Lessons Learned 26 NOV –30 NOV 01

Lessons Learned: [redacted]

It was frustrating not to have fire-fighting equipment. With the equipment they could have tried to do more.

The teamwork that day was great, military and civilian were all helping out.

Lessons Learned – [redacted] **US Park Police**

Communications need to be looked at so all organizations can communicate more easily over common frequencies. The military does not have a lot of resources to go to civilian frequencies.

SGT Kenneth S. Burchell
20 November 2001
Lessons Learned

1. Born and raised in Bethesda MD. Firefighter during and after college. Learned of the Park Police – a small federal agency that is limited to Washington, New York and San Francisco. With them 16 and a half years. On patrol, to SWAT Team, then to the aviation section. Was a rescue technician for three years (the flight paramedic) and then was selected to become a pilot. He attended flight school through the Park Police at Fort Reuckers for one year in Alabama. Four years of in-house training and became a pilot for the Park Police.

2. Speaks of interaction with other agencies. 60 different law enforcement agencies operate in Washington D.C. City only 48 square miles. Interact with all the police agencies and the fire departments. They are constantly training with these other agencies that made September 11, 2001 easier to handle.

3. Amazed at how calm the Pentagon people were. He found the triage officer to determine how many medevacs there were. He knew him; it was a part of their disaster plans. This was inside of ten minutes of the crash. He was told there were eleven to go by immediate air. The Incident Commander in a mass casualty situation assigns the triage officer. It is a fireman. Part of the Incident Command System.
   Question: couldn't the military departments at the Pentagon be structured similarly? Need an Incident Commander with preassigned individuals who would know their function and slip into their roles immediately. Exercise those functions and individuals periodically.

4. DoD should take credit for his going to the Army flight school. Pilot with him went to Pensacola. It was a grant through DoD to train pilots for the police force.

The medics in the second aircraft were DoD medics, part of an MOU (memorandum of understanding). This was an example of a direct integration of DoD personnel and local law enforcement that has been ongoing for over a decade. It worked because the day of the incident was not the first day they had trained together.

Lessons Learned
CAPT Steve O'Brien
15 November 2001

1. He was assigned to the Port Mortuary at Dover AFB (DE) to head the Navy Liaison Office there. He arrived 12 September 2001. CMD MC Gale Bond and PN1 Prince Brown, both active duty from Pers-6, were also assigned to the team. Upon arrival, they had to determine who was missing. His first list was from an Army O-6 that listed three people that were alive. There was a lot of work in correcting last names and social security numbers. Those providing information did not understand how important accuracy was. One digit wrong in an SSN means there was no DNA or fingerprint match for that individual. The mortuary's list was inaccurate because they were not accurately listing categories of remains.

2. Pers-6 initially took the lead on issues but follow up was not prompt. Spoke with CAPT Sepock, EA for Admiral Brown, who gave CAPT O'Brien the go ahead to make decisions on scene. The first 3-5 weeks an O-6 was essential on the team. After that period of time an O-6 would not be necessary. Having an Army and Navy liaison at the mortuary had never happened before. Necessary due to categories of folks, that it was local; the condition of the remains.

3. What was needed there was a military officer in charge of the investigation. A command post that would focus all the aspects of the effort. There was never a joint meeting held. He and MC Bond and Prince Brown had to go out every day and collect the information they needed. It took them a week to learn that there were different databases. One was the central database and that was kept sloppily at first with no attention to detail. This caused problems because in several cases the families had sent in medical records and the liaison cell had been told the records were still missing. This caused misinformation going back to the families. Efficiency was required to serve the family of the victims.

4. Flow of information was not consistent. He was not receiving information from external sources. They needed representation at the daily meeting with N1, Pers-6 and NDW. The SITREP generated by the liaison cell went to the Navy Comm Cell; they also received information from the JFAC (Joint Family Assistance Center). Sometimes that information did not agree. If he had been involved in the daily meeting they could have avoided that inconsistency. That would also have saved him from updating different staff.

5. Partial remains were an issue. Dover was willing to release them if the family signed a release. There was no process out there for accepting partial remains. The Navy liaison cell drafted the release form. Pers-62 sat on the form and actually made their own form and sent it to the families. However, it was wrong because it did not address the disposition of partial remains. So it had to be corrected, which meant contacting the families again. General Van Alstyne (JFAC) and VADM Ryan (CNP) were telling families that partial remains were not being shipped even though the day before LCDR Vauk was shipped. The chain of command at Pers-6 was not working.

6. Their chain in dealing with the CACO's: once identification occurred, it went from the liaison cell to Navy Comm Cell to the regional and then to the CACO's. They did not initiate direct calls to CACOs. Disposition forms were to be provided to the CACO's so that families could opt for disposition of partial remains. One recurring problem was that CACO's were unaware of the forms; of the availability of disposition of partial remains. Follow through – information obtained by the Navy Liaison to be given to the CACO's- was not done. There was not an effort at the regional level to track every CACO and what they had been told; when they had last come in to get information. The break in the chain in the beginning was the Navy Comm cell, due to lack of continuity. (They are located in Millington TE.) It was manned by reservists without leadership. Now that problem is solved. Great reservists in that cell now. The regionals did not track the CACO's properly. This resulted in next of kin who did not understand the partial remains process.

7. Death certificates: lots of detail. Accuracy is key for the Registrar of Vital Statistics in Virginia. This had to be initiated through Pers-6. The death certificate is required by Virginia to be issued within five days. That was violated here. They provided a death certificate to Pers-6 to be filled out immediately. Pers-6 generated a form and sent that to the regionals. They expected a response from Pers-6 within 24-48 hours. NDW casualty filled out the information based on their spreadsheet of the decedent. There was faulty information on those spreadsheets: consequently, the death certificates were incorrect. It needed to go directly to the CACO and to the next of kin. NDW's information was turned in instead, and that incorrect information was forwarded to the Registrar.

8. As for identification, DNA was not available for civilians. Some did not have medical/dental records. Some were identified by a major surgery. In one case the medical examiner discovered that one person had recently undergone heart bypass surgery. The question went out to family members to attempt to identify that person based on the recent surgery.

9. He recommends someone from the command be the escort of the body home. Was not done for N3/N5. (He does not know that N3/N5 provided CACO duties for their people. Due to the decimation of their ranks in the attacks and

OPTEMPO in the resulting war they were probably precluded from sending command participation as escorts.)

10. There was a proposal for a Flag Officer Casualty Advisory Board (FOCAB) several years ago; it was never realized. Now it is on a front burner to convene this board. Focus will be to pull together the lessons learned, and to be prepared for a subsequent attack.

Lessons Learned: Capt Joyce

They had the SPRINT team visit but it was about 3 weeks later. He thinks this was too late. Overall the SPRINT team did a good job and it was worthwhile.

He was impressed with all the different people that took charge, even endangering their lives. They immediately did what they were supposed to do, focusing on what they have been trained to do.

From the Homeland Defense aspect they will need more E-2's for surveillance, more helicopters to protect the ports, more precision guided munitions. His office is just now beginning to get invited to the Homeland Defense game. They need to get smarter on this issue, not just his office but the whole Navy.

Lessons Learned
[redacted]
19 November 2001

1. One of three aviation analysts in the bullpen (N80) at the Pentagon. His specialty is Non-tac air; now the head of aviation analyst as well. Working in 4D457 on September 11, 2001.

2. Smoke door closed 1st deck, 4th corridor. It was a large mechanical door shutting. Thought there were voices on the other side. Found out later these are pliable doors that can be pushed aside.

3. At one point touched door to left; hot door. Cipher lock on door; did not open due to heat. Did not hear a voice from inside. Wrapped his uniform around his face. Knew that the CNT was a rubber fire attraction. CDR Spence in front. Formed a human chain.

4. Tough time in temporary spaces in the Annex. First week was essential personnel only. Tremendous pressure to produce answers. Also realizing they were attacked; they were post-traumatic. Had to reconnect with the codes they had worked on concerning the budget. Prioritized his tasks. War College; Navy experience in general helped him to reconstruct his part of the budget. Same thing could have happened to a field headquarters.

Lessons Learned
CDR Joan Zitterkopf
27 November 2001

1. Her son attended 6th grade at [redacted] in [redacted]. The school handled the situation well. Called the military spouses together and asked what to do. Plan – all PTA volunteers were assembled; one was assigned to each child whose parent was in the military. Made the announcement that there was a dreadful accident at the Pentagon. If you were a military child and your parent worked in the Pentagon, had to see a PTA volunteer prior to boarding the bus. Did not want anyone to go home to an empty house. If one of the parents was not at home, children not allowed to go home alone.

2. She speaks on Women's History. She was the second class at the Academy; some of the animosity came as a shock to her. Being a girl had never been a big deal growing up. She had always believed that if there was something not available to women, you fixed it. Brought up in an even society where your talents counted. Hunkered down and hid. Decided to survive; that was her defense mechanism. Decided not to fight them but to beat them. Thought of the women in her hometown who had served. Reflecting that she had graduated from the Academy and knew nothing of the women who had served in WWII. Started reading women's history in the war. After getting her wings, a group called the Silver Salts in San Diego asked her to speak about her experience at the Naval Academy. Jill Hawkins, Class of 80, and she were asked to speak. As she spoke to them she realized it was an entire roomful of WWII vets, and a few Korean vets. Told them before her speech that she should be listening to them and not the other way around. One of them patted her on the head and said, "No, but you can thank us. We'd like to hear what a difference we made." They adopted her. None of them had children; they were not allowed to marry so no children. They called her their granddaughter and they invited her to different events. Got to meet some amazing women. Enjoyed their histories. When her mother came out the women hosted a party for their daughter, her mother. Her son is the most spoiled child because he has multiple great grandmothers. She was asked to speak at a Women's History Month event. She realized that everyone has a history to tell, and if you don't record it you will forget it. Talks of her thoughts on history. Talks of capturing September 11th, that it is still a wound, and should be recorded properly. She encourages people to tell a child their history, so that it will be remembered. Interested in Women's History, but wishes it were not Women's History Month but just History Month.