

ASSESSMENT REPORT ("Lessons Learned")

Newcastle Incident
Las Vegas, Nevada

Martin's Great Basin National Incident Management Team
January 16 to February 6, 2003

Executive Summary

On January 16, 2003 Martin's Type I National Incident Management Team (IMT) was assigned to support the USDA Animal and Plant Health Inspection Service (APHIS) in responding to an outbreak of Exotic Newcastle Disease (END) in Las Vegas, Nevada. This report *identifies lessons learned* experienced by Martin's Team in integrating with APHIS to provide support to the incident and *recommends measures* to expedite effective IMT support for future assignments.

What Went Well

1. Positive attitude and teamwork.
2. Fast and skillful initial attack by APHIS
3. Effectiveness of the Incident Command System (ICS) for supporting emergency response to animal disease outbreaks.
4. Unified Command at the Incident Commander level between the IMT and APHIS
5. Assistance from various departments within APHIS
6. Flexibility of ICS.
7. Presence of agricultural personnel (from Oklahoma) having ICS experience.
8. Support of other agencies.

Recommendations

1. Patience and communication are *essential* in managing unfamiliar types of incidents.
2. Use the ICS system to respond to animal disease incidents.
3. Establish protocol for Delegation of Authority to IMT by APHIS.
4. Identify the task and what is the mission. This would assist in the determining the IMT configuration, resulting in avoiding delays of personnel mobilization.
5. Integrate APHIS and IMT members in the working environment promptly at the start of an incident.
6. Provide ICS training and developmental incident assignments to APHIS employees.
7. Provide operational guidelines for administrative procedures on incidents.
8. Delegate emergency authorities to the IMT (purchasing, leasing, etc.).
9. Establish agency policy on which reporting system will be used on animal incidents (ICS or EMRS). Modify the system if necessary.
10. Include basic orientation to animal disease incidents in ICS training.
11. Do not utilize dual agency roles at the Section Chief, Officer and Unit Leader positions under a "unified command," rather use Chief and Deputy Positions only.

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Introduction

On January 16, 2003 Martin's Type I National Incident Management Team (IMT) was assigned to support USDA Animal and Plant Health Inspection Service (APHIS) in responding to an outbreak of Exotic Newcastle Disease (END) in northeast Las Vegas, Nevada. END is a contagious viral disease affecting all species of birds. Martin's Team was assigned to support APHIS in eradicating the disease.

The Newcastle outbreak in Las Vegas and in Southern California (detected in California in the fall of 2002) is the first incidents for which APHIS has requested support through the Incident Command System (ICS). This report will *identify lessons learned* experienced by Martin's Team in integrating with APHIS to provide support to the incident and *recommend measures* to expedite effective IMT support for future incidents. The report was developed through interviews with Command and General Staff and other positions, representing both APHIS and the IMT in a unified command structure. (See Incident Report for organization.)

Incident Objectives

1. Ensure safety and security of all incident personnel.
2. Contain Exotic Newcastle Disease to the current quarantine zone.
3. Eradicate Exotic Newcastle Disease within the containment area.
4. Use training opportunity for ICS incident management for agency personnel who are not familiar with the ICS system.
5. Enhance and maintain fiscal accountability and procurement procedures consistent with federal requirements.
6. Establish and ensure a multilingual communication capability.
7. Establish and maintain an education campaign for public and avian owners.
8. Adhere to biosecurity procedures.

An additional objective, to establish a laboratory on-site, was achieved on February 1. It was dropped from subsequent incident action plans (IAPs).

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What Went Well

1. Positive attitude and teamwork.

Dealing with an infectious animal disease outbreak is a new and very different experience for Martin's Incident Management Team. APHIS employees were faced with a new experience in adapting to Incident Command System procedures including ordering personnel and equipment, planning operations and providing public information. During interviews, APHIS employees and IMT members both praised the positive and flexible attitude displayed by people involved in the incident. Although frustrated at times by delays, complications, misunderstandings and uncertainties, they worked together to resolve problems as quickly as possible. And they were willing to learn.

2. Fast and skillful initial attack by APHIS.

APHIS had skillful leadership in place when the IMT arrived. Initial attack (emergency response to the outbreak) was well under way; they mobilized people and equipment from the California incident quickly. They were prepared with a good technical briefing about the outbreak when the IMT arrived.

3. Effectiveness of ICS for supporting emergency response to animal disease outbreaks.

Many APHIS employees including Command and General Staff, group supervisors and operational employees on the ground praised the effectiveness of the IMT in rapidly meeting their support needs. "Kudos" were offered for the quick and accurate acquisition of equipment and supplies. Other praise included skillful management of safety concerns; usefulness of the planning system (for instance, use of the ICS-215 to plan deployment of resources); responsiveness of the incident information team; expertise of the communications unit; efficiency of the ordering process, effectiveness of tracking equipment and supplies; efficiency of the demobilization process; and efficiency and convenience of ground support). Several people commented that IMT support enabled them to concentrate on their technical role, and to think strategically instead of having to focus on immediate needs.

4. Assistance from Departments of APHIS.

A number of departments and individuals were cited as being very helpful in providing advice and expediting requests. Dr. Jose Diez in the APHIS Western Regional Office located in Ft. Collins, CO was helpful in intervening in some delays to speed up processing. Arlette Johnson located in Minneapolis assisted the IMT's Communications Unit Leader in ordering procedures for communication lines and equipment.

5. Flexibility of ICS.

The IMT structure has the flexibility to incorporate functions specific to this incident. For instance, disease reporting and epidemiology were easily incorporated in the Planning Section as units with designated Unit Leaders and staff. It is not necessary—nor is it advisable—to compromise the IMT structure and operating principles to deal with specialized incidents.

6. Presence of agricultural personnel (from Oklahoma) having ICS experience.

Incorporating the State of Oklahoma and APHIS employees into a role of shadowing the IMT, who had ICS experience helped facilitate communication with other APHIS employees. They assisting in creating a “common language” for people involved in the incident. They in-turn received a great deal of on the job training (OJT) in ICS.

7. Support of other agencies.

Many agencies at the federal, state, and local level were very cooperative and supportive. The Las Vegas Metropolitan Police Department, Nevada Wildlife Services, Clark County Animal Control Department, Humboldt-Toiyabe National Forest, Bureau of Land Management (BLM), US Fish and Wildlife Service and Las Vegas Building and Safety Department were among the agencies mentioned by incident personnel.

Employees in the Interagency Federal Office (FS, BLM and FWS) located on Torrey Pines Drive were extremely helpful and courteous in supporting the END Task Force.

Doctor David Thain, State of Nevada Veterinarian and Doctor Paul Ugstad, APHIS Area Veterinarian-in-Charge were extremely helpful and supportive to the IMT. Without their support and leadership, the success of the Las Vegas Incident would have not occurred. Doctor Dave Warner later arrived and supported the Las Vegas Incident as Co-Incident Commander with Incident Commander Kim Martin, after Dr. Ugstad returned to California.

8. Area Command.

Area Command was managed by APHIS employees and the interest and involvement was very good. Daily conference calls and Incident Action Plans were helpful. The ordering process through Area Command will be discussed later in this document. The support received from a Forest Service Area Command initially with Edy Wilson and staff was an excellent decision and did bring additional support and direction.

Challenges Encountered

I. Incident Command

1. Uncertainty in signing the Delegation of Authority (Appendix 2).

Dr. Paul Ugstad, Area Veterinarian-in-Charge for California and Nevada, had drafted a Delegation of Authority when Martin's Team arrived. It was unclear, however, who had authority to sign it. It took most of the first day (January 17) to confirm through phone calls that Dr. Ugstad had the authority to sign the delegation (he received verbal approval to sign the delegation by Kevin Shea, Acting Administrator of APHIS). This contributed to delay in ordering additional resources.

Recommendation: APHIS should establish protocol for delegations of authority.

2. APHIS was already occupying two rooms at the interagency building where the in-briefing occurred. The IMT occupied other rooms. The two entities met periodically throughout the Holiday weekend. This physical separation created a "mental wall" that slowed integration of incident management and understanding of circumstances and procedures.

Recommendation: Mix APHIS and IMT personnel immediately to expedite integration.

3. Integration of personnel and understanding of procedures were slowed by the long delay in establishing an incident command post. Even in the third week of the incident, people were working in hotel rooms and lobbies, the staging area, and the local interagency office. It was hard to get acquainted, let alone work together, and this led to a variety of misunderstandings that took time to resolve.

Background: Incident operations started at an interagency office, but it was immediately apparent that a building was needed to accommodate the potential size and duration of the incident. A building (recently constructed) was selected the first day, but there was a delay of four days in getting the lease signed. (See discussion in the Buying Team section of this report.) Problems were encountered in procuring and installing phone and data lines (see the Communications section). The building owner was aloof and uncooperative in making improvements required for the building to be approved for occupancy by the Las Vegas Building and Safety Department. Some units moved into the building on an "operation test" basis late in the second week, but it wasn't formally occupied and units remained dispersed.

Recommendation: Establishing an Incident Command Post (ICP) immediately is essential to integration and teamwork. The buying team should have leasing and procurement authorities. The communication unit leader should have the authority to arrange for communication and data transmission services and equipment, or have an agency liaison with this authority on-site.

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4. The IMT's short team initially mobilized was inadequate to fulfill expectations.

A short team was ordered because the IMT's role was initially conceived as coaching and mentoring. However, discussion during mobilization with the Type III IC and the in-briefing and review of the draft Delegation of Authority between Kim Martin, IC and Dr. Paul Ugstad indicated that substantial incident support was needed from the IMT (maps, logistical support, public information, etc.). Dr. Ugstad agreed. Resource orders for additional team members were not cleared for submission until about 1800 on the first day (January 17), delaying mobilization until the following morning, and arrival of additional team members until the following day (January 19).

Recommendation: Mobilize a long team for animal disease incidents commensurate with task description and work to be accomplished.

5. Lack of ICS knowledge complicated and delayed incident operations.

Although the positive attitude of employees has been acknowledged and praised, delays, errors and confusion stymied incident operations because APHIS employees didn't understand, and had little or no experience in ICS operations. (Specific problems are identified in this report for each ICS organizational component.) APHIS employees said that the Regional Emergency Animal Disease Eradication Organization (READEO) "lacks the discipline" of ICS and is not as effective in providing support needs.

Recommendation: Because animal disease outbreaks will certainly occur in future, and because ICS system can adapt easily to this type of incident, APHIS should learn and participate in the ICS. Few APHIS people already have some knowledge of ICS but it is evident that additional formal and OJT is needed. This recommendation was voiced by many APHIS and state employees involved in the incident. In particular, the State of Oklahoma employees and Oklahoma-based APHIS employees, who have had some training and experience in ICS were excited for this experience. They wholeheartedly endorsed ICS use for animal disease incidents.

- a) Include basic orientation to the ICS organization and basic procedures (such as ordering) in the orientation that new arrivals are given about the outbreak.
- b) Provide basic ICS training to APHIS employees, including mock situation exercises.
- c) Provide advanced training in specific functions to selected employees.
- d) Provide shadowing opportunities on a variety of incidents.
- e) Consider making qualified APHIS employees available for team assignments.
- f) The *Foreign Animal Disease Emergency Response Guide* of the Oklahoma Department of Agriculture, Food, and Forestry (based on the ICS Fireline Handbook) could be very useful on animal disease incidents.
- g) Establish IMTs specifically trained for animal disease emergencies. Operational and Planning positions—or perhaps all positions—could be filled by APHIS and state agricultural department employees. The State of Oklahoma has a team for animal emergencies that could serve as a model—but teams need to be available for a wider geographical area than a state.

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6. APHIS reserved authority for approving certain actions such as acquisition of communications equipment and office space. This led to delay and inefficiency.

Recommendation: Provide operational guidelines that identify how authorities will be delegated. Possibility of delegating to the IMT the authorities needed to perform efficiently. Detail warranted procurement employees to the incident if authorities are not delegated.

7. Some departments of APHIS were not responsive to the needs of the incident nor lack the understanding of the urgency (for instance, expediting orders for phone lines and telecommunications, approving building lease).

Recommendation: By letter or formal policy, APHIS should direct administrative employees to expedite requests that support incident operations.

8. It was difficult to fill resource orders for Veterinary Medical Officers (VMOs) and Animal Health Technicians (AHTs) in a timely manner. (Resources may have been stretched because of the simultaneous needs of the California incidents and the duration of the END.)

Recommendation: Increase enrollment in the reserve VMO program. Raise the pay level for this program; GS-11 salary is not sufficient incentive for private veterinarians to leave their businesses.

9. There were many inconsistencies in the way the California teams and the Nevada team operated. This may be due, in part, to the fact that in California ICS was overlaid on an existing system. The Las Vegas incident benefited from everyone starting at the same time.

Recommendation: APHIS should establish clear agency policy to use the ICS system for animal emergencies. Modifications in reporting or other procedures could be made—but they should be minimized. ICS is flexible enough to accommodate animal disease incidents. (This recommendation came from APHIS employees.)

II. Planning Section

A. Situation

1. There were conflicting expectations between California and Nevada on which reporting system to use; the Emergency Management Reporting System (EMRS) that APHIS uses or the ICS-209. Use of the ICS-209 was suspended at the direction of Area Command in California after the first couple of days on Las Vegas incident. However, an “informal 209” is still being prepared for the agency liaison to use in writing the narrative report for Area Command because it is more useful for reporting resources. EMRS records support by individual name, so every person on a crew must be listed separately. On the 209 an entire crew can be identified with one entry.

Recommendation: Establish at the in-briefing which reporting system will be used. For the long term, establish agency policy on which reporting system will be used on incidents of this kind. Modify the selected system as necessary. (APHIS employees in the Planning Section felt the ICS-209 had advantages for planning and reporting, and should be used.)

B. Check-In/Resources

1. Because APHIS was not using the ICS ordering system initially (see III-B.1), people were arriving without O-numbers and they didn't know what position they were filling. They also failed to check-in. There were delays in receiving confirmation that orders were filled as well as arrival times. EMRS does not integrate well with the ICS ordering system. It produces only TF numbers that don't link to O-numbers. Moreover, if a person is demobed and then returns, he/she retains the same TF number, whereas the O-number would change. All of this confusion in ordering frustrates efforts to plan operations and assess resource needs.

Recommendation: Use the ICS system for ordering. If the decision is made to use EMRS, adapt it to meet incident needs, and provide training to IMT's in its use.

C. Demobilization

1. Area Command had prepared a demob plan tailored to cover both IMT and APHIS personnel. This was helpful. (Bugs are still being worked out.) However, a problem remained in determining when APHIS employees were to be demobed because some didn't formally check-in. Asking APHIS employees to review a posted demob list and make corrections helped establish an accurate demob schedule. Understanding of the process improved over time.

Recommendation: Check-in all resources using ICS procedures.

2. Because of the long delay in establishing an ICP, it was necessary to drive all over town to go through the demob process (for instance, people had to go to the staging area and various hotel rooms). It also delayed data entry.

This problem seems too diminished with the establishment of ICP, although the staging area will probably remain separate. The problem is not attributable to IMT/APHIS integration problems.

3. APHIS instituted a policy of 21-day details with travel packaged on Tuesday. Consequently it was difficult to provide for transition.

Recommendation: Normally it be more efficient to place resource orders as needed to provide transition, but under the circumstances (APHIS personnel stretched to the limit to respond to this emergency), it was not possible on this incident.

D. Operations Planning

1. APHIS personnel did not understand the usefulness of the ICS-215 for planning operations for the next operational period; some resisted its use at first. Some group

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supervisors preferred to plan operations for the next day “in their heads” – but these mental plans could not be visibly integrated with others. Use of the ICS-215 was explained at planning meetings, and acceptance grew over time as people saw its effectiveness for identifying work to be done and resources needed. Everyone could see and understand shifting operational needs.

Recommendation: Use the ICS-215 for planning.

2. It took time for the IMT to understand the nature of animal disease emergencies, and the support they need.

Recommendation: Consider including some basic orientation to these kinds of incidents in ICS training. More intensive training may be needed if there is significant potential for terrorist introduction of animal diseases.

III. Logistics Section

A. Facilities

1. There was a delay of four days in leasing a building to serve as the Incident Command Post.

The IMT was permitted to work in the interagency office for only three days (over the Martin Luther King holiday weekend). A new location had to be found immediately; moreover, it was apparent that leasing long-term office space was advisable because the incident might last six months. Two suitable buildings were identified on the day the team arrived (January 17), but only one was available for a 6-month lease. The buying team or the procurement unit leader could have signed the lease immediately upon arrival at the incident (January 18), but APHIS reserved this authority. The leasing officer in Minneapolis did not understand the urgency of the need, resulting in a delay of four days in getting the lease signed. It required the intervention of Dr. Ugstad and others to expedite the process.

(Subsequent delays involved installation of phone and data lines, and obtaining approval from Las Vegas Building and Planning Department for occupancy of the building. A temporary building permit was issued February 4 to the building owner with condition attached. These delays did not involve integration of APHIS and the IMT.)

Recommendation: Delegate leasing authority to the IMT. If authority is not delegated have the leasing officer on-site at the start of an incident when long-term office space is needed.

2. The staging area was a former administrative site for the BLM and United States Fish and Wildlife Service (USFWS). Historic problems did include continual phone and data line interruptions. Also the staging area is not large enough to include an ICP due to inadequate parking and a limited heating and cooling system.

Recommendation: Develop a list of basic requirements that can be used to identify suitable space for animal disease incidents (square footage, parking, number of phone and data connections, number of private offices, laboratory needs, etc.)

3. Initially samples were being sent to a laboratory in California. There was an empty building at the staging area compound that was suitable for a laboratory. It was easily isolated and close to both the “dirty” and “clean” areas. The IMT and APHIS personnel suggested that an on-site laboratory would be advisable for the long term, so the building was retrofitted and equipped to serve as a laboratory. This expedited work for the pathology unit. However, the final decision to allow the laboratory to be located in Las Vegas had to pass through approval procedures at another level.

Recommendation: Establish an on-site laboratory, if appropriate.

B. Supply

1. APHIS employees did not understand the ICS system for ordering, and there was some resistance to using it. When personnel were needed some APHIS employees simply called people they knew, or called Area Command. Personnel would arrive at the incident and fail to check-in. (Some went to the wrong incident in California.) They didn’t know what position they were requested for. There was duplication in some of these informal “orders.” Equipment would show up that had apparently been informally requested from the incident in California, or brought with employees who transferred to Las Vegas from California (i.e. cell phones, GPS units, vehicles).

Generally, it took over a week to get APHIS personnel accustomed to placing orders. Some individuals still resisted using the system, although many APHIS employees expressed satisfaction with its efficiency and accountability.

Recommendation: Train APHIS employees in a pre-established ordering process or follow an existing ordering procedure. (Calling employees to report to an incident may be appropriate in the first stages, similar to initial attack, but when an IMT assumes management, ICS ordering procedures must be used.)

2. Some APHIS employees resisted checking-out equipment and supplies.

Recommendation: Emphasize adherence to check-out procedures during briefings. Point out the need for accountability, as well as the need to plan for adequate levels of supplies over time.

3. Area Command in California said they would order certain items (such as highway signs and an identification badge system). This caused delays, and ordering is not normally the role of an area command. Incident Commanders Martin and Ugstad along with Dr. Thain finally directed Logistics to procure highway signs because of the need to identify the quarantine areas.

Recommendation: Clarify the role of Area Command in allocating resources among incidents and allow the IMT to handle ordering.

C. Ground Support

1. Highway signs informing travelers of the quarantine were needed in place by January 28. It was deemed advisable to display a message consistent with the one used in California; however, their message was not provided. Logistics decided to develop a message; it was approved by the Incident Commanders and the State Veterinary of Nevada. The State of Nevada Department of Transportation helped with appropriate wording and placement.

Recommendation: Concern for consistency of messages is appropriate—but if needs are not met timely by others, meet needs locally. Consider sign message boards that can accommodate two languages in culturally diverse communities.

2. Ground Support obtained over 110 vehicles from four rental companies, as ordered.

Recommendation: If this number of vehicles is typical of animal disease incidents, limit the number of vendors (rental companies) as much as possible to avoid problems in tracking vehicles and payments.

D. Communications

1. The IMT's Communications Unit Leader ordered phone lines and data lines for the ICP early in the incident (approximately January 19). He then received a phone call from the APHIS-Minneapolis telling the IMT that the order with Sprint was cancelled; the Minneapolis office would make the order. On January 24 the Unit Leader called Sprint and learned that the order for telephone lines had not yet been received from APHIS. Moreover, Sprint told him that it would take 14 days to fill a non-emergency order. The IMT reactivated the order convincing Sprint that the request was for an emergency. The lines were installed the next morning.

Arlette Johnson of APHIS-Minneapolis was very responsive and understood the urgency of the situation. The IMT's Communications Unit Leader requested that Arlette be detailed to the incident to act as a liaison between the Sprint and APHIS. The request was never filled.

Recommendation: APHIS should delegate authority to the IMT to procure communications equipment. If authority is not delegated, an APHIS employee should be detailed to the incident (at least for the first week) to expedite ordering. If this is not possible, provide contact name(s) or other means to facilitate the installation of communication lines and equipment.

Financial accounting concerns could be addressed through adjustments after the fact; they should not delay the acquisition of equipment needed for safe operations.

2. Sprint could have immediately (January 21) installed a DSL line at the ICP for high-speed data transmission for about \$200, with a monthly charge of \$60. Its capacity, although less

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than a T-1 line, would have been sufficient for start-up operations. Alternatively, MCI could have installed *Virtual On-Net* under government contract for \$4000, with a monthly charge of \$600. Its capacity is the same as a T-1 line, and it too could have been installed immediately (it's a satellite system). The IMT's Communications Unit Leader provided APHIS of these alternatives on three occasions. Instead, a T-1 line costing \$4000 was installed, with a monthly charge of \$1200. The T-1 line was not fully operational until 30 January. Moreover, this line may not be needed in the long term.

On January 29 APHIS cancelled the upgrade of phone switch for the new building. The IMT's Communications Unit Leader was told that Vince needed to inspect the system.

APHIS sent a representative of their IT staff (Mike Magrone) to the incident to facilitate acquisition and installation of equipment. This was very helpful.

Recommendation: Same as III-D.1.

3. APHIS employees were reluctant to use radios on the incident, because they are unfamiliar with them. (Use of cell phones is standard procedure on the California incident, where many APHIS employees had previously worked.) Moreover, they preferred to use their own cell phones, which incur substantial roaming charges, rather than cell phone procured locally for the incident. In addition to the convenience of using their own phone, APHIS employees cited reluctance to deal with the check-out procedure as a reason for using personal cell phones. The IMT's Communications Unit Leader calculated the cell phone cost for the first week of the incident at \$18,000. This cost would be considerably reduced by use of radios (free) and local cell phones.

In morning briefings, personnel were continually encouraged to use radios and local cell phone service, and volunteered use started to improve. Written instructions and one-on-one training were provided, including instruction in the communication plan in the Incident Action Plan (IAP).

Recommendation: Provide radio use orientation for operational personnel when they arrive at the incident as part of the mandatory orientation session, just as GIS training is provided on this incident. Provide additional instruction in the IAP's communication plan to help new users. Provide one-on-one orientation as needed. Direct incident personnel to use radios and local cell phones in daily briefings, crew briefings, etc.

4. There was confusion among the IMT's Communications Unit Leader, the buying team and APHIS about the type of cell phone service procured by APHIS for the incident. It took a couple of days to resolve.

Recommendation: Same as III-D.1.

IV. Operations Section

1. APHIS employees did not understand ICS and the IMT did not understand task force procedures and protocol. This led to delays in getting fully operational (for instance, delays in obtaining equipment). However, the IMT provided excellent operational support when basic mutual understanding was achieved; they were very responsive. Equipment was obtained quickly; accountability for equipment improved when ICS check-out procedures were used, and it was easier to plan for adequate quantities of on-hand supplies.

Recommendation: Use ICS for support of animal emergency incidents. Train APHIS employees in ICS. Some APHIS employees should take advanced ICS training and qualify for various positions. Clarify responsibilities and procedures for technical work versus support.

2. Some group supervisors' resisted filling out general message forms—they either went to Jack Swan, APHIS with their needs or gave verbal orders to the supply unit. In some cases this delayed procurement of specialized equipment because specifications were needed.

Recommendation: Group supervisors should be trained in ICS and required to use the ICS ordering system.

3. The Planning Operation Section Chief's role was not understood. The Planning OSC initially was working in the planning organization and not on the field side of the operations. This created some confusion, which resulted in an internal team meeting with Operation, Planning and the ICs to clarify roles and responsibilities.

Recommendation: Train APHIS employees in ICS. Consider establishing APHIS IMTs.

4. Group supervisors on the incident were veterinarians, except for OSC Jack Swan, an Animal Health Technician (AHT) were not in supervisory roles. Veterinarians in some cases resisted advice from technicians despite lacking on-the-ground experience. In some cases biosecurity measures were intentionally neglected by veterinarians who felt requirements should not apply to them. This appeared to have more to do with status than qualifications.

Recommendation: Establish ICS qualifications for animal emergency operational assignments, assign resources accordingly, and require adherence to supervisory direction as is standard in ICS. Home position and/or regular job titles in most cases do not qualify an individual for an ICS position.

5. There was no mobilization process for operational resource orders, causing delays in filling orders. People were calling around looking for help.

Recommendation: APHIS should establish a dispatch process nationally or in each geographic area of their organization. Or, a list of qualified personnel could be provided to the wildland agency dispatch organization for each geographic area. Use the ICS system for ordering.

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V. Finance Section

1. An agreement at the National level is needed between USDA (APHIS and USFS), USDI and other appropriate agencies to authorize exchange of funds to reimburse performance of emergency services (salary and contracting/procurement). It's currently in its fifth draft.

Recommendation: The agreement should continue through the review and approval process and be signed as soon as possible. Measures should be in-place to ensure that it's review be timely in the future and remain enforce. In fact, if future involvement of **interagency** IMT's will be included in other type of homeland incidents, an agreement between agencies should be drafted to allow for procurement authorities, as well as other type of operational activities.

2. The Exotic Newcastle disease outbreak was declared an emergency by the Secretary of Agriculture—not the President or FEMA—so expedited procurement was not authorized. See discussion under IX-4.

Recommendation: An agreement should be developed to authorize use of warrant procurement authority for buying teams and Procurement Unit Leader for purchases, contracts, etc. on animal disease incidents.

3. The payment office was not identified at the start of the incident.

Recommendation: A payment office (APHIS or other agency) should be immediately identified for all incidents.

4. APHIS reserved authority for long-term contracts, and acquisition of telecommunications and computers. This delayed and complicated obtaining space and equipment for this incident.

Recommendation: APHIS should develop an operational guide that states how authorities will/could be delegated on incidents.

5. APHIS does not have casual hire (AD) authority, which is useful for filling short-term incident needs. They have been hiring temporary employees on 180-day appointments.

Recommendation: APHIS should seek this authority. (Apparently this is being worked on.)

6. It was unclear whom to contact when administrative questions and problems arose.

Recommendation: APHIS needs to provide an Incident Business Advisor (IBA) for every animal disease incident. He/she does not need to be on-site, but must be readily available by phone and have authority to make decisions rapidly on various administrative issues.

An IBA was designated by APHIS (Debbie Smith). She was assigned to the incident the week of January 27.

7. The buying team initially had to purchase accountable property with government credit cards to meet emergency needs, even though this is not proper.

Recommendation: APHIS should provide a list of blanket purchase authorities and contracts so that proper sources can be used.

8. APHIS was concerned about tracking sensitive property. No system had been established.

Recommendation: Provide property tags to attach to sensitive and accountable property. Transfer property to APHIS using AD-107.

VI. Information

1. APHIS and the IMT did not understand each other's acronyms. This made communication difficult. The information unit prepared an acronym listing (*How to Speak Incident Command*) at the beginning of the incident. It listed both APHIS and ICS acronyms.

Recommendation: Assign a representative from APHIS and one for the ICS system to work together to prepare an expanded version of this listing for use on future incidents.

2. Efficient operation of the incident hotline was frustrated by the delay in establishing an ICP. Temporary employees could not be hired to staff the hotline because they did not have a security clearance to work in the interagency office (the hotline was originally established there in the first days of the incident). Until they were brought on, no one staffing the hotline spoke Spanish. When the phone lines were switched to the new building leased to house the ICP, voice mail capability was lost. Consequently, callers got busy signals, they couldn't leave a call-back message, and there was no recorded information message that could have answered many routine questions. Two answering machines were obtained to help provide service until voice mail was restored, but they had limited capability.

Recommendation: Same I-3.

3. The APHIS Public Affairs Officers (PAOs) appeared to be following agency protocol (under direction from the Secretary's Office) with respect to media and stakeholder updates and all other informational materials. Personal and phone contacts took much of the APHIS PAO's time. The production of updates and other important written information such as a question-and-answer sheet for the hotline staffers were seriously delayed (sometimes several days), again responsibility held by APHIS PAOs.

The APHIS PAOs according to agency policy have the responsibility to work with the media. Media interviews also took a lot of time, contributing to delays in written products. (There was only one APHIS PAO in the information unit at a time.)

They were unaware of the range of information services that qualified IOFs can provide.

Recommendation: IOFs from other agencies should be permitted to draft written materials for APHIS PAO review. (Experienced IOFs can write accurate information after receiving orientation and some experience on an animal disease incident.) They should also be permitted to work with the media. Another alternative is to have two APHIS PAOs concurrently assigned to the incident.

4. Local government contacts did not reliably receive updates early during the incident because the APHIS PAO e-mailed the update to only one person, assuming that individual would forward the e-mail to all other contacts. This lack of distribution created a bottleneck, especially when the individual was off work during the weekends. No other distribution systems were used.

Other concerned interests—such as pet shop owners, feed stores, and RV parks where seasonal visitors stay—were not receiving written information. The Lead IOF started faxing information and running “traplines” to distribute information.

Also, APHIS PAOs were not aware of the importance of state and local government officials (such as county commissioners) in influencing public opinion. The focus was on national-level legislators.

Recommendation: APHIS PAOs should have basic ICS training and S-203 Incident Information training, which addresses distribution of incident information. APHIS should emphasize the importance of consulting local PAOs and local key contacts to learn how and to whom information should be relayed.

6. The APHIS PAO initially assigned to the incident had the VMOs make personal contacts with the public (i.e. pet shop owners); apparently this was business as usual. This protocol prevented implementing a proactive community outreach program in the first days of incident. The consequence was misunderstanding and hostility among some segments of the community as the incident progressed. (Note: Both APHIS PAOs on the incident recognized the importance of community outreach. Meetings were held with veterinarians, residents of Pahrump, bird breeders and pet shop proprietors, etc. The State Veterinarian, Incident Commanders, and other IMT members participated.)

Recommendation: Proactive community outreach is essential. General public information about the disease and quarantine will satisfy most public needs. It need not come only from veterinarians.

7. The media update and the stakeholder update were not shared openly again apparently due to agency policy. This information would have been useful for answering questions from the public.

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Recommendation: Incident information officers and other IMT members should have access to these reports. The information unit can reproduce the situation report for other units on the team, just as they distribute the NIFC situation report on wildfire incidents.

8. Public service announcements were requested from Area Command during the first days of incident (by about January 20). As of February 1 they had still not been received.

Recommendation: Area command and other incidents should share information products promptly, especially when consistency of messages is important.

9. Incident employees called the hotline with internal questions, such as whom to contact to fill a need or coordinate work. The information officers had a hard time identifying appropriate contacts in the IAP—they noted that not all employees in support functions were listed (only Unit Leaders). A phone list was included in the IAP but it listed only names, not functional assignments.

Recommendation: List functional assignment (depopulation, supply, ground support, etc.) as well as phone number for each employee on the phone list.

VII. Safety

1. The END task force did not have an incident APHIS Safety Office in Las Vegas. Each group supervisor had to watch for hazardous situations, order appropriate equipment, oversee adherence to safe procedures. The IMT's Safety Officer relieved them of some of these responsibilities and improved the safety of operations. For instance, he found that operational personnel were using particulate matter respirators when they should have been using vapor respirators. Now, all operational personnel are using vapor respirators.

Recommendation: Use ICS for management of animal disease incidents, because safety is institutionalized in the ICS organization. Alternatively, APHIS should assign one or more qualified individuals to animal disease incidents for the sole purpose of overseeing safety. (APHIS personnel were extremely receptive to the safety officer's advice.)

2. The APHIS Office of Emergency Response in Washington D.C. under agreement with Human and Health Services (HHS) ordered the Nevada Disaster Medical Assistance Team (DMAT) for the incident. Their services were limited because the broad range of already available local medical services within the Las Vegas area. An emergency medical technician had already been assigned to the Las Vegas incident and health/safety measures such as providing drinking water and tetanus vaccinations to crews were already in place. The IMT's Safety Officer advised Nevada DMAT that one nurse would be useful. At one point in time additional medical resources were ordered including a field medical hospital, two administrative officers, and a physician's assistant from North Carolina, as well as a variety of equipment and supplies. All were ordered outside the ICS system. The Nevada DMAT

decided on its own what areas to patrol, rather than working with the IMT's Safety Office and Operations.

Recommendation: Resources should be ordered through the IMT. If agency administrators are considering sending additional resources, they should coordinate with the IMT.

3. Some VMOs were not using personal protective equipment (PPE) and saw no need for it. They said crew members needed PPE but they didn't. They were not used to oversight from a Safety Officer.

Recommendation: See VII-1. Safety should be institutionalized on animal disease incidents to emphasize management's concern.

VIII. Agency Liaison/Training Officer

1. It wasn't clear where training fit in the IMT organization.

Recommendation: The READO identifies the role of training more clearly. Incorporate this into the IMT organization for animal disease emergencies.

2. Lack of understanding of ICS caused confusion, delay, and inefficiency, although most people had a good attitude and demonstrated teamwork.

Recommendation: APHIS employees should attend basic ICS training (could be provided via computerized module), participate in mock exercises, take advanced training (at least in support functions) and shadow IMT members on incidents. Some APHIS employees should also participate as team members on IMTs. This would increase understanding and acceptance of ICS among other APHIS employees, especially on animal disease incidents.

3. The IMT did not understand EMRS. People were confused about how to use it, and how to integrate it with ICS.

Recommendation: IMTs should learn EMRS if it will be used on animal disease incidents.

4. IMT members didn't understand the character and impact of the Exotic Newcastle Disease outbreak. Daily orientation for new resources was not instituted until several days after the IMT assumed command.

Recommendation: A training officer should be ordered when the IMT is ordered.

IX. Buying Team

1. Under ICS, the buying team reports to the agency administrator. It is usually located separately from the ICP, where the supply unit operates. At the Newcastle Incident-Las

Vegas the buying team and supply were located at the same location. This made it easy to resolve questions resulting from the unfamiliarity of the incident (i.e. specialized equipment). Supply orders were filled by local purchase.

Recommendation: The buying team and supply should be located in close proximity on animal disease incidents.

2. At the beginning of the incident no administrative contacts were identified for APHIS. The buying team and others did not know what approvals were needed nor whom to contact.

Recommendation: APHIS should develop incident operating guidelines that identify name(s) and phone numbers for various administrative processes.

3. No billing address was identified to set up long-term contracts for APHIS.

The buying team used the interagency (BLM, USFS, USFWS) office's address in the absence of a billing address for APHIS. As of January 29, APHIS had still not informed them of a billing address. The team changed the current billing address to the Intermountain Regional Office of the Forest Service until APHIS could provide an address.

Recommendation: Determine and document the billing address for APHIS incidents.

4. The buying team lacked authority for emergency procurement of supplies and services for this incident even though the disease outbreak had been declared an Extraordinary Emergency by the Secretary of Agriculture, not the Federal Emergency Management Agency (FEMA) or the President. The team was therefore required to get three bids for procurements; they were restricted from acquiring certain items such as radios, motor vehicles, and telecommunication services; and they could not use agency credit cards for certain purchases without approval. A local BLM procurement clerk used BLM blanket purchase authority to obtain rental vehicles.

This situation was resolved when the Forest Service Director of Acquisition Management issued a letter dated January 24, 2003 waiving restrictions of FSH 6309.32 under exigency authority.

Recommendation: A similar waiver should be issued timely for incidents of this kind.

5. There was no contact identified who could advise the buying team on technical specifications for equipment ordered to respond to the outbreak (biosecurity equipment). Operations personnel were at times not responsive in providing detailed specifications. Brenda Reddel of APHIS joined the buying team for about five days and was extremely helpful in filling this need.

Recommendation: Have a technical advisor on-site at the start of an incident. After a few days, telephone contact would probably be sufficient.

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6. There was no interagency agreement between USDA and USDI authorizing expenditure of funds for an incident of this kind.

Recommendation: Agreement has yet to be approved among various agencies. See V-1.

7. There was delay in getting identification tags made for incident personnel. The buying team first contacted Kinkos, but learned they were unable to produce ID tags of appropriate quality. A system involving a laptop, printer and other electronic equipment is needed to produce the tags. The buying team then began the process of getting technical approval from APHIS to acquire the system, but it took some time (about 10 days) to identify the appropriate contact and get the required approval. In the meantime, Dr. Ugstad sought to obtain Area Command's system, but his request was turned down.

Recommendation: Same as IX-2

Appendix 1
Team Members Interviewed for This Report

Great Basin IMT

Kim Martin, Incident Commander
Hank Walters, Safety Officer
Kathy Jo Pollock, Information Officer
Steve Raddatz, Plans Section Chief
Fred Houston, Logistics Section Chief
Richard Rusk, Logistics Section Chief
Walter Warrick, Communications Unit Leader
Bill Bryant, Operations Section Chief

APHIS

Dr. Paul Ugstad, Incident Commander/Area Veterinary-in-Charge
Nolan Lemon, Information Officer
Mary Jo McBride, Liaison Officer
John Coakley, Training Officer
Jack Swan, Operations Section Chief
Dr. Arnoldo Gutierrez, Operations Group Supervisor (Surveillance)

State of Oklahoma

Dr. Carey Floyd, Incident Commander
Dr. Nancy Roberts, Plans Section Chief
Dr. Rick Woodbridge, Plans/Operation Section Chief
Joe Emberson, Logistics Section Chief

Buying Team

Scott Wintermute, Buying Team Leader

Appendix 2

Delegation Of Authority Animal And Plant Health Inspection Service

As of 1630, January 17, 2003, the New Castle Disease Incident shall be managed under Unified Command with a designated co-IC from APHIS and Kim Martin from the Great Basin Incident Management Team as commanders.

The disease was confirmed in Las Vegas, Nevada on January 16, 2003. My considerations for management of this disease are:

1. Provide for personnel and public safety.
2. Confine the disease to the smallest area possible.
3. Provide factual public information on continuing basis. APHIS will be responsible to review, approve and disseminate information as per agency policy and procedures.
4. As per directed under Unified Command in this delegation, procurement shall be delegated to IMT for supplies not now stock piled by APHIS or currently available through existing APHIS contracts. APHIS claims for indemnity procedures are followed and adhered to.
5. Assure all resources are tracked and accounted for.
6. Manage costs effectively and report to APHIS daily or as otherwise directed.
7. Provide training opportunities for personnel to strengthen APHIS organization.
8. Minimize disruption of residential access to private property, and visitor use consistent with public safety.

 Paul Upstead, AVIC

(Signature and Title APHIS Representative)

1/17/03

(Date)

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Appendix 3

Exotic Newcastle Disease Initial Order

The attached initial order was developed from the Newcastle Disease outbreak during 2003 in Las Vegas, Nevada by supply unit leaders Steve Blatt and Kay Shurtz (Marten's Type I National Incident Management Team). The initial order is developed to aid in the ordering of items to arrive quickly and be available for use or have them ordered early enough to have items arrive in a short period of time. The items ordered will outfit crews for cleanup/disinfection and surveillance and allow for the development of two vehicle wash stations at the "dirty area", three portable wash stations (use in a ¾- 1 ton pickup truck), and enough items to stock approximately two "Depop" U-haul vans. Also, when an individual enters a contaminated site, they will wear a Tyvek Suit Kit.

A Tyvak Suit Kit consists of the following:

- 1 Each Tyvek suit (sizes medium-5X) *Zipper Type Only*
- 1 Each Tyvek Bouffant Cap
- 1 Pair Tyvek Booties (Prefer Yellow/Gray Boot Style)
(recommend large and extra large sizes only)*
- 2 Pair of Latex Gloves
- 1 Dust Mask
- 1 Small Garbage Bag

* Even if the suit comes with the attached boots, booties will be slipped over for added protection and durability.

A DEPOP TRUCK consists of the following:

- | | |
|---|----------------------------------|
| 1 Each Stihl Fogger | 1 Each 45 Gallon Garbage Can |
| 1 Each Sprayer 3 gallon | 2 Each Safety Cones |
| 6 Each CO2 tanks (20 lbs) | 1 Each Fire Extinguisher |
| 1 Each Large Cooler | 1 Each Large Toolbox |
| 2 Each 22 Gallon Rubbermaid Tub | 1 Each Medium Toolbox |
| 3 Each Broom (push) | 1 Each Wheelbarrow |
| 3 Each Broom (sweep) | 1 Each Small Toolbox |
| 1 Each Flat Shovel | 4 Each Flashlight |
| 1 Each Rake | 1 Each Spotlight |
| 3 Each Large Fishnet | 12 Each Ratchet Straps |
| 1 Each Dolly | 3 Each Metal Shelving |
| 1 Each Bolt Cutter | 1 Each 2 Gallon Gas Can |
| 1 Each Crowbar | 12 Each Disposable Barrel |
| 2 Each Hose | 2 Each 10 lbs Container Vircon S |
| 6 Boxes of 3 mil Garbage Bags | |
| 2 Boxes Each of Gallon and Quart Ziplock Baggies | |
| Box of Each Tyvek suit (sizes medium-5X) <i>Zipper Type Only</i> | |
| Box of Tyvek Bouffant Cap | |
| Box of Tyvek Booties | |
| Box of Latex Gloves various sizes | |
| Box of Flexfit Gloves various sizes | |
| Box of Dust Mask | |
| Misc. Tools: screwdrivers, hammers, crescent wrenches, wire cutters, pliers, etc. | |

If additional information is needed regarding this initial order please contact Steve Blatt at (801) 625-5112 (work) or (801) 721-9788 (cell phone).

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