“OPERATION RESCUE 1999”: AN EVALUATION FOR DISASTER MANAGEMENT

Executive Leadership

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ABSTRACT

A disaster, manmade or natural, happens at least every day somewhere in the world. We all must be prepared to the best possible extent including those efforts for emergency response and mitigation. The performance of emergency responders and ensuring the best possible outcomes of these events require leadership.

The problem that prompted this research is that the Fairbanks North Star Borough annual disaster exercise after action reports noted communications as a recurring area of needed improvement. Past exercise evaluation attempts had not promoted the necessary changes desired. The purpose of this research was to define the essential enabling characteristics of successful disaster response communications. Through evaluation the discovery and documentation enabling factors were identified. To answer the following three questions of this applied research project the evaluative methodology was used.

1. Can evaluations be used to improve performance in emergency management?

2. What are the essential and enabling communication elements that should be identified and evaluated in a disaster response to prompt improvement?

3. What specific elements within the FNSB disaster response system can be identified for improvement to occur?

Research through literature review was used to identify the potential influencing communication factors in relation to this project and the characteristics of an effective evaluation for a community disaster response exercise. Exercise evaluation data was used in an attempt to answer the last research question.
The literature research clearly documented and emphasized the use of evaluation for program improvement and that to be successful the evaluation must focus on the process. Communication enabling elements were identified. Local elements identified for further improvement in disaster communication response as a result of this evaluation are communicating the plan, receiving and providing enabling information, establishing a sound command structure, communication liaisons, operating in task groups and sectors, and finally personnel accountability.

A summary of recommendations made as a result of this research project is as follows:

1. Needs assessment, planning, goals and objects, and evaluation are essential to community disaster preparedness.

2. Predefining organization structure is important to disaster response effectiveness.

3. Communication plans must take into the account the dynamics of the communication process.

4. Communication enablers, such as liaisons, must be present and to insure there is a mechanism for both upward and downward information flow.

5. Program evaluations, to be effective, must be comprehensive enough to identify the gaps in the process.
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INTRODUCTION

A disaster, manmade or natural, happens at least every day somewhere in the world according to the American Red Cross Disaster Word Watch Web Site. We all must be prepared to the best possible extent including emergency response and mitigation efforts. The fire and emergency services have always been willing and eager to assist in any disaster situations. History and public perception has held the service in high regard due to this willingness to serve at any time, no matter what the challenge. However, as the fire and emergency services field has become more professional along with the sophistication of society in general, just a “good” effort is becoming no longer acceptable. The cost of government, increases in education standards and the American legal system has also caused increased attention and rightfully so, to the performance of those involved, and most importantly to the outcome of these events. To say everyone got together and tried their best, and of course “meant” to do their best, is just not good enough anymore.

The fire and emergency services of the Fairbanks North Star Borough participate in a regional wide mutual assistance program. Every year the borough holds a full-scale field disaster drill to test emergency response preparedness. Each of these exercises during the last few years has been documented in some manner or another with an after action report. It was apparent from the review of these past after action reports that emergency responders are doing fairly well with the technical and micro aspect of the
exercises such as firefighting skills, rescue skills, patient care skills, survivor services, and hazmat skills.

The problem that prompted this research is that every year the after action reports of the annual exercises consistently reported communications as a re-occurring area of needed improvement. The vision to where the borough emergency services communication needed to be in a disaster response has been strong; however, a clear and workable pathway to that vision has never materialized. Current exercise evaluation methods have not promoted the necessary changes desired.

The purpose of this research is to define the essential enabling characteristics of successful disaster response communications. Once the enabling elements are identified, and an evaluation method developed and planned, this would then document communications during an exercise. Then using the findings implement improvements in communications and organizational structure which should and or could occur. The research used to conduct this study was the evaluative method in an attempt to discover and identify the significant enabling elements required to improve the Fairbanks North Star Boroughs disaster exercises and in particular “Operation Rescue 1999”. Research was used to answer the following questions:

1. Can evaluations be used to improve performance in emergency management?

2. What are the essential and enabling communication elements that should be identified and evaluated in a disaster response to prompt improvement?

3. What specific elements within the FNSB disaster response system can be identified for improvement to occur?
BACKGROUND AND SIGNIFICANCE

The community of Fairbanks is situated in the geographical center of Alaska on the banks of the Tanana and Chena rivers. The city and Fairbanks North Star Borough is home to 84,301 people (U. S Census Bureau), the University of Alaska, two military bases with airfields, a international airport, and is the gateway and commercial supply center to the Interior region of Alaska and the North slope. Recently tourism has also become a major community development factor bringing large numbers of tourist in the summer and winter with a total number equivalent as the community itself over the year (80-90,000). The borough has a landmass of over 7,404 square miles, approximately the size of Massachusetts (U. S Census Bureau). The city has a typical downtown, urban, and industrial core with the rest of the borough being rural. The closest neighboring urban area is Anchorage, which is 358 miles south across the Alaska Range, on a two-lane road or by air. The next significant urban center (U.S.) is Seattle 3500 miles away by air. Needless to say in the event of a disaster, help is what is available at hand. The rest of the state’s population is in even smaller isolated city, rural, and bush communities. Bush, by Alaskan standards, meaning isolated by lack of a highway. Weather in Fairbanks adds to the challenge of disaster response. Fairbanks is in a sub-artic climate, with snow over eight months of the year, with normal every day mid-winter average temperatures of –2F. to –19F, with lows to –70F.

The Fairbanks North Star Borough has seven public fire and rescue departments and three rescue organizations serving the community. The two military bases within the borough each have full air crash and structure departments along with, ambulance,
police and air med-e-vac capabilities. Both the State and Federal government operates significant air and land based wildland forces out of Fairbanks during the summer months. Additional initial disaster response agencies include the American Red Cross, Fairbanks North Star Borough Hazmat team, Fairbanks North Star Borough Office of Emergency Management, Army National Guard, Alaska Air Guard, and the local medical center. All fire rescue and ambulance departments are part of the Interior Fire Chief’s Association mutual-aid agreement. Alaska State Troopers, Fairbanks City, University, Airport and Military provide police protection in their respective jurisdictions and also operate under a mutual assistance plan.

Emergency 911 Public Service Answering Point (PSAP) dispatch and radio communications in the borough, is handled by a unique Enhanced 911 system and 5 separate PSAP’s and dispatch centers. The Fairbanks North Star Borough Office of Emergency Management coordinates all E911 PSAP functions; however, the five centers operate rather independently, although linked by technology and automation.

The borough’s emergency management division, the Interior Fire Chiefs Association, and the local police agencies, have lead the coordination effort for almost all emergency response and disaster exercise efforts in the borough. The borough emergency management division has initiated the annual exercises, and kept the proficiency and the importance of readiness for disaster response high on the radar screen. Every three years the exercise is held at the Fairbanks International Airport to meet FAA airport planning and exercise requirements.

The Interior Fire Chief’s Association and most recently the police chiefs association have developed written mutual aid agreements that coordinate the inter
agency response and aid on major incidents. The Interior Fire Chief’s Association developed the *Mutual Aid Communication Plan* (1998) to address the communication of multi agency incidents and the transition from small to large incidents. Unfortunately, despite continued “best” efforts, communication issues remain a source of needed improvement in every exercise.

In the 1993 Airport exercise evaluation the major recommendations were:

- More information for arriving units. Units arrived assuming that their preplanned role would be their primary role, only to have it changed.
- Suggested use of visual communications e.g. vests and a status board to keep track of units and tasks assigned.

In the 1996 Airport exercise evaluation communication was again specifically noted as:

- Some MA agencies could not contact the IC (either by not knowing how, or unable due to technical limitations)
- Responding agencies did not know who to report to in staging (no visual communication identification)
- Some agencies did not know what channel to communicate on.
- Ambulance crews did not know to whom to report to on scene.
- Communication of on scene transport area not communicated (verbally or visually)
- Communication between medical personnel was coordinated between themselves; no information given to or direction from the command structure.
- A recommendation that an established communication plan was needed.
In 1998 a borough wide exercise was held at Ft Wainwright (train vs. bus, a non-airport incident) and communications was again the primary issues noted in the evaluation:

- No reliable mechanism to communicate between radio frequencies.
- Incoming apparatus assignments and coordination was very difficult.
- Incoming units did not bring mass casualty equipment. Mass casualty equipment was not requested nor dispatched as such.
- Information was not always transmitted to the IC nor confirmed with the IC. This allowed false rumors to change the way tasks were performed and caused inefficiencies in handling the incident.
- IC was unaware of access need of specific task units, so could not assign assistance thus delaying task accomplishments.
- Check in at staging during the incident was not always followed by incoming units.
- Recommendation that communication to area hospitals is through one source of communication, a departure from day to day procedure of each ambulance giving its own detailed report.
- Recommendation that all persons authorized to work in and around the ICC, Staging, shelters etc., wear easily noticed (visual communication) armbands vest etc.

The National Fire Academy (NFA) course on Executive Leadership provides a model to employ appropriate strategic leadership processes to key organizational
subsystems. These subsystems are Technical, Structural, Managerial, Values, and Psychosocial. In this analysis and study the action subsystem is structural as the Communications and Information flow within the Fairbanks North Star Borough disaster response exercise will be evaluated. A key part of the NFA’s executive leadership program is to employ key processes at the executive managerial level for organization and personal improvement. Analysis and evaluation which when done, comprehensively and properly will allow for effective program improvement. (NFA, 1996)

LITERATURE REVIEW

This applied research project started with a literature review of articles, books and other publications on the subject of disaster exercises and evaluating communication processes at the Learning Resource Center of the National Emergency Training Center in Emmitsburg Maryland. It continued at the University and State of Alaska Library systems located at the University of Alaska Fairbanks, and from materials on the Internet. There is a significant amount of material on disaster management within the fire service literature; however, detailed studies and or guidelines on the evaluation of the communication processes, especially in association with disaster response and management, was noticeably limited. General social humanities and business literature provided better insight on the role of evaluations, process options to use, and to implement change on a general management level. It
seems that business, public education and health care managers have had considerable experience with program evaluations.

According to Bahme and Kramer in *Fire Officers Guide to Disaster Control* (1992) the evaluation of disaster response operations is the key to improvement of the emergency management program. “The evaluation is a systematic comparison of the outcomes of emergency response efforts to the response goals, objectives, and priorities established in the emergency operations plan. It is intended to identify specific changes in the operation required. As a final step in the evaluation process it is often useful to summarize and document the response to an incident or exercise in a case study. A great deal will be learned about what actually happened as participant viewpoints, experiences, and documentation is collected” (p. 538).

To be successful, an evaluation according to Kaufman and Thomas (1980) needs to linked with a needs assessment, with planning, and accompanied by specific goals and objectives. The evaluation can then be used to determine what is working, what is not working, what to change, and what to keep. “Evaluation is a process used to assess the quality of what is going on. Evaluation, if used correctly will provide quality control by identifying elements between what happened and what should have happened” (p.4).

The term evaluation often conjures up threat and blame placing. Evaluators have often been confused with judges and auditors. This is an incorrect use and interpretation of evaluation. “Evaluation is the determination of the gaps that exist between what you set out to accomplish and what you have accomplished” (Kaufman; Thomas, 1980, p.53). A key area for evaluators themselves is to report specific events
and to indicate the consequences of what they observed according to the Federal Emergency Management Agency (FEMA) on conducting disaster exercises. (1984, p.189)

Bachtler and Brennan (1995) describe evaluation as a management task that focuses on determining whether the plan is being executed. They perceive that this task is all too often treated superficially as it does not have a great deal of immediate response to most fire and emergency service managers and leaders. In their work Bachtler and Brennan cite that most all of contemporary management literature implies that evaluation is as important process as any other planning or management function. (p.12)

The National Fire Academy’s Strategic Management of Change Model also highlights the role of evaluation in change management. The change model first step is to analyze the existing organizational culture and assess what if any changes need to be made. Second, the model takes the information gained in the analysis to formulate a plan to bring about any desired change. Third, the change model implements the procedures and strategies detailed during the planning stage, and assures that they are executed, and behaviors are most likely to insure a successful outcome. And finally, once the changes are made, to continuously monitor and evaluate. The evaluation then relates to a new round of assessing the new status of the organizational culture and additional new changes required. (NFA, 1996)

According to FEMA’s Disaster Management Exercise Design (1984), the two reasons for evaluations are to identify needed improvements and to determine if the exercise has achieved its objectives. FEMA differentiates an evaluation from a critique.
“A critique is a debriefing by the players/participants to share viewpoint about what happened during an exercise. An evaluation is a written report based on observations of an observer or observer team for the purpose of improving the emergency management response and or system” (p.198). The evaluators collect data, which consist of observations, expected actions and procedures. This data may identify problem areas and/or provide measurement of the effectiveness of the operations. Determining data collection requirements starts with planning and design, based on the specific objectives of the exercise. Briefing evaluators is very important. Evaluators should be provided with a template that will allow anticipation of actions and reactions during the exercise. This is especially important in situations that require communication of information, decision making, and resources allocation. The template will show what event(s) are to occur, with who and when, and most importantly what processes and or enablers should be observed or looked for. (FEMA, 1984)

Kramer and Bahme (1992) listed specific aspects that should be documented to evaluate all incident exercises. Those applicable to this research are structure and control, notification processes, and communications. Defining the command structure and determining if it was effective, and setting and communicating the incident strategy and tactics, was important. This predefined structure along with mutual aid procedures in place, are necessary for control and coordination among all agencies participating. Kramer and Bahme listed alerting and notification as an important disaster incident enabler, as is how and what information was provided is critical to response success. Finally communications, information needs to be sufficient for responders and command to plan and react appropriately. Providing complete size up and situation statuses was
Communication is repetitively cited as a key in managing change, defining cultures, and improving operating efficiency. Much has been studied and written in the art and science of communicating. Taylor in *Communicating* (1977) describes communication as “a process composed of interactions among many elements, which is continually on going” (p.24). The model Taylor uses has eight descriptive elements to identify the process of communication basic essentials. The Taylor model defines communication as a complete process that happens when (1) information at a source, that (2) causes stimuli (transmission), (3) to a receiver, who (4) receives the information, then (5) interprets and process the information and (6) provides feedback via (7) action or in context. Any interference in the communication process is defined as “noise” and is considered the eighth factor in the model. (p. 24) Noise is further defined as internal and external. Internal noise is those factor(s) that interfere with the processing of the information by the sender or receiver. Examples of internal noise can be mental distractions, loss of concentration or a language barrier. External noise interferes with the transmitted information being received at all. Examples of external noise could be background sound, transmission interference, and poor lighting (in visual communication). In evaluating communications in a group and or on a network level Taylor (1977) provides two basic clues “Distinguishing between transmitted messages and received messages is important because a common breakdown is the difference in actual and received stimuli” (p.7). and “For communication to occur, both a source and a receiver are needed” (p.8). Carter and Rausch (1999) provide three additional
communication clues to enhance emergency operation communications. They are (1) A
good understanding of the communication process to be used, (2) attention to
standardized messages and or instructions that both the sender and receiver
understand the meaning, and (3) the feedback that the receiver understood the
communication.(p.98)

A different insight in emergency disaster management was looking at literature
from business, and in particular what the nuclear industry has planned for disaster
management. In the paper *Demonstrating Proficiency*, Sikich (1999) emphasis
templates, focusing on the strategic goals, creating systems for superior information
flow, practice upward as well as downward communications, and creating a seamless
vertical and horizontal structure that enhances communications within the ICS system
as necessary for success. Because of the limited opportunity to need to use disaster
management in the nuclear industry, and the very high profile nature and political need
to demonstrate proficiency, exercise evaluation is critical. Evaluation serves two
important functions according to Sikich. Evaluation of the exercise is critical to the
continual improvement of the management and response capabilities. The evaluation is
also used to verify proficiency in the demonstrated exercise. Sikich suggest using a
template for the evaluator that shows the anticipated response with the observed
response of the participants being evaluated.

In summary, the literature thoroughly demonstrated, that to be successful
evaluation must be accompanied with a need assessment, planing and goals. Further,
through evaluation, many gaps in the process can be characterized and improvements
can be made based on the documented findings. (Kaufman; Thomas 1980)
Organizational structure, incident management process, notification and size up, and status reports are enablers defined by Kramer and Bahme. (1992) The literature provided specific exercise enablers to focus on during evaluations such as information flow upward and downward, templates, and the pathways. (Sikich, 1999) The importance of the process of evaluation to the program, and organizational and individual success is stressed in the National Fire Academy’s Executive Leadership. (NFA, 1996) Also, Carter and Rausch the writers of Management in the Fire Service, recognized the importance of evaluation to the effectiveness of emergency management and response: “The purpose of evaluation is to provide the information a department needs that will make it more effective. Sometimes evaluations of the past efforts do not, by themselves, provide adequate and sufficiently detailed information for effective improvements. That’s when the cycle needs to start again from the beginning, with revisions, new efforts, and a new evaluation to identify the critical elements that will make the latest effort more effective than the previous” (p.192).

PROCEDURES

To answer the three questions of this applied research project the evaluative methodology was used. Research through literature review was used to identify the characteristics of an effective evaluation for a community disaster response exercise. Potential influencing communication factors in relation to this project were identified by using published disaster planning and incident command checklists. An evaluation template was created for each significant area of the exercise. This researcher was able
to use exercise evaluation data for identifying those characteristics of improving disaster
exercise communications in an attempt to answer the last research question.

Initial research was conducted at the Learning Resource Center at the National
Fire Academy in Emmitsburg, Maryland. The University of Alaska Library was also
used to research materials pertinent this project. Additional related material was also
found on the Internet at the following sites: U.S. Fire Administration
(www.usfa.fema.gov); The U.S department of transportation Federal Aviation
Administration (www.dot.gov/faa); and the American Red Cross (www.redcross.org).
Finally, historical information on past exercises in the Fairbanks area was obtained from
the Fairbanks North Star Borough Office of Emergency Management, and the Mutual
Aid Communication Plan for multi agency responses was obtained from the Interior Fire
Chief’s Association. (1998)

Past borough disaster exercise evaluations were based on only general
observations of no more than a few evaluators. Often these evaluations highlighted
vague deficiencies that were known to the evaluator, rather than documenting all the
was developed to focus on the communication and the incident coordination elements
essential for the successful and efficient mitigation using ICS. The evaluation process
was designed so observations by evaluators would be made and noted from each side
of the operational and communication interface. A structured format was utilized to
identify communication successes and identify elements of needed improvement. It
was also thought to use the evaluation process in itself to help promote improvement in
the exercise. This was to occur by pre-identifying essential communication benchmarks
that the evaluators would be looking for and to make these enablers known to all participants. The evaluation benchmarks were derived from the Incident Command System (ICS) checklist which are available from fire and emergency services sources. Also used and consulted in determining specific items for this research evaluation template was the Interior Fire Chief’s Association Mutual Aid Communication Plan (1998), the Federal Aviation Administration Advisory Circular on Airport Emergency Plan (1998), and exercise checklist found in the FEMA Disaster Exercise Planing Guide (1984).

An evaluation form was developed for each evaluation position. Two types of forms were developed. A general form (appendix A) to be used in evaluating at and with each participating agency, and a ICS function specific form (appendix A) for each identified major ICS communication point based on the IFCA mutual aid agreement and communications plan thought to be required in this exercise. After identifying possible communication characteristics that could effect each agency response, the next task was to identify specific sectors and or ICS functions with potential communication interaction not covered by the general form. The sector or ICS function specific evaluation forms were developed to track organizational structure and communications during the exercise that were considered unique and when additional information was warranted and needed beyond the general evaluation form template. The areas where there was an ICS or sector specific form for evaluators to use in addition to the general form were identified as follows. The Airport Dispatch Center, would be the initial call receipt agency, and primary jurisdiction dispatch center. The University Dispatch Center, would be the borough emergency operations center and dispatch for 2nd due
agencies and the majority of mutual aid. The First Due Airport Crash Fire Rescue and Operations sector would be responsible for setting the tone and structure of the incident. The Incident Commander would manage the incident. The Incident Command Center room at the airport was the dedicated and eventual fixed command site. EMS would have a major coordination communication effort. The Hospital would be a remote fixed site with special communication requirements. And finally, the Airline, as they are not normally an emergency responder, although in an airport incident would have a vital communication role and the management of passenger relatives etc. These areas for evaluation were identified and selected from the Interior Fire Chef’s Association *Mutual Aid Communication Plan* (1998) as central communication pathway centers. The unit forms were developed to be a template of 18 enablers and expectations. Each evaluator could look for the 18 enablers and expectations during communications, and structure of the exercise, if all agencies were to follow ICS and the IFCA communication plan. The ICS function forms had four to twenty thought-to-be essential communications items that were thought to effect communications and ICS structural items, that the evaluator was expected to look for and document in that sector.

The evaluation benchmarks and forms were distributed at the May 7, 1999, pre-exercise meeting and the May 12, 1999, IFCA meeting. This made it possible for all responders and participants to review, comment, and have an opportunity to revise the evaluation template forms. By pre-distributing materials to all potential responders, it was also an attempt to allow everyone to become familiar with the essential benchmarks for successful incident management and communications, and what the evaluators would be looking for during the exercise evaluation.
The evaluation process and forms were pre-tested during a mini-mass casualty exercise held at the University of Alaska on Tuesday, May 4, 1999, with University, Chena Goldstream and Steese Fire Departments participating. Although much smaller in scope, it allowed hands on evaluator and participants input into the development process.

On Friday June 4, 1999, the Fairbanks North Star Borough disaster exercise “Operation Rescue 1999” was held. Each operating agency and each defined ICS function or sector for this specific exercise was assigned an evaluator to observe and record communication and incident coordination. Each evaluator was to shadow the agency, and or assignment area throughout the exercise. An hour and a half before the start of the exercise the evaluators were briefed with last minute details, and given their evaluation form and assignments. All evaluators had some military and or emergency service experience. Some evaluators had extensive multi-agency ICS experience; however, the rest had limited practical experience in multi-agency ICS and in evaluations. This difference can be noted in the results, especially on the amount of significant information provided for this project.

The exercise was scheduled and commenced at 1600 hours. All evaluations were returned within 24 hours after the end of the exercise, with the exception for one unit that supplied a single ems transport unit, no evaluation was ever received. To quantify the data received the information was summarized and plotted shown in Figure 1. Evaluator’s comments and thus the enabler were ranked as optimal, less than optimal, not per the plan, and not recorded by the evaluator.
RESULTS

Figure 1 shows a summary matrix of the evaluator’s observations for each responding unit. Summary results for each identified enabling communication benchmarks as identified for evaluation is as follows. Records of the actual evaluator comments are found in appendix A in their entirety.
"Page Not Available. Please visit the Learning Resource Center on the Web at http://www.lrc.fema.gov/ to learn how to obtain this report in its entirety through Interlibrary Loan."
1. *How was each group activated to respond?*

Evaluators noted that almost all units were dispatched via radio through regular emergency dispatch procedures. Three exceptions did occur, two military units were pre-staging (due to being a planned exercise) and were activated by staging, American Red Cross was not initial notified, however, was also pre-staged and self dispatched when a task became known or assumed.

2. *Was activation/dispatch information sufficient in describing incident and groups initial purpose for responding along with a respond to location?*

Half of the evaluators from their perspective saw this as yes, with the notable exceptions of those who were not initiated by their normal dispatch agency. With the two military units and ARC the evaluators noted frustration with unknown purpose until these units “found” a home at the exercise. Information for two agencies was not noted.

3. *Did group respond as a task force or independently?*

Evaluators noted that all responding agencies responded and stayed in a task force concept (ones that had all same agency units working together on the same task with a commander) only exceptions were one single unit ambulance provider, and the American red cross personnel which responded and operated independently.

4. *Did the group communicate its response staffing (i.e. medic four-w/3 emts etc…) and its staging location to the staging officer (IC if no level II staging had been declared)?*

Evaluators noted that most units provided this upward information with two exceptions, the initial responding units nor the American Red Cross broadcasted their unit strength. A couple of evaluators did not comment on this enabler for their assigned unit.
5. In staging on location, and or scene how was the group given a task assignment?

Evaluators noted two methods of task assignments, via radio, most commonly on the mutual aid radio channel, or by face to face with the sector officer. For three agencies evaluators did not comment on this enabler.

6. What task was it?

Evaluators noted that in every instance all responders were given a clear and specific task.

7. Did group have a liaison at the IC or directing division or sector officer location for the purpose of coordination?

Evaluators did note that most units did have a chief officer liaison with the area division/sector officer or eventually to the IC area. Two units were noted as not having liaison. Several evaluators noted that there was significant difficulty establishing a liaison with the IC.

8. Did group use proper communication channels?

Evaluators documented that all agencies used one or more of the appropriate (per IFCA Communication Plan) approved methods of communications a. Own frequency for intra group communications, b. Mutual aid frequency, and or face to face with IC. c. Face to face for all assignments at level II staging and d. Medical frequency for EMS sector command and hospital communications only. The only exception to this was the IC evaluation, which noted the IC did not make himself available for face to face or on the mutual aid frequency.

9. Did group communicate to its liaison, IC, or division sector officer, the following?

Evaluations showed that six agencies did provide some upward communications, although one was delayed. All six provided their location of operations and five provided
information situation found. However, only four of the ten were documented with any report of progress being made and three with request for additional resources.

10. Did group adequately update the IC through its liaison or division and or sector officers of progress or lack thereof or any special challenges?

   Evaluators noted that seven of the ten agencies did provide communication on special challenges. In two evaluations no observation or comment was made, and one evaluator noted that its agency was disappointed that the IC didn’t contact them in a timely manner about progress.

11. Did group try to appropriate or reappropriate any non-group resources without going through command?

   Evaluator noted on two occasions, in the EMS sector, that units tried to appropriate equipment without going through command sequence for resources. One event involved getting additional backboards and the other was unspecified. Evaluators did not note the reason for the freelance action.

12. Did group stay together in its tasks?

   All groups evaluated stayed together according to the evaluators.

13. By who and how was personnel accountability maintained?

   Five agencies used their chief officer on scene as maintaining accountability, Evaluators report three agencies deferred that effort to the airport staging officer, two had no comment for this enabler, and one evaluation cited the agency used the “person in charge”.

14. Was group able to accomplish task, describe challenges – accomplishments?

   Evaluator noted eight groups were successful in accomplishing assigned tasks. Evaluators for two groups did not comment on this item.
15. Did group inform IC of task assignment being completed and ask for reassignment of their units?

Six evaluators noted that their observed group did notify the IC of assigned task being complete and for reassignment. This category was not noted for three groups. And one group did not notify command.

16. Did group go through any rehab and or debriefing?

Only four groups were noted as going through any rehab or debriefing. Evaluators specifically noted that three agencies did not rehab and or debrief. No comment was provided for three evaluations.

17. How did the group demobilize?

For six of the ten units there was no notation of how the group demobilized. Two were noted to released by staging, one by the operations sector, and only one by the IC.

The eight command structure elements of “operation rescue” that were identified in this project as pathways of communications were observed by an evaluator. These were the first due and operations sector, the two dispatch centers, the incident commander, the incident command center, the ems sector, the hospital, and the airline.

Summaries of evaluations based on the evaluators templates for each area are as followed. The actual evaluator comments in full detail can be found in appendix A.

First Due - Airport CFR, operations

Evaluators noted that first due units provided a good running account over the radio, both of the situation and the assignments being given. First due units were noted to have divided the incident into initial task assignments. Airport CFR operations,
University medical sector, and Airport police to provide security and staging. First responders also were noted in determining additional needs and resources and requesting such in a timely manner. The initial responders followed and implemented the airport emergency plan. Command was subsequently transferred and the first responder chief officer became operations officer.

*Dispatch - Airport*

Evaluators noted that Airport Dispatch originally was alerted to the incident via phone. Information amounted to two planes wrecked, the location, and that there were many casualties. It was noted that dispatch did not attempt to gain additional caller information. Evaluators then noted that Airport Dispatch notified University Dispatch of the incident, and no benchmark nor resource request was made other than that there was an incident at the airport. Evaluator noted that there was request from University Dispatch for specific resource requirements, and that due to the lack of specific request or benchmarks there was some confusion. A specific challenge noted was that a request to the military medical air transport helicopters (MAST) had been made, and not till after the second call (unknown how) MAST was dispatched to the airport, unknowing of the prior request. The airport dispatch operated out of the airport ICC. It was noted that it was expected that the IC would be at the center. Evaluator noted dispatch-fielding traffic that would have been more appropriate going to the IC, or would have been the case if the IC had been stationed at the ICC.

*Dispatch – University*

Evaluators documented that University Dispatch was notified by a 911 phone from airport dispatch with the data that an aircraft accident had occurred between a 707
and a C-46, 40-50 injuries, fuel spillage, and the location. University Dispatch did attempt to confirm 707 not a 747, and wind direction. Evaluators also noted that University Dispatch internally benchmarked as a most severe, an alert III, and dispatched University Fire, Ester Fire, Steese Fire, and Chena Goldstream Fire and Rescue Departments (all agencies within University dispatch jurisdiction) and that the dispatchers gave out the exact information on the incident as received. The evaluator commented that University Dispatch had minimal request from airport and was left to find out detail through other channels.

*Incident Command*

The Incident Command (IC) communication evaluation noted that at no time was there a well defined or central established location for the IC for radio and or face to face communications. Command was transferred three times, from the first responding units, to the next senior officer, and then to the airport manager in quick succession. Evaluators noted that before the first command transfer was complete, the airport manager arrived and immediately assumed command. This transfer was announced over the radio, evaluators noted there was little or no confirmation from operating units. Command did not take on an incident identifier. Evaluators noted a very good size up by initial responders. Evaluators documented at no time did the IC communicate the overall incident objectives and priorities. However, it was noted the operations and medical sectors did have a plan and communicated such. The evaluation stated that it was extremely difficult for agencies to have a face to face liaison at the IC, as the IC kept moving about in his vehicle. However, documentation did show that three agencies did attempt to provide liaison with limited success. Evaluators noted that the IC was not
updated on the incident. Evaluator noted information was coming in from operations and medical sectors, however not reaching the IC, nor was the IC aware of completed tasks in most cases.

*Incident Command Center*

This evaluator noted that the Incident Command Center (ICC) never functioned, as an ICC due to the lack of the IC being present to coordinate with command staff. The center did function as a logistics center, but again with no guidance’s, strategic or otherwise from the IC. The evaluator noted that several agencies and group reported to the ICC as was in the plan to find no IC and or direction. This evaluation stated that the IC had little if any communication contact with the ICC and believed the IC tried to do everything himself.

*EMS*

The evaluation for this special section showed that a medical sector officer was assigned very early into the incident, however the medical sector did not provide initial size up information on the scope of the medical challenge upon arrival. Visual communications (vest, cones, and tarps) were used to set up and clearly identify patient handling; equipment cashes, and transport areas. Face to face communications was used to coordinated ems, rescue, and transport resources once they were assigned to the medical sector. Evaluator noted that transportation officer was tasked with tracking patients and hospital contact via radio, and that this contact was not as organized or frequent as it should have been. The evaluation did note that the medical officer provided the IC with periodic updates and resource requirements.

*Hospital*
Evaluations noted that the hospital received the first report of the incident fifteen minutes into the exercise from University Dispatch via a phone call to the emergency room. Information provided that a mass casualty incident had happened at the airport in the form of a plane crash. Planes involved were a 707-passenger jet and a C46 cargo plane. ER was told to expect 40 to 50 casualties, the call was then transferred to administration who also took the same report. Information was sufficient for the hospital to initiate their Mass Casualty Incident (MCI) plan. Hospital evaluators noted that a liaison was sent to the incident site winding up at the ICC. Phone lines were used to maintain this link after the cell phone failed. It was noted that the incident transportation officer and hospital did have an established radio communications throughout the drill. Evaluator noted that a re-supply and re-stocking point was set up and the IC had been informed. Only one ambulance used the re-supply. Evaluators noted that visual signs were posted for relatives, and triage was not as clear; however, security did a good job redirecting.

Airline

The Airline evaluator noted that the airline first notification came from a casual report from an airline ramp worker five minutes into the exercise. It was also noted that no formal notification from IC or ICC was received. The Airline did send a person with a cell phone to the mobile command post, when was not documented. This evaluator noted that communication from command was lacking. Another challenge documented was that of the functions of the American Red Cross and the Airlines was not coordinated.
DISCUSSION

This applied research project sought to use program evaluation to improve communications during “Operation Rescue 1999” and to promote improvement in future disaster exercises and responses within the Fairbanks North Star Borough. This was by identifying communication processes needed for success and by evaluations identifying the communication enablers that needed further attention. The literature research clearly documented and emphasized the use of evaluations for program improvement, and to do so mandated focus on the process. The only time evaluation was not cited as affecting improvement, was when evaluation was “not taken seriously; not focused on discovery of improvement details; and not comprehensive enough to discover the true gaps in the process desired” (Bachtler; Brennan, 1995, p. 12). The literature also identified communication elements and enablers that would be necessary for this exercise and project. For effective communications during a situation such as in disaster management predefined structures (ICS) communication plans must be in place that are used. This will allow senders of information, to transmit the required message to a receiver and have that message interpreted properly with the desired action or feedback. The process must be comprehensive enough and in at least two directions - upward and downward to support strategic and tactical success in disaster management. (Sikich, 1999)

A significant unplanned occurrence happened during the exercise, which after evaluation reinforced many communication enablers, and the premise of the incident command system (ICS) itself. In an unexpected move during the exercise, incident
command (IC) was quickly transferred to the airport manager within the first few minutes of the exercise. This transfer was unexpected in several ways. First, transfer of command to this level wasn’t expected until fire and rescue operation units got initial response actions going. Also, a field experienced emergency services IC was expected to command the first portion of the exercise. Secondly, it was expected that when the airport manager did assume command, it would take place and or the IC would move to the designated Incident Command Center. The designated Incident Command Center was at the airport to coordinate strategy and the vast multi-agency responses to this scenario. However, the airport manager as IC, isolated himself in a staff vehicle with only one radio, and a cell phone near the exercise accident scene. This unexpected action could be contributed to an inexperienced IC who became focused on operational tactics rather than the overall strategy, and incident coordination. This event caused significant communication and resource bottlenecks that were identified in this exercise evaluation. Nonetheless, the multiple point evaluation showed that through the pre-determined communication plan many task functions achieved success although not as well coordinated as could have been.

Despite the aforementioned command structure surprise, the results did show that communication did significantly improve in several predefined areas. Previous exercise after action reports had noted that units often did not know what channel to communicate on. In this exercise, evaluators documented that every unit used the proper radio and or face to face communication method. Past after action reports also cited that responding units felt a need for more information as to what task, and or to whom or where to report, was needed. In this exercise and evaluation, all units that
were dispatched according to the Communication Plan, seven out of ten, did receive sufficient information to respond appropriately. These seven checked in with staging per the plan, and then were given a task assignment, which they completed rather well. The three units that were not dispatched per the plan, or did not follow dispatch procedure, did complete their tasks, however with some communication difficulty. Past after action reports noted communications with the hospital could be improved. This exercise demonstrated that with a plan, and communication enablers in place, this effort was much more successful. In fact, a veteran emergency responder who evaluated the hospital communications noted "most adequately informed" during the drill, a first for the hospital during a disaster exercise in the FNSB. Finally, previous after action reports called for better visual communications - vest, armbands, command and sector id. The communication plan addressed this issue and it was noted that staging, the ICC and EMS areas were well delineated visually and caused little confusion. All command personnel and sectors had vest on, the operations, staging, and EMS post were clearly identified. Traffic cones were used to funnel ems transport units and patients in and out of the triage, treatment, and transportation areas. Colored tarps were used to identify the separate areas of the ems triage sector.

Successful communication includes the proper message being sent in and received in a timely manner, and results in the desired action (Taylor 1977). It was found through this exercise and evaluation, that overall agencies that had a better grasp of the communication enablers generally had fewer problems. Interestingly, the one agency that had the most difficulty was also the one agency that did not perform the communication enablers to an optimal level most of the time. This research also
showed that communication templates, including the Interior Fire Chief's *Communication Plan* (1998), can be very successful if simple to implement and attention is paid to establishing the essential structural and communication benchmarks. One such enabler that can be improved requires agencies to put a liaison in an area to act as a communication advocate (a dedicated communication receiver and sender) for both upward and downward information. As was noted in the evaluation, several units did not provide upward information or a liaison at a command or sector location. The one agency that had most documented difficulty in this exercise was also the only agency that was documented to have the expectation for the IC to check in with them.

The research demonstrated that in the future attention to the process is required for continual improvement. The processes that the Fairbanks North Star Borough need to focus on as a result of this evaluation are: planning and knowing the plan; receiving and providing complete and enabling information in a timely manner; establishing a sound command structure; providing communication liaisons; keeping a manageable span of control and communications by operating in task groups and sectors; and finally personnel accountability.

The implication of this study is that evaluation, done well and comprehensively is an extremely important part of an organization and its programs, and is necessary for change and success. Through this evaluation and research, it was found poor or wanting communications may often be of our own doing. A serious look at communication enablers that ensure success needs to be done to insure it is meeting the challenges of our unique needs in disaster response. Deficiencies in
communications by design, or by omission, to be effective, program evaluations need to be comprehensive and specifically address the issues that will make a difference.

**RECOMMENDATIONS**

The purpose of this research project was to define the significant characteristics of the communication challenges during multi agency disaster response. Using this information and the evaluation process to stimulate improvements to the regional communication plan, and or its implementation, can improve disaster response efforts and minimize the consequences of such disasters on the Fairbanks community. These recommendations are made as a result of this research:

1. Performing need assessments, developing a plan, establishing goals and objectives, and evaluations, are essential to community disaster preparedness.

2. Organization structure is important to disaster response effectiveness. This structure must be predefined, known by all, and exercised regularly for successful disaster management.

3. Communication plans must take into account the dynamics and each element of the communication process. Once identified, to be put in place to assure these communications enablers are present when needed.

4. Key communication enablers must be present as so information is provided both responders and the command structure. There needs to be a mechanism for both upward and downward information flow. One key recommendation is that of placing a
chief officer from each operating unit or task group in a liaison position at the command center to facilitate this communication link.

5. Program evaluations, to be effective, must be comprehensive enough to identify the gaps in the process desired and be linked with assessment, planning, and finally the goals of the effort.
REFERENCES


APPENDIX A

“OPERATION RESCUE 1999”

EVALUATION FORMS
Evaluator observations and comments:

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First Due Operations

Group evaluated: Airport CFR
Evaluator: Steve Adams

1. Was an initial descriptive size up provided which included?
   a. Location
      Yes Responding units were strategically located to deal with obvious size up issues
   b. Situation found, including a description that help incoming units, chief officers and dispatch to get a handle on potential resource needs and task requirements. First in IC gave running account on radio as to what he was observing, implemented Airport emergency plan, and initiated follow up actions
   c. Initial objectives and tactical action to be taken by first in unit(s)
      Initial IC made assignments to available crews and as exercise unfolded made full use of arriving
   d. Establishing initial IC
      First in IC staged where he had a good view of the scene, announced his location and stayed at that location during the exercise.

2. Did first due IC divide incident into initial task assignments for incoming units
   I.e. Incident Stabilization (cash-fire) Upon arrival at scene
        Medical sector/officer Assigned to UAFFD, UAFFD BC designated area to be used.
        Area Security established
        Staging sector/officer. Established (prior to exercise)

3. Did first due IC define need and request specific resource assistance?
   Yes. Needs were established and resources requested. Additional resources were requested and utilized throughout the exercise as they become available.

4. Did first due IC implement airport disaster plan?
   Yes. Enroute to scene
   First in IC passed IC to Airport Command when that person checked in, then function from that point on as Operations

Comments:
Note: there was some initial confusion by AC as to what radio frequency was to be used. Op's resolved that problem.
General Check List

Group evaluated:       Evaluator:
Airport CFR       Steve Adams

1. How was group activated to respond?
   Airport dispatch

2. Was activation/dispatch information sufficient in describing incident and groups initial purpose
   for responding along with a respond to location?
   Yes, Fairly detailed description of emergency

3. Did group respond as a task force or independently?
   As a task force....first in units

4. Did group communicate its response staffing (i.e. medic four-w/3 emts etc...) and its staging
   location to the staging officer (IC if no level II staging had been declared)?
   N/A as response was on duty airport staff

5. In staging on location, and or scene how was the group given a task assignment?
   Radio and face to face communications were used by IC to start initial response to
   situation including evacuation. This communication continued throughout the exercise by
   first in IC/operations commander

6. What task was it?
   See above

7. Did group have a liaison at the IC or directing division or sector officer location for the purpose
   of coordination?
   N/A their commanding officer (shift commander) was also Operations Commander

8. Did group use proper communication channels?
   a. Own frequency for intra group communications,  Yes
   b. MA frequency or face to face with IC.  Yes
   c. Face to face for all assignments at level II staging  Unknown
   d. Medical frequency for EMS sector command and hospital communications only.  Unknown
9. Did group communicate to its liaison, IC, or division sector officer, the following?
   a. Location of operations    \textit{N/A}
   b. Situation found – size up of task area    \textit{Yes}
   c. Progress made    \textit{Yes}
   d. Request for additional resources \textit{On going throughout exercise}

10. Did group adequately update the IC through it liaison or division and or sector officers of progress or lack there of or any special challenges?

   \textit{Airport CFR staff communicated effectively with operations officer.}

11. Did group try to appropriate or reappropriate any non-group resources without going through command?

   \textit{no}

12. Did group stay together in its tasks?

   \textit{Yes, Appeared to be a very cohesive unit}

13. By who and how was personnel accountability maintained?

   \textit{Operations commander}

14. Was group able to accomplish task, describe challenges – accomplishments?

   \textit{See comments below}

15. Did group inform IC of task assignment being completed and ask for reassignment of their units?

   \textit{Several times during exercise}

16. Did group go through any rehab and or debriefing?

   \textit{Rehab yes, debriefing unknown}

17. How did the group demobilize?

   \textit{Released by Operations commander}

\textbf{Comments:}

\textit{I was quite impressed by the overall operation that I witnessed. What follows are some observations that may help you improve on the next exercise.}
First in IC/operations commander (Dale) appeared to stay on top of things throughout exercise, in spite of some communication problems. I guess “cool under fire” would be a good way to put it. Excellent contact/communication was maintained with CFR personnel.

The Operations Commander kept Command well informed of changing status and needs throughout exercise.

I didn’t observe any face to face communication between op’s and triage after the initial contact (w/UAFFD) Several radio request by operations commander to triage for total count of victims, how many to hospital, etc went unresolved to the best of my knowledge. When a count was transmitted over radio (source unknown) late in the exercise the numbers did not agree.

Several request were made by the operations Commander for passenger manifest but he never did get one. The first time he was aware that anyone had one was when he was advised by the medical examiner that she had one. This was at approximately 1730 hrs. when she checked in for clearance to retrieve bodies.

During the exercise the Operations commander was unable to immediately reposition a crash rig (unit 9) because the driver had left the vehicle.

Early in the exercise the Operations Commander requested additional manpower, was told they were enroute, they got lost and finally showed up at 1645 hrs.

I observed ADF, UAFFD, CGFR, City of Fairbanks, Medical examiner, Army, Air Force, and FNSB Haz Mat check in with Operations upon arrival (hope I didn’t forget anybody)

Operations Commander had good support from the Airport Police during the exercise.

I’m not sure what happened with MAST. Operations Commander was observed requesting them, then twice asking for their status after the initial request. Army Liaison Officer advised OC that units were not dispatched for response until 1700, quite some time after initial request. (Army liaison officer had been maintaining radio contact with choppers which were staged just off the airport, they finally returned to base when they were not dispatched)

If the equipment is available I would recommend that in future exercises, consideration be given to providing the evaluator(s) (at least on for Airport CFR) with radios so both sides of communications can be heard and evaluated. I was severely hampered by the fact with all of the noise around me I could not hear most of the radio communications and at best only one side of the communication. I did not ask questions of the operations commander during the exercise for the fear of hindering him in carrying out his duties. For that reason I’m afraid that I didn’t do a very good job of understanding and evaluation some aspect of the exercise.

I appreciate having had the opportunity to observe and evaluate the Airport CFR’s response in the exercise. Please feel free to contact me if I can be of any further assistance.
Fairbanks International Airport – FNSB Disaster Exercise
June 4, 1999 Evaluation Form

Dispatch

Group evaluated:       Evaluator:
Airport Dispatch

1. How was dispatch informed of the incident?
   (i.e. phone by party, phone by observer, radio, other dispatch center etc.)

   Via Phone from Airport Fire Department

2. What was the initial information given “known” about the incident?
   2-planes in wreck (crash) one 707 jet, one C-47 prop. Many casualties, at least 40 estimated. Located in front of Mark Air Terminal.

3. Did dispatch make any attempt to obtain additional “caller” information
   Negative. The original information was enough to start alert and preplans were activated.

4. What benchmark did the initial call tone go out as? (i.e. Alert I, II or III)
   None. When UAF dispatch was notified, Airport did not declare other than a general alert. UAF Dispatch kept requesting Airport dispatch of needs.

5. Was all initial pertinent information pass on to responders upon dispatch? (Information enabling responders to get a sense of the location and scope of the incident)
   Initially from the airport dispatch thought to be yes. There was a continuous stream of information provided. What I heard from UAF is that they were asking the airport how many and which units were being requested. It thought that they (UAF) were responsible to determine assistance calls (mutual aid and so forth) but it appeared that UAF was expecting Airport dispatch to provide (request) specific resource requirements.

6. Did dispatch receive additional “caller information” after initial report
   As units were arriving for duty, they checked in with the IC? And occasionally with dispatch. Not a clear cut response on this.

7. Was this information pass on?
   Yes As needed. The tower dispatch crew knew their job and performed their part of the exercise extremely well.

8. Did dispatch receive IC request for resources or did they come from multiple sources?
   Both: as I mentioned there was some confusion with the central dispatch (UAF) as to the initial resources needed
9. Was dispatch able to “fill” the IC’s request?

Yes: From what I observed.

10. Did dispatch give each “dispatch” unit sufficient information to appropriately respond
    I.e. location, brief situation, staging location, communication frequency for IC

    *The dispatcher due to extensive experience, was able to smooth out a lot of rough spots. Can we count on that next time?*

11. Did dispatch inform IC of any potential resource challenges as they arised.

    Yes – US Army MAST. As was requested by the IC, dispatch called FTWW MAST unit for assistance at 1620 hours. The Tower at 16:55 hours noticed that no MAST A/C had arrived. When dispatchers called again the MAST folks were still waiting for a call. Someone there did not pass the word. At 1707 1\textsuperscript{st} MAST A/C arrived. At 1710 the 2\textsuperscript{nd} A/C arrived.

12. What challenges did the dispatch face during this exercise.

    Certain agency were attempting to call IC, However there were really talking to a 2\textsuperscript{nd} party – confusion.

13. What was done to overcome these challenges?

    Not Sure

Additional Comments:

It was expected that sometime during the exercise the IC command would move from the location to the actual place that was set up as the ICC. (upstairs in the FIA fire station). I do not recall that ever happening. It was 16:30 hrs before the Incident commander (Doyle) was even identified and name posted in the ICC room. Half the people did not who was in charge when asked. They all had expected the ICC would be manned (at sometime) by the IC command

We had an unknown shouter on the radio (FIA Fx) somewhere in the vicinity of the crash. He was drowning out other calls, which made dispatch a difficult task.

Some radio traffic, it appeared that the staging officer was asking the “dispatcher” for a particular request, When they should have been asking through the IC.

I commend the Airport dispatcher Patti, Sharon, and Mary on a job well done. They took timely and accurate note during the operation.
Fairbanks International Airport – FNSB Disaster Exercise  
June 4, 1999 Evaluation Form  

Dispatch  

Group evaluated: University Dispatch  
Evaluator: ASDF SGT Durocher  

1. How was dispatch informed of the incident?  
(I.e. phone by party, phone by observer, radio, other dispatch center etc.)  
911 phone from Airport Dispatch at 1603 hrs.  

2. What was the initial information given “known” about the incident?  
707 vs. C-46 cargo aircraft accident, 40-50 injuries, unknown fuel spillage, at Mark Air hanger  

3. Did dispatch make any attempt to obtain additional “caller” information  
Confirm 707 not 747, and did obtain wind info. As out of the NW @ approx. 15 mph, Temp 58  

4. What benchmark did the initial call tone go out as? (i.e. Alert I, II or III)  
Dispatch as an airplane accident, benchmarked as the most severe. Dispatched UFD, CGFR, Ester and Steese.  

5. Was all initial pertinent information pass on to responders upon dispatch? (Information enabling responders to get a sense of the location and scope of the incident)  
Exact information passed on that was listed in #2.  
Took initiative to contact FMH at 1605 hrs. Basset notified at 1652 hrs.  

6. Did dispatch receive additional “caller information” after initial report  
No, did received call from ? that ARC rehab be organized.  

7. Was this information pass on?  

8. Did dispatch receive IC request for resources or did they come from multiple sources?  
Dispatch took the initiative to notify multiple resources without any specific request from Airport. (Steese, Goldstream, Ester)
9. Was dispatch able to “fill” the IC’s request?

Yes

10. Did dispatch give each “dispatch” unit sufficient information to appropriately respond
I.e. location, brief situation, staging location, communication frequency for IC

Gave out info that they received in #2.

11. Did dispatch inform IC of any potential resource challenges as they arised.

Asked Airport if they wanted specific resources

12. What challenges did the dispatch face during this exercise.

Apparently UAF dispatch had minimal requests from Airport during this exercise. They were disappointed that they seemed out of the loop. UAF dispatch was under the impression that they would be more involved filling specific request for resources. They were never notified of the haz mat or exact details of incident, injuries, etc.

13. What was done to overcome these challenges?

Basically they were notified of the initial crash and were left to find out the details on their own.
Command Operations Checklist
(To be evaluated from incident start, evaluator to follow or go with IC. I.e. CO evaluator is to observe first in units then follows the transfer of IC to the central command operations)

Evaluator: Ken Miler (Eielson AFB Fire Chief)

1. Was a central communication point established, well identified and easily found?
   NO – At no time was there a well-defined or established location for central communication transmitted via radio or face to face meeting with the Incident Commander.

2. Was transfer (if necessary) of command from first response units announced to all operating units and dispatch?
   Marginal – The first arriving crash vehicle established command and then it was passed on to the next Senior Fire Officer arriving, however before he could complete transfer of command the airport manager arrived and assumed command. The airport manager did broadcast the transfer, however not sure all agencies received information of change as several units arriving later did not know were to report to or who.
   
   a. Was the original command given an identifier? (I.e. operations, division xyz, sector xyz, etc.)
   
   No – At no time was a command identifier such as this is Mark Air Command, Ramp Command or Aircraft (Alaska Airline) Command ever established. Through out the exercise command was know as Incident Command.

3. Was a good and complete as possible size up information communicated to dispatch and to all responding groups?
   Yes – First in crash vehicle provide as actual information as possible and dispatch center repeated information.

4. Was incident objectives defined, prioritized, and clearly stated to all?
   Marginal - At no time was a meeting held by the incident commander to determine plan of action, however operations and medical sections did an excellent job of coordinating efforts to remove injured personnel.

5. Was a representative of each agency responding represented at the IC?
   
   NO – This was difficult due to the incident commander continuously moving about in his vehicle. However, one agency (UAF Fire Dept) did an excellent job of reporting into the IC and constantly being available for inter-face. Several other agencies (Fairbanks Fire Dept, Army MAST and Chena-Goldstream) that arrived later also did a good job of being available.
a. Did each of these representatives have direct communication with their own operating groups? How? (radio, phone, cell phone, computer, runner)

Yes, it appeared that most organizations were in contact via portable/mobile radios.

b. Did each of these representatives give the IC updates on?
   1. Location of unit operations - No
   2. Situation found – size up of units task area
      Marginal (Operations and Medical did excellent job)
   3. Unit's Progress made
      Marginal (Again Operations and Medical kept IC informed)
   4. Potential or request for additional resources or tasks
      NO – Each section seemed to handle their own needs

c. Did these representatives adequately keep their units informed on IC objectives?
   NO - the Incident Commander never spelled out Objectives.

d. Did these representatives adequately keep their units informed on surrounding actions that may effect their operations?
   Marginal – Operations and medical sections seemed to work well together.

6. Was a safety officer* part of this IC group?
   YES – However the Operations section appointed him and there was little or no feed back from him to the IC.

7. Was a planning officer* part of this IC group. Were alternate plans developed and ready for use? Were incident projections and timetables established?
   NO – Due to the compressed time frame of exercise not sure a planning officer would have had time to develop alternate plans.

8. Was a resource officer* part of this IC group. Did this officer coordinate adequate resources? Was staging able to keep request filled?
   NO did this officer coordinate adequate resources? N/A was staging able to keep request filled? N/A

9. * If any of these positions were not filed, Was the IC able address these items adequately and timely?
   NO – Incident commander just recently completed ICS training and still unfamiliar with concept.
10. Did the IC foster and emphasize the need for continual feedback information from all operating units?

NO

11. Was a task assignment objective orientated or function orientated? (i.e. provide water supply vs. send a tanker)

*Marginal – The IC had little impact in this area, the medical section seemed to perform very well in the area with decision being made as to what type of victims required either BLS or ALS support.*

12. When task assignments were given was it clear to who and where to report?

*Marginal - Not very well at the IC level, both operations and medical sections had a better handle on this.*

13. Were resources tracked and well-identified as per deployments?

NO

14. Were objectives benchmarked as accomplished?

NO

15. As objectives were accomplished were task groups reassigned or rehabbed

*Marginal – IC commander wasn’t aware of completed task in most cases, however operations and medical section did good job of redirecting personnel to other task as necessary. Medical section handled rehab of their rescuers once all victims had been transported.*

16. Was a demobilization plan developed and communicated?

NO – Again due to compress time frame for exercise.

17. Was there a plan developed for transition from immediate emergency ops to a longer-term disaster?

NO – *If this had been a real world situation outside agencies would still be arriving and the incident commander would need to have a plan of action to either hand off the situation or be prepared to limit access until relieved by a investigation team.*

**Additional comments:**

One major item was the continuous movement of the incident commander in his vehicle, and the fact he never really established a location of the command post. In fact the position of his vehicle was directly in the path established for the ambulance route and they (medical) had to readjust their route several times due to this.
Fairbanks International Airport – FNSB Disaster Exercise
June 4, 1999 Evaluation Form

General Check List

Group evaluated: Incident Command
Evaluator: Ken Miller (Eielson AFB Fief Chief)

1. How was group activated to respond?
Response was initiated by Fairbanks International Airport Dispatch center.

2. Was activation/dispatch information sufficient in describing incident and groups initial purpose for responding along with a respond to location?
Yes

3. Did group respond as a task force or independently?
Independently - Due to the nature of business and limited resources at the airport a group response can not be accomplished at the beginning of any situation located on airport grounds.

4. Did group communicate its response staffing (i.e. medic four-w/3 emts etc…) and its staging location to the staging officer (IC if no level II staging had been declared)?
Marginal – The medical section did well in letting the hospital know how many victims were enroute.

5. In staging on location, and or scene how was the group given a task assignment?
Marginal – Some assignment might have been given at the staging area, however very given by incident commander.

6. What task was it?
Medical

7. Did group have a liaison at the IC or directing division or sector officer location for the purpose of coordination?
Marginal – Operations and medical kept someone available for the IC.
8. Did group use proper communication channels? **YES**
   
a. Own frequency for intra group communications, **YES**
   
b. MA frequency or face to face with IC. staging *Marginal – Incident commander had contact with most sections through radio, however some organizations did not have radio contact and it was very late in the exercise when they attempted a face to face with incident commander.*
   
c. Face to face for all assignments at level II **Unknown**
   
d. Medical frequency for EMS sector command and hospital communications only. **Unknown**

9. Did group communicate to its liaison, IC, or division sector officer, the following?
   
a. Location of operations
   *Satisfactory – Operations and medical did very good, Red Cross rehab location was unknown until very late in exercise*
   
b. Situation found – size up of task area
   *Satisfactory – First crash and senior fire officer did good job however the exercise didn’t allow sufficient time between their arrival and the airport manager’s.*
   
c. Progress made
   *Satisfactory*
   
d. Request for additional resources
   *Marginal – Medical section ran out of ambulances*

10. Did group adequately update the IC through it liaison or division and or sector officers of progress or lack there of or any special challenges?  
    *Satisfactory – Operations and medical did excellent job*

11. Did group try to appropriate or reappropriate any non-group resources without going through command?  
    *N/A*

12. Did group stay together in its tasks?  
    *Yes – Medical and operations did not sure about others*

13. By who and how was personnel accountability maintained?  
    *Not accomplished at IC level*
14. Was group able to accomplish task, describe challenges – accomplishments?
Yes - Although not textbook tasks were accomplished.

15. Did group inform IC of task assignment being completed and ask for reassignment of their units?
NO – Did not occur at the IC level

16. Did group go through any rehab and or debriefing?
Marginal - Only group through rehab was medical. No debriefing took place.

17. How did the group demobilize? Some units went back through staging area others left without checking out.

Additional comments:
Overall exercise was a success as victims were transported to area hospitals. It's apparent that some of the departments that work together daily have the incident command system down. Difficult situation for airport staff to be held accountable to this same level when they only exercise yearly.
Recommendation: Conduct semi-annual, table top exercises or observe other departments exercises to gain more experience in the ICS.
Incident Command Center
(Observer comments, no checklist used as it was thought that the IC and Command Checklist would cover this portion. IC never got to the ICC)

Evaluator: Mark Dryer

I was assigned to evaluate the ICC (Incident Command Center) at the Airport Fire Station. In my understanding of ICS the Incident Commander needs to come to the ICC for it to fulfill its function. This never happened. The ICC was never staffed with a command staff.

The “ICC” did however function as a “logistics center” very well. There was some confusion in the beginning due to the fact that people were in place before the incident. There was no initial structure in the ICC. Becky (FIA Ops) was training a new person. She did not function as her role as the “logistics officer” but assisted her trainee in his decision making (she needed to be told to sit down and NOT take control and give suggestions to her trainee).

In the beginning the FIA Ops person was running the radio instead of running the room. He was eventually pulled off the radio and began to take control of the room.

Many people were being sent or coming to the ICC (as they should) but there was no command authority to have them check in with. The incident commander was aware of the resources available to him. Moreover, many things were not used to their ability.

Chief Eric Mohrman reported to (ICC) as planned and was unable to interface with the IC because he was not there.

Red Cross also came to the ICC. They were extremely distraught that they did not feel like they were being included in any fashion other than the “chip and dip” van. They reminded us that they had many other functions (mental health, housing). There was no Commander to report to that could check in with.

While there was a person making people sign in at the door. He was not aggressive enough in making assignments. There needed to be someone in charge to fill in the blanks in the ICC system.

Most of the people reported to the ICC to interface with the incident Commander. With the Commander not present most of the needed resources were not used to their capacity i.e. Medical Examiner, FMH, etc.

A very detailed plan was laid out by Chief Spukis and it was not followed.

Summary:

1. With the Incident Commander never reporting to the IC it was not able to fulfill its function. IC needs to be at the ICC!

2. A mobile command post is an oxy moron. A command post needs to be fixed so that people can find you.

3. At some point, the commander needs to pass control of the actual incident and get them resources they need.
4. Only one of the fire chiefs reported to the ICC. No one else did. It is in the “plan’ for a representative to report to ICC to meet with the Commander to help form the Command Staff.

5. As a logistics center the command room functioned well. I do not believe the incident commander contacted the logistics center for his needs and tries to do everything himself.
EMS

Group evaluated: UFD – (Medical Sector), CGFR, City FD, IARS, FTWEMS
Evaluator: Jenny Rambadt

1. Was a medical Sector Officer Assigned?
Yes

2. When? Was it the first medic unit on scene?
No – UFD BC

3. Did the medical sector provide an initial scopeing of the medical challenge of the incident to the IC?
No

4. Did the medical sector officer announce, “broadcast”, that this would be a MPI or MCI incident?
No

6. Did the medical sector quickly manage the walking wounded? (I.e. assign a green sector task group and identify a location)
Yes, Although did not denote location, green tarp was not set up initially

7. Did the medical sector set up and easily identifiable treatment and triage area for yellow and red patients (non-walking wounded)
Yes

8. Were these location communicated to all? (i.e. Did the medical sector insure the rescue groups know where to bring victims?)
Yes - Verbally

9. Did the medical sector set up an equipment cache? Was this communicated?
Yes - backboards only

10. Was the cache location an asset to the treatment area and the resupply of rescue folks bringing victims to triage and treatment?
Yes

11. Was a transportation coordinator appointed?
Yes
12. Was a medical staging and transportation areas identified and communicated.  
Yes

13. Did drivers stay with their ambulance units or were otherwise tasked by the MO?

14. Did responding EMS units communicate face to face with the medical staging officer and/or Medical officer for task assignments?  
*Wandered into triage area*

15. Did medical officer establish a communication link to FMH via radio frequency and or cell phone?  
*Transport officer – only communicated, FMH contacted him*

16. Did medical officer provide IC with periodic updates and resource requirements?  
Yes

17. Did transportation officer track patients?  
Yes

18. Was FMH given timely updates on arriving patients by the medical sector and NOT individual ambulances?  
*Yes – once transport officer was ?, ?ed not as organized*

19. Were patient, field assessment and treatment, appropriate within the context and scope of the incident?  
Yes

20. Were code black victims left as found (as practical) and marked to eliminate repetitive assessments?  
*Do not know*

*Additional comments:*
*Treatment officer loading pts.*
*No one keeping track of how many and what #*
*Triage within colors (red, yellow, green) not done, no one person overseeing each sector*
*Bassett not contacted until FMH requested*
*Good Comms between rescue and treatment*
*People other than Univ not checking in when done with task*
*People got lax during ambulance transport delays*
*Not clear who was going to what Hospital*
*City was only transporting to MAST*
*Very Good at short on scene times for ambulances*
*FMH not contacted until they contacted transport*
Fairbanks International Airport – FNSB Disaster Exercise
June 4, 1999 Evaluation Form

General Check List

Group evaluated: University Fire
Evaluator: ASDF 1st SGT Dutton

1. How was group activated to respond?
   Radio – dispatch to plane crash – 1606
   Mass Casualties 40-50 injured, no fire

2. Was activation/dispatch information sufficient in describing incident and groups initial purpose
   for responding along with a respond to location?
   Appeared to be main rescue group, location Mark Air Hangar
   Initial radio problems on MA channel and contact with IC

3. Did group respond as a task force or independently?
   Task force of 3 engines, 2 ambulances and 2 chief officers

4. Did group communicate its response staffing (i.e. medic four-w/3 emts etc…) and its staging
   location to the staging officer (IC if no level II staging had been declared)?
   Yes

5. In staging on location, and or scene how was the group given a task assignment?
   Yes, Radio MA channel

6. What task was it?
   Medical sector coordination, manpower

7. Did group have a liaison at the IC or directing division or sector officer location for the purpose
   of coordination?
   Yes, BC Chuck was at IC

8. Did group use proper communication channels?
   a. Own frequency for intra group communications, Yes
   b. MA frequency or face to face with IC. Face to Face & radio
   c. Face to face for all assignments at level II staging Yes
   d. Medical frequency for EMS sector command and hospital communications only.

9. Did group communicate to its liaison, IC, or division sector officer, the following?
   a. Location of operations Was directed to respond to crash site
   b. Situation found – size up of task area
c. Progress made  
reported via radio on MA to IC - Chuck

d. Request for additional resources  
request contact mast helio, Bassett hospital

10. Did group adequately update the IC through it liaison or division and or sector officers of progress or lack there of or any special challenges?
   2 buses coming for greens, (walking wounded)

11. Did group try to appropriate or reappropriiate any non-group resources without going through command?
   Extra blankets and backboards

12. Did group stay together in its tasks?
   yes

13. By who and how was personnel accountability maintained?
   Passports, and BC to IC on MA

14. Was group able to accomplish task, describe challenges – accomplishments?
   Not enough backboards and blankets

15. Did group inform IC of task assignment being completed and ask for reassignment of their units?
   Radio notices of # of red, yellow, and greens
   At end of exercise come back and move bodies

16. Did group go through any rehab and or debriefing?
   Regroup and picked up passports at staging

17. How did the group demobilize?

Other evaluator comments:
During change of transportation officers lost count of transported
Difficult communication with MAST helio and Basset.
Tarps for patient sorting – red critical, yellow – near critical, green – walking
Green tarp - watcher
Had vests for who & what position
More ambulances and engines available, this was an exercise
Ambulances transport to helios...first or second.
Fairbanks International Airport – FNSB Disaster Exercise  
June 4, 1999 Evaluation Form

**General Check List**

Group evaluated: 
*Steese Fire*

Evaluator: 
*Brian Leffingwell*

1. How was group activated to respond?  
*Stage at 1600 hrs*  
*Via radio*

2. Was activation/dispatch information sufficient in describing incident and groups initial purpose for responding along with a respond to location?  
*Yes*

3. Did group respond as a task force or independently?  
*Rescue rig and BC*

4. Did group communicate its response staffing (i.e. medic four-w/3 emts etc…) and its staging location to the staging officer (IC if no level II staging had been declared)?

5. In staging on location, and or scene how was the group given a task assignment?  
*1655 found 1 engine and one command vehicle*  
*no personnel*

6. What task was it?  
*Duties as assigned*

7. Did group have a liaison at the IC or directing division or sector officer location for the purpose of coordination?  
*No one main person acting as coordinator*

8. Did group use proper communication channels?  
   a. Own frequency for intra group communications,  
   *No radio communications used*  
   b. MA frequency or face to face with IC.  
   *  
   c. Face to face for all assignments at level II staging  
   *
d. Medical frequency for EMS sector command and hospital communications only.

* this group got most of their instructions face to face through a liaison

9. Did group communicate to its liaison, IC, or division sector officer, the following?
   a. Location of operations  West ramp Mark Air hanger
   b. Situation found – size up of task area
   c. Progress made
   d. Request for additional resources  N/A

10. Did group adequately update the IC through it liaison or division and or sector officers of progress or lack there of or any special challenges?

   Yes or it appears so

11. Did group try to appropriate or reappropriate any non-group resources without going through command?

   No

12. Did group stay together in its tasks?

   1 command vehicle and one engine

13. By who and how was personnel accountability maintained?

   By FIA personnel

14. Was group able to accomplish task, describe challenges – accomplishments?

   This group did well as rank filers, going where directed as needed

15. Did group inform IC of task assignment being completed and ask for reassignment of their units?

16. Did group go through any rehab and or debriefing?

   Released to rehab at 1740

17. How did the group demobilize?
General Check List

Group evaluated:       Evaluator:
Fairbanks Fire        Brian Leffingwell

1. How was group activated to respond?
   By dispatch.
   By airport police but should have contacted division chief

2. Was activation/dispatch information sufficient in describing incident and groups initial purpose for responding along with a respond to location?

3. Did group respond as a task force or independently?
   At 1635 seems to be as coordinated as it can be. FFD unavailable at this time.

4. Did group communicate its response staffing (i.e. medic four-w/3 emts etc…) and its staging location to the staging officer (IC if no level II staging had been declared)?

5. In staging on location, and or scene how was the group given a task assignment?

6. What task was it?
   One task was to evac victims to MAST chopper

7. Did group have a liaison at the IC or directing division or sector officer location for the purpose of coordination?

8. Did group use proper communication channels?
   a. Own frequency for intra group communications, group did monitor own radio
   b. MA frequency or face to face with IC. Liaison at IC
   c. Face to face for all assignments at level II staging Yes
   d. Medical frequency for EMS sector command and hospital communications only.
9. Did group communicate to its liaison, IC, or division sector officer, the following?
   a. Location of operations
   b. Situation found – size up of task area
   c. Progress made
   d. Request for additional resources

10. Did group adequately update the IC through it liaison or division and or sector officers of
    progress or lack there of or any special challenges?

11. Did group try to appropriate or reappropriate any non-group resources without going through
    command?
    No

12. Did group stay together in its tasks?
    Yes - 2 ambulances, 1 staff vehicle, 1 light rescue vehicle

13. By who and how was personnel accountability maintained?
    Division Chief Debbie Hassel

14. Was group able to accomplish task, describe challenges – accomplishments?
    Yes under the circumstances they did quite well

15. Did group inform IC of task assignment being completed and ask for reassignment of their
    units?

16. Did group go through any rehab and or debriefing?

17. How did the group demobilize?
   Other comments:
   Fairbanks fire dept vehicles were on actual call out so remaining ambulance was on stand
   by to “home base” although still at exercise. 1735 group called back into action
General Check List

Group evaluated:       Evaluator: 
Ester Fire        ASDF MGJ Gellinas

1. How was group activated to respond?
Radio dispatch 1616, 1620 on scene

2. Was activation/dispatch information sufficient in describing incident and groups initial purpose for responding along with a respond to location?

Yes

3. Did group respond as a task force or independently?

Task force

4. Did group communicate its response staffing (i.e. medic four-w/3 emts etc…) and its staging location to the staging officer (IC if no level II staging had been declared)?

Yes

5. In staging on location, and or scene how was the group given a task assignment?

Radio to Fairbanks ambulance #4

6. What task was it?

Assist in triage

7. Did group have a liaison at the IC or directing division or sector officer location for the purpose of coordination?

Yes

8. Did group use proper communication channels?

Yes

   a. Own frequency for intra group communications,    Y

   b. MA frequency or face to face with IC.        Y

   c. Face to face for all assignments at level II staging   Yes

   d. Medical frequency for EMS sector command and hospital communications only.

9. Did group communicate to its liaison, IC, or division sector officer, the following?

   a. Location of operations     Yes

Page A - 26
b. Situation found – size up of task area  Yes

c. Progress made  Great very professional

d. Request for additional resources  No

10. Did group adequately update the IC through it liaison or division and or sector officers of progress or lack there of or any special challenges?

Yes

11. Did group try to appropriate or reappropriate any non-group resources without going through command?

No

12. Did group stay together in its tasks?

Yes

13. By who and how was personnel accountability maintained?

14. Was group able to accomplish task, describe challenges – accomplishments?

Yes, need for additional backboards – Brought by Fairbanks

15. Did group inform IC of task assignment being completed and ask for reassignment of their units?

Yes

16. Did group go through any rehab and or debriefing?

No

17. How did the group demobilize?

1815 Airport security check point (staging)

other comments:

The team form Ester was outstanding and never left patients alone and continued to do first aid and see to their comfort.

How come 2 critical patients were left till it seems to second till last ambulance, when they were transporting less critical patients?
**General Check List**

Group evaluated: **Interior Rescue**  
Evaluator: **ASDF 2LT Farmier**

1. How was group activated to respond?
*FIA dispatch received at 1626 hrs.*
*FIA needed to dispatch IARS sooner due to geographic location. Other EMT ambulances were first?*

2. Was activation/dispatch information sufficient in describing incident and groups initial purpose for responding along with a respond to location?

*Dispatch complete*

3. Did group respond as a task force or independently?

*Independently*

4. Did group communicate its response staffing (i.e. medic four-w/3 emts etc…) and its staging location to the staging officer (IC if no level II staging had been declared)?

*Very good information given by ambulance crew*

5. In staging on location, and or scene how was the group given a task assignment?

*By staging officer, transport 4 pt's to FMH, 2x – 2 critical*

6. What task was it?

*Transport patients to FMH*

7. Did group have a liaison at the IC or directing division or sector officer location for the purpose of coordination?

*Yes*

8. Did group use proper communication channels?  
   a. Own frequency for intra group communications, **Yes**
   b. MA frequency or face to face with IC. **Yes**
   c. Face to face for all assignments at level II staging **Yes**
   d. Medical frequency for EMS sector command and hospital communications only. **Yes**

9. Did group communicate to its liaison, IC, or division sector officer, the following?
   a. Location of operations **Yes**
b. Situation found – size up of task area

c. Progress made

d. Request for additional resources

10. Did group adequately update the IC through it liaison or division and or sector officers of progress or lack there of or any special challenges?

   Yes

11. Did group try to appropriate or reappropriate any non-group resources without going through command?

   Yes-

12. Did group stay together in its tasks?

   See comments

13. By who and how was personnel accountability maintained?

   By lead medic

14. Was group able to accomplish task, describe challenges – accomplishments?

   Very well, excellent job – smooth control organization at medical sector

15. Did group inform IC of task assignment being completed and ask for reassignment of their units?

   Informed of back to scene, ready to transport 2\textsuperscript{nd} response to FMH

16. Did group go through any rehab and or debriefing?

17. How did the group demobilize?

Other comments:
Ambulance crew did very well in PT assessment, packaging TX, and transport. Communication was very good. Decon of ambulance at FMH. Grade :A Overall EMT skill rating “superior”, good ambulance provider.
General Check List

Group evaluated: FTWW Fire
Evaluator: ASDF MAJ Needham

1. How was group activated to respond?
   At staging

2. Was activation/dispatch information sufficient in describing incident and groups initial purpose for responding along with a respond to location?
   No information was given until arrival at scene

3. Did group respond as a task force or independently?
   Task force

4. Did group communicate its response staffing (i.e. medic four-w/3 emts etc…) and its staging location to the staging officer (IC if no level II staging had been declared)?
   Yes

5. In staging on location, and or scene how was the group given a task assignment?
   Staging officer-just follow fire truck in front-chief officer stayed back at staging.

6. What task was it?
   Manpower assist with rescue @ C-47

7. Did group have a liaison at the IC or directing division or sector officer location for the purpose of coordination?
   Yes at staging

8. Did group use proper communication channels?
   a. Own frequency for intra group communications,
   b. MA frequency or face to face with IC.
   c. Face to face for all assignments at level II staging Y
   d. Medical frequency for EMS sector command and hospital communications only.
9. Did group communicate to its liaison, IC, or division sector officer, the following?

   a. Location of operations     Yes
   b. Situation found – size up of task area Yes
   c. Progress made           Good
   d. Request for additional resources No

10. Did group adequately update the IC through its liaison or division and or sector officers of progress or lack thereof or any special challenges?
    Yes

11. Did group try to appropriate or reappropriate any non-group resources without going through command?
    No

12. Did group stay together in its tasks?
    Yes

13. By who and how was personnel accountability maintained?
    FIA firefighter on scene

14. Was group able to accomplish task, describe challenges – accomplishments?
    Yes, they said it took too long. needed supplies i.e. (backboards)

15. Did group inform IC of task assignment being completed and ask for reassignment of their units?
    Yes reassigned to remove deceased

16. Did group go through any rehab and or debriefing?
    No

17. How did the group demobilize?
    By IC
General Check List

Group evaluated:       Evaluator:  
FTWW EMS  ASDF MAJ Needham

1. How was group activated to respond?  
   At staging

2. Was activation/dispatch information sufficient in describing incident and groups initial purpose for responding along with a respond to location?  
   No, staging did not provide correct sign in information at first. Sent to scene no patient information until patients loaded and then had to ask where to take patients.

3. Did group respond as a task force or independently?  
   Task force

4. Did group communicate its response staffing (i.e. medic four-w/3 emts etc…) and its staging location to the staging officer (IC if no level II staging had been declared)?  
   Yes

5. In staging on location, and or scene how was the group given a task assignment?  
   Staging officer, then by medical transport officer on scene.

6. What task was it?  
   Transport victims to FMH…no medical eval given by triage

7. Did group have a liaison at the IC or directing division or sector officer location for the purpose of coordination?  
   Yes

8. Did group use proper communication channels?  
   a. Own frequency for intra group communications,  
   b. MA frequency or face to face with IC.  
   c. Face to face for all assignments at level II staging  
   Y
d. Medical frequency for EMS sector command and hospital communications only.

9. Did group communicate to its liaison, IC, or division sector officer, the following?
   a. Location of operations  Yes
   b. Situation found – size up of task area  Yes
   c. Progress made  Good
   d. Request for additional resources  No

10. Did group adequately update the IC through it liaison or division and or sector officers of progress or lack there of or any special challenges?
   Yes

11. Did group try to appropriate or reappropriate any non-group resources without going through command?
   No

12. Did group stay together in its tasks?
   Yes

13. By who and how was personnel accountability maintained?
   By chief officer

14. Was group able to accomplish task, describe challenges – accomplishments?
   Yes, needed more intel from IC

15. Did group inform IC of task assignment being completed and ask for reassignment of their units?
   Yes – 2 patients to Bassett

16. Did group go through any rehab and or debriefing?
   No

17. How did the group demobilize?
   Released by staging officer at 1819
General Check List

Group evaluated: Chena Goldstream Fire & Rescue
Evaluator: Unknown

CGFR provided a medic unit, command personnel and evaluators, unfortunately no group evaluation form was returned for this unit. Operationally CGFR was dispatched and assigned to the medical sector.

1. How was group activated to respond?

2. Was activation/dispatch information sufficient in describing incident and groups initial purpose for responding along with a respond to location?

3. Did group respond as a task force or independently?

4. Did group communicate its response staffing (i.e. medic four-w/3 emts etc…) and its staging location to the staging officer (IC if no level II staging had been declared)?

5. In staging on location, and or scene how was the group given a task assignment?

6. What task was it?

7. Did group have a liaison at the IC or directing division or sector officer location for the purpose of coordination?

8. Did group use proper communication channels?
   a. Own frequency for intra group communications,
   b. MA frequency or face to face with IC.
c. Face to face for all assignments at level II staging
d. Medical frequency for EMS sector command and hospital communications only.

9. Did group communicate to its liaison, IC, or division sector officer, the following?
   a. Location of operations
   b. Situation found – size up of task area
   c. Progress made
   d. Request for additional resources

10. Did group adequately update the IC through it liaison or division and or sector officers of progress or lack there of or any special challenges?

11. Did group try to appropriate or reappropriate any non-group resources without going through command?

12. Did group stay together in its tasks?

13. By who and how was personnel accountability maintained?

14. Was group able to accomplish task, describe challenges – accomplishments?

15. Did group inform IC of task assignment being completed and ask for reassignment of their units?

16. Did group go through any rehab and or debriefing?

17. How did the group demobilize?
Hospital

Group evaluated:       Evaluator:       Fairbanks Memorial Hospital  David Rockney, IREMS Training Coordinator

1. How was Hospital first informed of accident (IC, ambulance, or civilian)?

   The call was first received at FMH in the emergency room. An ER nurse took the call at 1615 from Tim at U of A dispatch. She was told that a mass casualty had occurred at the airport in the form of a plane crash. Two planes were involved, a 707 passenger jet and a C46 cargo plane. She was told to expect 40 to 50 casualties. The call was immediately transferred to administration who took the same report.

2. What was the first formal notification? Did notification provide information sufficient for Hospital?

   Mike Powers, the hospital IC, said the info in this call was sufficient to start the process at their end.

3. Did Hospital initiate MCI plan?

   Note Hospital MCI and internal medical operations to be evaluated separately

   At 1622 an announcement was made through the PA system activating a mass casualty incident.

4. Did hospital send a representative to the IC post?

   Yes

5. Did this representation maintain two way communications between the IC and the Hospital? How – radio, phone, and cell phone, other? Was this effort effective?

   Jamie Therber was sent to the command post at the airport as the hospital’s representative. He attempted to establish communications with FMH but had some problems. His radio was unreadable at the hospital and his cell phone would not work. He finally solved the problem by using a telephone at the command center. According to the hospital communications person and the IC, he kept them adequately informed throughout the drill.

6. Was hospital informed of scope of incident and potential number of patients in a timely manner?

   Yes

7. Did hospital keep IC informed of number of patients capable of receiving and where to bring casualties

   There was two way communications between the transportation officer and the hospital through out the drill. FMH kept the transportation officer informed of their capabilities and told them when to divert patients to Bassett. To my knowledge there were no major communication problems between FMH and the transportation officer.
8. Did hospital establish an ambulance resupply point and communicate this with the IC?

The hospital set up a resupply area and the IC told me that command at the scene had been informed. When I checked the supply area they told me that one ambulance had re-supplied through them.

9. Did hospital provide security and access control as so privately transported victims, relatives, responding hospital employees, and victims transported by ambulances were controlled and did not encumber critical MCI functions?

Security at the receiving point was established and access was controlled. Relatives were intercepted and sent to the correct area of the hospital. If they used the main entrance to the hospital there were signs designating where they should go. The triage area was not as clear but security did a good job of redirecting them.

10. Did the Hospital designate a family, friends, and relatives gathering and information area with security and communicate this location?

11. Did the Hospital designate a PIO to be available for media information concerning Hospitals role?

The hospital had a PIO available at their command post and he handled information concerning the hospital’s role. I never did see any media at the hospital although there was a specific area (the library) set aside for them.

12. Was a media location established that was well recognizable and did not hinder operations or compromise survivor privacy?

Comments;
Over all, the organization and communications at FMH was excellent. I saw no problems other than the minor communications problem with the hospitals representative at the command post.
Airline

Group evaluated:       Evaluator:
Airline (Alaska)       ASDF 1LT Brandt

1. How was airline first informed of accident (internal communications i.e. pilot, Airport IC, or civilian walk-ups)?
   Ramp worker notified Airlines rep @ 4:05 (before time simulation)

2. What was the first formal notification? Did notification provide information sufficient for airline?
   Communication problem from IC and ICC

3. Did airline representative initiate company emergency plan?
   Yes – passed out equipment and assigned tasks

4. Did airline send a representative to the IC post?
   Sent to mobile command post

5. Did this representation maintain two way communications between the IC and the airlines? How – radio, phone, and cell phone, other?
   (Peggy) via cell phone relayed info to IC

6. Did airline communicate possible passenger and cargo list to IC in a timely manner?
   Evaluator not aware of

7. Did the airlines designate a family, friends, and relatives gathering and information area with security and communicate this location to IC and Airport.
   Yes, but no signs posted to its location or to deter media

8. Did the airlines designate a PIO to be available for media information concerning airlines role.
   Yes
9. Was a media location established that was well recognizable and did not hinder operations or compromise survivor privacy?

   **Representative assigned to direct media to IC**

10. Did airline arrange for grief and survivors advocate counselors.

    Yes – Called a minister

11. Did airline coordinate resources and efforts with IC, FAA, and NTSB for post accident stabilization of aircraft etc.

    **Airline rep left for FMH at 4:30**

12. Did airline coordinate with IC to have CIS debriefings and counseling for all airline staff.

    Yes – Will meet on Monday 6/7/99 to self-brief, after work. During real world situation, conduct a debriefing within 24 hours after incident

**Additional observations and comment:**

1. Pre set up taken down good idea for realism.
2. Transportation problem during exercise to transport airline rep to hospital.
3. 4:20 told bus driver to start sending people in (family and friends of flight passenger players) - Still no OFFICIAL word of exercise start or accident
4. 4:22 American red cross arrived.
5. Announced over PA “people waiting for crash airlines flight #, pleas come to the airline ticket counter.” Should have had a better fictitious name other than “crash airlines”…out of character, made it hard to stay in character during simulation.
6. **Questioned each other on advise, etc. about real world…GOOD!**
7. **In family room , tried diligently to calm family & friends. Gave appropriate info when it came in. spoke to group and one on one…GOOD!**
8. Neither ICC nor IC kept the desk informed
9. Exercise coordinator should see that a restroom is available for exercise participants.
10. Communication from command post lacking, did not keep airline desk informed
11. Red Cross posted a sign of location of family room, contrary to airline procedure of not posting location to deter media.
General Check List

Group evaluated: American Red Cross
Evaluator: ASDF: CPT. E. Witt

1. How was group activated to respond?
*On scene ARC leader ordered ARC disaster relief vehicle at 1645 to move from FIA crash/fire rescue blg, to the on scene operations area near the Mark Air blg.*

2. Was activation/dispatch information sufficient in describing incident and groups initial purpose for responding along with a respond to location?
*As of 1700 ARC Fairbanks had received NO activation or dispatch information concerning the FIA incident….answer is NO.*

3. Did group respond as a task force or independently?
*One group of Two, and then thereafter independently*

4. Did group communicate its response staffing (i.e. medic four-w/3 emts etc…) and its staging location to the staging officer (IC if no level II staging had been declared)?
*Yes, by Fairbanks ARC director, but it was relayed, not a prompt response.*

5. In staging on location, and or scene how was the group given a task assignment?
*By ARC director*

6. What task was it?
*Giving food and drink to rescue workers, Mental health personnel cared for families in Mark Air Big.*

7. Did group have a liaison at the IC or directing division or sector officer location for the purpose of coordination?
*Yes, But delayed in arriving. See #2.*

8. Did group use proper communication channels?
*Yes*
   a. Own frequency for intra group communications,
   b. MA frequency or face to face with IC.
   c. Face to face for all assignments at level II staging
   d. Medical frequency for EMS sector command and hospital communications only.

9. Did group communicate to its liaison, IC, or division sector officer, the following?
   a. Location of operations *Yes*
   b. Situation found – size up of task area
c. Progress made: **Good, however delayed in action**

d. Request for additional resources: **none**

10. Did group adequately update the IC through it liaison or division and or sector officers of progress or lack there of or any special challenges?  
*Yes, But IC & others never called for ARC support in a timely manner*

11. Did group try to appropriate or reappropriate any non-group resources without going through command?  
*No*

12. Did group stay together in its tasks?  
*Yes*

13. By who and how was personnel accountability maintained?  
*Person in charge chain of command*

14. Was group able to accomplish task, describe challenges – accomplishments?  

15. Did group inform IC of task assignment being completed and ask for reassignment of their units?  
*No- Only contact w/IC was at near conclusion of exercise*

16. Did group go through any rehab and or debriefing?  
*On site, will continue after exercise*

17. How did the group demobilize?  
*On call, At completion of exercise activity*

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**Other comments by evaluator:**  
Larry Baillon, ARC – concerned about lack of initial notification and confusion, not by ARC, over ARC’s role and responsibility in aviation disaster. Lady in dispatch displayed an uncooperative attitude. Once ARC injected itself roles went well.

Dr. Jeanne Watson ARC Mental Health officer running family support service center for relatives in Mark Air Blg. Comforting family members, passing on information on victims of 35 “hysterical” family members. Kept them calm while waiting for updates from airport staff on #’s transported to the hospital and condition. All Staff in the Mark Air Blg. ARC mental Health (5) and airport staff and other guard members worked well together well. Only problem was ARC is mandated to help family members, but was not immediately notified of disaster.