Naval Historical Center
Oral Interview Summary Form

Interviewers:
CAPT Thomas Blake
CAPT(s) Michael McDaniel

Interviewer's Organization:
Navy Combat Documentation Det 206
Navy Combat Documentation Det 206

Interviewee:
CDR John Knowles

Current Address:
SPRINT Team

Date of Interview:
28 Sept 2001

Place of Interview:
Navy Annex

Number of Cassettes:
One (Digital)

Security Classification:
Unclassified

Name of Project: Pentagon Terrorist Attack Incident

Subject Terms/Key Words: Pentagon; Terrorist Attack; 11 September 2001; triage; evacuation; lessons learned; Defense Protective Service; FBI; carnage; Navy Command Center; renovation

Abstract of Interview:

Note: This subject is the Officer-in-Charge (OIC) of the SPRINT Team that was stood up at the Pentagon immediately after the 11 September 2001 incident at the Pentagon. SPRINT stands for Special Psychiatric Rapid Intervention Team. CDR Knowles background is in Social Work. He was commissioned in 1986 as a social worker in the Navy Medical Service Corp.

1. The SPRINT team is dispatched within 48-72 hours of a tragedy. The SPRINT team is a medical mobilization augmentation team. They provide critical incident stress management. There are five members that comprise a SPRINT team. The disciplines that make up a SPRINT team include social work, psychiatry, psychology, chaplains, psychiatric nursing, and corpsman psychiatry technicians. They work with survivors of a tragedy to help manage the aftermath of tragedy.

2. The enormity of the 11 September 2001 incident presented a huge challenge. The norm is usually a much smaller incident. There was initial confusion as to where they would be going and who they would be working with. Finding out that the Army and Air Force already had established entities at the Pentagon, the decision was made to coordinate their efforts out of the Navy Annex (FOB #2). There was good coordination by the various personnel in the medical commands based at FOB #2.

3. CDR Knowles described some of the challenges of setting up shop (coordinating office space, procuring computers, getting phone lines, etc) to enable the team to conduct business. Video

teleconferencing became an invaluable tool to disseminate information between key decision-makers, especially with ensuring awareness of SPRINT team role.

4. He was able to recognize that he was experiencing some of the very symptoms that the team was helping others affected by the incident to recognize. He talked about the requests from many fronts for urgent needs from senior people who all needed their requests taken care of right away. They were able to address some high level people to the need for SPRINT team functions early on – during the first couple of days.

5. After the high level meetings they were able to use group settings to be able to conduct critical incident stress debriefings that enable people in groups to discuss what they had experienced and start normalizing their experiences, which help get people back into somewhat of a normal routine.

6. He feels strongly that the whole SPRINT concept of crisis response needs to become a priority in Navy medicine. It needs to be more than just a paper drill. He feels this is particularly true with what are very real potential threats in the future.

7. Normally a command request through BUMED for a SPRINT team to be deployed. He felt the video conferencing helped awareness of the need for critical incident stress debriefings.

8. Command consultation, informational briefs, one-on-one debriefs, and critical incident stress debriefings. The idea is to help personnel process through some of what they have experienced and/or witnessed. This helps them understand some of the emotions they are experiencing and help them help each other in identifying normal and abnormal behavior in others in their work environment.

9. They had seen over 1600 people during the first 20 days. The ideal group is no more than 10-12. Large groups help to educate personnel but is not a optimum environment.

10. The SPRINT team is working on lessons learned themselves as they debrief in coming weeks.

11. Everything they talk with people about remains confidential. The “safety net” was discussed for those not proactively seeking help. He stressed the need for increased awareness of how people deal with trauma in different ways. He expressed the redemptive power in people being able to talk about what they experienced.

12. He suggested using various available Navy & Marine Corps media to educate the fleet on issues relating to stress management, etc. He suggested that the Fleet and Family Support Centers potentially developing stress management programs.

13. Having the team on-scene reaches many more people than if based out of a medical facility, even if a local medical facility exists. This prevents many from slipping through the safety net.

14. CDR Knowles feels strongly that the Navy needs to make the SPRINT team concept more than just a collateral role. He feels this should be as key as any other department in the hospital. He feels, especially with the potential for future terrorist activity, that this should become a priority.

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Interviewee Information: Born and raised in [redacted], Pennsylvania. Has a masters degree in social work. Commissioned in the Medical Service Corps in February 1986. – In 2000 he transferred to Bethesda Naval Hospital where he is the service chief for social work and was also appointed as the officer in charge of the SPRINT [Special Psychiatric Rapid Intervention Team] Team. He was serving in that capacity on September 11, 2001.

Topics Discussed:

Q. John if you would just take a few minutes to tell us what SPRINT Team stands for.

A. SPRINT stands for Special Psychiatric Rapid Intervention Team. The SPRINT Team is a medical mobilization augmentation team and its purpose is to provide what we call critical incident management to contingencies where some sort of catastrophe or tragedy has occurred, there may have been loss of life or severe injuries, major disruption of routine and there are on paper five members on our SPRINT team including the following disciplines: social work, psychiatry, psychology, psychiatric nursing, chaplain, and corpsman psych techs. Typically, we would be deployed, for example, to the site of

a helicopter crash that might have taken place 500 miles from here and we would be working with the survivors of that. It may have been family members or co-workers who were close to the scene, body handlers, photographers. Our job would be to try to make sure that the recovery from that particular type of traumatic stress could be managed in such a way that individuals would resume their normal functioning as soon a possible with the least amount of complication. We would hopefully prevent the development of any long-term psychological consequences that would be debilitating over time, for example, clinical depression or anxiety disorders or sleep disorders, post-traumatic stress disorders, that kind of thing.

What happened on the 11 of September was the kind of thing that we would respond to except to logarithmic proportion. We were awash in the enormity of it, and we ourselves were traumatized by what happened. Speaking for myself, I had just completed a meeting with my staff, I came out of the meeting at about a quarter after 9:00 that morning and our secretary was seated there. She told me that the World Trade Center had been hit by an airplane, and when I first heard that I thought, what a terrible accident. I was thinking maybe a small plane had flown into it. I then went into my office. The phone was ringing; it was my wife calling to tell me she had been watching the news and an airliner had crashed into the World Trade Center. While she was watching the news live, a second airliner hit the second Twin Tower. So, I knew then that there was some sort of terrorist attempt underway.

My immediate thoughts were; I'm glad my wife is safe. I'm glad I'm safe, but what's my future. I immediately began to think about the SPRINT Team and my thoughts were

that we might end up on the next day or so in the center of New York. But as everybody began to turn on the radios, and we had a TV down the hall from where I have my office, it became very apparent very quickly that this thing was a disaster. We then heard that the Pentagon had been hit by a plane. We also heard that there had been an explosion out in front of the State Department; that there were fires on the mall and everybody was just sort of shocked and in a numb state of disbelief. However, within a matter of hours the Command mustered and we were all placed into our disaster response postures. The ENMARC Team, SPRINT, was ordered to muster and to await direction. So that very day we were placed on standby and there was just a lot of anxiety and uncertainty about where we would be dispatched to and where it would actually be.

If I recall correctly we weren't exactly sure where we would be going and it wasn't until about 1900 that we were cleared to go home. But we knew that we had to get our seabags in order and be ready the next day to go where we would be needed, where we would be directed. I arrived the next day and there was some confusion in the morning, a lot of going back and forth about where we would actually be deployed to, when, and who had authorized that. Finally, about 12:45, I was directed by the Directorate Over Prevention and Wellness, which is where my department or service falls at the Naval Hospital, to take the Team and head down to the Pentagon. The plan was to take one of our psychologists and have him go to the DeLorenzo Clinic at the Pentagon and have him scope out what was going on there. We had heard, reliably, that the Army already had a footprint there and we were also hearing the Air Force did. The idea was to have CDR John Lazar go to the Pentagon clinic and the rest of us go to the Navy Annex where we

would begin to assess what was happening and formulate our game plan. I would say we arrived approximately 1345 or so.

We arrived at the Navy Annex and went to the Medical Clinic, located in, I think, it's the 3rd Wing, the 1st deck. There we were met by staff from the clinic and staff from the dental clinic nearby and also a CAPT Ken Schoer, who is a Captain working in the Medical Office of the Marine Corps. He was very instrumental in kind of giving us the lay of the land and what our role potentially might be. He told us what had happened basically in the first 24 hours; that the Navy nerve center had been hit and that all those who survived had been displaced. Many of them had been moved up to the Navy Annex including the very heartbeat of the Navy's leadership, Command and Control, and others had been displaced to Crystal City, to other office buildings and so forth. After getting an idea of the magnitude of those who were affected, and the lay of the land, I met RADM Johnson, I'm sorry I don't know his first name. He is the chief medical officer over at the Marine Corps; at least he was at the time. I think that since then he has been transferred to San Diego.

We explained to RADM Johnson we were trying to sort out where we were going to dispatch ourselves. This gentleman was just profoundly excellent in his ability to see through what was happening and to make a decision then and there. He made the decision that we Navy folks would stay up at the Navy Annex and let the Army and Air Force do whatever they were doing at the Pentagon. Our mission would be to support the

critical incident stress management of Navy leadership and of all of those who had moved to the Navy Annex and had moved to Crystal City.

We reeled in CDR Lazar and we began to set up a game plan. It was very confusing for the first few days because we needed to secure spaces to operate from. We needed to set up communication lines. We needed to have computers so we could track what we were doing and schedule appointments. But I'm speeding ahead a little bit.

What I do need to tell you though is that ADM Johnson, after he made the decision about what we were going to do, had me go up within two hours to do a video teleconference [VTC] before ADM Ryan, the Chief of Naval Personnel, and his entourage. The other parties connected in this VTC included ADM Weaver from Naval District Washington, and, forgive me, I can't remember the other Admiral's name, but BUPERS from Millington, TN. They were all connected and I was given about 5 minutes to explain the SPRINT team and the fact that we were here and we were ready and able to assist.

That was fantastic because we then got the support and endorsement of these very high powered leaders, so we were able then to kind of integrate in and get attention and people trade and to work in with a fairly wide spread population. I will tell you, speaking for myself, after that first day I felt very much like a lightning rod. Every five minutes I was getting a phone call, usually urgent, and it was very hard to keep track of all these urgent requests in the first day or so. I found that I had some of the symptoms that I think

most people have following something like this, poor concentration, some difficulty with short-term memory. As I look back through some of my notes, I can see why. I was getting phone calls and I was just scribbling and every scribble was important and it was just like I was being overwhelmed with sequential or important tasks to deal with; I'm a human being, too.

Within the first couple of days, I would need to look at my notes to get the sequence exact, but within the first couple days we were able to brief some pretty high powered people here including VADM Keating who is with N3/N5. We were able to brief ADM Rout, I don't recall exactly who he was with, I should know, but it is in my notes. Once we got the buy-in from these high level people, then it was easier to break out groups that worked for them and begin to provide the critical incidents stress debriefings that we use to hopefully get people to start talking about their experiences, to start normalizing their experiences. That in itself is healing. It creates human cohesiveness and gets people back to the point to hopefully carry out their individual responsibilities in support of the mission.

Q. Are those briefings, are they part of a normal protocol - the video teleconference that you did?

A. It just was happenstance. If we had gone to a quote normal SPRINT evolution we probably would have gone within minutes of our arrival, or hours of our arrival. We would have met with the Commanding Officer, would have done a quick overview of who and what we do. I felt like I was suddenly placed in an astrosphere I had never been

in before. I'm just a commander in the Navy who has not been around this kind of scene, so I had to quickly learn what N1 and N2 and 3 and 4 and N anything. It's kind of overwhelming at first. It's hard to describe.

Q. What we'd like to do for the remainder of this interview, John, because I'd like us to get a lot more of your personal observations, particularly in your capacity; but also personal testimony. But, right now we're looking at some lessons learned, things that we're putting together for the historians to put together next week. And if from a disaster relieve, looking at, potential terrorist threats aren't going to go away. We are going to have situations in the future. What are some things in your capacity, what are some of the lessons learned that are fresh in your mind right now? Realizing that we are going to go back and take a more in-depth look at this later, what are some things that worked, what are some things we can put into place from your purview?

A. First of all, I think that the whole SPRINT concept of crisis response and buoying up mental health has got to become a very prominent issue for Navy medicine and for the Navy at large. I don't know if I want this on record but I had been kind of disappointed that since I had been at Bethesda, it had just seemed to be just kind of a paper drill. In the past year I had been working with the time I had to get our team up and running right and to getting people to know one another, to arrange training and make sure everybody had a clue as to what our real purpose was and bring home the reality that this could happen to us. So, in retrospect, I think that a lot of attention needs to be paid to this since we're probably going to be attacked multiple times again in the future, that we have the assets,

that we have teams trained, that we have plans formulated, that we have teams located in different places where they are ready to go as soon as possible.

Also to answer your question, if all of us who were collectively involved with this are intending to do an after action report, where we kind of brainstorm together all of our thoughts and all our ideas about how we can make this thing work right in the future, work better in the future, I think that it did work right. I think we've done a lot of good, but l think we came in sort of a haphazard way. That doesn't make a good case for the future, so I'm hoping that from our after action and from our lessons learned we will be able to develop an SOP that would be useful for the Navy. I hope we can do something in concert with the other Services who were involved in this so there could be some joint effort, some sort of congruency among all of us in terms of how we approach these contingencies.

Q. Is there more than one SPRINT Team?

A. Yes, there is. I don't know exactly how many, but I think there are at least six. I know that there are at least four in the continental US and at least two overseas.

Q. And the normal makeup of all the SPRINT Teams is about the same, 5 or 6 people?

A. That's right sir.

Q. For deployment purposes do they keep you under the medical hat or do they chop you into a command when they send you out trying to make it easier?

A. Normally, a command has to request BUMED that a SPRINT Team be dispatched to a contingency. BUMED will designate which team will go and authorize a medical treatment facility where one is housed.

Q. Do you think the Video Teleconference that was set up with the Admirals actually helped to flow into the process and start showing up?

A. Yes, it did. Not for everyone, but it did for many. In one particular command folks were ordered to come the briefings. I'm sure that all must have benefited, but I'm sure that some who were forced to come were not as open and engaged in everything we were doing in the briefing. Hopefully, they got something from it. If anything, they could use the handouts in their own private moments or with whoever their own actual support system is to be able to try and address concerns and to be able to kind of open up and begin the healing process.

I ought to mention to you, too, that what the SPRINT team actually does when it intervenes in a situation. First, we do command consultation to make commands aware of who we are, what we do, and what we hope the outcomes will be. Secondly we do informational briefs that are like stress management briefs to large audiences. We also do one-on-one consultations for folks who may need that. We also do what we call the critical incidents stress debriefings. This follows a model that was developed probably 15 or 20 years ago by a gentleman named Jeff Mitchell who has had a lot of experience with crisis response and has developed this model. Now we don't use his pure model all the time, but we pretty much follow it. The model is all to do with trying to get people to

express the facts as they remember them and then, in sequence, have them express the thoughts associated with the moment they remember, the feelings and reactions that they had.

It moves into a period where we allow people to vocalize their response, to discuss the physiological symptoms that they may be having. Then we take a period of time to teach, to normalize these symptoms, and to make them realize that they are all having normal reactions to an abnormal event. We try to kind of restore their coping mechanism by normalizing and by providing some expectancy. We go into things like making sure people get enough rest, that they exercise, that they eat properly, that they avoid substances, alcohol abuse, and that they try to resume normal routine as quickly as possible and that they force themselves to do that a little bit at a time if that is what it takes. We also try to get people to avoid a morbid preoccupation with what happened by maybe watching too much TV, too many reruns of the event. We just don't want to have that imprinted too deeply to the point where it retards.

Q. So, it is pretty critical that your team is dispatched immediately?

A. Ideally, we should be dispatched 48 to 72 hours following an event. In this instance, because of the fact that we were so nearby, we were here within 30 hours. For many, that may have been just a little bit too soon because they were in a state of chaos and numbness, including ourselves to a certain extent. I think many of us were still rather stunned and shocked and trying to digest this psychologically ourselves when we were put into the role of having to be the healers in this.

Q. Did you get many people in the first day or two that you got here, or did you start to get more people later on?

A. I would say in the first day, yes, we had quite a few, but the growth curve went kind of like this; and then it went very high, and then this last week it has been tapering off a little bit. Altogether, I can tell you that we have seen over 1600 people in the two and one half weeks since we've been here, in various settings. Most of those folks we have seen in our debriefing sessions and the size of those groups has been from 3 or 4 to maybe as many as up to 30 or so, which is not ideal. We like the groups to be between maybe 15 or 20; and they last for maybe an hour and a half or two hours.

Q. So the group concept is pretty strong in getting them into there?

A. Yes, we would rather have people come in as a group and we would rather have there be some homogeneity to the group; people who maybe worked together or people who've had similar experiences. For example, body handlers or people who may have been close to a particular aspect of this that they all shared a common experience. That's what we try to do. If anybody needs individual attention, usually they fall out from the group or we are able to recognize them, or they come forward and tell us that, gee, this was helpful, but I think I need more.

Q. Is there any specific or general problem that you're seeing with the people after a traumatic terrorist type action rather than more of a typical accident that we might expect to see in the Navy, like a ship being hit or something?

A. Well, it may be too early to comment on that. The reason I say that is I have a colleague who is functioning as the OIC of the SMART Team down with the Army in the Pentagon.

Q. SMART Team?

A. I'm not sure what that acronym stands for, but it is the Army's SPRINT equivalent. This gentleman's name is Lieutenant Colonel Durham Kotter. He had direct experience with those who had been at the site of the bombing in Oklahoma City several years ago. He was telling me yesterday at lunch that a lot of people didn't begin to show troublesome symptoms and reactions to that until about 30 days out. So we've got to kind of try and track this and see where it goes. So far I can tell you that of the 1600, probably only about 5 or 6 people that we have seen are we pretty concerned about, maybe 2 or 3 have required some medication.

Some of those people had pre-existing issues, you know, maybe they had gone through trauma somewhere else in their lives and this triggered that event and it had never healed properly. Or, there may have been some other extraneous things going on in their lives that were sort of confounded and compounded by this. We've talked to some people that, for example, had morale problems in their work units and that sort of thing. And, by the way, when SPRINT goes in we treat everything that we do confidentially. We don't take names, and we don't take notes. Everything that is said in the room usually stays in the room. We're not secondary investigators. I think that is one of the perceptions the military has that prohibits deployments, that we'd like to have

their help, but if they do that, our dirty linen may be hanging and they're going to be a backup to NCIS. Well that is not our role at all. We do hear these things. You can't help but hear things like that, there might be some morale or some management problems, leaderships problems or rivalry or animosity among co-workers. Those are things that usually predispose the worst kind of reactions.

Q. Did you find any problem here, since you had both civilian and military, where you don't have the civilian medical records to fall back on?

A. Well, in the case of civilians we really have to refer them if we feel they are in need of some sort of acute attention. We need to tell them they ought to go and see their primary care provider or send them in the direction of where ever they seek their care. But for the military, of course, we can work through the clinic here to make sure people get the intervention they need or if they require some sort of medication.

Q. Would it all be voluntary on their part? I mean you just recommend to them on following up. Is there any way of following up, or does that break the confidentiality?

A. It kind of does, and I wouldn't be in a position to write prescriptions anyway. You really need to have a psychiatrist comment on that, but being that we're all military and in the Navy we do have to watch out for folks that we think are not functioning well, not returning to a healthy state. So, of course, we would have to track them. We do it by trying to protect their confidentiality to the best of our ability.

Q. What about a safety net? What is the safety net to make sure that those—obviously you can't make someone come to counseling, but you can create an awareness of what to look for. When I interviewed the Sailors from the USS COLE some five months after the actual incident, there were some of those who were just starting to deal with it, it appeared. And the question is, what is the safety net for some of those folks? What can we do better?

A. Well, I think we can begin to get more publicly known through all of the avenues that there are. Raise consciousness and teach the public to be aware of what happens when people suffer some sort of trauma and its not dealt with properly or they are not dealing with it properly, they are not talking about it. What we have found in this work is that when people are able to put words to the music that in its self is healing. Many of us, once we've had this have this multi-sensory kind of pain, had flashback and visualization from sounds and smells and thoughts and feelings. It's when people can put words around all that and just vocalize it to people who are listening that it self is cathartic. They can begin to heal. They then realize they are not alone in the experience and can share it and can go on speaking to each other about it.

Q. Obviously, situations like this will cause things to be brought up that will be trained and brought together and things instituted for response, etc. What are some short-term things that can be done Navy-wide? Military-wide? Country-wide?

A. I think, for example, all the media that Navy has at its disposal could be used. For example, Navy and Marine Corps News can be doing spots, it may be monotonous

regularity for a while about stress reaction and how to deal with it. What's normal, what isn't, so that the public at large at every base and every installation has that knowledge.

Every family service center should be doing weekly or bi-weekly critical incidents stress management sessions, or at least teaching about it. I think we need to put out as many fliers and as many tidbits of information as we can in periodicals such as the Navy Times; any media avenue where we can get the work out is the recommendation I would have. I think the Family Service Centers really need to develop their own critical incident stress management programs and advertise them and encourage people who are suffering any kind of residual emotional drain from this to come forward and avail themselves of the healing that we have to offer.

Q. Have you heard anything back from your colleagues, outside the local area, of more people showing up for the stress management conferences? Courses?

A. The other Services? No, I really haven't. I know they have been working a lot down below with the rescuers and the demolition workers and so forth, but I don't know what their numbers are and I don't know how long they are intending to remain here. I can tell you right now, as of Friday morning, the 28th, that we're planning, tentatively, to probably deactivate the SPRINT Team by the end of today and move out of this building back to the Behavioral Health Care Service line at Bethesda. Then we'll keep up a hot line or a number for people who continue to need our services to contact us. We can arrange to provide it from there. We'll probably have 2 or 3 facilitators at any given time being able to come to Crystal City or here at the Pentagon, or the Navy Annex to

continue to do this for as long as it takes. I would envision us needing to stay involved with this for the next month or two to a certain extent, if anything for the sake of tracking individuals and making sure we don't see what Jim Kotter said he saw 30 days out from the Oklahoma bombing.

Q. So kind of use that as a guide to get back in here and see if everything is going okay in 30 days?

A. We need to do some kind of surveillance. And not only for the sake of the individuals that need that, but for the sake of studying what we're doing and research to justify what we are doing and to justify continuing to do it and to justify improvements.

Q. How has it worked working with the chaplains, or the Chaplains Corps?

A. Very well; we had a chaplain on our team and we also had a Reservist join us. His name is CDR Keith Taylor. He is a Commander. As a civilian he is a Pastoral Counselor at a general hospital in Louisville, KY. He has done all the training for the critical incidents stress management chaplain's corps in the Navy for the last 10 years. He is a great asset to our team and having him plugged into our team has been very helpful to us.

Q. Where's he out of?

A. He lives in Louisville, KY. In fact, he'll be leaving this weekend. Our other chaplain on the team is chaplain Jerry Wadell, a Lieutenant Commander. Just a great asset. Just great.

Q. Is he at Bethesda?

A. Yes.

Q. Do you find many people coming in through the chaplain area, or do you think the words out through the different departments?

A. Some have, but I don't know too much about it. I know the chaplains here, through the Chief of Chaplains Office, have had some sort of a commensurate chaplain's and CIS program operating. We really haven't overlapped with each other or had too much of a mutual working relationship. I know they have been working, but I don't know to what extent or to what populations they have been able to reach out.

Q. We have gotten word that they are going to be holding a memorial service, a massive memorial service on the 11th of October. Are there any plans for you to attend?

A. Well, I hadn't heard that, but I hope and pray that they will have us. An event like that is a symbolic moment of closure. I think that that is a real opportunity for lancing the boil and for real healing. I think the SPRINT Team should be there, represented. In 1986 I deployed with a SPRINT Team out of San Diego and went to Kodiak, AL, following a helicopter crash at a Coast Guard Station. I remember that the whole base was affected by that accident. I recall that there were probably 3500 people there. One of the 10 passengers on the helicopter was a family practice physician who knew everybody. He took care of everybody and their children and was beloved. We stayed that week and the closure was a large memorial service that was held in a hanger, an

airplane hanger. I remember it being a very healing event. Yes, we need to be present for that. I hadn't heard about that, but I think it's a wonderful thing if they're doing it.

Q. They're bringing all of the families and having a mass affair. Obviously, I want to continue when we have some more time, particularly as time progresses, I think it will be great to get back together.

A. Please call me. You know where I am.

Q. Right. And just talk through some of the personal testimony things as well, but also after you guys have had time; which kind of leads to last question before we finish up this one – the downtime for you and your team, is it programmed into you all dealing with not just the national tragedy, but dealing with hearing about it from everyone else and where do you decompress?

A. We decompress through regular debriefings that we do ourselves at the end of the day. We get together and we talk about our experiences through the day or frustrations we've had through the day. Kind of just sort of dialogue with each other and that, itself, is a debriefing. Obviously, we need to pay attention to our own rest and our own relaxation. That was very difficult in the beginning because this was such a goliath, that we weren't sure if we would be working night and day. In f act, the first week, we were here we did arrange for day and night shifts, because we just weren't sure how humungous the problem would be and then we weren't sure about the first week-end, how necessary we were going to be.

I can tell you the Friday night after we got here, the first Friday night, I got home probably 10:30 at night. I walked in the house and I had that thousand mile stare. I know I was babbling because I sat with my wife for about half an hour. She just took me by the hand and took me upstairs and put me to bed. The next day she said I just let you speak, but whatever you said was completely disjointed and all over the place. I knew it. I knew I wasn't making sense but that's the toll I had paid. Fortunately I had that first Saturday off. I had a cell phone and I was getting calls at home. That first Saturday I was pretty wrecked, but by Sunday I began to feel like myself again. I remember I went to church that day and I drove around in the countryside to try to recharge my batteries. Monday I can back and felt like a new person. Those first three days knocked me for a loop.

A lot of it was because I was officer in charge. I was being bombarded with calls. Another thing, and I'm not saying this disrespectfully, but you know, you would have a plan, and then suddenly somebody's EA would call and say ADM So-and-so wants to see you at this time and interrupt everything else that you had planned. An admiral is an admiral, and you just had to drop everything and go. It was like Pistol Pete was shooting at your feet constantly. Like I said earlier, we are human beings, too. It was an extraordinary amount of stress that everyone was dealing with, including our selves. But it's tapered off as time has gone on. I think now our intervention has become much more manageable and we've become much more rehearsed and flowing about what we're doing.

Q. Do you think part of that stress was brought on by people not knowing about SPRINT Team, not knowing about what was going on, or was it just the situation that was going on after the attack?

A. I think it was a combination of everything. I think it was a combination of our own reactions to the tragedy. It was a combination of coming to a place that we never imagined in our wildest imagination envisioned we'd end up. Like I said a typical scenario is a helicopter crash at some other base. As a human being you have feelings for it but you are immune from it. But, we found ourselves at the very heartbeat of the Navy. CNO is in the building and right on down. This is not a world that any of us is used to. We found ourselves really feeling intimidated, but at the same time, knowing what our mission was and what we needed to do and trying to get that unfolded and starting it up as quick as we could,

Q. Okay. As we get back together next time and as days go by, be thinking of it not only what you're doing in your capacity, but from a historical standpoint, because, obviously, what you all do is a huge part of the story. There are a lot of lessons learned when people look back at an incident. I know even during the USS Cole we found out some things that happened on the USS Iowa incident. It helped put some things into place that helped grease the skids and helped put some things together, build a foundation for what took place, for some of the support particularly for some of the families and the crew on the mechanism for the Cole incident. So, as tragic as we look at what might happen in days ahead, there are a lot of lessons learned but also historical of the story that you all will be part of.

A. Okay, and, you know, I have to confess, that I really haven't had a lot of time, myself, to digest things. I have tons of notes and I really wanted to rehearse before I met with you guys today, but I realized I have no chance to do that. In time, once we all get together and collectively brainstorm and put on a timeline of the events that have happened hour by hour over the last two weeks, I wouldn't mind getting back with you and fill in these blank spaces.

I have to say this in conclusion—the Navy needs to make this more than just a collateral thing. It needs to be something that becomes, I don't know how to phrase it, but it needs to be something that is as important as any department in that hospital. It needs to be a service that's ready to go any time, any where—ready to provide services on site as needed. It shouldn't be something that is just stood up as a mobilization effort when and if a contingency happens. I think we're going to face contingencies, unfortunately. This is something that needs to be ready to go constantly.

Q. Great. Well thank you so much for your time. For all that you've done.

A. I hope it doesn't sound too disconnected there?

Q. No, not at all. Thanks again.

A. You're welcome.

Transcribed by:
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