III Corps and Fort Hood
05 NOV 09
After Action Review

17 NOV 09

Agenda

- CG Opening Remarks
- Mission
- Objectives
- Process
- Way Ahead
- Closing Comments

Mission

Fort Hood conducts an installation-wide after action review (AAR) to prepare a lessons learned document in response to the 5 Nov 09 incident.

Objectives

- Execute a Senior-level hot wash

- Identify immediate, mid-and long-term changes and track compliance

- Recommend input to Higher Hqs MASCAL OPLANS

- Document our lessons learned in a formal AAR

Process

- Follow the listed AAR topics sequentially
- Corps Staff Lead has collaborated unit and CORPS/USAG input and will lead discussion addressing approximately six-eight "issues"
- Keep the discussion to about 10 minutes per topic
- Recommend discussions not revolve around "internal" lessons learned but focus Installation-wide
- First step in an iterative process

AAR Topics with Enumerated Categories

1. Event Summary/Current SITREP (CHOPS)
2. 1St Response
   a. Law Enforcement (PMO)
   b. Medical (SURG)
3. MASCAL
   a. Triage, mass casualty declaration, policy (Surg)
4. Command and Control (CHOPS)
5. Immediate Care for Patients (Surg)
6. Installation Security (Force Pro)
   a. CRB
   b. FPCONS
7. Investigation (PMO)

8. Family/Survivor Care (G1)
   a. JVB
   b. Casualty Assistance
9. Media Response (PAO)
10. Reporting (CHOPS)
11. External Support
    a. Medical (Surg)
    b. Law Enforcement (PMO)
12. Deployment Effects
    a. SRP (G1)
    b. Affected Units (CHOPS)
13. Memorial Ceremony (FUOPS)
14. Donation Assistance (SJA)
15. Cost Tracking (G8)
16. Way Ahead

1ˢᵗ Response

Law Enforcement (PMO)

Medical (CRDAMC)

1st Response (2a) Law Enforcement

- Issue: 911 calls (improve)

- Discussion: Cell phone and family quarters 911 calls here on Fort Hood are processed through Bell County Emergency Dispatch which are then transferred to FT Hood DES dispatcher. Calls from DSN go directly to FT Hood DES Dispatch. This is the only work around for civilian phones regardless of location. While there is no indication that there was a significant delay in response due to this system, calls directly to DES Dispatch would clearly be quicker.

- Recommendation: IO Campaign to ensure personnel on FT Hood know to have DES Dispatch in their speed dial as well as 911.

1st Response (2a) Law Enforcement

- Issue: Active shoot scenario (sustain)

- Discussion: In the aftermath of mass shootings like Columbine and other more recent incidents, US Army CID published a document outlining alternative solutions to dealing with an active shooter. FT Hood DES began training this new solution last year which involved law enforcement immediately and aggressively taking the fight to the shooter versus creating a cordon and awaiting SWAT type forces. This training was cited by SGT Munley as the driver behind her and Senior SGT Todd's action that day. This action undoubtedly saved countless lives.

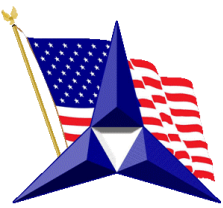- Recommendation: Continue this training and mandate Army wide.

1ˢᵗ Response (2a) Law Enforcement

- Issue: Post Closure (improve)

- Discussion: The CG made the decision early on to increase to FPCON Delta thus closing the post until further notice. ACPs reported getting calls from IOC and other agencies directing closure of the gate. This confused the guard force and prompted them to call for verification from DES. This order must be given to the DES for action. DES can facilitate simultaneous notification to ACPs and eliminate confusion.

- Recommendation: Ensure proper line of communication. Review Installation Force Protection Plan to ensure enclosure.

1st Response (2a) Law Enforcement

- Issue: Patrol equipment (improve)

- Discussion: No level III tactical vests available to non law enforcement first responders. No shotgun or rifle available for active shooter first responder (pistols only). MP units who provide response and surge capability do not currently have sufficient operations load within their arms room. MPs draw ammunition from DES for patrol duty. Potentially slows response for scenarios requiring significant MP force.

- Recommendation: Assess needs for first responders, to include firefighters and EMS for a high level threat and procure resources.

1st Response (2a) Law Enforcement

- Issue: C2 of the CRB Assets at ACPs (improve)

- Discussion: The CRB was deployed in a timely manner but once on the ground there was confusion about who was in charge.

- Recommendation: Once the CRB is deployed to support a critical incident, it must be OPCON to the DES. This is currently outlined in Phantom Shield.

1ˢᵗ Response (2a) Law Enforcement

- Issue: Preservation of critical evidence (sustain)

- Discussion: Early response by CID ensured critical evidence was preserved before crime scene was disturbed. DES and US Army Military Police first responders are trained in evidence preservation and played an important role in securing a large and complicated crime scene filled with victims, emergency medical personnel and bystanders.

- Recommendation: Evaluate installation law enforcement training program to ensure this skill is maintained and perhaps increased due to this incident.

1st Response (2b) Medical

- Issue: response time to scene, sufficient EMS support
- Discussion:
  - Ambulances arrived before scene was secure, were able to call for back-up from on and off post with good response
  - Good radio communication between Triage Doc at CRDAMC and EMS Incident Commander at scene; facilitated appropriate routing of some ambulances to other area hospitals, some air evac direct from the scene
- Recommendation: continue drills and support agreements between Ft Hood and community EMS entities

Mass Casualty

Triage

Mass Casualty Declaration

Policy

MASCAL - Triage

- Issue: doctrine calls for Triage at scene and secondary triage at hospital

- Discussion: when EMS were permitted on scene, Soldiers and SRP staff with medical training had already conducted emergency measures on injured Soldiers. They brought patients to the arriving ambulances and it became more of a scoop and run procedure than a choreographed plan with transport of the most critically injured first, consciously spreading them out between area hospitals.

- Recommendation: without sacrificing speed for doctrine, a short delay to assess the severity of wounds and allow EMS to prioritize transport might have reduced chaos and patient tracking later

MASCAL Evacuation

- Issue: Transferring of patients from outside facilities back to military MTF

- Discussion: Active duty Soldiers heal better in a military environment.

- Recommendation: Return military patients to military MTF as soon as possible

MASCAL - Declaration

- Issue: speed of declaring a MASCAL; access of staff to hospital

- Discussion
  - Overhead paging and electronic notification to hospital staff happened within 10 minutes of 911 call
  - Staff reported to their appropriate stations per plan and drills
  - Staff off-post when notified had difficulty getting on-post to care for patients

- Recommendation: 79th street gate should be open to anyone with a hospital ID badge and one other form of picture ID; CRDAMC has responsibility for educating staff

MASCAL - Patient Accountability

- Issue: It took longer than expected to get firm identification on all admitted patients at areas hospitals
- Discussion
  - Patient Administration (PAD) rehearsed going to the incident scene with the 1st EMS ambulance, but in this rapidly evolving situation, they were not called in time
  - Some patients were transported directly from the scene to area hospitals with no military accountability of name, unit, level of injury
- Recommendation: Send PAD representatives to area hospitals pre-emptively when CRDAMC capacity is exceeded. This will require MOU's with Metroplex and S&W for data sharing without HIPAA violation (Command exemption)

- Issue: Initial injury numbers reported to III Corps included victims admitted to local area hospitals. One unit later submitted names of staff they claimed received GSW but were treated and released at the scene.

- Discussion: further investigation revealed some had superficial or minor GSW, but others were seen and released at the scene for stress symptoms without physical injuries. The method of reporting terminology (i.e. RTD versus discharged and admitted versus treated) created confusion in the total number reported.

- Recommendation: report categories and be very specific about the criteria. Admitted, evaluated at hospital and released, evaluated on scene and released (also differentiate between physical and psychological injuries)

MASCAL - Casualty Reporting

- Issue: Initial report on 5 November that Dr. Hassan was in S&W Morgue confirmed by Judge Botkin.

- Discussion: The JP was in the casualty affairs office at CRDAMC. He was on the phone with representatives from S&W inquiring about the status of casualties at their location. He was informed by S&W that Dr. Hassan was in fact deceased and currently in their morgue. This erroneous information was given to PAD, who further reported to command.

- Recommendation: All casualty information will be verified through CRDAMC representatives at civilian facilities during MASCAL incidents, this new procedure will be addressed in additional MOUs that need to be established with civilian facilities.

MASCAL - Casualty Reporting

- Issue: Reporting of accurate and timely casualty information from civilian medical facilities.

- Discussion: Regardless of existing MOUs with civilian medical treatment facilities, the PAD was unable to obtain information on casualties who were transported to local hospitals. Due to possible security concerns for casualties and their facility, the local hospitals were reluctant to release casualty status to CRDAMC PAD.

- Recommendation: Enforce current MOUs and notify civilian facilities of MASCAL incident as early as possible in order to establish communication. Engage command immediately when issues are identified.

MASCAL - Casualty Reporting

- Issue: Engage III Corps Surgeon and CRDAMC Senior Officer Representative in III Corps IOC.

- Discussion: Absence of III Corps Surgeon PAD representative and senior CRDAMC officer in the IOC added to the confusion of casualty reporting (terminology).

- Recommendation: The III Corps Surgeon PAD representative and senior CRDAMC officer must be present in the IOC in order to further clarify casualty terminology and status for III Corps Senior Leadership.

Command and Control

COMMAND AND CONTROL

- <u>Issue</u>: Achieving COP early in the MASCAL

- <u>Discussion</u>: Info sharing and establishing COP is best conducted at Ops Center. Ops Center has multiple means to communicate with all parties involved (VTC, conference phone, radios, etc.). CMD GRP also received updates in offices but achieving COP at both Ops Center and CMD GRP was a challenge. Information flow is wherever the CG needs it to be, but responsive to the immediate decisions required – Phantom Seal, lockdown, CRB activation

- <u>Recommendation</u>: Once Ops Center is established, info needs to be shared between all. Need a deliberate battle handover to enable the EOC to pick up all reporting and routinely update the CMD GRP
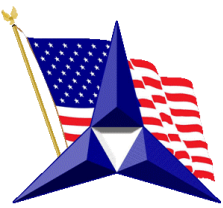
COMMAND AND CONTROL

- <u>Issue</u>: LNOs at the EOC

- <u>Discussion</u>: LNOs from units facilitated communication and provided both the EOC and unit with SA. LNOs from the CRB, Mobilization BDE, Hospital, DES, 36th EN and DA were very useful in facilitating two-way information flow

- <u>Recommendation</u>: Immediately require affected units to send an LNO to the EOC so information sharing/SA occurs early and units can address their concerns

COMMAND AND CONTROL

- <u>Issue</u>: Lead and Support Relationship

- <u>Discussion</u>: During the incident, III Corps and Garrison were intermixed and trying to solve the problem without a common means for communication. Reports continued to come in through IOC. Orders/Fragos, issued through CHOPS throughout became more challenging once SIPR was used for Memorial Ceremony. Phone rosters required on-the-fly updating and portal usage was not immediate.

- <u>Recommendation</u>: Initial FRAGOs should establish a stream-lined communications apparatus with EOC phone numbers and POCs, share portals, how orders will be issued, along with CCIR, LNO requirements, and reporting requirements.

COMMAND AND CONTROL

- <u>Issue</u>: Utilization of Big Voice

- <u>Discussion</u>: IOC initiated Big Voice during the incident to advise the Post of the situation and issue instructions. Use of the Big Voice prevented a lot of phone calls into the IOC/EOC for basic information. Big Voice initiated the moment of silence and used both recorded and scripted communications

- <u>Recommendation</u>: Continue to utilize Big Voice. Review pre-recorded messages and determine if more are needed or if a generic version fulfills need with a scripted follow-on announcement to add more details.

Immediate Care for Patients

Immediate Care for Patients

- Issue: sufficient numbers and type of staff, equipment, and supplies available to care for patients
- Discussion
  - ED provider staff augmented by Family Medicine Residents, Anesthesiologist, General Surgeons, & others
  - ED nursing staff augmented by additional RNs, & NCOs
  - Patient Administration assets in ED for patient tracking
  - Logistics push system for supplies implemented
  - Blood Bank provides blood per existing trauma protocols
  - Pharmacy staff present in ED and OR
  - Nutrition Care prepares and delivers meals and beverages
- Recommendation: continue with current plan

Installation Security

CRB

FPCONS

SUSTAIN

- Issue: Overall CRB Response Execution.
- Discussion: CRB provided outstanding support to crisis reaction/response. 3d ACR anticipated the requirement and redeployed 2/3 ACR (Sabre) from field training prior to official activation of the CRB. The CRB met or exceeded all timeline gates required by the Fort Hood FP Plan:
  - o Cordoned the crime scene.
  - o Augmented ACP operations IAW OPN Phantom Seal.
  - o CRB effectively executed enhanced FPCON at 22 sites.
- Recommendation: Continue exercising CRB during all installation FP exercises.

INSTALLATION SECURITY- CRB (6a)

IMPROVE

- Issue: CRB use of CRB Specific Equipment.
- Discussion: The CRB initially deployed without their distinctive CRB vests and vehicle placards. Although the unit had just redeployed from field training, this lack of distinctive identification had the potential to cause confusion since DES/CID were initially searching for an alleged 2nd Soldier assailant. CRB only has 24 LMRs plus base station.
- Recommendation: While designated as the CRB, the specified battalion should maintain ready access to CRB equipment (even while in the field) to ensure CRB deployment and mission execution in correct uniform. Garrison FP will work funding for additional radios through CVAMP.

3d ACR (CRB 6a): Post Lockdown

- Issue: Determination and Execution of Post Lockdown Tasks

- Discussion:
  - Dissemination of lockdown status by CoC, "Big Voice," media (channel 10), or other method (AM radio)
  - Enforcement of lockdown by DES, CRB, or unit personnel
  - Understanding of exceptions, such as CRB personnel or emergency vehicles
  - Method and order of "unlocking" post

- Recommendation: Publish clear lockdown and release from lockdown guidance

3d ACR(CRB): Communications (6a)

- Issue: All post responders, to include CRB, need to have a coordinated and synchronized communications architecture and plan.

- Discussion:
  - Multiple methods used during incident: FM, cell phone, DES radios
  - Require one "command net" for direction and cross talk

- Recommendation: Establish a principle means of communications for all responders, with the EOC as the lead. The CRB should use FM as the primary C2 means, and report to/from the EOC via phone or DES radio. CRB should use LMR or other to augment FM comms. EOC, IOC, or mobile CP should have FM capability.

INSTALLATION SECURITY- - FPCONs (6b)

SUSTAIN

- Issue: Overall FPCON Decision Making Process during Crisis Reaction.

- Discussion: Timely FPCON measures provided adequate protection against the threat. As threat diminished, FPCON measures changed, continuing to provide security without over reaction. Phantom Seal was executed only as long as necessary to verify elimination of threat. Modified FPCON measures provided enhanced protection against copy cat and potential follow-on attack. FPCON was methodically reduced to achieve normalcy.

- Recommendation: Continue threat based approach to FPCON during all FP Exercises and any future crisis response operations.

INSTALLATION SECURITY- - FPCONs (6b)

SUSTAIN

- Issue: Overt FP Guard of Non-Contiguous Housing.
- Discussion: FP Guards at Non-Contiguous Housing ACPs provided security to a portion of the community with long standing security concerns. Once specific threat was quickly eliminated, residents remained apprehensive due to perceived vulnerability. Extended guard presence enhanced resident security perception and allowed command information operations to prepare residents for normalcy.
- Recommendation: Continue FP guards at non-contiguous housing area ACPs during future terrorist crisis reaction/response operations. Revalidate/raise CVAMP prioritization to fund permanent fencing for all non-contiguous housing at Fort Hood.

INSTALLATION SECURITY- - FPCONs (6b)

SUSTAIN

- Issue: Coordination for FPCON reductions as the installation returned to normal operations.
- Discussion: Coordination with DFMWR facility managers, AAFES and DECA store managers, KISD, DHR, USADMC, and family housing mayors proved critical to reducing panic and preparing the installation and community for a return to normalcy. Active discussions with key stake holders created buy-in and allowed stake holders to prepare their constituencies for change of operations.
- Recommendation: Establish links with all key community stake holders; share themes and messages often; consult/acknowledge stake holder concerns prior to executing FPCON changes.

IMPROVE

- Issue: Execution of FPCON D/Shelter in Place.
- Discussion: Rapid VOCO decision implemented DES "Phantom Seal" lock down of the installation ACPs, FPCON D High Risk Target shelter-in-place and limit to all but mission essential movement. Even with community notification over "BIG VOICE" and mass Fort Hood email distribution, numerous Soldiers and family members continued to go about their daily non-mission essential business. Complacency potentially put them at risk.
- Recommendation: Push ATFP Command Information stressing required individual actions in heightened FPCON situations.

IMPROVE

- Issue: Force Protection Condition (FPCON) Compliance.

- Discussion: Garrison ATFP Red Team inspection of numerous high occupancy facilities during heightened FPCON found uneven enforcement by facility mangers (specifically measure C 4, limit high risk target access point to absolute minimum).

- Recommendation: Conduct Command Group directed threat assessment and FP Review. Use Command Information Program and reinforcement during monthly FPWG meetings to explain and reinforce facility execution of specific actions to comply with FPCON standards.

INSTALLATION SECURITY- - FPCONs (6b)

IMPROVE

- Issue: MSC Reporting of FPCON Execution and AT Training Status.

- Discussion: OPORD PC 09-11-650 instructed all organizations to report FPCON compliance to the EOC. FRAGO 1 to the OPORD instructed all MSCs to verify and report their AT Level 1 training status for Soldiers and civilian employees IAW AR 525-13 NLT 13 NOV 09. 4 of 26 Fort Hood units and 1 of 10 Garrison agencies complied with the reporting requirements.

- Recommendation: EOC ATFP reps establish tracking systems for report compliance. MSCs enforce AT training standards to ensure Soldier and employee AT training compliance(Levels I and II).
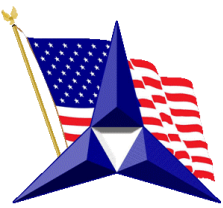
Investigation

Investigation

- Issue: Logistical support during initial phase of investigation (sustain)

- Discussion: Logistics support for interagency effort involving large numbers of investigators quickly overwhelmed internal resources of the CID Detachment and Battalion. Garrison quickly provided requested resources once made aware of the need.

- Recommendation: Designate a logistics LNO for CID to work billeting, sustainment, investigative requirements (large evidence receptacle), communications shortfalls and other requirements specific to a extraordinary event.

Investigation

- Issue: Public's desire for information versus integrity of sensitive case information that jeopardizes prosecution.

- Discussion: Must strike a balance to satisfy the press' need for information and the Command's desire to appear transparent, while ensuring case sensitive information is protected. Historically, defense teams use disclosed information to display carelessness and "prosecution in the press".

- Recommendation: Review of all proposed press releases concerning investigation by III Corps SJA and CIDC PAO.

Investigation

- Issue: Operational support from III Corps and FT Hood (sustain)

- Discussion: Numerous requirements surfaced that were beyond CID/FBI capabilities. III Corps and FT Hood staff responded quickly and effectively. Examples – obscuration fence, EXPANDO van, tentage, aerial photography, CRB crime scene security.

- Recommendation: Continue this outstanding support effort.

Investigation

- Issue: Army's commitment to giving Corps a dedicated Provost Marshal Cell facilitated MP functions throughout this event (sustain)

- Discussion: With the 89th MP Bde Cdr deployed, there would have been no 0-6 level Senior MP officer with staff to coordinate law enforcement and criminal investigative efforts and ensure vertical information flow to the command group. III Corps staff had a single responsive POC for these functions.

- Recommendation: This event validated this requirement. Maintain this requirement.

Family/Survivor Care

JVB

Casualty Assistance

8.a. Family/Survivor Care

JVB - Improve

- <u>Issue:</u> Mission & Roles of the JVB

- <u>Discussion:</u>
  - Started out as a JVB, morphed into something else
  - More of a family reception entity
  - Mission Creep; good ideas turned into JVB tasks with little or no analysis (travel, lodging, donation management, etc)
  - Expectation Management from higher, EOC, SGS, CDRs
  - JVB C2; G2 actual escorted Sec Army and CSA, DG2 picked up JVB supervision

- <u>Recommendation:</u> If the focus is on families and escorts, call it something other than a JVB. Give the task to an organization with the right experience to deal with grieving families, then assign Corps Staff to augment.

8.a. Family/Survivor Care

JVB - Improve

- Issue: Command & Control of Escorts

- <u>Discussion:</u>
  - Every family (whether of deceased or injured) required a Ft Hood assigned escort officer
  - Escorts and drivers not identified early on and frequently changed
  - Not enough initial emphasis on the criticality of this requirement
  - Not task organized under JVB
  - Roles & responsibilities of escorts not clearly defined early

- <u>Recommendation:</u> Direction, guidance, and emphasis to units early. All Escort Teams OPCON to JVB for planning and execution.
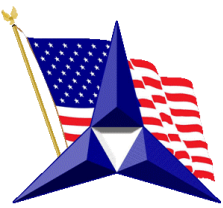
8.a. Family/Survivor Care

JVB - Sustains

- All families were received well and taken care of throughout the event

- JVB Team (including Escorts) were adaptive and highly professional

- External Community Organizations were vital to the overall success of the JVB
  - DOL, MWR, AUSA, Post Lodging, DHR Coordinator

Casualty Assistance - Improve

- <u>Issue:</u> Family Member Assistance of Deceased

- <u>Discussion:</u>
  - CAC must be allowed to carry on conducting their critical support actions ICW DA CMAOC per normal SOP as many actions are driven by legal or regulatory requirements
  - CAC was interrupted and distracted during this event by numerous RFIs, slide updates, requests for information that simply was not yet available due to normal CMAOC timeline

- <u>Recommendation:</u> DHR will maintain 24 hour casualty representation in the IOC with access to DCSIPS IOT update EOC Operations

8.b. Family/Survivor Care

Casualty Assistance - Improve

- <u>Issue</u>. External Donor Coordination

- <u>Discussion</u>.

  - No Garrison agency designated to coordinate and track donor support

  - DHR assumed the mission and was effective in making it happen ICW the JVB

  - DHR was consumed with casualty operations, re-establishment of SRP operations and care for their SRP employees affected by the incident.

- <u>Recommendation</u>.

  Designate the agency who has the lead for accepting, coordinating and distributing and tracking external donor support to family members. Logic points to Family Assistance Center or SFAC.

8.b. Family/Survivor Care

Casualty Assistance - Improve

- <u>Issue</u>. Family Member Assistance of Wounded

- <u>Discussion</u>.
  - Family assistance to wounded is a unit responsibility
  - The JVB was extremely successful and instrumental in coordinating and tracking this support ICW DHR and CRDAMC reps.

- <u>Recommendation</u>: Identifying JVB personnel as additional duty or designate the SFAC as the agency that will coordinate and be the lead for all assistance to wounded and their family members since that is their primary mission already. Stand up the SFAC with a rep in the IOC.

Media Response

PAO IMPROVEMENT ISSUE NO. 1

Issue: Lack of Media Ops Center located separately from Media Relations Branch

Discussion: Immediate activation of a pre-designated MOC could have significantly reduced pressure on small MRB staff

Recommendation: Designate, equip & exercise stand up of MOC to support all significant post incidents

PAO IMPROVEMENT ISSUE NO. 2

Issue: Lack of adequate communication assets to execute mission in crisis mode

Discussion: PAO staff disbursed across post to support myriad of media activities. Small number of cell phones & Blackberries meant staffers had to use personnel cell phones to coordinate efforts

Recommendation: Perform critical review of assets on hand and develop procurement package to meet staff needs & stand up of MOC

PAO IMPROVEMENT ISSUE NO. 3

Issue: Media query tracking process inadequate during initial surge.

Discussion: PAO has a SharePoint tracker, but queries came in too fast to keep pace. Paper copies were kept, but some calls weren't recorded. Actual numbers, as a result, are low.

Recommendation: Update & automate office SOP on query tracking. Grant staff augmentees access to SharePoint capability to ensure better documentation.

PAO SUCCESS STORY NO. 1

Issue: Demonstrated rapid growth & integration of PAO staffs to meet crisis response needs.

Discussion: Fort Hood PAD commanders, CRDAMC & DivWest PAOs all responded immediately so that staffing could be expeditiously augmented.

Recommendation: Review and update local, command & OCPA procedures on augmenting PAO staffs, to include all possible regional AC/RC assets. OCPA assignment of PAOs to support CAOs should become routine procedure, regardless of incident magnitude.
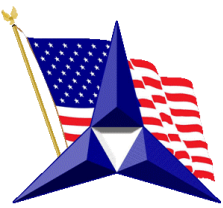
PAO SUCCESS STORY NO. 2

Issue: Rapid division of labor – based on areas of expertise – was crucial in quickly responding to media

Discussion: BG Boone, Deputy Chief of Army PA, on site to provide leadership council. Worked closely with PAO to develop focus areas:
- General inquiries
- Medical-related questions
- Investigation updates

Recommendation: Priority be given during initial PAO response efforts to identify & focus on critical topics.

PAO SUCCESS STORY NO. 3

Issue: Consolidation of locally generated activity reports, news releases & talking papers for up-channel situational awareness was consistent over time.

Discussion: All PAO elements – to include CID, CRDAMC & DivWest PAOs contributed daily feedback which was basis of daily (sometimes multiple) SitRep to all PAOs impacted Army-wide.

Recommendation: Direction be given by OCPA that all PAO Teams designate a specific staff member to gather & update senior leaders & external PAO.

PUBLIC AFFAIRS WAY AHEAD

- Stand up Media Ops Center in basement of Bldg 1001 staffed by PAD Soldiers

- Continue to facilitate access for all media reps remaining in the local area

-Evaluate requests for Soldier & witness interviews with CID and support as appropriate

- Maximize use of all Command Info products to inform & educate greater Fort Hood community
    • Rumor control is the parallel internal focus

- Coordinate & announce media events as needed

Reporting

REPORTING

- <u>Issue</u>: Initial Reports to IOC/EOC

- <u>Discussion</u>: Reports submitted were unformatted, contradictory and of varying reliability. As a result, erroneous data was either acted upon or reported as factual without a means to validate in a timely manner

- <u>Recommendation</u>: IOC/EOC enforces a 5w report format when another format is not specified. Recording Who is rendering a report may be useful in screening for reliability and enables more accurate confirmation if there is confusion or contradictory reporting.

REPORTING

- <u>Issue</u>: Reports to Higher

- <u>Discussion</u>: IOC initiated SIR reports to IMCOM and FORSCOM during the initial hours of the incident. Reports, approved by CHOPS, allowed IOC/EOC to focus on the situation and continue to gather information. DA provided a format for routine reporting.

- <u>Recommendation</u>: IOC continues initial reporting in SIR format using approved distribution lists.

REPORTING

- <u>Issue</u>: Standard Reports to Higher/Unity of Effort

- <u>Discussion</u>: As the situation stabilized, standardized, routine reports were submitted by various organizations (MEDCEN etc), but what was reported was not specifically tracked/coordinated through the EOC. The EOC had data slides and analysis slides to present to the CMD GRP but not all were report worthy

- <u>Recommendation</u>: Single approval chain for reporting through EOC and CMD GRP applies to all on post agencies and units. Other staff agencies/sections send reports only after EOC reviews to ensure compatible CMD approved information. Code EOC update slides for fact (reportable) vs analysis (non-reportable) and upon <u>approval report using update slides.</u>

REPORTING

- <u>Issue</u>: CCIR Established

- <u>Discussion</u>: III Corps established CCIR a couple of hours into the MASCAL. This served to focus EOC efforts in collecting reports and providing updates.

- <u>Recommendation</u>: (Sustain) Take the time early to collaboratively establish CCIR to focus the effort and provide a basis from which to adjust.

External Support

Medical

Law Enforcement

External Support (11a) Medical

- Issue: Dual reporting to Southern Region Medical Command and III Corps

- Discussion: Requirements to simultaneously report information to two separate chains of command added to the confusion of report to higher commands

- Recommendation: Ensure unity of command through the incident commander. All reports from CRDAMC must be routed through incident command headquarters (III Corps)

External Support (11a) Medical

- Issue: on 5 Nov, requests made for blood & rapid sequence intubation medications

- Discussion:

  - Blood products brought by air from BAMC and WHMC

  - Products received in trauma push-pack were primarily red blood cells, did not include clotting agents

  - RSI drugs brought by ground from Temple VA

  - ED was the only place short of RSI drugs, sufficient amounts available in ICU and OR – internal communication breakdown

- Recommendation: improve internal communication for cross-leveling when shortages exist; provide specific breakdown of blood products needed based on types of injuries

External Support (11b) Law Enforcement

- Issue: Multi-agency First Responder Cooperation (sustain)

- Discussion: Due to the outstanding relationship building efforts by FT Hood Emergency Response personnel, a multitude of civilian agencies monitored emergency net and responded to support without official requests from FT Hood. These agencies took direction from the FT Hood Mobile Emergency Command Post on scene who ensured unity of effort and unity of command. This gave the incident commander flexibility to surge and respond as needed.

- Recommendation: Continue this outstanding relationship.

External Support (11b) Law Enforcement

- Issue: Interagency Investigative Cooperation (sustain)

- Discussion: Waco FBI office maintains an LNO with FT Hood CID. Continuous coordination and active investigative cooperation between CID and FBI facilitates efficient interagency execution. Texas Rangers offered support and were quickly integrated into the investigative process.

- Recommendation: Continue cooperative relationship through frequent joint investigations and daily interaction.

External Support (11b) Law Enforcement

- Issue: CID Command's support in PAO and Crime Lab and the MP School's support in Critical Incident Peer Support (sustain)

- Discussion: While the FT Hood CID office had sufficient resources to handle this investigation, CID Command and the MP School sent subject matter experts to assist and provide on scene evidence collection support to our already proficient CID Agents. CID PAO worked closely with III Corps PAO to shape the message regarding the crime and support the Corps' PAO campaign.

- Recommendation: Continue to take advantage of these resources.

Deployment Effects

SRP

Affected Units

Deployment Effects (12a)

SRP- Improve

- <u>Issue</u>. Safety and Security at the SRP site

- <u>Discussion.</u>

  - DPW and DES provide limited visibility barrier over windows in Bldg 42000
  - Install silent alarm at front desk direct to MPs
  - Long term-barrier around compound to control flow and traffic
  - Short term actions for Iron Horse Gym SRP processing include armed guards and access control points.
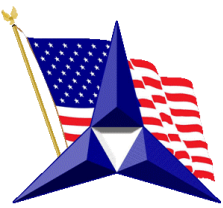
- <u>Recommendation</u>.

  Action items as deemed appropriate by DPW and DES subject matter experts, as quickly as possible. Directorates look at their internal operational facilities and determine actions based on lessons learned that may need to be implemented within their facilities.

SRP - Sustain

- <u>Issue</u>. Suspension of SRP operations for 3 days following incident

- <u>Discussion</u>.
  - The SRP staff which includes medical, dental, and finance were traumatized by this incident.
  - The decision to suspend SRP ops until after Veteran's Day allowed those employees and Soldiers down time to deal with the situation, spend time with families, attend the Memorial Ceremony, attend counseling and overall begin to recover.

- <u>Recommendation</u>. Sustain. Make the decision early in a traumatic event such as this.

Deployment Effects (12a)

SRP - Sustain

- Issue. Immediate trauma and grief counseling for employees and Soldiers

- Discussion.
  - Eight chaplains were on site immediately following the incident.
  - Medical personnel began receiving counseling the day after and the SRP personnel received counseling within 72 hours.
  - Behavioral Health Specialist set up on site to continue individual counseling which facilitated employees recovery and ability to "get back to normal" and move forward.

- Recommendation.   Sustain.

DEPLOYMENT EFFECTS – Affected Units 12b

- <u>Issue</u>: Units are affected by the 5 Nov incident which may have an impact on their deployability.

- <u>Discussion</u>: Affected units not only must deal with the aftermath of Soldiers killed and injured, they must also assess the impact on ability to deploy IAW the current timeline. This will include an updated status of personnel including critical MOS and an objective/subjective assessment of their ability to deploy and function.

- <u>Recommendation</u>: Formalize the timeline, assessment metrics and decision points initiated by 1st Army Division West to enable objectively based decisions on a unit's ability to deploy and establish a timeline to follow.

Memorial Ceremony

Memorial Ceremony Planning – FUOPs

- <u>Issue:</u> MSE and Garrison Staff support during planning efforts

- <u>Discussion:</u>
    - Ability of MSE/Garrison to retain flexibility to execute short-notice support requirements reflects positively on MSE capability
    - MSE/Garrison is poised to execute requirements effectively and efficiently
    - Uniformed staff needs to better understand MSE's role and how to best support the MSE/Garrison
    - MSE/Garrison collective resident knowledge of Fort Hood proved vital during planning and execution of memorial ceremony

- <u>Recommendation:</u> Sustain working relationship with MSE/Garrison staff to maintain III Corp's ability to react to a post-incident crisis

Memorial Ceremony Planning – FUOPs

- <u>Issue:</u> Use Major Subordinate Command (MSC) LNOs during planning

- <u>Discussion:</u>
  - Inclusion of MSC LNOs during OPTs mitigates the impact of short-notice tasking requirements

- <u>Recommendation:</u> Use existing tasking distribution list (MSE Tasking) to request MSC LNOs attendance during OPTs

Memorial Ceremony Planning – FUOPs

- <u>Issue:</u> Cell phone communication unreliable

- <u>Discussion:</u>
  - Cell phone communications were unreliable during the execution phase of the POTUS visit
  - G6 radios were utilized by ceremony personnel for coordination of actual ceremony
  - No additional radios were available for key personnel who needed them to handle unforeseen events

- <u>Recommendation:</u> Additional radios for action officers / POCs should be maintained by the EOC and available for distribution during crisis

Memorial Ceremony – SGS

- Issue: Handicap/Elderly Access to Memorial Ceremony

- Discussion: Currently, no wheelchair ramp exists at the command group entrance of Corps HQ. Wounded Soldiers had to be assisted down the steps to their seats. Elderly community leaders could not enter at the DV entrance and instead had to walk to the western VIP entry point.

- Recommendation: Construct or purchase a wheelchair ramp for the Corps HQ command group entrance. Plan for elderly community leaders to enter the ceremony through the shortest route possible.

Memorial Ceremony – JVB

- <u>Issue:</u> Synchronization of Visitor Movement

- <u>Discussion:</u>
  - Distinguished Visitor movement did not sync with family movement
  - Post ceremony plan for family and DVs not well known
  - Develop contingency plans for the unexpected; child care, lost items, water, lost/ wandering family members, facility maintenance, room temp, etc

- <u>Recommendation:</u> Define & rehearse actions on the objective

Donation Assistance

Donation Assistance

SUSTAIN

• Pre-established procedures were in place and responsive for gifts to MWR and the Chaplain's Fund.

• Commanders and staff understood the GENERAL rules on gifts, and raised issues before committing or accepting a gift/donation.

• Private Organizations (USO, AUSA, etc.) were very helpful and quick in filling gaps in re: the needs of Family and friends of victims (e.g. airline tickets, hotel rooms, rental cars).

Donation Assistance

IMPROVE

• DoD rules need to be more flexible on giving cash donations directly to Families.

•   Faster guidance on the SPECIFICS of donations, actual process, and POCs (both Army and Private Organizations) for sending and accepting various types of gifts (cash, items, plane tickets, etc.); need installation "crisis" SOP.

•   Faster distribution of the unit and CAO POCs for Families and victims (information pushed vs. pulled from unit representatives). Due to concern for privacy and Family contacts, information on wounded POCs was not as quick as for deceased Soldiers and civilians.

Cost Tracking

RM After-Hours Contacts

- Issue: Resource Management support for emergencies and crisis situations after normal work hours

- Discussion: Ops Center for MSE G8, Garrison RM and MEDCEN RM maintain a list of Resource Management contact personnel for after-hours funding situations

- Recommendation: Continue current practice, ensuring lists are updated as needed and provided to Ops Centers

Cost Tracking

- Issue: Cost tracking for emergencies or crisis events

- Discussion: HHQ guidance normally is received after a crisis situation occurs, directing establishment of cost tracking codes in the financial system and periodic reporting requirements IOT to identify support costs for potential reimbursement

- Recommendation: Resource Management offices establish a cost tracking methodology each fiscal year to identify costs for crisis situations; amend as required when HHQ guidance is received

Way Ahead

△ EXSUM NLT 20 NOV

△ Gather documents for archiving

△ Draft AAR 4 DEC

△ Final AAR and OPLAN recommendations: 11 DEC

III Corps and Forth Hood
05 NOV 09
After Action Review

17 NOV 09