

AN EXAMINATION OF THE ROLES OF MEDICAL UNITS IN SUPPORT OF
CHEMICAL, BIOLOGICAL, RADIOLOGICAL, OR NUCLEAR EVENT (CBRN)
UNDER JOINT TASK FORCE CIVIL SUPPORT (JTF-CS)

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MASTER OF MILITARY ARTS AND SCIENCES
General Studies

by

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The opinions and conclusions expressed herein are those of the student author and do not necessarily represent the views of the U.S. Army Command and General Staff College or any other governmental agency. (References to this study should include the foregoing statement.)

ABSTRACT

AN EXAMINATION OF THE ROLES OF MEDICAL UNITS IN SUPPORT OF CHEMICAL, BIOLOGICAL, RADIOLOGICAL, OR NUCLEAR EVENT (CBRN) APPORTIONED TO JOINT TASK FORCE CIVIL SUPPORT (JTF-CS), by MAJ Merbin Carattini, 88 pages.

Since the attacks of 9/11 and the subsequent creation of the Department of Homeland Security, the Department of Defense (DoD) has struggled with its role in Defense Support to Civil Authorities. While most disasters can be handled by first responders in coordination with the state units of the National Guard a CBRN catastrophic attack could quickly overwhelm the resources that would trigger a large-scale response of the total force of the Department of Defense. The current framework, while adequate for most disasters affecting the nation, may prove to be insufficient due to lack of interoperability between military forces and assets supporting civil authorities. Statutory and organizational challenges prevent the designation, fast preparation and use of military medical forces in support of civil authorities, when a national disaster occurs specifically the medical units. These challenges are the result of laws that restrict the development of a proper command structure and operational requirements that impede the preparation for response to incidents receive appropriate care. Effective disaster response requires an effort of interagency cooperation between federal and state governments to anticipate and overcome the challenges before an event. The aim, therefore, is to demonstrate how the appropriate use of military medical resources, in close coordination with civil authorities, governmental and non governmental organizations in the planning and execution of a CBRN event can have a positive impact on the timely restoration government functions after an attack.

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ACRONYMS

ADP	Army Doctrine Publication
AR	Army Regulation
ARNORTH	Army North
ASMC	Area Support Medical Company
BDE	Brigade
C2CRE	Command and Control CBRN Response Element
CBRN	Chemical Biological Radiological Nuclear
CM	Consequence Management
CONPLAN	Contingency Plan
CONUS	Continental United States
CRT	CBRN Response Team
DCE	Defense Coordinating Element
DCO	Defense Coordinating Officer
DCRF	Defense CBRN Response Force
Det	Detachment
DHS	Department of Homeland Security
DoD	Department of Defense
DOTMLPF	Doctrine Organization Training Material Leadership Personnel Facilities
DSCA	Defense Support to Civil Authorities
EMAC	Emergency Management Assistance Compact
EMEDS	Expeditionary Medical Support
EPLO	Emergency Preparedness Liaison Officer

ESF	Emergency Support Functions
FCO	Federal Coordinating Officer
FEMA	Federal Emergency Management Association
FM	Field Manual
FSO	Full Spectrum Operations
FST	Forward Surgical Team
GAO	Government Accountability Office
HQ	Headquarters
HSPD	Homeland Security Presidential Directive
HSS	Health Service Support
IC	Incident Commander
ICS	Incident Command System
IED	Improvised Explosive Device
IRP	Initial Response Package
JP	Joint Publication
JRMPO	Joint Regional Medical Plans
JTF-CS	Joint Task Force Civil Support
Med Log	Medical Logistics
MES	Medical Equipment Set
METL	Mission Essential Task List
Mgt Aug tm	Management Augmentation Team
MTOE	Modified Table of Organization and Equipment
MTTP	Multiservice Tactics Techniques and Procedures
NDMS	National Disaster Medical System
NDS	National Defense Strategy

NIMS	National Incident Management System
NMS	National Military Strategy
NRF	National Response Framework
NSS	National Security Strategy
OE	Operational Environment
OPCON	Operational Control
OPORD	Operation Order
PAR	Population at Risk
POTUS	President of United States
Prev Med	Preventive Medicine
QDR	Quadrennial Defense Review
RFA	Request for Assistance
SECDEF	Secretary of Defense
TF	Task Force
TTP	Tactics Techniques and Procedures
USACBRNS	U.S. CBRN School
USG	United States Government
USNORTHCOM	United States North Combatant Commander
USPACOM	United States Pacific Combatant Commander
Vet	Veterinary

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CHAPTER 1

INTRODUCTION

Americans have a lot to offer, so I've created a task force to develop additional ways people can get directly involved in this war effort, by making our homes and neighbourhoods and schools and workplaces safer. And I call on all Americans to serve by bettering our communities and, thereby, defy and defeat the terrorists.

— President George Bush, Address to the Nation

Introduction

The strategic direction from Department of Defense (DoD) is to have military medical units ready to support civil authorities if a Chemical, Biological, Radiological, or Nuclear (CBRN) event occurs.¹ Moreover, no notice support provided must be adaptable, responsive and available at the necessary speed when requested to avoid loss of life or further injury to civilians. With the creation of the Department of Homeland Security in 2003, the Secretary of Defense mandated a military response force to be structured and trained to support a CBRN event in the continent of United States and its territories in support to civil authorities.² Medical support provided by military forces is dependent on the activation of the National Disaster Medical System. Its purpose is a nationwide medical response system combining public and private sector partnerships that ensure that medical support is available if state and local resources are overwhelmed in case of an emergency.

When directed, Joint Task Force Civil Support (JTF-CS) provides command and control for DoD forces deployed in support of the Lead Federal Agency managing the consequences of a CBRN incident in the United States, and its territories. The mission of supporting civil authorities is not a new one for the DoD. The U.S. military has a long

history of providing assistance to civil authorities during emergencies and other instances of national concern. For example, U.S. military forces have assisted federal, state and local agencies during natural disasters such as hurricanes, floods and earthquakes. The role of JTF-CS in providing assistance to the Lead Federal Agency after a CBRN incident is in keeping with this long and proud tradition.³

In order to shape the topic, the process that governs the execution of medical support to civil authorities must first be defined. After September 11, 2001, a Presidential Directive created the Department of Homeland Defense and Homeland Security (DHS) of the Continental United States.⁴ The DHS when directed by the Secretary of Defense (SECDEF) conducts Defense Support to Civil Authorities (DSCA) as part of the National Response Framework and the Lead Federal Agency (DHS/FEMA). This mission, given to Northern U.S. Command (NORTHCOM), has the responsibility to provide a capable force in response to a CBRN event in the Continental United States (CONUS). NORTHCOM, in turn, has assigned, this mission to Army Northern Command (ARNORTH), the headquarters that possess authority over Title 10 Forces allocated to DSCA missions and will exercise employment of all forces assigned in order to support all mission requests within their geographic area of responsibility. The Department of Homeland Defense has divided CONUS into 10 regions (figure 1), each represented by a Defense Coordinating Officer that reports to NORTHCOM during DSCA missions.⁵

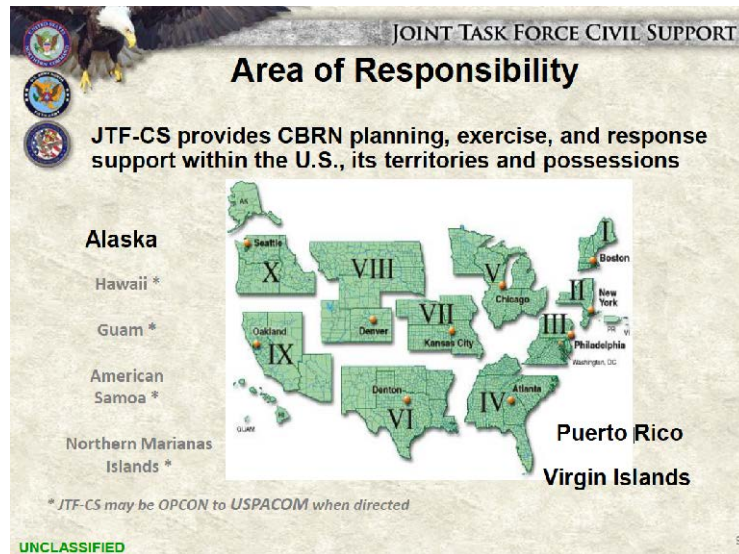


Figure 1. FEMA Regions with their respective DCOs Cartoon

Source: JTF-CS Briefing 101 (3 January 2012).

Defense Support of Civil Authorities (DSCA) refers to DoD support provided by Federal military forces, DoD civilians and contract personnel, and DoD agencies and components, in response to requests for assistance during domestic incidents to include terrorist threats or attacks, major disasters, and other emergencies. DSCA encompasses three operational mission areas: (1) Assistance to civil authorities, (2) Support to civilian law enforcement agencies and (3) Assistance for civil disturbances. The DSCA is responsible for the entire range of military operations during CBRN consequence management from Temporary Circumstances to Extraordinary Circumstances as mandated by CONPLAN 3500. Included in the operations are: Special Events, Disaster Relief, Civil Disturbances, and CBRN Consequence Management, which is the highest priority for the DoD.⁶ Within this criteria it is established the DSCA CBRN Response Process (figure 2). Once an incident occur, if the governor of a state or territory declares a

state of emergency and establishes that local resources are not enough he or she may decide to request assistance from the federal government. There are governing laws that regulate the use of Defense Assets in Support of Civil Authorities. These are Stafford Act, Economy Act, Insurrection Act and Homeland Security Act, which will be expanded under chapter 2 of this document.⁷

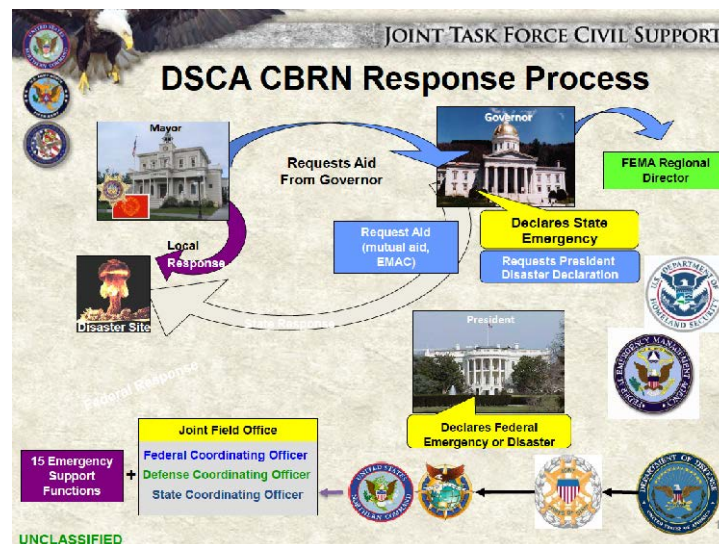


Figure 2. DSCA CBRN Response Process

Source: JTF-CS Brief 101 (3 January 2012).

The focus of this research will be on CBRN response in support to civil authorities. The scope will be restricted to medical units in support of Defense C-BRN Response Force (DCRF) under Joint Task Force-Civil Support (JTF-CS) particularly Task Force Medical. Today, Task Force Medical has evolved since 2006 as represented in figure 3 during a combined exercise conducted by NORTHCOM called Ardent Sentry to a more complete and robust force; however, (Department of Homeland Security 2008),

interoperability with other agencies and relevance of its capabilities will be assessed throughout this thesis. Requirements identified through the exercises conducted at the NORTHCOM level and information exchanges between the agencies involved have prompted changes that have allowed Task Force Medical to evolve.⁸

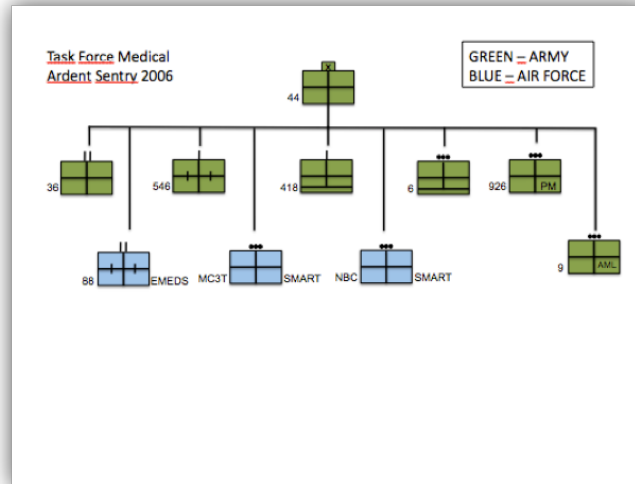


Figure 3. Task Force Medical Task Organization 2006

Source: Created by author.

Once a CBRN incident occurs, situational awareness gained by the commanders and staff of medical units will aid in the response and speed of force packages in order to properly support civil authorities. The National Response Framework (NRF) provides a guide to how the Nation conducts all-hazards response and serves as a guide for commanders and staffs. It is built upon scalable, flexible, and adaptable coordinating structures to align key roles and responsibilities across the nation. It describes specific authorities and best practices for managing incidents that range from the serious but purely local, to large-scale terrorist attacks or catastrophic natural disasters. Also, NRF

has created a series of fifteen Emergency Support Functions (ESF) in order to increase preparedness for the military units tasked to provide support to civil authorities.⁹

Emergency Support Function 8 is specifically developed for military medical units and is labelled as Public Health and Military Services. This ESF is broken down into three categories: Air, Land and Maritime. Within the land category, the capabilities needed are airborne medical evacuation, installation medical facilities, and manpower to support those requirements. Land forces required are, forward surgical teams, mortuary affairs, veterinary services, ground medical evacuation, installation medical facilities and necessary manpower.¹⁰ The maritime category specifies requirements for hospital ships, amphibious ships, installation medical facilities and manpower as appropriate. Where do medical units fit in the process of medical request for support? Do they have the proper configuration to fulfil the support requirements? The analysis will allow NORTHCOM planners to determine whether the capabilities and organizations are appropriate for the response required by civil authorities and satisfy the requirements established by the NRF.

When an event occurs, there are multiple entities involved such as Department of Homeland Defense, Joint Staff –Joint Director of Military Support, Military Services, Unified Commanders, (NORTHCOM and PACOM), Joint Task Force Commander-Civil Support, Defense Coordinating Officer and Defense Coordinating Element and Emergency Preparedness Liaison Officers. In coordination with state authorities and depending on the severity of the incident, the appropriate measures are taken to ensure an expeditious response in support of civilians.

Problem Statement

Integrated, synchronized, and structured medical units in Defense support for civil authorities are paramount for adequate medical response at a time of crisis. Based on NORTHCOM CONPLAN 3500 (CBRN), NORTHCOM CONPLAN 3501 (DSCA), professional journals, army regulations (AR), joint regulations, periodicals and additional documents published by the Department of Defense (DoD), the Department of Homeland Security (DHS) and open sources, the research will focus on the roles and organization of medical units apportioned to Joint Task Force-Civil Support (JTF-CS) in response to a catastrophic attack. The research will identify if doctrine, organization and training capabilities are aligned with the need to support civil authorities effectively. Additionally, research will consider if medical units have the proper configuration to support civil authorities based on consequence management during a CBRN incident. Research will also address order of response via force packages and how they are built in order to ensure speed of response and relevance within CONUS in order to ensure the right response capability for a CBRN event.

Proposed Research Question

What are the best military medical unit configurations for the support of civil authorities apportioned under Joint Task Force Civil Support in response to CBRN event?

Secondary Research Questions

How can military medical units effectively support civil authorities and the myriad of patient types in the civilian communities or population at risk with the current personnel structure and equipment?

If medical units are tailored to support civil authorities, does this change the configuration from that used for routine war fighting and force management requirements? What is the best configuration to support both missions simultaneously?

Significance

In order to establish the significance of this research it is important to understand that the threat evolves quickly and that the medical response force must adapt similarly to counteract the impact. When the United States transitioned from the “Cold War era” to the “Global War on Terrorism” the focus shifted to counterinsurgency.¹¹ The application of Medical Forces to support corresponding threats in a civilian setting must also allow these forces to perform their mission in a Decisive Action doctrinal framework. The Medical Forces should retain their ability to conduct offensive operations, defensive operations, stability operations, or support to civilian authorities. As technology advances, it is imperative that DoD medical forces maintain a baseline of the correct skills and equipment to assist civilian authorities in providing the best standard of care available when requested.

Assumptions

Based on the current operational tempo of medical units in support of the Global War on Terrorism it is difficult to maintain a dedicated force in support of civil authorities. Medical units selected to perform missions in support of civil authorities are challenged to provide the expected standards of care to civilian communities. Additionally, civilian medical personnel training and the medical equipment used in civilian hospitals changes at a different rate than the military medical forces personnel

and equipment. Therefore, the ability to keep up with techniques and procedures coupled with advances in technology increase the challenge of military medical support to civil authorities. Based on organizational design and capabilities military medical response forces are not sourced mainly to provide standard of care to patients outside the scope of Title 10 or Title 32 forces. For example, conditions such as diabetes, obesity, pediatrics, geriatrics, obstetrics, are some of the areas that the military medical response forces are currently not capable of providing adequate levels of care for.

Definitions of Key Terms

The following terms are defined as part of this thesis and are described below. These are the manner in which these terms are used in the context of this thesis.

C-BRNE: Chemical-Biological Radiological Nuclear and High Yield Explosives. It is used in the event or attack in which any of these four hazards have presented themselves.¹²

Defense Support to Civil Authorities: Support provided by U.S. Federal military forces, DoD civilians, DoD contract personnel, DoD Component assets, and National Guard forces (when the Secretary of Defense, in coordination with the Governors of the affected States, elects and requests to use those forces in title 32, U.S.C., status) in response to requests for assistance from civil authorities for domestic emergencies, law enforcement support, and other domestic activities, or from qualifying entities for special events. Also known as civil support.¹³

Disaster Relief: An occurrence such as a hurricane, tornado, storm, flood, high-water, wind-driven water, tidal wave, earthquake, drought, blizzard, pestilence, famine, fire, explosion, building collapse, transportation wreck, or any other situation that causes

human suffering or creates human needs that the victims cannot alleviate without assistance from military forces upon request.¹⁴

Economy Act: The Economy Act permits federal agencies to provide resources and services to other federal agencies on a reimbursable basis. The Economy Act is also the basis for the general rule that DoD will not compete with commercial businesses.¹⁵

Emergency Authority: A Federal military commander's authority, in extraordinary emergency circumstances where prior authorization by the President is impossible and duly constituted local authorities are unable to control the situation, to engage temporarily in activities that are necessary to quell large-scale, unexpected civil disturbances because (1) such activities are necessary to prevent significant loss of life or wanton destruction of property and are necessary to restore governmental function and public order or (2) duly constituted Federal, State, or local authorities are unable or decline to provide adequate protection for Federal property or Federal governmental functions.¹⁶

Emergency Support Functions: a grouping of governmental and certain private sector capabilities into an organizational structure to provide support, resources, program implementation, and services that are most likely needed to save lives, protect property and the environment, restore essential services and critical infrastructure, and help victims and communities return to normal following domestic incidents or disasters.¹⁷

Emergency: Means any occasion or instance for which, in the determination of the President, Federal assistance is needed to supplement state and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the United States.¹⁸

Federal Agency: Any department, independent establishment, Government corporation, or other agency of the executive branch of the Federal Government, including the United States Postal Service, but shall not include the American National Red Cross.¹⁹

Force development: Involves identifying a required capability, determining how to achieve that capability, and designing units and forces structured to accomplished national objectives. Determining personnel and materiel solutions and allocating them under fiscal constrained resources achieve this process.²⁰

Force management: Process of determining force requirements and alternative means of resourcing requirements. It encompasses all processes associated with the progression from requirements identification through execution of implementing programs.²¹

Major disaster: Any natural catastrophe (including any hurricane, tornado, storm, high water, wind driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought), or, regardless of cause, any fire, flood, or explosion, in any part of the United States, which in the determination of the President causes damage of sufficient severity and magnitude to warrant major disaster assistance under this Act to supplement the efforts and available resources of States, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby.²²

Medical Units: medical organization in support of civil authorities under JTF-CS specifically apportioned under Task Force Medical. These units are part of the medical

response force in a CBRN event. Additionally, they are required to provide medical care if requested via mission requests to Title 10 and Title 32 forces and to civilians.²³

Special Events: For the purposes of this research this is defined as military support for various events to enhance security and showcase armed forces capabilities as part of DSCA.²⁴

Stafford Act: The Stafford Act authorizes the President to issue a major disaster declaration and direct federal agencies including DoD to provide assistance to states overwhelmed by disasters. The Stafford Act gives the President authority to deploy federal military forces into the states or territories for defense support civil support missions at the governor's request.²⁵

Limitations

A limitation of this research is the use of open source information to conduct this research. In order to keep the work available to all interested parties, information used will only be unclassified. Additionally, it is important to understand the statutory differences between Presidential authority given by the Constitution to the President and the need for request by the states from the governors. Normally, the governors will command the National Guard, but there are provisions to have it under the command of the President. There are instances in which the President can act unilaterally, but there are onerous implications for such action. The law that established DHS made it the principal federal agency in preparation for and responding to domestic emergencies. Other federal agencies including DoD respond to DHS requests for assistance from DHS or governors of states and territories.²⁶

Sometimes these laws and policies create confusion in civil support operations following catastrophic events. DHS has the statutory authority to respond, but lacks the organic assets and capability to do so. The DoD has the capability to respond but lacks the statutory authority to take the lead unless directed by the President.

Delimitations

This research is restricted to only the medical units that comprise Task Force Medical under JTF-CS task organization. These units form the bulk of the interaction with civil authorities in order to save lives immediately or prevent further injury. By only covering medical units I will restrict the topic enough to establish a conceptual framework of support. The research will therefore be manageable within the time constraints established and can then be applied to other Task Forces under JTF-CS.

Summary

The purpose of this research is to study the how military medical forces should effectively support civil authorities. Evidently, this is a topic of immense importance. As the U.S. continues to face the CBRN threat and military forces continue to transform its capabilities to satisfy the demands of such a threat, it must also account not only for combat operations preparation but also for domestic response support. Achieving synergy and interoperability are probably the most important aspects of a unified effort towards responding to a CBRN attack while decreasing human suffering and protecting the infrastructure of the U.S. An important consideration is the different types of threat spread across the regions of CONUS represented by Defense Coordinator Officers. For example, the threat in Louisiana might be natural disaster-based, as evidenced by

Hurricane Katrina in 2005; other states, such as Washington, may be susceptible to threats based on the amount of nuclear reactors and the potential terrorist threat. Therefore, streamlined medical support across the continent is a challenge due to limited amount of medical resources.

¹Department of Defense, Concept Plan (CONPLAN) 3500, CBRN Response Force (DCRF), NORTHCOM, 2011.

²Ibid.

³Department of Defense, *Defense Support to Civil Authorities (DSCA) Handbook*. GTA 90-01-20 (Washington, DC: Government Printing Office, 2011).

⁴Defense Support to Civil Authorities - Online Instruction Module 2010, www.dsca.army.mil (accessed September 2011).

⁵Department of Defense, United States NORTHCOM, "CBRN Concept Plan," (accessed September 2011).

⁶Department of Homeland Security, Homeland Security Presidential Directive/HSPD-5, *Management of Domestic Incidents*, www.dhs.gov/xabout/laws/gc_1214592333605.shtm (accessed May 2011).

⁷Department of Defense, Directive Number 3025.18, *Defense Support of Civil Authorities (DSCA)*, December 2010.

⁸Department of the Army, "OPORD 07-11-CBRNE Consequence Management Response Force," OPORD, DCSOPS, 44th Medical Command, 2006.

⁹Department of Homeland Security, *National Response Framework*, January 2008, www.dhs.gov/nrf_core (accessed November 2011).

¹⁰Ibid.

¹¹Matt Hilburn, "Joint Army/Marine Corps Counterinsurgency Center Aims to 'Change the Mindset' of Military Strategy: Rethinking the Enemy," *Sea Power* (April 2007).

¹²Department of the Army, Field Manual (FM) 3-0, *Operations* (Washington, DC: Government Printing Office, 2011), 11.5.

¹³Department of Defense, Directive Number 3025.18.

- ¹⁴Red Cross 2010.
- ¹⁵Department of Defense, *DSCA Handbook*.
- ¹⁶Department of Defense, Directive Number 3025.18
- ¹⁷Department of Homeland Security, *National Response Framework*.
- ¹⁸Federal Emergency Management Administration (FEMA), *The Robert T. Stafford Disaster Relief and Emergency Assistance Act, as amended, and Related Authorities*, June 2007.
- ¹⁹*Ibid.*
- ²⁰How the Army Runs, 2-8.
- ²¹How the Army Runs, 5-3.
- ²²FEMA, *The Robert T. Stafford Disaster Relief and Emergency Assistance Act*.
- ²³Department of the Army, “OPORD 07-11-CBRNE Consequence Management Response Force.”
- ²⁴Department of Defense, *DSCA Handbook*.
- ²⁵FEMA, *The Robert T. Stafford Disaster Relief and Emergency Assistance Act*.
- ²⁶Chairman, Joint Chiefs of Staff, Joint Publication (JP) 3-28, *Civil Support* (Arlington, VA: The Pentagon, September 2007).

CHAPTER 2

LITERATURE REVIEW

The purpose of this literature review is to evaluate the existing literature relevant to the thesis. The research has examined a wide range of sources to obtain the necessary information in order to understand the current challenges that Task Force Medical faces to be able to support civil authorities effectively. Establishing a hierarchy of documents is essential to determine the importance that consequence management has at the highest levels of this nation. This review will begin with national level documents from the President such as National Security Strategy and working its way down through National Military Strategies, executive orders, articles, journals, and military doctrine.

As the research will show the relationship between national level guidance and the execution of such guidance, gaps will be identified as they relate to medical requirements from civil authorities. Additionally, training events between military forces and agency exchanges have made an impact through the years to ensure doctrine is evolving to address the problems and discrepancies identified through lessons learned. This chapter will examine unclassified resources to support the research question: What is the best configuration for medical units to support civil authorities in a CBRN event?

National Strategy Documents

The National Security Strategy (NSS) addresses emergency management as one of the most important areas that United States will focus in the near future. Additionally, it expands on how it is building the capacity to prepare for disasters and reduce or eliminate long-term effects to people and their property from hazards and to respond and

recover from major incidents. To improve in preparedness, civilian authorities are integrating domestic all hazards planning at all levels of government and building key capabilities to respond to emergencies. Agencies continue to collaborate with communities to ensure preparedness efforts are integrated at all levels of government with the private and nonprofit sectors to include military forces. The investment in operational capabilities and equipment is backed up by the need to secure the United States to ensure prosperity and safety of its citizens.

Recognizing that the health of the world's population has never been more interdependent, national security strategy states the need for improving public health and medical capabilities on the front lines, situational awareness, rapid and reliable development of medical countermeasures to respond to public health threats, preparedness education and training, and surge capacity of the domestic health care system to respond to an influx of patients due to a disaster or emergency. These strategic needs require our ability to work with international partners to mitigate and contain disease when necessary. In essence this strategic guidance provides a conceptual framework that allows military medical forces to work in concert with civilian authorities to achieve national security.

National Security Strategy dictates the direction that armed forces must plan to secure the borders of United States from all hazards. Therefore, the Secretary of Defense with his staff develops the *National Defense Strategy (NDS)*. It states: "U.S. forces will continue to defend U.S. territory from direct attack by state and non-state actors. We will also come to the assistance of domestic civil authorities in the event such defense fails or in case of natural disasters, potentially in response to a very significant or even

catastrophic event. Homeland defense and support to civil authorities require strong, steady state force readiness, to include a robust missile defense capability. Threats to the homeland may be highest when U.S. forces are engaged in conflict with an adversary abroad.”¹

Parallel to the *National Defense Strategy*, every four years the *Quadrennial Defense Review (QDR)* is published to ensure the direction of the military forces is in line with the strategic direction established by the President of the United States (POTUS). Within its guidance, the *QDR* establishes that “in the mid- to long term, U.S. military forces must plan and prepare to prevail in a broad range of operations that may occur in multiple theaters in overlapping time frames. This includes maintaining the ability to prevail against two capable nation-state aggressors, but we must take seriously the need to plan for the broadest possible range of operations—from homeland defense and defense support to civil authorities, to deterrence and preparedness missions—occurring in multiple and unpredictable combinations.”² Additionally, the *QDR 2010* emphasizes further the importance of defense support to civil authorities. Indeed, it puts it as a top priority. The Secretary of Defense directs a series of specific directives to ensure the *QDR 2010* is in accordance with POTUS strategic guidance. These directives are as follow: (1) Improve the responsiveness and flexibility of consequence management response forces; (2) enhance capabilities for domain awareness;³ (3) accelerate the development of standoff radiological/nuclear detection capabilities; and (4) enhance domestic capabilities to counter improvised explosive devices (IEDs).⁴

Furthermore, within the strategic objectives of the NSS is the NRF.⁵ The NRF is a guide to how the Nation conducts all-hazards response to include CBRN events. It is built

upon scalable, flexible, and adaptable coordinating structures to align key roles and responsibilities across the Nation, linking all levels of government, nongovernmental organizations, and the private sector. It is intended to capture specific authorities and best practices for managing incidents that range from the serious but purely local, to large-scale terrorist attacks or catastrophic natural disasters. The NRF also explains the common discipline and structures that have been exercised and matured at the local, tribal, State, and national levels over time. It also describes key lessons learned from Hurricanes Katrina and Rita, focusing particularly on how the Federal Government is organized to support communities and States in catastrophic incidents. Most importantly, it builds upon the National Incident Management System (NIMS), which provides a consistent template for managing incidents.⁶ It is relevant to note that NRF does not provide a foundation for a response to a CBRN event. Therefore, the applicability to this type of operation follows the guidelines of a disaster response that in turn are similar for the application of medical forces in support of civil authorities in general terms.

Prior to and during catastrophic incidents, especially those that occur with little or no notice, the State and Federal governments may take proactive measures to mobilize and deploy assets in anticipation of a formal request from the State for Federal assistance. Such deployments of significant Federal assets would likely occur for catastrophic events involving chemical, biological, radiological, nuclear, or high-yield explosive weapons of mass destruction, large-magnitude earthquakes, or other catastrophic incidents affecting heavily populated areas. The proactive responses are utilized to ensure that resources reach the scene in a timely manner to assist in restoring any disruption of normal function of State or local governments. Proactive notification and deployment of Federal resources

in anticipation of or in response to catastrophic events will be done in coordination and collaboration with State, tribal, and local governments and private-sector entities when possible.⁷

National Military Strategy

Using the National Security Strategy as the cornerstone of DoD planning to secure United States borders, the Secretary of Defense creates a National Military Strategy that states:

In response to an attack, cyber incident, or natural disaster, we will focus on rapidly providing planning, command and control, consequence management, and logistics support to the Department of Homeland Security, state and local governments, and non-governmental organizations.⁸

Follow on missions for DoD derives from NSS, NMS guidance and requirements. NORTHCOM designated as the lead organization for DoD will provide a consequence management response force to accomplish CBRN support to civil authorities. Thus, NORTHCOM created the Joint Task Force Civil Support and empowered them with the mission to train a ready force to support civil authorities in case it is requested through the governmental channels.

U.S. Army Strategic Documents

In the 2011 Army Posture Statement, Secretary of the Army, Paul McHugh describes the posture of the force in the immediate future. Following the posture statement, an information paper was generated and approved for publication that explains what the Army done in relation to CBRN Consequence Management (CM) and what the future may hold. It states: “Defense CBRN Response Force (DCRF) is designed to respond to a catastrophic or CBRN event through a Request for Assistance (RFA) by a

Governor, Lead Federal Agency, or the President through the Secretary of Defense. The Army will continue to properly source, equip, and train forces required to effectively respond to multiple, near-simultaneous domestic CBRNE events as directed by the Joint Chiefs of Staff CBRN Consequence Management Execution Order.”⁹

As a result, DoD has established a requirement for Defense CBRN Response Force (DCRF) to be trained and ready to respond to requests from civil authorities. DCRF is an evolution of the CBRN Enterprise that increases CBRNE Consequence Management Response Force (CCMRF) capabilities’ to a more rapid and flexible response force. DCRF does not supplant state, local, or other federal authority. Rather, it supports those authorities by providing response, rescue, relief, and recovery capabilities in which localities, states, and other federal agencies may lack in a CBRNE event.¹⁰

National Military Strategy assigns the United States and its territories to NORTHCOM as the lead military agency for CBRN response. Therefore, NORTHCOM established a mission which has two dimensions: one is a general statement that anticipates the need to conduct Homeland Defense and Civil Support operations within the assigned area of responsibility to defend, protect, and secure the United States and its interests, and the second dimension specifically DSCA address support during special events and to mitigate the effects of a disaster.

The document that covers all aspects of military support to civil authorities under CBRN event is CONPLAN 3500.¹¹ This document outlines relationships and sequence of steps required for mission approval in an event that requires military support to civil authorities. It also details the necessary steps to deploy to a no notice CBRN event or an imminent threat area. Within the guidelines of CONPLAN 3500 it specifies the

responsibilities of JTF-CS and the tasks associated with their mission in support of a CBRN event. Based on the creation of this organization to support civil authorities, research will determine if the mission scope of Joint Task Force Civil Support is too restrictive based on their state of readiness to respond only to a CBRN incident. If as currently stated in CONPLAN 3500, JTF-CS is ordered to be ready to deploy forces to CBRN incident site in 24 hours from notification. If the plan works as intended, with all the external variables and agencies in place working in a unified action framework, it would bring an exceptional capability to NORTHCOM if it needs to respond to other types of incidents outside of the full range of military operations. Some of these aspects will be covered in chapter 4, below using real world challenges that are currently being faced by units executing the mission.

Government Accountability Reports

Government Accountability Office (GAO) Reports originate from a Congressional request of information to ensure that systems established within the federal government are functioning as designed. Their mission is “to support the Congress in meeting its constitutional responsibilities and to help improve the performance and ensure the accountability of the federal government for the benefit of the American people. They provide Congress with timely information that is objective, fact-based, non-partisan, non-ideological, fair, and balanced.”¹²

This office has published multiple reports on the progress and status of defense support to civil authorities and the challenges that military forces have faced since the inception of the Department of Homeland Security. This research is evaluating some of these documents to highlight some existing deficiencies that have been investigated by

the GAO. This will assist in the analysis and establish some criteria in the evaluation of the interoperability and effectiveness of medical defense support to civil authorities.

In June 2008 the GAO published a report titled *First Responders' Ability to Detect and Model Hazardous Releases in Urban Areas Is Significantly Limited*. This report investigated the first responders' ability to detect hazardous releases in case of a man made attack or natural disaster. Additionally the reason this report was requested was because first responders are responsible for responding to terrorist-related and accidental releases of CBRN materials in urban areas.¹³ Today, the current response model for military forces is based on a request from the local government based on lack of resources upon a CBRN incident. If first responders' ability is limited in detection and extent of the damage that could cause a particular CBRN attack, their initial request for assistance could not be accurate enough for medical forces to be able to support effectively. The overall conclusions from GAO are that no agency has the mission to develop, certify, and test equipment first responders can use for detecting radiological materials in the atmosphere. Therefore, among their initial recommendations were that the Secretary of Homeland Security should reach agreement with agencies on who will have the mission and responsibility to develop, certify, and independently test first responders' equipment for detecting hazardous material releases.¹⁴

Another report from the Government Accountability Office studied the relationship between war fighting roles of military forces and their responsibility during a civil support request. This report written in March 2010 is titled, *DoD Can Enhance Efforts to Identify Capabilities to Support Civil Authorities during Disasters*, and was recently completed and presented to Congress. This study was requested based on the

poor execution by some DoD forces after Hurricane Katrina and the lack of ability to identify civil support requirements during a catastrophe.¹⁵

This report addresses the extent to which DoD (1) has identified and addressed its capability gaps for its civil support mission; (2) how it has clearly defined roles, responsibilities, and relationships and identified appropriate levels and types of personnel to assign to the FEMA regions; and (3) shares and tracks information concerning its civil support requirements response process with civil authorities. To do this, GAO analyzed DoD civil support guidance and plans and met with DoD and FEMA officials regarding the support that civilian authorities may request during a catastrophic incident.¹⁶ This research will analyze the implications of the gaps identified in this study and merge them with the capabilities that Task Force Medical provide today in support of civil authorities.

Among the recommendations offered by GAO in this study are that DoD updates its civil support guidance to reflect current doctrine. It also clearly defines the roles, responsibilities, and relationships for personnel assigned to manage civilian requests for assistance, conducts a staffing needs assessment for Defense Coordinating Officers; and establishes an official system to track requests for assistance across DoD that is accessible to DoD's inter-agency partners.¹⁷ These recommendations have a direct impact on the research question of: "What is the best configuration for medical units in support of civil authorities?" By delineating the current doctrine and establishing clearly defined roles these recommendations could potentially reduce the information gap and create a better force package to ensure civil authorities are receiving the capability requested at the minimum response time possible.

Another GAO report that shows results in the progress towards a more interoperable system between military forces and civilian authorities was written in September 2008. This report titled *U.S. Northern Command Has a Strong Exercise Program, but Involvement of Interagency Partners and States Can Be Improved*, establishes the need for a common approach between all stakeholders participating at the time of CM operations during a CBRN attack. Lack of coordination and participation increases the interoperable gap because this challenge is directly proportional to the lack of understanding the capabilities of military forces and their application. “Numerous local, state, tribal, and federal agencies and organizations--including DoD, DHS, and the Federal Emergency Management Agency (FEMA)--have jurisdiction over or can coordinate resources within the homeland and, therefore, may be involved in the response to an incident. According to the National Defense Strategy, a whole-of-government approach is only possible when every government department and agency understands the core competencies, roles, missions, and capabilities of its partners and works together to achieve common goals.”¹⁸

Joint Doctrine

Multiservice interaction through the years in response to CBRN training exercises has resulted in TTPs designed to streamline and increase efficiency in response to civil authorities. From planning to execution of military forces, it covers the necessary steps that must be taken into consideration when supporting civilian entities. *Multiservice Techniques, Tactics and Procedures (MTTP) for Chemical, Biological, Radiological and Nuclear Consequence Management (CBRN CM) Operations* is designed for use at the tactical level, but has implications at the operational and strategic level for CBRN CM

operations supporting strategic objectives.¹⁹ The document will support command and staff planning in preparing for and conducting CBRN CM operations. Additionally, this manual focuses on DoD support to domestic or foreign CBRN CM operations and aid research in determining if the current medical support structure within JTF-CS task organization covers the essential characteristics delineated in this publication.

Joint Publication (JP) 3-41 emphasizes on the goal that must be established by DoD to ensure CBRN CM is effective. JP 3-41 *CBRNE CM* states, “the primary goals of CBRN CM are to save lives; prevent injury; provide temporary critical life support; protect critical infrastructure, property, and the environment; restore essential operations; contain the event; and preserve national security.”²⁰ Out of the main goals of CBRN CM 50% fall into the medical support category therefore making Task Force Medical responsibilities greater than other Task Forces within JTF-CS.

Joint Publication 3-28 *Civil Support* discusses the procedures and requirements of how military forces should support civil authorities. The five-phases concept of civil support aligns the process in which Task Force Medical supports consequence management operations.²¹ On each phase there is a different interaction with Task Force Medical as they support civil authorities. The process combined with the medical force package assisting civil authorities when requested will determine if CBRN CM goals are met within the time needed.

The functions outlined in the phases for Task Force Medical are the mechanism for coordinated federal assistance to supplement state, local, and tribal resources in response to public health and medical care needs (to include veterinary and/or animal health issues when appropriate). As a supporting agency, DoD through the DCO as

explained in chapter 1 will coordinate these services by facilitating information management. JP 3-28 additionally refers to Immediate Medical Response and defines it as acute situations that may require response prior to detailed DoD and Health Service Support (HSS) coordination.²² Imminently serious conditions resulting from any civil emergency may require immediate action to save lives, prevent human suffering, or mitigate great property damage and is covered under the immediate response provision in DoD policy. During this research the author will analyze if Task Force Medical has the ability to respond with the requisite speed in these circumstances.

Joint Publication 4-02 *Health Service Support* also addresses specific areas that are relevant for this research. It explains the doctrinal way to conduct health care operations, mitigate health threat, and manage the risk to the population and damage to the health care infrastructure.²³ Using these references the researcher will analyze current composition of Force Packages in support to civil authorities and how they fulfill the need of medical assets.

Army Doctrine

Army Doctrine Publication (ADP) 3-0, is the military operations manual that specifies training and employment of forces for any scenario within the full range of military operations. This manual presents the changes from full spectrum operations to the decisive action framework and the importance of defense support to civil authorities within the spectrum of the conflict. “The homeland is a distinct part of the operational environment for Army forces. Homeland defense requires simultaneous and continuous application of combined arms maneuver and wide area security in coordination with designated civil authorities.”²⁴ With a higher emphasis on DSCA, research will

investigate if training of medical units is embedded into units training plans as part of the normal planning cycle to train the force in accordance with mission essential task lists (METL).

Understanding in broad terms real world's METLs of medical units within Task Force Medical, will help research show the emphasis medical units put into training cycles in order for them to support civilian authorities within ADP 3-0 scope. Moreover, the readiness state of units as part of DCRF plays a significant role in the execution of effective support to civilian authorities. The combination between wartime training and domestic support training is what makes medical units adaptable and capable to effectively support civilian authorities. Awareness of all mission requirements is needed in order to answer the question: Are we training to fulfill the requests from civil authorities at the medical unit based on current configuration and current doctrine?

Army Regulation 220-1, *Unit Status Reporting and Force Registration – Consolidated Policies* specifies the minimum status for a unit to be ready to deploy to any environment. In its overview and description it states, "...the process is a structured progression of increased unit readiness over time, resulting in recurring periods of availability of trained, ready, and cohesive units prepared for operational deployment in support of civil authorities and combatant commander requirements."²⁵ This publication specifies a minimum requirement for a unit to be ready to deploy utilizing the areas of personnel available, equipment readiness, training conducted and readiness of the unit overall. From being a mission ready level 1 that means that a unit is fully capable to complete the mission that is designed to accomplish to and mission ready 4 which means that a unit is not capable. Using these criteria and the commander's subjective assessment

of his unit's readiness a category is assigned to assess their ability to accomplish their mission. The pool available of units ready to deploy in support of civil authorities apportioned to JTF-CS is based on this criteria, therefore they must be addressed.

Research Papers

Based on the importance of the topic, other service members have taken the task to study similar topics. The first monograph that will be used for this study is titled, "DSCA–Are we organized right?" written by Mr. Joseph Austin. In his study, which was completed in March 2007, he reveals in his conclusions that DoD must improve its situational awareness after an incident of national significance. Additionally, he states that the orders approval process pertaining to request for assistance needs to be modified to accelerate response. Lastly he states that there must be an integration of Active Duty forces, Reserve and National Guard capabilities into the pre-operational planning and exercises for catastrophic events.²⁶ This research will use his finding to establish a parallel into how Austin arrived at his conclusions in relation to the research question established in reference to medical support to civil authorities.

Another research paper of quality and relevance for the research question is "DSCA Surveying Institutional Challenges" written by MAJ Anthony T. Murtha in May 2009. In his research he concluded that most of the challenges in military support to civil authorities are consequences of both statutory provisions that restrict the development of an adequate command structure and operating requirements that prevent preparation for incident response.²⁷ This thesis will compare MAJ Murtha's conclusions with the authors' and establish criteria that will allow arriving at conclusions and

recommendations. These conclusions and recommendations are intended to answer the research question within the parameters set for this study.

Articles and Journals

For the purposes of this thesis, it is not difficult to find information about military forces in support of civil authorities. However, information available that explains capabilities and relationships of Task Force Medical with civilian authorities, unclassified, is limited. This leads to challenges concerning how to distinguish sources with regard to what are personal opinions versus what comprises factual analysis.

In the article, “A Helping Hand from the Defense CBRN Response Force,” Jamie Stow explains the evolution of JTF-CS and how this organization has adapted to provide the necessary assets to support civil authorities. As it stands today DCRF stands ready to support civil authorities if requested. DCRF, which is comprised of four task forces, Medical, Operations, Aviation and Logistics, are prepared to respond with the necessary capabilities to address the needs of civilian entities.²⁸ “Today, the DCRF stands ready to respond, as directed by the President, in support of civil authorities to do whatever is needed to save lives, prevent further injuries, and provide temporary critical support to facilitate community recovery.”²⁹ From this statement stems an implication to the research question as to, what do the civil authorities need? JTF-CS is an organization ready to support when the call comes within the United States and its territories within a specific set of capabilities already apportioned from Task Force Medical.

In another journal, “Equipment Standardization – A new old approach,” Jordan Nelms explains how the Department of Homeland Security aids first and local responders maintain the needed edge to be able to face today’s operational environment. It also

alludes to the fact that interagency cooperation is key to be able to understand all key players involved in a CBRN incident. Additionally, refers to the need of Task Force Medical interaction with civilian authorities is essential to provide the support if requested within the capabilities of the Task Force.

There are numerous problems that surface during a no-notice catastrophe. The biggest challenge for first responders trying to contain the situation and use all resources available to prevent further injury and saving lives. In the article, “Finding Beds in the Middle of Disaster,” written by Beth McAtter in May 2012, she recommends that among the more important actions to be successful during an incident response is to determine the current state of medical readiness of any organization.³⁰ This can be achieved during a pre-planning operational exercise or by a capabilities gap analysis provided by the states requesting assistance.

Governing Laws

The role of the federal military in DSCA is carefully defined and deliberately circumscribed by the Constitution, statutes and policy. As many have noted, one of the laws that limits the role of the federal military is the Posse Commitatus Act.³¹ Posse Commitatus prohibits Title 10 forces (that is, the federal military, as distinguished from the National Guard in a state status-Title 10 of the U.S. Code is the title that governs the armed forces) from enforcing state or federal laws, except as otherwise authorized by law. Title 10 forces may not make arrests, stop and examine suspects, conduct searches and seizures, or perform domestic surveillance. The statutory prohibition on the use of the armed forces to enforce the law, however, does not mean that the military cannot engage with and support civilian law-enforcement agencies.³²

The Insurrection Act³³ provides for an exception to Posse Commitatus Act. The Insurrection Act allows the President to use federal armed forces to enforce the law in three instances: at the request of a state legislature or, if the legislature is not in session, a governor; either to enforce federal law or when a rebellion or unlawful “assemblage” precludes enforcement of the law through judicial proceedings; and to suppress “any insurrection, domestic violence, unlawful combination, or conspiracy” if a state fails to protect the constitutional rights of its citizens. “The changes made in October of 2006 to the law provide explicit examples of situations that may lead to events of public disorder justifying the President’s invocation of the Act’s authority. “It was never the purpose of the Constitution . . . that the militia should be sent to execute the laws, merely because they are not being at all times diligently executed or perfectly enforced in the particular area in question.”³⁴

The Robert T. Stafford Disaster Relief and Emergency Assistance Act (The Stafford Act) authorizes the President to issue major disaster or emergency declarations in response to catastrophes that overwhelm state and local governments.³⁵ The Economy Act permits federal agencies to provide resources and services to other federal agencies on a reimbursable basis. The Economy Act is also the basis for the general rule that DoD will not compete with commercial businesses.³⁶

Discussing DSCA operations, which include CBRN CM, in the same breath as the Insurrection Act only perpetuates misunderstanding. The Insurrection Act does not provide the legal authority for DSCA operations. Federal military (Title 10) forces, including CBRN CM response forces, conduct DSCA operations under the umbrella of the National Response Framework, promulgated by the Department of Homeland

Security. The specific statutory authority for DSCA operations is the Robert T. Stafford Disaster Relief and Emergency Assistance Act, commonly known as the Stafford Act.³⁷

Under the rubric of the Stafford Act, Title 10 forces perform only discrete and defined tasks, known as “mission assignments.” These mission assignments result from requests for assistance that are usually passed to DoD from the local and state levels through FEMA. The requests are vetted by the Joint Staff and approved by the Secretary of Defense. Many DoD lawyers at various levels review every request for legality as it progresses to the Secretary of Defense.³⁸

The Constitution, the United States includes the 50 states, the District of Columbia, and the territories of Puerto Rico, the Virgin Islands, Guam, and American Samoa and the Commonwealth of the Northern Mariana Islands. Under the Tenth Amendment of the Constitution, each state/territory of the United States has the primary responsibility to prepare for and respond to disasters and emergencies occurring within its borders. The Constitution establishes the sovereignty of the states over many aspects of government. Additionally, and of particular importance to domestic operations, are the authorities granted by Congress to the states. Article 1, Section 8, Clause 16 of the Constitution, the Militia Act of 1903, and the National Defense Act of 1916 are the basis for the distinction between National Guard forces and Active Component Title 10 forces. State governors retain authority over their respective National Guard forces. The authority over and control of DoD Title 10 forces are at the discretion of the President of the United States as the Commander-in-Chief.³⁹

In response to DSCA, expectations of DoD capabilities must be effectively managed and communicated. The goal is efficient execution of consequence management

operations and successful synchronization of military forces and civil capabilities after a disaster when local and state level infrastructure may be overwhelmed. This will be executed at the request of the Governor of the state in need and after declaring a state of emergency.⁴⁰

Homeland Security Presidential Directive–5 (HSPD–5), “Management of Domestic Incidents” (2003) required the Secretary of Homeland Security to develop and administer a National Incident Management System and a National Response Plan. (National Response Framework replaced the National Response Plan in 2008.) The directive requires all federal departments and agencies to adopt NIMS and use it in individual domestic incident management programs and activities, as well as in support of state, local, or tribal entities. It also provides detail on the authorities of various government officials within the national incident management system.⁴¹

NIMS is designed to aid in managing prevention of, preparation for, response to, and recovery from terrorist attacks, major disasters, and other emergencies. NIMS employ the Incident Command System (ICS), a standardized, on-scene approach to all-hazards incident management. Most civilian Incident Commanders (ICs) employ ICS.⁴²

HSPD-8, “National Preparedness” (2003), a companion directive to HSPD-5, establishes policies to strengthen preparedness of the United States in order to prevent and respond to threatened or actual domestic terrorist attacks, major disasters, and other emergencies. The directive requires a national domestic all-hazards preparedness goal, with established mechanisms for improved delivery of federal preparedness assistance to state and local governments. It also outlines actions to strengthen preparedness capabilities of federal, state, and local entities.⁴³

Summary

Each of the national strategies, military strategies, and national documents such as NRF and campaign plans assists in the production of the doctrine that governs the conduct of CBRN related missions. The doctrine produced regarding medical response of support related missions is utilized for decisions made at NORTHCOM to configure medical forces in support to civil authorities. As is stands today, medical planners continue to breach the gap between medical military forces application of capabilities and the needs of the civil authorities. Doctrine coupled with force structure and training is key elements in the analysis for the current structure of Task Force Medical. They help determine suitability to support civil authorities if requested and how much should be written and documented in regards to how medical support is given to the states.

¹Chairman, Joint Chiefs of Staff, *The National Military Strategy of the United States of America* (Arlington, VA: The Pentagon, February 2011), 5.

²Department of Defense, *Quadrennial Defense Review* (Arlington, VA: The Pentagon, February 2010), 12.

³Domain awareness as defined in the NSS is one of the approaches taken to ensure no access to U.S. enemies. Other examples are air, maritime, space, and cyberspace access venues.

⁴Department of Defense, *Quadrennial Defense Review* (2010), 12.

⁵The White House, *National Security Strategy* (Washington, DC: The White House, May 2010), 35.

⁶Department of Homeland Security, *National Response Framework*, 1.

⁷*Ibid.*

⁸Chairman, Joint Chiefs of Staff, *The National Military Strategy*.

⁹Department of the Army, *2011 Army Posture Statement*, https://secureweb2.hqda.pentagon.mil/VDAS_ArmyPostureStatement/2011/information_papers/index.asp (accessed May 2012), Information Papers.

¹⁰Ibid.

¹¹Department of the Army, Chairman of Joint Chief of Staff Defense Support to Civil Authorities, Execution Order, Unclassified, 141745ZAUG09.

¹²U.S. Government Accountability Office, “About,” <http://www.gao.gov/about/index.html> (accessed 20 May 2012).

¹³U.S. Government Accountability Office, *First Responders’ Ability to Detect and Model Hazardous Releases in Urban Areas is Significantly Limited* (Washington, DC: Government Accountability Office, June 2008), 2.

¹⁴Ibid.

¹⁵U.S. Government Accountability Office, *DoD Can Enhance Efforts to Identify Capabilities to Support Civil Authorities during Disasters* (Washington, DC: Government Accountability Office, June 2008), 3.

¹⁶Ibid., 10.

¹⁷Ibid.

¹⁸Department of Defense, *National Defense Strategy* (Washington, DC: Government Printing Office, June 2008), 17-18.

¹⁹MTTP CBRN CM, April 2008.

²⁰Chairman, Joint Chiefs of Staff, Joint Publication 3-41, *Chemical, Biological, Radiological, Nuclear and High Yield Explosive Consequence Management* (Arlington, VA: The Pentagon, October 2006), 76.

²¹Chairman, Joint Chiefs of Staff, JP 3-28, 61.

²²Ibid., 72.

²³Chairman, Joint Chiefs of Staff, Joint Publication 4-02, *Health Service Support* (Washington, DC: The Pentagon, September 2007), 20.

²⁴Department of the Army, Army Doctrine Publication (ADP) 3-0, *Unified Land Operations* (Washington, DC: The Pentagon, October 2011), 3.

²⁵Department of the Army, Army Regulation (AR) 220-1, *Unit Status Reporting and Force Registration–Consolidated Policies* (Washington, DC: The Pentagon, April 2010), 28.

²⁶Joseph Austin, “Defense Support of Civil Authorities–Are We Organized Right?” (Research Project, Army War College, Carlisle Barracks, PA, March 2007), 30.

²⁷Anthony Murtha, “DSCA Surveying Institutional Challenges” (Monograph, School of Advanced Military Studies, Fort Leavenworth, KS, May 2009), 39-40.

²⁸Jamie Stow, “A Helping Hand from the Defense CBRN Response Force,” *Domestic Preparedness Journal* (May 2012): 1.

²⁹Jordan Nelms, “Equipment Standardization,” *Domestic Preparedness Journal* (March 2012): 2.

³⁰Beth McAtter, “Finding Beds in the Middle of Disaster,” *Domestic Preparedness Journal* (May 2012), http://www.domesticpreparedness.com/First_Responder/Emergency_Management/Finding_Beds_in_the_Middle_of_a_Disaster/ (accessed 30 May 2012).

³¹MG Jeffrey A. Jacobs, “CCMRF and Use of Federal Forces in Civil Support Operations,” *Army Magazine* (July 2009).

³²Department of Defense, CONPLAN 3500.

³³Mark M. Beckler, “Insurrection Act Restored: States Likely to Maintain Authority Over National Guard in Domestic Emergencies” (Monograph, School of Advanced Military Studies, Fort Leavenworth, KS, May 2008).

³⁴Danielle Crockett, *The Insurrection Act and Executive Power to Respond with Force to Natural Disasters* (University of California, Berkley School of Law, 2007).

³⁵Department of Defense, *DSCA Handbook*.

³⁶*Ibid.*

³⁷Jacobs.

³⁸Bruce Lawlor, “Military Support of Civil Authorities-A New Focus for a New Millenium,” *The Journal of Homeland Defense* (November 2000), <http://homelandsecurity.org/journal/articles/lawlor.htm> (accessed December 2011), Abstract.

³⁹Department of Defense, *DSCA Handbook*.

⁴⁰*Ibid.*

⁴¹*Ibid.*

⁴²*Ibid.*

⁴³*Ibid.*

CHAPTER 3

RESEARCH METHODOLOGY

In response to Hurricane Katrina, the National Response Plan came up short. We need to rewrite the NRP so it is workable and so it is clear.

— Frances Townsend

The key question of this research study is what are the best military medical unit configurations for the support of civil authorities apportioned under Joint Task Force Civil Support in response to CBRN event? In addition, the research aims to discover what gaps might exist in the forces packages designed by NORTHCOM to support civil authorities. Many previous studies discuss the lack of emphasis of the DoD CBRN defense capability and the lack of interoperable systems between medical military forces and civilian agencies. For example, *Defense Support to Civil Authorities: Surveying Institutional Challenges*, states “The challenge is not only for Department of Homeland Security but also for DoD is to establish the interoperability and compatibility among Federal, State, and local capabilities needed to achieve the intended synchronization”¹.

Another example of structure and challenges between military forces and civil authorities specifically in interoperability was researched by Mr. Joseph Austin in his research project, *Defense Support of Civil Authorities—Are we organized right?* In his study he emphasizes the importance of accessibility to the incident site must be in concert with civilian authorities to ensure effectiveness in response. These studies establish a need for conducting further analysis of Task Force Medical’s ability to support what is required from civil authorities. First, it is necessary to understand the relationships between JTF-CS and civilian authorities in regards to decision-making in what type of

support is provided and their ability to affect change to command structures when military forces are strictly in a support role.

Research Design

This research will follow a qualitative design based on the article *Analyzing Qualitative Data* written by Ellen Taylor-Powell and Marcus Renner from the University of Wisconsin; the method to accomplish this goal will be primarily a document review. The qualitative method focuses on the review of narrative data and text. The research design was selected because the conclusions drawn from the method will be based on the view of the researcher based on experiences from the field executing the CBRN CM mission and not on quantitative data. In addition, given the limitations of this study it is not possible to compile enough quantitative data in order to draw meaningful conclusions.

The disadvantages of this qualitative research design are that the bias of the researcher plays a role in the conclusions and the conclusions drawn by this study are subject to interpretation as they are subjective in nature. As a mitigating step, this subjectivity will be reduced by conducting a review of the literature available and classify in a hierarchal order to identify any gaps in information that will aid in answering the research question. Despite these disadvantages, it is the aim of this study to present as unbiased a view as possible the primary and secondary research questions and to draw conclusions based on the data.

The research design will establish a series of steps that will guide the review process to allow detailed analysis. “This analysis process is fluid, so moving back and forth between the steps is likely.”² The first step would be to review unclassified data

available and determine if the quality of the data may be useful in answering the research question. The second step will focus the analysis and generate sub questions that will facilitate the research process by focusing in key concepts. The third step will categorize the information using a hierarchical method that will allow an analysis from the perspective of the 3 levels of war. From the strategic level documents such as National Security Strategy and National Military Strategy all the way down to the tactical application of unit reports on the execution of CM mission.

Background Document Review

This review will consist of an analysis of US Strategic documents; this research will conduct a hierarchical review of documents starting with the major national strategy documents and their statements regarding medical support during consequence management to civil authorities. The research will move to conduct an analysis of military strategy documents that are built from the national strategy documents, moving on to the army service strategies and finally army service doctrine. This method will show the relationship between national strategy documents and the military capability that is built based on these documents. The purpose behind the hierarchical review is to emphasize the importance placed on consequence management operations by the US government and how it does or does not translate to the medical units executing this homeland mission.

The basis of this method will be the doctrine, organization, training, material, leadership, personnel, and facilities (DOTMLPF) model. This acronym assists commanders and staffs in ensuring that all aspects of the systems are evaluated prior to execution of an effort.³ The DOTMLPF model will be utilized because it covers all

necessary aspects of the CBRN CM mission and the author will apply it to DCRF. In general terms the application of DOTMLPF to the research question is as follow:

1. Doctrine: the way Task Force Medical support civil authorities by laws, policies and regulations
2. Organization: how medical units are organized to support civilian authorities request for assistance;
3. Training: how medical units prepare to support military forces and train to become interoperable with civilian entities.
4. Materiel: all the equipment necessary to equip our forces
5. Leadership and education: how we prepare our leaders to understand and lead the support from squad leader to 4-star general/admiral; professional development
6. Personnel: availability of qualified people to support what is needed based on population at risk (PAR) and specific civil authorities requests
7. Facilities: real property; installations and industrial facilities (e.g. government owned hospitals) that support our forces

The idea is to identify and recommend changes to fix the capability gap and increase flexibility by creating a highly adaptable force if required. This study assumes that military medical support to civil authorities will be able to assist any civilian request within the capabilities of the force if requested. The design of this methodology can be utilized for each of the four task forces within JTF-CS; but this study will focus on Task Force Medical.

DOTMLPF Model Explanation and Design

All of the elements of DOTMLPF, while equally important, will not be considered in this study due to the nature of the study. In conducting analysis using the DOTMLPF model, it is essential to define each element and discuss the importance of each element to the study. These definitions will set the framework to allow conclusions regarding the capability of JTF-CS to be drawn. The criteria used to evaluate the different elements of DOTMLPF are the final component that will assist in answering the questions posed by this study.

The initial element of the DOTMLPF model that will be evaluated is doctrine, more specifically military doctrine concerning the medical support to civil authorities in the event of a CBRN incident. Doctrine is defined as “fundamental principles by which the military forces or elements thereof guide their actions in support of national objectives. It is authoritative but requires judgment in application.”⁴ Doctrine is established using history, theory and experience. Doctrine gives planners a starting point of departure in which to begin their analysis of a situation or problem. Doctrine is not military strategy; it is a series of fundamental principles by which the military forces or elements thereof guide their actions in support of national objectives. Doctrine will assist this study in establishing a baseline of designed capabilities for the conduct of CBRN CM.⁵

The doctrine pertaining to the conduct CBRN CM operations within JTF-CS will be evaluated using the criteria of completeness, and feasibility. Completeness addresses the ability of the doctrine to address all aspects of the mission set that it discusses; this includes the operational fundamentals, planning considerations and sustainment

operations. The nature of doctrine is that it discusses how to accomplish the mission in general terms. However, doctrine suffers from the fact that it takes much time and effort to change. In evaluating the doctrine governing the roles of military medical forces in support of civil authorities, it is important to ensure that this doctrine is as up to date as possible given the importance of this mission set. In establishing doctrine, writers must evaluate the ability of the force to conduct the operations that they have been tasked for. An evaluation of this ability will display the feasibility of the doctrine itself. The key question to ask is, “based on what is written; can the unit that is being considered to perform the mission can accomplish the task?” If either of these criteria is not met; then it is critical that an evaluation of the doctrine governing a specific mission set is conducted and potential changes to the doctrine be implemented.

Doctrine drives the way that the military sees itself. In addition, there are established guidelines to the way that a military unit is organized. The organization of a military unit is hierarchical in structure, and each unit is organized based on the necessary capability that it is designed for. The analysis of individual unit organization will allow the author to evaluate if the designed unit structure is adequate to answer the requests from civil authorities in order to save lives, reduce human suffering, and protect property infrastructure. Organization will be evaluated using the criteria of size based on scope of mission, capability of equipment to accomplish the assigned tasks, and the command structure necessary for mission accomplishment. These criteria will assist this study in evaluating gaps and shortfalls between the assigned mission of the unit and the ability of that the unit to conduct assigned missions in support of civil authorities.

The final element of the DOTMLPF model to be evaluated is training utilized to conduct CBRN CM, including personnel MTOE composition and specific requests for medical specialties based on request and the affected PAR. Evaluation of the personnel that a unit has available to conduct the technical elements of casualty evacuation and treatment in a CBRN environment is vital to answering the research questions posed by this study. Identification and evaluation of current force package structures based on existing capability evaluations since hands on evaluation is beyond the scope of this research.

Summary

The aim of this study is an examination of the roles of medical units in support of chemical, biological, radiological, or nuclear event (CBRN) under joint task force civil support (JTF-CS)? The importance placed on our national security concerning the application of military medical forces in support of civil authorities during a CBRN incident are the foundation of this study. Additionally, the importance of the application on DSCA operations is found in ADP 3-0, as part of the decisive action model that will drive the way military medical units train for the mission that they are designed in support of DSCA. The primary goal is to analyze the doctrine, organizational structure and personnel apportioned to JTF-CS could face the CBRN threat in the contemporary operating environment utilizing qualitative research. The aim of this methodology is to present an un-biased analysis of the readiness of Task Force Medical and assist in addressing any gaps that may exist. A description of this study is contained in the next chapter.

¹Anthony T. Murtha, “Defense Support to Civil Authorities: Surveying Institutional Challenges” (Monograph, School of Advanced Military Studies, Fort Leavenworth, KS, May 2009), 24.

²Ellen Taylor-Powell and Marcus Renner, *Analyzing Qualitative Data* (University of Wisconsin, Madison Wisconsin, 2003), 2.

³Chairman of the Joint Chiefs of Staff, CJCS Instruction 3170.01F, *Operations of the Joint Capabilities Integration and Development System* (Arlington, VA: The Pentagon, 1 March 2009).

⁴Chairman of the Joint Chiefs of Staff, Joint Publication (JP) 1-02, *Department of Defense Dictionary of Military and Associated Terms* (Arlington, VA: The Pentagon, November 2010), 104.

⁵Defense Acquisition University, *Joint Capabilities Integration and Development System (JCIDS) Manual*, updated 19 January 2012, <https://acc.dau.mil/CommunityBrowser.aspx?id=267116&lang=en-US> (accessed 12 March 2012).

CHAPTER 4

ANALYSIS

The aim of this research study remains to examine the roles of medical forces apportioned under JTF-CS to provide support the civil authorities effectively. This could be helpful to NORTHCOM in determining the mission of military medical forces in support of civil authorities specifically under a CBRN incident. Also, it could assist medical planners in understanding requirements from civilian authorities and help them tailor a capable force to support such requests. The strategic direction documents that guide the US government refer to the need to mitigate the human suffering and prepare for an imminent threat in CONUS; this study aims to identify what the US military, specifically Task Force Medical under JTF-CS, is doing to increase interoperability with civil authorities if medical support is requested. This mission plays an essential role not only in the protection of our country, but also more importantly in the proper utilization of medical forces to the protection of the homeland.

The research method utilized during this study was a document review analysis focusing on the Doctrine, Personnel and Training elements of the DOTMLPF model. The analysis will assess the conduct of medical support to civil authorities under JTF-CS if a CBRN event occurs. This study is limited in nature due to its dependence on document review and the inability to conduct field analysis based on time limitations.

The primary research question asks what are the best military medical unit configurations for the support of civil authorities apportioned under Joint Task Force Civil Support in response to CBRN event. The answer to this question is to be found through an examination of the evolution of Joint Task Force Civil Support under

NORTHCOM since its inception and its ability to effectively respond to a CBRN event if requested. The ability to respond to a CBRN event has not been tested in a real world scenario. Therefore, most of the lessons learned on how to increase interoperability between military forces and civil authorities come from exercises conducted yearly by NORTHCOM. Additionally, a recent development in Army Doctrine, ADP 3-0, which includes Defense Support to Civil Authorities as a main part of the range of military operations will potentially dictate the future of Task Force Medical in support to civil authorities as how their role will increase to create a more adaptable organization.

Doctrine

The United States Constitution invests Congress with the powers to provide for the common defense and general welfare of the United States and to raise and support armies. Title 10 of the United States Code states what Congress expects the Army, in conjunction with the other Services, to accomplish. This includes: (1) Preserve the peace and security and (2) provide for the defense of the United States, its territories and possessions, and any areas it occupies. Also it expects the military forces to support national policies, implement national objectives, and defeat any nations responsible for aggressive acts that imperil the peace and security of the United States. Based on these requirements military forces develop key concepts in which today's doctrine is founded.

Most modern US doctrine is based around the concept of full spectrum operations. Full spectrum operations concept used to combine offensive, defensive, and stability or civil support operations simultaneously as part of an interdependent joint or combined force to seize, retain, and exploit the initiative.¹ With the new doctrinal change within ADP 3-0, it is still combining offensive, defensive, and stability operations abroad

but it specifically emphasizes defense support to civil authorities within CONUS.² Using this change as a doctrinal basis for this study, the author establishes a trend towards an increase interaction between military forces and civil authorities within the entire range of military operations. The employment of synchronized action proportional to the mission requested by civil authorities is what doctrine should outline to allow military medical forces to effectively support by understanding what civil authorities needs are. Civil support operations are support tasks and missions to homeland civil authorities for domestic emergencies, and for designated law enforcement and other activities. This includes operations dealing with the consequences of natural or manmade disasters, accidents, and incidents within the homeland.

The strategic doctrine, which Defense Secretary Donald Rumsfeld issued in his Quadrennial Defense Review 2006, developed insights regarding the ways in which the capabilities of U.S. forces should evolve by evaluating alternative future forces in a diverse set of scenarios. The Department of Defense also assessed lessons learned from ongoing operations in Iraq, Afghanistan, and elsewhere.³ Collectively, these assessments helped inform decisions affecting capabilities in six key mission areas:

1. Defend the United States and support civil authorities at home;
2. Succeed in counterinsurgency, stability, and counterterrorism operations;
3. Build the security capacity of partner states;
4. Deter and defeat aggression in anti-access environments;
5. Prevent proliferation and counter weapons of mass destruction; and
6. Operate effectively in cyberspace.

The first key mission area refers to defending the US homeland as a top priority. Military medical forces must be ready to respond and provide assistance to civil authorities and be able to remain flexible for any other threat. This guidance given by Secretary of Defense set the conditions and directions of armed forces immediate future.

National Military Strategy 2011 further specifies how military forces will deter and defeat aggression. “In response to an attack, cyber incident, or natural disaster, we will focus on rapidly providing planning, command and control, consequence management, and logistics support to the Department of Homeland Security, state and local governments, and non-governmental organizations. We will continue to dedicate, fund, and train a portion of the National Guard for homeland defense and defense support of civil authorities.”⁴

The nature of military doctrine is that it will be adequate to cover the intended topic for what it is designed to guide. If it is not adequate, then more military doctrine can be written to adequately cover the intended topic through changes. This is the case with the military medical forces in support of civil authorities. The many doctrinal publications that contain elements of this mission are thorough and cover the topic well; however, in practice, the force structure of military medical forces is limited in their ability to conduct the interoperability tasks that will allow civil authorities to receive and understand the capabilities received. This is rooted in the fact that medical support will be given to civilian authorities only when requested and what is requested. This research found that the doctrine regarding the topic of medical support to civil authorities operations is adequate; although this has impacts to other elements of the study. For example, the need for training venues to increase the understanding of the scope of

support and the precise relationship between medical forces and civilian authorities must be established. Current configuration of Task Force Medical is required to deploy via force packages to allow a quick, flexible and adaptable response. However, there is still a need to identify needs of civil authorities to be able to tailor Task Force Medical effectively. With the addition of common training venues, this will allow an interagency common understanding of military medical capabilities and employ them as needed. Each state has different requirements based on population, location, resources and threats. Although Task Force Medical offer a general response medical package set it is imperative for the lead agency to identify what each state needs in the pre-planning phases of a response.

For adequate response to a CBRN event the US Army CBRN corps is the lead service for CBRN joint doctrine; the joint nature of CBRN doctrine assists in identifying resources necessary to conduct consequence management mission from all of the services. This study found that joint doctrine is adequate in addressing some aspects of conducting operations in support to civil authorities in case of a CBRN event. However, there is a need to interconnect states in need of CBRN capabilities with the U.S. Army CBRN Corps. As stated in GAO report, *First Responders Ability to Detect and Model Hazardous Releases in Urban Area is Significantly Limited*, thus, it appears that there is a lack of understanding along with a lack of detection equipment from the first responder's perspective.⁵ If Task Force Medical is required to respond in 24 hours from notification, preliminary assessments of the medical support need will be incomplete based on this lack of capability from the civil authorities.

Joint Publication 3-11, *Operations in Chemical, Biological, Radiological, and Nuclear Environments* and Joint Publication 3-41, *Chemical, Biological, Radiological and Nuclear Consequence Management*, discuss the conduct of the proper response mission as an essential element of the prevention of further human suffering or damages to the infrastructure, however they do not specifically address the interaction and or interoperability aspects with civil authorities to achieve a common goal. This study has found that even though there is an immense strategic emphasis on CBRN Consequence management related operations from the highest levels beginning with the NSS and NMS as explained in chapter 2 however, this is difficult to implement due to the all the constraints embedded in the constitution such as 10th amendment that allows the states to be sovereign and other restrictive laws such as Stafford Act.

The conduct of medical support to civil authorities operation is “joint” in nature based on resources and capabilities available. The DSCA Handbook provides the tactical level commander and staff the tools to conduct planning in support to civil authorities; but it lacks the necessary CBRN references and perspectives necessary to support of civil authorities. Even though it is clearly stated that JTF-CS will be ready to respond to a CBRN event the planning tools referenced in this doctrinal source are for events other than CBRN such as wild land fires, hurricane and tornadoes, earthquake, floods and winter storms. Even though it is stated in chapter 5 of the DSCA handbook the planning factors used for all hazards events should encompass all consequence management responses, it also lacks the planning process in regards to population at risks for specific hazards within the CBRN spectrum and regions within CONUS. For example a chemical response for an attack executed in a metropolis such as Washington DC, will necessitate

a different response package than a chemical attack in a small town. Population, census, area capabilities and first responders' ability to contain the event are the most critical elements in planning for an effective response. Therefore, DoD inability to know civil authorities resources needs pre-incident is an example that potentially renders a pre-tailored response force ready to support any event within CONUS incapable of assisting such catastrophe. It is nearly impossible for NORTHCOM through JTF-CS to prepare a well-rounded medical support package based on a gap analysis without knowing first the needs of the states or regions within CONUS.

As stated in the Stafford Act, military forces in support to civilian authorities will occur when requested. As military medical forces are in support of civilian authorities and not in the lead, it is imperative to know ahead of time what they need. Therefore, a more adaptive and responsive package can be tailored to fulfill the needs of the people of the United States in the event of a catastrophic CBRN event.

Multiservice interaction through the years in response to CBRN training exercises have developed TTPs in order to streamline and increase efficiency in response to civil authorities. Multi-Service Tactics, Techniques and Procedures (MTTP 3-11.21) for CBRN CM Operations addresses the planning considerations necessary for the conduct of the consequence management mission from both the operational and tactical levels. "DoD forces will be employed as part of a flexible tiered response, and military support will be tailored to support a Tier I, II or III response. The scope and magnitude of the military response will focus on providing capabilities that meet the response requirements that are beyond the resources of civil authorities."⁶ This publication also addresses each operational level task, by providing a checklist as a planning tool to be able to understand

medical capabilities of military forces in response to a CBRN attack. “Response units provide Health Service Support (HSS) during CBRN CM operations. HSS addresses services performed, provided, or arranged to promote, improve, conserve, or restore the mental and physical well being of personnel. These services include, but are not limited to, the management of health services resources, such as manpower, monies and facilities; preventive and curative health measures, evacuation of the wounded, injured or sick; selection of the medically fit and disposition of the medically unfit; blood management; medical supplies and equipment and maintenance thereof; combat stress control; and medical, dental, veterinary, laboratory, optometric, nutrition therapy, and medical intelligence services.”⁷ All this array of capabilities or services is provided to the civilian authorities via the force packages as outlined in the current planning doctrine. However, the question still persists as to what civilian authorities need in order to be able to effectively manage a CBRN attack. The publication outlines an all-encompassing force package necessary to conduct CBRN CM mission. This force package is extensive, and allows all services to understand the amount of forces necessary to conduct this type of mission. Also the publication highlights planning considerations for working within certain environmental conditions as well as special considerations regarding integration into the civilian health system but there is a lack of analysis in regards to what it is really needed based on a PAR analysis depending on CONUS location.

The overall assessment of both the Joint and Army doctrine regarding the conduct of the CBRN CM mission is that the doctrine is complete and addresses all the necessary aspects to address when a CBRN attack occur. The doctrine covers multiple planning and resource considerations regarding the application of medical forces and these

considerations are critical to planners when faced by an imminent threat. While the study has determined that the doctrine is complete, the feasibility of the identified units to conduct a mission of this scope is limited due to the lack of gap analysis from the civilian authorities that outlines their specific needs. This limitation will be highlighted in the following sections. This study has determined that the doctrine regarding the CBRN CM is complete as long as CM operations are conducted by the armed forces. However, doctrine explaining the interaction between applications of military medical capabilities in support of civil authorities is almost non-existent.

Organization

The current organizations executing the CBRN mission in support of civil authorities is managed by NORTHCOM. These units are designed to support civil authorities upon request of the states' governor when a state of emergency has been declared and local resources are lacking. As explained in Chapter 1, the creation of JTF-CS allows for military forces to support civil authorities within 24 hours of the request. As per 2011 Army Posture Statement, JTF-CS has evolved into a more robust, flexible, and adaptive reaction force in support of a CBRN event. "The new Defense CBRN Response Force (DCRF) is a 5,200 personnel rapid response force composed of two force packages. The first force package consists of 2,100 personnel prepared to deploy within 24 hours. The second force package consists of 3,100 personnel and is prepared to deploy within 48 hours of notification. The new structure also consists of two Command and Control CBRN Consequence Response Elements (C2CRE) composed of 1,500 personnel each. DCRF is designed to respond to a catastrophic or CBRN event through a Request for Assistance (RFA) by a Governor, Lead Federal Agency, or the President through the

Secretary of Defense.”⁸ It is evident that NORTHCOM is moving in the right direction in order to fulfill request from civil authorities in an efficient manner by having a more complete force. This progress is apparent in the GAO report, *U.S. Northern Command Has Made Progress but Needs to Address Force Allocation, Readiness Tracking Gaps, and Other Issues*, published in April 2008. This report states that “although NORTHCOM has taken actions to improve coordination of its homeland defense and civil support plans and operations with federal agencies, it lacks formalized guidance and procedures –such as memorandums of understanding– to help ensure interagency coordination efforts or agreements are reached can be fully relied on.”⁹ This statement can imply a lack of appropriate doctrine to guide NORTHCOM in establishing such agreements with civil authorities. It is not until the publication of ADP 3-0 that defense support to civil authorities has had the necessary emphasis to be able to tackle most of the issues that have come up.

A unit’s mission and designed capabilities help generate the Military Tables of Organization and Equipment (MTOE) document. These documents are constructed and divided by section within the larger unit being addressed. This division is annotated by individual line numbers and utilized for both the personnel and equipment sections of the document. The personnel section addresses personnel needs by position, grade or rank, and any specialized skill sets necessary for the position. The equipment section of the document addresses the type and amount of equipment that the unit will be allocated based on the unit mission. When we study the military medical units’ MTOEs, we find that these are designed specifically to support the warfighter during conflict or war. The analysis of the MTOE documents for medical units is the basis for this section of the

study and pertains to how the organization is organized in order to execute the assigned mission. MTOE documents are designed for units to be able to execute their wartime mission and lack consideration of effective support to civil authorities. This assumption stems on the fact that Medical Units are ready to provide medical support to military forces whenever there is a medical need within their organizations. When defense support to civil authorities becomes part of the full range of military operations medical units lack the necessary personnel and equipment to provide support to civilians. Example of civilians that potentially need assistance during a CBRN event will depend on the type of population and PAR. For illustration purposes, if the need for medical support required in a CBRN incident location is predominantly geriatrics and pediatrics, units that are part of force package 1 do not have the capabilities to provide the medical care based on their MTOE composition. This will create a capability gap and will require the Defense Coordinating Officer to submit request for additional forces to cover this gap.

Another illustrative example is the Area Support Medical Company (ASMC) MTOE that is part of Task Force Medical in support of civil authorities and they are authorized three chemical patient treatments and two patient decontamination medical equipment sets (MES). Each patient chemical treatment MES is stocked with enough supplies to treat 30 patients. Each patient decontamination MES is stocked with enough supplies to decontaminate 60 patients.¹⁰ By design the ASMC is not organized to support external requests from civil authorities effectively within 24 hours if the incident overwhelms first responders. This gap is further increased by the lack of resources for detection of CBRN hazard found in the GAO report explained earlier in this chapter.

However, it is known that the medical forces apportioned to execute this mission are the result of mission analysis conducted by NORTHCOM planners based on previous support given to civil authorities but no specifically CBRN. The bases of this support packages built by NORTHCOM are explained in the *Defense Support to Civil Authorities Handbook*, which has, an all hazards approach in chapter 5 but, it lacks CBRN planning factors as basis for analysis and assumes that response to all hazards is similar from a DSCA macro level support. It covers wild land fires, hurricane and tornados, earthquakes, floods and winter storms as planning factors for tactical and operational commander's use

The 2006 Quadrennial Defense Review became the driver for the design and implementation of JTF-CS. The JTF-CS is built around the CBRN operational requirements and is uniquely designed to command and control the CBRN operations. The design of the JTF-CS is mission-dependent. However, the general design consists of a Command and Control element, in charge of four task forces; Aviation, Logistics, Operations and Medical. JTF-CS was designed to account for the lack of resources to conduct CBRN response in CONUS expected from civil authorities. The unique capability necessary to conduct the CM operations can be found in this headquarters as well as its subordinate elements, specifically the CBRNE response teams (CRT), which are organic to JTF-CS. As shown by the finding that military forces should: “expand the Army's CBRNE capabilities to enable it to serve as a Joint Task Force capable of rapid deployment to command and control consequence management operations missions by 2007.”¹¹

While this design is ideal for the conduct CBRN CM mission; it is necessary that these capabilities be properly integrated into the request process of mission assignments. CBRN CM missions require specialized planning for each element, as highlighted in the previously discussed doctrine, and need to be fully integrated into the response. This integration must be facilitated by the DCE, JTF-CS or other CBRNE elements within their respective units conducting operations on the incident site.

The CBRN CM mission is planned and resourced at the strategic and operational levels, however they are conducted at the tactical level. The first unit capable of conducting the CBRN CM medical in support of civil authorities is Task Force Medical. This organization since its inception has evolved into a more adaptable, capable and flexible force. According to JTF-CS, the mission of the task force medical is “to provide medical advise to the JTF Commander, conduct medical regulating functions, and provide consultative services and technical advice to subordinate health services units. Liaison with civil and military responders and provide command and control to approximate 400-800 person subordinate elements (figure 3).

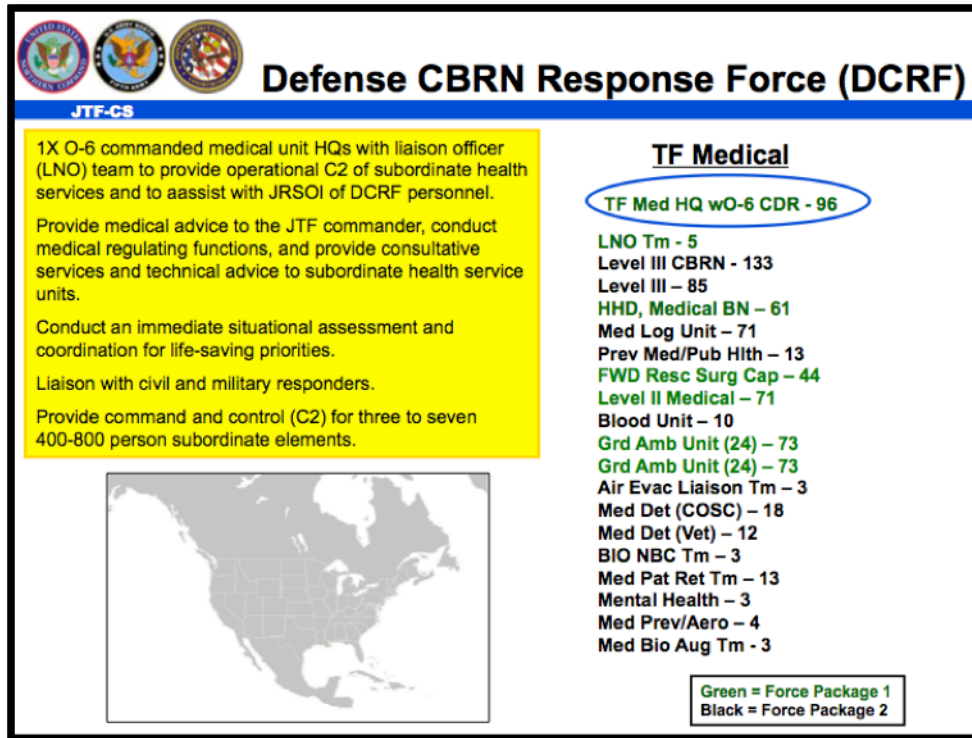


Figure 4. Task Force Medical Organization

Source: DCRF Capabilities Brief, JTF-CS Back Up Slide 34, March 25, 2012.

The focus of this study is on the organization of Task Force Medical and its ability to respond to any CBRN incident regardless of PAR. As stated in *Guidelines for First Response to a CBRN incident*: “In order for a response to be fully integrated it is vitally important that deliberate and effective pre-planning takes place between members of all responding agencies at local, regional, national and, where appropriate, international level. The development of regular training designed to test agreed roles, responsibilities, capabilities and protocols is also an essential component of the pre-planning process and will provide opportunities for all agencies to develop further their combined response to a CBRN emergency.”¹² Therefore, if Task Force Medical is an

organization comprised of multiple subordinate organizations from different locations across CONUS, the need to tailor the organization increases when tasked to respond to civil authorities requirements in case of a CBRN attack. As stated, the Initial Response Package (IRP) is required to deploy in 24 hours from notification. As explained earlier, if the requirements do not call for the package already built it becomes impossible to coordinate between Defense Coordinating Element, NORTHCOM, and JTF-CS to alert and prepare another unit that could fulfill such requirement in the time required.

“Saving lives is the top priority of all responding agencies. Contamination of victims/casualties must be considered as part of the initial assessment and effective methods of rescue, decontamination and medical treatment must be provided. The provision of timely warnings and/or evacuation of the public where appropriate, may also contribute to saving lives by reducing the risk of exposure.”¹³

Task Force Medical sourcing documents identify that the organization consists of a headquarters element (ninety six personnel), four area support medical companies (two hundred and eighty personnel), each consisting of a headquarter element, a treatment platoon and evacuation platoon. Also, a series of four forward surgical teams (one hundred and twenty personnel) with the ability to conduct surgical resuscitation is distributed between force packages. Two ground ambulance companies (146 personnel) each consisting of approximately 24 ground ambulances aid in the evacuation of casualties from the incident area. A portion of this constitutes force package number 1, which is categorized as initial response with a specific skill set of capabilities, mainly command and control, and rapid resuscitation. IRP mission requires them to deploy

within 24 hours of notification. This initial package is ready to deploy to any CBRN attack and set the conditions for follow on medical force packages (figure 5).

JTF-CS		DCRF MED Priorities Ranked	
IRP – 1st deployed group N+24:		FP2 – 3rd group (cont'd):	
#1	ASMC (1 of 4)	#16	ASMC (4 of 4)
#2	FST (1 of 4)	#17	FST (4 of 4)
#3	ASMC (2 of 4)	#18	Prev Med Det
#4	FST (2 of 4)	#19	Theater Epi Team
#5	Gnd Amb Co (1 of 2)		
#6	Med BDE HQ (-)		
#7	MLMC/Med Log		
FP1 – 2nd group N+36:		FP2 – 4th group N+72 or less:	
#8	Med BN HQ	#20	Blood Det
#9	Gnd Amb Co (rest of 1 of 2)	#21	Combat Stress Co
		#22	Med Log Co (-)
		#23	Vet Det
FP2 – 3rd group (A1 priority) N+48:		#24	EMEDS (2 of 2)
#10	EMEDS (CBRN) (1 of 2)	#25	EMEDS Mental Health Tm
#11	FST (3 of 4)	#26	EMEDS BEE NBC Team
#12	ASMC (3 of 4)	#27	EMEDS Mgt Aug Tm (1 of 2)
#13	Med Log Co ADVON	#28	EMEDS Ambulance Tm (1 of 2)
#14	Patient Decon Tm (1 of 2)	#29	EMEDS Bio Aug (Lab) Tm
#15	Med BDE HQ (-)	#30	Patient Decon Tm (2 of 2)
		#31	EMEDS Ambulance Tm (2 of 2)
		#32	Ground Amb Co (2 of 2)
		#33	EMEDS Mgt Aug Tm (2 of 2)

Figure 5. Medical Force Packages in support of civil authorities

Source: DCRF Capabilities Brief, JTF-CS Slide 9, March 25, 2012.

Today's DCRF structure is ready to support any CBRN event at a moment's notice. Medical force packages are designed to assist in the areas that are assumed to be in higher demand during a CBRN incident. Closer interaction must exist between civil authorities and military forces in order to increase situational awareness on capabilities and decrease the informational gap. As military medical forces continue to be on a support role during a CBRN attack, military medical planners at NORTHCOM are required to continue to analyze and tailor Task Force Medical organization to ensure the

capabilities needed to the civil authorities are available to reduce human suffering and further damage to infrastructure.

Training

In January 2004, the Assistant Secretary of Defense for Health Affairs directed the services to implement the initial and sustainment levels of a CBRN Training Program, which are based on medical CBRN Standards of Proficiency. These standards are required for medical professionals to be able to conduct the mission. Upon implementation of these guidelines an annual review was conducted. The results are shown in the following table.

Table 4-20 Tri-Service CBRNE Training Status FY05

U.S. Army Medical Command*	Trained	Total Inventory	% Trained
Medical Corps	604	3065	19.7%
Dental Corps	172	718	24.0%
Veterinary Corps	229	363	63.1%
Nurse Corps	548	2507	21.9%
Medical Service Corps	467	1421	32.9%
Medical Specialist Corps	174	678	25.7%
Physicians Assistant	38	214	17.8%
Enlisted Medical Personnel	4779	10928	43.7%
Total	7010	19893	35.2%

U.S. Navy	Trained	Total Inventory	% Trained
Medical Corps	2078	3978	52.2%
Dental Corps	413	1156	35.7%
Nurse Corps	1185	2952	40.1%
Medical Service Corps	388	2304	16.8%
Physicians Assistant	109	229	47.6%
Enlisted Medical Personnel	8899	24959	35.7%
Total	13072	35578	36.7%

U.S. Air Force	Trained	Total Inventory	% Trained
Medical Corps	2492	2931	85.0%
Dental Corps	710	910	78.0%
Nurse Corps	3254	3512	92.7%
Medical Service Corps	934	1132	82.5%
Biomedical Sciences Corps	1516	2034	74.5%
Physicians Assistant	260	322	80.7%
Enlisted Medical Personnel	16061	21360	75.2%
Total	25227	32201	78.3%

* U.S. Army Medical Command reflects MEDCOM assets only. It does not reflect medical personnel assigned to non-medical commands.

Figure 6. Training Status for medical CBRN Standards

Source: Office of the Assistant Secretary of Defense for Nuclear Chemical and Biological Defense Programs, *Chemical and Biological Defense Program Annual Report* (2006).

The training enterprise put in place back in 2006 by the Secretary of Defense has evolved since then. It is evident that the lack of participation by civilian agencies has not been helpful for the development of close working relationships with NORTHCOM. The latest report to Congress states the need to continue to refine their programs to ensure widest dissemination on lessons learned. “In support of and as directed by the 2010 Quadrennial Review, the United States Army CBRN School (USACBRNS) continues to engage key stakeholders in an enterprise approach to improve DoD’s CM response forces through the development of effective training and education products. The USACBRNS and its partner CBRN Services schools are actively engaged in collective efforts to shape and refine the CBRN Enterprise concept to better achieve synergy with our training and education goals. Over the past year, they have increased their capacity and capability through the development of an enterprise approach and partnering activities.”¹⁴

Task Force Medical units constantly face the challenge to balance requirements while on DCRF mission support. As medical units selected to be apportioned under JTF-CS and Task Force Medical during CBRN CM response, it is their responsibility of their parent unit at their installation to conduct all the necessary training to ensure the unit is capable to conduct their mission as designed. As stated by a current ASMC Commander, “our biggest challenge is to effectively train for the assign DCRF mission, while balancing day to day requirements. Adding to the level of dependence on post installation support to deploy in 24 hours to the CBRN incident site when the call comes.”¹⁵ The dependence on the medical unit’s installations for deployment to a CBRN incident is the biggest challenge to make sure medical units arrive when requested at the times stipulated by NORTHCOM in coordination with civil authorities.

As specified in the GAO report titled, U.S. Northern Command Has a Strong Exercise Program, but Involvement of Interagency Partners and States Can Be Improved, presented to Congress in September 2009, states that “nineteen federal agencies and organizations and 17 states and the District of Columbia have participated in one or more of the seven large-scale exercises that NORTHCOM has conducted since September 2005. However, NORTHCOM faces challenges in involving states in the planning, conduct, and assessment of its exercises, such as adapting its exercise system and practices to involve other federal, state, local, and tribal agencies that do not have the same practices or level of planning resources. Inconsistencies with how NORTHCOM involves states in exercises are occurring in part because NORTHCOM officials lack experience dealing with states and do not have a consistent process for including states in exercises. Without such a process, NORTHCOM increases the risk that its exercises will not provide benefits for all participants, impact the seamless cooperation by of all levels of government, and potentially affect NORTHCOM’s ability to provide civil support capabilities.”¹⁶ The result of this report continues to show a lack of synchronization between military forces and civilian authorities in establishing responsibilities during a CBRN incident. Part of the problem could be rooted in the need of a command structure that allow to mandate states to participate in National Level exercises and report findings to Congress. The justification for such action could be substantiated in the fact that states lack CBRN capabilities and resources, and in the event of a CBRN catastrophe declared, the lead federal agency should be assigned to DoD and NORTHCOM as the main effort in the execution of the response. Potentially this will reduce the information gap and allow military forces to be the lead agent in conducting gap analysis at the state level.

From the AR 220-1 perspective it emphasizes personnel, training, equipment and readiness and the foundation for a units assessment to execute the mission that they are assigned. “Today’s operational environment (OE) requires Army forces to continuously evaluate and adapt their tactics to ensure that they are appropriate. Accordingly, all Army units required to assess capabilities will do so by assessing their overall ability to accomplish their core functions and provide designed capabilities, when applicable, their assigned missions in light of the operational environment in which unit training is being conducted or the assigned mission is being executed.”¹⁷ Medical units commanders establish their assessment based on their METL established and approved by their higher headquarters.

Medical Units not apportioned to JTF-CS conduct training based on the go to war METL that covers all the necessary task associated to go to war and provides the capability that the unit has been designed to have. When a Medical Units is selected by the Force Provider to be apportioned under JTF-CS to execute the DCRF mission their METL must be adjusted to reflect the change in mission and therefore train for defense support to civil authorities as the main mission. The revised METL must be approved by the Medical Unit higher headquarters while assigned on DCRF mission to allow JTF-CS visibility on the medical unit’s readiness and issues to perform the mission at hand.¹⁸

Properly tailoring the medical unit’s METL will allow for issues to have the necessary visibility and be resolved promptly. Disparity in medical units METL revision during DCRF mission assignment could create a potential gap in information and delay the response process in a request for assistance is needed. This system should allow

subordinate commanders to receive the support needed to facilitate their training to increase effectiveness in support to civil authorities.

Summary

Using the elements of doctrine, organization and training as the foundation of this study allowed us to establish criteria for recommendations that will help increase medical support to civil authorities. Currently the research question asks if current configurations of medical units are the best to support civil authorities in the event of a CBRN attack. Based on all the limitations both operational and statutory, JTF-CS offers civil authorities the best capability from the Armed Forces inventory to be able to reduce human suffering and reduce further damage to infrastructure. In the next chapter a series of recommendations will be discussed to ensure NORTHCOM and civilian authorities can increase interoperability and increase understanding of medical forces apportioned to conducting this “no-fail” mission.

¹Department of the Army, FM 3-0, 25.

²Department of the Army, ADP 3-0, 9.

³Department of Defense, QDR 2010, 17.

⁴Ibid., 10-11.

⁵GAO, 2008, 3.

⁶Army, Marine Corps, Navy, Air Force, FM 3-11.21, *Multi-Service, Tactics, Techniques and Procedures for Chemical, Biological, Radiological and Nuclear Consequence Management Operations*, Army, *Tactics Techniques and Procedures* (Washington, DC: Government Printing Office, April 2008), I-6.

⁷Ibid, I-7.

⁸Department of the Army, *2011 Army Posture Statement*, Information Papers.

⁹Government Accountability Office, *U.S. Northern Command Has Made Progress but Needs to Address Force Allocation, Readiness Tracking Gaps, and Other Issues* (Washington, DC: Government Accountability Office, September 2009), 3.

¹⁰Department of the Army, FM 4-02.6, *The Medical Company: Tactics, Techniques, and Procedures* (Washington, DC: Government Printing Office, August 2002), 4-11.

¹¹Department of Defense, *Quadrennial Defense Review* (Arlington, VA: The Pentagon, February 2006), 51.

¹²NATO International Staff, *Project on Minimum Standards and Non-Binding Guidelines for First Responders Regarding Planning, Training, Procedure and Equipment for Chemical, Biological, Radiological and Nuclear (CBRN) Incidents, Civil Emergency Planning* (NATO: 2009), 1.

¹³*Ibid.*, 5.

¹⁴Assistance Secretary of Defense, *2011 DoD Annual Report to Congress on Chemical and Biological Warfare Defense*, April 2011, 5.

¹⁵ASMC Commander, E-mail correspondence on challenges while on DCRF, April 2012.

¹⁶Government Accountability Office, *U.S. Northern Command Has a Strong Exercise Program, but Involvement of Interagency Partners and States Can Be Improved* (Washington, DC: Government Accountability Office, September 2009), 3.

¹⁷Department of the Army, Army Regulation 220-1, *Unit Status Reporting and Force Registration—Consolidated Policies* (Washington, DC: The Pentagon, April 2010), 11.

¹⁸*Ibid.*, 69.

CHAPTER 5

CONCLUSION

Over the years, JTF-CS has transformed and transitioned to a more capable and responsive force. Task Force Medical has tailored its capabilities to the needs of the civil authorities based on analysis and exercises conducted at the NORTHCOM level. Based on the preponderance of needs that arise during a CBRN event it is imperative that civil authorities understand capabilities of JTF-CS so they understand what mission assignments can be executed within the limits of their ability to support. The research question is, what are the best military medical unit configurations for the support of civil authorities apportioned under Joint Task Force Civil Support in response to CBRN event? The current configuration offers the best response to date based on tactics, techniques and procedures (TTPs) and lessons learned. As per chapter 4, the way that force packages are broken down, they offer the capabilities necessary within a wide scope of possibilities and needs from civil authorities within the operational and statutory constraints.

Secondary questions were based on preliminary impressions of the problem that needed to be researched. If medical units are tailored for support to civil authorities, does this change the configuration for routine war fighting and force management requirements? What is the best configuration to support both missions simultaneously? During the research process it became apparent the role that military forces play in support of civil authorities. This role is strictly in support of their needs and lack of capabilities. Therefore, it is not necessary to change the configuration of units based on wartime requirements. Wartime mission is the number one priority for the armed forces.¹

Since there is not a need for change based on findings of this research, it is necessary to further research the level of understanding of the capabilities of military medical forces by civilian authorities. With an increase in participation to national level exercises led by NORTHCOM, the educational gap could be reduced and increase the level of understanding when a request for assistance is generated from civilian authorities through the DCO.

The training and events have yielded many “lessons learned.” These lessons are the genesis of the changes that transformed how Task Force Medical provides support to civil authorities. The long-term effectiveness of the application of their resources in a time of need will determine if the medical assets will continue to transform in order to suit the needs of the civilian authorities. The document review performed during this research shows that TF Medical is where they need to be in order to support civilian authorities effectively as a supporting agency. However, there are gaps that must be addressed to ensure support is adequate and timely. Another significant lesson learned is the fact that PAR based on location and demographics may significantly influence the type of mission request from civilian authorities. The recommendation should be to allow military forces to tailor their assets in regards to equipment and personnel to support a wide spectrum of patients. Based on the analysis and findings of this research, states lack the necessary resources to conduct detection of CBRN hazards. Therefore, since military forces possess the capability and the personnel to conduct detection and management of CBRN casualties, a command re-structuring would allow DoD to be the lead agency when a CBRN incident is declared.

The first major lesson involves the direct correlation between planning and effective transition from training to support civilian authorities to the utilization of medical assets when required. As stated in the new ADP 3-0, defense support to civil authorities is a major component of decisive action that replaced full spectrum operations. Therefore, a venue should exist for where the armed forces would be able to train jointly with civilian authorities and not be limited by NORTHCOM training exercises that lack participation by states and interagency involvement. While successful training events are the reason for partial success up to this date, it is important to recognize how the operational environment and the threat continuously change. This changing environment influences our actions and should influence our understanding of the medical capabilities of all stakeholders involved in CM response.

Geographical variables and, threat assessments based on high value targets, are a few considerations that states and or regions must evaluate to create a list or a system for identifying gaps in resources. This system will aid the NORTHCOM medical planner to tailor an organization that can respond to a “whole needs” approach based on capabilities gaps identified through analysis at the state level.

Another critical element for post-incident management organizations is the inclusion of other government agencies and international organizations in both planning and execution. This would help establish a common understanding of capabilities and the employment of specific unit’s request for assistance could become more focused. This common understanding is rooted on education at all levels of support.

Recommendations

Overall findings lead towards three recommendations for the research problem. First, a process or a system created at the state level that identifies the needs or gaps in medical assets. This program will allow DoD medical planners to plan for specific packages by region based on the needs of civil authorities. This list or system not only addresses needs independently, but it must be aligned with the PAR. Second, military medical infrastructure must be maintained to support requests for assistance from a state or near simultaneous requests from multiple states. As the armed forces undergo a reduction process it is imperative that the medical capabilities stay intact until medical support to civil authorities is refined further. Lastly, with the new edition of ADP 3-0, DSCA becomes an intrinsic part of FSO. Therefore, a more comprehensive guidance aligned with current NSS, a more detailed doctrine and the appropriate training venues are necessary to create the synergy to work in a unified action model towards a common goal.

Areas for further Research

In order to better understand the topic it is recommended additional detailed research on the impact of DOTMLPF, specifically the other areas that were not cover in this study. If states or regions of United States provide a list of requirements it will be necessary to determine if those required capabilities are available within the armed forces capabilities. The impact of a CBRN incident is catastrophic and based on current threat, the question is not if but when such an event is going to happen.

Another area that needs to be researched is how medical capabilities are understood across all services. JTF-CS is a joint organization designed to support civil

authorities when a CBRN incident occur. The personnel staffs are built from a multiservice approach; however, the bulk of medical support is from the Army component. An educational system on capabilities must be designed and implemented within armed forces to ensure all personnel and stakeholders involved in a CBRN catastrophe understand fully all the capabilities available to support civil authorities effectively.

Furthermore, it will be practical to research the relationship that exist between military medical forces executing DCRF mission and medical civilian counterparts in random locations throughout the U.S. These findings will potentially send a strong message to all stakeholders involve in CBRN CM. In addition to the understanding of the relationship that should exists to create synergy between all resources responding to a CBRN incident, what is the role of military forces to ensure the knowledge capability is breached now that ADP 3-0 establishes DSCA as one part of the range of military operations? It is understood that DCRF mission is going to be continuous until further notice therefore, is appropriate to examine other means to enhance interoperability if a catastrophic event occur.

¹Department of Defense, *QDR 2010*.

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