Operation Triple Play

October 27 & 28, 2006

AFTER ACTION REPORT / IMPROVEMENT PLAN

December 17, 2007

This page is intentionally blank.

HANDLING INSTRUCTIONS

1. The title of this document is Tri-County Omaha, NE, Urban Area Operation Triple Play After Action Report/Improvement Plan.

2. The information gathered in this AAR/IP is classified as For Official Use Only (FOUO) and should be handled as sensitive information not to be disclosed. This document should be safeguarded, handled, transmitted, and stored in accordance with appropriate security directives. Reproduction of this document, in whole or in part, without prior approval from the City of Omaha, Office of the Mayor, is prohibited.

3. At a minimum, the attached materials will be disseminated only on a need-to-know basis and when unattended, will be stored in a locked container or area offering sufficient protection against theft, compromise, inadvertent access, and unauthorized disclosure.

4. Points of Contact for Operation Triple Play:

   Federal POC:

   Cyndi Gutheridge
   Preparedness Officer
   US Department of Homeland Security

   Exercise Director:

   David Points
   Exercise Director
   Office of the Mayor, City of Omaha
   Omaha/Douglas Civic Center
   1819 Farnam Street
   Omaha, Nebraska 68183
   402-444-7800 x317 (office)
   402-681-8913 (cell)
   dpoints@ci.omaha.ne.us

This page is intentionally blank.

CONTENTS

This page is intentionally blank.

EXECUTIVE SUMMARY

The Omaha Metropolitan Medical Response System (OMMRS) and the Urban Area Security Initiative (UASI) understand that they have a responsibility to protect the public from, and mitigate the consequences of, the hazards associated with CBRNE acts of terrorism. Since the ability to communicate has been a major issue with any incident, the Tactical Interoperable Communications System needs to be tested. Several issues have been identified in previous exercises which were incorporated into the objectives of this exercise.

Operation Triple Play was a Full Scale Exercise, designed to assist with evaluating interoperable communication in the Urban Area Security Initiative (UASI) region (Douglas, Sarpy, and Washington Counties), several OMMRS plans and the Nebraska Biocontainment Unit located at the University of Nebraska Medical Center. The multi-agency Full-Scale Exercise was conducted on October 27 and 28, 2006. The exercise was to utilize the National Incident Management (NIMS) concepts and be NIMS compliant. This exercise tested mechanisms by exercising plans, policies, procedures, systems and facilities for responding to and recovering from a simulated terrorism event. It provided an opportunity for UASI counties, OMMRS, and the Biocontainment Unit to examine their roles and responsibilities. The exercise focused on the objectives of each participating agency. The exercise was conducted utilizing a controller/evaluation team, an evaluation team, a safety team, and a security team, and was carried out in accordance with HSEEP.

The City of Omaha, as administrators of the Tri-County UASI strategy, in collaboration with the Omaha Police Department, took the lead to produce and implement an interactive unified emergency operations center functional exercise for a large-scale multi-faceted terrorist attack event. The UASI/OMMRS Exercise Design Team designed the exercise and worked through the Exercise Command Team to develop the exercise. Four hours of training and preparation for evaluators and controllers was held on October 27, 2006. Additionally, the exercise was set up on that date. The exercise was held on October 28, 2006, from 8:00A.M. until approximately 12:00 P.M at Omaha's Rosenblatt Stadium, the Sarpy County Fairgrounds, and a site in Blair, NE. The exercise was dubbed Operation Triple Play. Some 500 people were involved in the exercise activity. The exercise was the culmination of months of preparation with the cooperation of an Exercise Planning Committee comprised of volunteers from the City of Omaha and the Counties of Douglas, Sarpy, and Washington as members of the Tri-County UASI Region. This was further supported by years of work within the Operational Area to strengthen their response capabilities, as well as actions to effectively address terrorism attacks involving weapons of mass destruction, biological agents, and improvised explosive devices. The exercise content focused on challenging inter-agency communications, focusing on interoperable communications technology and adherence to the National Incident Management System. Building response planning and resource deployment relationships between many of the public sector organizations was also included.

The exercise was specifically designed to provide the kinds of challenges and pressures that occur in actual breaking events without time compression. Those with experiences in such events, like 9/11, are painfully aware that the first eight hours of an unexpected, challenging

event are difficult to manage, if not to survive. The stage was set to put the participants in an environment of realistic tension that would require close, flexible responses to quickly changing threat environments.

Besides participants from the City of Omaha and Douglas, Sarpy, and Washington Counties, there were representatives from non-profit organizations involved in the exercise (United Way, American Red Cross, and the Salvation Army) as mass care would be a response activity during such an event. There were also observers from state and federal agencies. The FBI & ATF also participated in the exercise as part of the Law Enforcement Branch. The Controller/Evaluator staff was comprised of emergency management officials and leaders from several organizations within the UASI region.

The scenario started with a biological threat (weaponized smallpox) introduced to Washington County via contaminated clothing donated to a local Thrift Store in mid-October. On the last weekend of the month during an exhibition game held at Rosenblatt Stadium, improvised explosive devices were deployed via suicide bombers and detonated systematically throughout the venue for maximum impact. As a result of this event, intelligence was gathered from one of the terrorists indicating a potential radiological threat existed in Sarpy County.

This exercise included some unique aspects, including the use of simultaneous threat impacts that restricted resources and challenged effective inter-agency communications within the County. The overall ratings from the participants at the exercise were very high. The overall impression of participants was that the exercise was successful in achieving its intent and was highly valued. This was verified by the exercise evaluation team, which found that the participants met most of the exercise objectives.

The exercise activity was followed by an exercise critique. This allowed representatives from the various participant components and jurisdictions to present their positions on the exercise, including both successes and unmet needs. Participants were also surveyed using an online survey tool to provide additional input at the participants' convenience.

Participants noted many times that exercises regarding effective interoperable communications need to be scheduled and implemented on a regular basis. There needs to be more time to spend in the details of establishing collaboration between the Emergency Operations Centers (EOC) so that better understanding of inter-EOC communications can be achieved, as well as better mastery of documentation and planning systems. Improvements in inter-jurisdictional and inter-disciplinary coordination are a critical aspect of this continued level of practice involving all members of the Tri-County UASI Operational Area.

Comments and working documents were captured and compiled for this After Action Report. Resiliency Solutions was contracted to assist in the preparation of this AAR. It is important to note that any exercise of this scope and function must by its very nature find areas to improve, or the exercise is a failure. Specific areas that need further attention are noted in this report. An Improvement Action Plan (IP) is included with recommendations for future actions to address the gaps noted by the participants.

The Omaha Urban Area CBRNE Response and Interoperable Communications Full-Scale exercise Operation Triple Play was developed to test the following capabilities of the Tri-County area: Communications; WMD/Hazardous Materials Response and Decontamination; Medical Surge; Onsite Incident Management; Triage and Pre-Hospital Treatment; Emergency Public Information and Warning; and, Emergency Operations Center Management. The OMMRS/UASI Exercise Planning Team was composed of numerous and diverse agencies, including Omaha Police Department, Omaha Fire Department, Douglas County Emergency Management Agency, Nebraska Emergency Management Agency, Douglas County Health Department, Offutt Air Force Base, Douglas County 911, Sarpy County Emergency Management Agency, Washington County 911, Sarpy County 911, Sarpy County Public Health, Blair Police Department, United States Air Force, Papillion Police Department, Eppley Airfield Fire Department, Pottawattamie County Emergency Management Agency, Three Rivers Public Health, Sarpy County Sheriffs Office, Washington County Sheriffs Office, Metropolitan Area Transit, Federal Bureau of Investigation, The Nebraska Medical Center, Creighton University Medical Center, Alegent Health, Methodist Hospital, Childrens Hospital, VA Hospital, Immanuel Medical Center, Bergan Mercy Medical Center, Midlands Hospital, Lakeside Hospital, Jennie Edmundson Hospital, Region 5/6 Emergency Management Agency, Mercy Hospital, the Salvation Army, Walgreens, Crosby Burket et al., United States Postal Service, Douglas County Department of Corrections, Nebraska Center for Bioterrorism, American Red Cross, Marcotte Insurance, and the 72nd Civil Defense.

The exercise planning team discussed issues surrounding logistics of transporting patients to the ACF Phase II Clinics via Metro Area Transit. They also discussed the use of IsoPods to transfer patients via helicopter and squads.

Based on the exercise planning team's deliberations, the following objectives were developed for Operation Triple Play:

- Objective 1: Demonstrate NIMS compliance.
- Objective 2: Apply the Nebraska HSEEP Process.
- Objective 3: Test interagency communications from Public Health to hospital ICP.
- Objective 4: Test transfer of a contaminated victim via IsoPod.
- Objective 5: Test hospital Incident Command on implementation and ACF Phase I Clinics.
- Objective 6: Test the function of EOC Medical Table and implementation of ACF Phase II Clinics.
- Objective 7: Test the setup of Radiological Portal Monitor and Decon on patient at metro area hospitals.
- Objective 8: Test the setup of a Central Briefing Site.
- Objective 9: Test Behavioral Health role at assigned positions.
- Objective 10: Test implementation of the Personnel Processing Point.

The purpose of this report is to analyze exercise results, identify strengths to be maintained and built upon, identify potential areas for further improvement, and support development of corrective actions.

Major Strengths

The major strengths identified during this exercise are as follows:

- The 800 MHz Radios worked well in facilitating Interoperable Communications between all involved entities.
- Pertaining to the medical response, HICS was efficiently implemented, the Alternative Care Facilities (ACFs) were successful in treating the walking wounded and psychological casualties, behavioral health was effectively delivered to the planned sites, the EOC Medical Table was implemented, and ACF Phase II Clinics were implemented appropriately.
- The Central Briefing Site was established quickly and produced a press release.

Primary Areas for Improvement

Throughout the exercise, several opportunities for improvement in the Tri-County area's ability to respond to the incident were identified. The primary areas for improvement, including recommendations, are as follows:

- No Unified Command was established. Instead of separate Incident Commands for separate disciplines, a Unified Command should be established in future events of this scale.
- No Joint Information Center was established between the three sites meaning that Sarpy and Washington Counties were not included. A JIC should be established in any future event of this scale.
- The IsoPods were not compatible with the helicopters as they lacked the necessary FAA-approved straps. FAA-approved straps should be evaluated so that the IsoPods can be used in transporting patients via helicopter.

Overall, Operation Triple Play was a success. The Interoperable Communications component involving the 800 MHz Radios met expectations, as did the ACFs and the Central Briefing Site. Subsequent exercises should focus on Unified Command, the establishment of a JIC, and the steps necessary to make the IsoPods compatible with the helicopters.

SECTION 1: EXERCISE OVERVIEW

Exercise Details

Exercise Name
Operation Triple Play

Type of Exercise
Full-Scale Exercise

Exercise Start Date
October 27, 2006

Exercise End Date
October 28, 2006

Duration
4 Hours – October 27, 2006

4 Hours – October 28, 2006

Location
Rosenblatt Stadium, Omaha, Nebraska.

Sarpy County Fairgrounds, Springfield, Nebraska.

Blair Memorial Community Hospital, Blair, Nebraska.

Metro Area Hospitals.

Sponsor
Department of Homeland Security

Program
Fiscal Year 2005 Urban Area Security Initiative

Mission
Response

Capabilities
Communications
WMD/HazMat Response and Decontamination
Medical Surge
Onsite Incident Management
Triage and Pre-Hospital Treatment
Emergency Public Information and Warning
Emergency Operations Center Management

Scenario Type
CBRNE Response, Interoperable Communications

OMMRS/UASI Exercise Design Team – Operation Triple Play

Member	Agency	Member	Agency
Achenbach, Robert	First National Buildings	**McMaster, Andrea**	The Nebraska Medical Center
Barrow, Aaron	Blair Police Department	**Meier, Lori**	Biocontainment Unit
Bates, Melanie	Omaha Fire Department	**Meyer, Bill**	Nebraska Emergency Management Agency
Boulter, Katie	Nebraska Medical Center	**Mielke, Gayle**	Creighton University Medical Center
Bowes, Bill	Omaha Fire Department	**Morrison, John**	Douglas County Dept. of Corrections
Braswell, Nancy	Sarpy County Public Health	**Negron, Theresa**	Omaha Police Department
Carmody, Tim	Omaha Police Department	**Nelson, Cyndi**	The Nebraska Medical Center
Brazelton, Phil	Washington County 911	**Nevins, Jerry**	Creighton University Medical Center
Ciummo, Nicholas	US Postal Service	**Nitchals, Jane**	Alegent Health
Conrey, Mark	Douglas County 911	**O'Connor, Jane**	Alegent Health
Curington, Anita	72nd Civil Defense	**Orchard, Orin**	Papillion Police Department
Danon, Steven	Marcotte Insurance	**Otto, Joe**	Douglas County Health Center
DeRoos, Kathleen	Veterans Affairs	**Palensky, Jim**	Omaha Fire Department
Dodge, Barb	Nebraska Center For Bioterrorism	**Perkins, Donetta**	Childrens Hospital
Donovan, Patrick	US Air Force	**Perry, Terri**	Methodist Hospital
Dutton, Phyllis	Omaha Metropolitan Medical Response System	**Phillips, Joe**	Red Cross
Fuhlrodt, Rod	Blair	**Pieters, Jon**	Offutt AFB
Guido, Perry	Omaha Fire Department EMS	**Points, David**	Omaha Police Department
Gunning, Leslie	Center for Biopreparedness	**Pook, Bill**	Region 5/6 Emergency Management
Haese, Terry	Eppley Fire	**Raynovich, Bill**	Creighton University

Hauser, John	The Nebraska Medical Center	**Reiter, Maria**	Douglas County Health Department
Hermsen, Ken	Mass Fatality Subcommittee	**Rink, Lisa**	Sarpy County Emergency Management
Holtmeyer, Bill	Behavioral Health Subcommittee	**Roberts, Rosalee**	Media / RR Public Relations
Howard, Dena	American Red Cross	**Rogers, Jim**	Douglas County Emergency Management
Hummel, Terry	Pottawattamie County EM Coordinator	**Scherer, Ben**	Washington County Sheriff
Jenkins, James	Offutt Air Force Base	**Schott, Gary**	Eppley Airfield
Johnson, Paul	Douglas County Emergency Management Agency	**Shadden, Kelly**	Metro Area Transit
Kronne, Janice	Environmental Protection Agency	**Slagter, A.J.**	Federal Bureau of Invesigation
Kuzma, JJ	Salvation Army	**Snook, Dennis**	Behavioral Health / Region 6
Lane, Mark	Omaha Fire Department	**Spooner, Barry**	Omaha Fire Department
Larson, Marilyn	Three Rivers Public Health	**Stoker, Craig**	Salvation Army
Laughlin, Kevin	Omaha Fire Department	**Taylor, Gomer**	Walgreens
Lavelle, Larry	Sarpy County 911	**Varner, David**	USSTRATCOM J72
Lenaghan, Pat	Biocontainment Unit	**Weston, John**	Douglas County Health Department
Lewandowski, Jim	Mercy Hospital	**Whitted, Chris**	Papillion Police Dept.
Lindsley, Terry	Pottawattamie Co. EMA	**Yetter, Diane**	Creighton University Medical Center
Mangels, Mary	72nd CST	**Zeeb, Russell**	Sarpy Co. Sheriff Office
Marrs, Dearle	Crosby, Burket et al		
Mastandrea, Joe	Sarpy County Emergency Management Agency		
McCormick, Carol	Creighton University Medical Center		
McGrath, Mary	Media Subcommittee		

Participating Organizations

72nd Civil Support Team
Alegent Health Family Health Care
American Red Cross
Arlington Fire Department
Bellevue Fire Department
Bellevue Police Department
Bennington Fire Department
Bennington Police Department
Bergan Mercy Medical Center
Blair Memorial Community Hospital
Blair Police Department
Boys Town Clinic
Boys Town Fire Department
Boys Town Pediatric Clinic
Boys Town Police Department
Boys Town Research Hospital
Charles Drew Health Center
Children's Hospital
Children's Urgent
City of Omaha Public Works
Clarkson West Medical Center
Creighton Medical Center
Crosby, Burket et al.
Douglas County 911
Douglas County CSI
Douglas County Department of Corrections
Douglas County Department Roads
Douglas County Emergency Management Agency
Douglas County Health Center
Douglas County Sheriff Office
Educational Services Unit
Elkhorn Fire Department
Elkhorn Police Department
Environmental Protection Agency
Eppley Fire Department

Federal Bureau of Investigation
First National Bank Buildings
Ft. Calhoun Fire Department
Gretna Fire Department
Immanuel Hospital
Lakeside Hospital
LaVista Fire Department
LaVista Police Department
Marcotte Insurance
Medical Reserve Corps
Mercy Hospital
Methodist Hospital
Methodist Physicians Clinic
Metro Area Transit
Midlands Community Hospital
Nebraska Biocontainment Unit
Nebraska Department of Roads
Nebraska Emergency Management Agency
Nebraska Orthopedic Hospital
Nebraska State Patrol
Offutt Air Force Base
Omaha Airport Police
Omaha Fire Department
Omaha Metro Medical Reserve System (OMMRS)
Omaha Police Department
One World Community Center
Papillion Fire Department
Papillion Police Department
Ponca Tribe Fred Leroy Health & Wellness Center
Pottawattamie County Emergency Management Agency
Radiological (R Group) Control
Ralston Fire Department
Ralston Police Department
Region 5/6 Emergency Management Agency
Salvation Army
Sarpy County 911

Sarpy County Department Roads
Sarpy County Emergency Management Agency
Sarpy County Public Health
Sarpy County Sheriff's Office
Springfield Fire Department
The Center for Biopreparedness Education
The Nebraska Medical Center
Three Rivers Public Health
United States Air Force
United Way of the Midlands
UNMC Physicians
US Postal Service
Valley Police Department
Veterans Affairs Hospital
Walgreens
Washington County 911
Washington County Department of Roads
Washington County Sheriff Office
Waterloo Fire Department
Waterloo Police Department

Number of Participants

- Players: 229
- Controllers: 87
- Evaluators: 78
- Facilitators: 77
- Observers: 50
- Victim Role Players: 180

SECTION 2: EXERCISE DESIGN SUMMARY

Exercise Purpose and Design

Operation Triple Play provided an opportunity for agencies and organizations from the Tri-County UASI Area to operationally demonstrate the activation, implementation, and execution of their emergency plans and procedures in response to CBRNE events. In addition, it enabled agencies and organizations from the Tri-County Area to test the interoperability of its communications equipment and systems.

The Exercise Design Team for this full-scale exercise was composed of representatives from the pertinent organizations from both the public and private sectors from throughout the Tri-County Area. The full composition of the Exercise Design Team is provided in Section One: the Exercise Overview. The exercise was funded through the Fiscal Year 2005 Urban Area Security Initiative (UASI) Grant.

Exercise Objectives, Capabilities, and Activities

Capabilities-based planning allows for exercise planning teams to develop exercise objectives and observe exercise outcomes through a framework of specific action items that were derived from the Target Capabilities List (TCL). The capabilities listed below form the foundation for the organization of all objectives and observations in this exercise. Additionally, each capability is linked to several corresponding activities and tasks to provide additional detail.

Based upon the identified exercise objectives below, the exercise planning team has decided to demonstrate the following capabilities during this exercise:

- **Objective 1:** Demonstrate NIMS compliance.
  - **Emergency Operations Center Management:** Notify Government Agencies and Officials; Direct and Control Response Operations; and Alert and Mobilize EOC Staff.
  - **Onsite Incident Management:** Make Immediate Incident Scene Reports; Assess Incident and Develop Action Plan; Execute Incident Action Plan; Implement Post-Render-Safe Procedures; Direct Agent Release Mitigation Efforts; Preserve Incident Scene; Activate Traffic and Access Control Points; and Establish Incident Command/Unified Command.
- **Objective 2:** Apply the Nebraska HSEEP Process.
- **Objective 3:** Test interagency communications from Public Health to hospital ICP.
  - **Communications:** Standard Operation Procedures (TICP); and Usage (TICP).
- **Objective 4:** Test transfer of a contaminated victim via IsoPod.
  - **Medical Surge:** Transport Patients to Hospital; and Treat Patients at Hospital.

- **Triage and Pre-Hospital Treatment:** Conduct Search and Rescue Operations; and Track Patient Status/Location.

- **Objective 5:** Test hospital Incident Command on implementation and ACF Phase I Clinics.
  - **Medical Surge:** Prepare to Receive Patients.
- **Objective 6:** Test the function of EOC Medical Table on implementation of ACF Phase II Clinics.
  - **Emergency Operations Center Management:** Activate, Expand, and Operate the EOC.
- **Objective 7:** Test the setup of Radiological Portal Monitor and Decon on patient at metro area hospitals.
  - **WMD/ Hazardous Materials Response and Decontamination:** Collect Input for Hazard Assessment; Make Hazard Assessments and Predictions; Conduct Agent Release Mitigation Efforts.
- **Objective 8:** Test the setup of a Central Briefing Site.
  - **Emergency Public Information and Warning:** Prepare and Dissiminate Protective Action Messages; and Develop and Implement Protective Action Decisions.
- **Objective 9:** Test of Behavioral Health role at assigned positions.
  - **Medical Surge:** Provide Immediate Emergency Aid (Behavioral Health and Pshychological First Aid).
- **Objective 10:** Test implementation of the Personnel Processing Point.
  - **Onsite Incident Management:** Maintain Accountability of Responders and Citizens.

Scenario Summary

It is September 2006; several years have gone by since the last terrorist attack on U.S. soil. Increased security, aggressive investigations and preparedness have all been instituted on the "war on terror." However, the enemy we face is tenacious, dedicated, and highly motivated. The members of the terrorist group of Universal Adversary (UA) have waited, planned, and trained for the day they can launch an attack that will shake the nation of infidels; the United States of America. The United States is unaware, but this day is approaching rapidly.

On October 28, 2006 the Terrorist Group UA plans to launch a series of attacks against cities located across the United States. The urban areas of New York, Akron, Chicago, Omaha, Denver and San Diego have been targeted.

During early 2006 UA sent a reconnaissance cell to the Omaha area to compile intelligence on possible targets and other informational data that would assist the UA execution cell.

The reconnaissance cell has left the area and the execution cell has moved into the area to

replace it. The execution cell has set up in several "safe houses" in the Tri-County area (Douglas, Sarpy and Washington Counties). The UA terrorists plan for this area involves the detonation of a "dirty bomb" at the exhibition baseball game (New York Yankees vs. Kansas City Royals) at Rosenblatt Stadium on October 28, 2006. To push the response and recovery resources of the area beyond their capabilities, the UA terrorists also plan to infect the area with the smallpox virus.

On September 18, 2006, the UA terrorists feel that one of their safe houses may have been compromised. Following procedure in this matter, they immediately abandon the location. This means they leave the location immediately and will never return to that location. The location is an apartment in the Fairview Apartments, 1515 Rodeo Road in Springfield, Nebraska. Located in the basement is a storage area for the apartment. In this storage area the UA terrorists had stored the radiological material that they planned to use in their "dirty bomb" along with some explosives.

The UA terrorists must now change their original plan for 28 October 2006. They now plan to use improvised explosive devices (IED's) at Rosenblatt Stadium instead of a "dirty bomb." The smallpox part of the plan can be carried out unchanged. Unknown to the UA terrorists, their location at the Fairview Apartments was never compromised.

ATTACK COMPONENTS

Biological Attack (Small Pox)

The UA terrorists know that in order for the smallpox to have the optimum effect on the area's response and recovery elements and to allow for its incubation period, they will have to release it into the area well before October 28, 2006.

On October 14, 2006, the UA terrorists take a large amount of designer clothes to a retail consignment store in Blair, Nebraska. The retail store, GiGi's Fashion Clothes located at 1362 Washington St. in Blair, buys used clothing and resells it. The designer clothes that the UA terrorists have sold to the store are infected with smallpox. JR Jones and PJ Thomas work with the stores' incoming clothes inventory. Jones lives in Blair and Thomas lives in northwest Omaha.

On Monday, October 23rd JR Jones has not been feeling well, has a headache and slight temperature.

On Tuesday, October 24th at 0800 Jones is admitted to Blair Memorial Community Hospital with an elevated fever of 101, headaches, body aches and malaise.

On Wednesday, October 25th there is no significant change in Jones condition.

On Thursday October 26th the nurse on the unit notices with rounds that Jones has broken out into a full-blown rash. The physician is contacted and Blair Hospital sends a sample to the State

of Nebraska health laboratory to test for small pox and other diseases. The test is ordered for chicken pox later. Jones is placed in a negative pressure unit.

On Friday October 27th Jones condition has become progressively worse. In the morning the hospital laboratory calls back and says that the test for chicken pox has come back negative. Later in the afternoon the State laboratory calls back and says that the test for smallpox has come back positive. Blair Hospital Infection Control Nurse starts the process with Three Rivers Public Health to have the patient transferred to the Bio-containment Unit at the Nebraska Medical Center. The Nebraska Department of Health and Human Services is notified and they determine that the criteria have been met to admit the patient to the Biocontainment Unit and arrangements are made to admit Jones to the Biocontainment Unit.

On Saturday, October 28th at 0700, Blair Memorial Hospital communicates with Three Rivers Public Health Department and the Biocontainment Unit to arrange for transportation of Jones to the Biocontainment Unit at the Nebraska Medical Center. The patient is to be transferred utilizing an IsoPod via medical helicopter. Also on October 28th in Omaha, PJ Thomas comes into the Emergency Room at Immanuel Medical Center with a full-blown rash, elevated fever of 102, headaches, body aches and malaise. The hospital staff is aware of the situation in Blair and through history connects this patient to the same exposure that occurred with the Blair patient. Thomas is placed in a negative pressure room. The IMC Infection Control nurse notifies Douglas County Public Health to have the patient transferred to the Bio-containment Unit at the Nebraska Medical Center. The State Department of Health and Human Services is notified and they determine that the criteria have been met to admit the patient to the Biocontainment Unit. Arrangements are made to transport Thomas via ambulance, utilizing the IsoPod.

Transportation of both patients to the Biocontainment Unit is concluded by noon on October 28, 2006.

Improvised Explosive Device Attack

On Saturday October 28, 2006 at 0800, crowds of persons are moving into Rosenblatt Stadium to watch the New York Yankees play the Kansas City Royals in an exhibition baseball game. Among the crowd are six members of the UA terrorist execution cell moving quietly to their assigned locations.

Because of the event the Omaha Police Department has brought in their Mobile Command Post to coordinate public safety options. There is also an Omaha Fire Department Rescue Squad on the scene. (Before the exercise started the mobile command post and its staff were pre-staged. Five police officers were pre-staged, as well as the Omaha Fire Department Rescue Squad).

At 0900, during the singing of the National Anthem, two of the UA terrorists detonate themselves while sitting in two different seating sections. The crowd moves away from these seating areas and into the concourse area. Two more UA suicide bombers are waiting in the concourses; one is in the concourse to the right of the main entrance and the other to the left. When the concourses are full of people, the terrorists detonate themselves. The crowd storms

out of the stadium and many persons are injured as a result of being trampled. Once in the parking lots many run towards their cars and nearby buses. At this time a fifth UA terrorist boards a bus and detonates himself on board the bus.

During this time period a sixth terrorist attempts to detonate himself in the seating area of the stadium but the explosives don't go off. He pulls off his coat and attempts to work with the wiring. At this time an officer sees the suspect and begins to chase him to the far end of the stadium. During the foot pursuit the terrorist attempts to place a notebook in a trash container, but it falls out onto the stadium floor. After taking several more steps, there is a partial detonation of the terrorist's explosives which kills him, but injures no one else. The officer picks up the notebook and keeps persons from going near the terrorist as other explosive devices can be seen on his body.

Radio communication from police officers and fire rescue quickly alert the Incident Commander to the seriousness of the situation. The Incident Commander calls for mutual aid assistance and for the activation of the Douglas County Emergency Operations Center (EOC) through the chain of command. Because of the nature and the large amount of mutual aid units moving from other counties to the scene, both Sarpy County and Washington County stand up their Emergency Operations Centers. (All the EOC'S were up and operational at 0900 working on a compressed time concept).

Assistance is quick in coming from area fire and law enforcement agencies. Some of the first police units to arrive are the Bellevue Police, Ralston Police, LaVista Police, Papillion Police, Eppley Airfield Police, Sarpy County Sheriff, Nebraska State Patrol and the Douglas County Sheriff. Some of the first fire units to arrive are the Bellevue Volunteer Fire Department, La Vista Fire, Papillion Fire, and Ralston Fire Department. Offutt Air Force Medical Response Unit also arrives to assist as needed.

The next wave of assistance comes in the form of law enforcement units from Boys Town Police Department, Elkhorn Police Department, Waterloo Police Department, Valley Police Department and Bennington Police Department, and fire units from Boys Town Fire, Elkhorn Fire, Waterloo Fire, Valley Fire, and Bennington Fire.

The last wave of assistance comes in the form of law enforcement units from the Washington County Sheriff's Office and the Blair Police Department, and fire units from the Ft. Calhoun Fire, Blair Fire and Arlington Fire Departments.

Because of the nature of the event, a Special Agent of the Federal Bureau of Investigation proceeds to the Command Post at the site. The Omaha Bomb Squad is also called to the scene to deal with the unexploded ordinance on the body of Terrorist #6. The FBI sets up a Fusion Center and calls for the Douglas County Sheriff's Mobile Crime Lab to assist in the investigation.

The Communication Departments from all three counties begin to institute the Tactical Interoperable Communications Plan (TICP) developed for such an event. This plan involves the

Communications Centers in Douglas, Sarpy, and Washington Counties.

Law enforcement units form a perimeter to keep persons from coming back to the stadium and provide a secure area where EMS can treat and triage individuals injured by the blasts. EMS realizes that they do not have enough resources to transport the injured to area hospitals and call for transportation assistance from Metro Area Transit (MAT). (MAT Buses were put into play from staging area in staggered sequence)

Metro Area Transit Buses transport injured persons to Immanuel Medical Center, Bergan Mercy Medical Center, Children's Hospital, Methodist Hospital, Creighton Medical Center, Nebraska Medical Center, Lakeside Hospital, Douglas County Health Center, Midlands Community Hospital and Mercy Hospital. Transportation starts immediately and continues through the course of the rescue operation at Rosenblatt Stadium.

Debris from the blasts is hindering some of the EMS workers so a request is made to Douglas County EOC to have Public Works assist in clearing and removing it. Omaha Public Works arrives with the Douglas County Roads Department and request mutual aid assistance from the Nebraska Department of Roads, Sarpy County Department of Roads, and Washington County Department of Roads through the Douglas County EOC. Soon thereafter, units arrive from Sarpy County Department of Roads, Washington County Department of Roads and the Nebraska Department of Roads. (Public Works and Roads from Douglas, Washington, Sarpy Counties and the Nebraska Department of Roads were sent from a staging area in a staggered manner).

Radiological Attack

The notebook that Terrorist #6 tried to dispose of contained information that the terrorists had taken clothing contaminated with small pox to GiGi's Fashion Store, 1362 Washington St., Blair, Nebraska, and that radioactive material and explosives were stored in an apartment at the Fairview Apartment Building, 1515 Rodeo Road, Springfield, Nebraska. The Incident Commander at Rosenblatt relays this information to the Douglas County EOC. It is then relayed to the Sarpy County EOC and Washington County EOC. (This should include the relay of the information to the EOC Medical Table at the Douglas County EOC).

Sarpy County EOC contacts the Sarpy County Sheriff's Office and the Springfield Volunteer Fire Department regarding the situation at the Fairview Apartment Building. Sarpy County Sheriff's Office activates their Emergency Service Unit. The deputies, upon interviewing the apartment manager, find that the occupants of Apartment # 7 had abandoned the apartment several weeks ago. The manager was not sure of the status of the storage unit in the basement.

The deputies enter the apartment with radiation detectors and pick up readings; they immediately leave the building. The occupants of the apartments, through the use of vehicle speakers, are told to leave the building. Springfield Fire completes a gross decontamination of the Fairview Apartment complex occupants. Some of the occupants display symptoms of radiation sickness. The occupants are transported to area hospitals to be checked out and treated according to the area hospital plan for this type of event. (Evacuation of the Apartment building and gross

decontamination of the occupants will be artificialities in the exercise. Volunteers portraying Springfield victims will be transported to hospitals from the Rosenblatt site).

Because of the radioactive material and the possibility of explosives, the Sarpy County EOC has also requested the Omaha Bomb Squad through the Douglas County EOC and the use of the 72nd Civil Support Team (CST) through the Governor's Office via Nebraska Emergency Management Agency (NEMA). The Unified Command at the Sarpy site has also requested the Bellevue Fire Department's HazMat Unit because of the radioactive material.

The Omaha Bomb Squad, dressed in proper PPE, enter the basement of the apartment building and conduct a survey for booby traps and explosives. They find that vandals, transients or juveniles had forced the door to storage unit #7 open. They find that there is a booby trap, and explosives are stored in the unit. They disarm the booby trap and remove all explosives from the building.

Knowing that the basement of the apartment building is cleared of booby traps and explosives, the 72nd CST, the Bellevue Fire Department, the Springfield Fire Department and Offutt Bioenvironmental Detection Team do a joint entry of the basement to survey for radioactive material. They find the container of radioactive material had been opened and traces of the material were found in the basement. They finish their survey and make recommendations on how to proceed with the situation.

SECTION 3: ANALYSIS OF CAPABILITIES

This section of the report reviews the performance of the exercised capabilities, activities, and tasks. In this section, observations are organized by capability and associated activities. The capabilities linked to the exercise objectives of Operation Triple Play are listed below, followed by corresponding activities. Each activity is followed by related observations, which include references, analysis, and recommendations.

CAPABILITY 1: COMMUNICATIONS

Capability Summary: Communications is the fundamental capability within disciplines and jurisdictions that practitioners need to perform the most routine and basic elements of their job functions. Agencies must be operable, meaning they must have sufficient wireless communications to meet their everyday internal and emergency communication requirements before they place value on being interoperable, meaning being able to work with other agencies.

Communications interoperability is the ability of public safety agencies (police, fire, EMS) and service agencies (public works, transportation, hospitals, etc.) to talk within and across agencies and jurisdictions via radio and associated communications systems, exchanging voice, data and/or video with one another on demand, in real time, when needed, and when authorized. It is essential that public safety has the intra-agency operability it needs, and that it builds its systems toward interoperability.

Operation Triple Play performed the Communications capability by utilizing 800 MHz Radios to facilitate interoperability between all participating organizations. Additionally, the Communications Centers in all three counties instituted the Tactical Interoperable Communications Plan (TICP).

Activity 1.1: Standard Operation Procedures (TICP)

Observation 1.1.1: Area for Improvement. UASI and OMMRS have different Standard Operating Procedures regarding self-identification.

References: None.

Analysis: Sarpy County Incident Commander informed that UASI communication Standard Operating Procedure (SOP) is to self-identify and then to identify the call site. The OMMRS SOP is to identify the call site and then one's self. This created some confusion, although most sites utilized the OMMRS SOP. This may be a result of no ICS Form 205 (Incident Radio Communications Plan) being implemented. It should also be noted that Operation Triple Play was a complex, detailed Full-Scale Exercise that incorporated numerous scenarios.

Recommendations:

1. OMMRS Hospital Network for 800 MHz radios and Public Health's Network for 800 MHz radios should be tested monthly for interoperability.
2. Interoperability between OMMRS and Public Health should be tested in future exercises that are less complex.

Observation 1.1.2: Area for Improvement. The HazMat team and 72nd CST had different communications protocols.

References: None.

Analysis: Response to the Sarpy County site was weakened by HazMat and the 72nd CST having different communications protocols. 72nd CST, Sarpy HazMat, and Offutt HazMat did not communicate plans with each other effectively.

Recommendations:

1. Test the interoperability of the various HazMat teams in future exercises.

Observation 1.1.3: Area for Improvement. Some players were unsure as to which Talk Groups and channels should be used.

References: None.

Analysis: The 800 MHz radios bring great potential in Interoperable Communications which, for the most part, were exhibited during Operation Triple Play. However, a few players were not fully knowledgeable with the TIC plan that governed the communications in the exercise. Additionally, Field Commanders did not efficiently relay information to the EOCs regarding which channels were assigned to whom.

Recommendations:

1. Each responder should be aware of and trained on the TIC plan, including which channels and Talk Groups are to be used and by whom.
2. Assure clear call signs, including differentiating between hospital contacts.
3. Communications Leader should assign channels.

Observation 1.1.4: Area for Improvement. Communication between the Emergency Operations Center and Personnel Processing Point was lost due to equipment failure and no alternative form of communication flow was immediately available.

References: None.

Analysis: EOC to PPP communication was lost after one hour due to equipment failure. This impacted the deployment of Behavioral Health personnel. An alternate form of communication flow is needed that is not dependant on land lines or cell phones. Some miscommunication between the Ham operator and the EOC was also experienced.

Recommendations:

1. A pool of amateur radio operators needs to be identified and accessible.

Observation 1.1.5: Area for Improvement. OMMRS Hospital network and Public Health's network are not coordinated to work together.

References: None.

Analysis: The OMMRS and Public Health networks are not coordinated to work together which detracts from the interoperable communications capability.

Recommendations:

1. The hospital network and the Public Health network should have monthly testing together to ensure radio utilization competency.
2. Identify those areas where communications were not established and evaluate the issue for resolution.
3. Monthly 800 MHz Roll Calls should take place to assure that communications are maintained between hospitals, Incident Command Posts, and Public Health.

Activity 1.2: Usage (TICP)

Observation 1.2.1: Area for Improvement. Some entities did not respond to the roll call.

References: None.

Analysis: Several hospitals did not respond to the initial roll call, although some did report later. Some were unable to be contacted throughout the day.

Recommendations:

1. Monthly 800 MHz Roll Calls should take place to assure that communications are maintained between hospitals, Incident Command Posts, and Public Health.

Observation 1.2.2: Area for Improvement. Omaha Fire Department experienced internal and external challenges to Interoperable Communications.

References: None.

Analysis: Some communications from Sarpy County were not patched through to OFD correctly, and the usage of outside agencies radio channels was problematic. Additionally, it was difficult to communicate with the Bomb Squad. Both terminology consistency and channel usage were issues for the Omaha Fire Department, as well.

Recommendations:

1. Conduct training on terminology consistency.
2. Conduct training to ensure proper channel usage on radios.
3. Test with future exercises.

Observation 1.2.3: Strength. Common response communication (i.e., plain language) was used.

References: None.

Analysis: Common response communication was used instead of special codes in most instances. This ensured that all parties could communicate effectively and without confusion. However, several plain language terms can apply to one idea (e.g., Rosenblatt, Command Post, CP), which caused communications problems at times during Operation Triple Play. Additionally, the effective use of Public Health Control and Hospital/Health Encrypted Talk Groups further enhanced the ability to communicate without confusion.

Recommendations:

1. Train responders to consistently clarify location and post to avoid confusion.

Observation 1.2.4: Strength. 800 MHz Radios facilitated interoperable communications.

References: None.

Analysis: The 800 MHz radios enabled participating organizations to communicate by utilizing a common system. This was a major strength exhibited during Operation Triple Play. However, Federal agencies are currently not able to purchase these 800 MHz radios because they cannot obtain permission to have the User ID.

Recommendations:

1. Address the issue of Federal agencies not being able to purchase 800 MHz radios.

Observation 1.2.5: Area for Improvement. Sarpy County uses both analog and digital

radios.

References: None.

Analysis: Sarpy County communications is part analog, part digital. Participants in this exercise were to use analog communications, but this needs to be worked out better for future events.

Recommendations:

1. Sarpy County should evaluate their 800 MHz radio systems to ensure necessary communications occur.

Observation 1.2.6: Area for Improvement. Public Health could not reach Incident Command Posts at three facilities.

References: None.

Analysis: Public Health was unable to contact Incident Command Posts at three facilities. There was some confusion over call signs, channels, and talk groups.

Recommendations:

1. Clarify call signs, channels, and talk groups.
2. Provide additional 800 MHz radio training for responders.
3. Conduct monthly roll calls.

CAPABILITY 2: EMERGENCY OPERATIONS CENTER MANAGEMENT

Capability Summary: Emergency Operations Center (EOC) Management is the capability to provide multi-agency coordination (MAC) for incident management by activating and operating an EOC for a pre-planned or no-notice event. EOC management includes EOC activation, notification, staffing, and deactivation; management, direction, control, and coordination of response and recovery activities; coordination of efforts among neighboring governments at each level and among local, regional, State, and Federal EOCs; coordination public information and warning; and maintenance of the information and communication necessary for coordinating response and recovery activities.

The scope of Operation Triple Play required the activation of Emergency Operations Centers (EOC) and the EOC Medical Table in Douglas County. The Incident Commander called for mutual aid assistance and for the activation of the Douglas County Emergency Operations Center (EOC) through the chain of command. Because of the nature and the large amount of mutual aid units moving from other counties to the scene, both Sarpy County and Washington County stood up their respective Emergency Operations Centers.

Activity 2.1: Activate, Expand, and Operate the EOC

Observation 2.1.1: Strength. Information was well-exchanged between tables at the Emergency Operations Centers.

References: None.

Analysis: The Douglas County EOC received many updates from the incident scene and shared the transmitted information between all entities. The Sarpy County EOC maintained a visual log for all players in the EOC to see. Washington County reported no issues in the pertaining to intra-EOC communication.

Recommendations: None.

Observation 2.1.2: Area for Improvement. No communication between the EOCs early in the exercise.

References: None.

Analysis: Sarpy and Washington County EOCs reported a lack of communication between the EOCs and did not know what other responding agencies were doing.

Recommendations:

1. Create a direct link between all three EOCs.

Observation 2.1.3: Area for Improvement. ACF Clinics experienced difficulty in communicating with the EOC Medical Desk during the exercise.

References: None.

Analysis: ACF Clinics communicate with the EOC Medical desk via fax machine, but this method has proved unreliable.

Recommendations:

1. Utilize email, radio, or some other method of communication between ACFs and the EOC as a backup measure.
2. Conduct tabletop exercise with an emphasis on form utilization.
3. Evaluate use of hospital system for patient tracking and the media injury report form.

Observation 2.1.4: Area for Improvement. The Law EOC (LEOC) located at the Central

Police Station, not the Law table at the Douglas EOC, received most of the law enforcement-related communication from the incident scene.

References: None.

Analysis: The LEOC, not the Law table at the Douglas EOC, was the driving force behind the law enforcement issues at the Rosenblatt site. As such, confusion resulted over which entity—the Law table or the LEOC—had which responsibilities. Additionally, the players at the LEOC, EOC, and Incident Site have minimal training for their roles and the people who staff many of these positions may be different if a real-world event were to occur. The players at all positions need to know how to obtain the proper resources and how the Incident Command System functions.

Recommendations:

1. Define the responsibilities of the LEOC and the Law table in the EOC to ensure that information flow is from the scene to the EOC to the LEOC.

Observation 2.1.5: Area for Improvement. Information flow from the Emergency Operations Center to the Central Briefing Site regarding patients and clinical information was limited.

References: None.

Analysis: The flow of information from the EOC to the CBS regarding medical issues was limited and slow. No diagram of information flow was available which caused confusion.

Recommendations:

1. Appoint media/public information liaison in the EOC under the Incident Commander to ensure that information is driven to the CBS.
2. Diagram flow of information within the EOC to identify gaps.
3. Create alternative communications method.
4. Clarify process for tracking radio information.

Observation 2.1.6: Area for Improvement. Sarpy County EOC was unsure about certain operating procedures.

References: None.

Analysis: Sarpy County EOC was unsure how to request equipment authorization. Additionally, not all requests were properly recorded in the log. Sarpy EOC was also not sure who activates OMMRS and at what level. Finally, there was confusion as to which

person performs which function in the EOC.

Recommendations:

1. Appoint scribe to keep track of events.
2. Train Sarpy EOC and Washington EOC on OMMRS implementation.

Observation 2.1.7: Area for Improvement. Sarpy County EOC was very loud.

References: None.

Analysis: The Sarpy County Emergency Operations Center was too loud. Radio traffic and face-to-face conversations contributed to this situation.

Recommendations:

1. Evaluate Sarpy EOC setup for possible reconfiguration of persons to reduce confusion and noise.

Activity 2.2: Alert and Mobilize EOC Staff

Observation 2.2.1: Strength. All EOCs were operational shortly after notification.

References: None.

Analysis: EOCs were made operational in line with Critical Task Res.B1c 3.1: Establish organization/operation of EOC.

Recommendations: None.

Observation 2.2.2: Area for Improvement. Douglas County EOC Management felt that more support staff was necessary.

References: None.

Analysis: Douglas County EOC was operating at about half of the necessary staffing level.

Recommendations:

1. Douglas County EOC Management should evaluate staffing problems and discuss the issue with the appropriate agencies.

Activity 2.3: Direct and Control Response Operations

Observation 2.3.1: Area for Improvement. Sarpy County did not create an incident action plan.

References: None.

Analysis: No incident action plan was developed in Sarpy County.

Recommendations:

1. Develop Incident Action Plan in future exercises.

Activity 2.4: Notify Government Agencies and Officials

Observation 2.4.1: Area for Improvement. Douglas County EOC reported that some phone numbers were incorrect.

References: None.

Analysis: In making notifications to other governmental agencies, the Douglas County EOC discovered that a few of the telephone numbers they had were incorrect. This issue was corrected shortly thereafter.

Recommendations: None. This area for improvement was addressed shortly after it arose.

CAPABILITY 3: EMERGENCY PUBLIC INFORMATION AND WARNING

Capability Summary: The Emergency Public Information and Warning capability includes public information, alert/warning and notification. It involves developing, coordinating, and disseminating information to the public, coordinating officials, and incident management and responders across all jurisdictions and disciplines effectively under all hazard conditions.

Operation Triple Play utilized a Central Briefing Site to conduct Emergency Public Information and Warning operations.

Activity 3.1.1: Develop and Implement Protective Action Decisions

Observation 3.1.1: Douglas County EOC received the information necessary to develop Protective Action Decisions.

References: None.

Analysis: By 10:11am, EOC was notified of the possibility of two victims contaminated with smallpox and that these victims were being transferred to the Nebraska Medical Center's Biocontainment Center. This allowed for appropriate information to be disseminated from the Central Briefing Site.

Recommendations: None.

Activity 3.2: Prepare and Disseminate Protective Action Messages

Observation 3.2.1: Strength. Sarpy County EOC disseminated evacuation messages to affected areas.

References: None.

Analysis: Sarpy County EOC created evacuation maps that were projected on the video wall in the EOC and established sheltering. This allowed for the appropriate protective action messages to be disseminated to affected areas in Sarpy County.

Recommendations: None.

Observation 3.2.2: Area for Improvement. The Public Health Media Line was overwhelmed.

References: None.

Analysis: The Public Information Hotline was not implemented early enough. As a result, the Public Health Media Line was overwhelmed.

Recommendations:

1. Implement Public Information Hotline earlier in future events.
2. Activate the Family Assistance Center (FAC) quickly so that calls to the Public Information Hotline can be deflected there.
3. Behavioral Health Public Information Messages need to be developed and be made available to the Central Briefing Site.

CAPABILITY 4: MEDICAL SURGE

Capability Summary: Medical Surge is the capability to rapidly expand the capacity of the existing healthcare system in order to provide triage and subsequent medical care. This includes

providing definitive care to individuals at the appropriate clinical level of care, within sufficient time to achieve recovery and minimize medical complications. The capability applies to an event resulting in a number or type of patients that overwhelm the day-to-day acute-care medical capacity. Planners must consider that medical resources are normally at or near capacity at any given time. Medical Surge is defined as rapid expansion of the capacity of the existing healthcare system in response to an event that results in increased need of personnel (clinical and non-clinical), support functions (laboratories and radiological), physical space (beds, alternate care facilities) and logistical support (clinical and non-clinical equipment and supplies).

Medical Surge in Operation Triple Play included Phase I and Phase II Alternate Care Facilities and the Medical Reserve Corps. Utilizing these resources allowed for the effective expansion of the Tri-County Area healthcare system for external surge capacity.

Activity 4.1: Prepare to Receive Patients

Observation 4.1.1: Strength. Hospitals were notified of event so that preparations for patients could begin.

References: None.

Analysis: The evaluator at Methodist reported that communication regarding patients that would be brought in was adequate. Evaluators at Midlands, Methodist, and Douglas County Mental Health were all notified by 9:30am. All facilities were operational with at least a skeleton crew within one hour of notification.

Recommendations: None.

Observation 4.1.2: Area for Improvement. Activation of Phase I and Phase II ACF Clinics was hindered by communications issues.

References: None.

Analysis: Hospital Incident Command did not contact the correct person upon activating ACF Phase I. Upon activation of Phase II, two Creighton and two Methodist facilities did not receive notification from the EOC Medical Table. Additionally, the ACFs were notified only of the Smallpox incident, not the explosions. Furthermore, personnel within the ACFs were unable to efficiently communicate with one another.

Recommendations:

1. Clarify how hospitals are notified that Phase I and/or Phase II have been activated.
2. Phase I and Phase II clinics need a Situation Report upon receiving the first call to ensure they are properly prepared to treat incoming patients.

3. Create a backup system for the telephone/cell system currently in use.
4. Update recall list, including the addition of area codes.
5. Institute radio communication for internal ACF use.

Observation 4.1.3: Area for Improvement. Authorized personnel were not identified by badge in the ACFs.

References: None.

Analysis: Authorized personnel were not identified through a badging process. As a result, it was not immediately clear who was authorized to be in the ACF.

Recommendations:

1. Create a badging process to identify those who are authorized to be in ACFs during emergencies.

Observation 4.1.4: Area for Improvement. ACF Clinics did not know which staff was necessary.

References: None.

Analysis: Internal utilization of essential and non-essential personnel at ACF clinics was not as efficient as it could have been.

Recommendations:

1. ACF clinics need to determine the role of personnel, both essential and those considered non-essential.

Activity 4.2: Provide Immediate Emergency Aid

Observation 4.2.1: Strength. The backpack version of Medical Reserve Corps Go Bags worked effectively.

References: None.

Analysis: The backpack version of MRC Go Bags were adequate to accomplish the necessary tasks.

Recommendations: None.

Activity 4.3: Transport Patients to Hospital

Observation 4.3.1: Strength. Biocontainment Unit handled the transportation of contaminated patients appropriately.

References: None.

Analysis: Both hospitals, all volunteers, and the Biocontainment Unit took the IsoPod exercise seriously. The goal of preparing the unit to receive a patient in less than three hours was met. Additionally, a patient was successfully transferred from the external location to the unit in line with the BCU objectives.

Recommendations: None.

Observation 4.3.2: Area for Improvement. Certain procedures pertaining to the usage of the IsoPod were not followed.

References: None.

Analysis: IsoPod operators did not have all emergency equipment inside the unit. Additionally, patient charts that should not have been inside the unit were inside the unit. Security PPE procedures, including the use of taped booties, were not fully followed, and one hospital did not have a blower. Also, the door to the IsoPod unit was not closed at all times as it should be. Finally, a lack of communication on the timing of the transport was a detriment.

Recommendations:

1. Ensure that the door to the patient's room door is closed at all times.
2. Enhance protocols to ensure better patient isolation.

Observation 4.3.3: Area for Improvement. Some patients were sent to the wrong level of care.

References: None.

Analysis: Some patients in critical condition were sent to ACF Phase II clinics, an inappropriate level of care for such victims. Additionally, there was some confusion regarding where to go at the ACFs as some patients were sent to the wrong place.

Recommendations:

1. Place more specific signage outside of clinics to direct patients to the necessary area.

Observation 4.3.4: Area for Improvement. IsoPod could not be used with helicopoters.

References: None.

Analysis: Federal regulations require that any IsoPod transferred via helicopter utilize FAA-approved straps. No such straps were available for the IsoPod during transportation. This observation was made during the planning stages and was excluded from the exercise.

Recommendations:

1. Evaluate FAA-approved straps for the IsoPod.

Activity 4.4: Treat Patients at Hospital

Observation 4.4.1: Strength. Patient flow inside ACF Phase I and II clinics was smooth.

References: None.

Analysis: The goal to maintain steady patient flow through the Phase I and Phase II clinics was met as a result of the diligent work of the staff members at said clinics.

Recommendations: None.

Observation 4.4.2: Area for Improvement. ACF Clinics were not fully supplied at the level necessary to respond to a large-scale incident.

References: None.

Analysis: Tetanus and other controlled agents were not available in the quantity necessary. Phase II clinics did not have the N95 masks necessary to treat patients in a biological event. Phase I clinics faced internal delivery issues that made the flow of necessary supplies to the needed locations more difficult.

Recommendations:

1. ACFs should contact EOC Medical Table for supplies.
2. Consider purchasing N95 masks for ACFs.

Observation 4.4.3: Area for Improvement. No stand-down notification occurred at ACFs.

References: None.

Analysis: No stand-down notification occurred. As a result, ACF staff members did

not know when to close the clinics.

Recommendations:

1. Appropriate procedures should be added to EOC Medical Table protocols to ensure ACFs know when to stand down.

Observation 4.4.4: Area for Improvement. The timing of ACF implementation was problematic.

References: None.

Analysis: Some patients were transported to ACFs before the hospitals were ready to receive them. Additionally, some facilities received too much direction and implemented activity before they should.

Recommendations:

1. Follow Master Scenario Event List (MSEL) in future exercises.

CAPABILITY 5: ONSITE INCIDENT MANAGEMENT

Capability Summary: Onsite Incident Management is the capability to effectively direct and control incident activities by using the Incident Command System (ICS) consistent with the National Incident Management System (NIMS).

The Incident Command System was utilized during Operation Triple Play as to effectively direct and control incident activities.

Activity 5.1: Make Immediate Incident Scene Reports

Observation 5.1.1: Strength. The officer that received the intelligence information and saw the terrorist immediately passed the information on to the Incident Command Post.

References: N/A

Analysis: The officer accurately reported the on-scene situation to the Command Post. This includes identifying the terrorist and reporting said individual. This is in line with Critical Task Res.B1a 4.1.1: "Conduct initial assessment (size-up) (first arriving units)."

Recommendations: None.

Activity 5.2: Assess Incident and Develop Action Plan

Observation 5.2.1: Strength. Prepared tactical action plan and communicated the plan to the Incident Command Post.

References: None.

Analysis: Bomb Squad members received an adequate brief from the on-scene police officer. From there, they conducted the necessary sweep and established a tactical action plan. This plan was communicated with the ICP as required.

Recommendations: None.

Observation 5.2.2: Area for Improvement. Bomb Squad members approached the device twice without protection.

References: None.

Analysis: Bomb Squad members approached the device twice without protection. The evaluator did not feel this was necessary.

Recommendations:

1. Bomb Squad needs to evaluate procedures for PPE when approaching possible devices.

Activity 5.3: Execute Incident Action Plan

Observation 5.3.1: Strength. The Incident Action Plan was executed as designed.

References: None.

Analysis: The Bomb Squad addressed several suspicious packages during the exercise. As a result, the Bomb Squad prioritized their tasks well, deployed the robot as necessary, explained any intelligence with the crime scene investigators, and continued taking input from all Bomb Squad members. The evaluator felt that a good Render Safe Procedures plan was created and that it was well executed on the scene.

Recommendations: None.

Observation 5.3.2: Area for Improvement. Law Enforcement and Fire officials were providing contradictory instructions to victims at Rosenblatt.

References: None.

Analysis: Many victims reported that they were told different things by Police Officers and Firefighters. The Police generally told the patients to self-evacuate the stadium while Fire personnel told them to stay in place. Fire policy at the site was to stay back until the area around and in the stadium was "cleared" of secondary devices. In Police terms, this "cleared" does not occur until the bomb team is able to make a through search/sweep of the site, a process that normally takes two hours or more. This resulted in a delay in care to downed victims.

Recommendations:

1. OPD and OFD need to review their procedures for entry into an incident site to ensure they comport.

Observation 5.3.3: Strength. Deployment of Bomb Squad to two different locations worked well.

References: None.

Analysis: The deployment of the Bomb Squad to two different locations worked well. ATF and Pottawattamie County responded, as well. The crew had enough personnel and equipment, and all evidence was treated appropriately. However, some additional equipment such as light search suits and cutting/breaching tools for the robot would have made the process more efficient.

Recommendations:

1. Obtain light search suits for the Bomb Squad and cutting/breaching tools for the Bomb Squad robot.

Observation 5.3.4: Area for Improvement. Sarpy County Law Enforcement had insufficient flow of communication to the Incident Command Post regarding its activities.

References: None.

Analysis: The flow of information from Sarpy County Law Enforcement officials to the Incident Command Post was insufficient. Additionally, intelligence communication regarding the notebook obtained as evidence was not processed and delivered in a timely manner to the Sarpy Incident Command.

Recommendations:

1. Assign a liaison from the primary agency responsible for the Render-Safe Procedures Plan (RSP) to the Incident Command Post to maintain contact with responders.

Activity 5.4: Implement Post-Render-Safe Procedures

Observation 5.4.1: Strength. The scene was cleared and the unexploded device was removed in a safe manner.

References: None.

Analysis: The RSP plan was high-quality and was well-executed. As such, the incident scene was cleared and the unexploded device was able to be removed in a safe manner.

Recommendations: None.

Activity 5.5: Maintain Accountability of Responders and Citizens

Observation 5.5.1: Strength. The Personnel Processing Point operated properly.

References: None.

Analysis: The Personnel Processing Point demonstrated many strengths including adequate staffing levels, efficient use of equipment, rapid processing of volunteers, and efficient setup by the moulage team.

Recommendations: None.

Observation 5.5.2: Area for Improvement. The Personnel Processing Point was too small to accommodate the amount of staff that was present.

References: None.

Analysis: The Personnel Processing Point did not have adequate space to conduct the operations required of it. The proximity of the PPP to the incident contributed to this issue.

Recommendations:

1. Ensure Personnel Processing Point is large enough to handle all volunteers in future exercises.

Observation 5.5.3: Area for Improvement. Not enough volunteers followed through with their commitment to participate in the exercise.

References: None.

Analysis: Too few volunteers followed through with the commitment they made at the orientation. Some 254 volunteers committed to participate at the orientation, but only 180 reported to the Personnel Processing Point.

Recommendations:

1. Continue pre-training volunteers prior to exercises.
2. Train at least fifty additional actor volunteers than the exercise requires.

Observation 5.5.4: Area for Improvement. Symptom cards were not provided to volunteers who did not undergo moulage.

References: None.

Analysis: Only moulaged victims had symptom cards. This complicated the exercise process as the participation of non-moulaged volunteer victims was delayed.

Recommendations:

1. All volunteer victims should receive moulage cards in future exercises.

Observation 5.5.5: Area for Improvement. Food was not provided for those at the Personnel Processing Point nor for Medical Reserve Corps volunteers until specifically requested.

References: None.

Analysis: Food was not provided for volunteers and staff at the Personnel Processing Point or for the Medical Reserve Corps members until it was specifically requested. This impeded their ability to maintain the check-in process and assist victims, respectively.

Recommendations:

1. Better communication should be established between the food provider and the locations to which food is to be provided.
2. Food should be provided to pre-determined locations without being requested during the exercise.

Activity 5.6: Preserve Incident Scene

Observation 5.6.1: Strength. Responders worked well together despite coming from various agencies.

References: None.

Analysis: Preservation of the incident scene means that any criminal investigation, rescue, or agent mitigation can continue without interference with appropriate records being kept during said preservation. Responders developed a plan, were aware of crime scene contamination issues, and were able to identify and record evidence appropriately despite representing different agencies.

Recommendations: None.

Activity 5.7: Activate Traffic and Access Control Points

Observation 5.7.1: Strength. Police officers on scene secured the area and kept unauthorized people away.

References: None.

Analysis: The officers followed the typical steps outlined on the EEG. Unauthorized access into the hazard area was prevented and updates were communicated to the EOC.

Recommendations: None.

Activity 5.8: Establish Incident Command/Unified Command

Observation 5.8.1: Area for Improvement. No Unified Command was established.

References: None.

Analysis: Operation Triple Play met expectations as per the conduct of all players. However, some improvement is required in establishing and practicing a Unified Command model. Unified Command was announced early in the incident in good faith, but each IC remained in his or her command post and never met face-to-face. Some communication occurred between agencies, but communication was strained by the Command Post runner system not functioning properly and the physical separation of the OFD and OPD command posts.

Recommendations:

1. Leaders of all agencies need to collaborate and identify the Unified Command process to ensure that it is implemented in future incidents.
2. Put a table between the OFD and OPD command posts to ensure face-to-face collaboration.
3. More ICS training needs to be conducted for those who will take command positions in a large IC/UC incident.

CAPABILITY 6: TRIAGE AND PRE-HOSPITAL TREATMENT

Capability Summary: Triage and Pre-Hospital Treatment is the capability to appropriately dispatch emergency medical services (EMS) resources; to provide feasible, suitable, and medically acceptable pre-hospital triage and treatment of patients; to provide transport as well as medical care en-route to an appropriate receiving facility; and to track patients to a treatment facility.

Operation Triple Play demonstrated the Triage and Pre-Hospital Treatment capability by treating victims onsite with both volunteer responders (Medical Reserve Corps) and Emergency Medical Responders. Additionally, the IsoPod was used to transfer contaminated victims to the hospital for treatment.

Activity 6.1: Conduct Search and Rescue Operations

Observation 6.1.1: Strength. Responders triaged downed victim at scene.

References: None.

Analysis: The downed victim was medically stabilized in line with the expected outcome listed on the EEG. Additionally, Law Enforcement managed to secure the incident scene and maintain a safe perimeter. Triage tags were used appropriately approximately 90% of the time.

Recommendations:

1. Conduct additional training for MRC volunteers and Offutt Personnel to ensure proper usage of triage tags in all instances.

Observation 6.1.2: Area for Improvement. Medical Reserve Corps and the Offutt Personnel did not communicate their respective triaging tagging procedures to one another.

References: None.

Analysis: There was confusion between the MRC and Offutt regarding whether triage should take place at the hospital or at the incident site.

Recommendations:

1. Conduct additional training for MRC volunteers and Offutt Personnel to ensure proper usage of triage tags in all instances.

Activity 6.2: Track Patient Status/Location

Observation 6.2.1: Strength. Interoperable communications between hospitals and the Emergency Operations Centers.

References: None.

Analysis: The 800 MHz radios were used to ensure interoperable communications took place. This method worked well by allowing for rapid communication between the hospital and the EOCs. Additionally, the hospitals faxed hospital status updates to the EOCs every 30 minutes to keep them abreast of the medical issues such as patient status and location.

Recommendations: None.

Observation 6.2.2: Area for Improvement. A lack of communications between Washington County EOC and hospitals in the area was reported.

References: None.

Analysis: No hospital representative was present in the Washington County EOC. Additionally, Washington County's EOC did not communicate with the hospitals.

Recommendations:

1. Hospital representatives should be in the Washington County EOC.

CAPABILITY 7: WMD/ HAZARDOUS MATERIALS RESPONSE AND DECONTAMINATION

Capability Summary: Weapons of Mass Destruction (WMD)/Hazardous Materials Response and Decontamination is the capability to assess and manage the consequences of a hazardous materials release, either accidental or as part of a terrorist attack. It includes testing and identifying all likely hazardous substances onsite; ensuring that responders have protective clothing and equipment; conducting rescue operations to remove affected victims from the hazardous environment; conducting geographical survey searches of suspected sources or contamination spreads and establishing isolation perimeters; mitigating the effects of hazardous materials, decontaminating on-site victims, responders, and equipment; coordinating off-site decontamination with relevant agencies, and notifying environmental, health, and law enforcement agencies having jurisdiction for the incident to begin implementation of their standard evidence collection and investigation procedures.

Operation Triple Play demonstrated the WMD/Hazardous Materials Response and Decontamination capability by treating victims of terrorist attacks, including biological and radiological attacks.

Activity 7.1: Collect Input for Hazard Assessment

Observation 7.1.1: Strength. Initial reports about the incident were received by the EOCs in a prompt manner.

References: None.

Analysis: Initial reports received by the EOCs for the purpose of Hazard Assessments were conducted as expected. The Douglas County site had a news report two minutes after the exercise started and meteorological information four minutes after the exercise started. The Sarpy County Site tracked meteorological conditions throughout the exercise and issued a Copespear notice one minute after the exercise started. By doing these things, players in the EOCs were able to make initial estimates of the incident's impact and direct resources accordingly.

Recommendations: None.

Observation 7.1.2: Area for Improvement. Additional updates from Incident Command were necessary at the Sarpy County EOC.

References: None.

Analysis: The Sarpy EOC needed updates from Incident Command, but only Law Enforcement had contact with the site at the Sarpy County Fairgrounds.

Recommendations:

1. Sarpy EOC needs to establish contact with ICP in future exercises.

Activity 7.2: Make Hazard Assessments and Predictions

Observation 7.2.1: Strength. Sarpy County EOC created evacuation maps that were projected on the video wall and established sheltering.

References: None.

Analysis: Activity was carried out in line with the Citizen Evacuation and Shelter-In-Place Target Capability, a capability linked to Weapons of Mass Destruction (WMD)/Hazardous Materials Response and Decontamination target capability.

Recommendations: None.

SECTION 4: CONCLUSION

Operation Triple Play exhibited both strengths and areas for improvement in the Tri-County UASI Area with respect to the following Target Capabilities: Communications; WMD/HazMat Response and Decontamination; Medical Surge; Onsite Incident Management; Triage and Pre-Hospital Treatment; Emergency Public Information and Warning; and Emergency Operations Center Management.

Three major strengths were exhibited during Operation Triple Play. The first major strength was that the 800 MHz Radios worked well in facilitating Interoperable Communications between all involved entities. The second major strength was that the Alternative Care Facilities (ACFs) were successful in treating the walking wounded and psychological casualties. The third major strength was that the Central Briefing Site was established quickly and was able to produce a press release.

Three major areas for improvement were identified during Operation Triple Play. The first major area for improvement was that no Unified Command was established. Instead of separate Incident Commands for separate disciplines, a Unified Command should be established in future events of this scale. The second major area for improvement was that no Joint Information Center (JIC) was established between the three sites meaning that Sarpy and Washington Counties were not included. A JIC should be established in any future event of this scale. The final major area for improvement was that the IsoPods were not compatible with the helicopters as they lacked the necessary FAA-approved straps. FAA-approved straps should be evaluated so that the IsoPods can be used in transporting patients via helicopter in future events.

APPENDIX A: IMPROVEMENT PLAN

This IP has been developed specifically for Tri-County UASI as a result of Operation Triple Play conducted on October 27 and 28, 2006. These recommendations draw on both the After Action Report and the After Action Conference.

Table A.1 *Improvement Plan Matrix*

Issue	Recommendation	Improvement Action	Lead Agency / Responsible Party	Responsible Party if Known	Support Agency	Timeline for Completion	Completion Date
1.1.1: UASI and OMMRS have different Standard Operating Procedures regarding self-identification.	1. OMMRS Hospital Network for 800 MHz radios and Public Health's Network for 800 MHz radios should be tested monthly for interoperability.	Organize network and conduct monthly testing.	OMMRS Communication Committee and Douglas County Public Health.	Tom Williams, Maria Reiter			08.09.2007; Monthly testing implemented for hospitals & Public Health.
	2. Interoperability between OMMRS and Public Health should be tested in future exercises that are less complex.	Test interoperability in monthly trainings and other exercises.	OMMRS / UASI Exercise Design Team.	Jane O'Connor, Phyllis Dutton		08.2008	
1.1.2: The HazMat team and 72nd CST had different communications protocols.	1. Test the interoperability of the various HazMat teams in future exercises.	Include interoperability aspect in future exercises.	OMMRS / UASI Exercise Design Team.	Jane O'Connor, Phyllis Dutton		08.2008; Continuing with future exercises.	
1.1.3: Some players were unsure as to which Talk Groups and channels should be used.	1. Each responder should be aware of and trained on the TIC plan, including which channels and Talk Groups are to be used and by whom.	Law Enforcement & Fire Departments in UASI educate staff on TIC plan.	Law Enforcement & Fire Departments (Douglas, Sarpy, Washington Counties).	Mark Conrey, Larry Lavelle, Phil Brazelton		07.2008	

Issue	Recommendation	Improvement Action	Lead Agency / Responsible Party	Responsible Party if Known	Support Agency	Timeline for Completion	Completion Date
	2. Assure clear call signs, including differentiating between hospital contacts.	Determine desired call signs and educate/train radio users on them.	911 Centers (Douglas, Sarpy, Washington Counties).	Mark Conrey, Larry Lavelle, Phil Brazelton		07.2008	
	3. Communications Leader should assign channels.	Assign channels; train; exercise.	911 Centers (Douglas, Sarpy, Washington Counties).	Mark Conrey, Larry Lavelle, Phil Brazelton		07.2008	
1.1.4: Communication between the Emergency Operations Center and Personnel Processing Point was lost due to equipment failure and no alternative form of communication flow was immediately available.	1. A pool of amateur radio operators needs to be identified and accessible.	Assign and provide HAM operators to Personnel Processing Point.	OMMRS Communications: Recruitment & Training.	Terry Lindsley			08.09.2007
1.1.5: OMMRS Hospital network and Public Health's network are not coordinated to work together.	1. The hospital network and the Public Health network should have monthly testing together to ensure radio utilization competency.	Organize and conduct monthly training/testing.	OMMRS Communication Committee & Douglas County Public Health.	Tom Williams, Maria Reiter			08.09.2007
	2. Identify those areas where communication was not established and evaluate the issue for resolution.	Implement monthly roll calls to establish sites not responding; resolve issues;	OMMRS Communication Committee & Douglas County Public Health.	Tom Williams, Maria Reiter			08.09.2007

Issue	Recommendation	Improvement Action	Lead Agency / Responsible Party	Responsible Party if Known	Support Agency	Timeline for Completion	Completion Date
		train; exercise.					
	3. Monthly 800 MHz roll calls should take place to assure that communications are maintained between hospital Incident Command Posts and Public Health.	Conduct monthly roll calls; identify sites not responding; resolve; train; exercise.	OMMRS Communication Committee & Douglas County Public Health.	Tom Williams, Maria Reiter			08.09.2007
1.2.1: Some entities did not respond to the roll call.	1. Monthly 800 MHz roll calls should take place to assure that communications are maintained between hospital Incident Command Posts and Public Health.	Conduct monthly roll calls; identify sites not responding; resolve; train; exercise.	OMMRS Communication Committee & Douglas County Public Health.	Tom Williams, Maria Reiter			08.09.2007; Refresher training scheduled; continuous monitoring.
1.2.2: Omaha Fire Department experienced internal & external challenges to Interoperable Communications.	1. Conduct training on terminology consistency.	Include terminology usage in all trainings.	Omaha Fire Department.	Jim Palensky		08.2008	
	2. Conduct training to ensure proper channel usage on radios.	Schedule & conduct training; exercise.	Omaha Fire Department.	Jim Palensky		08.2008	
	3. Test with future exercises.	Include 800 MHz radio terminology, procedures in future exercises.	OMMRS / UASI Exercise Design Team.	Jane O'Connor, Phyllis Dutton	Omaha Fire Department.	08.2009	

Issue	Recommendation	Improvement Action	Lead Agency / Responsible Party	Responsible Party if Known	Support Agency	Timeline for Completion	Completion Date
1.2.3: Common response communication (i.e., plain language) was used.	1. Train responders to consistently clarify location and post to avoid confusion.	Educate and train responders on communication protocols.	Fire Departments & Law Enforcement (Douglas, Sarpy, Washington Counties).	Jim Palensky, Tim Carmody, Dale Tedder, Russ Zeeb, Dave Aten Phil Brazelton.			Ongoing
1.2.4: 800 MHz radios facilitated interoperable communications.	1. Address the issue of Federal agencies not being able to purchase 800 MHz radios.	Evaluate & pursue issue, if appropriate; Federal agencies should purchase of 800 MHz radios.	911 Communications (Douglas, Sarpy, Washington Counties).	Mark Conrey, Larry Lavelle, Phil Brazelton			Not OMMRS / USAI issue
1.2.5: Sarpy County uses both analog and digital radios.	1. Sarpy County should evaluate its 800 MHz radio systems to ensure necessary communications occur.	Review & evaluate current 800 MHz radio systems in Sarpy County; adjust if appropriate; train; exercise.	Sarpy County 911.	Larry Lavelle, Russ Zeeb		08.2009	
1.2.6: Public Health could not reach Incident Command Posts at three (hospital) facilities.	1. Clarify call signs, channels, and talk groups.	Evaluate & resolve issues with facilities not communicating with Public Health.	Douglas County Public Health.	Maria Reiter			Standard Operating Procedures updated 08.29.2007.
	2. Provide additional 800 MHz radio training for responders.	Evaluate & resolve issues with facilities not in communication.	Douglas County Public Health.	Maria Reiter			Training provided 08.09.2007.

Issue	Recommendation	Improvement Action	Lead Agency / Responsible Party	Responsible Party if Known	Support Agency	Timeline for Completion	Completion Date
	3. Conduct monthly roll calls.	Evaluate & resolve issues with facilities not in communication.	Douglas County Public Health.	Maria Reiter, Tom Williams	OMMRS Communication Committee.		08.09.2007
2.1.1: Information was well-exchanged between tables at the Emergency Operations Centers.	1. No communication between the EOCs early in the exercise.	Evaluate & resolve issues resulting in lack of communication.	UASI County EOCs (Douglas, Sarpy, Washington Counties).	Paul Johnson, Larry Lavelle, Bill Pook		01.2008	
2.1.2: No communication between the EOCs early in the exercise.	1. Create a direct link between all three EOCs.	Evaluate & resolve failure in communication; train; exercise.	UASI County EOCs (Douglas, Sarpy, Washington Counties).	Paul Johnson, Larry Lavelle, Bill Pook		01.2008	
2.1.3: ACF Clinics experienced difficulty in communicating with the EOC Medical Desk during the exercise.	1. Utilize email, radio, or some other method of communication between ACFs and the EOC as a backup measure.	Evaluate need for alternate means of communication; establish protocols; train; exercise.	OMMRS Alternate Care Facility Committee.	Jane O'Connor, Barry Spooner, Melanie Bates	OMMRS EOC Medical Table Committee	03.2008	
	2. Conduct tabletop exercise with an emphasis on form utilization.	Conduct orientation workshop, work through issues; establish protocols as appropriate; train; exercise.	OMMRS Media Committee.	Mary Balluff, Mary McGrath, Barry Spooner, Melanie Bates, John Young, Jane O'Connor	EOC Medical Table Committee; Public Health; Red Cross; ACF Clinics.	Scheduled for 11.01.2007.	11.01.2007.

Issue	Recommendation	Improvement Action	Lead Agency / Responsible Party	Responsible Party if Known	Support Agency	Timeline for Completion	Completion Date
	3. Evaluate use of hospital system for patient tracking and the media injury report form.	Evaluate and resolve issues related to forms; establish appropriate procedures; train; exercise.	Hospital Personnel; EOC Medical Table Committee; ACF Committee; Public Health; Red Cross.	Hospital representatives / safety ffficers, Mary Balluff, Barry Spooner, Melanie Bates, Jane O'Connor, Mary Balluff, John Young		Scheduled for 11.01.2007	Evaluate with future exercises.
2.1.4: The Law EOC (LEOC) located at the Central Police Station, not the Law table at the Douglas EOC, received most of the law enforcement - related communication from the incident scene.	1. Define the responsibilities of the LEOC and the Law table in the EOC to ensure that information flow is from the scene to the EOC to the LEOC.	Clarify & educate on procedures; train; exercise.	Douglas County Law Enforcement.	Tim Carmody		01.2008	
2.1.5: Information flow from the Emergency Operations Center to the Media Briefing Site regarding patients and clinical information was limited.	1. Appoint media/public information liaison in the EOC under the Incident Commander to ensure that information is given to the Media Briefing Site.	Identify point person; establish protocols; train; exercise; develop Joint Information Center protocol.	Douglas County EOC Incident Command; Region 5-6 EOC; Sarpy County EOC.	Paul Johnson, Bill Pook, Larry Lavelle, Don Thorson	UASI	09.2008	

Issue	Recommendation	Improvement Action	Lead Agency / Responsible Party	Responsible Party if Known	Support Agency	Timeline for Completion	Completion Date
	2. Diagram flow of information within the EOC to identify gaps.	Evaluate current procedures & resolve issues; train; exercise.	Douglas County Emergency Management; Mayor's Office.	Paul Johnson, Bill Pook, Larry Lavelle, Don Thorson	Tri-County UASI.	09.2008	
	3. Create alternative communications method.	Identify & establish protocols for implementation of alternative communication; train; exercise.	EOC Medical Table Committee; Douglas County Health Department; Douglas County Emergency Management; Mayor's Office.	Barry Spooner, Melanie Bates, Carol Allensworth, Paul Johnson, Don Thorson		09.2008	
	4. Clarify process for tracking radio information at the EOC.	Review and implement effective protocols.	EOC Medical Table Committee; Douglas County Health Department; Emergency Management; Mayor's Office.	Barry Spooner, Melanie Bates, Carol Allensworth, Paul Johnson, Don Thorson		09.2008	
2.1.6: Sarpy County EOC was unsure about certain operating procedures.	1. Appoint scribe to keep track of events.	Identify person to fill this role; train; exercise.	Sarpy County EOC	Larry Lavelle		12.2007 Next scheduled exercise	
	2. Train Sarpy EOC and Washington EOC on	Educate; train; exercise.	Sarpy County EOC;	Larry Lavelle, Bill Pook		12.2007	

Issue	Recommendation	Improvement Action	Lead Agency / Responsible Party	Responsible Party if Known	Support Agency	Timeline for Completion	Completion Date
	OMMRS implementation.		Washington County EOC.				
2.1.7: Sarpy County EOC was very loud.	1. Evaluate Sarpy EOC setup for possible reconfiguration of persons to reduce confusion and noise.	Evaluate current setup; adjust as needed and appropriate to site.	Sarpy County EOC.	Larry Lavelle		12.2007	
2.2.3: Douglas County EOC Management felt that more support staff was necessary.	1. Douglas County EOC Management should evaluate staffing problems and discuss the issue with the appropriate agencies.	Evaluate staffing issues and provide adequate resources to resolve problems; exercise.	Douglas County Emergency Management.	Paul Johnson		12.2007	
2.3.1: Sarpy County did not create an incident action plan.	1. Develop Incident Action Plan (IAP) in future exercises.	Develop IAP and protocols; implement with future exercises.	Sarpy County Emergency Management.	Larry Lavelle		Next exercise and ongoing.	
3.2.2: The Public Health Information Line was overwhelmed.	1. Implement Public Information Hotline earlier in future events.	Establish protocols for implementation; exercise.	Douglas County Public Health.	Carol Allensworth, Dr. Adi Pour, Jamie Moore	United Way	01.2008	
	2. Activate the Public Health Hotline quickly so that calls from the public can be handled in efficient manner.	Establish / clarify protocols for activation of Safe & Well website.	Douglas County Public Health.	Carol Allensworth, Dr. Adi Pour	Red Cross		
	3. Behavioral Health Public Information Messages need to be developed and be	Create stock messages that can be used to calm /	OMMRS Behavioral Health	Dennis Snook, Jack Wineman	Behavioral Health Committee	03.2008	

Issue	Recommendation	Improvement Action	Lead Agency / Responsible Party	Responsible Party if Known	Support Agency	Timeline for Completion	Completion Date
	made available to the Media Briefing Site.	instruct the public as appropriate.	Committee.				
4.1.2: Activation of Phase I and Phase II ACF Clinics was hindered by communications issues.	1. Clarify how hospitals are notified that Phase I and/or Phase II have been activated.	Establish protocols; train; exercise 1. Plan in place. 2. Include in future exercises. 3. Suggestion to add Phase II Clinics to Codespear System.	OMMRS ACF Committee; OMMRS EOC Medical Table Committee.	Jane O'Connor, Barry Spooner, Melanie Bates		3. 08.2008	1.Completed 2. Ongoing
	2. Phase I and Phase II clinics need a Situation Report upon receiving the first call to ensure they are properly prepared to treat incoming patients.	Establish content & protocols for issuing Situation Report; test; exercise. 1.Discuss fax/email process with EOC. 2. Establish standard template for Situation Report.	OMMRS ACF Committee; OMMRS EOC Medical Table Committee.	Jane O'Connor, Barry Spooner, Melanie Bates			11.2007

Issue	Recommendation	Improvement Action	Lead Agency / Responsible Party	Responsible Party if Known	Support Agency	Timeline for Completion	Completion Date
	3. Create a backup system for the telephone/cell system currently in use at ACF sites.	Identify alternate communication; establish implementation protocols; exercise 1.Establish protocol for 800 MHz cache distribution. 2. Explore ARES/HAM network to support communication.	OMMRS ACF Committee.	Jane O'Connor, Tom Williams, Terry Lindsley	OMMRS Communic-ation Committee; Communic-ation Recruitment & Training Committee.	1. 02.2008 2. 08.2008	
	4. Update recall list, including the addition of area codes.	Review and periodically update contact data; exercise. 1. Update new Master Contact list-3 deep quarterly. 2.Each clinic update / review quarterly	OMMRS ACF Committee.	Jane O'Connor, Barry Spooner, Melanie Bates	OMMRS EOC Medical Table.	1. 10.2007 2. 10.2007	
	5. Institute radio	Develop system of	OMMRS ACF	Jane O'Connor,	OMMRS	08.2008	

Issue	Recommendation	Improvement Action	Lead Agency / Responsible Party	Responsible Party if Known	Support Agency	Timeline for Completion	Completion Date
	communication for internal ACF use.	internal radio communication; train; exercise.	Committee.	Tom Williams, Barry Spooner, Melanie Bates	Communi-cations EOC.		
4.1.3: Authorized personnel were not identified by badge in the ACFs.	1. Create a badging process to identify those who are authorized to be in ACFs during emergencies.	Identify needs and develop appropriate identification system; exercise	OMMRS Badge Committee.	Jamie Moore		06.2008	
4.1.4: ACF Clinics did not know which staff was necessary.	1. ACF clinics need to determine the role of personnel, both essential and those considered non-essential.	Evaluate roles; identify needs; establish protocols and identify staffing activation priorities; train; exercise.	OMMRS ACF Committee.	Jane O'Connor			
4.3.2: Certain procedures pertaining to the usage of the IsoPod were not followed.	1. Ensure that the door to the patient's room door is closed at all times.	Evaluate current protocols; update as appropriate and train / exercise.	Hospitals.	Hospital Safety Officers; Infection Control Officers.	Bio-contaminant Unit at UNMC.	Training completed.	Closed; Annual Training 02.2008.
	2. Enhance protocols to ensure better patient isolation.	Evaluate current protocols; update as appropriate; train; exercise.	Hospitals	Hospital Safety Officers; Infection Control Officers.	Bio-contaminant Unit at UNMC.	Training completed	Closed; Annual Training 02.2008
4.3.3: Some patients	1. Place more specific	Determine needs;	OMMRS ACF	Jane O'Connor		10.2007	

Issue	Recommendation	Improvement Action	Lead Agency / Responsible Party	Responsible Party if Known	Support Agency	Timeline for Completion	Completion Date
were sent to the wrong level of care.	signage outside of clinics to direct patients to the necessary area.	have signs made and provide as appropriate; test/exercise.	Committee.				
4.3.4: IsoPod could not be used with helicopters.	1. Evaluate FAA-approved straps for the IsoPod.	Contact IsoPod manufacturer for resolution	Nebraska Bio-containment Unit.	Pat Lenaghan, Phyllis Dutton	OMMRS		Closed; per manufacturer unable to adapt to helicopter; will transport via ambulance.
4.4.1: Patient flow inside ACF Phase I and II clinics was smooth.						01.2008	
4.4.2: ACF Clinics were not fully supplied at the level necessary to respond to a large-scale incident.	1. ACFs should contact EOC Med Table for supplies.	Establish protocols for supply requisition; train; exercise. Plan if funding is available; Phase II should obtain resources from Charles Drew/One World.	OMMRS ACF Committee.	Jane O'Connor, Barry Spooner, Melanie Bates	EOC Medical Table Committee.	01.2008	07.2008
	2. Consider purchasing N95 masks for ACFs.	Evaluate needs; purchase items if determined appropriate.	OMMRS ACF Committee.	Jane O'Connor, Barry Spooner, Melanie Bates	OMMRS EOC Committee.	07.2008	

Issue	Recommendation	Improvement Action	Lead Agency / Responsible Party	Responsible Party if Known	Support Agency	Timeline for Completion	Completion Date
4.4.3: No stand-down notification occurred at ACFs.	1. Appropriate procedures should be added to EOC Medical Table protocols to ensure ACFs know when to stand down.	Evaluate current procedures; establish appropriate protocols; train; exercise. Options: fax, 800 MHz radio, Codespear. Redundancy options: fax, 800 MHz, Codespear.	OMMRS EOC Committee; OMMRS Medical Table Committee.	Barry Spooner, Melanie Bates, Jane O'Connor	OMMRS ACF Committee.	03.2008	
4.4.4 The timing of ACF implementation was problematic.	1. Follow Master Scenario Event List (MSEL) in future exercises.	Evaluate past scenarios; establish and follow MSEL procedures in future exercises.	OMMRS Exercise Command Team	Jane O'Connor, Phyllis Dutton, Committee Members	OMMRS Exercise Design Team.	12.2008	
5.2.2: Bomb Squad members approached the device twice without protection.	1. Bomb Squad needs to evaluate procedures for Personal Protective Equipment when approaching possible devices.	Evaluate current protocols; revise as needed; train; exercise.	Law Enforcement	Tim Carmody		12.2007	
5.3.2: Law Enforcement and Fire officials were proving contradictory instructions to victims at Rosenblatt.	1.OPD and OFD need to review their procedures for entry into an incident site to ensure they comport.	Evaluate current protocols for effectiveness; revise as needed; train; exercise.	Omaha Law Enforcement & Fire Departments.	Tim Carmody, Joe Fuxa		Ongoing	

Issue	Recommendation	Improvement Action	Lead Agency / Responsible Party	Responsible Party if Known	Support Agency	Timeline for Completion	Completion Date
5.3.3: Deployment of Bomb Squad to two different locations worked well.	1. Obtain light search suits for the Bomb Squad and cutting/breaching tools for the Bomb Squad robot.	Identify needs; obtain appropriate equipment; train; exercise.	Law Enforcement.	Tim Carmody		12.2007	
5.3.4: Sarpy County Law Enforcement had insufficient flow of communication to the Incident Command Post regarding it activities.	1. Assign a liaison from the primary agency responsible for the Render-Safe Procedures Plan (RSP) to the Incident Command Post to maintain contact with responders.	Identify and document individual to assume this role; train; exercise.	Sarpy County Law Enforcement.	Russ Zeeb, Tim Carmody, Phyllis Dutton	Omaha Bomb Squad	Ongoing	
5.5.2: The Personnel Processing Point was too small to accommodate the amount of staff that was present.	1. Ensure Personnel Processing Point is large enough to handle all volunteers in future exercises.	Evaluate current system; develop system to resolve issues; train; make more realistic in next exercise.	OMMRS Personnel Processing Point Committee.	Jamie Moore		12.2008	
5.5.3: Not enough volunteers followed through with their commitment to participate in the exercise.	1. Continue pre-training volunteers prior to exercises.	Evaluate current system; develop system to resolve issues; train; exercise.	OMMRS Personnel Processing Point Committee.	Jamie Moore		12.2008	Ongoing
	2. Train at least fifty more actor volunteers than the exercise requires.	Identify, train and provide number of volunteers required.	OMMRS Personnel Processing Point Committee.	Jamie Moore		12.2008	Ongoing
5.5.4: Symptom cards	1. All volunteer victims	Review current	OMMRS	Jamie Moore		Ongoing	

Issue	Recommendation	Improvement Action	Lead Agency / Responsible Party	Responsible Party if Known	Support Agency	Timeline for Completion	Completion Date
were not provided to volunteers who did not undergo moulage.	should receive moulage cards or triage tags in future exercises.	procedures; revise as appropriate; train; exercise.	Personnel Processing Point Committee.				
5.5.5: Food was not provided for those at the Personnel Processing Point nor for Medical Reserve Corps volunteers until specifically requested.	1. Better communication should be established between the food provider and the locations to which food is to be provided.	Review issues and identify gaps; establish effective system of food provision; exercise.	Salvation Army; Red Cross.	JJ Kuzma, John Young			Closed; IC changed food site location; food was set up as directed by IC.
	2. Food should be provided to pre-determined locations without being requested during the exercise.	Review issues and identify gaps; establish effective system of food provision; exercise.	Salvation Army; Red Cross.	JJ Kuzma, John Young			Closed; IC changed set up location for food; food was set up as directed by IC.
5.8.1: No Unified Command was established.	1. Leaders of all agencies need to collaborate and identify the Unified Command process to ensure that it is implemented in future incidents.	Appropriate leadership from each agency meet to identify & resolve issues; train; exercise on new protocols.	Law Enforcement & Fire Departments (Douglas, Sarpy & Washington Counties).	Tim Carmody	Community Effort.	Ongoing	
	2. Put a table between the OFD and OPD command posts to ensure face-to-face collaboration.	Provide Unified Command table to facilitate effective communication.	Law Enforcement & Fire (Douglas, Sarpy, & Washington Counties).	Tim Carmody	Community Effort	Ongoing	
	3. More ICS training needs	Identify needs;	Law Enforcement	Tim Carmody,	Community	Ongoing	

Issue	Recommendation	Improvement Action	Lead Agency / Responsible Party	Responsible Party if Known	Support Agency	Timeline for Completion	Completion Date
	to be conducted for those who will take command positions in a large IC/UC incident.	provide training; exercise.	& Fire (Douglas, Sarpy, & Washington Counties).	Mike Kennelly.	Effort.		
6.1.1: Responders triaged downed victim at scene.	1. Conduct additional training for MRC volunteers & Offutt Personnel to ensure proper usage of triage tags in all instances.	Identify issues; establish protocols; train; exercise.	Medical Reserve Corps.	Jamie Moore, Jim Jenkins	Offutt Air Force Base.	06.2008	
6.1.2: Medical Reserve Corps and the Offutt Personnel did not communicate their respective triaging tagging procedures to one another.	1. Conduct additional training for Medical Reserve Corps volunteers and Offutt Personnel to ensure proper usage of triage tags in all instances.	Identify issues; establish protocols; train; exercise.	Medical Reserve Corps	Jamie Moore, Jim Jenkins	Offutt Air Force	06.2008	
6.2.2: A lack of communications between Washington County EOC and hospitals in the area was reported.	1. Hospital representatives should be in the Washington County EOC.	Establish protocols; implement with training; exercise.	Region 5-6 EOC	Bill Pook, Pat Callaway	Fremont Hospital	06.2008	Closed; Hospital physician invited to EOC but did not attend.
7.1.2: Additional updates from Incident Command were necessary at the Sarpy County EOC.	1. Sarpy EOC needs to establish contact with ICP in future exercises.	Establish protocols; implement with training / exercise	Sarpy County EOC.	Larry Lavelle			Closed; Protocols in place; test with future exercises.

APPENDIX B: LESSONS LEARNED

While the After Action Report/Improvement Plan includes recommendations that support development of specific post-exercise corrective actions, exercises may also reveal lessons learned which can be shared with the broader homeland security audience. The Department of Homeland Security (DHS) maintains the *Lessons Learned Information Sharing* (LLIS.gov) system as a means of sharing post-exercise lessons learned with the emergency response community. This appendix provides jurisdictions and organizations with an opportunity to nominate lessons learned from exercises for sharing on *LLIS.gov*.

For reference, the following are the categories and definitions used in LLIS.gov:

- **Lesson Learned:** Knowledge and experience, positive or negative, derived from actual incidents, such as the 9/11 attacks and Hurricane Katrina, as well as those derived from observations and historical study of operations, training, and exercises.
- **Best Practices:** Exemplary, peer-validated techniques, procedures, good ideas, or solutions that work and are solidly grounded in actual operations, training, and exercise experience.
- **Good Stories:** Exemplary, but non-peer-validated, initiatives (implemented by various jurisdictions) that have shown success in their specific environments and that may provide useful information to other communities and organizations.
- **Practice Note:** A brief description of innovative practices, procedures, methods, programs, or tactics that an organization uses to adapt to changing conditions or to overcome an obstacle or challenge.

Exercise Lessons Learned

Omaha Metro Medical Response System (OMMRS) has developed the OMMRS Network to allow communication between hospitals on 800 MHz radios. Douglas County Public Health also developed a network for communications between itself and hospital infectious control practitioners. From this exercise, it has been determined that monthly testing of the radios should be conducted. It was also evident from this exercise that Public Health's network and the OMMRS hospital network need to be tested together.