMMUNITY ILLINOIS CSEPP EXERCISE 2003
(NECD IL CSEPP EX 03)

ADDENDUM TO THE EXERCISE REPORT

Table of Contents

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NEWPORT (IL) COMMUNITY CSEPP EXERCISE 2003
(Newport IL CSEPP EX 03)

ADDENDUM TO THE EXERCISE REPORT

INTRODUCTION

The Newport (IL) Community CSEPP Exercise 2003 (NECD IL CSEPP EX 03) was conducted on July 23, 2003 to demonstrate the emergency response capabilities of the Newport (IL) Community CSEPP and to validate correction of findings identified during past CSEPP exercises. This was a Federally Managed Alternate Year Exercise (F/AYE). The Newport Chemical Depot (NECD), the State of Illinois, Edgar County (IL), and Vermilion County (IL) participated in the exercise.

The requirement for conducting Chemical Stockpile Emergency Preparedness Program (CSEPP) exercises was established in the August 1988 Memorandum of Understanding (MOU) between the Federal Emergency Management Agency (FEMA) and the U.S. Army (DA). Exercise design, planning, evaluation, and reporting guidance is contained in the *Chemical Stockpile Emergency Preparedness Program Exercises* document, dated March 19, 1999.

The Army Exercise Planning Co-Director and representatives from the NECD accomplished exercise design and planning for Newport (IL) CSEPP EX 03 for DA for on-post activities. The FEMA Region V Exercise Co-Director and representatives from the State of Illinois, Edgar County, and Vermilion County (IL) accomplished design and planning for off-post play.

This exercise used the Integrated Performance Evaluation (IPE) process; an evaluation method based upon seven "response streams."

1 Hazard Mitigation

2 Hazard Assessment

3 Population Warning

4 Protective Action Implementation

5 Victim Care

6 Evacuee Support

7 Public Information.

The scope and substance of play for the Army and off-post jurisdictions are described in individual Extent of Play Agreements and are summarized in the Exercise Plan.

EXERCISE SCENARIO

On July 23, 2003 a replacement of a damaged TC valve operation was planned for one of the VX filled TCs stored on the depot. The work crew consisted of 5 NECD Storage personnel: 4 operators, and one Surety Supervisor. The work crew was wearing OSHA Level C protective clothing with M40 mask in slung position. The following equipment was present at the work site: RTAP, forklift, safety truck and water trailer.

The simulated operation began at approximately 0820. As the TC was being moved to the designated location by the forklift M1 Beam one clamp broke off the beam supporting the TC. The end of the TC impacted the safety vehicle, knocking off the bonnet and breaking off a plug. The TC fell to the ground next to the truck. The TC also hit the trucks fuel tank, rupturing it, causing VX and fuel to mix on the pavement. The spilled VX and fuel were ignited following an explosion of the truck battery.

LIST OF FINDINGS

A list of Findings identified during the Newport (IL) Community CSEPP EX 03 is listed in the following table. They are grouped by the responsible jurisdiction. Required action plans have an assigned identifying number that may be used to identify the corrective action throughout the report and in completing the action plans. The number is structured as follows: XX03.Y.1. The "XX" is a two-letter identification of the response organization to which the corrective action applied [e.g., IL for State of Illinois, ED for Edgar County, VL for Vermilion County]; "Y" indicates the response stream in which the finding requiring corrective action was found, this will be an Arabic number representing the appropriate stream [e.g., 1 for Hazard Mitigation, 2 for Hazard Assessment, 3 for Public Warning, 4 for Protective Action Implementation, 5 for Victim Care, 6 for Evacuee Support and 7 for Public Information] and "1" is the sequence number of the corrective action under the response stream. Action Plans can be found in Section 4 of this Report.

SECTION 1. COMMUNITY STREAM REPORT

ADDENDUM TO THE EXERCISE REPORT

The following is a summary of the Newport (IL) Community CSEPP performance during the exercise sequenced by response stream. Jurisdiction specific information can be found in Section 2 of this report.

Hazard Mitigation
Hazard Assessment
Population Warning
Protective Action Implementation
Victim Care
Evacuee Support
Public Information

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STREAM 1 HAZARD MITIGATION

The Hazard Mitigation Stream includes all response tasks at the accident scene to contain the source and limit the magnitude of the agent release. This stream includes all tasks performed at the accident site except for those specifically associated with the Victim Care Stream.

An assessment of the Hazard Mitigation Stream activities was not conducted during the exercise at the Newport Chemical Depot.

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STREAM 2 HAZARD ASSESSMENT

The Hazard Assessment Stream includes tasks beginning with detecting the accident, gathering information, determining its impact, classifying the event, conducting environmental monitoring, and making government-to-government notification. On-post, it also includes tasks related to Emergency Operations Center (EOC) direction and control. It also includes government-to-government updates and situation reports and briefings.

The Newport Chemical Depot (NECD) EOC was activated, following standard procedure, to direct operations to identify and mitigate the simulated VX fire on the apron of the igloo. Information was gathered for hazard analysis that enabled hazard assessments and predictions to be completed rapidly and accurately by NECD. Recommendations of Chemical Event Notification Level (CENL), Protective Action Recommendations (PARs) for off-post, using the PAR-PAD Matrix, was made correctly and in a timely manner, as were reports to government agencies and officials. On-post protective action decisions (PADs) were provided to all personnel in a timely manner. The accident was properly categorized as a Category III "Community Emergency" with PAR's as follows; IN: Vermillion Township West to shelter-in-place, Eugene Township West to evacuate; IL: protective action sub area (PASA) 3 and PASA 2 to evacuate.

IEMA provided Edgar and Vermilion Counties a PAR of "none" twice at 0833 and 0910 on the NECD notification form, when in fact the initial NANS call from NECD recommended that citizens within PASA 2 and PASA 3 should evacuate the area. The first Illinois CSEPP Follow-up County Notification Form changed the PAR to SIP for PASA 2 and PASA 3. Edgar County personnel in the EOC were not knowledgeable on the use of the State of Illinois CSEPP Follow-up Notification Form and did not take any action to respond to this PAR. Edgar County needs to improve their hazard assessment proficiency through training.

The initial alert and notification call from NECD communicated all required information within 5 minutes, as required, using the Newport Alert and Notification System (NANS).

The analysis of the Hazard Assessment Stream activities that were observed during the exercise indicates that the Newport Community CSEPP is **Capable** of performing Hazard Assessment activities in an emergency.

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STREAM 3 POPULATION WARNING

Population Warning includes those tasks associated with protective action decision making and warning the affected populations. Off-post it includes all tasks from receipt of the Protective Action Recommendation (PAR) and Chemical Event Notification Level (CENL), through making the Protective Action Decision (PAD), to activation of warning systems, including sirens, Indoor Alert System (IAS), route alerting, cable interrupts, telephoning those in special needs database, and the first EAS message. It also involves mobilizing Emergency Operation Center (EOC) staff and activating the EOC.

Newport Chemical Depot (NECD) initiated a phone call via the Newport Alert and Notification System (NANS) to the State of Illinois 911 center, State of Indiana SEMA, Indiana; Vermillion, Parke and Fountain Counties indicating that a chemical event had occurred and declared the VX accident as a Category III "Community Emergency". The protective action recommendation was for; Indiana Vermillion Township West to shelter-in-place; Indiana Eugene Township West to evacuate; Illinois protective action sub area (PASA) 2 and PASA 3 to evacuate. The NECD passed the essential elements of information to the CSEPP jurisdictions within five minutes as required by the CSEPP Planning Guidance. NECD activated their on-post indoor and outdoor warning siren systems as required by CSEPP policy and initiated required protective actions.

Illinois Emergency Management dispatch staff noted that no EMIS information had been received by NECD, including the daily work plan, plume, and PAR. IEMA dispatch staff contacted NECD to get assistance on bringing up EMIS information. The NECD information management technician assisted IEMA with opening up the EMIS D2PC plume projection. The State Emergency Operations Center (SEOC) did not indicate any additional problems with receiving EMIS D2PC plume projections from NECD. The EMIS plume plots indicated wind speed, direction of the plume, and plume dispersion.

The SEOC dispatch center received the initial NANS telephone message from NECD. The NANS call from NECD notified the SEOC of a category II "Depot Only Response" for a VX spill. During this same initial NANS call to the SEOC dispatcher, the report was changed to a category level III "Community Emergency" for the subsequent simulated VX fire. The SEOC dispatch rewrote the notice on a state incident report sheet and notified IEMA officials. IEMA officials initiated a NANS call to Vermilion and Edgar counties and asked the call takers if they received IEMA message #1 via fax. Both counties concurred that IEMA message #1 was received and understood.

During the CSEPP exercise the protective action decision (PAD) for the simulated VX accident provided by the Illinois Emergency Management Agency (IEMA) to Vermilion and Edgar counties was inappropriate and not timely. PAR "none" was provided to Vermilion and Edgar counties twice at 0833 and 0910 on the NECD Notification Form, when in fact, the initial NANS call from NECD recommended that citizens within PASA 2 and PASA 3 should evacuate the area. The first Illinois CSEPP Follow-up County Notification Form changed the PAR to SIP for PASA 2 and PASA 3. Additional EMIS training is needed for IEMA staff to ensure proficiency is kept current.

The analysis of the Population Warning Stream activities that were observed during the exercise indicates that the Newport Community CSEPP is **Partially Capable** of performing Population Warning activities in an emergency.

STREAM 4 PROTECTIVE ACTION IMPLEMENTATION

The Protective Action Implementation Stream includes the flow of activities related to evacuation and sheltering-in-place, of residents, schools, special populations, and special facilities. It also includes transportation support activities, establishing traffic and access control points, adopting declarations of emergency, host facility support, responses involving infrastructure and agriculture, and screening and decontamination of the general population.

The analysis of the Protective Action Implementation Stream activities that were observed during this exercise indicates that the Newport Community CSEPP is **Capable** of performing Protective Action Implementation activities in an emergency.

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STREAM 5 VICTIM CARE

The Victim Care Response Stream includes all activities related to treating on-post contaminated casualties at the accident site and depot, victim transport, treatment at off-post contaminated casualties at the accident site and depot, victim transport, treatment at off-post medical facilities, patient tracking, and handling and tracking disposition of human remains.

The Illinois medical community demonstrated the ability to receive contaminated patients, perform decontamination, and medical treatment throughout the NECD IL CSEPP EX 03. Paris Community Hospital, Paris Fire Protection District, Provena United Samaritan Medical Center, Chrisman Fire Protection District, Danville Fire Department, and EMS agencies from Edgar and Vermilion Counties participated in demonstrating victim care during the NECD IL CSEPP EX 03. It should be noted that all participants were well motivated and eager to participate. Some areas for improvement have been noted relating to overall patient tracking during initial triage, decontamination, and medical treatment. In addition, overall numbers of decontamination personnel at the medical facilities need to increase to ensure safety and more effective operations at the medical facility decontamination locations. Establishment of standardized protocols relating to Mark I antidote kits and administration of Mark I antidote kits would elevate the awareness, timeliness, and usage relating to victim care.

Paris Community Hospital (PCH) participated in out of sequence play. It should be noted the hospital has made efforts to improve the effectiveness of their response plan to a CSEPP event over the past year. Hospital response staff has noted that an increase in personnel, specifically relating to the decontamination team, is mandatory in order to ensure safety and operations that are more effective.

PCH received two VX-vapor-exposed patients from the Edgar County Ambulance Service (ECS) and Chrisman Ambulance Service (CAS) during the exercise. Both patients received appropriate and timely evaluations, however full treatment was delayed in one case because PCH ED nurses do not administer Mark I antidote kits. Opportunities for growth identified by Evaluator/Controllers in this exercise include the need for protocols that empower PCH ED nurses to administer Mark I antidote kits and the need to consider standard color-coded wristband systems and tags to preserve identifying medical information that follows the patient.

Fire, EMS, and law enforcement personnel from Paris and Chrisman Fire Protection Districts, Edgar County Sheriff's Office, Edgar County EMS, and Northern Edgar EMS efficiently coordinated and conducted decontamination operations and demonstrated appropriate victim care during out of sequence play. While the previous year's finding regarding the carriage and use of Mark I antidote kits by first responders has not yet been cleared, resolution of the regulatory issues involved is nearing completion and responders anticipate receiving antidote kits in the near future. Edgar County's responders were well motivated and actively identified opportunities for continued improvement.

Personnel from the Danville Fire Department (DFD), multiple EMS Agencies, Vermilion County Health Department, Law Enforcement, and the American Red Cross also participated in the exercise. Their performance was both professional and successful in demonstrating decontamination and patient care. It should be noted that this was the first time that some of these agencies (EMS) were evaluated in a CSEPP exercise. The attention to process detail was precise and procedure oriented.

Provena United Samaritans Medical Center also participated in out of sequence play. The entire emergency department staff exhibited interest and enthusiasm in participating in this exercise. Four issues were identified by the facility staff and the evaluators: 1) It is recommended that security (dressed in PPE) be available at all open entrances to monitor and direct incoming patients, staff and visitors. 2) Consistent operations as per the established hospital disaster plan will facilitate expedient patient triage, tracking and care. 3) It is strongly recommend that the ED staff, both physician and nursing, be trained in the use and administration of these kits, to include a protocol that allows the RN to administer these kits without the direct order of a physician. 4) Further education in the specific effects of toxic materials would be beneficial, focusing in the areas of decontamination, PPE, and recognition and treatment of potentially contaminated patients.

The analysis of the Victim Care evaluation was **Capable** for the one IRZ hospital, which demonstrated significant improvement over the previous exercise and EMS treatment observed during this exercise. A total of four medical facilities and multiple field response agencies participated this year, improving upon the overall community response, a result of significant training efforts. However process improvement and additional equipment and training is needed to expand and improve medical services.

STREAM 6 EVACUEE SUPPORT

Evacuee Support includes all tasks following the Protective Action Decision through opening, operating, and supporting reception centers and shelters.

The analysis of the Evacuee Support Stream activities that were observed during the exercise indicates that the Newport Community CSEPP is **Capable** of performing activities in an emergency.

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STREAM 7 PUBLIC INFORMATION

The Public Information Stream includes all tasks related to providing public information, exclusive of the initial Emergency Alert System messages. It includes the dispatch of persons to an activated Joint Information Center (JIC) and a Joint Information System and capability at the JIC and in jurisdiction EOCs to respond to information needs, prepare additional EAS messages and new advisories, handle rumor control, and do media briefings.

The Finding in the previous report that the JIS was not effective is considered resolved, and the Newport Community CSEPP is considered **Capable** of performing emergency public information activities related to an accident at NECD. However, there remains a need to update, approve, and implement the draft Newport Community CSEPP Emergency/Public Information Plan, and to support the plan by agreement on a Newport Community JIS.

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SECTION 2. JURISDICTIONAL EVALUATION SUMMARIES

ADDENDUM TO THE EXERCISE REPORT

STATE OF ILLINOIS

Response Stream 1 – Hazard Mitigation

Not applicable.

Response Stream 2 – Hazard Assessment

The State Emergency Operations Center (SEOC) dispatch center received the initial NANS telephone message at 0823 from the Newport Chemical Depot (NECD). The call notified the SEOC of a Community Event Notification Level (CENL) 2 spill and release. During the call, the event changed to a CENL 3 fire. The dispatcher rewrote the notice on a state incident report sheet and notified IEMA officials. Utilizing the Illinois State to counties NANS, a roll call was initiated at 0827 to include Vermilion and Edgar Counties. The call was to verify that the counties received State Message #1. This message was based upon the NANS call from NECD, but the faxed message did not represent all accurate information contained in the NANS call as evidenced by the fax records of the dispatch center and counties. As faxed, a PAR of "none" was given and did not include the evacuation PAR to the counties as provided by NECD. The standard CSEPP form was not used for the State Message #1. No PAR to evacuate was received by the counties, until the 0920 state message to shelter-in-place.

At 0840 the State Emergency Operations Center (SEOC) dispatch staff noted that no EMIS information had been received, including the daily work program, plume, and PAR. Beginning at 0851, dispatch staff contacted NECD to get EMIS assistance. After direct telephone assistance, plume information was secured. From 0851 to 1020, SEOC staff discussed issues about the plume information and analyzed whether the plume projected entry into Illinois. Staff also was confused about a PAR and whether any PAR had been sent by EMIS. At 0926, SEOC issued a SIP PAR. At 1050 the SEOC received a PAR from the NECD to open windows of SIP residents and ventilate. The SEOC staff decided not use the PAR recommendation from NECD, but to instead issue a PAR to keep residents sheltered. No additional PAR was issued through ENDEX.

Finding Requiring Corrective Action IL03.2.1

Title: Incorrect PAR Information

Discussion: Almost 30 minutes into the exercise, dispatch staff contacted NECD to get EMIS assistance. Only after direct telephone assistance, was plume information secured. Significant time for SEOC staff to discuss issues about the plume information and analyze whether the plume projected entry into Illinois caused delay in providing accurate PARs to the counties. Staff also was confused about a PAR and whether any PAR had been sent by EMIS. The PAR to evacuate was not provided to the counties until the shelter-in-place PAR was given. A final PAR from NECD to terminate SIP and ventilate was not provided throughout the exercise.

Recommendation: **A**dditional hazard analysis and EMIS training is recommended.

Response Stream 3 – Population Warning

At 0823 the State of Illinois received the initial notification of a spill involving the chemical agent VX at the Newport Chemical Depot via the NANS. This was initially reported as a Community Event Notification Level (CENL) 2 incident, but was upgraded to a CENL 3 at 0824 during the same notification call. The upgrade was made because a fire started shortly after the spill. The PAR from NECD was for IL PASA #2 and #3 to be evacuated. The State initiated a call-down and the EOC was activated at 0825. The State prepared initial notification messages for Vermilion and Edgar counties, at 0825 and included the initial NECD PAR "none" rather than the updated PAR of evacuate PASA #2 and #3. The NANS call between the State of Illinois and Illinois counties was completed at 0834. The faxed message did not represent all accurate information contained in the NANS call as evidenced by the fax records of the dispatch center and counties. The standard CSEPP form was not used for the State Message #1. The SEOC paged applicable agency contacts, activated the SEOC, and at 0835 the first representative arrived. Most key SEOC staff was in place was 0845. The state EOC was declared fully operational at 0840. The State Forward Command Post (SFCP) was activated at 0841. The State of Illinois notified the State of Indiana of protective actions taken at 0850. No PAR to evacuate was received by the counties, until the 0920 state message to shelter-in-place. Overall, the State demonstrated the ability activate the State EOC, activate the SFCP, to notify the proper agencies, and activate alternate warning methods in a timely manner.

Observation For Further Consideration

Title: Dispatch Training

Discussion: The dispatch officer took notes during the call and rewrote the message. The second version included only a PAR of "none" rather than evacuate. Dispatch staff utilized existing report forms for the first two messages. SEOC staff later advised dispatch to use the CSEPP form. This may have led to confusion about the number and content of state messages. The PAR of evacuate was not provided until the SIP PAR.
Recommendation: Close examination of initial notes immediately after transmission of written incident information for verification would be advisable. Additional dispatch training is needed.

Status of Previous Findings

- **Previous Finding Number: IL02.3.1**

Title: Initial Notification of Surety Event

Resolved: Yes

Response Stream 4 – Protective Action Implementation

At approximately 0855, the SFCP anticipated evacuating from PASA #2, 320 people to South View Middle School and evacuating from PASA #3, 309 people to Crestwood Elementary School. At approximately 0935, a change in the PAR to SIP for PASA #2 and #3 was received. All personnel were briefed and the appropriate actions taken by SFCP staff. The SFCP per telephone conversations with dispatchers in the State EOC took initial protective actions of Evacuation for PASA #2 and #3.

With the State Forward Command Post (SFCP) being pre-staged in the area it is estimated that the vehicles would not arrive from Springfield, Illinois until approximately 2 ½ hours after being deployed. The State Regional coordinator will be deployed to the SFCP location and arrive approximately 45 minutes after initial notification to the area. The State Regional coordinator would take charge of deploying assets to the required TCP/ACP's. The SFCP demonstrated the capability and resources necessary to control access, evacuate restricted areas and control evacuation traffic flow. The plans were accurate, used and followed ensuring the necessary requirements was met in a timely manner.

Response Stream 5 – Victim Care

Not Applicable.

Response Stream 6 – Evacuee Support

Not Applicable.

Response Stream 7 – Public Information

The extent of play for the Public Information (PI) stream for the State of Illinois included conducting SEOC media operations, the direction and control of public information activities and the provision of emergency information to the media and public. Normal response operations include JIC activation; however, since the JIC was not activated for this exercise, the IEMA Public Information Officer (PIO) and team of three functioned out of the SEOC.

At 0835 the lead PIO briefed the PIO team on the initial event notification. At 0855 the PIO staff notified NECD that the State EOC had been activated. Vermillion and Edgar County PIOs were initially contacted at 0911 and 0913 respectively. At 0926 a shelter-in-place PAR was issued to the counties for PASA #2 and #3. At 0932, State PIO staff contacted the NECD PIO to confirm the PAR for Illinois and Indiana. The State faxed NECD press releases, supplied requested information and contacted affected counties.

At 1000, the NECD informed the State that the JIC had been activated (simulated) at the South Vermillion High School in Clinton Illinois. Beginning at 1010, calls were made to the Vermilion County, Edgar County, SEOC, and the SFCP informing them that the JIC had been (simulated) opened in Clinton. At 1110, the State PIO called the NECD PIO for an update and was informed that press release # 4 was being drafted. The State PIO staff successfully fielded numerous inquiries from public official and concerned citizen calls through the course of the exercise.

Status of Previous Findings

- **Previous Finding Number: IL02.7.1**

Title: The JIS Was Not Effective

Resolved: YES

EDGAR COUNTY

Response Stream 1 – Hazard Mitigation

Not Applicable.

Response Stream 2 – Hazard Assessment

The initial notification from the State of Illinois to Edgar County was made to the Edgar County Sheriff's Dispatch at 0834. The notification was made via fax, with receipt verified by phone, on the Newport Chemical Depot (NECD) Notification Form. The PAR given on the Notification Form was "none". This was the PAR used by Edgar County throughout the exercise despite a change in PAR made on the State of Illinois CSEPP Follow Up County Notification Form, received at 0921, which showed a PAR recommending SIP for PASA #3 of Edgar County. The personnel in the EOC were not knowledgeable on use of the Form and did not take any action to respond to this PAR.

Although the Coordinator continued to request the IEMA representative in the Edgar County EOC provide a plume and a PAR at 0933 from the State; but the PAR confusion was not corrected. The County did not receive a plume plot from the State until 1012 and this plume plot did not show any impact from the incident on the State of Illinois. An earlier plume plot generated at NECD, which was not sent to Edgar County, would have had an impact. The County does not have EMIS and relies on the State for plume plot and PAR. Personnel in the EOC identified confusion on the PAR at 1105. By this time there was no action required because the plume plot in effect at that time did not show any impact on Edgar County.

Finding Requiring Corrective Action ED03.2.1

Title: Hazard Analysis Training

Discussion: Personnel in the Edgar EOC are not familiar with the notification forms used by the State. To add further to the confusion, the information on the Notification form was not correctly interpreted so the State PAR was not evaluated or PAD made.

Reference: The Illinois Plan for the Chemical Stockpile Emergency Preparedness Program (CSEPP)

Recommendation: Additional training on hazard analysis and use of forms should be provided to the Edgar County EOC personnel.

Response Stream 3 – Population Warning

The initial notification from the State of Illinois to Edgar County was made to the Edgar County Sheriff's Dispatch at 0834. The notification was made via fax, with receipt verified by phone, on the NECD Notification Form. The dispatcher immediately contacted the EOC to verify who was there and then faxed the notification to the EOC. The dispatcher recall is based on a minimal operational level staffing list which includes the Coordinator, Assistant Coordinator, Secretary, Radio Operator, Support Staff, Board Chairperson, Sheriff, Highway Representative, and American Red Cross. There are other personnel who are notified by the EOC once the EOC staff determines what type of response is required. This includes hospital, ambulance, fire, education, state liaison and public information. The dispatcher was efficient in notifying personnel of the requirement to report to the EOC. The EOC notified the additional staff personnel; however, there was a delay in the response of the PIO because the EOC did not notify her until 0927.

The EOC opened at 0820 and declared operational at 0847. Personnel continued to report until 0932. Commercial telephone, radio, and ham radio systems were operational. The EOC had the appropriate maps and a method of recording events that all EOC personnel would see. Computer support with internet access was available and functioning. One fax machine was available. There was a delay in sending some faxes due to the volume of incoming faxes. A copy machine was available for reproducing messages and distributing them to the EOC staff.

The EOC activated the public warning sirens at 0857. The siren was sounded every 12 minutes for the first hour and every 20 minutes until the exercise ended. The EOC also sent an exercise message to the National Weather Service (NWS) requesting broadcast of an exercise message. The NWS did broadcast an exercise message. The County did not prepare a message that they would have had the NWS broadcast if this had been an actual event. The EAS message, which was pre-scripted and contained in the State CSEPP Plan, was sent to the local radio station for broadcast. Citizens were told no protective actions were required and they should continue to monitor the local radio for additional information. Since Edgar County did not think they had a PAR that required any public protective actions, the PAD was issued, no action required. The EOC initiated their indoor and outdoor public warning measures for a PAD of no actions required.

Observation

Title: Indoor and Outdoor Warning Systems

Discussion: The Indoor Warning System was activated by the EOC requesting the NWS broadcast emergency public information for the exercise to be sent out for the radio units; however, the County did not prepare the message that would have been utilized in an actual event. The Illinois CSEPP Plan does have a pre-scripted message for the NWS warning so an actual message should have been developed. Sounding of the sirens throughout the exercise activated the Outdoor Warning System. Even after the plume plot was received at 1003 and showed no impact on Edgar County the sirens continued.

The activation of county sirens and the notification to local media and the NWS were not in accordance with the county/state plan and there is no documentation to support these decisions. While the resultant notifications did not have an adverse effect (they could have been seen as proactive involvement), county officials could not explain why these actions were taken when they were, and did not have a reference in their concept of operations to justify the action.

Recommendation: The Indoor Warning System recommendation is to utilize the pre-scripted message for the NWS emergency notification. The Outdoor Warning System recommendation is to have Edgar County re-evaluate their decision process of when to start and stop the siren activation. If the county takes protective action measures in the absence of an Illinois PAR, they should have a provision to implement and define these as a protective action decision. The evaluation team did not recognize the implementation of these measures as a conscious decision to protect the public.

Response Stream 4 – Protective Action Implementation

At 0921 a form was numbered "2," and described a Category III emergency was received from IEMA. Wind speed and direction were not included, and only vague indication of siren/radio activation defines Illinois Protective Action as required. The EC EOC Director misinterprets the instruction for SIP of PASA #3 as a recommendation to open a shelter. Consequently, Edgar County still believed they had no PAR from IEMA. Between 0923 and 1003, members of the EOC staff attempt to gain some clarification from IEMA liaison representatives in the EOC.

At 1003, the first plume projection is received via email from IEMA. This plume projection showed no plume penetration into Illinois, but was incorrectly interpreted as affecting PASA in Vermilion County, IL for approximately 15 minutes. At 1022, the sheriff dispatched two deputies to northern Edgar County to stand by for evacuation or roadblocks. At 1032, the Deputy Director is overheard stating, "No protective action is required." At 1056, and after extensive consultation with IEMA liaison representatives, the EC EOC Director stated the sounding of sirens; notification to local media and the test message transmitted by the NWS may have been premature based on non-receipt of a PAR from IEMA. At 1200, the exercise terminates in Edgar County without formal declaration of a PAD. Therefore, protective action implementations such as SIP, evacuation, and TCP/ACPs were not included in the exercise.

Status of Previous Findings

- **Previous Finding Number: ED02.4.1**

Title: Antidote Kits Not Available to Responders

Resolved: No. New Finding Number – ED03.4.1

Response Stream 5 – Victim Care

Responders from the Paris and Chrisman Fire Protection Districts, Edgar County Sheriff's Office, Edgar County EMS, and Northern Edgar EMS successfully demonstrated patient screening and decontamination in out-of-sequence activities at Edgar County Airport (ECA). While some areas for improvement were noted, activities were conducted quickly, efficiently, and with excellent attention to detail. Activities at this site began when a sheriff's deputy encountered a motor vehicle with one adult and three juvenile occupants. The vehicle's occupants complained of illness and of having a "liquid" on them. The deputy contacted his dispatcher by radio and requested EMS response to the scene.

EMS personnel (one Advanced Life Support (ALS) unit and a supervisor) from Edgar County EMS arrived on scene to find four victims of an unknown explosion. On arrival, personnel from the ALS unit began evaluating the patients; on determining that a chemical agent might have been involved, the supervisor called for a hazardous materials response. The supervisor also alerted Paris Community Hospital (PCH) by radio.

The first victim (10 yrs. old) complained of a compound fracture of the arm, difficulty breathing, profuse sweating, miosis, and chest pains. Second victim (12 yrs old) symptoms were a burn on the leg, chest pains, miosis, and profuse sweating. The third victim (4 yrs. old) complained of nausea. The fourth victim (37 yrs. old) had symptoms of runny nose, chest pains, and profuse sweating. The first three victims had a history of asthma. The paramedics took blood pressure, pulse, and respiration. They administered oxygen to all victims. Victims one, two, and four were given atropine and saline thru IV. At this time, Edgar County EMS providers do not have Mark I kits. All patients were treated appropriately. In the process of treating the patients, the two paramedics on the ALS unit were contaminated; cross-contamination was identified by responders and affected providers were later decontaminated. However, the affected providers did cross-contaminate an ambulance while retrieving equipment. EMS responders need to be aware of the potential for cross-contamination of personnel and equipment when treating contaminated patients. Following the initial assessment and treatment described, all four patients were decontaminated. After decontamination, patients were further assessed and treated by ALS providers from Edgar County EMS and Northern Edgar EMS, and were transported to PCH.

Decontamination operations at the ECA were conducted by firefighters from the Paris Community Fire Protection District and Chrisman Fire Protection District. Arriving on the scene a few minutes after dispatch, responders established and staffed ambulatory and non-ambulatory decontamination lines in approximately twenty-five minutes. As site setup progressed, a primary team of site workers and a backup team dressed out, assisted by support personnel. Medical surveillance of each site worker was conducted prior to donning PPE. Responders operated in compliance with the appropriate regulations; an incident command system was implemented, a safety officer designated, and a site safety and control plan was used. Responders demonstrated notable attention to detail in patient tracking and responder accountability.

While the decontamination area was being established, four patients were being assessed and treated by EMS personnel. Following initial triage and treatment, each patient was appropriately

decontaminated, two each ambulatory and non-ambulatory. Site workers had some difficulty handling the non-ambulatory patients. Additional personnel would have been useful to allow the handling of heavier patients and more efficient handling of back boarded patients; further practice in manipulation of back-boarded patients would increase efficiency as well, since workers had difficulty rolling the patients to decontaminate their backs. Following decontamination of the patients, site workers decontaminated the cross-contaminated EMS providers. Once all patients and providers had been handled, site workers self-decontaminated and site operations terminated.

Paris Community Hospital (PCH)

PCH participated in out-of sequence play. In order to stress differential diagnosis and help emphasize the relevance, the patient simulated a person who had ingested malathion, an organophosphate pesticide, in a suicide attempt. The evaluators moulaged and briefed the patient.
While waiting to begin play, the pharmacy supplies of atropine and 2-PAM chloride were checked. These were mainly in the form of 406 Mark I antidote kit with an expiration date of October 2006. They have typical small quantities of atropine in pre-loaded syringes and vials. They had 31 pre-loaded syringes with 10 mg diazepam, expiration March 2004. The had about 75 mg of injectable lorazepam that could be used to back up the diazepam if necessary

After initial notification, the staff began setting up a decontamination line and preparing to receive contaminated casualties. The triage nurse at the Emergency Department (ED) stayed in partially suited condition to minimize potential heat stress. One of the canisters on her PAPR was slightly loose. An evaluator held an ampoule of ammonia "smelling salts" near the loose threads, with no odor detected by the nurse.

The patient presented at the ED entrance. All external entrances to the hospital had signs advising people that an exercise was underway and in an actual situation, they would be asked to report to the ED entrance. The ED entrance itself had a sign saying that an exercise was in progress and directing people to talk to a staff person before entering. The staff confronted the patient and held him outside the entrance (by voice command) until a nurse in PPE arrived shortly thereafter. She had been partially suited and was waiting.

The patient was instructed to strip (wearing swimming trunks under clothing.) and to bag his clothing. He donned a hospital gown with a short blanket over his shoulders and back for privacy. He was directed on foot to the decontamination line about 100 feet away. Wheelchairs and stretchers were available for non-ambulatory patients. He did not have slippers or foot covering; that was not a problem with the prevailing weather, but could have been difficult in either in hot weather or cold weather. An ambulance idling at the entrance made hearing difficult.

The triage nurse escorted the patient to the decontamination corridor. No tagging or paper work was brought with him. The decontamination team had completed setting up the shower facilities and dressed in PPE as soon as they saw the patient arrive at the ED door. Decontamination team members directed the patient to remove the hospital gown provided by the triage personnel and

step into the decontamination shower. Decontamination team members instructed the patient to thoroughly wash from head to toe with a sponge and soap provided at the decontamination corridor. The patient completed washing and was directed to step from the shower to a second area within the runoff containment structure to be rinsed again by decontamination personnel.

The decontamination site manager notified the PCH EOC that the patient had completed the decontamination process and a wheelchair would be needed to transport the patient from the decontamination corridor to the hospital for further medical evaluation.

The triage nurse was bringing a wheelchair from the hospital ED to the decontamination corridor to transport the patient. At that time the decontamination site manager recognized that the triage nurse including the wheelchair were in the potentially contaminated area and could not be used to transport the patient to the hospital. A second wheelchair was requested from the clean side to transport the patient. The patient was taken to the ED by wheelchair. The person aiding transport was able to hold the door open with one hand and pull the wheelchair up a shallow ramp with the other, but noted that was difficult. Once in the ED, nurses rapidly assessed the patient, instituted appropriate initial care, and called the physician.

The physician took a history including all salient points, ordered one Mark I antidote kit, directed admission with a psychiatry consult, and directed nurses to begin planning transfer to a regional hospital in Champaign.

At 1800, controller/evaluators began exercise play by directing the four mock patients, whom they had moulaged and instructed in their presentation to arrive at ECA where the Fire Department (FD) was receiving and decontaminating patients. At 1805, ED staff monitoring FD scanner calls learned that the four mock patients had presented to ECA. Then, ED staff learned at 1808 from the FD scanner that the Edgar County Ambulance Service (ECS) had arrived at ECA. The ECS called the ED at 1810 on the Mercy Radio System to notify them that there were four VX-vapor-exposed patients at ECA.

At 1830, the ED staff heard on the FD scanner that ECS at ECA requested that the Chrisman Ambulance Service (CAS) respond to aide in transport. The ECS called the PCH ED at 1831 on the Mercy Radio System to notify them that a total of two patients were being transported.
CAS called the ED at 1900 on the Mercy Radio System to notify them that Patient One was a 12-year-old VX-vapor-exposed boy with a small right leg burn and a history of asthma. He had miosis, and he was suffering chest tightness and anxiety. CAS triaged Patient One as "immediate" and had administered one Mark I antidote kit to him. They decontaminated him and marked him accordingly with duct tape. They put him on a backboard, started an intravenous line (IV), and administered oxygen. CAS noted pertinent history, triage category, and treatment given on masking tape, which they applied to Patient One. Patient One arrived at the ED at 1907. An ED nurse assessed Patient One's vital signs, symptoms, and exposure history in the entry hall, completed a paper record sheet, and directed him into a treatment room.

At 1910, ECS called the ED on the Mercy Radio System to notify them that Patient Two was a 10-year-old VX-vapor-exposed patient with a left arm open fracture. Patient Two had miosis and profuse sweating. He complained of anxiety and some difficulty breathing, which had

improved since transport. They decontaminated Patient Two and marked him accordingly with duct tape. They triaged Patient Two as "immediate". They had cleaned the fracture wound, dressed it; and immobilized the left arm. They started an IV and administered oxygen. ECS noted pertinent history, triage category, and treatment given on masking tape, which they applied to Patient Two.

Patient Two arrived at the ED at 1918. An ED nurse assessed Patient Two's vital signs, symptoms, and exposure history in the entry hall. ED staff placed Patient Two on a stretcher and located him at the side of the entry hall. (The treatment rooms were filled with several real patients.) They planned to transport Patient Two to X-ray for neck and left arm X-rays.

At 1927, ECS called the ED on the Mercy Radio System to notify them that there were no more patients at ECA that would be transported to PCH. The ED physician was seeing several real patients so physician evaluation of Patients One and Two was delayed. At controller/evaluator instructions, Patient Two injected into the exercise further complaints of renewed difficulty breathing. An ED nurse spoke with him and noted the complaints but did not administer antidote to him. At 1952, The ED physician evaluated Patient One. He noted that Patient One's symptoms had improved with the Mark I antidote kit antidote administered by CSA and planned to get X-rays of the injured leg. At 1954, the ED physician evaluated Patient Two. He ordered administration of one Mark I antidote kit and oxygen to Patient Two. He reinforced the plan to obtain neck and left arm X-rays.

The PCH received two VX-vapor-exposed patients from the ECS and CAS ambulance services in out-of-sequence play. Patient One received appropriate and timely evaluation and treatment. Although Patient Two received timely evaluation, full treatment was delayed because PCH ED nurses do not administer Mark I antidote kits. Opportunities for growth identified by evaluator/controllers in this exercise include the need for protocols that empower PCH ER nurses to administer Mark I antidote kits and the need to consider standard color-coded wristband systems and tags to preserve identifying and medical information that follow the patient.

Strength

Title: Slippery Decontamination Tarp

Discussion: The patient found the tarp slippery. This is likely to be a problem at most sites. PCH has initiated a modification that should be considered as a best practice, worthy of emulation elsewhere: They have an aluminum walker at the dirty end of the decontamination line and plan to acquire one for the clean end. They did not use the walker to mitigate the slip hazard in this exercise.

Recommendation: Use walkers routinely at each end of the decontamination line. Recommend sharing as best practice on the CSEPP portal.

Observation

Title: Proper PPE

Discussion: Boots supplied are so large that they create a trip hazard if worn. Street shoes cannot be worn under the protective garments. The nurse thus worked with socks inside the booties of the suit. A canister on a triage nurse's PAPR was not tight.

Recommendation: The hospital has begun action to obtain proper sized boots for use over the protective garments. Recommend this be followed up as well as having a checklist for PPE checks upon donning.

Observation

Title: Additional signage for the triage and decontamination areas

Discussion: The triage nurse in particular had trouble making herself heard over the noise of a large diesel ambulance parked idling at the entrance. The problem was less severe in the decontamination area, which was quieter, but still difficult, owing in part to mild deafness of the patient.

Recommendation: Signs that staff personnel could use to ask simple questions would be helpful.

Observation

Title: No Patient Tag or Paper Work Was Used

Discussion: No patient tag or paper work accompanied the patient from triage to decontamination and then to the ED. Inasmuch as the patient might lose consciousness along the way, this could create a serious problem. The shortage of personnel able to work in PPE may explain the deficiency.

Recommendation: As the staffing problem is resolved, plan to add a patient triage tagging station with a minimal basic history that can accompany the patient.

Observation

Title: Antidote Administration Protocols for Nurses and EMS

Discussion: Illinois now allows nurses and EMS providers to administer antidote auto injectors in Mark I antidote kits. However, in this exercise, Patient Two required antidote but did not receive it for some time because ED nurses waited on the ED physician to order the Mark I antidote kits. When discussed with hospital staff, they indicated that they had no protocol written for nurses to administer Mark I antidote kits.

Although they indicated that they should readily be able to pull the ED physician aside to order administration if it was needed, this did not come to pass in this exercise.

Recommendation: PCH should write protocols and take whatever other steps are necessary to empower all nurses and EMS providers to be able to administer Mark I antidote kits to patients who need them. Delays in treatment of the length of time observed in this exercise could have serious consequences for nerve agent casualties.

Observation

Title: Lack of Banding and Tagging Systems

Discussion: ECS, CAS, and PCH marked decontaminated patients with numbers handwritten on duct tape and stuck to the patient. The marked identifying information and medical data by hand on masking tape and stuck it on the patient. It is very good that the ambulance services and ED are making an effort to track this information. However, information may be lost if the tape fell off of patients or patients went through wet decontamination and handwritten information smeared or washed off.

Recommendation: The ambulance services and ED staff should consider using standard wristband systems of different colors to indicate patients who have been decontaminated and how many Mark I antidote kits have been administered. They should consider standard tagging systems to record identifying and medical information that stay with the patient.

Finding Requiring Corrective Action ED03.5.1

Title: Inadequate Hazardous Material Staff

Discussion: Only one person in PPE was available at the triage end and only two people were in PPE in the decontamination area. OSHA regulation states when PPE is in use it requires a backup team, dressed or partly dressed in PPE, to continue the work in the event the first team remains the maximum permitted stay time. They may also be needed to rescue members of the first team in the event of injury or illness.

Although the hospital demonstrated a remarkable capacity to respond with the personnel available, the absence of sufficient personnel had an impact on the ability to tag patients and would prevent a critical problem if they had a heavy (>180 pounds) non-ambulatory patient. They could not safely attempt movement with the personnel at hand; if they did, there would be a very high risk of personal injury to both staff members and the patient.

The hospital has opened negotiation with the health department to obtain qualified hazardous materials responders and have discussed the problem with the Paris Fire Department.

Reference: 29 CFR 1910.120 (q)(3)(vi)

Recommendation: Continue efforts to obtain trained rapid response help from sources outside the hospital. Although the Fire Department has warned that all of their personnel might be committed to the scene of a hazardous materials release and would be unavailable; suggest that the hospital inquire about personnel to backup the Fire Department. In some areas, Community Emergency Response Teams, made up of citizen volunteers with appropriate training can be called on to help in civil emergencies of any type. The hospital should not rely on such an organization for its primary response, but they could supplement the hospital and fire department staff.

Status of Previous Findings

- **Previous Finding Number: ED02.5.1**

Title: No Respiratory Screening Program / Mask Fit Test Procedures

Resolved: No. New Finding Number – ED03.5.2

Response Stream 6 – Evacuee Support

At the Edgar County EOC, after receiving a Notification Message at 0930, which was interpreted to mean there was a need to activate a shelter, the Disaster Center at Crestwood was called. The Crestwood facility could accommodate 250 to 300 evacuees. The Edgar County ARC Chapter could supply 30 cots in 30 minutes. The State could supply 200 cots in 45 minutes and 50 mats are on hand at the site.

In out-of-sequence play the ARC demonstrated the capability to conduct reception and shelter operations for five evacuees at the Crestwood School in Paris. Procedures, facilities, and equipment for congregate care of evacuees were adequately demonstrated.

Staff personnel included the site manager, ARC volunteer staff, Paris Law Enforcement, ARC State Lead, ARC Emergency Coordinator and a Physician Assistant. This ARC reception center and shelter site at Crestwood School in Paris, Illinois was staffed with three experienced-trained volunteers and a well-trained site manager. The volunteers performed their duties effectively and efficiently.

Response Stream 7 – Public Information

The Edgar County PIO coordinated with the Illinois Emergency Management Agency (IEMA) for information on the event. She provided information to individuals and responded to media requests for information. There was an initial problem with the PIO responding to the EOC. She

was not notified with the other EOC Support Staff members. She did respond within 10 minutes when notified.

The simcell had a problem contacting the Edgar County EOC. The simcell received numerous busy signals when contacting the EOC. It is not known what the problem was but it did delay request for information at the EOC. It also decreased the amount of media requests for information processed at the EOC. There were only two requests for information from the media to the County PIO. One came immediately after the PIO arrived at the EOC. She took the request information and called the individual back once she had gotten some information from the state. Since the state had only forwarded the information from NECD to the counties, no State news releases were issued, and the County did not think they had a PAR she was not able to respond quickly to this request. After contacting the IEMA PIO she returned the media call and provided information. The second request for information from the media was referred to the IEMA PIO, in accordance with the Illinois CSEPP Plan. The media requester was further directed to the State EOC PIO. It is unclear if this was exercise artificiality or a change in State procedure. The County PIO is new to the position and was not familiar with the action required to interface with the PIO personnel at the State and was unfamiliar with the functions of a Joint Information Center.

Observation

Title: PIO Training

Discussion: The County PIO is new to the position and was not familiar with the action required to interface with the PIO personnel at the State and was unfamiliar with the functions of a JIC. She followed the procedures outlined in the Illinois CSEPP Plan but that did not match the procedures being utilized at the State EOC.

Recommendation: Additional PIO specific training be conducted between the State and the Illinois CSEPP counties. Verify or change procedures identified in the CSEPP Plan.

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VERMILION COUNTY

Response Stream 1 – Hazard Mitigation

Not applicable.

Response Stream 2 – Hazard Assessment

Vermilion County was notified at 0833 of a CENL-Level III event at the NECD using the NANS from the State. This call was taken at the county 24-hour warning point and monitored in the EOC communication center. The initial state notification gave a PAR of "none". Vermilion County was notified by IEMA at 0910 to SIP PASAs 2 and 3. The county decided to SIP Love, McKendree, and Elwood Townships at 0932. Initially only Love Township and a portion of Elwood Township were notified by EAS message and by the Indoor Warning System by calling the NWS to send out a message to have the citizens SIP. Subsequently, the County Chairman, EMA Director, and sheriff discussed how best to implement and notify residents of Vermilion County's decision to SIP. At the recommendation of the sheriff, the area south of a line from Georgetown to the Indiana State line and east of Route One was to SIP. This was done to ease the method of communication to public. The State of Illinois was informed of this change from the county plan. Vermilion County successfully demonstrated hazard assessment through their proactive actions in information gathering.

Response Stream 3 – Population Warning

The county EMA Director, as a precautionary measure, ordered the activation of the EOC and started the EOC "call down". The EMA Director declared the EOC operational at 0844. All EOC personnel arrived by 0930.

Vermilion County EOC utilizes the NANS CSEPP dedicated phone line. A volunteer in the EOC Communications Room answered the NANS call at 0839. The call was from the SEOC. The caller indicated that the call was a "drill" and inquired if the Director had received a fax, then roll call was taken. The Director also received a call at 0841 from the 911 Center, regarding a call they had received from the SEOC giving notice of an exercise incident at the NECD. This fax was delivered to the Director at 0849. The fax message indicated that the incident was a "type III event" with a "spill on the ground" and the PAR was "none". Responding to the NANS call and reacting in a "precautionary" mode, the Director began calling the primary EOC staff at 0842 to begin setting up the EOC. The EOC Director then called the Sheriff to deploy him to the EOC and the hospital to give them a heads-up about the incident. Completion of the Vermilion County roster call-down was then turned over to the Assistant Director. It was observed that the Assistant Director had problems getting in touch with the PIO. After several attempts, he went to the computer and sent the PIO a text message phone message. It was later discovered that the number listed for the PIO on the roster was incorrect. The number was corrected and the PIO arrived in a timely manner because of the text messaging capabilities. This is a good back-up

system for manual roster call-down failure. Even though all external agencies had not arrived yet, the EOC Director determined the EOC was sufficiently set-up for operation at 0844.

The NANS rang again at 0909 and the person on the phone inquired if the Director had received the second fax regarding the NECD incident. The call lasted for at least five minutes before the Director finally called the State directly to inquire about this fax. The second fax finally arrived showing a "sent" time of 0908 with a PAR of "none". At 0919 a fax was received from the SEOC that indicated that the classification of the incident was still a CENL-III and a PAR to evacuate PASA 2 & 3. Discussion with the EOC staff followed at 0916 as to whether McKendree should be evacuated or SIP.

The first briefing to the EOC staff by the Director of the Vermilion EOC occurred at 0918. The briefing included reporting that the plume was at 109 degrees from the NECD, was a CENL-Level III and that the State of Indiana was sheltering-in-place with no causalities. The Director also informed the staff that he had earlier informed the hospitals to give them a heads-up about the NECD incident.

Although they knew that Indiana was to SIP and because information regarding the plume was slow in coming from the SEOC, the EOC Director made a decision at 0941 that the plume had crossed the State Line into Illinois and discussed the evacuation of PASA 3. They also consulted their maps to determine the location of the plume from their current information and the potential of evacuation routes to include decontamination units at Georgetown and Southview.

When the EOC was declared fully activated at 0930 the Director conducted his second briefing. The briefing included instructions on the use of the new phone system; passed on the information that Indiana was sheltering-in-place and discussed TCPs/ACPs with the Sheriff. The Townships of Love, McKendree and Elwood were instructed to SIP 0932. At 0938 the EOC Director contacted the NWS to send out a message to have the Townships SIP.

The first EAS message was sent from the Vermilion County EOC PIO to the Vermilion County local radio station requesting all residents of Love Township and that portion of Elwood Township east of Vermilion County Road 1720E to SIP. A second EAS message was sent from the Vermilion County EOC to the Vermilion County local radio station requesting "All citizens south of Georgetown and east of Route 1 SIP until further notice". Also, the EOC Director called the NWS at 0938 and 0946 asking them to put out a message of instruction for these townships to SIP.

Given the lack of information that the Vermilion County Director received from the SEOC, the Director performed his duties in an exemplary and timely manner. Working with a "precautionary" frame of mind, the Director was very proactive in seeking out the information he needed and making recommendations and decisions to protect the citizens of his jurisdiction based on this information.

Response Stream 4 – Protective Action Implementation

The county simulated two TCPs. These were located in Georgetown and Chrisman. A third TCP was set up at Southview Middle School to direct the flow of traffic into the decontamination site and American Red Cross shelter. This TCP and the decontamination were successfully demonstrated through out-of-sequence play. The TCP, patient screening, decontamination, both gross and technical, as well as patient triage were successfully demonstrated by personnel from the Danville Fire Department (DFD), multiple EMS agencies, Vermilion County Health Department, Law Enforcement, and the American Red Cross.

Response Stream 5 – Victim Care

Provena United Samaritan Medical Center (PUSMC)

A review of the PUSMC's decontamination setup reveals that they have on hand four responder suits (all in XL and XXL sizes,) with integrated gloves, 14 PAPRs, four sets of boots. Their decon shower is a single patient pre-assembled nylon enclosure with hot water. They utilize hard plastic brushes and green soap. They do not have capability to handle non-ambulatory patients at this time. Fluid containment is accomplished by using a submersible sump pump in the decon vestibule. Fifty-five gallon (or larger) containers receive the contaminated fluid from the sump pump. Provisions are being made to enclose the decon area which is located on the upper tier of the trash dock on the north side of the hospital. Traffic control at the hospital will be provided through the local police department.

The hospital is developing a Hospital Emergency Incident Command System. The Risk Manager at the hospital is currently functioning as the hospital's incident commander. This aspect of victim care was not demonstrated. Decontamination was not demonstrated. According to the Trauma Coordinator, this was due to inadequate numbers of available trained hospital staff.

Security at the facility was observed at the Emergency Department entrance. During the hot wash it was stated that when Phase II was implemented all entrances to the hospital were locked down.
The only two entry access points were the ED and one receiving dock for employee access. No demonstration or discussion was held concerning security procedures at these entrances. The hospital is currently not prepared for security to monitor entrances while donned in PPE. Security did not continuously monitor the ED entrance to screen and direct incoming patients, visitors or staff. This could present a significant risk for contamination of the facility.

Radio communication between the ED and emergency medical responders was excellent. The ED was able to expedite the treatment and disposition of patients already in the ED in order to make accommodation for the incoming patients. There appeared to be no formal patient and belongings tracking. Although the facility has triage tags, none were used. Within this same context, this is felt to present a point of confusion for the staff. They did not demonstrate the use of the Disaster Supply Carts that, according to their Emergency Plan Code D Mass Casualty Plan Phase II, are kept in the storeroom and Emergency Department. They did not demonstrate

utilization of sites within the facility that have been selected for expansion of patient treatment areas. The hospital's medical staff response was timely.

The staff demonstrated their ability to treat a large number of potentially contaminated and/or injured patients on short notice and within a critical timeframe. Although the hospital has 460 Mark I antidote kits, the pharmacy and ED staff were not familiar with their use. Rather than use these kits, the staff chose to administer, in 0.5-2mg increments, IV atropine from their bulk stock. 2-PAM Chloride was administered in a similar fashion. This caused a significant delay in antidote administration time. Because the pre-hospital personnel do not carry Mark I antidote kits, this potential delay is of concern.

Observation

Title: Facility Security

Discussion: Security staff was present only periodically at the ED entry.

Recommendation: Security should be present and visible at all open doors to ensure safe and proper movement of patients, staff and visitors as well as ensure no entry of contaminated or potentially contaminated individuals until adequate triage and decontamination procedures are completed. This will prevent the unnecessary closure and quarantine of the facility.

Observation

Title: PPE and Decontamination Training

Discussion: The ED and Security staff requires PPE and decontamination training. The Security staff was not dressed out in PPE. Because individuals presenting to the hospital could potentially be contaminated, security in these areas should be dressed in appropriate PPE to prevent injury/exposure.

Recommendation: All ED staff should receive chemical training through the CSEPP.

Observation

Title: Antidote Administration Protocol

Discussion: ED staff is unfamiliar with the indication and use of the Mark I antidote kits.

Recommendation: All ED staff should receive chemical training through the CSEPP.

Establishment of a countywide protocol for the use of Mark I antidote kits would also be beneficial.

Observation

Title: Patient Tracking

Discussion: Utilization of the hospital's disaster plan, which includes patient tracking modalities, was not implemented. There was no way to track or document arriving patients that had been through the decontamination process in the field.

Recommendation: Follow the established hospital disaster plan. In addition, there should be a standardized format for patient tracking that is utilized throughout the county.

Status of Previous Findings

- **Previous Finding Number: VL02.5.1**

Title: Need for a Respiratory PPE Program

Discussion: A finding from 2000 regarding utilization of a Respiratory Personal Protection Equipment Program has partially been addressed. The hospital has contracted with an outside medical source to perform Pulmonary Fit Testing on employees. Routine annual medical surveillance examinations and surveillance screening records are not currently being kept as required by OSHA.

Reference: 29 CFR 1910.134

Recommendation: Include a physical examination to the already utilized Pulmonary Fit testing on all employees expected to perform duties in PPE. Records must be kept on file as per OSHA requirements.

Resolved: Partially Addressed. **New Finding Number – VL03.5.1**

Danville Decontamination

Personnel from the Danville Fire Department (DFD), Multiple EMS Agencies, Vermilion County Health Department, Law Enforcement, and the American Red Cross arrived at the Southview Middle School to establish a decontamination site. The objective was successfully demonstrated in out-of-sequence play. The Incident Command System was established upon arrival of the duty Battalion Chief and a Safety Officer was also established. A mass decontamination system was set up using an aerial ladder and master stream fog nozzle. This was to be used in case the decontamination lines were not operational when the victims arrived. A team from DFD started to set up two technical decontamination lines (ambulatory and non-ambulatory). Medical evaluation and dress out was started on the decon personnel utilizing support personnel "Angels". Technical decon was not established when the first victims arrived. There were fifteen victims with varying degrees of injuries and symptoms. The mass decon system was put into operation. Problems occurred in the mass decon area due to staffing of one

person to operate the system and manage the victims. It was recommended and agreed that this will be changed in the plan. As the last victim was finished in the mass decon, technical decon became operational. Victims were directed to the proper decon line. During the operation there was a back up at the ambulatory decon. Victims were directed to the non-ambulatory decon to facilitate the process. A non-ambulatory patient, in a wheelchair, was processed. Problems ensued due to the patient being decontaminated in a wheelchair. Patients in wheelchairs should be transferred on a backboard before being decontaminated.

After victims were decontaminated, the health department nurses performed triage. After vitals signs were taken, victims were categorized according to severity and then EMS provided the needed medical treatment. There was a breakdown; due to EMS taking victims before the health department nurses completed triage. All victims were treated appropriately. The demonstration was professional and successful. It should be noted this was the first time that these agencies were evaluated in a CSEPP exercise. The tagging system for decon was ineffective. It is recommended a banding type of system needs to be instituted. The attention to process detail was precise and procedure orientated.

Response Stream 6 – Evacuee Support

The ARC Representative in the Vermilion County EOC requested at 1030 that the reception center at Southview Middle School be opened. The Southview Middle School could accommodate 350 evacuees. The Vermilion County ARC could receive 300 cots in 30 minutes from the State of Illinois.

In an out-of-sequence demonstration the ARC demonstrated the capability to conduct a reception center and shelter operations for evacuees at the Southview Middle School in Danville. Staffing included: a Site Manager, five ARC volunteers, three Medical Assistants, the ARC State Lead, the ARC Emergency Coordinator and the ARC Emergency Management representative. Included in this staff were three full time and one part-time experienced-trained volunteers and a well-trained site manager. Procedures, facilities, and equipment for congregate care of nine evacuees were successfully demonstrated. The ARC medical assistants volunteered to participate in the decontamination demonstration occurring at the same location since there were only a limited number of evacuees at the shelter.

Response Stream 7 – Public Information

The EM Assistant Director notified the PIO that there was a CENL 3 incident at the NECD and to report to the EOC.

The PIO arrived at the EOC at 0919 and immediately began gathering facts and making phone calls about the event in order to put together an initial response and emergency information for the public. By 0936, the PIO completed a pre-scripted message that was reviewed by the EMD and then faxed to the media. At 0939, the EMD directed the PIO to prepare a news release to

provide the public with new information regarding the incident. This information was faxed at 0950.

During the briefing at 1005, the PIO reported that the media was advised of the event. By 1035, the local media arranged to interview the PIO.

At 1430, the PIO conducted a press briefing to report the status of the incident. During the briefing, the Fire Captain explained the details of the decontamination process to the media.

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SECTION 3. ACTION PLANS

ADDENDUM TO THE EXERCISE REPORT

This Section contains the action plans of the Newport Community jurisdictions for findings identified in Newport (IL) CSEPP EX 03 and/or the resolution of findings from Newport CSEPP 02:

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ACTION PLAN FOR THE STATE OF ILLINOIS (IL)
Newport Community (IL) CSEPP Exercise 2003
(July 23, 2003)

FINDING NUMBER	SHORT TITLE	RESPONSIBLE FOR CORRECTION	COMPLETION DATE
IL03.2.1	Incorrect PAR Information	SEOC Director and Dispatcher	21 April 04

CORRECTIVE ACTION/COMMENT:

The Newport Community has moved from use of EMIS to D2Puff for hazard analysis. Numerous training sessions and practice to ensure proficiency has occurred. Standardization and training for NECD and IEMA forms has been conducted.

Appropriate functional areas (check all that apply):

X	Training	___	Facilities	X	Plan(s)	___	Other
___	Equipment	___	Staffing	X	Procedures		

FINDING NUMBER	SHORT TITLE	RESPONSIBLE FOR CORRECTION	COMPLETION DATE
~~**IL02.3.1**~~ **CLOSED**	Initial Notification of Surety Event	IEMA communications dispatch	~~**June 15, 2002**~~ **CLOSED**

CORRECTIVE ACTION/COMMENT: A NANs procedure has been written in coordination with the off-post communities. The procedure addresses protocols for receiving information and asking questions. At each subsequent CAIRA exercise the depot and community will review the form, process and procedures for improvement.

Appropriate functional areas (check all that apply):

X	Training	___	Facilities	X	Plan(s)	___	Other
___	Equipment	___	Staffing	X	Procedures		

ACTION PLAN FOR THE STATE OF ILLINOIS (IL)
Newport Community (IL) CSEPP Exercise 2003
(July 23, 2003)

FINDING NUMBER	SHORT TITLE	RESPONSIBLE FOR CORRECTION	COMPLETION DATE
~~**IL02.7.1**~~ **CLOSED**	The JIS Was Not Effective	NECD CSEPP PAO and Jurisdictional PIOs	~~**September 30, 2002**~~ **CLOSED**

CORRECTIVE ACTION/COMMENT: Recommendation from JIC evaluators will be reviewed by the public affairs sub-group and action taken to improve the JIC operation to facilitate information sharing. In addition, the sub-group will ensure that the draft Newport CSEPP Community Emergency/Public Information Plan is finalized.

Appropriate functional areas (check all that apply):

X	Training	___	Facilities	X	Plan(s)	___	Other
___	Equipment	___	Staffing	X	Procedures		

ACTION PLAN FOR EDGAR COUNTY (ED)
NEWPORT COMMUNITY (IL) CSEPP EXERCISE 2003
(July 23, 2003)

FINDING NUMBER	SHORT TITLE	RESPONSIBLE FOR CORRECTION	COMPLETION DATE
ED03.2.1	Hazard Analysis Training	County Director with IEMA support	21 April 04

CORRECTIVE ACTION/COMMENT:

Hazard analysis training and practice to ensure proficiency on D2Puff plumes provided by IEMA has occurred. Additional training for NECD and IEMA forms has been conducted.

Appropriate functional areas (check all that apply):

X	Training	___	Facilities	___	Plan(s)	___	Other
___	Equipment	___	Staffing	X	Procedures		

FINDING NUMBER	SHORT TITLE	RESPONSIBLE FOR CORRECTION	COMPLETION DATE
~~**ED01C10.1**~~ ~~**ED02.4.1**~~ **ED03.4.1**	Antidote Kits Not Available to Responders	IDPH	21 April 04

CORRECTIVE ACTION/COMMENT:

IDPH has provided Mark I kits to PCH which are to be available for first responders. Mark I administration protocols were developed and available for EMS and hospital providers, but not utilized. Standardized procedures to indicate number of kits administered should be considered countywide for adoption (i.e. color coded wrist bands).

Appropriate functional areas (check all that apply):

X	Training	___	Facilities	X	Plan(s)	___	Other
X	Equipment	___	Staffing	X	Procedures		

FINDING NUMBER	SHORT TITLE	RESPONSIBLE FOR CORRECTION	COMPLETION DATE
ED03.5.1	Inadequate Hazardous Materials Staff	IDPH in coordination with PCH, PFD, & ED EM	21 April 04

CORRECTIVE ACTION/COMMENT:

An agreeable solution to supplement staff shortages for decontamination at PCH is being addressed. Then a Memorandum of Agreement will be signed and included in plans and procedures. Subsequent to the agreement adequate training and PPE should be provided.

Appropriate functional areas (check all that apply):

x	Training	___	Facilities	X	Plan(s)	___	Other
X	Equipment	___	Staffing	x	Procedures		

FINDING NUMBER	SHORT TITLE	RESPONSIBLE FOR CORRECTION	COMPLETION DATE
~~**ED00C012.1**~~ ~~**ED01C12.1**~~ ~~**ED02.5.1**~~ **ED03.5.2**	No Respiratory Screening Program/Mask Fit Test Procedures	IDPH in coordination with PCH staff	21 April 04

CORRECTIVE ACTION/COMMENT:

The requirement for an annual medical surveillance examination, pulmonary fit test for workers who wear respiratory protection, and maintaining surveillance screening records is a federal OSHA requirement. PCH and IDPH staff should be familiar with these and ensure these requirements are followed. This finding has remained open for numerous years.

Appropriate functional areas (check all that apply):

X	Training	___	Facilities	X	Plan(s)	___	Other
___	Equipment	___	Staffing	X	Procedures		

ACTION PLAN FOR VERMILION COUNTY (VL)
NEWPORT COMMUNITY (IL) CSEPP EXERCISE 2003
(July 23, 2003)

FINDING NUMBER	SHORT TITLE	RESPONSIBLE FOR CORRECTION	COMPLETION DATE
~~**VL00C012.1**~~ ~~**VL01C12.1**~~ ~~**VL02.5.1**~~ **VL03.5.1**	Need for Respiratory PPE Program	IDPH in coordination with PUSMC staff	21 April 04

CORRECTIVE ACTION/COMMENT:

Although pulmonary fit testing on employees has been accomplished through a contracted medical source, the requirements for an annual medical surveillance examination for workers who wear respiratory protection and surveillance screening records are not being accomplished. This is a federal OSHA requirement, which has still not been met. PUSMC and IDPH staff should be familiar with this and ensure these requirements are followed. This finding remains open.

Appropriate functional areas (check all that apply):

X	Training	___	Facilities	X	Plan(s)	___	Other
X	Equipment	___	Staffing	X	Procedures		

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APPENDIX 1: ACRONYMS AND ABBREVIATIONS

ADDENDUM TO THE EXERCISE REPORT

ACP.....	Access Control Point
ADP.....	Automated Data Processing
ALS.....	Advanced Life Support
AMC	Army Materiel Command
AOC	Army Operations Center
AR.....	Army Regulation
ARC	American Red Cross
ARES	Amateur Radio Emergency Service
AYE	Alternate Year Exercise
BLEVE.....	Boiling Liquid Expanding Vapor Explosion
BLS	Basic Life Support
CAI.....	Chemical Accident or Incident
CAICO	Chemical Accident or Incident Control Officer
CAIRA	Chemical Accident or Incident Response and Assistance
CCL.....	Contamination Control Line
CENL	Chemical Event Notification Level
CDT.....	Central Daylight Time
CFR.....	Code of Federal Regulations
CLA.....	Chemical Limited Area
CMA……..	Chemical Materials Agency
COSIN.....	Control Staff Instructions
CSEPP.....	Chemical Stockpile Emergency Preparedness Program
D2PCw.....	Computer Model for Chemical Hazard Dispersion
DA.....	Department of the Army
DNR	Department of Natural Resources (IN)
EAS.....	Emergency Alerting System
ECF	Entry Control Facility
ED	Emergency Department
EEI	Essential Elements of Information
EMA.....	Emergency Management Agency
EMIS.....	Emergency Management Information System
EMS	Emergency Medical Service
EMT	Emergency Medical Technician
ENDEX.....	End of Exercise
EOC.....	Emergency Operation(s) Center
EOD	Explosive Ordnance Disposal
EOP.....	Emergency Operations Plan
ERD.....	Emergency Response Director

ESDA	Emergency Services Disaster Agency
EST	Eastern Standard Time
ETA	Estimated Time of Arrival
ETO	Exercise and Training Officer
EXPLAN	Exercise Plan
FAA	Federal Aviation Administration
FAX	Facsimile
FCP	Field Command Post
FCPO	Field Command Post Officer
FD	Fire Department
FEMA	Federal Emergency Management Agency
FEMIS	Federal Emergency Management Information System
FME	Federally Managed Exercise
FY	Fiscal Year
GIS	Geographic Information System
HQDA	Army Headquarters
ICAM	Improved Chemical Agent Monitor
IDEM	Indiana Department of Environmental Management
IDLH	Immediately Dangerous to Life or Health
IDPH	Illinois Department of Public Health
IEMA	Illinois Emergency Management Agency
IL LNO	Illinois State Liaison Officers
IPT	Integrated Process Team
IRF	Initial Response Force
IRFX	Initial Response Force Exercise
IRZ	Immediate Response Zone
JIC	Joint Information Center
JIS	Joint Information System
kW	Kilowatt
LEPC	Local Emergency Planning Committee
MACOM	Major Command
MCE	Maximum Credible Event
MCP	Mobile Command Post
MEDDAC	Medical Department Activity
MEOC	Mobile Emergency Operations Center
MHz	Megahertz
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding

MPDS.....	Mobile Personnel Decontamination Station
MSC	Major Subordinate Command
NANS.....	Newport Alert and Notification System
NAWAS.....	National Warning System
NECD.....	Newport Chemical Depot
NECDF	Newport Chemical Demilitarization Facility
NOK.....	Next-of-Kin
NTSB	National Transportation Safety Board
NWS.....	National Weather Service
O2.....	Oxygen
OC.....	Operations Center
OPCW.....	Organization for the Prohibition of Chemical Weapons
OSC.....	On-Scene Coordinator
OSHA.....	U.S. Occupational Safety and Health Administration
PAC.....	Type of status board kit used in Vermilion County (IL)
PAD.....	Protective Action Decision
PAM.....	Pamphlet
PAO.....	Public Affairs Office(r)
PAPR.....	Powered Air Purifying Respirators
PAR.....	Protective Action Recommendation
PASA	Protective Action Sub-Area
PAZ.....	Protective Action Zone
PBX.....	Type of telephone switching system
PCE	Personnel Clothing and Equipment
PCEMA.....	Parke County Emergency Management Agency
PDS	Personnel Decontamination Station
PIO	Public Information Office(r)
PMCD	Program Manager for Chemical Demilitarization
POR.....	Points of Review
PSI.....	Electric generating station located north of NECD
PPE.....	Personal Protective Equipment
RACES.....	Radio Amateur Civil Emergency Service
RTAP	Real Time Analytical Platform
RTM.....	Response Team Manager
SCBA	Self Contained Breathing Apparatus
SEMA	State Emergency Management Agency
SEOC	State Emergency Operations Center
SFCP	State (Illinois) Forward Command Post
SIMCELL	Simulation Cell
SIP.....	Shelter-in-Place
SOP	Standing Operating Procedure(s)

SRF	Service Response Force
SSCC.....	Site Security Command Center
STARTEX.....	Start of Exercise
SUN E450	Type of computer
TAP	Toxicological Agent Protection
TAR.....	Tone Alert Radio
TC	Ton Container
TCP	Traffic Control Point
TracSys	Emergency Tasking and Response Tracking System software
TVA	Tennessee Valley Authority
TWA	Time Weighted Average
UHF.....	Ultra High Frequency
USA.....	United States Army
USAF	United States Air Force
VA.....	Veteran's Administration
VCR	Video Cassette Recorder
VHF.....	Very High Frequency
VTC.....	Video Teleconference
VX.....	Type of nerve agent
WAN	Wide Area Network

NEWPORT COMMUNITY TWO-LETTER IDENTIFIER CODES:

NE	Newport Chemical Depot	PK	Parke County
NJ	Newport Community	VR	Vermillion (IN)
IN	State of Indiana	ED	Edgar County
FO	Fountain County	NI	Newport Community JIC

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