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## **Columbia Shuttle Incident East Texas Response**

### **Lessons Learned**

#### **What was the most notable success at the incident that others may learn from?**

##### **Incident Commander**

Although the incident's Delegation of Authority indicated a single command structure, a unified command structure was utilized. This structure worked extremely well for this incident whereby there were three distinct purposes with one mission. The roles of each of the three Incident Commanders were well defined and each worked within those definitions. Additionally, the IMT IC chose to integrate local agencies as part of the Team gaining the expertise of the locals to accomplish the incident's mission.

Early on, the need was identified to relocate certain functions within the camp to better serve the mission. The Planning Section was moved to the same location and Information was relocated to the front of the camp allowing easy access to the public.

##### **Information**

Several community meetings were conducted prior to the arrival of CIIMT4. The intent of earlier meetings was to update residents and local media on incident strategies. Community volunteers were very involved in all aspects of the recovery effort during the early stages. When the incident management teams were activated, volunteers were displaced. Upon our arrival, at the request of NASA, we scheduled town meetings in Hemphill and San Augustine. The objectives were to provide an update, begin to move toward closure, and to show appreciation for and reengage the communities. The agenda focused on a PowerPoint presentation and addresses by community leaders and incident management personnel. The result was very positive and no additional meetings were necessary.

Two PowerPoint presentations were created during the incident. The first was developed for use at the public meetings. The theme was to show appreciation for the efforts of the local residents during the initial stages of the incident and to link their efforts to the crews currently searching the area, and the incident management teams. The presentation began with a memorial to the astronauts, followed by scenes featuring local residents and firefighters involved in the search effort. Lastly, the presentation concluded with slides supplied and narrated by NASA identifying specific shuttle materials and a presentation describing the role of EPA in the search. The second PowerPoint presentation was a tribute to those serving our Country in the military and other American heroes. The target audience was all incident personnel. This program can be used for any incident occurring concurrently with the War in Iraq. Both presentations were successful and numerous copies were requested.

The Joint Information Center retained the responsibility for media relations and specific information pertaining to shuttle material, personal effects, and human remains. There was little media interest during our time at Hemphill. Due to the lack of media attention, we were able to focus on the remaining functions included posting information authorized by the JIC at public locations, postings within camp, camp tours, VIP visits, motivational presentations, and community meetings.

## **Logistics**

Issues were resolved and plans easily established as the result of the enormous cooperation demonstrate by the TICC, TSF, FEMA, EPA, NASA and the IMT. Each emulated an enormous “spirit of working together” to get the job done in the most efficient, effective manner. The daily conference calls and face-to-face meetings worked well.

Increased communications capability to the critical dive operations. By adding repeaters and changing user groups on existing TFS and USFS repeater stations, communications was improved tremendously to the dive operations site.

The Supply Unit had control of all resource order numbers. Common problems such as duplicate orders, requests, etc. were avoided.

## **Finance**

The working relationships between the Team, EPA, and NASA were phenomenal. The concerns and uncertainties of coming to an assignment such as this was put to rest early on with the coming together by these three agencies in developing a strong bond with common goals and expectations.

## **Operations**

The successful integration of non-traditional agencies working together for a common mission was a great success both in the field and in camp. Utilizing the versatility of the teams available assured success in this “all-risk” assignment.

Crew/Overhead Orientation was valuable. Orienting each new crewmember to the incident ensured clearly defined expectations, roles and rules of engagement for the incident.

## **Plans**

The Columbia Shuttle Recovery brought together a mix of agencies that normally do not work together. Under the Incident Command System and unified command, the integration of information from various local, state and federal agencies (i.e. NASA, EPA, Sabine and Angleen National Forest, Texas Forest Service and FEMA) resulted in an effective Incident Action Plan and mapping product that was the most notable success.

## **What were some of the most difficult challenges faced and how were they overcome?**

### **Command**

When an “Incident with an Incident” occurred, roles of the Team were not clear. In the future, the Incident Commander will ensure rules of engagement for initial attack are clearly defined in the Delegation of Authority.

### **Logistics**

Ordering overhead and the coordination of the switching out of crews. The difficulties were easy to overcome due to the cooperation and availability of counter parts with TICC, TSF and FEMA.

The most difficult challenge was the rolling terrain, which averaged between 200 and 350 feet above sea level, with only an occasional 500 or 600-foot hill. Two repeaters were installed in abandoned fire lookouts, by using contracted tower climbers.

Ground Support was faced with the task of tracking of over 175 vehicles assigned to Hemphill. Invoices were used to pay for rental vehicles. For an unknown reason, shift tickets, ICS form 297, and “T” cards, ICS 219-1, 2, 3, 4 were not used to track the vehicles prior to the Team’s arrival.

15 passenger vans were used to transport the crews. A 10-person limit per van was implemented for safety reasons. For the number of personnel on this incident, more than 80 vans were required for our 40 crews, and more than 35 support rigs were needed for the STL, FOBS, and Safety officers. However, the number of vehicles assigned to Ground Support when the Team arrived numbered only 65 vans, 16 pick-ups and 2 crew buses. Without the proper paperwork, there was no way of tracking or managing any of them. In order to rectify the situation, a complete physical inventory of everything in the Hemphill ICP was conducted. Data was gathered from each vehicle and matched to the resource orders. Using both the resource orders and our physical inventory, “T” cards were assigned to each vehicle. A database for tracking all vehicles was constructed and updated daily, as we gathered more data. During the same time period, the process was applied to pickups. The pickups proved to be more difficult to find simply because they are not corralled in one parking area. To date, we have identified and paired up with a driver and/or section 100 % of the vans and 75% pickups with E #'s found at the Hemphill ICP. The remaining 25% will be paired with a driver or section within days.

### **Recommendations:**

1. Apply basic ICS practices and utilize the “T” card system to pair vehicles up to drivers and their section or group. The system then can be managed within Ground Support every time there is a driver or crew change. A quick walk around inspection of the vehicle can be performed at the time of the driver change and “T” card update, holding the assigned operator accountable for the vehicles condition.
2. Utilizing the ICS shift ticket, even on a weekly basis, through equipment time would ensure accountability and management of all the rolling stock on the incident. If the information were passed on to Ground Support, utilizing the ICS 213 General Message

form, there would be a paper trail that a blind man could follow. In other words, just get back to basic ICS; it works every time it's used.

Not having clear and formal transfer of property from previous IMT was an issue. An inventory was conducted and most property was located. In the future, on a FEMA incident, all equipment will be physically accounted for prior to assuming responsibility for such equipment. Additionally, equipment responsibility will be clearly defined in the Delegation of Authority.

## **Finance**

We were notified FEMA was going to remove all computer equipment contracted through an East Texas computer company and replace with FEMA equipment on March 25, 2003, 55 days after the incident commenced. The Finance Section was down for most of the day while all equipment at Hemphill was swapped out for FEMA equipment. The swapout took place a day before we were scheduled to demob 16 crews, and this resulted in significant disruption for the time unit. As a result of the equipment change, we lost the capability to provide the Lufkin office with a daily cost report, which ran from a database query on the server. Additionally, on April 6, 2003, we discovered that we lost our ability to FAX FTR's electronically. We used this process at the end of the previous pay period, which was very efficient. There was no indication we would not have that capability for this pay period. The Time and Cost personnel overcame these challenges through hard work.

## **Operations**

Learning the road systems within the search area. There many roads that were unmarked or not identified on the maps. This was mitigated to some degree by using locals working on the incident who assisted with locations needing to be searched.

## **Plans**

Lack of support staff and key unit leader positions was the most difficult challenge faced. This was overcome by working longer hours, developing more efficient methods and training entry level AD's.

## **What changes additions, or deletions are recommended to Wildland Fire Training Curriculums?**

### **Command**

Recommend Federal Response Plan Training for Command and General Staff in preparation for all risk management incidents.

### **Logistics**

Encourage all agencies to adopt similar processes such as ordering and purchasing for incidents, including similar, if not identical, forms used in the ICS system and Purchasing.

More RADO and INCM classes need to be taught at the local and regional levels in order to provide more qualified individuals to Communications Units at incidents.

An introduction to the FEMA ordering system including all contact information would be good for the Supply Unit as well as the IMT, since this could be the future of the IMT's assignments. FEMA has different guidelines to acquire supplies and equipment, such as direct purchasing from GSA, instead of using caches.

### **Plans**

Make training for AD's more available. Due to lack of qualified agency personnel, regions should be more proactive in recruiting and training AD's in support and unit leader positions.

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

#### **Command**

The responsibility of the Incident Commander for property and cost management should have been delegated to the Agency in charge of the incident or included in the IC's Delegation of Authority.

Resources were hard to obtain. This, in part, was due to the lack of information regarding the vital importance of this mission available to participating agencies and the public.

#### **Logistics**

Staffing, filling orders, and filling resource requests are major issues. We suggest possible time constraints within each level. For example: 6 hours at Expanded, 12 hours at GACC, and 24 hours at NICC. If there are no fills by then, they should accept name suggestions. The current system allows orders to go unfilled for days and weeks, and name suggestions are only coming in after those days have been exhausted.

#### **Plans**

Ordering and obtaining additional overhead staff was difficult and cumbersome. If the teams are going to be utilized for increasing "all risk" incident management, the year round availability of additional overhead staff needs to be addressed. Many hours were spent by the planning section locating and ordering personnel for positions that were denied somewhere beyond the incident GACC level. Name requests were dropped or rejected.

#### **Recommendations:**

1. Assign a fill or kill date to all overhead requests, after which all name requests will be honored up and down the ordering chain.
2. Post all UTF's on internet and open to the world.