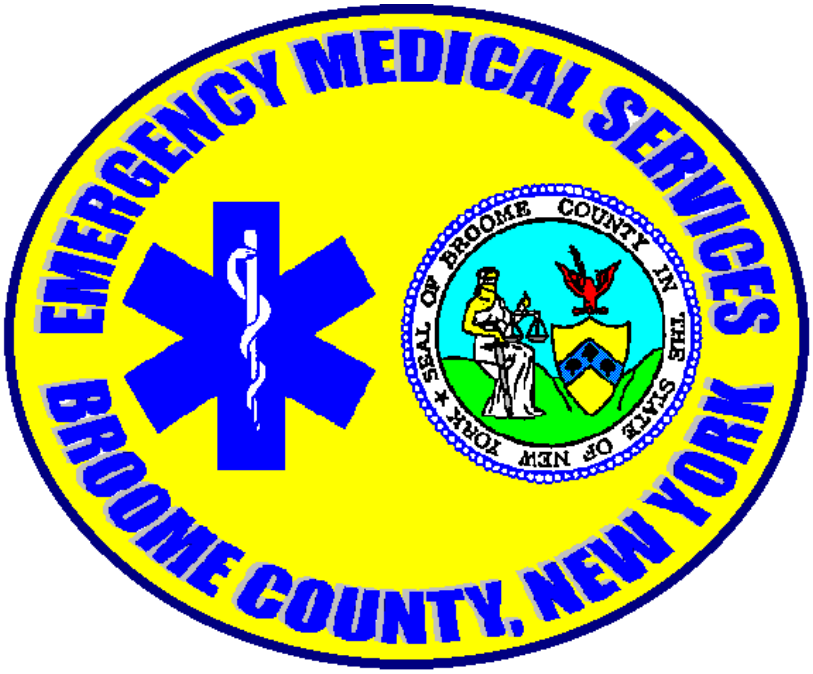
BROOME COUNTY EMERGENCY MEDICAL SERVICES SYSTEM



HAZARDOUS MATERIALS INCIDENT RESPONSE PLAN

Revised: December 2008

I. Introduction

Hazardous materials in Broome County are found both at fixed facilities, and in transit. Incidents resulting in the uncontrolled release of such hazardous materials may occur in any place, at any time, and all emergency responders must be prepared to act appropriately to prevent death and injury to persons, and to minimize loss of and damage to property.

II. Purpose

The purpose of this plan is the coordination of on-scene emergency medical care, transportation, and hospital treatment for victims of a hazardous materials emergency in Broome County.

III. The Incident Command System

The Plan presupposes the use of the Incident Command System (ICS), and specifically of the Susquehanna Regional Medical Incident Management Protocol (see attached), for the management of all personnel and other resources responding in conjunction with a hazardous materials emergency.

IV. Anticipated Scenario

A release of a hazardous material into the environment creates the potential for multiple casualties. Emergency medical assistance will be needed to provide care to employees of the facility using or of the shipper hauling the substance, emergency responders to the incident, and members of the affected public.

The hazard analysis of Broome County has identified certain vulnerable zones surrounding fixed facilities that have extremely hazardous substances in use and storage. In addition, all road, rail, and pipeline corridors in the County have been identified as likely sites of hazardous materials releases. All Emergency Medical Services agencies with such target hazards within or adjacent to their response districts must be prepared to respond to such incidents.

V. Roles and Responsibilities

Emergency Medical Services are provided by local ambulance and EMS first response agencies, as well as by area hospitals. The role of county government is the coordination of medical resources responding or otherwise mobilized in conjunction with hazardous materials emergencies.

VI. Participating Agencies

1. Ambulance Services
2. EMS First Response Teams
3. Local Hospitals
4. Broome County Health Department
5. Other County Agencies
6. Other Municipal Governments
7. Broome County Office of Emergency Services
   - A) Communications
   - B) Disaster Preparedness
   - C) EMS Coordinator
   - D) Fire Coordinator
   - E) Hazardous Materials Response Team

VII. Response Levels

Three levels of response have been identified for the purpose of categorization of the incident, and initiation of appropriate and proportionate response. It should also be understood that the level of response to an incident may be re-categorized at any time, as dictated by newly-emerging information or changing conditions. The response levels are summarized in the following table:

Response Level	Description	Response	Actions
I.	A minor incident, limited in scope, involving hazardous substances. It does not require evacuation of other than the immediately-involved structure or immediate outdoor area, and can be handled by local emergency responders and resources	• First-due local ambulance and EMS first response agency (if any) respond to the scene.	• Most senior/experienced EMS provider reports to Command Post and establishes Medical Sector.
		• County EMS Coordinator Staff is notified	• Receives information about nature/location of incident from Dispatch Center.
II.	An incident involving hazardous substances, which is beyond the capabilities of local responders, and which therefore requires the response of an appropriately organized Hazardous Materials Response Team, including specially trained and equipped EMS providers. Evacuation beyond the immediate release area is contemplated, or is being carried out.	• All Level I EMS response agencies.	• Same as Level I Response
		• Nearest Available ALS unit (if not included in Level I). •	• Reports to designated resource staging area.
		• EMS members of Broome County Hazardous Materials Response Team	• Reports to scene, or to designated resource staging area, as directed.
		• County EMS Coordinator Staff to the scene.	• Reports to Command Post, assist in implementing Medical Incident Management Protocol
		• Local hospital emergency departments are notified.	• Initiate internal emergency plans, and prepare to receive exposed victims
		• Additional EMS resources as requested by Incident Command	• Report to designated resource staging area.
III.	An incident in which it is readily apparent that a large-scale, life-threatening event requiring a large-scale evacuation. Use of extensive resources from state, federal, or private sector sources are likely.	• All Level I and II agencies.	• Same as Level I and II Responses.
		• Additional EMS resources as requested by Incident Command Post.	• Report to designated resource staging area.

SUSQUEHANNA REGIONAL EMS COUNCIL – REGIONAL MEDICAL ADVISORY COMMITTEE
MEDICAL INCIDENT MANAGEMENT PROTOCOL

I) **Policy:** Emergency Medical Services providers operating in this region will utilize the *National Incident Management System*, in conjunction with *Incident Command System* principles, and will function within a unified command structure. This required medical protocol will be implemented in concert with all other public safety agencies who will establish and function within a Command Post when:

a) There are two or more patients involved in an EMS ambulance call/response or incident.
b) The potential for multiple patients is likely to exist (e.g. stand-bys at Fire/Rescue/HAZMAT scenes, firefighter rehab operations, high risk law enforcement operations, public events/gatherings, motor vehicle crashes, complex rescues, searches, etc.)

Consider Protocol Use for Single Critical Patients:
EMS Providers are strongly encouraged to use parts of this Protocol to better manage a single "serious" or "critical" patient situation. For example, having the "in-charge" EMS provider wear the "Medical Branch Director vest" or by establishing an on scene Command Post, you may improve care through better coordination of on-scene resources.

* Once a Command Post has been established and the location broadcast to all inbound and on-scene responders, size up and resource requests will **then** originate from the Command Post. The Command Post radio designation will be named after the Incident/Command Post **location** (i.e. "Route 207…Command Post").

The "In-Charge EMS Provider" will don the "**Medical Command**" vest and is the Medical/EMS representative at the Command Post and will be responsible to ensure that:

a) The Command Post recognizes that certain medical decisions are dictated in regulation and New York State law and require a New York State DOH CFR, EMT or Advanced EMT certification to practice. Often, the Certified First Responder or Emergency Medical Technician will need to communicate directly with the destination hospital(s) and the Command Physician(s) for consultation and physician medical direction relative to on-scene medical operations, patient clinical care decisions, and for physician orders (e.g. medications, fly/no-fly clinical decision making, patient extrication and treatment priorities, communication of both routine and critical clinical patient information to hospital Command Physicians, the need for specific additional EMS resources that might include ALS, MedEvac helicopter(s), number of patients that can safely be placed in any one ambulance based on patient clinical care needs and intensity of medical care resources required, etc.)
b) The "In-Charge EMS Provider" at the Command Post will either become a component of the Unified ICS or will become "Medical Branch Director" within the operations sector.

Triage tags will be applied to all patients triaged at the scene and transported under this Protocol.

II) **Rationale:** Early Implementation and utilization of the Incident Command System (ICS), specifically the "MEDICAL BRANCH", improves a patient's chances for recovery and survival through the establishment of a well-organized, clearly defined unified incident management structure that insures timely and optimal clinical care decision making and utilization of emergency resources. Early, patient-specific clinical notification to hospitals Emergency Department Physicians/Charge Nurse by certified EMS providers will optimize the hospitals opportunity to prepare for each inbound patient. The goal is to minimize out-of-hospital time while optimizing pre-hospital care and hospital

preparedness.

III) **Authority:** This protocol is REMAC approved and shall be considered a **physician order**, and will be followed by all EMS providers and agencies operating within this three county region. Each implementation of this protocol will be reviewed at a minimum by the primary EMS agency leaders, as part of the EMS agency Quality Management Program. Appropriate written records of these reviews along with general opportunities for development/ improvement and training, will be shared with the agency and REMAC.

IV) **Procedure:** Upon arrival of the "First-due" EMS Unit, the EMS provider "in charge" will report to or establish an incident command post (if not already established) and implement this protocol by establishing a unified Command Post or the "Medical Branch" as soon as it is determined that this protocol applies. This EMS provider shall assume the radio designation of "_____ Command Post or "Medical Branch Director" (an orderly transition of Medical
Location
Branch Leadership may occur as additional EMS units, agencies, leadership, and/or personnel arrive).

Protocol: "First Due EMS Unit":

a) The "first-due EMS unit" due to arrive on-scene will utilize all available information (e.g. dispatch, law enforcement, bystanders, etc.) to request the "Stand-by" or RESPONSE OF ADDITIONAL SPECIFIC EMS RESOURCES at the earliest indication of need (e.g. helicopter stand-by or launch, additional EMS personnel, ambulances, ALS response, fire/rescue, EMS Coordinator, agency management/ leadership, law enforcement, dive team, search and rescue, etc.). If a Command Post has already been established, the "first due" EMS unit will request these resources through the Command Post.

b) Assure or establish scene safety in conjunction with the on-scene command post (Fire and/or Law Command Post Leaders) (reassessment of scene safety should be an ongoing effort by all public safety personnel and leaders). If the Command Post does not communicate "Scene Safe" to all responders then a good deal of duplication of scene safety surveys may occur.

c) As the First-Due EMS unit arrives, broadcast a size-up if no command post has been established to include what you can see or what you are told (e.g. number of vehicles, actual or potential hazards, number of possible patients visible, description of structure or scene, nature/severity of injuries, etc.) Establish a Command Post if one does not exist.

Establishing a Command Post:

"_____ Command Post is established".
Command Post will be
(Geographic incident location)
operating on _____ radio channel.

State: Incident Operations will be operating on radio channel _____ . (if different)
Medical Operations will be on radio channel _____. (if different)
You may request the Communications Center to do this for you assuring notification to all on-scene and responding units.)

d) EMS/Medical Leader at Command Post or "MEDICAL BRANCH DIRECTOR" will don the "MEDICAL COMMAND" vest. Other Command Post leaders will don the appropriate ICS vest.

e) **<u>First In Report</u>:** Following an immediate medical scene survey, the Medical Branch Director will cause through the Command Post or, if no Command Post is yet established, broadcast a first-in medical report to be relayed (re-broadcast by 911 Center) to all on-scene and responding units that includes: **(BROADCAST LIFE SAFETY HAZARDS FIRST!)**

1. Scene Safety Issues/Cautions/Directions
2. Life Safety Hazards: HazMat? Weather?
3. Number of Patients and Severity (Red, Yellow, Green, Black) *If there are two or more red patients, the County 911 Center will dispatch EMS Agency leadership and a County EMS Coordinator per their own County Protocol (if available)
4. Staging Area Location (if needed)
5. Number Trapped/Type of Rescue Needed
6. Best Access (Road Blocked?)
7. Orders for additional units/personnel
8. Cause(s) of Injuries/Illnesses (if known)
9. Directs 911 Center to notify "all" or "specific" hospital(s) of incident location, nature, <u>medical</u> details.

f) **<u>Requesting Resources</u>:** Request through the Command Post the Response of Additional Resources **(examples of such might include the following):**

Medical	Other
Additional Ambulances and EMS Personnel (plan on at least one ALS ambulance for every red patient).	Fire/Rescue units and personnel
ALS Rapid Response Vehicles and Medics	Law Enforcement
Aero MedEvac Units/MedEvac Helicopters	Specialty Terrain Vehicles (boats, snowmobiles, URV's, ATV's, etc.)
EMS Agency Leadership/Management	Air boats or military assets (National Guard, etc.)
County EMS Coordinator Staff County 911 Field Operations "Command Post" type vehicles (staffed?)	Specially trained/technical response teams (HAZMAT, Dive, SAR, High Angle/Low Angle Rescue)
Additional medical supplies/assets for prolonged operations. Special needs?	
Consider the need for County and State Health Department resources	
Consider the need for Critical Incident Stress Support Personnel	
IMAT (Incident Management Assistance Team (if available)	

In Broome County, you might consider requesting the following:

a. CV-1, HAZMAT-1, the Dive Team, the Broome County Medical Support Trailer, etc.

In Chenango County, you might consider requesting the following:

a. Dr. Masarech (Chenango County to add to their list)

In Tioga County, you might consider requesting the following:

a. The 911 Communications Trailer (Tioga County to add to their list)

NOTE:
EMS PROVIDERS OR EMS AGENCY OFFICIALS WILL NOT <u>CANCEL</u> OR <u>DIVERT</u> RESOURCES IF NOT ON THE SCENE OF THE INCIDENT.

g) **<u>Hospital Contact</u>:** Medical Branch Director or designee will establish and maintain early and frequent contact with destination hospitals. Develop a specific single contact at each hospital (Command Physician or Charge RN) in order to maintain consistency and accuracy of information

1. Consider continuous, open-line of communication with hospital(s) if possible. You may have to go through the 911 Center.
2. Provide Hospital Medical Command Physician with event details, number of suspected patients, nature of injuries/illness, contamination, special needs, etc.
3. Ascertain Emergency Department capacity for each hospital (# red, # yellow, # green they can/will accept). (i.e.("We have ___ red, ___ yellow, ___ green, and ___ black patients on scene at _____and given the scope of this incident, how many ___ red, ___ yellow, green patients will you accept? Our likely ETA(s) will be _____."
4. Provide updates as they become available.
5. Consider appointment of a dedicated "Hospital Communications" EMS provider to maintain contact with hospitals and provide updates as the situation progresses.
6. Consider notification to out of area hospitals for larger incidents (Consult with EMS Coordinator Staff to assist you).
7. Consider direct helicopter MedEvac of major burn injuries in an MCI situation directly to regional burn center. Consult with Medical Command Physician at trauma center.

h) **<u>Leadership Positions within Medical Branch</u>:** Working and communicating effectively within the Unified Incident Command Post Structure, assign additional EMS responders to appropriate roles and establish EMS organizational units as necessary.

1. Medical Branch Director (consider "Medical Communications Coordinator")
2. Triage Unit/Triage Unit Leader
3. Treatment Unit/Treatment Unit Leader
4. Medical/Ambulance Transportation Unit/Transportation Unit Leader
5. Medical Supply Coordinator
6. Medical Group Supervisor (if needed) (What's he do?)
7. IMAT (Incident Management Assistance Team)
8. County EMS Coordinator Roles: County EMS Coordinators will support the "Medical Branch Director" and Command Post as directed. They may perform the following functions as assigned:
    i. Vest Command Post or Leadership Staff
    ii. Poll hospitals for capacity and/or establish regular or continuous communications with hospitals
    iii. Record incident /command post data for command post
    iv. Issue radios or assist with medical communication functions
    v. Support/Consultant to Medical Branch Director
    vi. Arrange for Physician response to scene.
    vii. Other duties as assigned by Medical Branch Director or Command post (within scope of practice)

V) Definition of Terms:

Term	Definition
Event	Any planned, non-emergency activity for which Medical Incident Management/NIMS will be utilized (e.g. parades, concerts, sporting events, etc.)
Emergency	Any unplanned occurrence, natural or human-caused, that requires an emergency response to protect life or property.
Incident	An occurrence or event, natural or human-caused that requires an emergency

	response to protect life or property. Incidents can include major disasters, emergencies, terrorist attacks, terrorist threats, wild land and urban fires, floods, hazardous materials spills, nuclear accidents, aircraft accidents, earthquakes, hurricanes, tornadoes, public health and medical emergencies, and other occurrences requiring and emergency response.
Major Disaster	As defined under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5122), a major disaster is any natural catastrophe (including any hurricane, water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought) or, regardless of cause, any fire, flood or explosion in which any part of the United States, which in the determination of the President, causes damage of sufficient severity and magnitude to warrant major disaster assistance under this Act to supplement the efforts and available resources of States, tribes, local governments, and disaster relief organizations in alleviating the damage, loss, hardship or suffering caused thereby.