

# **EXERCISE POPEYE**



**POPEYE**

After Action Report

March 14, 2000

# EXERCISE POPEYE AFTER ACTION REPORT

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## Introduction

On October 2, 1999, the Preparedness Observation Planning Emergency Exercise, known as POPEYE, was conducted in Highland, Indiana. The exercise was a cooperative effort between the State of Indiana; Lake County, Indiana; Lake County Local Emergency Planning Committee; DOE Transportation Emergency Preparedness Program; the DOE Chicago Operations Office; the DOE Radiological Assistance Program; DOE Richland HAMMER; the Oak Ridge Institute for Science and Education (ORISE); and private industry. Other participants included representatives from the U.S. Environmental Protection Agency (EPA) and Congressional Staffs. The exercise demonstrated an integrated response to a transportation accident involving radioactive materials.

## Purpose

POPEYE provided an opportunity for local, state, federal, and industry emergency response organizations to coordinate response and recovery actions related to a transportation accident involving radioactive materials. Through coordination and conduct of activities, organizations identified strengths and weaknesses in emergency plans, procedures, training, and resources.

Specifically, POPEYE tested the following:

- ! The unified incident command system with local, state, federal, and private industry organizations and assets
- ! The Lake County Emergency Management Plan, primarily Annex N, *Radiological Protection* (including industrial responders).
- ! The Lake County emergency response structure
- ! The DOE Transportation Emergency Preparedness Program (TEPP)
- ! DOE TEPP and Lake County Local Emergency Planning Committee Radiological Emergency Response Training.
- ! Community Alert and Notification (C.A.N.) System

## Scope

POPEYE participants represented public agencies, private industry, as well as local, state, and federal government. The exercise scope permitted each entity to take part at one of three levels of participation (full, partial, or simulated) [Table 1: Organizations' Participation in POPEYE]. The exercise covered the initial notification, the unified incident command system, the coordination of radiological response efforts, and the development of a recovery plan. Due to safety concerns, the initiating events were simulated and the event scene was staged.

A recovery tabletop was conducted at the Highland, Indiana Fire Station #1 immediately following the response portion of the exercise. The scope of the tabletop was for organizations represented by local, state and federal representatives to develop a recovery plan that provided for the turn over of incident command to the EPA along with the consideration for health, safety, and the environment in the post-emergency phase.

The following table defines the participating organizations and their level of participation

**Table I - Organizations Participation in POPEYE**

<b>ORGANIZATION</b>	<b>LEVEL OF PARTICIPATION</b>
<b>TOWN OF HIGHLAND</b>	
Fire Department/Emergency Management	Full
Police Department	Full
Dispatch Center	Full
Public Works	Partial
Town Council President	Simulated
<b>TOWN OF GRIFFITH</b>	
Fire Department	Partial
<b>TOWN OF DYER</b>	
Fire Department	Partial
<b>LAKE COUNTY</b>	
Lake County Emergency Management	Full
Lake County Sheriff's Department	Full
Lake County Sheriff's Police	One Team
Lake County Sheriff's Helicopter	Full
Lake County Coroner Office	Full
Red Cross	Full
Methodist Hospital – North Lake	Limited to Emergency Room and dispatch
Saint Margaret Hospital – North	Limited to Emergency Room and dispatch
Saint Margaret Hospital – South	Limited to Emergency Room and dispatch
CO-Med Ambulance Service	Full
Lake County Fire Chiefs Association	Full
Fire Chief Association HAZMAT Team	Full
County Commissioners and County Council Members	Simulated
<b>STATE OF INDIANA</b>	
Department of Emergency Management	Full
Department of Health	Full
Department of Health Radiological Response Team	Full
Department of Environmental Management	Full
Department of Natural Resources	Full
State Area Radiation Emergency Committee	Simulated
EOC Duty Officer	Full
<b>U.S. DEPARTMENT OF ENERGY</b>	
DOE Headquarters Watch Office	Notification only, not evaluated
DOE Headquarters EM Action Officer	Full
DOE Chicago Ops Office EOC Duty Officer	Simulated
DOE Chicago Ops Office EOC	Simulated
DOE Chicago RAP Team	Full
REAC/TS	Representative via telephone; not evaluated
<b>U. S. ENVIRONMENTAL PROTECTION AGENCY</b>	
EPA	Notification and cleanup planning
<b>MOBILE COMMAND POST AND RESPONSE TEAM</b>	
NRC	Notifications only
<b>PRIVATE INDUSTRY</b>	
Northern Indiana Public Service Company	Partial – Notification, Dispatch, and Radiological Monitoring Team
U.S. Steel – Gary Works	Partial – Notification, Dispatch, and Radiological Monitoring Team
Ispat Island	Partial – Notification, Dispatch, and Radiological Monitoring Team
BP Amoco	Partial – Notification, Dispatch, and Radiological
B & J Cartage Company (simulated)	Partial – Truck, driver, notification point

## Exercise Scenario

A delivery truck operated by the B & J Cartage Company stopped to deliver a shipment to the Cracker Barrel Old Country Store (Cracker Barrel) on Kennedy Avenue near I-80/94 in Highland, Indiana. While unloading the shipment from the rear of the vehicle, the driver was approached by three (3) individuals who demanded the keys to the vehicle and told the driver that they were stealing his vehicle. After giving the keys to the perpetrator, the driver, who feared for his safety, escaped to the front of the building to get help. After advising a Cracker Barrel employee at the front counter of this incident, the driver called 911 to report the theft of his vehicle. In the meantime, the perpetrator had pulled down the vehicle's rear door, exited the Cracker Barrel parking lot and proceeded south on Kennedy Avenue.

The information from the driver's report of the vehicle theft was provided to the Lake County Sheriff's Department and the Highland Police Department. An alert was issued to all units in the vicinity and the nearest Highland Police vehicle was dispatched to the Cracker Barrel to investigate. While traveling north on Kennedy en route to conduct the initial investigation, the Highland Police Officer observed the hijacked truck traveling south at a high rate of speed. The officer turned around to initiate pursuit. The stolen vehicle continued south on Kennedy Avenue until it reached the LaPorte Street intersection where the driver of the vehicle made a right turn onto LaPorte Street which dead-ends approximately three hundred (300) yards from the intersection. Due to his unfamiliarity with the road, the driver did not realize that this street ended in a city park and was not a through street. The truck continued westward on the bike path in the park.

As the truck careened down the bike path, one of the perpetrators opened the rear door and began throwing packages at the pursuing police vehicle. Some of the packages (containing simulated radioactive and hazardous materials) bounced off the vehicle and street and landed in the wetland area to the south of the path. Some of the packages were simulated to burst open and discharge their contents about the scene. The truck then struck a bicyclist on the bike path and immediately afterward crashed into a metal stanchion supporting high-tension power lines. The truck crash was immediately west of the NIPSCO Sub Station. As a result of the impact with the stanchion, the truck tipped over on its side. The driver of the vehicle was fatally injured; one person was trapped and unconscious in the wrecked truck and required extrication. The bandit, who was throwing boxes at the police car, fled the scene on foot.

Additional security assets from the Highland Police Department and Lake County Sheriff's Department were requested. Upon arrival, one responding Highland Police Officer assisted the injured bicyclist and other officers pursued the fleeing perpetrator.

The Highland Fire Department arrived at the scene and a unified incident command was established. Mutual aid was requested from surrounding fire departments and county, state, and private industry radiological monitoring teams.

Lake County activated and staffed the county EOC. The State Emergency Management Agency was notified and participated in the exercise. The National Response Center, U. S. Department of Energy, and Environmental Protection Agency were notified. The State requested RAP support from DOE, as well as radiological monitoring support from local private industries.

Lake County Sheriffs deputies and Highland Police captured the escaping perpetrator, but one officer was critically injured with a stab wound in subduing the escapee. This officer was evacuated by helicopter with the perpetrator to a nearby hospital.

Local hospitals were notified that contaminated and contaminated injured were at the scene and would be transported for treatment. CO-Med and the Sheriff's helicopter were used for transport.

Private industry, county, state, and Federal radiological monitoring teams arrived at the staging area. These teams were deployed to identify the contaminated footprint and to establish a decontamination center.

Field monitoring and assessment was conducted by DOE RAP and information was provided to the Incident Commander regarding radiological contamination at the scene. The Incident Commander, State of Indiana and EPA began discussions and planning on clean up and recovery of the site. Incident command was transferred from the Highland Fire Chief to the EPA.

## **Exercise Planning**

During the spring of 1999, David Crose, Indiana Emergency Management Agency, recommended to the DOE to conduct a joint transportation emergency preparedness exercise with the Lake County, Indiana Local Emergency Planning Committee (LEPC) as the lead. The DOE Office of Transportation and Emergency Management and the Indiana Emergency Management Agency were the co-sponsors of the exercise, with strong support provided by both. Exercise planning and design meetings were held with representatives of the various local, county, state and federal agency representatives as planning partners. HAMMER provided the initial planning support and ORISE Emergency Management Laboratory provided the majority of the exercise support before, during and after the exercise. Strong interest in the exercise was shown by Representative Peter J. Visclosky (1st-IN) during a briefing by William Timmer (LEPC), Dale Dietzel (DOE CH) and Dean Larson (LEPC). The Congressman further demonstrated his interest by attending the exercise. Attachment A lists the persons involved in the planning, design, development and conduct of POPEYE. Attachment B outlines the details of the POPEYE Exercise Management Plan.

## **Exercise Lessons Learned**

### **Coordination**

- ! The "face time" provided by regular, twice monthly meetings of the Senior Planning Group was invaluable to the exercise conduct and the overall readiness of the response assets. It is believed that the effect of the interaction of these three response teams will last for an extended period.
- ! The use of E-mail aided in the exchange of information and overall coordination.
- ! Asking each organization to submit objectives was a useful way to encourage planning and solicit buy-in. This initiative could have been more useful if the objectives would have been converted to actual exercise evaluation criteria by each of the organizations.
- ! Job titles are not required (these were made up after the exercise for the purpose of the After Action Report).
- ! Schedule group exercise planning meetings prior to LEPC exercise planning meetings. The group planning meetings are useful in identifying exercise issues and priorities that can be addressed in the LEPC exercise planning meetings.

## Control

- ! Local management of a major exercise did work. If local leadership is going to be used, the DOE support representative, should be a DOE manager from the appropriate operations office.
- ! Implement changes based on decisions reached by the DOE representative and the planning group. Although the group agreed to keep the controller and the evaluator roles separate and distinct, the exercise support materials, which were distributed the night before the exercise, presented the roles as being “combined”. This created confusion and generated negative comments because 65 people had been assigned a specific role (controller or evaluator) then given materials that combined the two roles.
- ! The Exercise Management Plan, initially provided by HAMMER, proved to be an invaluable exercise management tool. Information was centralized in one place.
- ! No detail is too small to be managed during the exercise planning process.

## Resources

- ! The assignment of controllers and evaluators should incorporate resumes to match people to functional areas. Training for controllers and evaluators is very important.
- ! Limiting the number of contractors to one should enhance future exercise planning.
- ! The Exercise Objectives Course should be made available on the TEPP website.
- ! The Exercise Evaluation Criteria, made available on the TEPP website, proved to be very user friendly.
- ! Evaluator and controller considerations for the future should include closely looking at span of control and issuing radios to all.
- ! Provisions should be in place for feeding exercise participants (i.e., controller’s, evaluators, observers and players).
- ! Safety professionals should be used to ensure exercise safety.

## Training

Beginning in 1998, two courses were offered by the Lake County LEPC (*Radiation Emergency Response Train-the-Trainer* and *Radiation Emergency Response - Operations Level*) to the Lake County radiological response assets. Prior to the exercise, the DOE TEPP Modular Emergency Response Radiological Transportation Training (MERRTT) was provided to responders. Controller and evaluator training was provided. Controller training reviewed the Master Scenario Events List (MSEL) and exercise injects. Evaluator training covered the evaluation criteria and the process of evaluation. Prior to the exercise, the controllers and evaluators were briefed on the exercise scenario and objectives. A safety briefing and briefings for actors and responders were conducted to ensure all participants understood the safety and scope of the exercise.

Lake County EMA, Town of Highland and SEMA/IDEM (in Indianapolis) set up learning centers using MERRIT material. The learning centers provided responders another option for learning or refresher learning.

## **Exercise Conduct**

### **Simulations**

POPEYE incorporated several simulations to add realism and to initiate action by responders. Simulations included, an overturned truck (the stolen transport truck), smoke flares (fire and smoke), radiological packaging and releases, moulage (injuries), contamination injects (radiological contamination of ground, personnel, etc.), mock media, and a rescue dummy (dead perpetrator). The response time for the Lake County Radiological Response Assets (industrial responders), the State team and the DOE Radiological Assistance Program (RAP) was compressed by pre-staging the three teams at the Highland Central Fire Station. The actions of the shipping company, B&J Cartage, Inc., were simulated. Shippers that are normally used by DOE were reluctant to participate.

### **Control Organization and Process**

The control organization provided inject messages at designated times for various functions within the scope and parameters of the exercise. Additionally, the control organization maintained safety of the responders within the scope and parameters of the exercise. The controllers also timed the response as needed to allow responders to meet some exercises objectives. Controllers were stationed strategically at the exercise staging location (fire hall) event scene, the incident command post, the incident staging area, and medical transport and hospitals. A lead radiological controller remained at the immediate incident scene and handed out controller messages to anyone who responded to the immediate incident scene. This worked well and should be used in the future.

### **Evaluator Organization and Process**

The Evaluator Organization was responsible for evaluating the performance of emergency responders for each functional element of the response. Each evaluator used an evaluation checklist, which allowed them to determine if a task had been performed and exercise objectives met. Evaluators were stationed strategically at the event scene, the incident command post, the incident staging area, and medical transport and hospitals.

## **Exercise Functional Breakdown**

### **1. Event initiation**

Participating organizations were pre-staged at the Highland Fire Station No. 1, approximately one-half mile from the event scene. The event was initiated at 0807 by Highland Dispatch notifying all frequencies of a theft of a truck from a local restaurant. Highland Police Department dispatched officers to the scene who notified dispatcher in route of a southbound pursuit of a vehicle on Kennedy Avenue. The officer notified dispatch of hitting a bike rider while pursuing perpetrator on a bicycle path and of a fire in a wetlands area just off the bike path.



*Police Approaches Down Bicyclist*

### ***Strengths***

- ! The event initiation went well from the perspective of response organizations being put into play in a timely manner.

### ***Weaknesses***

- ! Because law enforcement took custody of the perpetrator so quickly, the follow-up medical and radiological response actions were not demonstrated as expected. This weakness indicates concerns in the area of exercise control. A controller should have been used to slow down the law enforcement response.

## **2. Initial law enforcement response**

When the Highland Police and County Sheriffs deputies arrived at the scene at 0814, they saw an overturned truck with a perpetrator close by.



*Overturned Stolen Truck*

The police officers and sheriffs deputies captured the perpetrator on foot and took him into custody. During this time, police and sheriff deputies walked through contaminated areas without apparent concern. At 0817 the Sheriffs deputies departed the scene while the police officers remained at the scene with the perpetrator.

As the Highland Fire Department arrived at the scene, Highland Police coordinated with Fire and requested Lake County HAZMAT Team.



*Police Coordinating with Fire Department*

At 0834 Police reported to the incident command post and requested that county EPA and EMA report to the scene. Police requested additional Sheriffs response at 0845. At 0830 the IC requested the Lake County Sheriffs Department Helicopter. The helicopter landed at the site at 0836 and departed to the hospital with the perpetrator and injured police officer at 0842. Sheriffs Deputies and police were told to go through decontamination at 0900.



*Contaminated Police Officer Is Escorted to Decon Area*

### ***Strengths***

- ! Adequate staff and resources were available for the exercise.
- ! Lake County Sheriff staff reported to the IC upon arriving on-scene.
- ! The Sheriffs department helicopter responded and departed from the scene with the perpetrator and police officer in a very timely manner.

### ***Weaknesses***

- ! No protective zone was established around injured/contaminated individuals and police seemed unaware of hazardous material procedures.
- ! No steps were taken to limit contamination of personnel, vehicles or site through access control.
- ! No protective measures were taken for police personnel nor did police seem to know that the injured required protective measures.
- ! Lake County Sheriff's Police would benefit from awareness level HAZMAT training.

### **3. Notification**

At 0807 Highland Dispatch began notifications to local law enforcement, fire and medical response. The dispatch also notified Lake County and Cedar Lake HAZMAT, County EPA and EMA, then SEMA/IDH. Additionally, Griffith and Dyer fire departments were notified of the event at 0836 and dispatched at 0842. At 0853 the IC recommended that SEMA activate the Radiological Response Plan and specifically asked for industry radiological support (ISPAT/Inland, US Steel and BP Amoco) to the event. At 0858, the industry teams were dispatched from the Highland Fire Department to the incident scene. SEMA notified the DOE Radiological Assistance Program (RAP) and industry response at 0858. Industry response was dispatched at 0905. RAP notified DOE Headquarters about the request immediately afterward and RAP was dispatched at 0910. The Indiana Department of Health/Radiological Response Team was notified at 0950. The IC requested dispatcher to notify Red Cross at 0908.

#### ***Strengths***

- ! Though all organizations were pre-staged at a local fire hall, all notifications resulted in timely response of participating organizations to the site.

#### ***Weaknesses***

- ! There were no apparent weaknesses in the notifications for this exercise. All notifications occurred per the emergency plan.

### **4. Staging**

A staging area was established by the Highland Fire Department for emergency response assets, approximately 600 feet away from the scene. The staging area, though a little crowded at times because of the number of response vehicles, adequately accommodated these response vehicles and response teams. RAP reported to staging at 0905. At 0908, the Staging Officer reported to the Incident Commander that the staging area was empty and the Incident Commander called for two more ambulances and two additional fire and rescue units.



*Highland Fire Rescue in Staging Area*

### ***Strengths***

- ! The Staging Officer did a good job staging response vehicles as they arrived. All movements into the response area initially went through staging and were well controlled.

### ***Weaknesses***

- ! The need for Incident Command training and exercises for new police personnel was identified. This was the first time some new fire personnel were involved in Incident Management. It was not clear that police and some of the other response organizations understood the staging process. This caused some minor delay and confusion during the response as more response organizations arrived on scene.
- ! Backup resources were often not available in the staging area. After 0852, no backup crews were available.
- ! At 0940, the coroner's van was blocking access to the event scene and no keys were left in the ignition. All keys should be left in vehicles to prevent this problem.
- ! No zone control was maintained to control access of responders other than at the roadway.

## **5. Incident Command/Direction and Control**

The City of Highland Fire Chief arrived at the scene at 0814 and assumed the role of Incident Commander. He immediately established an Incident Command Post approximately 500 feet to the east of the event. The Incident Command Post remained at this location and was the center for overall direction and control throughout the event. At 0822 the IC determined that the event was a HAZMAT event and requested assistance from Lake County Fire Chiefs HAZMAT Group through dispatch. The Incident Commander established branch operations for Operations, Fire/HAZMAT, Logistic and Staging. The Incident Commander

worked within the Incident Command system and began coordinating with local, state and federal emergency response organizations at the event scene. The IC advised responders that one of the perpetrators in the event was trapped in the truck and that extraction was needed at 0831. The IC requested activation of Lake County EMA at 0833 and requested additional resources including law enforcement support, Sheriff Department helicopter, and additional fire support from Griffith and Dyer Fire Departments by 0836.

The IC coordinated regularly with the SEMA representative on scene regarding radiological needs and with radiological response organizations as they arrived and deployed them to both the contaminated area near the scene and the decontamination area. When the Lake County Fire Chiefs HAZMAT Group arrived on Scene at 0831, the Incident Commander directed them to establish a decontamination site and a hot line east of the fence line near the scene. At 0841 the IC advised that one of the perpetrators would be flown to Methodist Hospital by helicopter.



*Event Area Secured -- Decontamination Hot Line*

At 0841 the Lake County EMA Director arrived on site and at 0848 the IC requested one to two additional ambulances be sent to the scene. The Incident Commander briefed the Lake County EMA Director on the event at 0855. The EMA Director continued to provide oversight of the response, coordinating with the Incident Commander and response organizations at the scene from the Mobile Emergency Operations Center. The EMA Director coordinated emergency public information activities with the Incident Commander and State Emergency Management Agency representatives, onsite as well as with the County Public Information Officer (PIO).

At 0859, the IC requested that SEMA activate the state plan, which would provide industry radiological response support. At 0914, the IC advised Police of a vehicle that came through but did not stop at the staging area and at 0919 EMA advised the IC that the site was secure.

When DOE's Radiological Assistance Program Team (RAP) arrived at the Incident Command Post at 0923, the Incident Commander provided a briefing on the event situation for RAP, the HAZMAT Branch Coordinator, EPA and the IDH. Shipping papers arrived at the Command Post at 0920 and was discussed

with the IC and IDH. Though Unified Command was not identified as such, it was effectively established with local fire, police and EMS and with U.S. EPA, ISDH, SEMA and RAP as part of a Unified Command for the event.



*RAP and State Arrive and Conduct Briefing Near the Incident Command Post*

At 0937, the IC directed all personnel to pull back to the Decontamination line. The IC continued to direct response from the Incident Command Post and began discussion with DOE, EPA and the State of Indiana regarding recovery operations up to the point the exercise was terminated.

### ***Strengths***

- ! Highland Fire responded as the Incident Commander according to plans/procedures.
- ! The Unified Command System was implemented with the city, county, state and federal organizations, effectively coordinating activities under the Unified Command structure.
- ! Incident command branch operations, which included, Fire, HAZMAT, Logistics and Staging were obvious most of the time.
- ! Mutual aid was activated with other local jurisdictions and medical organizations and was effectively coordinated and implemented within the unified command system.
- ! The Incident Commander coordinated emergency public information through the PIO and with the various organizations represented within the Unified Command System.

### ***Weaknesses***

- ! Although part of the IC organization, police and EMS were difficult to find.
- ! Branch operations for medical and law enforcement were not clearly identified.

- ! Safety and Liaison functions were also not clearly identified.
- ! Meteorological conditions should have been identified earlier in the event.
- ! A closer look should be made at procedures which may place emergency victims at risk, because of delay in medical response. Though conditions may be present which require caution by responders, victims should not be subjected to conditions that may impact their health and safety.

## 6. Radiological monitoring and assessment

Highland Fire Department Firemen approached the scene with radiological instruments, in turnout gear and with SCBAs at 0827.



*Firefighters Approaching Scene with Caution*

They began to survey the area around the truck with instruments and reported readings to the Incident Commander who instructed them to move forward. Personnel from Griffith and Dyer Fire Departments dressed in turnout gear and SCBA and surveyed the area near the truck for radiological contamination from 0900 to 0935. Lake County HAZMAT conducted radiological surveys at the scene as directed by the Incident Commander. HAZMAT approached the scene with caution and maintained good communications with the Incident Command Post. HAZMAT provided results of the survey to RAP and to the IC during the monitoring process. DOE RAP survey teams began surveying the scene at 1017. The State Radiological Response Team was assigned a backup role to RAP for the event. At 0945 EPA returned from the Hot Zone and briefed RAP and IDH on readings. At 0950 RAP coordinated with the HAZMAT Branch Coordinator, State Board of Health (BOH) and State Department of Environmental Management (DEM) at the Incident Command Post. A second RAP team entered the Hot Zone at 1100 and continued to conduct surveys of the area around the truck. At 0957 The IC dispatched radiological monitoring teams to the hospitals to perform secondary evaluation of patients. At 1009, ISDH advised the IC of hazards identified by RAP. The IC directed all responders to hold at decontamination area until cleared. Some concern over Alpha contamination was expressed. At 1029 a wind-monitoring device was set up near the Command Post.

## ***Strengths***

- ! The firefighters were well dressed with PPEs and demonstrated good communication procedures.
- ! The State Radiological Response Teams were well trained and well equipped.
- ! There was excellent communications between the State Radiological Response Team and RAP.

## ***Weaknesses***

- ! Personnel were observed removing PPEs inside the hot zone.
- ! Stay times were not established or observed
- ! Team members exhausted air supply and did not have any left for the decontamination process.
- ! There was no emergency decontamination line for victims/responders who were out of air.
- ! There needs to be consistent use of PPEs for all responders (some did not wear gloves while using a survey meter).
- ! The State should not have given up the lead to RAP during the exercise.

## **7. Decontamination**

The Incident Commander directed that decontamination be established, just east of the event and near a fence line which bordered part of the event area.



*Response Personnel Prepare Decon Facility*

The EPA assisted in the coordination of multiple organizations during the establishment and process of decontamination. Ongoing communication was maintained among decontamination personnel throughout the event. Decontamination teams were dressed out with gloves, booties, and other protective clothing. Personnel were re-routed to bathe and rinse if contamination was still detected after decontamination.



*Response Personnel Conduct Decontamination*

The BP Amoco, NIPSCO, US Steel and Ispat Inland radiological response team members performed well after quick instructions from the EPA representative. Surveying techniques were perfected by means of numerous opportunities to survey people and equipment during the event. The industry radiological personnel discussed procedures among themselves during slow periods and formulated improved procedures during the play. Upon arrival at the scene, EPA briefed the team members and directed them to the decontamination area for the issue of PPEs and to assist with monitoring at the hot line.

After industry personnel donned tyvek gloves and booties, they performed together as a single unit (team) to provide radiological monitoring assistance at the hot line. Under close guidance from the EPA, the team demonstrated monitoring on about 20 individual responders as they were released from the incident scene. Survey techniques were sufficient to detect contamination.

The team was directed to assist with the monitoring of the HAZMAT team (decontamination team) as they completed their assignments and started to break down their operation.

### ***Strengths***

- ! The industry representatives immediately reported to the Incident Commander upon arrival and asked what they could do to assist with the event.
- ! Industry representatives worked very well with other responders and under the direction of the EPA in the survey process.

- ! Thorough monitoring of personnel was conducted prior to their release for rehabilitation.
- ! Showers, bath and rinse were conducted thoroughly even to the end of exercise.
- ! A spillover from bath/rinse was cleaned up and marked as contaminated area.
- ! Good ongoing communication was demonstrated among decontamination personnel.
- ! Decontamination teams were clothed appropriately with gloves, booties, etc.
- ! Personnel were re-routed to bathe and rinse if contamination was still detected.
- ! Responders were motivated and ready to respond and learn.
- ! As play progressed and new situations arose, the team openly discussed issues and “what next” situations. They were enthusiastic and professional.
- ! An ambulance staff with two personnel was always ready just beyond the decontamination line.
- ! Good conservative assumption regarding residual contamination on personnel was used following final rinse.
- ! Good use and acceptance of technical assistance (from EPA) across zone lines was demonstrated . This was especially true of coroners office personnel regarding decontamination when leaving the hot zone.
- ! Good decon procedures by decon staff at close of exercise with proper disposal of PVC, gloves, etc. was also demonstrated.

### ***Weaknesses***

- ! Decontamination of the prisoner was not conducted prior to entering the helicopter.
- ! During the exercise, the industry radiological representatives at the exit survey location did not consistently direct contaminated and non-contaminated individuals along separate exit paths.
- ! Several “clean” HAZMAT team members exited along the same path as contaminated individuals and simply sidestepped the decontamination wash tubs.
- ! The survey instruments were not equipped with headphones, therefore, team members had a difficult time hearing. In addition, several of the meters had their audio switches off.
- ! The flow and control of the decontamination operation needs additional thought and some modifications.
- ! Delineation of specific areas within the decon area is confusing for the incoming responders. After individuals were monitored, they were either instructed to go to the decon wash area or to the clean area. This required that they step over a rope marker. Individuals determined to be clean should be more clearly identified to assist with internal control of the area.

- ! Medical needs to be a function at the exit area of the hot zone decontamination line. This was not demonstrated in the exercise. One person (a RAP Team member) experienced very high blood pressure upon exit and it was not detected when it should have been.

## **8. Safety**

A Safety Plan was developed as part of the exercise planning process. The Safety Plan outlined responsibilities of controllers, evaluators and other participants for eliminating unsafe activities and actions during the exercise. The Safety Plan also outlined the process for identifying and correcting unsafe activities and the process for stopping the exercise if necessary. A safety briefing was provided to controllers, evaluators and players prior to the exercise.

### ***Strength***

- ! The Safety Plan and briefing were provided as a guide to good exercise safety practice.
- ! Safety professionals planned and implemented exercise security. Given the number of hazards in the exercise (active railroad track, high power lines, helicopters, people in close proximity) the presence of professionals was critical to safety.

### ***Weaknesses***

- ! Exercise actors were exposed to very cold conditions during the exercise. This could have been prevented by the controllers at the scene immediately calling attention to the actors when conditions presented a risk.
- ! The media and several spectators were allowed to move around the scene without restriction. This could have resulted in injury to spectators at worse and could have influenced the participants in the exercise.
- ! Better access control grid lines for media and spectators should have been provided during player and controller briefings.

## **9. Emergency public information**

PIOs were pre-positioned at the VIP tent. From 0848 to 0910, ad hoc PIO and media interviews took place within 50 feet of the overturned vehicle. During the exercise, actors and actual media were actively involved in interviewing the participating DOE PIO and Highland Fire PIO. Information used by PIOs mostly was information provided from the Incident Command Post though media roamed freely over accident site. Off the trail area, they were exposed to a very positive story of first responders and their state and federal counterparts. At 0931 simultaneous interviews were conducted by the media with the IC and the EPA Team Leader near the Incident Command Post. At 1050 the IC, EPA and RAP conducted a joint news conference at the Incident Command Post.

### ***Strengths***

- ! During the exercise, good communication was maintained between the PIO and the Incident Commander. This exercise provided a great opportunity for real media to participate in a positive aspect of emergency response.

- ! The exercise provided good experience responding to the media for the Incident Commander and other team leaders.
- ! Value of media participation and access to the scene.
- ! The PIO and Incident Commander were honest and straight-forward.
- ! DOE provided an experienced PIO who assisted other PIOs at the scene.

### ***Weaknesses***

- ! The media did not receive news releases or press packages. Actors and actual media activities were not clearly separated, particularly at the beginning of the exercise.
- ! The presence of three film crews, though necessary, was a source of confusion. Other media may have been controlled better if the film crews had more distinct markings such as vests or caps.

## **10.0 Medical response**

Three medical contamination situations were presented in the exercise. The first situation was presented when the Highland Police officer was wounded while trying to apprehend a perpetrator who was running from the wrecked truck.

The second medical situation involved the injured and contaminated bicyclist and a third medical situation involved the injured perpetrator who was driving the wrecked truck containing the radioisotopes.

Additionally, because of the medical considerations handling a contaminated fatality, the dead perpetrator will be discussed in this section.

### **10.1 Injured Police Officer and Perpetrator- Lake County Sheriffs Department Helicopter and Methodist Medical Hospital Northlake**



*Victim Loaded on Helicopter for Transport*

The Lake County Sheriffs Department Helicopter was notified at 0830 of the emergency. After the media was cleared from the landing site, the helicopter landed at the scene and picked up the perpetrator and the wounded police officer and departed to Methodist Hospital Northlake. Methodist Northlake was contacted by CO-Med Dispatch of a potential HAZMAT situation at 0849. At 0855 the Sheriffs Helicopter arrived at the hospital with the two patients. Despite the short notice, hospital staff donned PPEs after taking pre-incident vitals and a Code Yellow was called for the hospital. At 0900 the Charge RN advised there was no medical emergency present on either patient and at 0905 approached the landing pad to retrieve patients. The police officer was placed on a gurney (Suspect was not secured - under arrest) and taken into the ER for Evaluation. No decon was performed on the police officer prior to entering the ER. At 0911 the suspect was taken into the HAZMAT Decon room and clothes were removed and he was showered. At 0917 the ER staff surveyed the police officer after request by MD and his clothes were removed and disposed of. At 0932 the suspect was surveyed by nuclear medicine and contamination was found on his hands. The suspect was decontaminated and released to security at 0943.

At 0947, an MD was advised of a Pneumothorax to the chest of the police officer. The staff set up a chest reassessment of the officer with a survey meter. The MD inserted a chest tube without proper decontamination and called for a chest x-ray. Two decontaminations of the patient were conducted with soap and water after which monitoring was conducted. At 1002 the Charge Nurse identified the isotope as I-131. At 1004 a portable X-ray was used on the patient. The X-ray was properly evaluated by the MD and the patient was declared medically stable. (Did not dispose of contaminated sheets prior to or following x-rays). At 1008 the patient was removed to a clean area and the ER staff removed the PPE and a final frisk was conducted.

### ***Strengths***

- ! The Staff as a whole worked well together and there was a good team effort.
- ! There were excellent resources available for the hospital to respond to this type of event.
- ! Despite little warning of patient's arrival, staff adjusted quickly to circumstances.
- ! Good decision making regarding prioritization of trauma versus contamination priorities was demonstrated.
- ! The hospital demonstrated an excellent use of code yellow during the emergency.
- ! The ER Charge person demonstrated an excellent command of two situations and ancillary staffs.

### ***Weaknesses***

- ! There was no communication with the ER staff from the helicopter in transit.
- ! The hospital had a great HAZMAT situation manual even though it was not always followed.
- ! The transfer of the patient to the ER was done improperly.
- ! Gross decontamination was conducted inside ER (not done outside).
- ! Nuclear medicine staff/security did not wear PPE. Monitoring was conducted too fast.

- ! Staff did not properly decontaminate or drape areas where invasive procedures were done (IV, chest tube).
- ! When the patient was moved to the clean area, some cross contamination was noted.
- ! Removal of staff's PPE showed gross cross-contamination.
- ! Perpetrator-victim was not provided adequate security.

## 10.2 Injured/Contaminated Bicyclist – Saint Margaret Mercy South

A bicyclist struck by the stolen truck driven by the perpetrators, was injured and contaminated at the initiation of the event.



*Injured and Contaminated Bicyclist*

EMS (CO-Med) arrived at the event scene at 0845. The IC requested additional ambulances at this time. Medical teams assembled at the exit point from the hot zone dressed in PPEs at 0852. Based upon a controller prompt at 0856, the bicyclist was covered with a blanket because of the cold and his limited activity. The medical team was briefed by HAZMAT at 0858 on conditions at the scene. At 0905, the bicyclist was stabilized with a C-Collar, placed on a stretcher, surveyed, decontaminated and sent to Saint Margaret Mercy South by 0924. While the patient was traveling to the hospital by ambulance, his clothes were removed and bagged. At 0936 the hospital was contacted and provided patient information (minimal rad information provided). The hospital provided directions to the decontamination area. The patient arrived at hospital at 0945 and the ambulance crew coordinated with the radiation safety officer regarding patient contamination. At 0958 the patient was surveyed by the hospital Radiation Safety Officer (RSO) and contamination was found. After further decontamination, no contamination of the patient was found. Additionally, the ambulance was surveyed by the RSO, contaminated articles were removed (radio and B/P cuff), and metal surfaces were decontaminated. The ambulance and crew was released soon afterward.



*Firefighters Prepare to Extract Bicyclist*

### ***Strengths***

- ! The EMTs did a good job of removing patients clothes and assessing for injuries while transporting to the hospital.
- ! The EMTs provided a good report on the patient in route to the hospital.

### ***Weaknesses***

- ! No covering was used on the floor or over equipment at the hospital.
- ! No spinal stabilization was used while moving the patient.
- ! The EMT did not change gloves before handling the telephone.

### 10.3 Injured/Contaminated Truck Driver – Saint Margaret Mercy North

The “perpetrator” (actor) driving the truck was injured and unconscious in the wreck at the onset of the event. At 0914, the Fire Department began extraction of the driver.



*Firefighters Extract Truck Driver*

In the process of the Fire Department Staff trying to extract the player from the truck, cribbing dropped from the window and struck him. At 0930, a C-collar was placed on the driver before removal from the truck. At 0952, after there had been considerable effort to cut away the roof and windshield of the truck, the injured “perpetrator” was taken from the truck, transported out of the hot zone and through decontamination at 1000. He was wrapped, placed in the ambulance and was en route to the Hospital at 1007. After removing the patient, the ambulance and crew were monitored for contamination, and decontamination was conducted on personnel and the vehicle.

#### ***Strengths***

- ! CO-Med demonstrated good response to a medical contamination event. Good decontamination procedures and processes were used.

#### ***Weaknesses***

- ! No security to control access and egress was evident at the hospital. Additionally, the hospital did not ask the patient for personal information that would have been needed for assessment..

## 10.4 Coroner

At 0940 the Lake County Coroner arrived at the staging area and was briefed by the Incident Commander on the contaminated fatality. The IC instructed the coroner to bring the body to Decontamination.

At 0955 the Coroner briefed his team on dressing out and the presence of radiological materials and the team entered the area and began to photograph the scene. The Coroner then examined the body and placed it in a body bag on a gurney.



*Coroner Extracting Victim from Area*

At 1012 the Coroner team left the scene. Some contamination was identified at hot line on hands, feet, gurney wheels and handles and outside of body bag. At 1025 Coroner arrived at decon with the body. A survey of the gurney indicated 200 cpm at wheels. At 1035 the Coroner confirmed with law enforcement regarding the identification of the victim. At 1050 the Coroner called REAC/TS in Oak Ridge (after prompt) and was instructed to decontaminate the body at the scene, wrap it in plastic, and place it in a body bag, and obtain, National Council on Radiological Protection -37 (NCRP37) guidelines for more details on further disposition of remains. At 1038, the Coroner team was surveyed out of the hot zone.

### *Strengths*

- ! The Coroner requested and received good information from the Incident Commander upon arrival at the emergency scene and conducted a very good briefing for his team.
- ! The Coroner demonstrated concern for and asked questions of the Incident Commander regarding whether his team was adequately protected for this type of event.
- ! The Coroner coordinated very well with REAC/TS regarding disposition of the contaminated body.

## ***Weaknesses***

! The Coroner Team did not have an HP with them when inside the hot area.

## **11. Recovery**

After the response phase of the event had been terminated, a recovery phase tabletop was conducted at the Highland Fire Department with participants who would have a major involvement in the recovery process. Discussion was as follows:

At 1216 the EPA made a formal request to State of Indiana to support clean-up operations. The issue of responsibility for the cleanup was discussed at length. The responsible party was the shipper; however, EPA indicated the vehicle was under DOE control because the shipping papers were theirs. EPA also stated that they could spend funds under CERCLA or use EPA cleanup contractors in the recovery effort.

DOE stated that they were currently in the process of trying to identify ownership. Indiana Department of Health stated that they would trim their involvement down as it became an environmental issue (rather than response) and that they would provide technical support to the recovery effort. EPA stated that they still needed IDH to provide monitoring of the area and that there was some severe contamination on the site. DOE indicated that a recovery plan should be written and that one multiple party agreement should be developed as opposed to several separate ones. The possible need to remove topsoil was discussed along with covering the ground with tarps. Additionally, it was indicated that a temporary storage location was needed.

Bill Timmer stated that confirmation was needed from Headquarters to sign on to “parties of agreement”. The EPA indicated that the scene needed to be stabilized so as not to create additional problems. In addition, EPA discussed with Bill Timmer the concerns for; cleaning up quickly, providing security for the operations (EPA security guards) and needing to continue with a unified command structure. DOE indicated that they would not leave the area until the recovery plan was approved by the EPA. Setting up a Joint Information Center (JIC) was discussed and the need to continue to provide information from a JIC even after the cleanup had been completed.

Some discussion oriented around who was in charge of the recovery. The IDEM stated that EPA could take control of the incident with IDH assistance and DOE’s continued involvement.

Additionally, removal of the containers of radioactive material and a back calculation to determine the amount of radiological material released was discussed. Isotopes/isopleths would need to be determined. A health and safety plan would be generated along with an excavation plan. Air sampling would use NRC limits and the samples would be held for decay if short half lives. The mixed waste (TCLP/diesel fuel) could be temporarily stored (not permanent) at Argonne, if needed, while being tested and the determination being made for proper disposal at Barnwell or even Envirocare. EPA also explained the issue of the mixed waste disposal problem.

The need for the Indiana Department of Natural Resources to become more involved with the cleanup and especially the wetlands area was discussed. Also DNR would be involved with any endangered species issues during the cleanup. DOE explained that rain had reduced airborne particulate and that the site could now be characterized.

### ***Strength***

- ! There was a very good discussion of recovery planning between Local, State, EPA, and DOE

### ***Weakness***

- ! Not all participants could identify how to apply existing plans to determine who is in charge of the recovery

## Attachment A - Exercise Planning Committees

### Exercise Planning Team

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## Attachment A - Exercise Planning Committees (Continued)

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## Attachment A - Exercise Planning Committees (Continued)

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Larry Blanchard, LEPC, Lake County Council	
Alex Brown, Town of Highland	
Val Taneff, Public Representative to the LEPC	

## Attachment A - Exercise Planning Committees (Continued)

### Controllers and Actors

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## Attachment A - Exercise Planning Committees (Continued)

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Joe Calhoun, Portage FD	
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## **Attachment A - Exercise Planning Committees (Continued)**

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Glen Cekus, EPA

Mike Beach, Methodist Hospital

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## **Attachment A - Exercise Planning Committees (Continued)**

### **Exercise Safety**

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Dave Fronczak, U.S.Steel Gary Works

Tim Zaberdac, U.S.Steel Gary Works

N. Joe Hudson, NIPSCO INDUSTRIES

Ron Gang, NIPSCO

Gene Radio, NIPSCO

Steve Wright, NIPSCO

Matt Pepelea, Indiana University

John Graun, NIPSCO

Milo Roscoe, NIPSCO INDUSTRIES

Dana Clark, NIPSCO INDUSTRIES

### **Site Security**

Kenneth Balon, Highland PD, Chair

## Attachment B - Exercise Management Plan

This planning tool was critical to effective and efficient management before, during and after the exercise. The plan was maintained on the computer of the Co-Exercise Manager and shared with all planners by EMail. The day before each exercise-planning meeting, the senior planning team members (listed before) met to resolve issues. The management plan was corrected and distributed to all participants in the planning meetings. From changes made and issues identified during the meetings, the plan was corrected and distributed to all participants who provided EMail addresses by electronic mail. The plan format was provided by HAMMER (Hazardous Materials Management & Emergency Response) from Richland, WA.

We hope that you will find this tool useful to you.

William Timmer, Jr., Chief, Highland, Indiana Fire Department & Chair, Lake County LEPC Exercise Manager

Dean Larson, Manager, Safety & IH, U.S. Steel Gary Works and Training Chair, LC LEPC Co-Exercise Manager

Dale Dietzel, DOE Region 5 TEPP Coordinator, DOE Exercise Support Coordinator

Darrell Lankford, Director, Emergency Management Laboratory, Oak Ridge Institute for Science and Education (ORISE), Exercise Director

### Introduction:

This management plan covers the activities that should be completed prior to conducting the POPEYE transportation emergency response exercise. Each section lists a completion due dates along with sub-tasks that may also list a due date. If the subtask has no listed due date than the subtask completion date is the same as the main section due date.

<b>I.</b>	<b>Exercise Package</b>	<b>Timmer &amp; Larson</b>	<b>9/17/99</b>
	[x] Scope		<b>7/08/99</b>
	[x] Objectives		<b>7/08/99</b>
	[x] Scenario		<b>9/10/99</b>
	[x] Limitations	Lankford	<b>9/10/99</b>
	[x] Timeline/MESL	Dietzel, Lankford & VanHorn	<b>9/10/99</b>
	[x] Message Injects	Dietzel, Lankford & VanHorn	<b>9/10/99</b>
	[x] Hazardous Materials Data	Jascewski & VanHorn	<b>9/10/99</b>
	[x] Inventory by Type and Amount (Source Term)		
	[x] Data Graphs/Charts		
	[x] Data Maps	Lankford & St.Clair	
	[x] Contamination of Equipment and Personnel		
	[x] North American Emergency Response Guide		
	[x] Radioisotope Data		

<input type="checkbox"/>	Special Data Developed		<b>9/24/99</b>
<input checked="" type="checkbox"/>	Medical	Lankford	
<input checked="" type="checkbox"/>	Shipping Documents & Labels Papers	Rymer & Lankford	
<input checked="" type="checkbox"/>	Shipping Container B Rad and General	Rymer & Lankford	
<input checked="" type="checkbox"/>	Shipper/Carrier Vehicle	Timmer	
<input checked="" type="checkbox"/>	Non-rad shipping containers	Larson	
<input checked="" type="checkbox"/>	Sand bags for shipping containers	Miller	
<input checked="" type="checkbox"/>	Media/Public/Political/Other Federal Agency Injects	Lankford	
<input checked="" type="checkbox"/>	Evaluation Criteria (evaluating TEPP material)		<b>7/15/99</b>
<input checked="" type="checkbox"/>	Controller/Evaluator Instructions	Larson & Lankford	<b>9/17/99</b>
<b>II. Safety</b>			
		<b>St. Clair</b>	<b>9/10/99</b>
<input checked="" type="checkbox"/>	Safety Plan - Final		<b>9/17/99</b>
<input checked="" type="checkbox"/>	Emergency Services Resource Plan	Timmer & Balon	<b>9/10/99</b>
NOTE:	An emergency services resource plan is required if the exercise involves emergency resources (Fire/Medical/Law Enforcement) and resources are not sufficient to support the exercise and assure public safety.		
<b>III. Exercise Security and Access Control</b>			
		<b>Balon</b>	<b>10/1/99</b>
<input checked="" type="checkbox"/>	Hosts for Observers/VIPs	Colby & Sattler	<b>9/24/99</b>
<input checked="" type="checkbox"/>	Exercise Access Control	Balon	<b>9/24/99</b>
<input checked="" type="checkbox"/>	Secure Public Parking Area for VIP guests	Balon	<b>10/1/99</b>
<input checked="" type="checkbox"/>	Barricades for Parking Area	Balon	<b>9/24/99</b>
<b>IV. Media and Public Involvement</b>			
		<b>Mika</b>	<b>9/21/99</b>
<input checked="" type="checkbox"/>	Plan Developed		<b>8/6/99</b>
<input checked="" type="checkbox"/>	Public and media schedule of events		<b>9/21/99</b>
<input checked="" type="checkbox"/>	Public Service Announcements Produced		<b>9/20/99</b>
<input checked="" type="checkbox"/>	Media Releases Developed and Issued		<b>Ongoing</b>
<input checked="" type="checkbox"/>	Exercise Development		<b>8/2/99</b>
<input checked="" type="checkbox"/>	Training Program		<b>9/10/99</b>
<input checked="" type="checkbox"/>	Pre-Exercise Announcement		<b>9/25/99</b>
<input type="checkbox"/>	Exercise Results		<b>10/15/99</b>
<b>V. Training</b>			<b>9/6/99</b>
<input checked="" type="checkbox"/>	Needs Assessment Completed		<b>6/24/99</b>
<input checked="" type="checkbox"/>	Learning Center Identified		<b>6/24/99</b>
<input checked="" type="checkbox"/>	Learning Center Materials Received		<b>7/25/99</b>
<input checked="" type="checkbox"/>	Learning Materials Duplicated		<b>8/4/99</b>

<input checked="" type="checkbox"/>	Answer Key for MERRT materials		8/6/99
<input checked="" type="checkbox"/>	MERRTT Training Schedule		8/5/99
<input checked="" type="checkbox"/>	Tabletop and Practical Drills Schedule		8/5/99
<input checked="" type="checkbox"/>	Responder Exercise Briefing	Timmer	9/28/99
<input checked="" type="checkbox"/>	Controller Training and Exercise Briefing	Lankford	10/1/99
<input checked="" type="checkbox"/>	Actor Briefing (TV, radio, perpetrators, victims)	Lankford	10/1/99
<input checked="" type="checkbox"/>	Evaluator Training and Exercise Briefing	Lankford	10/1/99
<input checked="" type="checkbox"/>	Safety Briefing	St.Clair	10/1/99
<input checked="" type="checkbox"/>	Host Briefing	Colby	10/2/99
<input checked="" type="checkbox"/>	Safety briefing for VIP hosts	St.Clair	10/2/99

**VI. Logistics**      Dietzel/Lankford/Timmer/Larson      **9/24/99**

<input checked="" type="checkbox"/>	Exercise Date and Location Identified		6/11/99
<input checked="" type="checkbox"/>	Exercise Participants Identified and Notified		6/24/99

**Local Agencies**

- Emergency Management
- Fire
- HazMat
- Law Enforcement (City/County)
- Ambulance
- Hospital(s) - three
- Red Cross
- Health
- Coroner
- Emergency Operations Center (City/County)
- Public Works
- Political Officials

**State Agencies**

- Emergency Management
- Health
- Environmental Management
- Natural Resources

**DOE Programs/Program Offices**      Dietzel

- DOE Area/Field/Operations Office
  - TEPP Coordinator
  - RAP Coordinator
  - DOE-HQ
    - Watchroom
    - DP-23
    - RAP

**Other Federal Agencies**

- Environmental Protection Agency

**Private Sector Private Sector**

**[x] Utilities**

- [x] Electrical (NIPSCO)
- [x] Natural Gas (NIPSCO)

**[x] Industry**

- [x] Manufacturing (USS B Gary Works, Ispat Inland)
- [x] Chemical (BP Amoco)

<b>[x]</b>	<b>Participant Logistics</b>		<b>9/24/99</b>
[x]	Number of Lunches Determined Piment (Responders, Controllers, Evaluators, Actors, Designers, Observers)		<b>9/24/99</b>
[x]	Portable Toilets		<b>9/8/99</b>
[x]	Public Address System	Colby/Sattler	<b>9/24/99</b>
[x]	Power Source	Colby	<b>9/24/99</b>
[x]	Vehicle to Transport VIP/Observers	Colby	<b>8/1/99</b>
[x]	Observer Viewing Area Identified, and Cover and Seating Determined	Colby/Sattler	<b>9/17/99</b>
[x]	Observer Logistics Plan Developed		<b>8/1/99</b>
[x]	Pre-event Notification Letters	Timmer/Larson	<b>9/20/99</b>
[x]	National Response Center		
[x]	Indiana EOC		
[x]	FEMA V		
[x]	Highland Post Office		
[x]	Neighborhood Flyer		
[x]	Meeting Rooms (responder, controller, evaluator, actor, observer training, and various levels of exercise debriefings)	Timmer/Larson	<b>9/9/99</b>
[x]	Transportation (vans, buses etc.)	Colby/St.Clair	<b>8/2/99</b>
[x]	Extension Cords	Colby/Sattler	<b>9/24/99</b>
[x]	Current emergency call lists (including any required modifications due to simulations)	Timmer/Larson	<b>9/10/99</b>
[x]	Maps/Accommodations/Rest. for out-of-town participants		
[x]	Letters of Invitation		<b>8/19/99</b>
[x]	Exercise Activity Schedule	Timmer/Larson	<b>9/10/99</b>
[x]	Meeting Schedule	Timmer/Larson	<b>9/17/99</b>
[x]	List of Meeting Rooms/Directions	Timmer/Larson	<b>9/17/99</b>
[x]	Back-up Resources Identified	Timmer/Larson	<b>9/7/99</b>
[x]	Overtime Issues Resolved and Approved	Timmer	<b>9/7/99</b>
[x]	Signs	Johns	<b>9/24/99</b>
[x]	Sign Needs	Balon, Mika	<b>9/24/99</b>
[x]	Vests for Controllers, Evaluators	Dietzel	<b>9/24/99</b>
[x]	Name badges	Colby/Larson	<b>9/28/99</b>
[x]	Video Taping Exercise	Price	<b>9/8/99</b>
[x]	Narrator for Exercise	Price	<b>9/8/99</b>
[x]	Scenario to Narrator	Dietzel	<b>9/17/99</b>
[x]	Helo Landing Zone	Timmer	<b>9/24/99</b>

[x]	Refreshments for Briefings	Swike	10/1/99
[x]	Refreshments for Staging Area	Whitehead	10/2/99
[x]	Photographer (Digital)	Jody Lopez & HazMat Group	9/24/99
[x]	NAERG	Miller	9/24/99
[x]	Parking Area for EPA Command Post	Timmer	9/24/99
[x]	Folders for VIP Packets	Dietzel & Colby	9/24/99

**VII. Simulation Aids** **9/24/99**

[x]	Shipping Container (Type B)	Lankford/Rymer	9/24/99
[x]	Shipping Container (Type A)	Lankford/Rymer	9/24/99
[x]	Incidental Packages	Miller/Larson	9/17/99
[x]	Barricade Signs/Tape/Rope	Timmer	9/24/99
[x]	Exercise Vehicle	Timmer	9/7/99
[x]	Bicycle	Timmer	9/17/99
[x]	Injury/Medical Indicators	Doolin	9/24/99
[x]	Moulage	Doolin	9/24/99
[x]	Contamination Indicators (water, line chalk)	Johns	9/24/99
[x]	Actors		9/20/99

**VIII. Exercise Conduct** Timmer/Larson **9/24/99**

[x]	<b>Controllers</b>		9/10/99
[x]	<b>Controller Locations Identified</b>	Dietzel & Lankford	
[x]	Highland Dispatch/911		
[x]	LC Sheriff Dispatch		
[x]	Medical Facilities/Hospitals		
[x]	Emergency Operations Center		
[x]	Event Scene:		
[x]	Incident Commander		
[x]	HazMat		
[x]	Rad Teams		
[x]	EMS		
[x]	PIO		
[x]	Staging		
[x]	Federal and State Agencies Points of Contact		
[x]	<b>Controller Needs</b>	Dietzel/Lankford	9/24/99
[x]	Equipment/Instrumentation		9/10/99
[x]	Individuals Identified to be Controllers	Larson	9/24/99
[x]	Ball caps		9/9/99
[x]	Vests		9/17/99
[x]	Radio		9/9/99
[x]	Cellular Telephone		9/9/99
[x]	Tape Recorder		9/9/99
[x]	Identify Frequency		9/9/99

	[x]	Recharge Batteries		9/9/99
	[x]	Test Radios/Radio Maintenance	Miller	9/12/99
	[x]	Identify Additional Communication Equipment		9/9/99
		Install four land lines		
	[x]	Test C.A.N System scheduled	Miller	10/2/99
	[x]	Test message for C.A.N.	Timer/Miller	9/24/99
	[x]	Liaison with C.A.N. Administrators		8/30/99
	[x]	Letter to Controllers on 10/1/99 Training-	Larson	9/21/99
	[x]	Office supply needs identified		
		(controllers & evaluators)	Lankford	9/17/99
	[x]	Office supplies	Zwike	9/24/99
[x]		<b>Actors</b>		9/20/99
	[x]	<b>Actors Identified</b>		
	[x]	Casualties B bicyclist		
	[x]	Casualty		
	[x]	Fugitive		
	[x]	Field Media		
[x]		<b>Control Cell</b>	Miller	9/10/99
	[x]	<b>Control Cell Facility</b>		
	[x]	Location		
	[x]	Phones		
	[x]	Radio Communications		
[x]		<b>Exercise Evaluation Needs</b>	Dietzel & Lankford	9/17/99
	[x]	Evaluation Locations Identified		
	[x]	Evaluators	Larson	9/24/99
	[x]	Caps		
	[x]	Vests		9/17/99
	[x]	Letter to Evaluators on 10/1/99 Training	Larson	9/21/99
	[x]	Office supplies	Zwike	9/24/99
	[x]	Transportation for Evaluators/Controllers	St.Clair	9/24/99
[x]		<b>Observers/VIPs</b>	Colby & Sattler	9/17/99
	[x]	List of Observers Developed and Approved		
	[x]	Hosts Identified		9/24/99
	[x]	Observer Plan Developed		8/2/99
	[x]	Safety Briefing for VIP's and Hosts		10/1/99
	[x]	Identify Observer Areas	Colby/St. Clair	9/17/99
	[x]	IC Spotter	Timmer	9/24/99
		<b>“Plan B”</b>		
	[x]	Backup Ambulance in case of no helo ops		9/28/99
	[x]	Alternate radioactive simulation in case of rain		9/28/99
	[x]	Smoke bomb		10/1/99

**X. Post Exercise** Timmer/Larson/Dietzel/Lankford

<input checked="" type="checkbox"/>	Exercise Debriefing	Lankford	<b>10/2/99</b>
<input checked="" type="checkbox"/>	Refreshments for Debriefing	Swike	<b>10/2/99</b>
<input checked="" type="checkbox"/>	Thank you letters - key players	Timmer/Larson	<b>10/15/99</b>
<input checked="" type="checkbox"/>	Outline for Final Report	Lankford	<b>9/17/99</b>
<input checked="" type="checkbox"/>	Video Interviews	Price	<b>9/30/99</b>
<input checked="" type="checkbox"/>	Participant Critique Forms	Larson	<b>9/24/99</b>
<input checked="" type="checkbox"/>	Report Writing Support	Dietzel/Lankford	<b>11/1/99</b>
<input checked="" type="checkbox"/>	Count for Final Reports	Dietzel/Lankford	<b>10/1/99</b>
<input type="checkbox"/>	Report Duplication	Dietzel	<b>1/10/00</b>
<input type="checkbox"/>	Report on DOE TEPP Website	Lankford	

## Attachment C - Overall Exercise Timeline

- 0807 – Exercise began. Highland Dispatch notifies local law enforcement, fire, and medical response units on all frequencies.
- 0810 – PD dispatched to scene and notifies dispatcher of southbound pursuit of vehicle on Kennedy Avenue.
- 0813 – PD notifies dispatch of vehicle hitting bike rider and of fire in swamp.
- 0814 – City of Highland Fire Chief arrives at scene and assumes the role of Incident Commander (IC). Establishes Incident Command Post (ICP).
- 0814 – Two Highland Police and Three Sheriff's Department vehicles arrive at scene and immediately chase perpetrator.
- 0817 – Sheriff's deputies leave scene and police maintain custody of perpetrator.
- 0818 – Other Highland Fire Department units arrive at scene. Staging area is established.
- 0820 – Dispatcher requests senior police officer to report to accident scene.
- 0822 – Police and fire communication on perpetrator. Entry team relays information to OPS unit. Police at scene call dispatcher and request Lake County HAZMAT.
- 0825 – Lake County HAZMAT team requested by Highland Dispatch. Three fireman approached scene. Size up conducted by Fire Department with binoculars about 100 feet from truck.
- 0827 – Fire Department continues to approach using radiological monitoring equipment. Reports findings to IC and is instructed to move forward.
- 0830 – Fire Department enters contaminated area. IC requests the Lake County Sheriff's Department helicopter.
- 0831 – HAZMAT unit arrives and IC directs them to set up DeCon. IC advises responders that one of the perpetrators is trapped in the truck and extrication is required.
- 0834 – Police arrive at the ICP and request that county EPA and EMA report to the scene.
- 0836 – EPA Region 5 arrives. Griffith and Dyer Fire Departments are notified.
- 0836 – Lake County Sheriff's Department helicopter lands.
- 0840 – Hot Zone established east of fence line.
- 0841 – Lake County EMA Director arrives at the scene.
- 0842 – Lake County Sheriff's helicopter departs for the hospital with perpetrator and injured police officer.
- 0842 – SEA called and REST requested. Griffith and Dyer Fire Departments are dispatched.
- 0845 – Police Department requested additional Sheriff resources to scene. Media was cleared from helicopter landing area. Police read packaging labels to HAZMAT team.
- 0845 – EMS (CO-Med) arrived at the event scene.
- 0847 – C.A.N. system activated.
- 0848 – Media interviews PIO near scene.
- 0849 – Methodist Northlake Hospital is contacted by CO-Med Dispatch of a potential HAZMAT situation.
- 0850 – Noticed too much access to IC by unnecessary people.
- 0852 – Medical teams assembled at exit point from Hot Zone in protective equipment.
- 0853 – IC recommended SEMA activate Radiological Response Plan. IC requested industry radiological support (ISPAT/Inland, US Steel, and BP Amoco).
- 0855 – IC briefs Lake County EMA Director. Highland Fire Department units stop Griffin Fire Department from entry to Hot Zone to ensure all skin was covered. Lake County Sheriff's helicopter arrives at Methodist Northlake with perpetrator and injured police officer.
- 0857 – Air running low reported from initial Fire Department entry team. Controllor provided for bicyclist to be covered because of the cold and rain.

## Attachment C - Overall Exercise Timeline (Continued)

- 0858 – SEMA notifies the DOE Radiological Assistance Program (RAP). Highland Fire Department dispatched the industry teams to the incident scene. Medical team is briefed by HAZMAT on conditions at the scene.
- 0900 – U.S. Steel Monitoring Arrives at scene and checks in with Highland Fire Department.
- 0900 – EMA contacts NIPSCO. Sheriffs Deputies and police told to go through DeCon.
- 0901 – EMA Director coordinates with IC. Four members of the Indiana radiological monitoring team report to the Incident Command Post (ICP).
- 0904 – BP Amoco arrives (4-5 member team). Indicated need for protective gear and told it was available at Hot Line. Briefing conducted near command truck. EPA leading the effort.
- 0905 – Bicyclist is stabilized with a C-collar, placed on a stretcher, surveyed, decontaminated, and sent to Saint Margaret Mercy South by 0924.
- 0907 – Radiation specialist arrives at ICP.
- 0908 – Staging reports to IC that staging is empty. IC calls for two more ambulances and states he will call in additional fire and rescue. Command Post requests dispatcher notify and request assistance from Red Cross.
- 0910 – Began radiological survey of first victim and DeCon by the DeCon team. Good use of sump and waste collection during DeCon.
- 0910 – DOE RAP dispatched.
- 0912 – Second team was out of air and third team began entry. Sheriffs deputies and police released and told there was no contamination. Vehicles were not checked.
- 0915 – US Steel Radiological monitoring team assisted with rad DeCon.
- 0917 – Briefings provided by DOE for state and local responders . Additional briefings with PIOs - Media requests interview with IC. SEA representative arrives at scene.
- 0918 – First patient removed. Roof cut from truck.
- 0919 – EMA advised the IC that the site was secure.
- 0920 – Contents of radiological packages called in by HAZMAT. EPA hands out meters (Ludlum model 3/model 2241) at DeCon point and instructs in use.
- 0920 – Shipping papers arrive at ICP. DeCon teams split into two prior to and two after DeCon.
- 0923 – DOE RAP arrives at ICP. Perpetrator hit by cribbing dropped from window of truck. IC provides a briefing to RAP, the HAZMAT Branch Coordinator, EPA, and the Indiana Department of Health.
- 0927 – BP Amoco and other DeCon units put on protective equipment.
- 0929 – PIO states that C.A.N. used to notify neighborhood. Media interviews RAP. Media not controlled by security.
- 0930 – C-Collar applied to Perpetrator in truck. Rehab section set up. Shipping papers secured from truck by FD.
- 0930 – EPA conducts survey of box (without P.E. on).
- 0931 – Simultaneous interviews are conducted by the media with the IC and the EPA Team Leader near the ICP.
- 0934 – State teams briefed re: status of event, coordinate with DOE RAP.
- 0935 – BP Amoco surveys HAZMAT – Too fast at first but is corrected by EPA – Then BP Amoco surveys second HAZMAT with proper procedure.
- 0935 – Lake County Coroner’s office is called.
- 0937 – IC directs all personnel to pull back to the DeCon line.
- 0939 – IC called for staging resources.
- 0940 – Lake County Coroner arrives at staging area.
- 0944 – Request is made for shipping papers.

## Attachment C - Overall Exercise Timeline (Continued)

- 0945 – Media requests information on driver of the vehicle. P.O. has no information but said they would investigate.
- 0945 – IC briefed Coroner on fatality (contaminated). Instructs Coroner to bring the body to DeCon and report to LT. and wear protective equipment.
- 0950 – Three responders surveyed. State receives trucking manifest information. Indiana Department of Health/Regional Response Team is notified.
- 0952 – Injured perpetrator is removed from truck, transported out of the Hot Zone and through DeCon at 1000 and was en route to the hospital at 1007.
- 0955 – Coroner briefs team on dressing out and presence of radioactive materials.
- 0957 – IC dispatches radiological monitoring teams to the hospitals to perform secondary evaluations of patients.
- 1001 – Coroner team arrives at scene and photographs scene.
- 1003 – Non-exercise participant walks through Hot Zone.
- 1004 – Fire fighter injured (no “Popeye out of box” given).
- 1005 – DOE RAP co-locates with IC.
- 1007 – DeCon and survey station broken down.
- 1008 – Coroner examines body and places in body bag on gurney.
- 1010 – Last victim removed from Hot Zone for survey.
- 1012 – Coroner team leaves scene. Some contamination identified at Hot Line on hands, feet, gurney wheels and handles and outside of body bag.
- 1012 – Hospital notified of Alpha emitter/hold all people in DeCon area – re-notify EMS to have units and personnel return to scene and be resurveyed for alpha contamination. SEA and RAP survey firefighters for Alpha.
- 1019 – US EPA taking action that shipping company could not authorize.
- 1020 – DOE RAP team assists industry teams with DeCon and enters Hot Zone – Two responders surveyed.
- 1025 – Coroner arrives at DeCon with body – survey indicates 200 cpm at wheels.
- 1030 – IC advised of Alpha contamination and that responders should be brought back to DeCon.
- 1030 – US EPA begins setting up of monitoring station at edge of cold zone.
- 1035 – Coroner confirms with law enforcement regarding the re-identification of victim.
- 1050 – Coroner calls REAC/TS in Oak Ridge (after prompt) and is instructed to DeCon the body at the scene, wrap in plastic, place in body bag, and obtain from NCRP37 more details on further disposition of remains.
- 1037 – HAZMAT team surveyed (500 cpm at DeCon).
- 1038 – Coroner team is surveyed and leaves the area.
- 1050 – IC, EPA, and RAP conducted a joint news conference at the ICP (very good press conference -Ed Vasil).
- 1050 – Person in DeCon slipped and fell (not injured).
- 1100 – Second RAP team enters Hot Zone and surveys areas around the truck.
- 1216 – EPA makes a formal request to State of Indiana for support of clean-up operations.