

Hurricane Rita - Texas Support

California Interagency Incident Management Team 2

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AAR Rollup - Lessons Learned

1. **What was the most notable success at the incident that others may learn from?**
 - **Communication, coordination, and issue resolution at the base camp with those agencies using the base camp.** The IMT established a daily leadership meeting with all cooperating agencies. The IMT embraced FEMA, the Texas National Guard, American Red Cross, and anyone else who would attend these daily meetings in an effort to ensure better coordination, issue resolution, and reduction in misinformation surrounding the emergency response. This effort was successful, but required diligence on the IMT's part to bring those agencies to the table daily.
 - **Ending "Forest Service" base camp support when FEMA had no clear plan for its demise.** This required support from Area Command at the Joint Field Office (JFO) level to bring it to a decision point with the FEMA operations chief. This occurred in concert with on-the-ground discussion with the FEMA IC and other affected groups. This effort required a deliberate plan for closure with enough lead time to allow those agencies time to relocate or bring in the necessary support to continue their operations. While this initially caused both FEMA and Red Cross some concerns, in the end it brought the closure of Ford Base and the saving of that support cost.
2. **What were some of the most difficult challenges faced and how were they overcome?**
 - **Racism and hostility toward outsiders in some of the rural areas.** While this did not directly affect CIIMT 2 or those under its command, both the Red Cross and Army National Guard received verbal threats and remarks from some of the locals at several of the Point of Distribution (POD) locations. This amounted to complaints of the race of some of the volunteers/soldiers dispensing supplies. CIIMT 2 maintained the stance that this was unacceptable behavior and provided moral support to these two groups. The military command and Red Cross with FEMA backing provided resolution. Due to these incidents, CIIMT 2 leadership was cautious about individual assignment locations. The IC also established a sign-out plan to identify who was leaving camp, location of travel and estimated time or return. The IMT also established a two person minimum and check in/out system for non-operational team members traveling off base.
 - **Law enforcement and security for camps occupied by Non-Governmental Organizations (NGO) and non-supervised government employees is problematic.** These types of persons come from environments and organizations where base camp rules and behavior are alien at best. It is important that the IMT receive a copy of the standard operating procedures of each group assigned to their base camp. If those rules are less than or are non-existent than the IMT's

SOP, then the IMT's SOP for base camp operations will apply. Also included in this is an accountability system for personnel identification. Many systems are available ranging from wristbands to photo identification cards. Establishing a clearly visible and easily managed system is crucial to maintaining security and accountability.

- **Communication with on-site leadership was difficult.** Attempts at engaging in discussion, issue resolution, and planning were difficult and frustrating. Even though a lunchtime meeting was established to facilitate this dialogue it was often necessary to search these group leaders out and ask them to attend, daily. Future assignments should establish a similar meeting schedule. It would be advantageous to identify a FEMA leader who would run the meeting and thereby give it more importance to all participants.
- **Managing an incident support base for volunteers (Red Cross) and paid (FEMA, Army Corp. and others) agencies.** There were a number of entities located at Ford Arena facility for sleeping and feeding. Several of these groups had never experienced any situation that was comparable to living for extended periods of time in very close quarters, with little or no privacy. There was very little leadership and oversight from each agency and little direction on protocol and behavior in a base camp. An attempt at educating both groups was difficult. The problem was aggravated by the fact that most of the volunteers, who came to the facility, were trained for 1 to 3 days and then moved on to outlying areas. There was a constant flow of new people coming into the base camp. The difficulties were never completely overcome. Constant maintenance on the part of CIIMT 2 seeking out and including the major groups helped keep information channels open. This flow of information decreased the frequency of misunderstandings. Future assignments should include liaisons who work with each group on base camp rules, policies, and protocols. Also, an identification system along with security checks must be initiated from the first establishment of a base camp.

3. What changes additions or deletions are recommended to Wildland Fire Training Curriculums?

- FEMA response missions need to be discussed at all command and general staff sectional and team training sessions. Logistics chief training should address establishing camps occupied by non-fire agencies, NGO, and evacuees.

4. What issues were not resolved to your satisfaction and need further review? Based on what was learned, what is your recommendation for resolution?

- Base Camp security as discussed above.
- Transition from Response to Recovery. Related to the shut down of Ford base camp, but applies to many other situations. There must be an open dialogue with FEMA regarding this issue with a resolution that is manageable from the IMT's standpoint. Objective statement with measurable success would facilitate this understanding.
- Coordination with cooperating agencies as discussed above.

- The 33 person roster limitation proved to be a failure. Limiting teams to 33 members when assignments clearly require additional personnel are both costly and inefficient. In disaster situations, logistical personnel are critical to meeting any base camp situation. Operational success cannot wait on personnel to be ordered and arrive 72 hours late. The incident commanders need to have the flexibility to call ahead, identify the team composition and quantity, and arrive with sufficient personnel to engage at full operational strength.
- A system of identification cards or badges for all incident personnel needs to be available for entry into base camps. Equipment needs to be available, whether supplied by FEMA, carried by the IMTs, or maintained by the cache system. This would allow identification cards to be produced on site in a timely manner. Issues include security for camp, supplies issued to various agencies and organizations, and food and laundry use, all of which contribute to cost containment. FEMA has some systems that have been used, but availability has been limited and timing has been very poor. It is recommended that the national logistical working team in concert with the national incident commander workgroup discuss this issue and establish a guideline and a proposal for national direction.