PROTECTING VIPS AND POLITICAL LEADERS FROM CBR THREATS

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Political leaders have required protection since antiquity. The technical means available to assassins, terrorists, and political rivals has evolved with history. Chemical, biological, and radiological (CBR) substances certainly have technical and operational characteristics that make them possible threats. By necessity, the assigned length of this paper dictates only an introductory discussion of this topic. The author apologizes for the necessary generalizations contained in this paper. This paper represents the opinion of the author and does not necessarily represent opinions or policies of his past or present employers. Within this document, the terms "close protection team" and "protective detail" are used interchangeably to refer to the small staff of bodyguards in the immediate vicinity of a protected person.

SCOPE OF THE THREAT

Protective security personnel need to look at the entire spectrum of potential CBR threats. Some CBR agents are more useful than others, for the purposes of attacking a political leader. Because chemical and biological agents were originally developed as military weapons, they have certain physical and logistical characteristics that do not necessarily overlap with the characteristics of desirable or plausible terrorist weapons. The classic examples are the mustard agents (H, HD, HN, etc.) which are classic military agents useful not only for causing casualties but for their usefulness in interdiction of terrain and equipment. However, the mustard agents have actually very low prompt lethality, have generally good warning properties (smell), and provide no immediate gruesome effects upon which the media and public can fixate. Potential threat agents can be assessed by their ability to create a desired effect, speed of action, routes of exposure, warning properties, physical characteristics, and technical complexity (plausibility/feasibility.) A detailed methodology could be used to examine each potential chemical warfare agent (CWA) or toxic industrial chemical (TIC) using these criteria. In close protection, however, it has far more utility to examine potential threat agents by their practical, immediate, and noticeable effect on the protectee or those around him/her.

CLASSIFYING THREAT AGENTS INTO SIX THREAT PROFILES: The majority of the spectrum of threat CBR agents can be radically simplified for close protection work through categorizing potential threats by syndrome and countermeasure. In other words, threats can be classified by how they present themselves in human victims and what can be done about them at the field level. Perhaps 95% of the CBR threat in the close protection environment can be classified into six distinct threat profiles:

(1) Nerve agent syndrome: Organophosphates and carbamates, with either liquid or vapor exposure, provide a unique and discrete set of signs and symptoms readily recognized early in an incident. This syndrome is indicated by prompt nicotinic and muscarinic signs and symptoms. Miosis and the time honored and apocryphal acronym SLUDGE (generally given as standing for salivation, lachrymation, urination, defecation, gastrointestinal distress, and emesis)[1]

(2) Blood agent syndrome: This is the distinct set of signs and symptoms brought about rapidly by hydrogen cyanide and/or cyanogen chloride vapor.[2]

(3) Toxic inhalational syndrome: This is the set of prompt effects on the respiratory tract brought about by exposure to myriad toxic industrial chemicals in vapor, gas, aerosol, mist, or dust.[3] Such classic threats as chlorine would be in this category, as would most riot control agents. While specific etiologies and mechanisms of injury (asphyxiation, topical damage, systemic effects etc.) vary widely, the actual decisions that must be made by a protective team and the required tactical course of actions are effectively the same. This syndrome may be accompanied by eye irritation and skin irritation, depending on the agent used.

(4) Skin and or eye irritation syndrome: This syndrome occurs when some corrosive or other irritant is applied to the skin, primarily in liquid form, but possibly in mist, aerosol, or vapor form as well. Acids would fall into this category, as would most riot control agents.

(5) Percutaneous ("needle stick") exposure: Exposure to an unknown agent through a cut, injection, or other breach of the skin. The Georgi Markov ricin assassination would be an example of this threat profile. These are likely to be asymptomatic.

(6) Asymptomatic episode: Exposure to unknown liquid, vapor, or powder with no signs and symptoms. This would include practically all ionizing radiation sources, agents with delayed onset of signs and symptoms (HD and phosgene, for example) as well as hoax incidents.

OPERATING CONCEPTS

Close protection in the CBR environment can be divided into three phases: advanced preparation, immediate response, and secondary/advanced responses. For the purposes of this paper, advanced preparation is everything that occurs prior to an incident, immediate response is the first five or so minutes of an incident and secondary response are operations that occur after the initial drama of an event.

ADVANCE OPERATIONS

Any person who has spent any time in VIP or executive protection will tell you that appropriate advance team work is the key to successfully protecting a political leader in dangerous environments. Advance operations from a CBR perspective are both an art and a science and can be the subject of an entire study themselves.

APPLY NORMAL SECURITY PROCEDURES: Planning for CBR response is supplemental to normal protective operations, not a substitute. Indeed, excellent general security practices designed to provide protection against conventional threats will also help prevent unconventional attacks, such as those with CBR agents. The advance team should understand the physical characteristics of the buildings and areas to be visited, develop multiple routes of egress, physically search the area to be visited to the greatest extent feasible within limits of policy and manpower, curtail personal access to the protectee to the extent practical, and maintain general vigilance for unusual activity.

IDENTIFY EXISTING HAZARDS: It is almost axiomatic that accidents happen more than incidents. Political leaders travel every day in proximity to CBR agents that are used for normal commercial, medical, and industrial purposes. Accidents occur; toxic industrial chemicals present for legitimate purposes can be used to create incidents. Event venues, residences, hotels, airports, and transportation routes should be thoroughly evaluated for the

presence of existing hazards. An advanced team, or at least a single advance coordinator, should travel to the area sufficiently ahead of the protectee's visit to physically examine the entire operational area from this perspective. Known hazards, even exotic ones, can be planned for in advance.

DEVELOP PLANS FOR EACH VENUE: Having distilled the CBR threat into six categories, the advanced team can survey the entire itinerary of the protectee. For each stage of the operation (and likely locations of impromptu movements), the advanced team can develop plans for each of the six threat profiles. There should be primary and alternative plans for each venue.

ASSESS LOCAL CAPABILITY: The advanced team should assess the local ability to respond to CBR incidents. Within the limits of operational security and local capabilities, the advanced team should develop general and/or specific plans to react to CBR attacks during the protectee's visit.

ASSESS LOCAL MEDICAL CAPABILITY: In most cases, the tactical objective of a protective detail in CBR environments is to deliver a live, stabilized protectee into the hands of definitive medical care. The advanced team should investigate the local area's ability to provide definitive medical care in CBR scenarios. The team should select a primary and secondary medical facility for each stage of the protectee's movements. Where practical, the medical facilities should be visited.

IMMEDIATE RESPONSE

If the concept of a "golden hour" is axiomatic in emergency medicine, the analogue in close protection is the "golden minute." Having excellent follow-on support for decontamination and medical care is all very good, but if the protective team makes poor tactical decisions at the outset of an incident, probability of success plummets. The principle operating practices in the immediate response phase are: identification of a hazard; speed; use of protective equipment; and medical intervention.

IDENTIFICATION OF HAZARD: While conventional attacks, such as firearms or explosives are easily recognized within a fraction of a second, the insidious nature of CBR threats is that their effects may be latent rather than immediate. Their physical characteristics may not be evident; they often have poor "warning properties." However, as discussed above, many of the threats with the highest potential for use in this context are either immediately acting (e.g. nerve agents and hydrogen cyanide) or have some kind of warning property, principally odors (e.g. phosgene). Exact identification of a threat agent is not needed for a protective team to react. The analogy would be that a protective team does not need to know the caliber or weight of bullets being shot at it to take simple protective measures against a firearms threat. A protective detail needs only to be able to recognize the six threat profiles discussed above.

The use of detectors, while excellent in principle, is only of limited utility in this context. The simple truth of the matter is that even the best detectors have false positives. The practical and operational penalties for false alarms are several orders of magnitude higher in this environment than in the military contexts for which most detectors were developed. A President or Prime Minister is likely to be evacuated and decontaminated only once for a false alarm. Additionally, the speed at which detectors sample the air and provide alerts is

often unsatisfactory for close protection work. Protective details are better served by relying on their ability to recognize means of dissemination and signs and symptoms of agent exposure. Only the smallest, lightest, and fasted operating devices, such as the Smiths LCD 3.2E, for example, have anything approaching the technical capability required.

SPEED: Any CBR attack has a defined hazard area. The tactical imperative in these scenarios is to move quickly from the scene of the attack. Seconds matter. If proper advance work has been done correctly, multiple routes should be available to the protective detail. Tactical considerations prevail at this juncture; potentially the purpose of a CBR attack or a nuisance attack (such as smoke or riot control agents) can be a ruse to force a protective team into taking actions increasing their vulnerability to conventional attacks.

EQUIPMENT: Since we have defined the acute tactical threat above, we can focus on the minimum essential equipment required for protective operations. The last fifteen years have seen hundred-fold improvements in the variety and quality of quick-don masks, which are the primary requirement in this area. Small, lightweight decontamination equipment (kits, mitts, etc.) is also very important. It is not a likely scenario that any normal protective team under routine conditions will carry a full military-style respirator. However, sufficient quantities of quick-masks can either be carried with or near a protective team.

MEDICAL INTERVENTIONS: Basic and advanced medical interventions are likely to be required. Basic interventions ("basic life support" in the USA) can be summarized by the acronym ABCD (airway, breathing, circulation, decontamination.) Advanced interventions ("advanced life support" in the USA) in the field CBR environment primarily consists of advanced airway management and drug therapy, such as antidotes. All protective team members should be trained to conduct basic interventions and have an appropriate cache of equipment available to them. At least one team member, or a member of a follow-on support team, should be trained and equipped to operate at the advanced level.

The narrowed threat spectrum provides framework for basic emergency medical protocols, which can be memorized and rehearsed. Six CBR medical protocols, one for each of the threat profiles above, would cover perhaps 95% of the potential scenarios. If a protective team develops a basic protocol for each of these six scenarios, they will be well served in most situations. The length limitations for this paper preclude a full discussion of examples of six protocols. Existing protocols, such as those published in the USA by the state of Maryland[3] could be adapted from a purely medical procedure into a tactical procedure.

SECONDARY / ADVANCED RESPONSE

The personnel and equipment of the immediate close protection team will be devoted primarily to conventional threats under most circumstances. If the providing agency's personnel and budget permit, significant consideration should be given to having a back-up team, even if it is only one or two persons, who can provide additional support to the protective team. A support team could follow the movements of a protectee, or stage nearby. In the event of an incident, the protective detail could rendezvous with the support team at pre-designated locations, or the support team could respond to the site of the incident.

Several countries, including the United States, have had some success with this model of operations. Such a team should be fully equipped for CBR situations and can be equipped with a higher level of protective equipment than the protective detail. The United States has

fielded teams of 2 to 6 individuals for this purpose, with varying degrees of training and equipment. A support team should fill the following roles:

REPLACE THE PRIMARY TEAM: One or more members of the close protection team may have become victims of the attack. A support team should be at least minimally trained and equipped to assume the responsibilities of the primary team.

MEDICAL CARE: The practical reality is that the primary close protection team may only have training at a basic life support level and is probably limited, in many situations to a backpack or suitcase for medical equipment. A support team could provide additional medical support at the basic and advanced level, and could have significant additional equipment above that carried by the close protection team, not just for CBR incidents, but for conventional trauma and medical scenarios as well. Oxygen, advanced airways, defibrillation, antidotes for nerve agent and cyanides, and intravenous fluids can be carried. The team should be able to provide a competent hand-off to definitive medical care.

DECONTAMINATION: While the protective detail is likely only to be able to conduct a minimal emergency decontamination, a support team can provide a greater level of decontamination. Water and/or specialty decontaminants, such as Fuller's earth, reactive skin decontamination lotion, and US M291 kits could be carried in quantity.

DETECTION: While only the lightest and fastest equipment is of immediate use to the protective detail, heavier and more thorough detection equipment could be used. While the first two of the threat profiles effectively provide agent identification through observable phenomena, the other four do not. Although tactical operations during the first minutes of an incident are unaffected by the lack of agent identification in this model, a general classification or precise identification of the threat agent is essential for successful definitive care. Various detectors are now available that use Fourier transform infrared spectroscopy or Raman spectroscopy to provide reliable identification of unknown substances. Biological detection and identification is years behind chemical detection technology. However, recent advances, particularly in LATE-PCR, have yielded hand-held devices that would be of use in this context.

LIAISON: The support team should be responsible for calling in additional support from local fire, medical, and hazardous materials units. The support team is probably better positioned to coordinate pre-arranged emergency plans with local authorities.

Notes:

(1) Training curriculum, **Field Management of Chemical Casualties**, US Army Medical Research Institute of Chemical Defense, February 2003.
(2) S. Baskin and T. Brewer, **Textbook of Military Medicine, Medical Aspects of Chemical and Biological Warfare**, Chapter 10. 1997, Office of the Surgeon General, US Army, Falls Church, Virginia.
(3) J. Urbanetti, **Textbook of Military Medicine, Medical Aspects of Chemical and Biological Warfare**, Chapter 9. op cit.
(4) Maryland Institute of Emergency Medical Services Systems, **Clinical Treatment Guidelines for Weapons of Mass Destruction**, 2002. Available online at www.miemss.org