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STATEMENT OF

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BEFORE THE

Subcommittee on National Security, Emerging
Threats, and International Relations
COMMITTEE ON GOVERNMENT REFORM
U.S. House of Representatives

ON

“Assessing Anthrax Detection Methods”

April 5, 2005

WRITTEN TESTIMONY

Thank you, Mr. Chairman and members of the subcommittee, for inviting me to participate in this important hearing.

I am Philip Schaenman, president of the TriData division of System Planning Corporation (SPC). I was Associate Administrator of the U.S. Fire Administration in its early days and am an engineer by training.

Corporate Background

SPC has been providing emergency and analytical services to governments at all levels for over 35 years. We have undertaken over 50 after-action reports for FEMA and other agencies, and have evaluated public safety services in over 150 communities and 40 U.S. Navy installations. SPC is one of the few companies that has in-depth experience in both national-level homeland security issues and public safety in state and local governments.

We work directly with local, state, and federal agencies and their personnel in the interdiction, response, and consequence management areas. SPC understands the different perspectives and mission assignments of each and effectively communicates with all.

SPC is composed of two major divisions, the System Technology Division, which, among other things, develops instrumentation radar and flight termination systems and the National Intelligence, Security, and Response (NISR) division, of which TriData is a component.

The NISR division provides a broad range of homeland security services including data collection and analysis; performance measurement and management; local public safety evaluations; and the activity that brings me here today, after-action reviews and analysis of major incidents and exercises.

The Incidents

Key local and state officials in Virginia, Maryland, and the District of Columbia voiced concerns about the timeliness and accuracy of the information flow during the suspected anthrax incidents of March 11–15, 2005. They decided to charter a rapid after-action review of local and state actions by an objective third party, in parallel with a planned Department of Homeland Security (DHS) study of federal agency actions and

timelines. SPC was selected on March 17 to undertake the urgent one-week study. The task was assigned to our TriData division and I served as project manager.

The incidents tested the readiness of emergency communications and response systems in National Capital Region (NCR) local governments and two states for a biological attack, and the approaches for disseminating information among local, state, and federal agencies and to the public.

The basic objectives of this study were to determine when and how various entities of state and local government learned about the incidents and how information then flowed between federal, state, and local levels. The goals were to determine how well the information exchange worked and how it could be improved in the future.

Key Findings

The following is a summary of the key findings of our study. A parallel DHS study considered federal agency actions and information flow.

Positives

1. Arlington County and Fairfax County governments are battle-hardened in homeland security and performed extremely well both on the ground and in terms of information flow.
2. Overall, the entire emergency management complex at the state and local levels acted professionally. There was generally good state and local interagency cooperation and communication. The emergency responses were good and the information flow much better than would have been the case even 5 years ago. Many aspects of communications could improve, but most of the essentials were in place.
3. The two principal counties involved (Arlington and Fairfax) did an outstanding job of communicating within themselves, and with each other.
4. The State agencies in Virginia and Maryland were mobilized and ready to support the local governments. These jurisdictions used many resources to keep informed and be supportive as needed.
5. The State of Maryland and District of Columbia mobilized quickly and adequately monitored the developing situation. They used good judgment in how far to go in the light of uncertainty and the potential impacts of the incident.

Concerns and Issues to Be Resolved

While the big picture was good, there were many communication issues.

1. ***Was it a real attack?*** – The major information flow and operational problems centered on the lack of clarity as to whether there was anthrax present or not, what tests had been performed, what the results were, and what they meant. The problem was compounded by the more subtle problem of not adequately communicating the level of uncertainty about the status of the anthrax tests.
2. ***Does any agency have the latest information?*** The state and local governments were not sure if they were getting the latest and best information from the Department of Defense (DoD), or whether DoD itself was having problems obtaining clear test information, or both.
3. ***How should information flow beyond the jurisdiction of origin?*** – When a local government has an incident, who should they inform external to themselves and how should they pass on the information? Local to state to NCR? Local to NCR to state to all locals? Should flow go from office of emergency management to office of emergency management and then to each network coordinated by each OEM? Or should information flow by discipline, e.g., health department to health department, police to police, fire to fire, etc.? Essentially all of the above paths were used in just a two-day period. Each discipline has its own protocols for alerts and updates. State agencies have formed policies that local governments are expected to follow. A region-wide protocol needs to be established to ensure timely information flow and reduce redundancy. State and local laws regarding emergency information need to be considered in the protocols. There are differences of opinion state to state and among the counties on what should be the prime path of communication and alerting. That needs to be resolved.
4. ***Over-Communicating?*** – In part, there was a problem of over-communicating (too many people getting information from too many sources) without being sure one had the latest information in a continually changing biological testing situation. The large numbers of people and agencies involved in sending and receiving information, especially multiple, large scale conference calls, made it difficult at times for the key actors to exchange information on the test findings, and to have time to act on it.

5. ***Early DHS Involvement*** – The state and local governments felt that the DHS needs to be involved earlier in such incidents, and that they all should have been informed by the DoD Pentagon earlier. According to some state and local agencies, the DHS/NCR should have been the prime agency to spread the word earlier to the region to ensure credibility and clarify information flow. (Others felt the information should be distributed by the state.)
6. ***Boy Who Cried Wolf Versus Giving Early Warning*** – Another issue to resolve is the balance between notifying stakeholders about a potential but unconfirmed threat too soon, causing undue concern and wasted actions, versus getting all relevant parties informed as soon as possible in case the threat turns out to be real. Early notice helps in making preparations and avoiding political embarrassment. But if false alarms occur too often, it can be detrimental. There needs to be discussions and decisions at the chief executive level (governors, mayors, county chief administrators) as to when they should be alerted and how far to go in setting up emergency operations centers and taking other steps for various levels of information. Some steps in information flow plans depend on the jurisdiction of origin deciding on whether it is a “significant” incident, but “significant” is not defined, even qualitatively, and it needs to be. In this incident, good judgment was generally exercised by state and local governments on passing along information, but with much uncertainty as to whether the right thing was being done (setting up emergency operations centers, informing chief executives, putting out press releases, etc.).
7. ***Public Health Decision-Making*** – Public health leaders must have early involvement in notification and decisionmaking on medical issues. When antibiotic prophylaxis decisions are made, local public health agencies must be able to assess the threat, perform epidemiological assessment, ready patient assessment and care personnel, tools, and facilities, and be able to offer other organizations access to resources. Fairfax, Arlington, and Commonwealth health officials felt that the public health coordination with DoD health officials was not adequate, especially regarding the decision to use prophylactic drugs on those who might have been exposed, before the problem was confirmed. Localities want to be involved in medical decisions affecting their constituents.

8. ***Large-Scale Conference Calls Need To Have More Structure and Order*** – Teleconferences should be conducted in an orderly and meaningful manner. Conference sponsors should determine who needs to participate and exclude others. The information needs to be more structured, and terminology used carefully, especially on the tests that were undertaken and their results. The 80-person conference calls were considered disorderly by almost everyone we interviewed. One individual, a “net control,” needs to manage the call, make announcements, and then poll specific agencies. Call participants should not be allowed to speak free-lance; the participating agencies can assign one spokesperson, and they can be polled for questions by the moderator. There also is telephone technology to allow moderators to identify who wants to ask a question.
9. ***Timing of Public Information Releases*** – Coordination, timeliness, and content of public information release were not a total success here. Public information officials were concerned about releasing information about a muddy picture. It was often unclear as to what was fact, but that could have been explained to the public. Reliable internet sources for the media and public were not adequately established. The Joint Information Center might have been set up earlier and maintained longer. At least general information on the uncertainty of the situation could have been released earlier, along with general information on anthrax. One can tell the public what one knows at an earlier point in time and that the situation may change.
10. ***Sources of Regional Information*** – Federal agencies should use the appropriate, federally promulgated alerting systems for disasters. Some local and state officials felt that the DoD Pentagon should have notified the Homeland Security Operating Center (HSOC) in a more timely manner. The HSOC would quickly gather preliminary information and alert the appropriate state and local authorities. Others felt that DoD should notify the nearby jurisdictions and the state directly. The alert should consist of an incident summary, threats, and an initial recommendation for action. Getting an alert from a pre-arranged route makes it clearer to state and local officials that it is real and not a rumor.
11. ***Time to Validate Information*** – Information accuracy is crucial to state and local governments charged with providing emergency responses. In this instance, it took several days for emergency management leaders to get

enough information to determine the validity of the threat and the alerting mechanisms that were used (detection alarms, collected samples, human interaction, observations, etc.).

12. **Consistency with NIMS** – The federal government should assure that incident operations are in line with the National Incident Management System (NIMS).
13. **Identifying Employees at Risk** – Federal agencies must assure that notification procedures are in place so that private or contracted agencies can identify their employees at risk.

Timelines for key communications and more details on issues concerning information flow are available in the forthcoming report, “Anthrax Incidents in the National Capital Region, State and Local Government After-Action Review,” dated March 29, 2005, prepared by System Planning Corporation for the Commonwealth of Virginia, District of Columbia, and State of Maryland. The report includes timelines and viewpoints from all the major participating state and local governments, and a number of recommendations.

Thank you again Mr. Chairman for inviting me to participate in this important hearing. I would be pleased to discuss the results of our review with you and your colleagues and respond to any questions.