LESSONS LEARNED

11 September 2001 Attack on the Pentagon

Information Source: This is the second set of lessons learned submitted in reference to the 11 September 2001 attack on the Pentagon. These lessons learned are gathered from an additional 26 taped interviews conducted with Navy Pentagon personnel, Navy Liaison team members at Port Mortuary Dover, and U. S. Park Police. Interviews were conducted by Naval Historical Center/Naval Reserve Combat Documentation Detachment 206 personnel.

New Findings:

1) The lighting in the renovated areas of the Pentagon was poor. The new glass installed in these areas saved lives by preventing the explosion from getting into the spaces, however it also prevented the smoke from getting out. The roof burned because of all the wiring and insulation running through the attics, with few firebreaks.

2) The fire doors in the Pentagon closed in response to the attack, trapping some people behind them. People did not generally know how the doors operated.

3) Communications were very difficult among the various people attempting to rescue the injured and trapped in the Pentagon. This made it difficult to coordinate with each other concerning rescues and equipment requirements.

4) Communication was difficult among the various emergency personnel called to the scene. Rescuers included many civilian organizations such as the U.S. Park Police, local fire departments and MEDSTAR, as well as military units. The military does not have many resources to communicate over civilian frequencies.

5) The civilian responders were able to quickly access the situation and recognize their various counterparts due to frequent training among the local agencies. Many of the agencies have preassigned jobs for responding to mass casualties. In this way the chain of command is preset at the start for the civilian responders.

6) Remains recovery was made difficult because of the lack of ability to communicate with respirators. There was confusion among the recovery team about who was in charge. Many people identified their first aid military training as helping them in this effort. Non-medical personnel, unused to dealing with human bodies, were the most adversely affected by trying to help in the recovery efforts

7) There was a great deal of work lost on the hard drives of computers. Backups of paperwork on CD ROMs in separate areas from the primary office locations were not routinely kept, making continuity of operations more difficult. Many people had to recreate months worth of work from their memories.

8) The Navy Liaison team at Dover experienced difficulty in setting up initial operations due to the lack of an instruction for the person in charge of Navy mass casualties. They were also lacking any guidance on the process for a family to accept partial remains. In this case they created their own form. Communications problems with the CACOs led to misinformation being passed on to the families. Some CACOs were unaware of the various forms and options the families had. Communications breakdowns also caused inaccuracies, notably on the death certificates, which were filled out incorrectly in some cases.

9) The Navy needs to get smarter on Homeland Defense.

.

Previous Findings, reiterated:

1) The military people that attempted to rescue others felt that it took a long time for the EMT's and Fire departments to respond. They were frustrated because of the lack of emergency response equipment available to them, even though they were trained in damage control, firefighting and related training. They feel that they could have done much more if the equipment had been available to them.

2) Blackberry was the best way to ensure communications between individuals. Cell phones and landlines were overloaded or inoperable

3) The Special Psychiatric Rapid Intervention Team (SPRINT) is vital to helping naval personnel cope in the aftermath of a disaster. This support enabled many otherwise traumatized naval personnel to continue to function with more continuity of operations. The SPRINT team is most helpful immediately after the incident, but there is a need for them to be available 2 to 3 months after the incident as well. The use of the SPRINT team, however, cannot be made an option. Everyone involved in the trauma needs to be required to see the SPRINT team. This alleviates the onus of not receiving the SPRINT services because someone does not want to appear weak.

Recommendations:

1) Place radios for communications at various locations around the Pentagon to be used in case of emergency. Other emergency evacuation and rescue equipment that people would have liked to have were fire hoses, and oxygen breathing apparatus (OBAs). Look at the possibility of stationing a fire truck inside the courtyard area of the Pentagon to ensure minimal response time.

2) Designate preassigned individuals as Incident Commanders who have the ability to respond and function in their roles immediately. Exercise those functions and individuals periodically. Make these emergency roles and the personnel assigned known to others.

3) Research use of a common frequency that may be used by military and civilian agencies during emergency operations. More frequent training evolutions between military and civilian units will facilitate this.

4) When doing recovery operations limit personnel to those with prior medical training as much as possible. The use of non-medical personnel may cause those people to become more of another casualty rather than an asset.

5) Implement some type of emergency preparedness training within the military training program. Even civilian personnel can benefit from some type of mandatory emergency certification. Encourage a proportion of each command to have Emergency Medical Technician (EMT) training. Continue to provide the solid military training, especially damage control, first aid and fire prevention that people continually credit for their automatic responses in the face of this emergency.

6) When faced with mass casualty initially establish a military officer in charge of any mass casualty liaison operation who is at least an O-6 (first 3-5 weeks). Set up a command post to focus all the aspects of the effort, ensuring a common database with all offices, and a joint meeting held routinely to cover all incoming pertinent information. This enhanced flow of information will increase the accuracy of record keeping. In addition write an instruction in cookbook version to document how to set up the liaison office for mass casualties.

7) Transfer mortuary affairs to the Casualty Branch thus enhancing communication between liaison personnel at Dover and CACO's.

8) Establish a Flag Officer Casualty Advisory Board.

.