Letter in response to ‘UK’s initial operational response and specialist operational response to CBRN and HazMat incidents: a primer on decontamination protocols for healthcare professionals”

Dear Editor,

We read with great interest the recently published guidance by Chilcott and colleagues on UK’s initial operational response and specialist operational response to CBRN and HazMat incidents.1

Their main point is to insist on the importance of the spot decontamination, which also seems to us to be the predominant point concerning the care of victims. This is the emergency disrobe and dry decontamination step. Its importance and the interest of its precocity have imposed it as the first link in the CBRN environmental survival chain that we recently described.2 We even hesitated to draw it with a much larger size than the other links, by analogy with Deakin’s work on cardiac arrest: in the survival chains ‘Not all links are equal’.3

The authors use a Step 1-2-3+ procedure for identifying a potential CBRN incident. We would have preferred, from the first person involved, the CBRN risk considered high in the case of a ‘VIP’ or similar victim. Indeed, the organophosphorus neurotoxic attacks in Kuala Lumpur, or the ‘Bulgarian umbrella’, have demonstrated the possibility of targeted state terrorism. It, therefore, seems to us that public entities should be assigned a chemical ‘over-risk’. Logically, when these VIPs have them, their protection teams must be trained in emergency decontamination. They should carry it out without waiting to know whether a possible sprayed liquid is, or is not, contaminating as suggested in the first step of the basic flow chart for determining the appropriate response for managing contaminated casualties of the work of Chilcott et al. Thus, any spray of liquid causing pain should be immediately washed with abundant water and, in the absence of pain, with the Reactive Skin Decontamination Lotion.

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