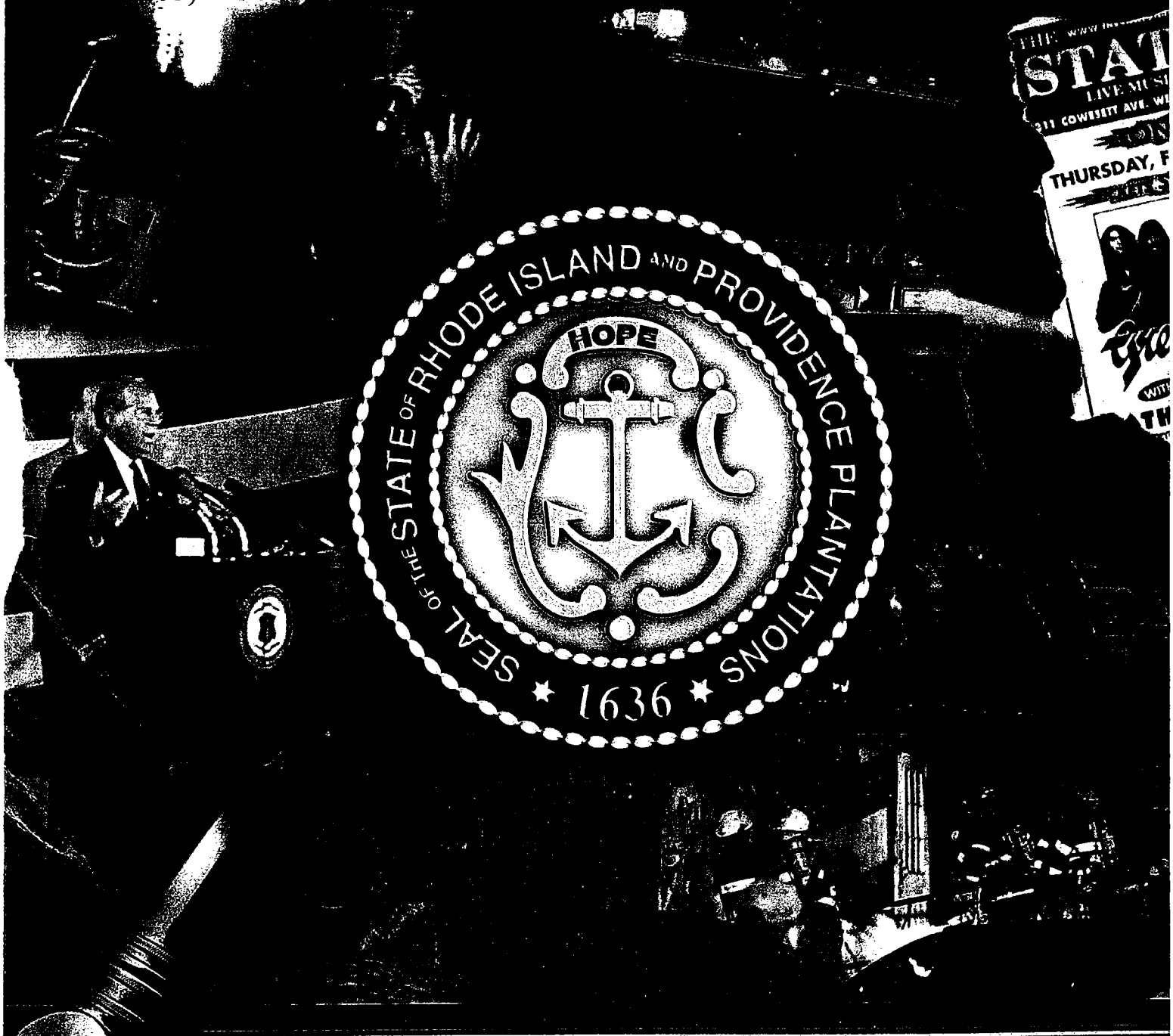
Rhode I

THE STATION CLUB FIRE

AFTER-ACTION REPORT

State, Local, and Federal Government and the Private Sector



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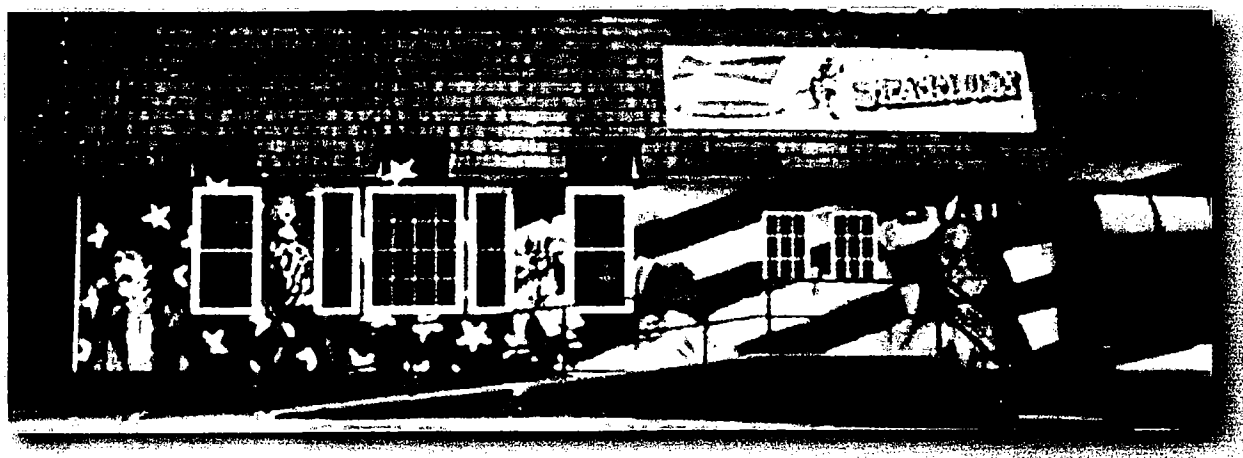
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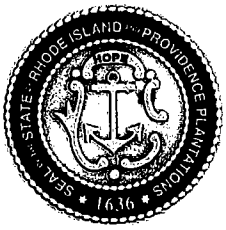

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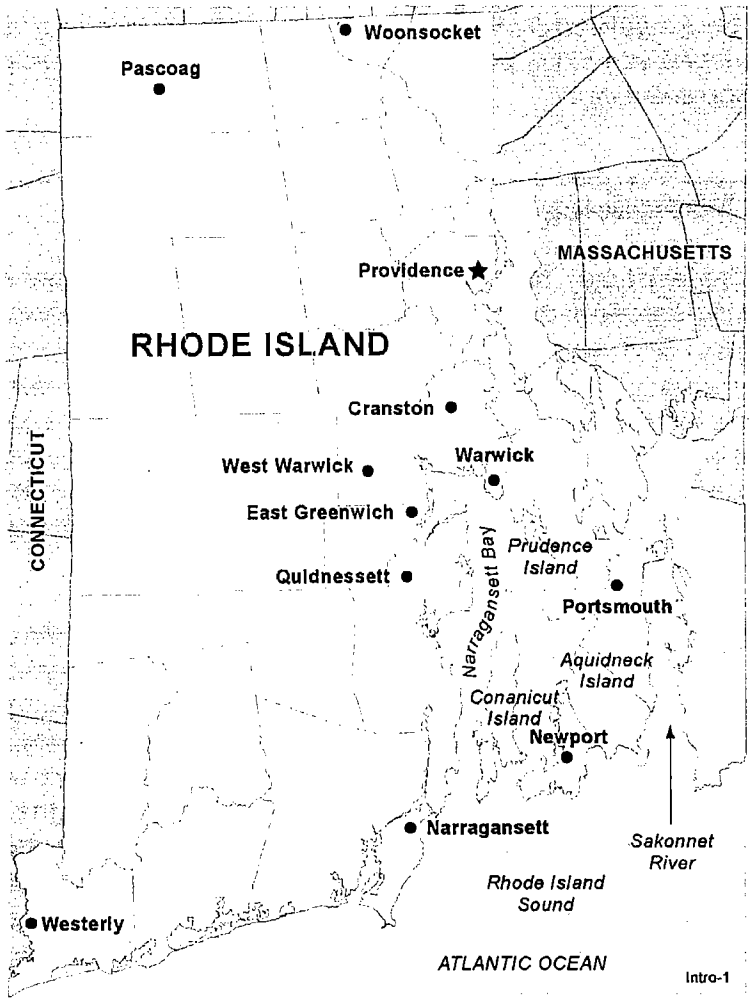
RHODE ISLAND
THE STATION CLUB FIRE AFTER-ACTION REPORT
STATE, LOCAL, AND FEDERAL GOVERNMENT AND THE PRIVATE SECTOR RESPONSE AND RECOVERY

"This report will enable the State of Rhode Island to gather and review information on how key components of the State, Local and Federal governments, as well as the private sector, responded and coordinated assets *during and after* the West Warwick Station Nightclub Fire."

—Governor Donald L. Carcieri



Minutes after 11:00 p.m. on Thursday, February 20, 2003, sparks from a pyrotechnic display ignited the foam soundproofing insulation on the stage behind the rock band "Great White" during its opening number at the Station club in West Warwick, RI. Within seconds, the flames raced across the ceiling, enveloping the nightclub in billowing black smoke. In a matter of minutes, the raging fire claimed 96 lives and injured more than 200 others. Four of the injured subsequently died from their wounds, raising the total number of fatalities to 100.

Although the cause of the fire is under investigation by proper authorities, the response to this horrific event also merits detailed scrutiny. An unintended accident that occurred in a notably confined space within a residential setting in the smallest State in the Union, the Station club fire possesses important characteristics often associated with a potential terrorist strike. It occurred without warning, at a site crowded with unsuspecting patrons, and in a densely populated region of the country. It caused immediate mass casualties and fatalities far beyond the experience of the local response community.

This event also provided an unexpected, but nonetheless thorough, test of the plans, procedures, equipment, personnel, and capabilities that comprise the Rhode Island emergency management system, including volunteer organizations and applicable Federal response resources. The lessons learned regarding the response to this event will help authorities in Rhode Island better prepare for future cataclysmic events, regardless of their cause. Equally important, they can be extrapolated so that other communities across the country can fit them to their particular circumstances, thus providing a baseline for tangible grassroot improvement of the Nation's homeland security.

The Process and Methodology

In a meeting at the Rhode Island State Capital on May 21, 2003, Governor Donald L. Carcieri and other State leaders agreed that the focus of the After-Action Report (AAR) would be exclusively on response and recovery activities and actions during and after the fire. The holistic report would convey, through the eyes of the response community, what went well, what challenges were encountered and how they were met, and the impediments that must now be removed. The primary goal of the project would be to identify opportunities to improve future response capabilities. In a June 13, 2003, letter to State and local officials and to leaders of volunteer organizations, Governor Carcieri conveyed the purpose and intent of this project (see **Appendix 1 – Governor's Letter**).

Between June 17 and July 3, 2003, the project team met with leaders and selected staff members of key State and municipal organizations to describe the process and seek their support and cooperation, which was forthcoming almost without reservation. The grand jury investigation, ongoing at the time, produced hesitancy, as might be expected among some responders, but, in most cases, did not prohibit efforts to gather data from alternative sources. However, concerns voiced by the Rhode Island Attorney General's Office impacted the timely completion of this report by prohibiting discussions with first responders and other critical organizations for a period of approximately 80 days while agreements among various parties were achieved. Additionally, access to a report published by the Rhode Island Association of Fire Chiefs was denied. This report would have added precision to some of the facts regarding the numbers and identity of responding organizations.

Another important constraint was that West Warwick Fire Chief Charles Hall did not permit direct contact with members of the West Warwick Fire Department (WWFD), although he was forthright in discussions with the project team. Thus, the information reported in **Annex A – Fire Department Operations** reflects discussions with most of the mutual-aid fire department chiefs and firefighters and with Chief Hall, but not firefighters from West Warwick.

In the weeks following the initial orientation meetings, project team functional area lead analysts and other project staff met with individuals and groups from throughout the broad response community. Participants included elected, appointed, and career State and local officials; members of supporting mutual-aid organizations; Federal agency representatives; and volunteer organizations such as the American Red Cross and The Salvation Army. More than 116 interviews and group debriefings directly engaged approximately 200 individuals in the review process. Concurrently, the project team collected and reviewed dozens of documents, plans, standard operating procedures, logs and journals, media articles, analytical and academic papers, and other records of the event (see **Appendix 3 – After-Action Report Project Team** for additional information on the project team members).

The information gathered during this data collection process was analyzed and topically organized within each functional area. For example, within **Annex D – Emergency Management System and Operations,** information addresses initial response; command, control, and coordination; policies, plans, and procedures; and other relevant topics. The *findings*, acquired directly from the response community during the data collection process, are organized under subtopics so that related information drawn from a wide variety of sources leads to specific observations. Thus each set of *findings*, from which *recommendations* are ultimately derived, supports a general observation.

As the functional area analytical teams compiled critical pieces of the evolving report, a detailed and painstaking multitiered validation process commenced. First, all members of a particular functional area analytical team reviewed the compiled material to ensure it was complete, accurate, and properly stated. Second, each draft functional area annex was reviewed independently by all the other functional area analytical teams to identify conflicting information or apparent inaccuracies based on the unique perspectives of different constituencies. After resolving discrepancies identified during this internal review, the functional area lead analyst presented the draft annex to selected members of the appropriate segment of the Rhode Island response community for review and validation. A total of 50 members from the various Rhode Island subject area constituencies participated in this validation review. Their charge was to read the material and identify any factual inaccuracies or glaring omissions. Participants were advised that they might disagree with some of the content, which was drawn from many different sources, but that did not necessarily mean that it was erroneous. The resulting comments were then incorporated into the draft annex or were otherwise resolved.

Following this third step in the review and validation process, the various functional area annexes were brought together for the first time. Graphics, photographs, and other supporting materials were added. The draft report was properly formatted and underwent editorial review. Finally, the fully compiled camera-ready draft was submitted for review by representatives of the U.S. Department of Homeland Security (USDHS), Office for Domestic Preparedness (ODP) and by a select committee organized by the Rhode Island Governor's Office.

This report is organized into the following six annexes that describe specific functional areas:

- Annex A – Fire Department Operations
- Annex B – Emergency Medical Services
- Annex C – Law Enforcement
- Annex D – Emergency Management System and Operations

- Annex E – Public Health, Healthcare Facilities, Mental Health, and Mass Fatality Management
- Annex F – Family Services and Support

Each annex includes sections that describe the observations, findings, and recommendations pertaining to that functional area.

The remainder of this Introduction is intended to provide sufficient background so that readers understand the unique circumstances surrounding this event. It describes the State of Rhode Island—its history, demographics, government structure, and provisions for emergency management. It also describes the town of West Warwick, along with its government infrastructure and emergency response resources. This section also presents the tragic events of the evening of February 20, 2003, as they occurred at the Station club. Finally, it describes four representative overarching issues that others should emulate and four that Rhode Island must address.

Setting the Stage

History and Culture

Rhode Island is something of an enigma for most Americans. Its diminutive size, geographically the smallest member of the United States, is common knowledge. With a population of slightly more than 1 million, only seven States have fewer residents. But it is also the second most densely populated State, with more than 1,000 people per square mile; only New Jersey is more crowded. Nearly half of the population of Rhode Island lives within a comfortable 20-minute car ride from the State House. When one thinks of crashing waves, sand dunes, sea shells, and meandering beaches, images of the Carolinas, Florida, and California come to mind. Yet tiny Rhode Island, comprising 35 separate islands and 400 miles of shoreline, properly earns its title as "the Ocean State."

In many respects, modern Rhode Island is the offspring of its unique and colorful history. The land was once home to 20,000 Native Americans—fishermen, farmers, hunters, and, sometimes, warriors. Many of the rivers, streams, mountains, other terrain features, and even population centers still bear names reflecting this Native American heritage, including Narragansett Bay, Conanicut Island, the Woonasquatucket River, Pawtucket, Scituate, and Woonsocket. Others were named for, or by, early European explorers. Block Island, the quintessential summer vacation destination, is named for Dutch explorer Adriaen Block, who visited the area in 1614. Rhode Island traces its own name to the 1524 observation of Italian navigator Giovanni de Verrazano, who noted that the area was reminiscent of the Greek Isle of Rhodes. Ironically, the smallest of the United States has the longest official State name, Rhode Island and Providence Plantations, originally bestowed by a Royal Charter granted by King Charles II on July 8, 1663, and subsequently retained in the 1843 State Constitution. The first governor of Rhode Island, elected by popular vote and designated as such in the 1663 Royal Charter, was the Honorable Benedict Arnold, grandfather of his dishonorable namesake.

In some ways, Rhode Island is a State of contradictions. On May, 4, 1776, it became the first colony to declare its independence from the Crown, yet it is the last of the original 13 colonies to ratify the Constitution. Having renounced one external political authority, its citizens were apparently reluctant to quickly accept another. Similarly, although its shipping industry profited greatly by transporting slaves to the United States, Rhode Island enacted the first law banning slavery and, during the Civil War, it raised the all-black regiment celebrated in the movie *Glory*.

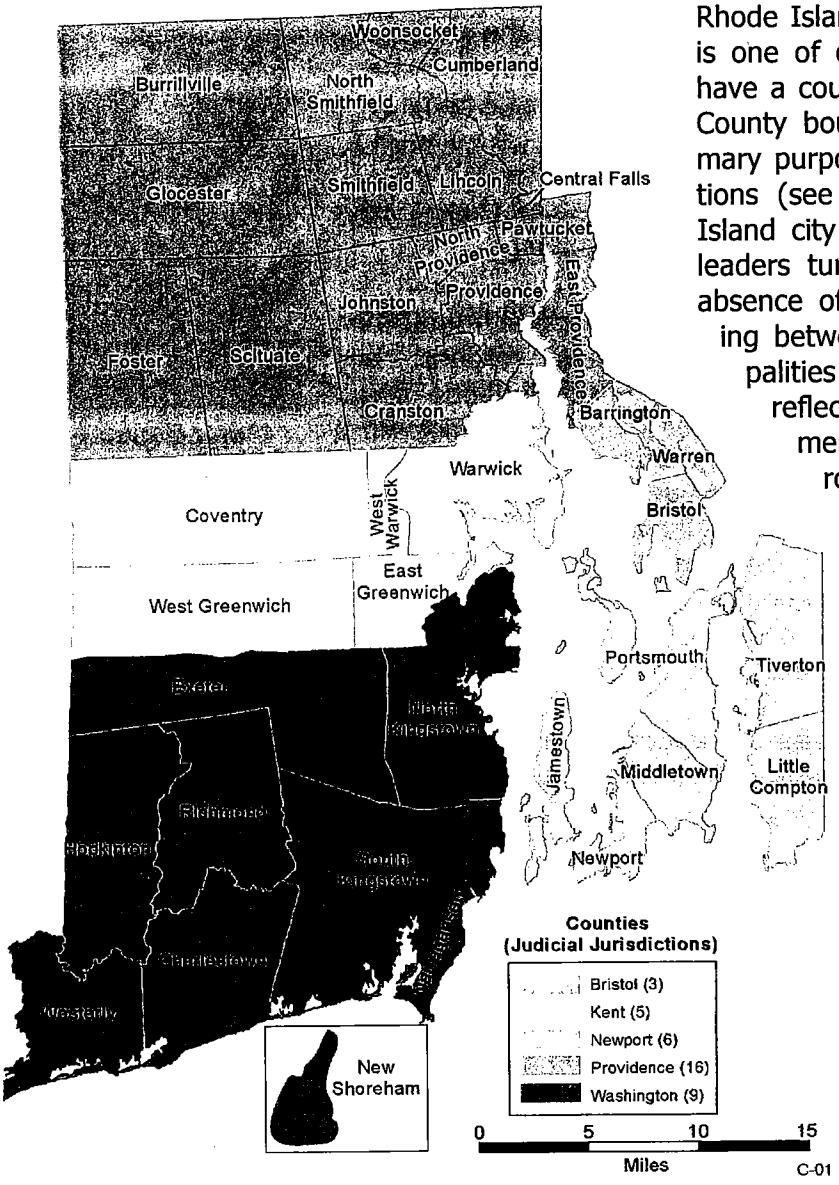


Figure 1. Area map of Rhode Island.

Rhode Island is "America's city-State." It is one of only two States that does not have a county government infrastructure. County boundaries exist but for the primary purpose of defining judicial jurisdictions (see **Figure 1**). When a Rhode Island city or town needs assistance, its leaders turn directly to the State. The absence of additional bureaucratic layering between Rhode Island's 39 municipalities and its State government reflects a historic distrust of government intervention that has its roots deeply seated in the colonial era. It is not by accident that the official State operations handbook is titled *The Rhode Island Government Owner's Manual*.

Rhode Island State Government

The governor of Rhode Island is elected every 4 years and is limited to two terms in office. He or she is the Chief Executive of the State and the Commander-in-Chief of the National Guard, ultimately responsible for the safety and security of the citizens of Rhode Island. Donald L. Carcieri was elected governor on November 5, 2002, and took the oath of office on January 6, 2003, just 6 weeks before the Station club fire.

Governor
Donald L. Carcieri

The adjutant general of Rhode Island is appointed by the governor and serves as the Commanding General of the National Guard. He or she is also designated as the director of the Rhode Island Emergency Management Agency (RIEMA) and, since October 2001, as homeland security advisor. The current adjutant general is Major General Reginald A. Centracchio. He has served in that capacity since 1995 and was reappointed by Governor Carcieri in January 2003.

Major General Reginald A. Centracchio

In the event of a crisis or disaster, RIEMA is charged with protecting lives and property through mitigation, preparedness, response, and recovery. It publishes and maintains the all-hazard Rhode Island Emergency Operations Plan (EOP) and requires that municipalities possess complementary plans. In 1996, RIEMA moved from the Rhode Island State House to the National Guard complex adjacent to the John O. Pastore Center, approximately 10 miles from the Capital. Its facilities include office space for RIEMA's staff as well as a small Emergency Operations Center (EOC) planning area. A larger EOC operations area is regularly used as a shared National Guard and RIEMA classroom, which must be reconfigured and properly equipped to support emergency operations. Mr. Albert Scappaticci is the RIEMA executive director.

Lieutenant Governor Charles J. Fogarty

To advise the governor on matters pertaining to emergency preparedness, Title 30 of the Rhode Island General Laws prescribes an emergency preparedness advisory council chaired by the lieutenant governor with the adjutant general as vice chairperson. The council has 31 members, 16 ex officio members specified in the law, and 15 members appointed by and serving at the pleasure of the governor. It traditionally convenes quarterly to receive briefings and reports on various emergency preparedness topics and to provide direction and guidance regarding preparedness issues. However, since the Station club fire and during periods of heightened alert, the council meets more frequently. Its working groups and subcommittees meet more often and regularly report progress to the advisory council. It has no operational responsibilities.

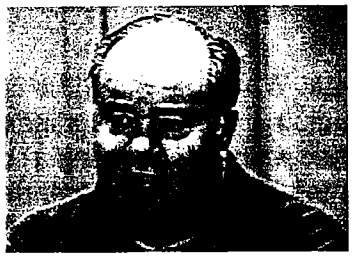
Rhode Island Local Government

Although the specific nature and composition of municipal government varies throughout Rhode Island, each of the 39 cities and towns has a designated emergency management director. In a few cases, these are full-time, dedicated municipal employees. Other towns have part-time paid directors. In the smallest jurisdictions, emergency management is an additional assignment for one of the regular town employees. About half of the towns and cities have applied for and received Federal Emergency Management Performance Grant funds administered by RIEMA.

West Warwick is the tenth largest Rhode Island municipality, with a population of nearly 30,000. It is also the youngest community in the State of Rhode Island. Established in 1913, West Warwick is one of only two towns formed during the twentieth century in Rhode Island. It has a council-manager form of government. The five Town Council members are elected for 2-year terms and choose from among their ranks a Council president. The current president of

the West Warwick Town Council is Ms. Jeanne-Marie DiMasi. The Town Council appoints the town manager, who serves as chief executive. Mr. Wolfgang Bauer is the current West Warwick town manager and Mr. Thomas Senerchia is the West Warwick emergency management director.

Jeanne-Marie DiMasi



Wolfgang Bauer

Thomas Senerchia

West Warwick's fire and police departments are responsible for protecting property and ensuring public safety. The WWFD, under the leadership of Chief Hall, has 66 career firefighters and emergency medical professionals, operating from four fire stations. Police Chief Peter Brousseau, with 22 years on the force and 4 years as chief, leads a department of 57 sworn officers and 13 civilians. Mutual aid from neighboring communities reinforces organic fire and police resources when circumstances are beyond the capacity of West Warwick.

Taken as a whole, the Rhode Island emergency management structure has a certain homespun character. At its base are citizen-volunteers. In the case of West Warwick, these volunteers are led by one of their own, in a part-time municipal position. They devote time, energy, and often more tangible assets on behalf of the citizens of West Warwick when disaster strikes, coordinating external support not otherwise available to the town's first responders. West Warwick fire and police departments are minimally staffed with career professionals who rely on neighboring communities for reinforcements when confronted with extraordinary circumstances. Statewide resources are readily accessible through RIEMA and, when necessary, the governor can obtain support from neighboring States and from the Federal Government. This bottom-up approach to emergency management is emblematic of the tradition of independence embedded in this cradle of American democracy.

The Event

The watering hole most recently known as The Station was a West Warwick fixture spanning six decades—a landmark for some, an eyesore for others. A low-slung, nondescript building, its name changed frequently over the years, usually signaling a change in ownership: The Wheel, Red Fox, Tammany Hall, Glen's Pub, Papa Brillo's, and Cracker Jacks. In its most recent incarnation, the Station club had established a reputation as a gathering place for fans of rock music.

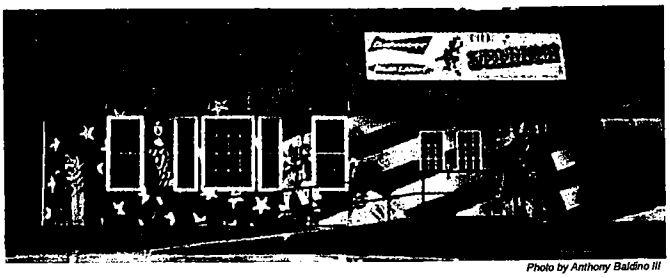


Photo by Anthony Baldino III

The Station club before the fire.

The mural portrays images of Janis Joplin, Steven Tyler, Elvis, Jimi Hendrix, and Ozzy Osbourne.

The return of the 1980's band Great White, which performed at the Station club in 2000 shortly after it reopened under its current ownership, was widely anticipated. A total of 115 tickets were sold in advance of the scheduled February 20 performance, and another 50 tickets were distributed through local radio stations promoting the show. Ticket sales at the door were brisk.

A few minutes after 11:00 p.m., Great White took to the stage before a crowd already primed by the pounding rhythms of earlier performers. As lead singer Jack Russell launched into the opening song, "Desert Moon," a display of pyrotechnics intended to further enthrall the rock-and-roll crowd was set off between the drummer, seated in a rear alcove, and the other members of the band. The pyrotechnics quickly ignited a portion of the wall behind the band. As the flames took hold and began to spread, it took several seconds for the crowd to recognize that something had gone horribly awry. A local television cameraman filming the performance was able to capture the next several desperate minutes as revelers struggled to escape the blazing inferno.

Pyrotechnics are lit as part of Great White's stage act, igniting portions of the wall behind the band.

Tests conducted in the wake of the disaster by the National Institute of Standards and Technology concluded that most of the 96 fatalities found inside the club died within the first few minutes. According to a December 7, 2003, article by *The Providence Journal*, at about 1 minute, 25 seconds, the video shows two people emerging from the greenhouse-style window near the front door. Heavy black smoke is seen pouring from the window. At about 1 minute, 36 seconds, the camera captures fallen people wedged in a pile at the front door. By about 2 minutes, 6 seconds after the fire started, the thick black smoke is streaming from nearly every opening in the building—people are still fleeing through doors and broken windows.

Individual and Organizational Special Achievement

During the extensive interview process for this report, respondents were invited to comment on any aspect of response and recovery that was particularly successful, favorable, or beneficial. The examples that follow are representative of those comments. The selfless performance of these individuals and organizations exemplify the compassion and ingenuity that characterized Rhode Island's response to a human tragedy of unimaginable proportions. Their stories, and those of countless others described in this report, are testimony to the indomitable strength of community that binds all Americans when confronted with adversity.

Mr. Peter Todd, a retired Rhode Island National Guard Command Sergeant Major, has worked for RIEMA for more than 15 years and is currently the Rhode Island radiological officer. His responsibilities deal primarily with problem detection and population protection associated with the nuclear power plants located in nearby Plymouth, MA, and in Waterford, CT. When Mr. Todd responded to RIEMA Operations Chief Diana Arcand's call for help at 2:00 a.m. on February 21, he brought with him an invaluable network of personal and professional associations, uncommon powers of persuasion, and an incredible dedication to successfully completing even the most challenging assignment. Among his many noteworthy accomplishments, possibly the most spectacular was the transformation in less than 36 hours of a vacant 25,000-square-foot automobile dealership into a fully equipped and furnished office complex where government and private organizations provided advice and assistance to victims' families. The Family Resource Center (FRC) operated from 10:00 a.m. on February 26, 2003, until 6:00 p.m. on March 14, 2003. Mr. Todd contacted long-standing friends and associates in every relevant field of endeavor, arranging for telephone lines, computers and network connectivity, and office machines and supplies. He arranged for the Rhode Island Department of Corrections (RI DOC) Prison Industries to provide furniture and office partitions. He negotiated with adjoining businesses to prevent media broadcast vehicles from parking in areas inappropriately close to the grieving families. Virtually all materials needed to operate and sustain those working at or using the FRC were donated by local businesses or service providers. Because of the generous donation of time, facilities, and materials, the total cost to the government after nearly 3 weeks of operations is estimated at less than $5,000. Mr. Todd's final act was to write a thank you note to every person who donated time or materials at the FRC. That personal acknowledgement is precisely why Mr. Todd was able to accomplish so much with so little.

In the wake of a devastating incident, help comes from many predictable sources, and a few that are not predictable. One would not normally expect, however, that the corrections community would assume a significant role in the recovery process. In the case of the Station club fire, RI DOC became an invaluable source of resources and support. Charged with custody over an average daily incarcerated population of 3,500 persons, RI DOC is a fully self-sustained operation. It has every capability one would find in other population centers: healthcare staff and facilities, electricians, plumbers, computer and communications technicians, commercial food services, transportation, and much more, along with the requisite administrative and management staff. Although RI DOC is not listed in the Rhode Island Emergency Operations Plan (EOP), on Friday morning, February 21, 2003, Director Ashbel T. Wall instructed Mr. James Berard, the associate director for Management Information, to offer RIEMA any assistance needed in response to the Station club fire. In the subsequent hours, days, and weeks, RI DOC was an important part of almost every dimension of the recovery process. Communications and network engineers installed telephone lines and computer networks. RI DOC computer

programmers constructed and installed custom database systems at RIEMA headquarters (HQ) and at the FRC. Twenty-four volunteers from the RI DOC Public Information Office and its trained hostage negotiation teams manned eight of the victim information hotline telephones working three 8-hour shifts. The two RI DOC psychiatrists were present at each hotline shift change to debrief the outgoing volunteers. Other Rhode Island volunteers staffed the computer network at the FRC, entering data collected during the entitlement and support application process. The RI DOC kitchen staff delivered meals for persons working at RIEMA HQ. The scores of RI DOC volunteers, including some of the most senior staff, contributed hundreds of hours, 24 hours a day, 7 days a week, yet the volunteers did not record any overtime. Each acted on a purely personal commitment to help their stricken neighbors.

West Warwick Council Member Leo Constantino was elected to public office for the first time in November 2000. A semi-retired businessman, Mr. Constantino had for some time been very active in West Warwick youth programs. A U.S. Marine Corps Vietnam veteran, he is a sailing instructor in the summer months and a ski instructor during the winter. Mr. Constantino was at the New Hampshire ski resort where he is employed when he learned of the Station club fire. He returned to Rhode Island on Saturday, February 22, 2003, where his instincts led him to the Family Assistance Center (FAC) at the Crowne Plaza Hotel. He was stunned at what he found. Grief-stricken family groups sat in somber clusters throughout the huge ballroom. Some groups formed links and eventually merged into one, offering comfort to each other's members. Other family groups stayed to themselves, sharing their agony only with one another.

Agence France-Presse

Family and friends comfort one another.

Mr. Constantino wanted to help, but didn't have any idea how a novice public official could be of service. He wandered unobtrusively among the distressed families, introducing himself only if an occasion to do so was apparent. He listened to their conversations, searching for clues to help define his own role. His youth work over the years had acquainted Mr. Constantino with Mr. Tom Iannitti, the director of West Warwick Department of Human Services (WW DHS). He telephoned Mr. Iannitti and described his dilemma. Mr. Iannitti suggested that he remain at the FAC and stay in touch with the WW DHS. Before long, Mr. Constantino began to understand some of the seemingly insignificant issues that were quickly becoming a major irritant to victims' family members. An automobile that could not be located at the Station club scene, the need to replace house and car keys melted in the fire, transportation for a dozen family members to a Massachusetts hospital where a survivor was located, and many similar situations added to the difficulty of the situation. Mr. Constantino soon became a recognizable resource whose help was increasingly sought as he worked with Mr. Iannitti on behalf of his distressed constituents.

One relationship is particularly revealing about the value of Mr. Constantino's efforts. Over the next several days, he became especially close to an elderly gentleman who had driven from Pennsylvania to await definitive information about his son, who had been at the Station club that fateful night. The son's remains were eventually identified and his father asked that they be cremated, after which he would take them with him back to Pennsylvania. On the day his son's remains were scheduled for release, the father told Mr. Constantino that he would like to meet and thank the West Warwick officials who had been so kind and thoughtful throughout

the ordeal. They first went to the West Warwick Town Hall, where the father met Town Manager Bauer, Mr. Iannitti, and several other town employees. Next, they traveled to the fire station that first responded to the blaze. Each stop was an emotional catharsis. Although the employees at Town Hall had been fully absorbed in response and recovery activities for every waking hour since the fire, few had dealt face-to-face with a victim or immediate family member. In this case, the father wanted each of them to know something personal about the son whom he loved so dearly. When it was time to pick up the remains, Mr. Constantino insisted on driving the father to the funeral home. He did not want him to suffer through the experience alone. From the funeral home, the two men drove in silence to the FRC, where the father had left his car. Mr. Constantino carefully held the box containing the urn, while the father unlocked the car. They placed the remains in the front passenger seat and secured the seat belt. The father placed a photograph of his son, which he had shared with West Warwick officials, inside the cover of the box with the remains. Worried about his new friend's well-being, Mr. Constantino asked if the father would be okay and suggested he delay the drive until the following morning. The father put his hand on the box in the passenger seat and replied that with his son at his side, he would be just fine and that they would take their time on the drive home. While a grief-stricken father sought comfort and solace after losing his beloved son, a novice public official searched for a meaningful role in the midst of an egregious human tragedy.

The name most frequently mentioned as a positive force in these challenging circumstances was that of Governor Carcieri. At the time of the fire the governor was out of the State. He returned early on Friday morning and immediately took control. He set priorities, insisting that the victim identification investigation be pursued diligently and without interruption until every deceased victim was known and every family notified. He spoke with the families frequently, sharing with them the latest information so they were not caught off guard by public news reports. He promised them help in obtaining support from State, Federal, and nongovernment agencies. Toward that end, he directed the establishment of the FRC, which remained in operation until every family had obtained all the necessary available assistance. He visited injured victims in Rhode Island and Massachusetts hospitals and prayed at memorial services and funerals with the families of those who had died. One senior community leader who actively participated in response and recovery efforts, and who admits that he did not vote for Governor Carcieri, described the situation this way: "He was elected in November, sworn into office in January, and became our governor in February."

The Results

The Station club fire is the second deadliest U.S. nightclub fire in the past 50 years. A total of 100 persons died, more than 25 percent of the occupants of the building that night. It is estimated that 230 people were hurt, many with serious life-threatening injuries. Seventy-eight children lost one or both parents. It is estimated that the lives of between 5,000 and 6,000 persons—family members, friends, neighbors, and coworkers of victims—have been irreversibly altered by this tragedy. According to materials prepared in support of Rhode Island's request for an emergency response Substance Abuse and Mental Health Services Administration (SAMHSA) grant, 583 fire, police, and emergency medical personnel responded to the fire.

The healing process continues in Rhode Island and in the surrounding communities affected by this event and its aftermath. Important changes have already occurred to prevent similar disasters. On July 7, 2003, Governor Carcieri signed new fire regulations that many consider the toughest in the country.

This AAR contains more than 375 recommendations aimed at improving all aspects of response and recovery. Although the recommendations are directly applicable to Rhode Island, many are also pertinent to other communities seeking to improve response and recovery capabilities and strengthen homeland security. Many are discrete and apply to very specific areas. Others are more general, with broader implications. A sample of findings with especially significant implications, both positive and negative, follows.

Lessons for Others to Emulate

1. The first responder fire and Emergency Medical Services (EMS) staff, along with the hospital emergency department and treatment physicians, nurses, and technicians, managed to rescue, evacuate to area hospitals, and treat 186 patients, many with critical injuries. Every victim evacuated from the site by EMS rescue units arrived safely at area hospitals. About 50 additional victims reported to hospitals on their own. With a total of approximately 230 injured victims, this was a monumental accomplishment.

2. The Rhode Island Office of the Medical Examiner (OME), supported by a Federal Disaster Mortuary Operational Response Team (DMORT), and volunteers from the Rhode Island Funeral Director's Association, the Rhode Island Dental Association, and from the Rhode Island Department of Health (RI Health), performed 96 autopsies and victim identification investigations in less than 5 days. An average of 35 professionals worked in 12-hour, round-the-clock shifts until every deceased victim was accounted for and the family notified.

3. The Family Assistance Center (FAC) and the Family Resource Center (FRC) proved to be very valuable in the response and recovery process. The FAC, patterned after the approach used to offer safe haven to families of victims following the 1999 crash of EgyptAir flight 990 and other commercial airline crashes, protected the grieving families from external intrusions and offered physical, psychological, emotional, and faith-based support while awaiting definitive identification of missing family members. Representatives from State, local, and Federal agencies, as well as voluntary organizations at the FRC, provided assistance to surviving victims and family members in applying for and obtaining government benefits and entitlements as well as support from private charities.

4. Fundraising and the distribution of funds to survivors, their families, and the families of the deceased were accomplished in exceptional fashion. The generosity of Rhode Island citizens immediately fueled the Station Nightclub Fire Relief Fund (SNFRF), while the external oversight committee appointed by Governor Carcieri established operating rules that enabled social workers to disburse funds promptly to meet the immediate needs of those suffering from the consequences of this tragedy. Sufficient money had been accumulated and disbursement and accountability mechanisms were established allowing the first SNFRF check to be issued on Thursday, February 27, just 1 day after the FRC opened.

Areas Requiring Significant Improvements

1. The Statewide Rhode Island emergency management system failed to function effectively. Emergency response and recovery plans are badly out of date and do not incorporate current emergency management doctrine. RIEMA did not serve as the management focal point providing regular situation reports and updates to the governor with information from the incident site, FAC, medical examiner, healthcare facilities and public safety organizations, charitable groups, and the myriad of other organizations engaged in response and recovery activities. The heart of this system is RIEMA. It suffers from years of insufficient funding, inadequate facilities and equipment, and deficiencies in organization and staffing. RIEMA has many dedicated and competent staff members whose contributions in support of West Warwick and at the FAC and FRC are described throughout this report, but dedication and hard work cannot overcome systemic flaws. In light of the unique relationship between State and municipal governments in Rhode Island, it might also be poorly positioned within the Rhode Island Military Department. Elsewhere in the country, local governments confronted with emergency conditions turn first to county political jurisdictions before seeking help from the State. In Rhode Island, there is no intervening county government. The State is the first recourse for help when disaster strikes a local community, and it must be able to respond in a quick, decisive, and fully coordinated manner. Significant improvement is needed in this area.

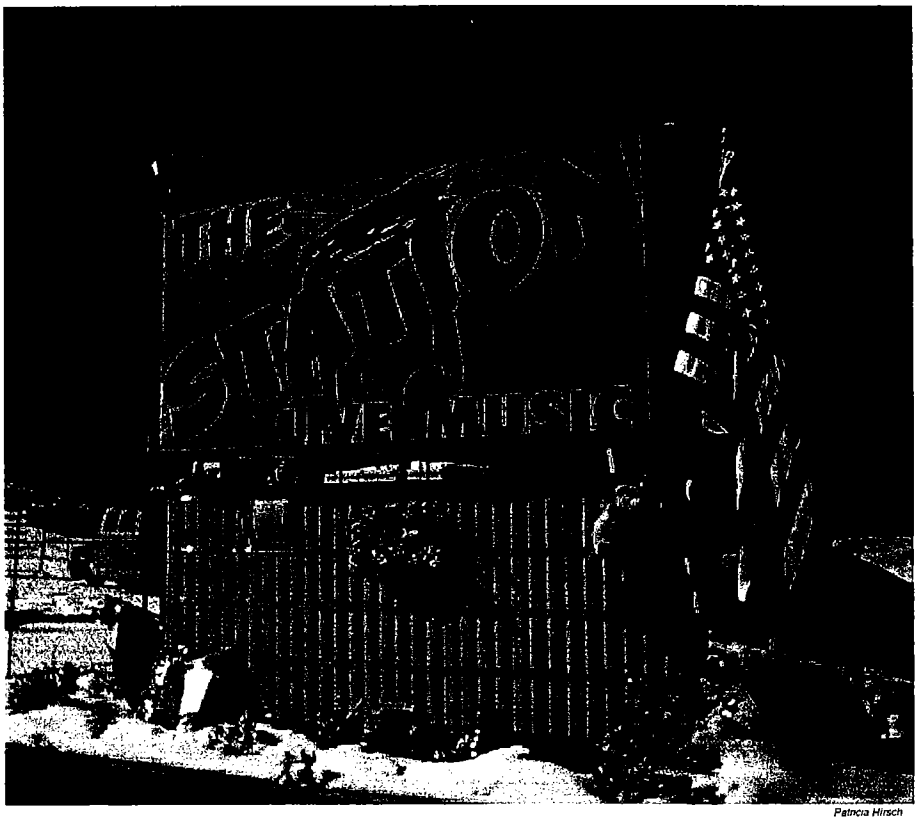
2. The Rhode Island OME failed to respond with sufficient resources and experienced leadership to measure and meet the requirements of this demanding incident. Despite early and repeated warnings that this was an event with significant fatalities, the OME never marshaled the necessary investigative and transportation resources. The on-scene OME investigator was clearly overwhelmed by the circumstances at the Station club, yet neither the chief medical examiner nor any other senior OME staff member visited the scene. As a result, EMS rescue units, as well as administrative vans with drivers untrained in transporting the deceased, were pressed into service by Incident Command.

3. There was little communication between receiving hospitals and the incident site or with inbound EMS units transporting patients. Patients arrived unannounced at hospital emergency departments, often in rapid sequence. Receiving hospitals assigned physicians and nurses to patients on a first-come, first-served basis without the advantage of minimum advanced planning. This was compounded by the fact that patients were transported to hospitals from the incident site without the benefit of information concerning hospital capacities and capabilities. This should not have been the case as the capability to obtain such information was in place and an early survey of hospitals during emergency conditions is common practice. Unfortunately, the deficiencies in Statewide emergency response plans, interagency coordination, and regularly scheduled drills involving dispatch centers, EMS units, and hospital emergency departments were apparent on this occasion.

4. The Rhode Island emergency management system suffers from inadequate policies, plans, procedures, and technologies. Symptomatic of these deficiencies is the absence of a Statewide alert and notification system that provides timely notification to senior officials in relevant government agencies. Although the Statewide 9-1-1 system alerts police, fire, and EMS organizations, most Rhode Island agency leaders learned about this event in the same way as the general public, from public news sources or telephone calls from

relatives, friends, or associates. Even if a Statewide alert and notification system were in place and used to immediately contact all relevant government agencies, most agencies do not have internal alert and notification procedures in place. For example, even though elements of RI Health knew about the fire as early as 11:30 p.m. and the Rhode Island OME was continuously engaged in recovery operations beginning shortly after midnight, no one called Dr. Patricia Nolan, the department director. Thus, the cabinet officer responsible to the governor for the health and well-being of Rhode Island citizens learned of the event from the Friday morning news. There is also a system to alert area hospitals of a mass casualty event using Nextel radios—it was not used when the Station club fire occurred.

It is difficult to conceive of a more terrifying and helpless situation than imminent death by fire without hope of escape—the smoky darkness, the toxic fumes and superheated air, the uncontrollable advance of all-consuming flames, and the press of the bodies of other terrified, screaming persons. This report describes the actions that occurred on the night of February 20, 2003, and the days, weeks, and months that followed as told by the broad community who responded to the tragedy and participated in the recovery process.



Patricia Hirsch

ANNEX A
FIRE DEPARTMENT OPERATIONS

WPRI-TV Channel 12

"Don't say it can't happen, because it can!"

Chief Charles Hall
West Warwick Fire Department

INTRODUCTION

West Warwick Fire Department

The town of West Warwick is the youngest community in the State of Rhode Island, having been statutorily separated from the town of Warwick on March 14, 1913. The town has a population of 29,581, which ranks tenth among Rhode Island's 39 cities and towns. West Warwick contains 7.93 square miles of land area and 0.18 square miles of water. As of April 1, 2000, the town had 13,186 housing units.

The West Warwick Fire Department (WWFD) provides fire suppression and Emergency Medical Services (EMS) for the town. The WWFD employs a total of 72 personnel, 66 of whom are in sworn, uniformed positions. The department staffs four engine companies, one truck company (Ladder 1), two rescue units (ambulances), and one special hazards unit (heavy rescue or squad). The department operates four fire stations (see **Figure A-1**) and firefighters are deployed in four platoons. Each platoon works an average workweek of 42 hours on a rotating schedule with two consecutive day shifts of 10 hours each, followed by two consecutive night shifts of 14 hours each. Each platoon then has 4 consecutive days off. The minimum staffing for each platoon is 13 firefighters, including a battalion chief.

Station	Location	Apparatus and Personnel
1	1176 Main Street	Car 3 with a battalion chief Engine 1 with a captain and a firefighter Rescue 1 with two firefighter/EMT-Cs*
2	834 Main Street	Engine 2 and Rescue 2 cross-staffed by two firefighter/EMT-Cs
3	683 Providence Street	Engine 3 with a lieutenant and a firefighter
4	110 Cowesett Avenue	Ladder 1 with a lieutenant and a firefighter who cross-staff the special hazards unit Engine 4 with a lieutenant and a firefighter

* EMT-C is an EMT-Cardiac Rescue Technician, an intermediate certification between EMT-Basic and EMT-Paramedic.

Figure A-1. West Warwick fire station locations.

West Warwick Fire Department Facilities

Fire Station 1 serves as the fire department headquarters (HQ) and is located at 1176 Main Street adjacent to the Town Hall and the West Warwick Police Department (WWPD). HQ staff include the fire chief, a secretary, the fire marshal, an assistant fire marshal, and the director of communications. The WWFD Fire Alarm Office is also located at the HQ station. The Rhode Island Enhanced 9-1-1 Uniform Telephone System, which is a State agency located in North Providence, answers all 9-1-1 calls in the State of Rhode Island. The 9-1-1 Center transfers requests for service to the appropriate public safety agency based on the location and nature of the emergency. The local Fire Alarm Office is responsible for dispatching fire apparatus and rescue vehicles.

West Warwick Fire Department Leadership

The chief of the WWFD is Charles Hall. Chief Hall joined the Cranston Fire Department in October 1974, rising to the rank of assistant chief. In 1999, he left to become the Rhode Island director of the Fire Training Academy. Fire Training is a division of the Office of the State Fire Marshal. Chief Hall was appointed to his current position in September 2002.

Historic Tragedy

According to the National Fire Protection Association (NFPA), the Station club fire was the fourth deadliest nightclub fire in the history of the United States (see **Figure A-2**) and the ninth deadliest fire in a place of public assembly. Although the fire was the catalyst for this tragedy, it was relatively short-lived. The highly flammable nature of the foam insulation (as reported by *The Providence Journal*), the large open area of the club interior, and the absence of an automatic fire sprinkler system allowed the fire to spread quickly. Most of the building was consumed within the first hour of the incident.

Fire	Location	Date	Fatalities
1. Cocoanut Grove nightclub	Boston, MA	November 28, 1942	492
2. Rhythm Club dance hall	Natchez, MS	April 23, 1940	207
3. Beverly Hills Supper Club	Southgate, KY	May 28, 1977	165
4. The Station nightclub	**West Warwick, RI**	**February 20, 2003**	**100**
5. Happy Land social club	Bronx, NY	March 25, 1990	87

Source: National Fire Protection Association (NFPA)

Figure A-2. Five deadliest nightclub fires in U.S. history.

Immediate Response Concerns

The most pressing issue facing the emergency responders was the rescue of survivors and the monumental task of transporting them to area hospitals. Initial fire suppression efforts were directed at supporting this rescue effort. Equally challenging was the subsequent recovery and removal of those who perished in the inferno.

Tragic Results

Published reports have estimated the number of occupants in the Station club at the time of the fire at 432 (*The Providence Journal,* December 21, 2003). This estimate is based on legal documents acquired by the newspaper and the accounts of survivors and others who were in the Station club when the fire occurred. Ninety-six of the occupants were killed during the incident and 186 people were transported to area hospitals by fire department-based EMS and

private ambulance services. A number of other victims were transported to hospitals in private vehicles. Four victims subsequently succumbed to their injuries while hospitalized.

Crowded conditions, limited exit capacity, and the absence of an automatic fire sprinkler system combined to produce the tragic results. This deadly combination of factors led to the death or injury of approximately three-fourths of the occupants. Even though there was a fire station within three-tenths of a mile of the Station club, most of the deaths and injuries had already occurred by the time firefighters arrived at the scene.

Information Collection

Information for this annex was obtained through a series of personal interviews with key members of the fire departments and EMS that responded to this incident. The only individual interviewed from the WWFD was Chief Hall. Chief Hall elected not to allow other members of the WWFD to be interviewed. Therefore, the overwhelming majority of those interviewed for this annex were members of mutual-aid departments, principally from Warwick and Cranston. Chief Hall and the fire chiefs from Warwick and Cranston indicated that the members of their respective departments performed 90 percent of the fire suppression effort. In addition, attempts to obtain access to a list of the responding agencies was denied by the Rhode Island Attorney General's Office and attorneys representing the town of West Warwick.

This annex consists of four sections, each of which convey the observations, findings, and recommendations regarding fire department operations:

- Section 1 – The Building
- Section 2 – Fire Suppression and Rescue Operations
- Section 3 – Recovery Operations
- Section 4 – Critical Incident Stress Management

SECTION 1 – THE BUILDING

Observations

The Structure and Its Characteristics

The Station club was located at 211 Cowesett Avenue in West Warwick. The single-story, wood-frame building was situated on the southwest corner of the intersection of Cowesett Avenue and Kulas Road. The building, constructed during the Word War II era, had been occupied by a number of establishments before the current owners, Michael and Jeffery Derderian, purchased the club in 2000. Ironically, a portion of the original building was destroyed by a previous fire that occurred in 1972.

The building contained 6,278 square feet on the main level and had a 1,700-square-foot basement. There were four exits in the building, two on the east side, the main entrance on the north side, and an exit by the stage on the west side. Accounts given by survivors published in *The Boston Globe* indicated that the door by the kitchen on the east side of the building was hidden from the view of most patrons and that a second door on the east side of the club in the bar area was not easily accessible. Other patrons reported that a bouncer directed them away from a door by the stage located on the west side of the club. Therefore, the main exit on the north side of the building became the primary means of escape. The ticket booth area and the walls of the entry hallway, however, restricted egress from the main door (see **Figure A-3**).

The building did not have an automatic fire sprinkler system. The only fire protection in the club consisted of a few handheld fire extinguishers and a smoke alarm system, which can be heard on the videotape produced by a local television cameraman filming inside the club.

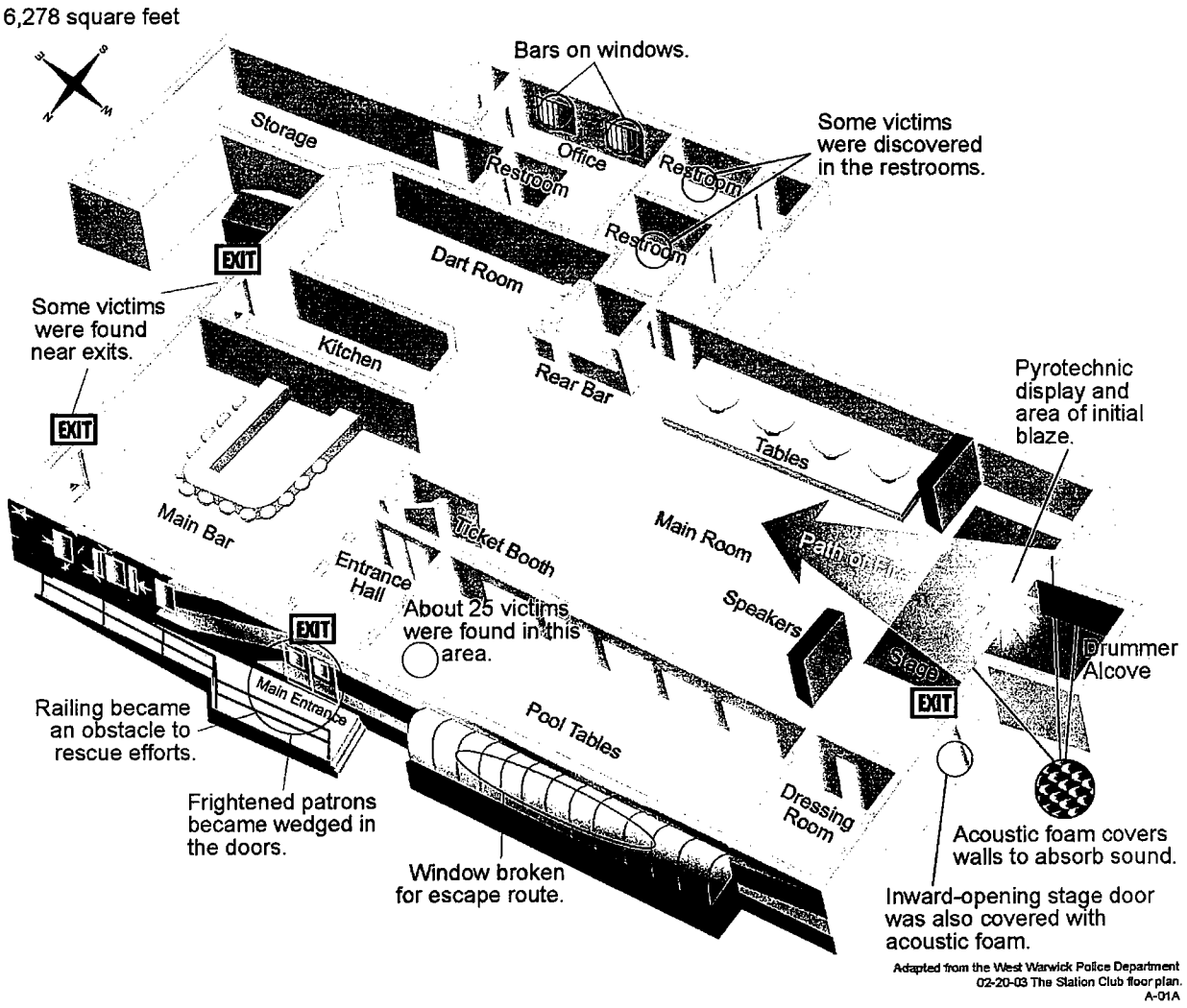


Figure A-3. Floor plan of the Station club.

SECTION 2 – FIRE SUPPRESSION AND RESCUE OPERATIONS

Observations

The Fire Ignites

On Thursday night, February 20, 2003, the band Great White was performing at the Station club. Published reports in *The Providence Journal* place the occupant load on the night of the fire at 432, although the permitted occupant load was only 404. Shortly after 11:00 p.m., the band's manager set off a pyrotechnic display as part of the band's stage act. Sparks from the pyrotechnics quickly ignited the polyurethane foam insulation on the walls near the stage.


WPRI-TV Channel 12

According to published reports in *The Boston Globe*, the owners of the club had applied a layer of 2½-inch thick polyurethane packing foam to some walls of the club in the vicinity of the stage to reduce the noise levels in response to complaints of people who lived nearby. The foam wall coverings were highly combustible and allowed the fire to spread rapidly. The thick, heavy black smoke produced by the burning foam was highly toxic and quickly obscured visibility within the club.

Initial Reaction


WPRI-TV Channel 12

Shortly after the walls begin to burn, patrons start making their way toward the exits.

A cameraman from a local CBS television station (WPRI-TV Channel 12) was filming inside the club when the fire started. His videotape shows that the patrons began to make their way toward the exits shortly after the walls began to burn. At 11:07 p.m., Patrolman Tony Bettencourt, a West Warwick police officer working a security detail at the Station club, made the first emergency notification reporting the fire by means of a two-way radio transmission. Patrolman Bettencourt requested that the West Warwick police dispatcher send the fire department, and he reported that there were already people trapped inside the burning structure. It appears that others at the club used cellular telephones to call for help, as the Rhode Island 9-1-1 Center received four wireless calls between 11:08:48 p.m. and 11:08:54 p.m.

Fire Department Response

At 11:10 p.m., the WWFD dispatched a standard structural fire response. This included the three closest engine companies, the ladder truck, and a rescue unit (ambulance), all under command of a battalion chief (shift commander). Based on the 9-1-1 calls and radio traffic from the scene, the WWFD fire alarm operator upgraded the initial assignment to include West Warwick's remaining engine company.

West Warwick's Fire Station 4, located at 110 Cowesett Avenue, is only three-tenths of a mile west of the club. Engine 4 and Ladder 1 responded from Station 4 and were the first fire companies to arrive at the scene at approximately 11:13 p.m. The sirens from the apparatus from Station 4 can be heard on the WPRI-TV videotape at approximately 4 minutes and 30 seconds after the walls ignited.

Firefighters Arrive at the Scene

Engine 4 pulled into the driveway of the club and parked perpendicular to the building just west of the main entrance to the building. The parking lot was very congested at that time because the majority of the club's off-street parking was located immediately in front of the building. There were two firefighters on Engine 4 and they pulled a 1¾-inch handline and used the water in the booster tank on the apparatus to attack the fire at the main entrance protecting the primary means of escape. Ladder 1's driver parked the WWFD Tower Ladder at the corner of Kulas Road, just east of the Station club and joined the firefighters from Engine 4 who were attacking the fire and pulling victims from the growing crowd of people jammed in the front doorway. Occupants of the club had tripped while attempting to exit the club and victims were literally entwined and wedged on top of one another.

Leadership Alert

The WWFD hockey team had just concluded practice when the fire alarm operator contacted Chief Hall, the team's coach, on his cellular telephone. The operator told the chief that the department had an "all-hands" working incident at the Station club on Cowesett Avenue and that the initial radio transmissions from the scene and the 9-1-1 calls he was receiving did not sound good. Chief Hall relayed the information to the off-duty firefighters who had attended practice and proceeded to the incident, which was approximately 2 miles from the ice rink.

While en route, Chief Hall could see smoke rising from the blaze. He monitored the radio traffic from the scene and heard descriptions of a large fire with multiple casualties. Chief Hall ordered Fire Alarm to activate the mass casualty incident (MCI) portion of the Southern New England Fire Emergency Assistance Plan and to relay the information to Metro Control in Cranston. Once this occurs, the local Fire Alarm Office is free to manage the incident while the local regional dispatch center is responsible for dispatching mutual-aid companies.

Mutual Aid

The Southern New England Fire Emergency Assistance Plan specifies four Rhode Island regional mutual-aid control centers: Metro Control (Cranston), Eastbay Control (Portsmouth), Southern Control (Exeter), and North Control (Smithfield). **Figure A-4** shows the location of each control center and the departments dispatched by each center are indicated by the color-coded map. The regional centers operate the mutual-aid fire radio network, referred to as Intercity, established in 1962 to provide an integrated communications network for the fire departments in the State of Rhode Island. The system operates on an assigned frequency of 154.280 MHz. Providence is designated as an alternative control center for the metropolitan region in the event that Cranston has a major incident.

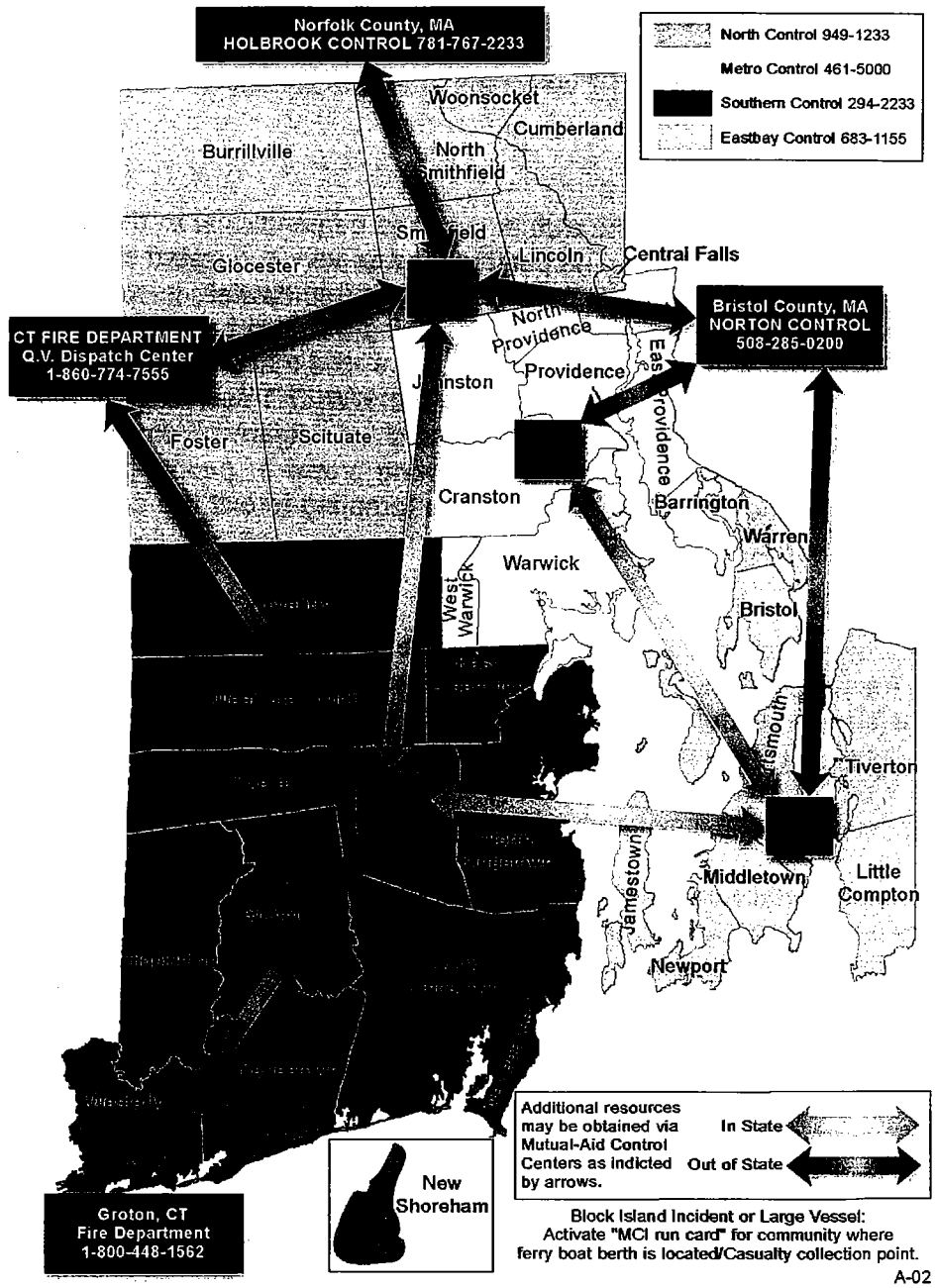


Figure A-4. Schematic of Rhode Island Mutual-Aid Control Centers.

According to the mutual-aid plan, West Warwick is designated as Box 2838 (see **Figure A-5**). The box card assignment system is patterned after the telegraph pull-box system still used in much of New England, including West Warwick. It provides an organized response and relocation plan through a system of seven alarms. The response scheme makes 15 additional engine companies and four ladder companies available to West Warwick beyond the initial alarm. The plan also provides fill-in companies to cover West Warwick's fire stations and those of the surrounding communities that send apparatus into West Warwick.

Southern New England Fire Emergency Assistance Plan

West Warwick						Mutual-Aid Box 2838			
Local Alarm Level	To Fire					Relocate			
	Engine			Ladder	Chief	Engine			Ladder
1st									
2nd		WAR	WAR	WAR	WAR	CRAN TO E-1			CRAN TO L-1
3rd	(CRAN)	CRAN		(CRAN)		COV TO E-1			COV TO L-1
4th	(COV)	COV		(COV)	COV	EGREN TO E-1			EGREN TO L-1
5th	(EGREN)	COV	WAR			SCIT TO E-1			
6th	(SCIT)	PROV	PROV	PROV	PROV	WGREN TO E-1			
7th	(WGREN)	NK	FOST			JOHN TO E-1			
8th									

Additional Available Apparatus

Engines: JAMS, SMITH, GLOC, EXTR, SK, NPROV

Ladders: COV, JAMS, CRAN, PROV

Task Forces: FOAM TASK FORCE #29, TANKER TASK FORCE

Source: Southern New England Fire Emergency Assistance Plan

Figure A-5. Mutual-Aid Box 2838.

When the mutual-aid plan is implemented, a task force is dispatched from Warwick on the second alarm and an engine and ladder company from Cranston are dispatched to West Warwick as fill-in companies. On the night of the Station club fire, many firefighters in these communities were already asleep. Others, monitoring the radio scanners at the fire stations, learned of the fire and alerted their comrades, including the on-duty chief officers. These firefighters first thought the fire was at West Warwick Fire Station 4 on Cowesett Avenue, but later realized that it was down the street at the Station club. Aware that they would be dispatched to the incident, firefighters were already dressing and heading for their apparatus when alerted to respond by their respective Fire Alarm Offices.

The communities of Warwick, Cranston, and West Warwick provide each other with mutual aid almost daily. When a mutual-aid assignment is dispatched into a neighboring community, each department usually sends a task force of two engines, a truck company, one rescue unit, and a chief officer. Although staffing levels vary somewhat among the fire departments, a typical task force would have a complement of at least 11 firefighters.

West Warwick Establishes Incident Command

Chief Hall arrived at approximately 11:16 p.m., just 6 minutes after the incident had been dispatched. He parked his car at the Nissan dealership across Kulas Road from the Station club. As he walked toward the building, he observed that several handlines and master streams were being used in an effort to control the fire and recognized that this would be a very difficult rescue situation. Chief Hall sized up the incident by walking sides 1, 2, and 4 (Alpha, Bravo, and Delta) of the building and located the captain who was acting as battalion chief that night. He ordered him to take command of the rear (Charlie) sector, and Chief Hall assumed overall command of the incident.

Chief Hall established a forward command post near the front entrance to the building and used the trunk of a parked car as a worktable. From his vantage point, he could closely observe the fire suppression and rescue operations, which were being conducted simultaneously. His first concern was for the safety of his firefighters because the rapid growth and spread of the fire was already causing portions of the building to collapse. Chief Hall designated two captains from West Warwick and a Warwick Fire Department (WFD) officer to act as safety officers.

Warwick Fire Department Dispatch and Deployment

The fire alarm operators in Warwick had also been monitoring radio traffic from the scene and had received a number of 9-1-1 calls. Based on this information, when the Warwick task force was dispatched at 11:14 p.m., the dispatchers took it upon themselves to upgrade the response, sending an additional engine, rescue unit, and the WFD special hazards unit. Before the Warwick task force was dispatched, Battalion Chief Henry "Skip" Heroux was already en route to the incident from the Warwick HQ station. He was the first chief officer from Warwick to arrive at the scene.

WPRI-TV Channel 12

Chief Heroux arrived at the incident at 11:19 p.m. The fire was already breaking through the front of the building. He parked his command vehicle in the parking lot of the Cowesett Inn across the street from a Nissan automobile dealership that was next door to the Station club. He observed a crowd of people in the street in front of the Station club, including a person operating a television camera, which he thought a bit odd. Later he learned that the camera operator had been filming Great White's performance inside the Station club when the fire started.

Chief Heroux was told that there were people inside the Cowesett Inn with severe burns. He advised the crews responding on Rescue 4, Rescue 1, and Engine 5 to check the status of the victims inside the Cowesett Inn. He then proceeded on foot toward the Station club, encountering more injured victims along the way. He also witnessed desperate people loading victims into the trunks of automobiles and moving them away from the burning building.

Initial Actions at the Scene

Chief Heroux found the West Warwick shift commander (a captain riding as acting battalion chief) and began to assist in sizing up the incident. There was blood on the ground and on the snow in the parking lot. Injured victims were lying on the ground and people were packing snow on some of the burn victims. Many victims asked him for help. He could also see firefighters pulling people from among the victims stuck in the front doorway of the club.

Chief Heroux instructed Engine 9's crew to begin treating the people in the street, and he asked his Fire Alarm Office to send all of Warwick's rescue units to the scene. He also ordered buses to help transport those with injuries that were not life threatening. Later, he contacted the

Warwick Fire Alarm Office and told them to use the Yellow Pages and ask private ambulance companies to respond with as many ambulances as possible.

As West Warwick Engine 4 had exhausted its water, West Warwick Engine 2 laid two 3-inch supply lines from the hydrant in front of the Cowesett Inn. The second engine pulled into the parking lot behind Engine 4 and when the supply lines were charged, opened up its deck gun on the main body of the fire.

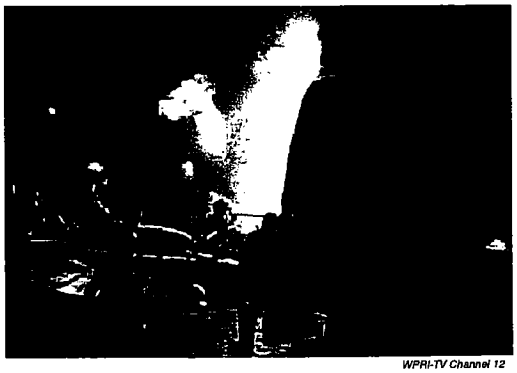
When Warwick's Ladder 1, under the command of Captain Kevin Sullivan, arrived on the scene at about 11:19 p.m., firefighters could see a lot of people in the street and along a guardrail, which separated the sidewalk on the north side of Cowesett Avenue from the parking lot of the Cowesett Inn. Captain Sullivan quickly realized that they were all fire victims. He was approached by the crew of a West Warwick rescue unit and they told him that there were a lot more victims and that more ambulances were needed. He relayed this message to the Warwick Fire Alarm Office.

Gathering the Injured Victims

As he stepped out of his apparatus, Captain Sullivan was met by a group of walking wounded. He gathered as many victims as he could and verbally instructed them to follow him. Motioning with his hands, he walked backward and away from the burning club. As he led the group away from the incident scene, he encountered a police officer who advised him that they were allowing people to go into the Cowesett Inn. Captain Sullivan told them to go into the building. He later learned that this was the primary triage area. When Warwick Rescue Captain Peter Ginaitt and Cranston Rescue Captain Leo Kennedy arrived, they were offered the use of the Cowesett Inn to evaluate injured victims.

Creating Space for Apparatus

When the fire broke out, the band bus had been parked immediately in front of the club near the front door. Shortly after the firefighters began to arrive, the bus, which at that time was located between West Warwick Engine 4 and the Station club, was pulled out of the parking lot. This gave firefighters additional space from which to operate.



WPRI-TV Channel 12

Fire Suppression

When Warwick Ladder 1 first arrived, access to the front of the building was blocked by the two 3-inch supply lines that had been laid from the fire hydrant in front of the Cowesett Inn. These lines were feeding West Warwick Engine 2. The lines were repositioned and Ladder 1 was able to back in beside the two engines from West Warwick. Ladder 1 raised its platform and Chief Hall ordered the next due engine company to lay them a supply line.

Cranston Engine 4 had been dispatched as a fill-in company but was subsequently diverted directly to the fire and laid a 4-inch supply line to Warwick Ladder 1 from a hydrant on Narragansett Avenue. They apparently did not realize that Warwick's tower ladder was not equipped with a pump, because they hooked their supply line directly to the hydrant and did not pump the line from Engine 4. This provided Ladder 1 with volume, but not the pressure necessary to develop an effective water stream. West Warwick Engine 4 shut down its deck gun and began to pump into Warwick Ladder 1, providing the pressure it needed. Once it had

a water supply, Ladder 1 raised its ladder and used the master stream device on the platform to sweep the fire area and push flames back from the main entrance. Master streams are not typically used when there are people still alive in a building, but this action was credited by a number of firefighters with assisting the rescue effort, which was still ongoing at that point.

Warwick's Ladder 1 uses its ladder pipe to knock down the flames and to protect the rescue effort in the front doorway.

From Warwick Ladder 1's elevated position, Captain Sullivan could observe handlines being used on sides Bravo, Charlie, and Delta, which were not being supervised by a chief officer. A handline was actually inside the building on side Delta. (WPD identifies the various sides of a burning structure by assigning alphabetic designators; WWFD uses numeric designators.) To prevent injury, Captain Sullivan used hand signals to alert firefighters before sweeping the area with his ladder pipe. The main body of the roof had already collapsed into the building, burning debris and bodies beneath, but the walls were still standing.

When Warwick Engine 1 arrived at the scene at about 11:19 p.m., the crew members observed fire coming through what remained of the roof and out of every window and door in the Station club. The crew went around the block and laid 300 feet of 4-inch supply line from a hydrant at #7 Kulas Road to the northeast corner of the building. They used the deck gun in an attempt to push the fire away from main entrance of the club. The cold temperatures, combined with the spray from the deck gun, caused ice to form on Kulas Road and Engine 1 slid partway down the hill, hitting West Warwick's ladder truck before coming to a rest. See **Figure A-6** for a schematic of apparatus deployment.

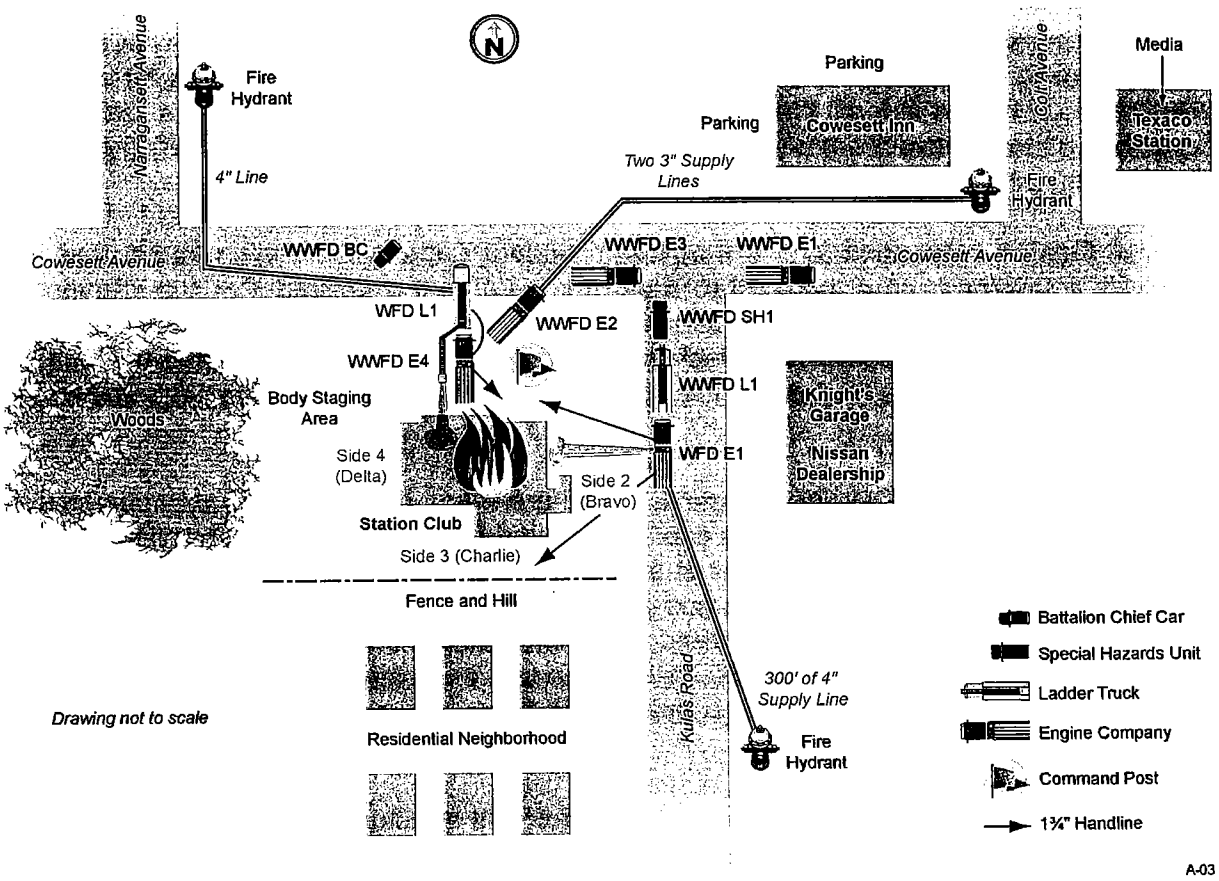


Figure A-6. Schematic of apparatus deployment.

Continuing Rescue Efforts

Victims converged on Warwick Engine 1, where the crew administered oxygen to the most seriously injured. They helped those who were ambulatory walk to the triage center at the Cowesett Inn. When the stream of victims ended, Engine 1's crew went to the front of the club and began extinguishing car fires with 1¾-inch handlines. They also took a line around to the rear of the building, but that proved ineffective, so they returned to the front and attempted to extinguish the gasoline burning on the ground beneath the vehicles. They tried to use their foam system, but it failed. They also joined in the effort to remove victims from the main entrance. An Engine 1 officer commented that in the future it will be much more difficult to presume that everyone is dead inside a burning structure.

WFD command vehicles are equipped with command boards to assist in tracking progress. However, Chief Heroux chose instead to use a clipboard and the department's tactical work-sheet rather than the command board. He also remained on the WFD frequency throughout the incident rather than switching his radio to the Intercity frequency. In hindsight, he realized that this was a mistake, although it proved to be somewhat beneficial. Realizing that more ambulances would be needed, he radioed WFD Chief Jack Chartier and told him that he believed there could be as many as 100 victims.

Warwick Fire Department at the Scene

Chief Chartier is the fire chief in Warwick and was at his home, approximately 15 miles south of the incident, when the fire occurred. He received a telephone call from the Warwick Fire Alarm Office informing him that the department was responding with a beefed-up task force to assist West Warwick with a fire at the Station club on Cowesett Avenue. When a task force is dispatched outside the city limits, it is standard procedure to notify the fire chief, the assistant fire chief, the training chief, and the EMS chief.

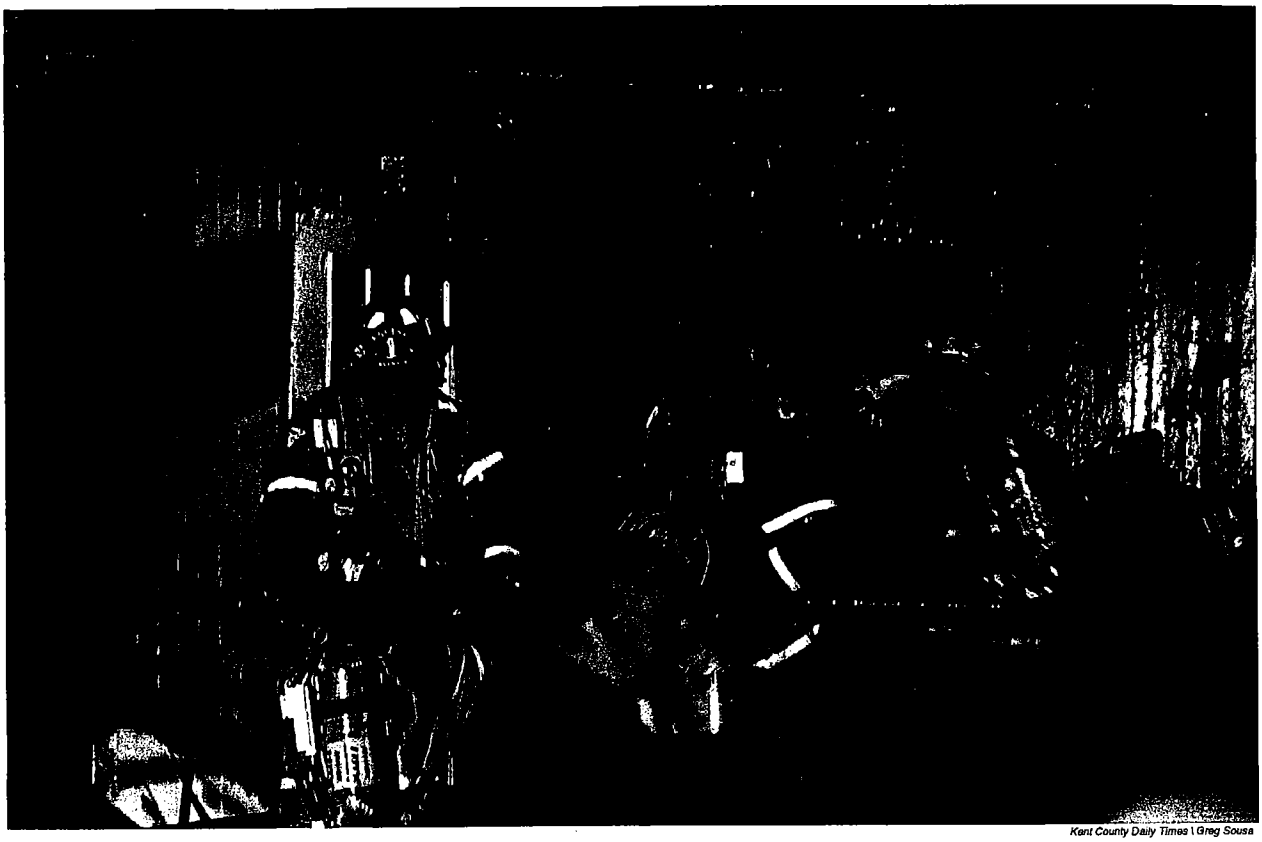
As Chief Chartier responded to the incident, he heard Captain Sullivan's request that all of Warwick's ambulances be dispatched to the scene. When it appeared that the Warwick Fire Alarm Office was initially reluctant to send all of the rescue vehicles, Chief Chartier contacted the Fire Alarm Office on his cellular telephone and ordered that all of the reserve units be sent. He further directed the dispatchers to initiate an Intercity request for mutual-aid ambulances to backfill the WFD.

Upon his arrival, Chief Chartier observed that there were many emergency apparatus and significant numbers of victims at the scene. He located Chief Heroux and determined that they should remain on the WFD radio channel to coordinate WFD personnel. He then found Chief Hall in front of the building and assumed the position of liaison officer to the Incident Commander (IC) while Chief Heroux supervised and coordinated the WFD companies. WFD's training chief responded to the scene as well and acted as safety officer for WFD personnel, assembling a rapid intervention team (called a FAST Team in Rhode Island).

Rescue at the Main Entrance

By the time the fire was burning through the roof of the structure, the bodies of victims were jammed together, one on top of another, in the front doorway. Some had already died; others were still trying to escape. There were four or five companies from West Warwick and Warwick operating at the front doorway trying to rescue victims. A chief officer coordinated the rescue effort.

Most occupants had tried to exit through the front door, but the ticket booth restricted egress. Some people tripped and fell, becoming intertwined with others. The pile up made it difficult to separate the living from the dead. Firefighters used ladder belts and ropes to pull victims from the pile—removing living victims from the top of the pile, discovering deceased victims beneath them. They tried to treat the deceased with as much dignity and respect as circumstances permitted without sacrificing additional lives. Firefighters lined up the corpses on tarps near the northwest corner of the building. They used fire apparatus, tarps, and the adjacent tree line to shield the bodies from the view of bystanders and the media.



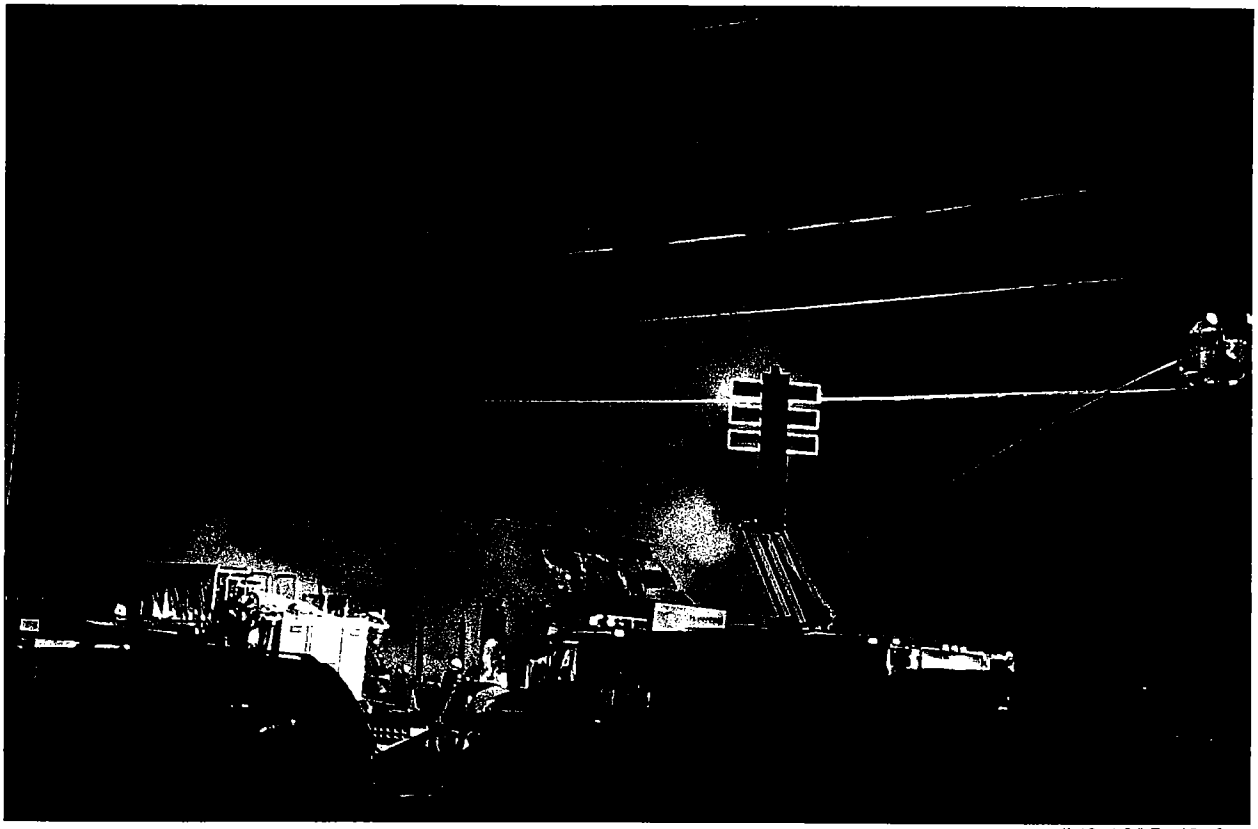
Rescue efforts at the main entrance.

Call for More Help

Chief Hall repeated his call for as many ambulances as could be located and asked for a recall of the off-duty shift, recalling the platoon that had worked the previous day shift. He subsequently extended the recall to the entire department. Most firefighters responded to their stations to gather protective clothing and staff the reserve apparatus. Some responded directly to the incident scene, catching rides with fill-in companies.

Backfilling the West Warwick Fire Department

When mutual-aid companies relocate to cover West Warwick stations, an off-duty WWFD firefighter is routinely assigned to ride the out-of-town fire apparatus, acting as a guide to help companies that are unfamiliar with streets and fire hydrant locations. Off-duty fire alarm operators also responded to the recall, and the number of available personnel in the West Warwick Fire Alarm Office increased from one dispatcher to four dispatchers, plus the communications supervisor.



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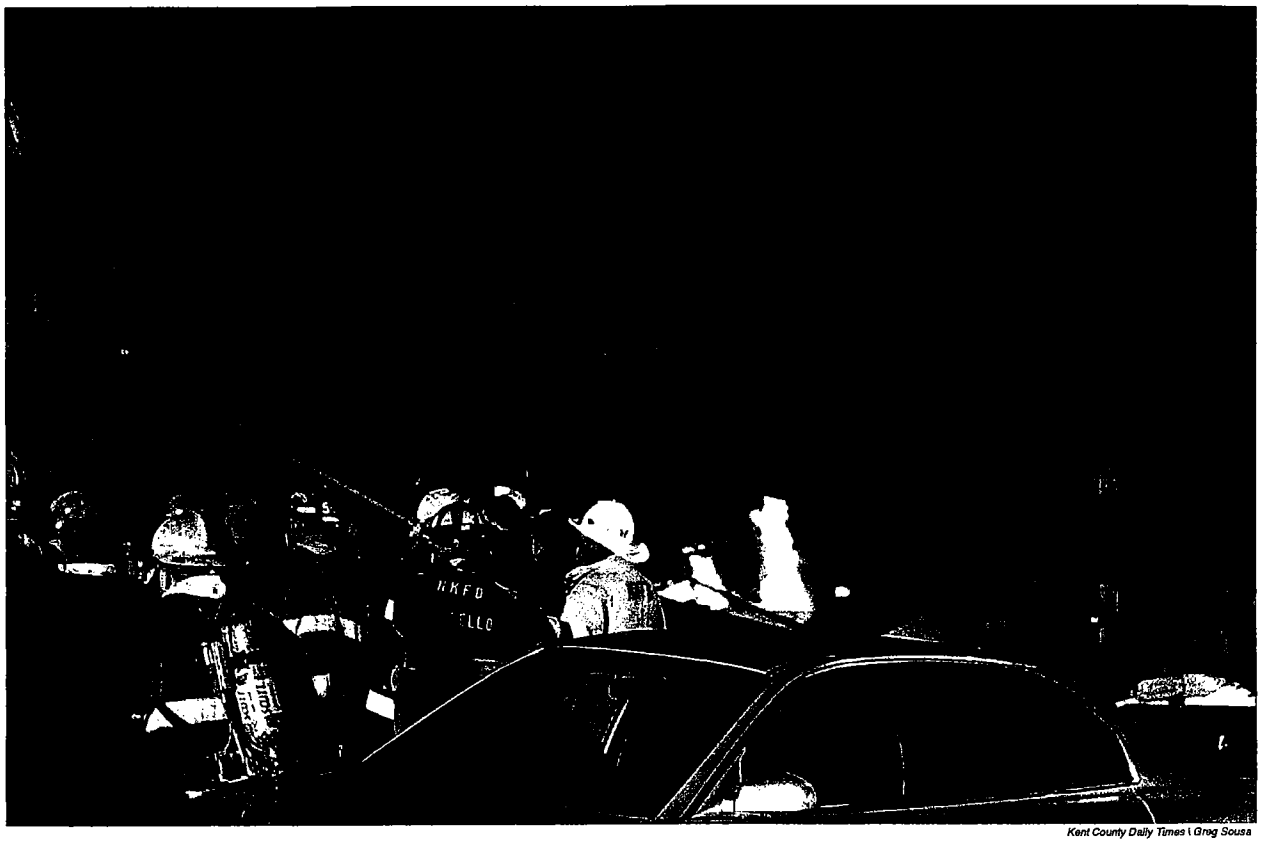
WWFD Special Hazards Unit uses its light tower to illuminate the scene.

Coventry Fire District Responds

Fire Chief Robert Seltzer, from the Central Coventry Fire District, came to the command post to meet with Chief Hall. Fire Chiefs Hall and Seltzer have a long-standing personal and professional relationship. Chief Seltzer is a cardiac technician and Chief Hall asked him to take charge of the triage area, which had been established diagonally across Cowesett Avenue at the Cowesett Inn. Most of the ambulatory victims had migrated to the Cowesett Inn, which had become the triage area by default. The use of evacuation helicopters to remove victims was immediately ruled out because the closest practical landing zone was nearly 1 mile from the incident.

Structural Collapse

The rescue operation was ongoing during the early stages of the incident. West Warwick's Special Hazards Unit was positioned at the corner of Kulas Road and Cowesett Avenue and the vehicle's light tower was used to illuminate the rescue scene. Approximately 30 to 40 minutes into the incident, a wall collapsed in the right front of the building and at least two firefighters were hit by falling debris but were not injured. When the wall collapsed, Chief Hall ordered the structure evacuated. This was announced over the radio and by sounding the sirens and air horns on the assembled apparatus. A personnel accountability roll call (PAR) was conducted to account for all emergency responders on the scene. Each department did its own count. The roll call accounted for all of the firefighters. Realizing that potentially there were still live victims inside, Chief Hall ordered firefighters back into the building. The transition from the rescue to the recovery phase occurred approximately 40 minutes into the incident.



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Approximately 30 to 40 minutes into the incident, a wall collapses in the right front of the building.

Incident Commander's Location

The collective interviews, including that of Chief Hall, indicated that the primary entry point for interior operations for rescue and fire suppression operations was the front door. Chief Hall positioned himself there because he could observe not only the suppression efforts, but the rescue effort as well. Rescue efforts consisted primarily of firefighters leading the ambulatory people out to safety and disentangling live victims from the mass of bodies that had piled up in the entryway in what was essentially an air lock. That area was about the only part of the building that was tenable. All accounts indicate the roof had quickly collapsed into the interior of the building.

A rescue path in the front doorway was simultaneously being protected by the interplay of a deck gun from side 2 and an elevated platform on side 1 as well as multiple 1¾-inch handlines. Chief Hall stated that he believed at least 100 individuals either self-rescued or were extricated from the building.

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A rescue path in the front doorway is simultaneously being protected by the interplay of a deck gun and an elevated platform as well as multiple handlines.

Cranston Fire Department

Robert Warren, the fire chief in Cranston, was at home asleep at the time of the fire. He was awakened by the traffic on his portable radio, got dressed, and drove to West Warwick, arriving just before midnight. By that time, most of the fire was out and he could see at least seven bodies at the northwest corner of the building. He went to the command post and met with Chiefs Hall and Chartier. For the remainder of the incident, he acted as an aide to Chief Hall, recording information on a tablet, answering radio calls, and acting as a gatekeeper to keep Chief Hall from being overwhelmed by everyone wanting to talk with him.

Three additional chief officers responded from the Cranston Fire Department. Deputy Chief Stephen McGovern, Cranston's EMS coordinator, responded from his home and acted as transportation officer for the EMS Branch. Deputy Chief William McKenna, Cranston's training officer, also responded from his home and acted as the Cranston safety officer. He also assisted with the recovery effort. Cranston's on-duty Deputy Chief William Lavey responded and coordinated the efforts of the Cranston firefighters deployed at the scene.

Growing Crowds and Increased Congestion

Bystanders were a problem during the early phases of the incident; however, many persons initially thought to be bystanders turned out to be victims. As time went on, the growing number of family members congregating at the scene also proved to be a problem. Police cleared the Station club parking lot and both Cowesett Avenue and Kulas Road, moving the bystanders across the street into the parking lot of the Cowesett Inn. The police also set up roadblocks to prevent unauthorized personnel from entering the area.

The police were credited with doing a good job of keeping the media from approaching too closely. Representatives from every form of media began to gather in large numbers. They, too, were confined to the parking lot of the Cowesett Inn. The IC appointed a WWPD officer to serve as the information officer and liaison to the media. Periodic updates were given to the media and the officer kept Chief Hall informed about requests from the media.

Closing Out the Rescue Phase

As the rescue phase began to wind down, all of the firefighters were assembled near the front door for a briefing. The first alarm firefighters from West Warwick were released, placed on a bus, and taken to Station 1 for rehabilitation and defusing by the Rhode Island Critical Incident Stress Management (CISM) Team. WWFD chief officers met to develop the recovery plan, which included a system for rotating personnel to minimize exposure of individual recovery team members to the deceased. Chief Hall stated that when all was said and done, emergency responders made more than 100 rescues through doors and windows, primarily through the front door because sides 2 (Bravo) and 4 (Delta) had limited rescue options. The total number of apparatus that responded to this incident was not recorded and has not been reconstructed, but it would appear that at least a four-alarm assignment ultimately responded. Warwick sent seven engines, two trucks, six ambulances, its special hazards unit, and the recruit bus, along with a battalion chief and 63 personnel. Cranston sent four engines, one truck, and three rescue units and committed 27 firefighters and four chief officers to the incident. Coventry also dispatched a task force to the incident. (See **Figure A-7** for a chronology of events.)

Thursday	Event
11:00 p.m.	The band Great White arrives on stage at the Station club
11:07 p.m.	First emergency call received by the WWPD from a town police officer working security detail inside the Station club
11:10 p.m.	WWFD dispatched to fire at Station club
11:14 p.m.	Warwick Fire Alarm dispatches a task force to fire (Engine 1, Engine 5, Engine 9, Ladder 1, Rescue 1, Rescue 2, Rescue 3, Rescue 4, Special Hazards 1, Battalion Chief 1)
11:16 p.m.	Chief Hall arrives at the fire
11:18 p.m.	Warwick Engine 7 dispatched
11:19 p.m.	Battalion chief and Engine 5 from Warwick arrive at the scene; remaining rescue units are requested
11:20 p.m.	Additional rescue units requested from Cranston
11:28 p.m.	Warwick Engine 7 onscene
11:33 p.m.	Warwick Engine 3 dispatched
11:38 p.m.	Warwick Engine 6 dispatched
11:40 p.m.	Warwick Rescue 8 and recruit bus dispatched
11:44 p.m.	Warwick Rescue 2 dispatched
11:55 p.m.	Warwick recruit bus arrives on scene

Figure A-7. Chronology of events.

Friday	Event
3:22 a.m.	Warwick Engine 8 dispatched
3:50 a.m.	Warwick Ladder 2 dispatched
4:00 a.m.	Chiefs meet in Cowesett Inn to develop an action plan for demobilization
6:00 a.m.	Crane brought to scene to demolish building and assist in recovery effort
12:00 noon	Last body recovered
12:57 p.m.	Last Warwick company returns to service
11:15 p.m.	Last company departs the incident site

Figure A-7. Chronology of events (continued).

Although the exact number of apparatus and agencies was not recorded, it is estimated that approximately 575 fire, police, and emergency medical personnel from more than 35 agencies responded to this tragic event. A total of 186 injured victims were treated and transported to area hospitals. Five firefighters were injured, two of whom were evacuated to a healthcare facility. None of the injuries were serious, most consisting of smoke inhalation, cuts, and bruises. The most serious of these injuries occurred when an EMS technician from Coventry slipped on the ice and broke his ankle.

Findings and Recommendations

FDO-001 When the fire occurred, WWFD had 13 firefighters on duty. There were two firefighters on each of the four engine companies, two firefighters on the ladder truck, two firefighters on an ambulance, and one individual was riding in the battalion chief's vehicle. The entire on-duty platoon responded on the initial alarm. WWFD's staffing is less than that recommended by the applicable national standards. While staffing companies to nationally recognized standards is desirable, it is beyond the reach of many financially strapped communities.

Section A.8.4.1.1 of NFPA 1500, Standard on Fire Department Occupational Safety and Health Program*, 2002 Edition states that "It is recommended that a minimum acceptable fire company staffing level should be four members responding on or arriving with each engine and each ladder company responding to any type of fire." A minimum of four firefighters per engine and ladder company is also required by Section 5.2.2.2.1 of NFPA 1710,* Standard for the Organization and Deployment of Fire Suppression Operations, Emergency Medical Operations, and Special Operations to the Public by Career Fire Departments*, 2001 Edition.*

FDO-002 As a part of their incident management plan, WWFD numbers the sides of an incident in a clockwise manner beginning with the front of the building. The sides are numbered consecutively as 1 (front), 2 (left), 3 (rear), and 4 (right). Cranston and Warwick use a similar system of identification. They, however, designate the sides as A (Alpha), B (Bravo), C (Charlie), and D (Delta).

To eliminate the possibility for confusion, the Incident Management System should be standardized. This includes the use of common terminology and uniform standard operating procedures (SOPs) and guidelines.

FDO-003 Cranston, Warwick, and West Warwick provide each other with mutual aid almost daily, however, their apparatus have similar radio designations. For example, all three departments have both an Engine 1 and a Ladder 1. This can be very confusing when attempting to work together in a normal situation, much less one as chaotic as this incident.

A system for identifying apparatus from neighboring jurisdictions that avoids duplication of identifiers should be developed.

FDO-004 When Chief Warren and Chief Chartier arrived, they joined Chief Hall at the command post, where they remained throughout the incident, providing assistance with logistical and operational support. Their presence also helped in relaying orders from the IC to their respective companies. Each department typically remains on its own radio frequency during a mutual-aid operation because most apparatus does not have the radio frequencies of neighboring jurisdictions installed in their radios. The Intercity radio frequency quickly becomes overloaded if everyone tries to use it.

Radio equipment should provide interoperability with every jurisdiction responding to an incident and sufficient radio frequencies should be available to allow each sector of an incident to operate without interfering with one another.

FDO-005 The entire off-duty contingent of firefighters from WWFD was recalled to assist in combating the fire at the Station club. The recall was completed by using a cascading telephone system and by radio transmissions that were heard over the scanners that many of the personnel have in their homes.

Many small- and medium-size fire departments depend on the response of off-duty personnel during peak periods to staff reserve apparatus for response to subsequent incidents and to augment the firefighters already committed at the scene of a large incident. A manual recall by telephone allows the dispatcher to accurately gauge the number of off-duty members who will be responding. However, a manual recall is time consuming and prevents dispatchers from attending to other pressing matters. It also ties up telephone lines that may be needed for other purposes. The quickest and easiest solution is to use pagers. Fire departments that depend on the recall of off-duty personnel on a regular basis should issue pagers to all personnel.

FDO-006 Chief Hall established a command post in the parking lot where he could closely observe the simultaneous fire suppression and rescue efforts. Chiefs Chartier and Warren remained with Chief Hall throughout the incident, providing advice and support. Although everyone knew that Chief Hall was in command of the fire, command was never formally announced, nor was there ever an official declaration of the command site.

Command should be formally announced giving responders both the location of the command post and the name of command. For example, "Chief 1 to Fire Alarm, Chief 1 will be command, the command post will be located at the corner of Cowesett Avenue and Kulas Road, and will be designated as Cowesett Command."

FDO-007 Although the various agencies communicated with one another periodically, a unified system of command was never established. Throughout the incident, law enforcement agencies maintained their own command post, as did other organizations that responded to the incident. For a time, a West Warwick command post was set up in the Cowesett Inn, but the fire department did not have a representative at that command post.

A formal Unified Command structure should be established at a large-scale incident that includes all of the agencies that have responded to the incident.

FDO-008 Command vests or other identifiers were not used to identify the various command functions. Rhode Island is a small State and most of the initial responders knew one another. The strength of their personal relationships helped to successfully resolve this incident. Responders from the private ambulance services and those that responded from agencies that do not usually work together found the identification of those in a position of authority problematic.

A formal means of identifying individuals serving in key positions within the Incident Command System (ICS) should be used. A commonly used system involves the use of vests that have the names of the positions printed on the back.

FDO-009 Adequate documentation was problematic because none of the command staff from the departments that responded had aides. Events were unfolding so rapidly and the fire was so large that they had to focus their entire efforts on managing the incident. Therefore, no one was available to document any of the critical decisions and benchmarks during the early stages of the incident. The documentation process did not occur until the arrival of Chief Warren from Cranston. Regrettably, his notes were misplaced and were never recovered.

The Incident Management Plan must include a provision that requires appointing someone to serve as a scribe to document key events and decisions that are made during the incident. Documentation is essential to provide a chronological history of a large incident and serves as the basis for an After-Action Report (AAR).

FDO-010 Chief Hall thought that a forward command presence was necessary, so he didn't use the shift commander's vehicle, which was located across the street from the incident. He never thought the close proximity of the command post created a problem; however, others thought that his position made it possible to bypass the normal chain of command. There was some concern expressed that the location of the command post unnecessarily placed the leadership in harm's way because of the potential for the wall to collapse on them.

Ideally, the command post should be located close enough to allow the IC to observe operations, but far enough away to provide safety and shelter from the noise and confusion that accompanies normal operations. A command vehicle is often ideally suited for this purpose.

FDO-011 Each department was responsible for the safety and accountability of its own personnel at the incident.

A common system of accountability should be used to guarantee the safety of firefighters working at a large incident. There should also be an incident safety officer responsible for managing the accountability system.

FDO-012 Chief Hall stated that command personnel probably should have been rotated, but he thought that he had to be there for his firefighters.

Rehabilitation SOPs should provide for the timely rotation of personnel to prevent injury and to ensure their effectiveness. This should include command personnel.

FDO-013 The Cowesett Inn provided a sheltered area on a very cold night for the triage efforts and for the rehabilitation of firefighters. The owner of the Cowesett Inn called in his staff to prepare food and beverages for the emergency responders. Chief Hall indicated that it would have been necessary to use another building or a tent for triage and rehabilitation had the Cowesett Inn not been available. One possible location might have been Knight's Garage, the Nissan dealership across Kulas Road from the fire.

Mass casualty plans as well as preincident planning should address the need for a sheltered area for the rehabilitation and triage sectors.

FDO-014 A formal post-incident analysis was not conducted.

A formal post-incident analysis should be conducted as soon as possible following an incident so that lessons can be learned and applied to future incidents.

SECTION 3 – RECOVERY OPERATIONS

Observations

Response Phases

The incident at the Station club had three separate and distinct phases. The first involved extinguishing the fire and rescuing the occupants trapped inside the building. The fire spread so quickly that the entire building was immersed in flames within 5 minutes. Within approximately 40 minutes, the first phase ended. The second phase involved the recovery of the bodies of the deceased. It began around midnight and lasted until approximately noon on Friday. The final phase overlapped the second and involved investigating the cause and origin of the fire and determining the identity of the victims. Identifying the deceased is addressed in Annex E – Public Health, Healthcare Facilities, Mental Health, and Mass Fatality Management. Investigating the cause and origin of the fire is outside the scope of this AAR.

The Deadly Outcome

An investigation conducted by *The Providence Journal* concluded that there were 432 people inside the Station club at the time of the fire. Investigators arrived at this figure based on the legal documents acquired during their inquiry and the accounts given to reporters by survivors and other individuals interviewed during the preparation of their report. Slightly more than 100 patrons, through their own efforts or with assistance from firefighters, were able to exit the burning structure without injury. Approximately 200 patrons were injured and 186 of those were transported to area hospitals by emergency responders. Ninety-six people perished in the fire and four later died as a result of their injuries.

There were four potential exit doors from the Station club. Accounts given by survivors indicate that the door by the kitchen on the east side of the building was hidden from the view of most patrons and that a second door on the east side of the club in the bar area was not easily accessible to most patrons. Other patrons reported that a bouncer directed them away from a door by the stage located on the west side of the club because it was reserved for use by the band members. Thus, the main exit on the north side of the building became the primary means of escape. This door was soon blocked as patrons tripped and piled up on each other. Others escaped by breaking windows and climbing out.

The Body Staging Area

Early into the rescue effort, Incident Command established a body staging area at the northwest corner of building at the junction of sides 1 (Alpha) and 4 (Delta). This location was chosen because of its proximity to the club entrance. The bodies of the deceased in the entranceway had to be removed first to attempt to reach live victims. A tarp was spread out on the ground and the bodies were arranged on top of the tarp in orderly fashion and covered with a sheet.

AP Photo

Recovering the Remains of Victims

Usually, when a person dies under questionable circumstances in Rhode Island, the Office of the Medical Examiner (OME) is responsible for removing the body and transporting it to the morgue located in Providence. Transporting the remains of a deceased person is accomplished using a contract livery service. The OME was contacted by the West Warwick police dispatcher at about 11:30 p.m. and requested to respond to the fire. This was not, however, a normal situation. Initial estimates as to the number of deceased all proved to be incorrect as the body count steadily climbed. When the OME investigator arrived, Chief Hall advised him of the procedure that was to be used to recover and remove the remains of the deceased (see Annex E, Part IV – Mass Fatality Management for details of OME involvement in this incident).

The initial recovery plan was to organize teams of three firefighters and an officer composed of off-duty personnel from West Warwick and the mutual-aid companies. As many as six teams would line up at the front door, enter the club, find and remove a single body, go to rehabilitation, and then be released to perform other duties. Unfortunately, the large number of victims compelled the teams to remove several bodies.

A chief officer from the recovery team's department was assigned as interior sector coordinator to identify which body was to be removed. As a body was removed from the entranceway, representatives from the State Fire Marshal's Office and law enforcement agencies took photographs and collected other evidence. A West Warwick police officer stood outside the front door and assigned an extraction number to each victim, recording that number and the location where the victim was found on a makeshift form.


AP Photo

Tarps were hung to shield the bodies from public view.

Tarps were spread on the ground to lay the victims on, and additional tarps were hung to shield the bodies from the view of growing numbers of family members and media representatives gathering across the street in the parking lot of the Cowesett Inn. Apparatus were also repositioned to create a privacy shield. Each body was treated with as much respect and dignity as possible under the circumstances. One of the fire department chaplains offered a prayer for each victim.

Office of the Medical Examiner Response

The OME responded to the fire with only one investigator and two transport vehicles, therefore, four ambulances with volunteer crews were also used to transport the remains of the deceased from the incident site. This is not normal practice, but it became necessary to expedite body removal. Vans from the West Warwick Department of Public Works were also pressed into service to take the remains to the morgue. Members of the Providence Fire Department met the ambulances and the vans at the morgue, unloaded the bodies, and took them into the morgue. The Rhode Island Emergency Management Agency (RIEMA) was able to locate additional body bags when the supply was exhausted midway into the incident.

Shortly after daylight, media helicopters appeared on the scene and the downdraft from the rotors blew open some of the body bags, exposing the remains of the deceased. The WWPD solved this problem by asking the Federal Aviation Administration (FAA) to establish a no-fly zone over the area. Some members of the media used elevated cameras and a few photographers climbed nearby trees hoping to get a better view of recovery operations. The vast majority of media representatives, however, were cooperative and respectful of the circumstances.

Early in the morning, a crane was brought to the scene to remove collapsed portions of the roof and other debris, allowing firefighters access to the remaining bodies. The last body was removed at noon on Friday.

West Warwick Police Department

A crane was brought to the scene to remove collapsed portions of the roof and other debris, allowing access to the remaining bodies.

Chief Hall remained on the scene until around 7:00 p.m. on Friday evening. He went home, cleaned up, and returned to the scene. The last fire company departed at 11:15 p.m. The fire claimed the lives of 100 people. Ninety-six people died at the scene and four others later died at area hospitals.

Findings and Recommendations

FDO-015 There is a practical limit to how much body recovery an individual can do and some people are simply not suited for such work. Incident Command decided to limit the recovery effort to off-duty West Warwick firefighters and responders from mutual-aid companies rather than expose additional firefighters to the carnage.

Removing the deceased is an unpleasant but necessary task. Whenever possible, it should be accomplished using volunteers. Recoveries performed by each volunteer should be limited to the fewest number possible and Critical Incident Stress Management (CISM) teams should be on standby to offer immediate and continuing support to those involved in the recovery effort.

FDO-016 Chief Hall expressed his frustration with the absence of a Rhode Island mass fatality management plan at the time of this incident.

Emergency Operations Plans (EOPs) should include a plan for managing mass fatalities. The Rhode Island Association of Fire Chiefs should participate in developing the plan.

FDO-017 Most of those interviewed believe that the response by the Office of the Medical Examiner (OME) to this incident was inadequate and quickly exceeded its resources and capabilities. It was apparent to Chief Hall that the OME was unprepared for an incident of this size and scope and was quickly overwhelmed. He believed that it was also obvious that more resources were needed at the scene. For example, the OME ran out of body bags midway into the recovery. A call to the airport failed to obtain any additional bags. RIEMA did, however, locate additional bags, which were brought to the scene.

A mass fatality management plan should identify sources for additional resources, including personnel and supplies.

FDO-018 Firefighters were forced to use EMS rescue vehicles and vans from the West Warwick Department of Public Works to transport bodies to the morgue in Providence. Providence fire companies met them and unloaded the bodies.

A mass fatality management plan should identify transportation resources, such as vehicles belonging to private mortuaries, that can be pressed into service to facilitate the timely removal of the deceased. Ambulances, buses, and commercial or public agency vans are not an adequate substitute.

SECTION 4 – CRITICAL INCIDENT STRESS MANAGEMENT

Observations

Just after midnight, the Rhode Island CISM Team was contacted and asked to respond to the WWFD HQ station. Established in 1988, the team is coordinated by Dr. Anne Balboni and is sponsored by the Rhode Island Association of Fire Chiefs. The team is independently incorporated and includes fire and police peers who follow established national protocols. As the team mobilized, it was contacted again and requested to respond directly to the incident scene.

Upon arrival, Dr. Balboni checked in with Chief Hall and began to pass the word that CISM assistance was available. That assistance was both immediate and continuing. A rehabilitation area was designated inside the Cowesett Inn and team members were available to talk with the firefighters. Chiefs Hall, Warren, and Chartier decided that no firefighter would be released from the scene until engaging in a debriefing session with a CISM team member.

After the incident was over, members of the Rhode Island CISM Team called every fire department and sent faxes to all of the Rhode Island fire chiefs and union leaders asking them to tell their members that the CISM team was available for support. They also mailed notices to the departments to be posted on bulletin boards announcing the availability of CISM assistance. The Rhode Island CISM Team conducted station visits to all of the departments and all of the fire stations that responded to the incident. The first visits were in West Warwick, followed by visits to Warwick, Cranston, and Coventry. The team initially conducted defusing sessions, which were followed up by debriefing sessions. Continuing mental health assistance was available to firefighters through the Employee Assistance Program (EAP). For additional discussion of mental health support for first responders, see Annex E, Part III – Mental Health.

When the first alarm personnel from West Warwick boarded a bus to return to the HQ fire station, Chief Hall ordered them to go through the CISM process before going off duty. This was accomplished when the firefighters arrived at the HQ station. Additional regularly scheduled briefings were conducted during the following days while the firefighters were on duty. The command staff participated in the meetings with the firefighters. A separate debriefing was conducted for family members 2 weeks after the fire. Family members met with CISM team members in a West Warwick elementary school without the presence of firefighters. Although the principle CISM effort was coordinated by the Rhode Island CISM Team, the WWFD chaplain also participated actively in the process. Individual follow-up assistance was available through the West Warwick EAP.

In Warwick, fire department chaplains visited personnel at every station and at the Fire Alarm Office on Friday night, February 21. Meanwhile, the chief officers remained in contact with each other throughout the weekend to provide emotional support. Participation in the CISM process by WFD personnel was mandatory. After a meeting with the union executive board, Chief Chartier decided to delay the group debriefing session for a week, which produced some criticism from the rank and file. This session was conducted by a mutual-aid CISM team from Massachusetts.

At the WFD HQ station, several retired firefighters prepared dinner for the firefighters on the weekend, which they greatly appreciated. A separate CISM session was conducted for family members at the Warwick Central Baptist Church.

In Cranston, all firefighters were required to go through the CISM debriefing process. Individual chief officers followed up with the crews by telephone and personal visits throughout the weekend. The chaplain visited the stations throughout the weekend and later conducted a roundtable discussion with everyone who had responded to the incident. A separate session was conducted for the families. This had never been done before and was well-received. The chief officers remained in touch with each other as well as offering support to one another.

AP Photo

Findings and Recommendations

FDO-019 Rehabilitation and the initial defusing sessions were conducted in the Cowesett Inn. Televisions in the bar area of the restaurant were tuned to CNN; the network was providing ongoing coverage of the incident. Additionally, family members of the patrons of the Station club were gathering in the bar area while a portion of the Cowesett Inn was being used as a triage site. As additional resources became available, this situation was rectified.

Rehabilitation and debriefing areas should be separated from members of the general public, particularly family members of victims. Ideally, this area should also be separated from triage and treatment areas. The presence of injured victims receiving medical treatment only adds to the grief and trauma experienced by firefighters when confronted with multiple casualties and fatalities.

FDO-020 CISM services were made available for the first time to family members of the firefighters who responded to the incident. Sessions were well-attended and all of the chiefs reported positive feedback from firefighters and family members.

The experience of the departments involved in this incident clearly demonstrates the value of including debriefing sessions for the families of firefighters in a department's CISM SOP.

FDO-021 Fortunately, only a small number of firefighters will ever be subjected to the magnitude of death, injury, and suffering experienced by those who responded to the Station club fire. Accounts of the incident were repeated almost daily in the local media, and the subsequent criminal investigation and proceedings will continue well into the future, making it virtually impossible for emergency responders to put this experience behind them.

CISM is absolutely vital following an incident involving the death or injury of a child or one with multiple casualties or fatalities. Continuing mental health counseling should also be made available to those members who might require additional assistance in the future.

ANNEX B
EMERGENCY MEDICAL SERVICES

INTRODUCTION

Rhode Island Emergency Medical Services System

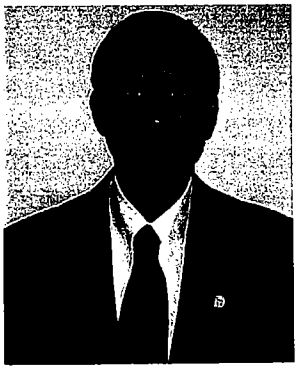
The purpose of the Rhode Island Emergency Medical Services (EMS) system is to save lives and speed healing by providing lifesaving medical services to seriously injured or ill patients and transporting them to treatment centers.

Currently, there are 88 licensed EMS organizations in Rhode Island responding on a daily basis to 9-1-1 calls for medical assistance as well as transferring nonemergency patients between healthcare facilities. Sixty-eight of these are government-operated organizations belonging to Rhode Island's 39 cities and towns. Twelve are independent EMS companies and eight are university or industrial-based responders.

Rhode Island recognizes three levels of EMS qualifications. The Emergency Medical Technician-Basic (EMT-B) technician has completed the basic level of emergency medical training. EMT-Cs are cardiac rescue technicians trained in additional lifesaving skills. The highest level of EMS certification is the paramedic (EMT-P). At present there are approximately 2,000 EMT-Bs, 1,850 EMT-Cs, and 250 nationally registered EMT-Ps licensed to practice prehospital care in Rhode Island. In 2001, there were 123,734 emergency calls for assistance—93,551 patients were transported to area hospitals.

Rhode Island Department of Health Oversight

The Professional Regulation Section of the Rhode Island Department of Health (RI Health) provides daily oversight of the EMS system. Mr. Peter Leary, RN, is the State EMS director. He is responsible for supervising all ambulance and rescue services available for prehospital care to Rhode Island citizens and also for EMS vehicle licensing. His staff includes a licensing clerk, a field inspector, and a training officer.



Peter Leary

Dr. Ken Williams, a practicing emergency department (ED) physician, serves as the medical consultant to the EMS Division, offering recommendations on State EMS protocols and related matters. He is also a member of the Ambulance Service Coordinating Advisory Board. The board includes 20 members who are appointed by the governor for 5-year terms. Most members are appointed from the healthcare community, but two are chosen from the general public. It meets quarterly to provide recommendations and advice on EMS-related matters to the EMS Division director, review proposed protocols, and participate in disciplinary hearings involving EMS personnel.

Rhode Island EMS Programs

In 2003, the EMS Division established a Trauma Systems Advisory Committee to undertake a thorough examination of all aspects of the Rhode Island trauma treatment system. An Emergency Medical Services for Children (EMSC) program was established in conjunction with the Department of Emergency Medicine of Hasbro Hospital. Its goals are to develop EMS protocols and training that emphasize pediatric emergency care, to develop health promotion training, and to encourage proper use of local EMS systems by parents and communities.

EMS Training and Recertification
Vehicle operation certification and refresher training for all three levels of professional EMS providers adheres to U.S. Department of Transportation (DOT) standards. Instructor coordinators licensed by the EMS Division teach the classes.

In addition to the initial certification training, each EMS provider must maintain his or her license by meeting stringent State refresher requirements. EMT-Bs and EMT-Cs must take a refresher course and pass written and practical skills tests every 3 years. The National Registry recertifies paramedics every 2 years. Refresher courses must be approved by the State and are offered by the individual EMS response agencies, area healthcare facilities, and private EMS education companies.

EMS agencies may name a medical director, who is intended to provide clinical oversight and quality assurance activities.

Standards of Practice
The State publishes Prehospital Care Protocols and Standing Orders to serve as the standards for clinical practice for all three EMS provider levels. These standards form the basis of patient care. Judgment by EMS providers regarding medical treatment is permitted up to a point delineated in published protocols. Beyond that point, approval of further intervention by protocol by a designated Medical Control Center is required.

Activity Reports
The EMS Division also produces various reports concerning the delivery of emergency services. One report consolidates data from Rhode Island EMS Ambulance Run Reports. Upon completing an EMS transport, the response crew completes this report, a portion of which is sent to the RI Health EMS Division, where it is entered into an automated database. Incomplete or incorrect reports are returned for correction and resubmission. The data files are tabulated each month and used to evaluate the care given.

Requesting EMS Assistance
All 9-1-1 calls in Rhode Island are answered in North Providence at the Rhode Island 9-1-1 Center. The calls are then directed to the appropriate response agency (fire/police/EMS). Municipal EMS units are dispatched by Fire Alarm Offices in each community fire department. These Fire Alarm Offices obtain pertinent caller information and dispatch the closest available EMS unit. In some communities, fire equipment is also dispatched to assist in life-threatening circumstances. Private ambulance companies have call centers that accept calls from families and healthcare facilities for transport assistance. They then dispatch vehicles using their own radio systems. In some communities, private companies also respond to emergency calls, while in others, their principle role is nonemergency, interfacility transportation.

A few of the Fire Alarm Offices and some private ambulance company call centers in Rhode Island have implemented national emergency medical dispatch curriculum and priority dispatching. This 40-hour training program teaches call takers how to rapidly obtain key information from callers to prioritize among concurrent requests for support. The program also teaches how to impart lifesaving instructions to callers, such as cardiopulmonary resuscitation (CPR) and delivering a baby. Rhode Island is currently considering a broad implementation of this standard curriculum.

Rhode Island does not have a single EMS communications system that allows EMS personnel to talk with one another during operations. Thus, each agency or community maintains its own system. This becomes problematic when EMS units provide mutual-aid assistance outside their own communities. The Intercity radio system is used to communicate between Fire Alarm Offices. Ambulances use cellular telephones to talk with hospitals.

The staffing level of an EMS vehicle depends on whether it is classified as a basic life saving (BLS) or advanced life saving (ALS) unit. Minimum staffing for a BLS unit is two EMT-Bs for career EMS services. However, a volunteer BLS unit is allowed to be staffed with one EMT-B and a driver who is not required to be trained or licensed. The minimum staffing of an ALS unit is one EMT-C or EMT-P in addition to an EMT-B.

This annex contains the following seven sections:

- Section 1 – Initial Response and Arrival
- Section 2 – Incident Management System – EMS Branch
- Section 3 – Staging
- Section 4 – Triage
- Section 5 – Patient Treatment
- Section 6 – Transportation
- Section 7 – Post-Rescue Activity

SECTION 1 – INITIAL RESPONSE AND ARRIVAL

Observations

Initial Dispatch

As calls asking for help were received from individuals at the scene, the West Warwick Fire Alarm Office requested EMS units from nearby Coventry, Warwick, and Cranston Fire Departments. As Incident Command was established, task forces were formed and dispatched with both EMS units and fire equipment. Each subsequent request for help brought more distant fire departments and private ambulance companies. Eventually, Metro Control received a mutual-aid request from Incident Command to send "all available EMS units" to the fire scene.

Arriving at the Scene

First alarm units arrived at the scene less than 5 minutes after the fire started. They immediately began rescuing victims who were attempting to escape the raging fire already burning through all sides of the Station club, including the roof. A few moments later, a rescue unit from the Hopkins Hill Fire Department in Coventry arrived on Cowesett Avenue near the front of the building, where it was surrounded by what first appeared to be a large group of bystanders. Captain Brad Anderson quickly realized that most were victims seeking medical attention. He estimated as many as 50 persons were converging on the vehicle, some with burned skin surfaces and clothing, others with soot-covered faces, many screaming in pain. As soon as the rear door of the rescue vehicle opened, four of the victims rapidly climbed in seeking assistance. Captain Anderson left his partner to tend to these four while he attempted to better assess the situation. Outside the vehicle, he could barely see the burning building because the rush of people surrounding him obstructed his view.

The Providence Journal \ Kris Craig

First alarm units are on-scene within 5 minutes after the fire starts.

By default, the area where the Hopkins Hill crew parked their rescue vehicle became the first triage sector. Captain Anderson began assigning victims to each newly arriving EMS unit and quickly got them under way to Kent Hospital, only 3 miles away.

Warwick Fire Department (WFD) Rescue 4 EMS Captain Peter Ginaitt and his partner Todd Berthiaume noted a bright glow in the sky while they were still some miles from the fire scene. Chatter on the unit's radio indicated that this was indeed a significant working fire. Somewhat familiar with the Station club, Captain Ginaitt commented to his partner that "we might have five to six burn victims on this one." They didn't even make it all the way to the fire before a man flagged them down on Cowesett Avenue and asked that they treat a badly injured woman who was sitting in his car. While his partner bandaged the patient, Captain Ginaitt went to the front of his vehicle and saw 50 or 60 injured people near the Cowesett Inn, so he headed in that direction. Warwick Rescue 1 with Lieutenant Brian Cobb and Erik Andersen arrived simultaneously with Rescue 4.

Cranston EMS Captain Leo Kennedy and his partner Nelson Pedro were watching the initial news report of the fire on television when the first Cranston Fire Department units were dispatched. Realizing his unit was closer than one of the other rescue units being dispatched, he notified Fire Alarm that Rescue 3 would be responding and cancelled the Rescue 1 response. Following a 10-minute drive to the scene, they arrived to find the building in a "free burn" and people lying everywhere, on the ground, on hoods of cars, and in the cargo areas of pickup trucks. They managed to make their way close to the front of the Cowesett Inn, where they parked and reported to Captain Ginaitt.

Additional first alarm fire and EMS units were also approached by scores of victims seeking assistance. Other victims began to congregate across the street from the Station club at the Cowesett Inn, where the staff offered aid and comfort while waiting for further assistance from fire department and EMS personnel. Observing the large number of victims moving on their own toward the Cowesett Inn, an EMS command officer began directing other victims in that direction in an effort to congregate the injured at a single site while clearing the area directly adjacent to the burning building.

Battalion Chief Henry "Skip" Heroux from WFD, the first Warwick chief officer to arrive at the scene, immediately realized the gravity of the situation. He called the WFD dispatcher on the radio and directed that all available EMS vehicles be sent to the scene. As chiefs from other departments arrived, many of them also asked their dispatchers for additional rescue units.

Fire alarm personnel in West Warwick, Warwick, Cranston, and Coventry responded by dispatching all available EMS units, holding back only a few to cover their respective jurisdictions (see **Figure B-1**). More than 34 fire department EMS vehicles were dispatched to the scene from throughout Rhode Island while private ambulance companies also sent EMS vehicles: American Medical Response (AMR) sent 10 units, New England Ambulance sent seven units, and Universal Ambulance and MedTech each sent three units. Additional rescue units reportedly came from Connecticut and Massachusetts.

Agency	# of Vehicles
West Warwick Fire	2
Warwick Fire	4
Cranston Fire	3
Central Coventry	1
Hopkins Hill Fire	1
Coventry	1
East Greenwich	1
East Providence	1
Exeter Rescue	1
Foster Ambulance	1
Harmony Fire	1
Johnston Fire	2
Narragansett Fire	1
North Kingstown	1
North Providence Fire	1

Agency	# of Vehicles
North Smithfield Fire	1
Providence Fire	1
Portsmouth Fire	1
Scituate Fire	1
Smithfield Fire	1
South Kingstown Rescue	1
Tiverton Fire	1
Attleboro Fire	1
South Attleboro Fire	1
Oakland Mapleville	1
Warren Fire	1
North Attleboro Fire	1
Plainville, MA	1
Harrisville	1

Agency	# of Vehicles
Private Ambulances	
American Medical Response	10
New England Ambulance	7
Universal Ambulance	3
MedTech	3
Other Agencies	
Theodore F. Green Air Crash	1
Smithfield Emergency Management Agency	1
Ride Bus	2
Pawtuxet Valley Bus Lines	1

Report on the Station club fire compiled by Captain Leo F. Kennedy, Cranston Fire Rescue 3. This is a list of some of the units and agencies engaged on February 20 and 21.

Figure B-1. Rhode Island EMS units dispatched to the fire.

Congestion at the Incident Site
As more and more EMS and fire units arrived from both directions on Cowesett Avenue, the area quickly became congested. Emergency vehicles parked wherever they found space, and crews gathered their equipment and walked toward the fire scene. This practice of initially leaving unoccupied vehicles contributed to the growing traffic problems.

The absence of a common radio channel made it impossible for units to talk directly to one another. Although individual units were reporting size-up information back to their dispatcher, no one could hear all of the reports, including those in command.

Notifying Off-Duty Personnel
Off-duty EMS officers learned of the fire in several ways. Rescue Battalion Chief David Kurowski, EMS coordinator for WFD, was getting ready for bed when WFD Fire Alarm notified him of a task force being sent to a significant incident in West Warwick. Once en route, he asked Fire Alarm via cellular telephone if the Southern New England Fire Emergency Assistance Plan been implemented. He was told that it had been activated.

The Cranston Fire Alarm Office called EMS Director and Deputy Chief Stephen McGovern on his cellular telephone while he was driving home from Providence. He was told that the fire chief wanted him to go to Cranston Fire Department headquarters (HQ), but was subsequently redirected to the fire scene.

Fire Chief (and EMT-C) Robert Seltzer of the Coventry Fire Department was watching the news when an on-duty station captain called him. He quickly responded to the scene, which was less than 6 miles away.

Many departments reported that they initiated call-back procedures for off-duty EMS personnel.

Findings and Recommendations

EMS-001 The absence of a common radio channel made communications among responders virtually impossible. Thus, units could only hear information emanating from their own agency. This limitation made it difficult for command personnel to manage resources and direction operations.

Efforts under way to implement a Statewide EMS communications system should be completed without delay. The Station club fire reinforces the pressing need for a system that incorporates municipal and private sector EMS organizations. It should have built-in redundancy, adequate signal strength, and dedicated channels for tactical operations, communications among EMS personnel, and between EMS units and area hospitals.

EMS-002 Using standard operating procedures (SOPs), the dispatchers from the various fire departments and EMS agencies did an admirable job of rapidly dispatching large numbers of rescue units in a short period of time. However, some SOPs were incomplete or out of date.

Dispatch personnel should be applauded for making dispatch and notification decisions quickly and efficiently. SOPs should be revised based on this experience to help guide initial actions during a major incident.

EMS-003 The Southern New England Fire Emergency Assistance Plan lists a dispatch sequence for municipal and private sector EMS organizations that was not followed. Participants interviewed indicated that the planned sequence should have been followed.

The current dispatch sequence found in the Southern New England Fire Emergency Assistance Plan should be reviewed and revised based on the lessons learned from the Station club fire.

EMS-004 "Self dispatching" by some units caused confusion for Fire Alarm personnel and Incident Command. In some cases, units left their areas of jurisdictional responsibility without notifying the dispatcher.

The response community must resist the urge to respond without a request to do so.

EMS-005 Many private EMS companies do not usually respond to 9-1-1 emergencies. Thus, when Metro Control dispatchers were asked to call for additional assistance, they reportedly had to look up numbers of private companies in the telephone book.

Fire Alarm Offices should have a complete list of all potential emergency response resources with appropriate contact information.

EMS-006 The Theodore F. Green State Airport sponsors a regional disaster drill every 2 years. Participants interviewed reported that additional regional disaster training and exercises are needed.

Fire departments and EMS agencies should ensure personnel are adequately prepared to respond to a mass casualty situation. Regional exercises using different disaster-related scenarios should be regularly held.

EMS-007 Incident Command requested that the Southern New England Fire Emergency Assistance Plan be implemented. The plan provides for backfilling fire stations from outlying areas, but it does not result in EMS vehicle relocations.

The Rhode Island Association of Fire Chiefs should consider revising the Southern New England Fire Emergency Assistance Plan to include fill-in EMS coverage.

SECTION 2 – INCIDENT MANAGEMENT SYSTEM – EMS BRANCH

Observations

Establishing the Incident Management System

West Warwick Fire Chief Charles Hall established the Incident Command System (ICS) assisted by Warwick Fire Chief Jack Chartier and Cranston Fire Chief Robert Warren. The command post was located in the center front of the Station club parking lot (Alpha side). When Coventry Chief Seltzer reported to the command post, Chief Hall asked him to go to the Cowesett Inn and assess the medical treatment situation. Warwick Captain Ginaitt had already established a triage and treatment operation inside the Cowesett Inn, with Cranston Captain Kennedy performing triage at the front door after his arrival and assignment. Incident Command was unaware of any other triage and treatment areas providing care at that time.

Forming the EMS Leadership Team

Once Chief Kurowski arrived on the scene, he met with Captains Ginaitt and Kennedy and, collectively, they recognized the danger of the growing traffic gridlock. He directed the relocation of EMS units to a parking lot farther down Cowesett Avenue. From there he began redirecting EMS vehicles to the Cowesett Inn triage and treatment area, thus establishing the EMS staging function. Chief McGovern, aware that there was neither a transportation officer nor a communications officer, began redirecting ambulance traffic and, with the assistance of Cranston Fire Alarm, attempted to establish hospital communications.

Captain Anderson and his partner, along with several other rescue crews, continued to work at the first triage area without the knowledge of EMS command personnel. Incompatible radios prohibited communications among key EMS leaders.

Although the EMS Branch command was largely self-appointed, it quickly became evident to Chief Seltzer that important functions were being competently performed. Thus, he assumed the position of EMS liaison to Chief Hall, the Incident Commander (IC). In that role, he met or communicated via radio with the various section leaders to determine what assistance was needed and relayed that information to the Incident Command Post (ICP).

Chief Seltzer, Chief McGovern, Chief Kurowski, Captain Ginaitt, and Captain Kennedy continued their respective roles until all of the activities in those areas of responsibility were completed.

Findings and Recommendations

EMS-008 The fact that experienced and capable EMS officers came forward on their own initiative and assumed critical EMS Branch command positions was key to the success of this effort. The participants knew one another, they were seasoned EMS professionals, and when they saw a leadership void, they filled it. It is invaluable when those in charge know each other.

Senior-level EMS personnel with leadership experience should be appointed early to Incident Command positions.

EMS-009 The EMS Branch command positions were filled spontaneously by experienced EMS officers. Had this not happened, it is doubtful that victims would have been so quickly assessed, treated, and transported.

Incident Command should appoint EMS Branch leadership positions as soon as possible into an incident. A mass casualty plan should identify how command positions are initially filled. For example, the first arriving EMS unit establishes triage, the second arriving unit is treatment, the third is staging, and so on.

EMS-010 The Rhode Island Mass Casualty Disaster (MCD) Plan provided little guidance to those in charge or to the average responder. Several participants indicated they found it incomplete and lacking sufficient detail to be helpful. Others admitted that they were unfamiliar with the plan.

The Rhode Island Emergency Management Agency (RIEMA), the Rhode Island State Association of Fire Chiefs, the RI Health EMS Division, and the Hospital Emergency Preparedness Committee should review the MCD Plan and ensure it includes comprehensive and effective response instructions. Fire and EMS personnel should be provided with regular opportunities to train on and exercise the plan.

EMS-011 There were no comprehensive regional EMS Incident Command position checklists or administrative logs available for reference by command officers or to record critical decision-making or incident management information.

Consideration should be given to creating a standard EMS Incident Command tool kit. It should include summaries of EMS Branch roles and responsibilities that can be stored with the appropriate command vest, a write-on command board, and preprinted administrative logs to record vital information such as staging data, hospital patient receiving capability, patient transportation information, and resource requests.

EMS-012 None of the EMS command personnel wore distinguishing identification indicating a command position. Not all EMS mutual-aid personnel easily recognized those in leadership positions.

All command officers should wear an Incident Command vest or other unique identification.

EMS-013 EMS command personnel were exceptionally busy coordinating the various activities in their assigned areas listening to and talking on the radio and, therefore, had little time to write things down. No one used an aide to assist in these efforts.

As soon as resources allow and conditions warrant, EMS command personnel should assign an aide to help with the administrative aspects of command.

EMS-014 Most municipal fire departments made formal attempts to periodically account for the location and safety of personnel. However, this was not the case for the private EMS companies.

All EMS units, public and private, should adhere to a rigorous system of accountability strictly enforced by Incident Command. It is preferable for all units Statewide to follow a single system.

SECTION 3 – STAGING

Observations

The magnitude of this incident demanded a large number of emergency response vehicles, however, as more vehicles arrived, access and egress to the scene became increasingly difficult. Initially, emergency response vehicles parked wherever there was space, sometimes crossing over fire hoses or creating other problems. Chief McGovern, the Cranston Fire Department EMS director, instructed response personnel who parked close to the fire to reposition vehicles to open up one lane of traffic along Cowesett Avenue. At about 11:40 p.m., Chief Kurowski assumed responsibilities of the staging officer. He set up the EMS staging area approximately 500 feet from the Station club in the Galaxie Restaurant parking lot.

Chief Kurowski personally directed vehicles into the staging area and instructed crews to remain with the vehicles until he gave them an assignment. He called Chief Chartier at the ICP on a cellular telephone and asked that all EMS vehicles not otherwise assigned be sent to the Galaxie Restaurant parking lot. The parking lot was large enough to accommodate all EMS vehicles and supported rapid departure from the scene to area hospitals. Each time an EMS rescue unit was needed, Chief Seltzer at the triage area called Chief Kurowski using the Intercity radio system, usually reserved for communications with the five regional Fire Alarm Offices. Chief Kurowski then assigned an EMS crew to the task.

In some cases, EMS crews carried their stretcher and medical equipment to the designated site, picked up the assigned patient, returned to their vehicle in the staging area, and departed for the hospital. Alternatively, the crew and vehicle moved forward together, especially if the patient was critically injured. If a vehicle was temporarily left unattended in the staging area, the keys were left behind. A police officer helped to provide security at the staging area.

Without a common radio channel, it was initially difficult to notify incoming vehicles of the staging area location. However, once in the staging area, personnel notified their dispatcher of its location and the message was relayed to later arriving units.

Because of the rapid pace of triage, Chief Kurowski coordinated a continuous stream of EMS personnel and vehicles from the staging area. As a result, there were generally 5 to 12 vehicles in the parking area at any given time with some continuously arriving and others departing. Most of the responding EMS units were ALS licensed. The staging operation minimized the occasions for "freelancing" (i.e., EMS crews operating independently without direction from a central authority).

Findings and Recommendations

EMS-015 Once operational, the staging function played an important role in resource management at the scene. Chief Kurowski provided very effective and much needed leadership. However, responders agree that it should have been established sooner.

Early during a major incident, a staging area should be established and a visually identifiable command officer should be assigned to coordinate it. The area should be of adequate size to contain the number of vehicles anticipated and allow for rapid access and egress. The vehicles should be organized by function, and crews should remain with the vehicles until given an assignment.

EMS-016 Staging records of vehicles, providers, or assignments were not kept. The staging officer spontaneously created a record that contained some information, but reconstructing the remainder of this important information was not possible.

The staging officer should record pertinent information about the operation on a standardized preprinted disaster response log.

EMS-017 Although not intended to be used for this purpose, the Intercity radio channel worked effectively most of the time to communicate resource requirements to the staging officer.

A separate channel should be used whenever possible to request resources from the staging area.

SECTION 4 – TRIAGE

Observations

Initial Triage Site

Triage of the reported 186 victims transported by EMS personnel took place at two primary locations (see **Figure B-2**). Captain Anderson of Hopkins Hill Fire District Rescue 6 established the first triage location on Cowesett Avenue in front of the burning building. An estimated 50 patients received triage and were transported to hospitals from that location within approximately 20 minutes of Captain Anderson's arrival.

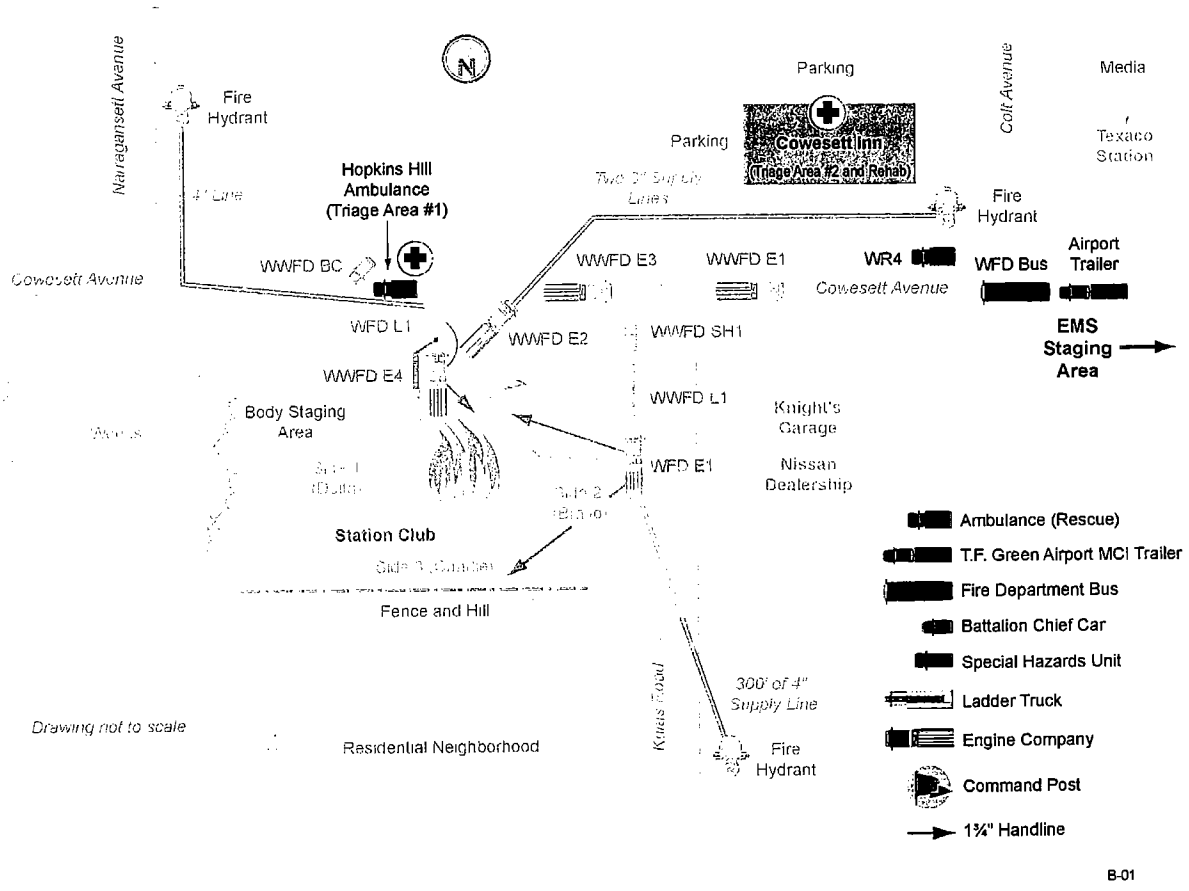


Figure B-2. Two primary EMS triage areas.

Primary Triage Site

Most patients were directed or carried to the Cowesett Inn, less than 100 feet across the street from the Station club. Upon their arrival, Captains Kennedy and Ginaitt found nearly 60 victims in various locations within the Cowesett Inn. They quickly set about to triage these victims and reorganize the area. Captains Kennedy and Ginaitt scanned each patient's face, nose, and mouth for signs of smoke inhalation and burns. The victims were mostly young and had similar

injuries. The most critical patients were easily identified because they had significant burns to the face, neck, torso, and upper extremities or signs of severe smoke inhalation.

As patients came to the Cowesett Inn, Captain Kennedy would perform a triage assessment and direct critical patients to the next available vehicle and direct the less critical patients inside where Captain Ginaitt and others would reassess their condition. While waiting to be transported, all of the patients were given a preliminary classification of red (critical), yellow (serious), or green (minor). All critically injured patients were assigned to a waiting rescue unit as soon as possible, usually within 5 minutes of being evaluated. Yellow and green category patients were periodically reassessed as time and resources allowed. Captains Kennedy and Ginaitt frequently met face-to-face.

At the left front corner (Alpha side) of the Station club, several EMS crews, with backboards and equipment, were stationed and awaiting the badly injured patients as they were removed by firefighters. They were transferred to the next EMS crew in line, which immediately carried them to the Cowesett Inn for triage. It is unclear how many victims were handled in this manner. Some estimates are as high as 20 to 25 patients, while others report 8 to 10.

As triage activity began to lessen, Chief McGovern asked two EMS crews to sweep the entire parking lot and adjacent areas for additional victims. This search located five or six additional victims requiring medical assessment and transport.

As triage activity begins to lessen, EMS crews sweep the entire parking lot and adjacent areas for additional victims.

The Less Seriously Injured

Although many victims had serious injuries, some had only minor cuts, abrasions, or less severe burns. Only a few patients were bleeding. Many were emotionally distraught. A few patients with a history of asthma had a relapse of that condition brought on by smoke from the fire or from the emotional response to the circumstances.

Triage Tags
Rhode Island public health regulations for ambulance inventory recommends that all rescue units carry triage tags and that EMS training and exercises include their use. None were used during this incident. A triage officer or one of the treatment sector personnel inside the Cowesett Inn gave the transporting rescue crew a brief verbal report on patient conditions.

Findings and Recommendations

EMS-018 Those personnel who performed triage did a phenomenal job of assessing and prioritizing nearly 190 victims in a short period of time. The speed and efficiency displayed in triaging so many patients, including the most critically injured, illustrates what an adequate number of experienced, dedicated personnel using a basic approach to triage can accomplish.

The procedures used by EMS commanders during the response to the Station club fire should be analyzed by other jurisdictions so that they can replicate these results.

EMS-019 The immediate implementation of triage was critical to gaining control of the incident and saving lives.

Assigning sufficient personnel to implement a standard triage process is one of the most important early steps for Incident Command. Adequate numbers of qualified personnel must be assigned early by Incident Command to implement the triage.

EMS-020 The IC and the independent triage officers were unaware of the number and location of triage areas that were actually in operation.

Incident Command must be told of the location of each functional area at an incident scene. Where possible, multiple triage areas should be consolidated to optimize manpower resources and operational coordination.

EMS-021 Responders reported that it was not difficult to distinguish between critical and noncritical patients. Thus, patient prioritization was assessment-based in accordance with the Rhode Island Prehospital Care Protocols and Standing Orders rather than the result of applying the Simple Triage and Rapid Transport (START) system. START, outlined in the Rhode Island MCD Plan, uses physiological criteria such as respiration, heart rate, and mental status. The procedures followed conformed to criteria outlined in the State Medical Practice Protocol 53-1 (Mass Casualty Incident).

The RI Health EMS Division should reevaluate the current dissimilar triage practices recommended, which are contained in the MCD Plan and in the Prehospital Care Protocols and Standing Orders. This reevaluation should determine if changes are warranted in view of the experiences obtained from this incident.

EMS-022 As circumstances began to settle, sweeping the incident site and adjacent parking areas for additional victims proved to be important.

Before terminating operations, the Incident Command should assign personnel to search for victims at the incident site and adjoining areas.

EMS-023 Several responders noted that the triage process at the Cowesett Inn was particularly well organized and operated. A well-managed triage operation reduces the number of personnel needed to perform this function, freeing others to provide other needed assistance.

The use of multiple triage operations coordinated by experienced officers should serve as a model for other communities.

EMS-024 Captain Kennedy directed that 10 backboards be brought to the front entrance of the Cowesett Inn for use as evacuation devices if needed. This proved to be prudent because they were used to move patients to treatment areas and to waiting transport vehicles.

The triage officer should inform Incident Command as soon as possible if additional supplies and equipment such as backboards and triage tags are needed.

EMS-025 In a few instances, law enforcement personnel used police vehicles to shelter injured victims. EMS personnel were not initially aware of their need for medical attention.

Any responders providing comfort and shelter to the injured should notify Incident Command as soon as possible of their location, along with the number of persons and the extent of their injuries.

SECTION 5 – PATIENT TREATMENT

Observations

Limited Opportunities for On-Site Treatment

The rapid manner in which the first critical patients were identified and transported to area hospitals limited the opportunity to provide medical care onscene. Airway management, oxygen supplementation, intravenous (IV) therapy, and pain management were for the most part initiated in the rescue vehicle while en route to a hospital.

The noncritical patients initially assessed by Captain Anderson were often partnered with a more critically injured patient to expedite transportation to a hospital. Few of these patients received medical interventions such as dressings, bandages, or oxygen before departing in a rescue unit.

Establishing the Treatment Areas

After conferring with Captain Kennedy, Captain Ginaitt established the yellow and green treatment areas inside the Cowesett Inn. He met the patients sent inside by Captain Kennedy and, after a quick confirming "eyeball triage," he assigned them to one of the two treatment areas. Again his technique was assessment-based, similar to what Captain Kennedy was doing outside.

Kent County Daily Times \ Greg Sousa

Triage and treatment area outside the Cowesett Inn.

Outside Help
Periodically, firefighters from West Warwick and Warwick, some of whom were EMT trained, entered the treatment areas, offering assistance. They were sometimes asked to monitor a patient or assist in moving patients outside to a waiting rescue unit. Beginning at about 12:20 a.m., four experienced registered nurses (RNs) individually reported to the Cowesett Inn and offered assistance. Some EMS personnel working in the treatment sector knew the nurses, so Captain Ginaitt accepted their help and assigned them to a treatment area.

As the number of patients increased, the treatment area space became increasingly cramped, making it difficult to move around without encroaching on space occupied by someone else. In one instance, a brief fight broke out between two patients. It was quickly settled by a nearby police officer assigned to building security. Alcohol consumed during the earlier hours of revelry was presumed to be a contributing factor in the incident.

Around midnight, Dr. Robert Baute, the chief executive officer (CEO) at Kent Hospital, arrived at the Cowesett Inn and offered to help. He also described to Captain Ginaitt the busy state of the Kent Hospital ED. They agreed that more patients should be sent to other hospitals. This information was relayed to Captain Kennedy. Dr. Baute assisted several patients before returning to Kent Hospital.

Medical Supplies and Equipment
Because of the speed in which patients were evaluated and transported, most of the medical equipment and supplies were used en route. EMS crews attempted to restock as much as possible at the receiving hospital before returning to the scene. Thus, limited medical equipment and supplies, as well as constraints on the number of available qualified staff, restricted the extent of medical care provided to patients onsite. Some patients were started on oxygen while others had dressings and bandages applied to wounds while awaiting care.

Chief Seltzer, acting as the resource officer, asked several times about medical equipment and supplies that might be needed in the triage and treatment sector. Dressings and bandages, along with oxygen equipment, were the items used the most. Frequently, these items were taken from rescue units at the scene. In addition, the Theodore F. Green State Airport Mass Casualty Incident (MCI) trailer brought medical supplies to the scene.

Other Forms of Support
Psychological support was another important part of the care that victims received. The EMS personnel, firefighters, and the four "Good Samaritan" nurses offered words of encouragement and reassurance. The staff of the Cowesett Inn provided warm drinks and other forms of support and comfort.

Patients generally remained in the treatment area at the Cowesett Inn for less than 30 minutes, with many departing much faster. The treatment area dispatched its last patient to a hospital around 1:30 a.m. However, it remained staffed until about 2:30 a.m. in case more live victims might be located. Regretfully, that was not to be the case.

Findings and Recommendations

EMS-026 The expeditious manner in which critical patients were evaluated and transported to the hospital no doubt contributed to saving all but four of those who sustained life-threatening injuries.

The rapid manner in which the large numbers of injured patients were assessed and transported to area hospitals should serve as a national example to other EMS communities.

EMS-027 Members of the Rhode Island response community cited the seasoned leadership of Captain Ginaitt and Captain Kennedy as major reasons why triage and treatment activities were so successful.

The importance of strong and decisive leadership in the triage and treatment areas was demonstrated during this incident. Other communities should take note of this successful experience.

EMS-028 Personnel assigned to the treatment sector worked diligently and compassionately to meet the challenges they faced. Most believe the treatment sector needed additional staffing.

Incident Command should assign adequate numbers of qualified personnel to conduct triage and treatment. The personnel in command of these functional areas must identify critical resource requirements and make them known to Incident Command early and often.

EMS-029 There were several police officers in the Cowesett Inn to assist with perimeter security. This presence had a calming effect and was also helpful in controlling unruly patients.

Incident Command should request law enforcement personnel to support activities at the triage and treatment areas.

EMS-030 Unsolicited volunteers, such as the four nurses who assisted at the scene, should be anticipated. In this case, their patient care contribution proved important. Currently, Rhode Island has no definitive procedure for using medically trained volunteers at the scene of a major incident.

The RI Health EMS Division should develop a "Good Samaritan" on-scene response procedure that addresses the use of volunteers at major incidents. The response SOP should include the accountability for these persons.

EMS-031 Incident Command did not request an experienced physician to respond to the scene and assist with triage or medical care. Currently, there is no approved procedure for such a request. Many of those interviewed believe that the concept of engaging experienced medical practitioners in prehospital emergency care should be explored and a procedure written for use throughout Rhode Island.

The RI Health EMS Division should consider the need for, and the benefits of, having a cadre of trained and equipped emergency physicians and nurses available to respond to the scene of a major incident and assist with triage, treatment, and hospital communications.

EMS-032 The ability of responders to care for victims in relative comfort was due largely to the availability of the Cowesett Inn. Had there been no nearby facility for triage and treatment, the victims would have spent more time in dangerous environmental conditions and risked further clinical deterioration.

Incident Command should be cognizant of the important need for environmental protection for incident victims. When a fixed facility is not available, resources such as decontamination tents or buses should be brought to the scene as soon as possible.

EMS-033 The Cowesett Inn was not only a triage and treatment site, it was also the rehabilitation site for firefighters and the focal point for State and local government leaders. Friends and relatives wandered around the Cowesett Inn seeking additional information about the condition of a victim or the whereabouts of a missing person. This resulted in increased pedestrian traffic in an already crowded area, heightened noise levels, and created awkward moments for patients and responders.

The treatment area should be isolated from extraneous activities and not exposed to stimuli that will increase already high stress and anxiety levels.

EMS-034 The nature of the incident created a need to coordinate available medical equipment and supplies. Chief Seltzer did an admirable job filling the role of resource officer while performing other command duties.

During large-scale incidents, the resource officer has a particularly important role. A qualified individual should be appointed to that position as soon as possible.

EMS-035 The Theodore F. Green State Airport MCI trailer unit arrived later at the incident scene. Few on-scene personnel were familiar with its content and layout.

Airport officials should provide familiarization training on the medical supply unit to Rhode Island EMS personnel and senior fire department officials. Included in the training should be instructions on how to request the unit.

SECTION 6 – TRANSPORTATION

Observations

Initial Transport Coordination

The first EMS units on the scene quickly loaded patients into vehicles and transported them to nearby Kent Hospital. In some cases only one critical patient was taken at a time, while as many as four minimally injured victims were often sent in one vehicle.

Chief Seltzer, working with Captains Kennedy and Ginaitt, helped to coordinate transportation for the patients at the Cowesett Inn. Basic Life Saving (BLS) and Advanced Life Saving (ALS) crews were positioned outside the Cowesett Inn near Captain Kennedy's triage station at the front door. He assigned critical patients to ALS qualified rescue crews and less critically injured patients to BLS crews. Once the patients were on board, often with three or four patients and two providers in the back, the rescue vehicles departed for the designated hospital. As EMS crews left for the hospital, the staging sector sent additional personnel to the triage and treatment site.

In some cases, to maximize the use of available resources, EMS personnel rode in rescue vehicles belonging to other units. In at least two cases, local police officers drove ambulances, freeing the assigned EMT driver to ride in the back and help provide patient care. These are a few manifestations of the teamwork and lifesaving commitment that prevailed that night.

Captain Kennedy attempted unsuccessfully to call hospitals on his cellular telephone to determine their receiving capability. Often there was no answer or the telephones were continuously busy with callers seeking information about missing persons. On the rare occasion when he did get through, no one was available to provide definitive information. Captain Kennedy attempted to use a set rotation of healthcare facilities, depending on the severity of injuries and familiarization of the EMS crew with the receiving hospital.

Bus Transportation

Buses were also used to transport patients. Pawtuxet Valley Bus Lines provided several buses. WFD also provided a bus. Six or seven ambulatory patients were placed on a bus, along with one or two EMT-Bs to attend to the patients while en route to the hospital.

Transport Fees

Many fire department rescue units and all of the private EMS companies charge patients a hospital transport fee. In this case, none of the patients were billed for services rendered on the night of the fire.

Measuring Success

Based on unofficial records, more then 68 rescue units responded to the Station club fire and made one or more trips to area hospitals. According to most reports, the last live victim left the scene en route to a hospital less then 2 hours after the fire started. There is no doubt that the expedient care and transport of these patients, coupled with the extraordinary teamwork of EMS, fire, and law enforcement personnel, contributed to the fact that not more than four victims died from their injuries after arriving at a receiving hospital.

Kent County Daily Times \ Greg Sousa

Patient leaving treatment sector en route to waiting EMS vehicle.

Findings and Recommendations

EMS-036 Captains Kennedy and Ginaitt performed in stellar fashion both as triage officer and loading officer. However, they were severely taxed trying to simultaneously triage patients, make vehicle assignments, and contact receiving hospitals.

As soon as resources permit, different personnel should be assigned to the positions of triage officer, treatment officer, and loading officer.

EMS-037 EMS command officers knew many, but not all, responders that night because of their years of service and other professional activities. They had to ask those they did not know "Are you BLS or ALS?" because there was no visible distinguishing identification.

EMS leaders must be able to easily distinguish between BLS and ALS qualified personnel and vehicles under all light and weather conditions.

EMS-038 Chief Kurowski considered using helicopters to transport badly burned victims directly to burn centers in Boston. However, when he inquired, Metro Control replied that none were available because the hospitals were using them for inter-facility patient transfer.

Currently, there is no helicopter disaster response plan. Northeast Aeromedical Alliance should meet with local EMS officials to discuss how they can best support Incident Command during a major disaster. The results should be included in the helicopter response to a disaster plan that Northeast Aeromedical Alliance is reportedly developing.

EMS-039 The use of buses to transport patients with minor injuries worked well. Accompanying medical personnel sometimes encountered problems loading all of the required medical equipment and supplies on the bus.

Buses should be considered as an alternative patient transportation vehicle for victims with minor injuries whenever appropriate. However, it is important that each bus have assigned EMS personnel and appropriate medical equipment and supplies for use en route to the hospital.

EMS-040 Captain Kennedy attempted to write down on a card the number of patients he sent to each hospital. Given the hectic pace of his work, this proved impossible. Thus, the exact number of patients transported and their destinations were not documented.

The loading officer should use a preprinted patient-tracking log to record which patients went to what hospitals and the vehicle that transported them.

EMS-041 Those interviewed expressed mixed views about the value of triage tags. However, there is strong agreement that a rapid, efficient, and user-friendly method for tracking patients is needed. The failure to complete and retain part of the triage tag prevented the prescribed patient-tracking system from working.

The RI Health EMS Division should review the design of the current triage tag based on the lessons learned from this incident and determine if changes are needed. Consideration should also be given to the use of emerging handheld wireless devices for patient tracking during major incidents.

EMS-042 Concerted efforts were reportedly made to distribute patients among several hospitals. However, hospital records show that most patients went to one of five hospitals. Six hospitals treated only one or two patients and six did not receive any (see Annex E, Part II – Healthcare Facilities).

Plans and procedures must be developed to ensure patients requiring hospital treatment will be distributed in a manner so that no single facility is overwhelmed and other hospitals in reasonable proximity to the scene are effectively used.

EMS-043 EMS personnel quickly recognized that a large number of badly burned victims needed care at a burn center. However, none were taken directly from the scene to a burn center. During the next 24 hours, air and ground units transferred 38 patients to four burn centers in Massachusetts.

The RI Health EMS Division should review current protocols to determine if further guidance is warranted in transporting critical patients directly to burn centers.

EMS-044 The mutual-aid rescue companies were not always familiar with the assigned destination hospital. In some cases, the loading officer changed the receiving hospital to one with which they were familiar. Some EMS crews reportedly changed the receiving destination on their own without informing Incident Command.

The RI Health EMS Division should provide EMS organizations with directions to all Rhode Island hospitals and require that they be kept on each rescue unit. Destination decisions should not be changed without the knowledge and concurrence of Incident Command.

SECTION 7 – POST-RESCUE ACTIVITY

Observations

En Route Medical Care

EMS rescue units provided medical care en route to area hospitals as prescribed in State protocols. Airway management skills and IV therapy techniques of the crews transporting critical burn victims were thoroughly tested. Oxygen was provided to all victims suffering from smoke inhalation. Wounds were also dressed and bandaged during transport whenever possible.

Several unsuccessful attempts had been made by individuals at the scene to get permission from Medical Control (as required by the current Prehospital Care Protocols and Standing Orders) to administer morphine sulfate. Finally, Lieutenant Ray Medeiros of the North Providence Fire Department (NPFD) called Mr. Tom Lawrence, a well-respected EMS provider at Rhode Island Hospital. Almost immediately, authorization was given by Dr. Selim Suner at Rhode Island Hospital for ALS providers to medicate patients with up to 5 mg of morphine sulfate IV.

Many rescue units carried at least two patients to expedite the evacuation process. The number of victims simultaneously transported, coupled with short travel times to hospitals, limited the extent of care delivered en route to those patients suffering non-life threatening injuries. Nonetheless, all medical care was provided in a competent and compassionate manner.

AP Photo \ Robert E. Klein

Many rescue units carried at least two patients to expedite evacuation.

Hospital Assistance by EMS Personnel

Once the last of the victims were transported from the scene, EMS rescue units sometimes remained at the hospital to assist hospital personnel. In addition to helping in the EDs, some EMS units at Kent Hospital assisted in transferring the most critical patients by helicopter to the Massachusetts burn centers. This effort was coordinated by Lieutenant Cobb. On other

occasions, Incident Command was asked to send EMS units from the scene to a particular hospital to perform a ground-based patient transfer (see Annex E, Part II – Healthcare Facilities, Figure E-5 for a list of air and ground patient transfers).

Rehabilitation

Lieutenant Medeiros of the NPFD was asked to coordinate the rehabilitation sector inside the Cowesett Inn as the fire suppression and rescue efforts wound down. The restaurant staff provided food and beverages to the fatigued responders.

Three rescue crews supported Lieutenant Medeiros at the rehabilitation sector. Two responders were evacuated to a hospital from the rehabilitation sector. One of them had slipped on the ice outside the Station club and broke an ankle. The second suffered from exhaustion and smoke inhalation. In addition, because of the numbers of deaths and the shortage of resources available to transport the deceased, four EMS rescue crews volunteered to transport the deceased to the morgue in Providence.

The Rhode Island Critical Incident Stress Management (CISM) Team, which had arrived at the scene about 12:30 a.m., set up operations in three small rooms at the Cowesett Inn. All firefighters and EMS personnel were ordered to meet with a CISM team member before going back into service. Police officers were not mandated to participate, but several chose to speak with a team member.

Communications

Communication was a major challenge. Because there was not a common EMS channel, numerous radio channels were used by EMS units. In some cases, command personnel stood next to each other to listen to a conversation on the other person's radio. Command officers used cellular telephones to talk with one another and with the EMS transport units. Chief McGovern was able to communicate regularly by cellular telephone with Mr. Lawrence at Rhode Island Hospital and with a nurse at Kent Hospital, but not with any of the other hospitals. For some reason, the Nextel telephones did not always work from inside the Cowesett Inn. Because of communications system limitations, face-to-face communications were critical, but not always convenient.

The inability to easily establish contact with each of the hospitals and speak with someone knowledgeable about its status was frustrating for EMS personnel and counterproductive to the hospitals being served. Members of the Smithfield Emergency Management Agency, who were assisting the West Warwick Emergency Management Agency (WWEMA) at the Cowesett Inn, had modest success in contacting area hospitals; however, they too encountered many of the problems that EMS command experienced—busy telephones lines, incorrect numbers, failure to answer, or untrained persons answering the telephones.

The use of a fax machine at the Cowesett Inn proved helpful in gathering information from area hospitals until the media learned the telephone number and saturated the line.

Metro Control struggled to handle all requests for information from fire and EMS command personnel. As a result, some information requests were processed late or not at all.

EMS Support at the Family Assistance Center

When the Family Assistance Center (FAC) became operational on Friday morning, February 21, a decision was made to have a rescue unit standby to handle medical emergencies. The assignment was originally given to a Warwick rescue crew that had worked the fire scene throughout the previous night. The crew raised concerns about the appropriateness of such back-to-back assignments, and a second crew that had not responded to the Station club fire replaced them.

On Saturday, it was suggested that Rhode Island Disaster Medical Assistance Team (DMAT) personnel might be better suited for providing FAC support than a fire department rescue unit. They had extensive experience in supporting shelter operations and at mass gatherings. Mr. John Aucott from RIEMA contacted Mr. Lawrence, the Deputy DMAT task force leader, and made those arrangements.

A physician was paired with a nurse or paramedic each day until the FAC closed. A portion of the Rhode Island DMAT pharmaceutical cache was also taken to the FAC for use. There was no on-site ambulance. Only one patient, a pregnant woman with abdominal pain, required transportation to a hospital for evaluation. She was transported by New England Ambulance. Task force members at the FAC were kept busy treating family members with headaches, emotional distress, and minor maladies. Two shifts provided daily coverage until the FAC was closed on the evening of February 25.

Documentation

Usually rescue personnel leave a copy of an Ambulance Run Report with hospital personnel and also verbally describe the patient's condition and the care that was provided. However, that did not routinely occur the night of the Station club fire. Crews were often "too busy to write," as one responder explained. Verbal reports were rendered, but they were often abbreviated so that the unit could quickly return to the incident scene. The failure to use triage tags also limited the information immediately available to hospital personnel.

Because only a few crews recorded patient information on the Ambulance Run Report, reconstructing data back at the station was problematic. Further complicating the problem was the large number of unidentified patients requiring extensive use of "Jane and John Doe" identifications with sequential numbering.

Findings and Recommendations

EMS-045 Despite physical and emotional fatigue, EMS units provided valuable assistance at several hospitals after all of the victims had been transported.

Incident Command personnel, RI Health, and RIEMA must consider the possibility that during large-scale incidents, hospitals might request EMS assistance in providing patient care and conducting interfacility transfers.

EMS-046 Questions arose concerning the legality of using EMS personnel to assist in hospitals when their physical presence is defined as a mutual-aid responder.

The RI Health EMS Division, working with the Hospital Emergency Preparedness Committee, should provide guidance on the parameters for using EMS personnel to assist the hospital staff during a major incident.

EMS-047 ALS providers recognized that the badly injured victims needed morphine sulfate. Current ALS protocols for analgesia prohibits its use without first obtaining permission from a Medical Control facility.

The RI Health EMS Division should review the current ALS protocols, including 23-1, Pain Management and Sedation, to determine if greater treatment latitude should be given to EMS personnel when caring for victims of a major accident or disaster.

EMS-048 Some mutual-aid rescue crews from distant jurisdictions reported that they were uncertain how to contact the destination hospitals.

The Southern New England Fire Emergency Assistance Plan should contain contact information for all area hospitals.

EMS-049 Because of the number of deaths and shortage of resources available to transport the deceased to the morgue in Providence, four EMS rescue crews were volunteered to assist (see Annex E, Part IV – Mass Fatality Management). Each crew of experienced EMS providers made two trips carrying two bodies each time. This proved to be a difficult assignment at the end of a very physically and emotionally demanding response effort.

Incident Command should coordinate with the Office of the Medical Examiner (OME) to minimize the need for response personnel to transport deceased victims to the morgue. If this assistance is needed, consideration should be given to dispatching fresh personnel to perform this service.

EMS-050 The rehabilitation sector for response personnel was operating while patients were still in the nearby treatment area and family members were using another area established by the American Red Cross in the Cowesett Inn. This proved emotionally troubling for many responders.

Whenever possible, the rehabilitation sector should be established in a quiet area a reasonable distance away from the intense on-scene activity.

EMS-051 The lessons learned from the Station club fire reinforce the need for a comprehensive communications plan that can accommodate the needs of all responders, including area hospitals.

Current State-led efforts to improve the communications capabilities of all responders should be accelerated and funding provided to implement a comprehensive communications plan.

EMS-052 Communicating with the hospitals proved frustrating and disappointing for everyone concerned. In many cases, EMS attempts to reach the hospital to obtain patient care capabilities were unsuccessful. Often there was no answer or telephones were continuously busy.

The current system for communicating with hospitals during a major incident should be reviewed and modified based on the lessons learned from the Station club fire.

EMS-053 Fire Alarm Office personnel did the best they could to serve a variety of needs, but were understaffed and inadequately equipped to meet all of the challenges posed by this incident.

The current regional fire alarm concept should be reviewed and modified in light of the lessons learned from this incident. Staff augmentation should occur early in a major incident.

EMS-054 Cellular telephones proved useful during this incident, despite occasional problems with cell strength and low batteries caused by continual use. Callers also discovered the importance of having preprogrammed numbers for key contacts that are likely to be called.

Cellular telephones should be used judicially and contain preprogrammed numbers for critical personnel, and battery replacements should be readily available.

EMS-055 The assignment of a fire department EMS rescue unit to support the FAC was considered appropriate. What proved distressful to Warwick Fire Department personnel was the use of duty staff who had been involved in the fire suppression and rescue effort the night before.

Standby support at the FAC should not be assigned to personnel who were active participants in the incident response unless there is no alternative.

EMS-056 The DMAT presence was well-received and keenly appreciated by the families and FAC staff. The presence of a DMAT physician allowed on-scene management of some problems that would otherwise have required transport to a hospital.

FAC operations should have on-site medical support that includes personnel familiar with shelter operations. The presence of a DMAT physician and a pharmaceutical cache proved invaluable and provided family members with medical problems an alternative to leaving their vigil and seeking medical treatment at a hospital.

EMS-057 The DMAT members who volunteered to work at the FAC received liability protection under Rhode Island law because the State requested the mobilization. However, no compensation was paid to them for their services. A request to have them federalized as National Disaster Medical System (NDMS) responders and thereby be eligible for financial compensation was denied by U.S. Department of Health and Human Services (HHS) officials.

Alternatives to compensating the DMAT members when activated by the State should be explored.

EMS-058 The combination of incomplete Incident Command notations about the number and destination of transported patients, coupled with the shortage of completed Ambulance Run Reports, made it exceptionally difficult to determine precisely the hospital transport history of this event. The RI Health EMS Division received only 43 out of a potential 186 patient care Ambulance Run Reports with timelines that corresponded closely with those of the Station club fire.

The limited availability of transportation and patient care documents made it impossible to reconstruct accurately the full effort expended in response to the Station club fire. EMS leaders should stress that pertinent patient care activity must be recorded and submitted to appropriate authorities in accordance with published procedures.

EMS-059 The current staffing of the RI Health EMS Division is already taxed in meeting its daily responsibilities.

The current staffing levels of the RI Health EMS Division should be reviewed.

ANNEX C
LAW ENFORCEMENT

INTRODUCTION

Rhode Island Law Enforcement Resources

Public safety and law enforcement responsibility in Rhode Island is vested in the 39 municipal police departments and the Rhode Island State Police (RISP). Additionally, the Rhode Island Sheriff's Department, with 198 personnel, provides courtroom security, transports prisoners, and serves court documents. Although not considered a law enforcement agency, the Rhode Island Department of Corrections (RI DOC) has 82 sworn law enforcement officers, including a highly trained Special Weapons and Tactics (SWAT) team, who provide security at the State corrections complex located at the John O. Pastore Center in Cranston.

With the second highest population density in the Nation, and without interceding county boundaries, Rhode Island municipal jurisdictions abut other towns or cities in all directions. Thus, neighboring police departments habitually work closely together while respecting each other's jurisdictional primacy. Police chiefs are often hired from candidates applying from other Rhode Island municipal departments. With the exception of the Providence Police Department and the RISP, which have their own academies, all municipal officers are trained at the Rhode Island Municipal Police Training Academy. The close working relationships, common training facilities, and shared leadership experience have helped forge uncommon bonds throughout the Rhode Island law enforcement community and contributed to a long history of cooperation among the various police departments and the RISP.

It is therefore not surprising that on the night of February 20, 2003, when the Station club burst into flames, police from several jurisdictions and from the RISP responded to the call for help from the West Warwick Police Department (WWPD). They did so despite the absence of formal mutual-aid agreements or other planned arrangements.

Activities at the Station Club

Law enforcement activities at the scene were numerous and varied. The first priority was to assist in rescuing those who survived the fire and help with on-site medical aid. The second priority was directing the flow of the 68 ambulances evacuating patients to area hospitals and other emergency vehicles responding on the heavily congested roadways. Although traffic and crowd control, victim identification, site security, and, eventually, crime scene security were all essential law enforcement operations at the scene of the fire, the law enforcement responders' immediate goals were to rescue victims and ensure they had immediate access to lifesaving medical care.

Activities Away from the Incident Site

Law enforcement personnel performed vital roles away from the incident site as well. The WWPD spearheaded the effort to identify victims of the fire at the Rhode Island Emergency Management Agency (RIEMA) headquarters (HQ) and at the Family Assistance Center (FAC), located in the nearby Crowne Plaza Hotel. They collected information from callers on the victim information hotline, completed missing person reports, and interviewed family members to obtain antemortem information (such as descriptions of clothing, jewelry, and distinguishing characteristics). Police interviewed surviving victims at area hospitals and people still at the scene to help determine who else might have been present at the Station club. They compiled information from missing person reports filed by loved ones who feared that a family member was among the unidentified victims of the fire. They also tracked the registration of auto-

mobiles found in the Station club parking lot through the Department of Motor Vehicles (DMV) database.

Upon positive identification of a deceased victim by the Rhode Island chief medical examiner, family notification took place at the FAC. However, if the family had chosen not to wait at the FAC, State or local police performed the notification. The RISP and the Warwick Police Department (WPD) provided security at the FAC and elsewhere; escorted victims' families on the site tour conducted on Sunday, February 23; provided security at memorial services; and, along with other jurisdictions, pitched in wherever help was needed.

Law Enforcement Organizations

The West Warwick Police Department (WWPD) was established when the city of West Warwick was officially chartered in 1913. Serving nearly 30,000 people and covering an area of 8 square miles, the WWPD has 57 full-time officers and employs 13 civilian support personnel. Commanded by Chief Peter Brousseau, the WWPD uses three teams to provide 24-hour coverage with three 8-hour shifts. A police captain assisted by a lieutenant and a sergeant leads each shift of officers. Supplementing the three shifts is the Detective Division. Other services provided by the WWPD include investigative services, two canine officers, and a 15-person SWAT team that the WWPD operates in partnership with the Coventry Police Department (CPD) (see **Figure C-1**).

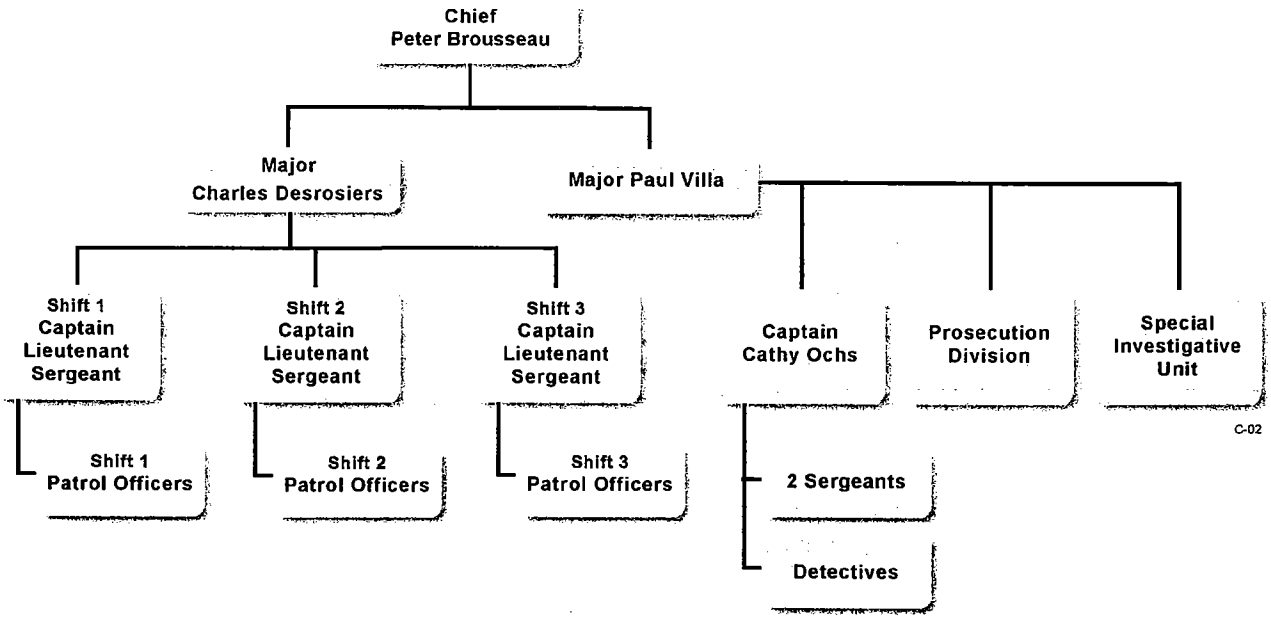
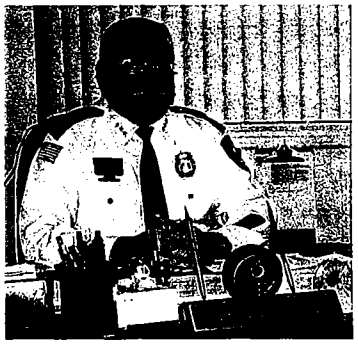


Figure C-1. WWPD organization.

Chief Brousseau is a 22-year veteran of the WWPD. He began his career as a patrolman and was promoted to chief in 1999. In addition to his police service, Chief Brousseau served for 4 years as West Warwick's assistant emergency planner and, from 1995 to 2001, as the town emergency management director. He has a bachelor's degree in criminal justice from Bryant College in Rhode Island. He is very active in the Rhode Island and national police chiefs associations and serves on the Domestic Preparedness Committee under the direction of the Rhode Island Emergency Management Advisory Council (RIEMAC), chaired by Lieutenant Governor Charles Fogarty.



Chief Peter Brousseau

The Coventry Police Department (CPD) jurisdiction borders West Warwick on the west, and the two departments jointly operate a SWAT team. The CPD is led by Chief Brian O'Rourke and has 56 officers. In an average year, the CPD responds to more than 25,000 calls for service. The department has three major organizations—an Administrative Division, a Patrol Division, and a Detective Division—each commanded by a police captain.

Because of the close working relationship with the WWPD, the CPD supervisor dispatched all CPD officers to the Station club fire even before the WWPD requested mutual aid. With all CPD evening shift officers assisting at the fire, the midnight shift was called in early to provide coverage for the city. The CPD continued to assist long after the initial response. Four CPD detectives worked closely with investigators from the WWPD and other jurisdictions for several weeks, assisting in various aspects of the investigation.

The Warwick Police Department (WPD), established in 1931, has 178 officers and 59 support personnel. It is Rhode Island's third largest police force, serving its second largest city. Colonel Stephen McCartney leads the WPD. A retired Marine Corps Reserve Colonel, he commanded a battalion in Operation Desert Storm. The WPD's jurisdiction contains three patrol districts supported by several special divisions including detectives, SWAT, an Explosive Ordnance Division, a Canine Division, and an Underwater Dive Team, as well as several narcotics and investigative task forces.

The WPD was one of the first agencies to arrive in response to West Warwick's Intercity radio call for help, and they also provided the largest number of responding officers. This was possible, in part, because the call for assistance coincided with the 11:00 p.m. shift change. Therefore, a significantly large number of officers were available to respond.

WPD's support role did not end the night of the fire. Colonel McCartney pledged continued support and assigned three WPD detectives to assist full time in the criminal investigation. These detectives remained active on the case for more than 6 months. WPD officers also assisted at the FAC and provided traffic control and security for the memorial events.

The Rhode Island State Police (RISP) was established in 1925 by the Rhode Island General Assembly. It is Rhode Island's only organized police force with Statewide authority. The RISP has 225 officers and is Rhode Island's second largest law enforcement agency. Superintendent Colonel Steven Paré is appointed by, and reports directly to, the governor.

The RISP has several part-time specialized units, such as a Canine Team, Underwater Recovery Team, a Tactical Team, an Accident Reconstruction Team, and a Motorcycle Team. The RISP also has a Uniform Bureau providing uniform police and highway patrol services throughout the State. There are five RISP barracks located in Chepachet, Hope Valley, Lincoln, Portsmouth, and Wickford. RISP HQ is in Scituate, and its training academy is in Foster. RISP has an Investigative Bureau consisting of seven units. The specialized units are the Auto Theft Unit, Criminal Identification Unit, Financial Crimes Unit, General Investigation Unit, Intelligence Unit, Major Crimes Unit/Violent Fugitive Task Force, and Narcotics Unit. The RISP also has a full-time Commercial Enforcement Unit that inspects commercial vehicles.

The RISP was one of the first law enforcement agencies to arrive in support of the WWPD at the Station club fire. Their involvement during the response ranged from assisting in the removal of deceased victims at the Station club in the early morning hours of Friday, February 21, to providing a police escort for the National Disaster Medical System (NDMS) portable morgue between the State of New York and Providence, RI.

The Cranston Police Department HQ is located approximately 7 miles northeast of West Warwick. With 149 officers, it is the third largest municipal law enforcement agency in Rhode Island. Colonel Michael Chalek commands the agency.

Answering the request for mutual aid, the shift supervisor retained two patrol cars in Cranston and dispatched the other three to the fire. At the fire, several Cranston officers assisted in the rescue and triage operations and helped question survivors and bystanders to determine who else might have been inside the Station club. Cranston officers also assisted at the body staging area, providing security and obtaining sheets to cover the growing number of bodies.

The Johnston Police Department (JPD) was established in 1898, and its 70 officers are commanded by Chief Richard Tamburini. Located approximately 8 miles north of West Warwick, eight JPD officers responded to the request for mutual aid. In addition to providing site security and assisting at the body staging area, JPD detectives photographed vehicles in the Station club parking lot and provided the photographs to WWPD investigators.

Additional Mutual-Aid Police Departments

The CPD and WPD, along with the RISP, played the most significant roles in providing mutual-aid support, many other departments responded despite their own limited resources and absent a formal mutual-aid agreement. Although detailed records were not compiled, the WWPD estimates that as many as 20 of Rhode Island's 39 municipal police departments provided assistance.

This annex contains the following two sections that convey the observations, findings, and recommendations pertaining to law enforcement support in response to the Station club fire:

- Section 1 – Initial Response
- Section 2 – Law Enforcement Operations

SECTION 1 – INITIAL RESPONSE

Observations

Police Presence at the Station Club

It is not unusual for police to arrive at a fire scene even before the first responding firefighters because police are already mobile, routinely patrolling area streets, and are quickly diverted when an emergency is first reported. On the night of February 20, police were at the Station club even before the fire occurred. WWPD Patrolman Tony Bettencourt had been hired by the Station club to help with security at the concert that night. Police officers are encouraged to accept uniformed secondary employment positions for public events. It enables them to augment regular compensation and also adds to the public presence of uniformed police. Additionally, WWPD Patrolman Mark Knott arrived at the Station club at about 10:30 p.m. as part of his regular patrol. He completed a routine walk-through shortly before the Great White performance commenced.

Actions When the Fire Started

At 11:07 p.m., after the pyrotechnics had been ignited and flames began to spread, Patrolman Bettencourt was just inside the entrance to the club. Patrolman Knott was outside the entrance in the parking lot, preparing to continue his patrol. Literally within seconds of the outbreak of the fire, Patrolman Bettencourt radioed the WWPD Dispatch and reported the fire. Video taken by a Channel 12 television cameraman filming the performance shows Patrolman Bettencourt pinned against the wall near the entrance by the terrified crowd attempting to escape the racing flames. Moments later, he reports being freed from his position on the wall and "pushed out the door like a cork out of a bottle." Patrolman Bettencourt's presence of mind during those chaotic early moments saved vital seconds from the response time. At some point during his escape from the fire, Patrolman Bettencourt's microphone speaker was torn from his uniform, leaving him unable to hear numerous calls trying to determine his safety.

WPRI-TV Channel 12

Once outside, he joined Patrolman Knott in efforts to rescue people inside the Station club. Initial efforts focused on persons who were trapped inside the main entrance by others who fell or were pushed down while trying to escape the smoke- and fire-filled structure. As efforts to free people from this area became increasingly unlikely, Patrolman Bettencourt directed his attention to windows near the entrance. He broke the windows with his ASP baton and called for persons inside the Station club to come to the windows where he could help free them.

West Warwick Police Department Response

Captain Greg Johnson was the WWPD officer-in-charge of the night shift on the night of the Station club fire. After directing all available officers to the fire, Captain Johnson instructed the WWPD dispatcher to transmit a mutual-aid request to the nearby cities of Warwick and Coventry. Within minutes of the initial request, he directed an additional request for mutual aid from all Rhode Island law enforcement agencies. These requests were transmitted over Rhode Island's Intercity radio system. Before departing from the police station, Captain Johnson directed a recall of all essential personnel and instructed that Chief Brousseau and Major Paul Villa be notified. He then proceeded to the scene of the fire and assumed command of law enforcement operations. Upon his arrival, Captain Johnson was immediately confronted with a growing number of injured persons in the parking lot. He directed those able to walk to move to the Cowesett Inn, a restaurant across the street from the Station club.

Time Lapsed	Action
	Start of fire.
>1 minute	Patrolman Bettencourt, inside the Station club, radios the WWPD dispatcher to contact the fire department.
1 to 2 minutes	Patrolmen Bettencourt and Knott (who was outside the club) make additional radio transmissions requesting fire, ambulance, and additional police support. Captain Johnson, the WWPD shift commander, directs all available officers to the Station club.
2 minutes	Captain Johnson clears all officers from other commitments and directs all WWPD officers to the fire.
2 to 3 minutes	Captain Johnson instructs Dispatch to request mutual aid from CPD and WPD.
3 to 4 minutes	WWPD Dispatch transmits mutual-aid request to all Rhode Island agencies via the Intercity radio.
4 minutes	Captain Johnson orders a recall of extra help and the notification of Chief Brousseau and Major Villa.
5 to 6 minutes	Additional WWPD officers begin arriving and assist in rescue operations.
7 to 8 minutes	Mutual-aid officers from Coventry and Warwick begin arriving at the scene.
11 minutes	Captain Johnson arrives at the scene as a law enforcement commander.
17 minutes	Cowesett Inn is officially designated as the triage site.
35 minutes	Law enforcement operations are moved inside the Cowesett Inn.

Figure C-2. West Warwick police initial response timeline.

West Warwick Police Detectives Brian Araujo and Garry Appolonia had just completed interviewing a breaking and entering suspect when they heard Patrolmen Bettencourt's and Knott's radio transmissions requesting assistance. Upon arriving at the scene, they helped free victims trapped in the doorway, then began clearing a pathway through the extremely crowded parking lot so that the approaching fire trucks could reach the burning building. Seven West Warwick police officers were at the site before the first fire truck arrived. Despite the lack of adequate personal protective equipment (PPE) and with only basic emergency lifesaving training, these

officers worked diligently and desperately to free persons from the front exit and windows. Even after the arrival of the first West Warwick Fire Department (WWFD) units, officers continued to assist in freeing persons from the inferno.

Lieutenant Richard Ramsay, the WWPD public information officer (PIO), lives near the Station club and heard the sirens from the steady stream of responding emergency vehicles. After reporting to Captain Johnson at the scene, Lieutenant Ramsay began assisting with the triage effort. He then enlisted volunteer bystanders and used pickup trucks to transport nonambulatory injured persons from the parking lot to shelter in the Cowesett Inn.

At approximately 1:30 a.m., on February 21, after assisting with the triage efforts, Lieutenant Ramsay was directed by Chief Brousseau to coordinate media interviews and queries. At the time, it appeared as though Lieutenant Ramsay would serve as the central point of media contact for West Warwick. As more and more media arrived, Mr. Wolfgang Bauer, the West Warwick town manager, held the first press conference.

Upon his arrival at the scene, WWPD Captain Richard Silva began assisting Captain Johnson at the law enforcement command post inside the Cowesett Inn. Once rescue and triage operations were completed, they determined law enforcement priorities to be the following:

- Gathering the names of victims
- Establishing, maintaining, and securing the body staging area
- Helping establish a Family Assistance Center (FAC)
- Assisting in victim-information tracking at RIEMA HQ

At the command post, Captain Johnson and Captain Silva began making assignments to ensure the above priorities would be appropriately staffed. Later, Captain Silva would lead the WWPD's involvement at the FAC.

Coventry Police Response

Sergeant Robin Winslow, the CPD night shift supervisor, immediately dispatched two cars to the Station club fire. This initial dispatch was made before receiving the WWPD request for law enforcement mutual aid. This was not unusual given the close working relationship of the Coventry and West Warwick Police Departments.

When the formal request for mutual aid was received a very short time later, the entire shift of seven patrol officers and two detectives responded to the scene. To provide coverage for its own jurisdiction, the officers scheduled to begin work at midnight were called in early. All of them responded promptly. Officers from the CPD described their first impression of the scene as chaotic and reported seeing more than one altercation between members of the band Great White and persons who had been inside the club.

Upon his arrival at the scene, Lieutenant John Sullivan of the CPD worked with Captain Cathy Ochs of the WWPD to monitor the situation and manage the activities of CPD personnel. Assisting in rescue, triage, site security, and traffic control, members of the CPD played important roles in all areas of the initial response.

Warwick Police Department Response
In nearby Warwick, the WPD was in the midst of its 11:00 p.m. shift change when West Warwick's request for mutual aid was transmitted at approximately 11:10 p.m. Sergeant Thomas Hannon was the highest ranking officer present in the initial response. The brief overlap of the outgoing and incoming shifts was very beneficial because 25 WPD officers were immediately available to respond.

Upon arriving at the scene at approximately 11:15 p.m., Sergeant Hannon encountered "walking wounded" wandering throughout the Station club parking lot. He directed the WPD officers to join the WWPD officers directing and assisting persons to the Cowesett Inn. While assisting Emergency Medical Services (EMS) personnel at the Cowesett Inn triage site, several WPD officers volunteered to drive ambulances so that the EMS drivers, who were better trained in emergency medical care, could remain at the site and care for the injured.

Rhode Island State Police Response
Lieutenant Stephen Bannon was serving as third-shift officer-in-charge for the RISP when he was informed of West Warwick's request for assistance. After directing five of the seven two-person cruisers on duty that evening to the fire, Lieutenant Bannon immediately proceeded to the Station club and offered the full assistance of the RISP. Members of the RISP assisted in triage and traffic and crowd control and were involved in the first efforts to obtain information about possible victims. At the triage site at the Cowesett Inn, two State troopers were used to keep unnecessary personnel out and prevent injured persons from returning to the site. Lieutenant Bannon notified RISP District Commander Captain Leo Messier of the scope of the emergency and the request for RISP assistance. At the request of Chief Brousseau, Lieutenant Bannon also arranged to dispatch a RISP Crime Scene Investigation Unit to the incident site.

Captain Messier responded to the scene after notifying RISP Major Brendan Doherty, who would later take over command of RISP response operations. In the next several hours, Captain Messier and Major Doherty continued to manage RISP resources while establishing and maintaining communications with Governor Donald L. Carcieri's RISP security detail in Florida. Upon his arrival at the scene, Major Doherty assumed command of RISP operations and ensured all non-uniformed officers donned "raid" jackets to identify them as law enforcement.

Law Enforcement Operational Priorities
Inside the Cowesett Inn, Captain Johnson (WWPD), Lieutenant Bannon (RISP), Captain Messier (RISP), and Sergeant Hannon (WPD) were leading law enforcement operations from a command post collocated with the triage site. Upon their arrival, Chief Brousseau and Major Villa of the WWPD directed law enforcement activities outside of the Cowesett Inn. Subsequently, Chief Brousseau led all law enforcement operations from a single location inside the Cowesett Inn. The RISP, WPD, and all other responding police departments served in a support capacity. The first officers on the scene were focused almost exclusively on lifesaving operations and triage. Chief Brousseau did not implement a formal law enforcement Incident Command System (ICS). At that time, there were insufficient personnel available to establish the ICS. Once sufficient command personnel were available, an ICS was not considered necessary.

Acknowledging that the WWFD was in charge of the scene for the duration of fire suppression and rescue efforts, Chief Brousseau prioritized law enforcement operations to meet the following needs:

- Ensure the treatment of the injured
- Secure the scene
- Initiate a criminal investigation (including victim identification and tracking)
- Recovery operations

The WWPD had an excellent initial response. Many West Warwick police officers reported for duty on their own initiative, including all of the available WWPD command staff. Chief Brousseau decided not to recall all WWPD officers to have an adequate number available for relief the following morning.

Findings and Recommendations

LE-001 There are few formal or clearly defined mutual-aid agreements among local law enforcement organizations in Rhode Island. Although a request for assistance was transmitted over the Intercity radio and many agencies responded, the full extent of how they would be coordinated and integrated into the response was not sufficiently clear. In addition, law enforcement authority while operating in another jurisdiction is unclear.

The law enforcement community within the State of Rhode Island needs to develop more comprehensive mutual-aid agreements between, and in support of, municipalities. Such agreements should be regional in scope and accommodate direct support as well as procedures to backfill jurisdictions closest to the emergency by those furthest away. In doing this, all agencies in the region shoulder some of the mutual-aid burden. Jurisdictional and law enforcement issues should also be addressed in these agreements to ensure responding officers have the legal capacity to act.

LE-002 Rhode Island's Intercity radio system is a point-to-point or station-to-station system. It was able to transmit to all area police departments the call for help from the WWPD. However, because of the lack of equipment interoperability, responding officers from other jurisdictions were often unable to communicate directly with the WWPD. As a result, the WWPD primarily used mutual-aid officers for traffic and crowd control.

Radio communications systems should be acquired that will ensure interoperability among responding mutual-aid law enforcement jurisdictions. Once developed, personnel should be trained on the operations of the systems, and the systems should be regularly tested to ensure officers responding to a request for assistance from another jurisdiction are capable of communicating with that jurisdiction and are also familiar with the protocol for contacting its dispatch center.

LE-003 Parking was as much of an issue as crowd control. Staging of emergency vehicles during the initial response was especially problematic. With the substantial mutual-aid response and the limited physical area in which operations occurred, the emergency vehicles quickly saturated the parking areas.

It is essential that the Incident Commander establish staging areas early in the response. Care should be taken to coordinate among police, fire, and rescue organizations to minimize confusion in assigning response resources to these areas.

LE-004 In the early stages of the response, the need for law enforcement personal to participate directly in rescue operations prompted the call for additional police to perform other, more traditional, law enforcement tasks. As sufficient fire, rescue, and EMS personnel arrived and assumed their specific responsibilities, the redirection of existing on-scene police and the requirement for additional police personnel should be determined based on the need to perform law enforcement tasks.

Once sufficient fire and rescue personnel arrive at the incident site, supervisors should plan for an organized and coordinated disengagement of police from the rescue efforts. A coordinated disengagement will allow police officers to concentrate on more germane law enforcement activities while ensuring rescue operations are continuing in the most advantageous manner.

LE-005 The Station club fire demonstrated that law enforcement officers are often the first to arrive on the scene and may very likely be faced with incredibly challenging life-saving circumstances. Although police officers are trained in first aid, little, if any, of the training deals with the complex medical issues inherent in a mass fatality event.

Law enforcement officers should be trained in the basic concepts of triage, including site management, injury assessment, and victim prioritization.

LE-006 The area of operation was very small and extremely crowded with victims, responders, and bystanders. Rescue operations were conducted at a hectic pace. With so many units responding to the incident, deficient communications interoperability, and the failure to implement a law enforcement ICS, it was impossible to account for all personnel engaged at the scene. All law enforcement administrators present on the night of the fire readily admit that a formal ICS, preferably a unified ICS with the WWFD fire operations, would have been beneficial.

Law enforcement ICS should be established as soon as sufficient personnel are available to establish and maintain accountability of all responding law enforcement personnel and ensure officer safety, maximize efficient personnel assignments, and minimize individual exposure to traumatic situations.

LE-007 Because of the failure of communications interoperability, it was not possible for mutual-aid police departments to regularly update the command post with activity information. Additionally, some responding agencies, such as the JPD, were unable to communicate with their home stations after deploying to the incident site.

Agencies should consider the use of the mobile data terminals, Internet, instant messaging, and e-mail to allow communications personnel from mutual-aid agencies to instantly update their agency's presence at the site.

LE-008 With nearly 600 response personnel descending on the scene, it was often difficult to readily identify law enforcement personal. Many officers that self-responded were not in uniform and did not wear "raid" jackets or other distinctive items identifying them as police officers.[1]

Agencies should have a ready supply of raid-style jackets that can be issued at the site and identify the wearer as a law enforcement officer. The ability to readily identify law enforcement personnel at an incident site is vital to security and overall control. Non-uniformed or "plain clothes" officers are especially problematic. As operations stabilize, a formal identification process, such as discipline-specific identification cards, should be implemented.

LE-009 Many spontaneous acts contributed to the success of law enforcement response. WWPD Dispatch directly telephoned private ambulance companies, who usually transport patients between healthcare facilities, and engaged them in medical evacuation at the site. The dispatching of private ambulances augmented available EMS resources. Dispatchers arranged for buses from various sources, such as the WPD and the Rhode Island Public Transit Authority to transport victims with noncritical injuries to area hospitals. Police at the scene enlisted volunteers with pickup trucks to shuttle nonambulatory patients from the Station club to the Cowesett Inn. Other police officers drove the ambulances carrying victims to area hospitals, allowing the emergency medical technician (EMT) drivers to remain onsite assisting with triage. These spontaneous actions were not formally recorded as actions that should be incorporated in future plans.

It is essential to capture institutionally successful impromptu actions immediately after the event so that they can be shared with others and incorporated in future response plans. Ingenuity and spontaneity are important attributes in circumstances demanding quick lifesaving actions and should be nurtured among the community of first responders.

LE-010 When the request for mutual aid was made, law enforcement agencies from all over the State answered the call. Upon their arrival, most officers received little direction as to what needed to be done and attempted to provide assistance wherever it was needed. Often, this did not lead to the most efficient use of manpower.

An agency requesting mutual aid obviously has a desperate need for additional manpower. However, to facilitate an efficient mutual-aid response, the requesting agency should immediately assign a person to serve as a liaison that coordinates the mutual-aid response. Ideally, this person should be located at the staging area where the mutual aid is being directed.

[1] Since the fire, WWPD has purchased a portable identification card system to be used for site access control.

SECTION 2 – LAW ENFORCEMENT OPERATIONS

Observations

Victim Identification Efforts at the Scene

Although the last survivor escaped from the burning nightclub within the first few minutes after it burst into flames, law enforcement operations continued at a high level of intensity long after rescue efforts ended. By about 2:00 a.m., less than 10 bodies had been recovered from the charred ruins, and nearly all of the 186 injured victims had been evacuated to area hospitals. While it was apparent that a significant number of bodies were located near what was the main entrance to the club, it was unsafe to proceed with recovery efforts until the unstable structure could be safely brought down. The exact number of victims remaining inside the club was still unknown and law enforcement officers were busy attempting to compile three lists: a list of missing persons, a list of victims who had been transported to hospitals, and a list of known fatalities.

Boston Globe \ Tom Landers

Fire personnel search the charred remnants of the Station club.

Automobile Registration Information

Lieutenant Ramsay of the WWPD began recording license plate numbers of automobiles in the Station club parking lot to obtain vehicle registration data from the Rhode Island DMV database. Other police officers had for some time been circulating among the injured victims and those who managed to escape unscathed from the fire, attempting to ascertain the names of others who were in the club when the fire started. Lieutenant Ramsay planned to compare the list of vehicle registrants to the lists of deceased, hospitalized victims, and those known to have been inside the club but not otherwise accounted for. The new names were then added to the list of missing persons.

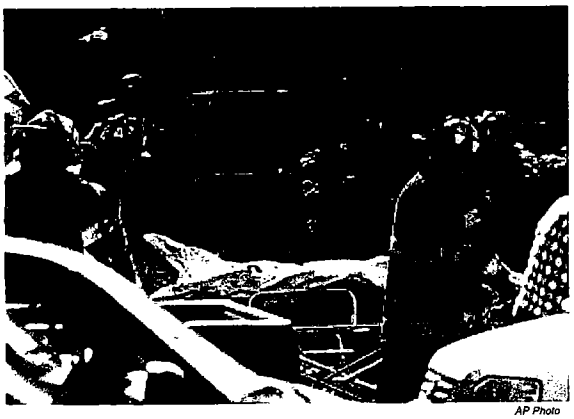
Collecting Data from Hospitals

Lieutenant Bannon of the RISP assigned one of the RISP troopers at the scene to help record automobile license numbers, while others checked with area hospitals to collect an accurate list of victims at healthcare facilities, including walk-in patients. The license plate data was used to cross-check the information Lieutenant Ramsay was compiling. The hospital data was obtained by having State troopers and local police department officers visit each healthcare facility, including those in Massachusetts. Eventually, a protocol was established by which hospital staff could telephone or fax patient identity information to the law enforcement command post at the Cowesett Inn and subsequently to the WWPD at RIEMA HQ.

Troopers from the RISP and local officers were also used to retrieve records from dental offices throughout the region to further aid in the victim identification process.

Recovery and Removal of Remains

In Rhode Island, the State medical examiner has jurisdiction over the recovery of remains. Bodies can be moved to facilitate the rescue of survivors or similar circumstances, but as a rule, a member of the Office of the Medical Examiner (OME) must recover the remains. An investigator from the OME arrived at the incident site at about 1:00 a.m. with two transport vehicles provided by one of several OME standby livery services. A body staging area was established in the parking lot adjacent to the Station club. As fire and police personnel removed the majority of the victims from the club, police officers covered the bodies and stood guard. In many cases, police were required to search for personal effects that would help identify the victim.



AP Photo

Intentionally omitted from this report are circumstances dealing with the origin of the fire and any subsequent criminal investigations. However, it is important to point out the vital role criminal investigators from the WWPD, RISP, and WPD played in the initial response and subsequent law enforcement operations. In addition to several WWPD investigators' involvement in rescue operations shortly after the start of the fire, police investigators began the process of interviewing victims, witnesses, and members of the band Great White while firefighters were still engaged in suppression efforts. These interviews and subsequent investigative activities continued for more than 6 months and were vital to identifying critical data regarding the fire.

West Warwick Police Department

West Warwick police investigators at work.

West Warwick Police Department at RIEMA Headquarters

At approximately 5:00 a.m. on Friday, February 21, the victim information telephone hotline and all other associated efforts were relocated to RIEMA HQ at the Rhode Island National Guard Command Readiness Center in Cranston. Lieutenant Albert Giusti established the WWPD command operations at RIEMA and continued the work of compiling and analyzing missing persons information. As additional victim information was obtained from the scene of the fire, from the FAC, and from the OME, it was recorded, analyzed, and distributed. Eventually RIEMA staff members established the following four victim information lists that were regularly updated:

- **Hospital Victims List.** Persons who had been treated at area hospitals. The list indicated whether or not the person had been released or admitted.
- **Safe List.** Persons who were present at the Station club and were known to be safe. This information was obtained from interviews at the scene of the fire and from persons who had been at the club and subsequently called the hotline.
- **Missing Persons List.** When family and friends completed a missing person report at the FAC, that person's name was added to the missing persons list. The name remained on this list until the person was confirmed to be safe, hospitalized, or their remains had been identified.
- **Confirmed Dead on Arrival (DOA) List.** As the State medical examiner released the name of a victim whose remains had been identified, the victim's name was added to this list.

Law Enforcement Support at the Family Assistance Center

At approximately 5:00 a.m. on Friday, February 21, the American Red Cross of Rhode Island (ARC RI) and RIEMA established the FAC at the Crowne Plaza Hotel. One of its primary purposes was to serve as a safe haven for family members awaiting confirmation of the fate of a loved one. The RISP and WPD secured the area around the main ballroom and its adjacent salons, which served as the FAC, thus protecting the families from unauthorized persons gaining access to the FAC.

Inside the FAC, Captain Silva and Lieutenant Ramsay of the WWPD, along with Lieutenant Tom Snow of the WPD, and additional officers from the WWPD and RISP continued collecting information from family members, focusing on information that would help the State medical examiner identify the remains of deceased victims. Such information included items from which a DNA sample might be taken, descriptions of jewelry and clothing, and any identifying personal characteristics. This information was sent to the OME staff at the State morgue.

After all persons at area hospitals had been identified, the families gathered at the FAC had little hope that their loved ones had survived the fire. The FAC served as a central point where friends and families of missing persons could receive support while waiting to be notified that their loved ones had been positively identified. In the cases where identification was confirmed and the family was not present at the FAC, law enforcement officers from the appropriate jurisdiction, accompanied by clergy, performed the notification. To provide the agency performing the notification some assurance that the victim's family had been accurately identified, Captain Silva of the WWPD created a Death Notification Request Form. This form was faxed to the notifying law enforcement agency and contained detailed follow-up instructions.

Extended Site Security

Even after the remains of the 96 victims were removed from the scene, law enforcement involvement at the scene continued. Throughout nearly 5 months of crime scene investigation, the WWPD provided site security 24 hours a day. Mr. Tim Brown was dispatched to Rhode Island as part of Governor Carcieri's request to the U.S. Department of Health and Human Services (HHS) for assistance. His experience, which included working in the New York Mayor's Office of Emergency Planning during September 11, proved to be invaluable. At the recommendation of Mr. Brown, an 8-foot fence was erected, sealing off the entire area. This became the focal point for impromptu memorials as friends and relatives left mementos honoring the victims. Soon it was festooned with flowers, photographs, and stuffed animals.

Kent County Daily Times \ Greg Sousa

Remembrances of the victims.

Site security was also required at the State morgue in Providence. Because the number of deceased victims exceeded the storage capacity of the morgue, RIEMA had arranged for two refrigerated trailers to expand the available storage space. The RISP provided 24-hour security at the morgue. Additional information regarding the operations of the OME can be found in Annex E – Public Health, Healthcare Facilities, Mental Health, and Mass Fatality Management.

Mental Health Care

Although the Station club fire rescue and recovery operations ended fairly quickly, law enforcement operations continued for several months. Post-traumatic event counseling has been offered to all law enforcement officers who were at the scene. The WPD conducted a mandatory debriefing for each shift, giving officers an immediate opportunity to discuss the tragedy with their peers. Counselors from the Rhode Island Department of Mental Health, Retardation and Hospitals (MHRH) conducted these debriefings. The WWPD and RISP used a peer support team as well as the Rhode Island State Critical Incident Stress Management (CISM) Team for this purpose. The CISM team responded to the scene the night of the fire and offered their

services. Many police took advantage of this opportunity although it was not required. (See Annex E, Part III – Mental Health for more information.)

Media Impact

Kent County Daily Times \ Greg Sousa

When the national news programs began broadcasting on Friday morning, February 21, the Station club fire was the lead story. The number of reporters and volume of media vehicles and equipment at the incident site was staggering. All major local and national television networks, as well as newspaper and radio correspondents from around the country and the world, were gathered in the limited space around the scene. Most media vehicles were parked in and around the Texaco Station, which had been the site of the first press conference and was the designated location for media interface. This was within 100 yards of the smoldering ruins of the Station club. It enabled the media to film the recovery operations and provided direct access to first responders at the scene. When family members of the victims were brought to the site for a memorial, the buses used to transport them were intentionally positioned to shield the media and other onlookers from viewing the family members' visit.

In hindsight, officials from the WWPD express regret that the media was not kept farther away from the operations and that the initial press conference had not been held at a different location. Compounding the problem of controlling media presence at the scene was the delay in establishing a Joint Information Center (JIC). A JIC, operating offsite and away from the incident scene, would have required the media to physically leave the area of operations to cover press briefings and obtain the latest information. This is precisely what happened after the JIC became operational at a National Guard armory on Saturday, February 22. The JIC also served as the single source for data dissemination, which was useful in media interaction and also for briefing senior government officials.

AP Photo

News helicopters create a distraction for rescue workers.

As daylight broke, helicopters carrying camera crews appeared, hovering over the scene. The presence of these helicopters served as a distraction to the ongoing recovery efforts and presented a hazard to the rescuers. Additionally, footage obtained of body recovery procedures was clearly not appropriate. Chief Brousseau asked Major Doherty, the officer-in-charge for the RISP, to arrange for the air space over the Station club to be restricted. Contacting the Federal Aviation Administration (FAA) at the nearby Theodore F. Green State Airport in Warwick, he was able to have the air space restricted for a ½-mile radius around the club. Because of the close proximity of the scene to the airport, a broader restriction was not possible, but this limited restriction served its purpose.

Findings and Recommendations

LE-011 A large number of bodies were recovered near the main entrance of the Station club. The body recovery process was delayed at one point on Friday morning because parts of the nightclub that were still standing became unstable. A Coventry building wrecking service crane assisted in temporarily shoring those areas so recovery could continue. A second delay occurred at about 11:00 a.m. that same morning when the response force ran out of body bags. It is difficult for those who were involved in the recovery of bodies to understand how supplies of such a critical item could be overlooked 12 hours into the operation. Following on the heels of the earlier delay, this was particularly frustrating and could have been avoided.

A mass fatality management plan must be in place and address such items as the supply of body bags. RIEMA should coordinate with the Rhode Island Department of Health (RI Health) and the Rhode Island OME to fix responsibility and ensure adequate stocks can be readily obtained in the future.

LE-012 The OME response was insufficient to deal with the number of Station club fire fatalities. Chief Brousseau spoke with the chief medical examiner, Dr. Elizabeth Laposata, at approximately 3:00 a.m., requesting that she come to the scene, along with additional OME personnel. Dr. Laposata indicated that her people were already present at the scene and that the situation was under control.

In mass fatality incidents such as the Station club fire, sufficient numbers of experienced forensic medical staff must assess the situation at the incident site to direct a responsive recovery effort.

LE-013 The bulk of the process of removing victims from the ruins of the Station club fire fell to police officers and firefighters. As victims were located, police and OME investigators logged, photographed, and diagrammed the necessary information. Once cleared to proceed, a recovery team then placed the bodies in body bags and moved them to the body staging area. Because of the difficult nature of recovering bodies, recovery teams were then assigned to alternative duties. Unfortunately, as more and more bodies were located, it became necessary for some officers to participate in multiple recoveries.

In mass fatality circumstances, it is likely that first responders will be engaged in body recovery efforts. However, exposure to the recovery of remains should be minimized. Such assignments should be rotated, preventing one person from prolonged exposure to these stressful conditions. Supervisors overseeing the process should also be rotated, and all persons involved should be monitored for signs of stress and shock. Training, including discussions with CISM counselors, should be provided to law enforcement officers to better prepare them for such situations.

LE-014 The OME had limited transport capabilities. In the absence of a more suitable conveyance, most bodies were placed in vans belonging to the West Warwick School Department and West Warwick Department of Public Works and delivered to the State morgue.

Administrative vehicles should not be used to transport the remains of victims from an incident site. The Rhode Island medical examiner should ensure sufficient transport is available by engaging all required contract livery providers.

LE-015 West Warwick officials asked for a RISP escort to help the vehicles carrying remains to navigate the typically high volume of Rhode Island highway traffic. Somehow, this request fell through the cracks and the RISP did not escort the vehicles to the morgue. This was one of the few areas where there was a clear breakdown in communications among the law enforcement agencies. An operational law enforcement ICS would have tracked such a request and ensured it was acted on.

Action tracking should be rigorously implemented and executed with regular follow-up inquiries by law enforcement commanders.

LE-016 During efforts to determine the disposition of hospitalized victims, it was decided to canvas area hospitals in person, using a combination of State troopers and officers from the closest police stations. This proved to be an effective way of establishing a communications channel for patient information.

When first attempting to account for injured victims who have been transported by ambulance or who have self-evacuated, face-to-face communications with area hospitals is the best way of avoiding miscommunications. This procedure should be noted in response and recovery plans and coordinated in advance between law enforcement agencies and local hospitals.

LE-017 Early during law enforcement operations, attorneys from the Rhode Island Attorney General's Office visited the scene to assist in the investigative process. They provided helpful and practical advice to the RISP, WWPD, and other local law enforcement officers regarding such areas as searching vehicles and personal effects to obtain victim information without prejudicing the criminal investigation. Their advice regarding the legal aspects of the event was very beneficial and greatly appreciated.

At the scene, the Attorney General's Office acted on its own initiative in commendable fashion. Timely advice from competent authority is essential whenever first responders are confronted with unusual circumstances. Local law enforcement officers are not normally knowledgeable of the legal complexities of all of the situations that might confront them.

LE-018 Law enforcement organizations tend to be somewhat hesitant in embracing the benefits of stress management counseling. The use of peer counselors as practiced by the Rhode Island CISM Team seems to be a good model, with retired fire

service, police, and emergency management personnel acting not as counselors, but as intervention team leaders.

Law enforcement agencies should adopt formal policies regarding counseling after critical incidents such as the Station club fire. Relations with counseling sources such as the Rhode Island CISM Team should be established and nurtured on a regular basis so that mutual trust and respect are firmly grounded before an event occurs. Additionally, departments should develop long-term counseling plans that provide officials exposed to incidents, such as the Station club fire, an opportunity to obtain counseling well after the incident.

LE-019 Many members of the WWPD were involved in the extremely traumatic rescue operations at the Station club fire. As part of ongoing law enforcement operations, it was required that members of the WWPD constantly remain at the scene of the fire for security purposes. In some cases, members involved in rescue operations or otherwise affected by the fire may have been reassigned to the scene before receiving counseling. Most departments have strict guidelines regarding the assignment of officers after involvement in a critical incident such as a shooting.

Police departments should broaden their guidelines to include exposure to a mass casualty incident (MCI). Officers who cannot be placed on leave following an MCI should be assigned duties away from the scene of the incident.

LE-020 Securing a site of an MCI poses several challenges. In addition to the need to secure what is at the site, the need to protect the scene from persons wishing to express sympathy by leaving flowers or other personal effects must be considered.

As soon as possible, a barrier fence should be erected around the entire site. Preferably, this fence should be 8 to 10 feet high and constructed of material to prevent people from intruding on the site. Ideally, a second fence should be constructed to provide an additional barrier to prevent persons from easily throwing objects over the primary barrier. Arrangements should also be made to facilitate the leaving of items such as flowers or other expressions of sympathy near the scene.

LE-021 The presence of news helicopters over the scene of the Station club fire was distracting to officers and firefighters engaged in rescue operations. This overhead perspective also afforded the media footage of victims being recovered from the remnants of the club.

Law enforcement officials should be aware of their authority to immediately request that air space be restricted around incidents such as the Station club fire and should have contact numbers for the area FAA control tower available.

LE-022 As news of the fire spread, family and friends of persons who had been at the Station club began to arrive at the scene in an attempt to gather information about their loved ones. This influx of people further taxed an already overwhelmed law enforcement community. Once the families were directed to an off-site Family

Assistance Center (FAC), law enforcement officers were better able to focus on their on-scene priorities.

Although there is no way to eliminate the response of loved ones to the scene of a tragedy such as the Station club fire, the sooner they can be directed to a FAC the better. Efforts should be made to have the FAC available to families as soon as possible.

ANNEX D
EMERGENCY MANAGEMENT SYSTEM AND OPERATIONS

INTRODUCTION

Rhode Island Emergency Management System

Rhode Island's emergency management system consists of response and recovery policies, plans, procedures, facilities, technologies, organizations, staff, training programs, and exercises at State and municipal levels, as well as channels for obtaining support from Federal authorities, other States, and volunteer organizations. The West Warwick Station club fire, which occurred late at night on February 20, 2003, tested State and local emergency management systems and operations, revealing many challenges and opportunities for improvement.

Rhode Island Emergency Management Polices and Authorities

Rhode Island emergency management policies are contained in legislative statutes, executive orders and directives, and other documents promulgated by authorized elected, appointed, and career officials. Plans, procedures, and the resources needed to implement them are derived from these approved policies. Title 42 of the Rhode Island General Laws designates the governor as the head of the executive department, with all powers and duties prescribed by the Rhode Island Constitution and general and public laws. The governor is further designated by Title 30 as the captain general and commander-in-chief of the military and naval forces of Rhode Island. The Rhode Island Emergency Management Advisory Council (RIEMAC) is established by Rhode Island General Law 30-15-6 and is charged with advising the governor and the adjutant general on all matters pertaining to disaster and emergency preparedness. The lieutenant governor chairs RIEMAC and the adjutant general serves as vice chair. Title 30 also mandates the establishment of the Rhode Island Emergency Management Agency (RIEMA) as the implementing agency within the executive department headed by the adjutant general.

Rhode Island Emergency Management Agency

RIEMA is charged with protecting the lives and property of the citizens of Rhode Island when disasters strike. It maintains the all-hazard Rhode Island Emergency Operations Plan (EOP) and ensures each of the 39 municipalities has a compatible plan. In August 2001, Rhode Island became one of the first States in the Nation with a federally approved 3-year Statewide domestic preparedness strategy. RIEMA also coordinates a robust emergency management training program. RIEMA reported that between October 1, 2002, and August 18, 2003, more than 2,100 Rhode Island emergency responders participated in 109 instructional courses.

As depicted in **Figure D-1,** RIEMA had a staff of 13 persons and 3 contract employees at the time of the Station club fire. The physical space allocated to RIEMA within the Rhode Island National Guard Command Readiness Center includes four areas. One area is organized into offices and work cubicles for RIEMA staff. A second, smaller room is designated as the Emergency Operations Center (EOC) planning area and is also organized for meetings between the governor and key Rhode Island officials during emergency situations. A larger space is designated as the EOC operations area, but its day-to-day use is as a multipurpose classroom shared by RIEMA and

RIEMA EOC planning area.

the National Guard. It must be reconfigured during an emergency into work areas for representatives of Rhode Island government agencies supporting response and recovery operations. Finally, a small communications and computer equipment support center is located between the EOC planning area and the designated operations area.

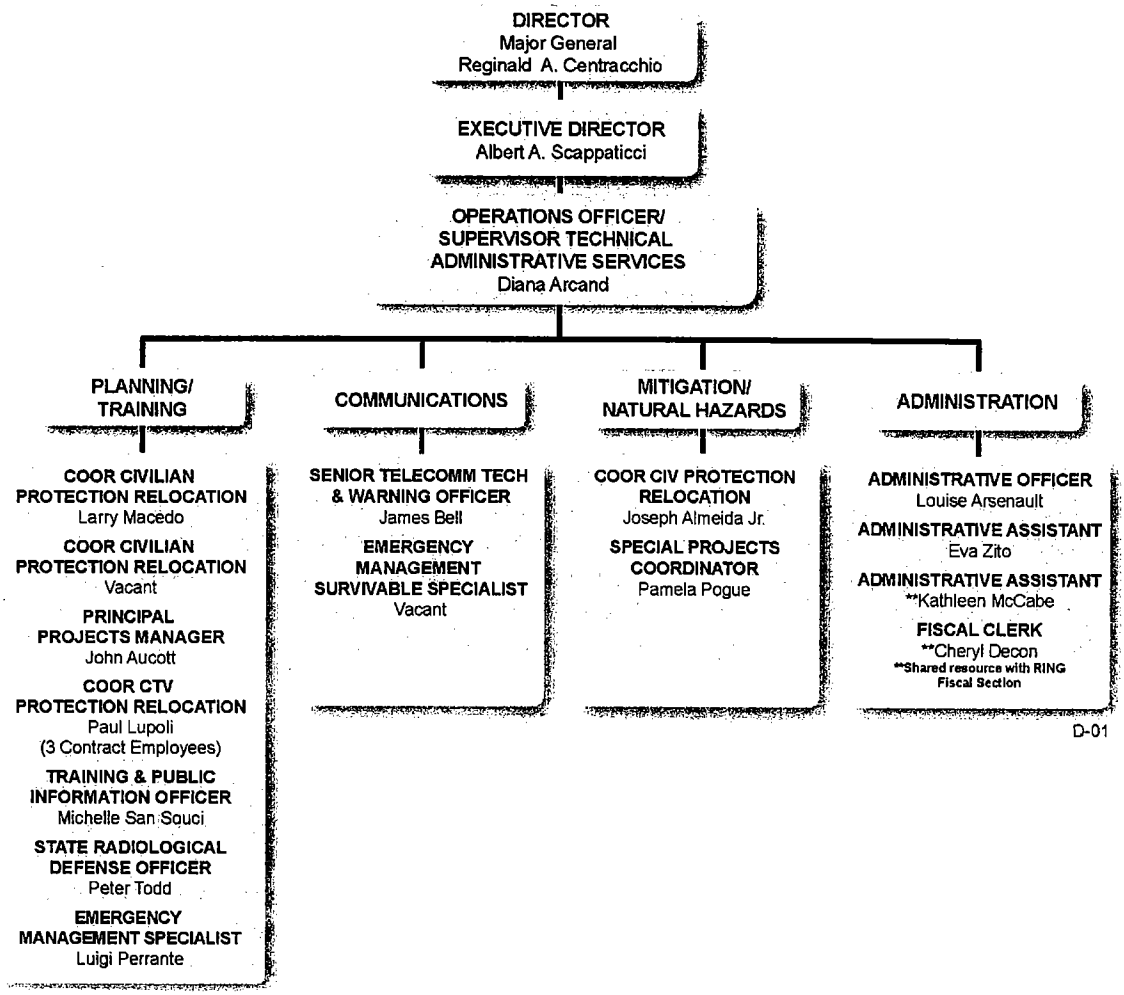


Figure D-1. RIEMA organization chart as of February 20, 2003.

West Warwick Emergency Management

Mr. Thomas Senerchia is the West Warwick emergency management director. A 12-year volunteer ham radio operator, Mr. Senerchia applied for, and was appointed to, the newly established part-time position in September 2002. Before that date, emergency management was the additional responsibility of the West Warwick police chief. Mr. Senerchia heads an active organization of 40 volunteers, including two Town Council members, ensuring the importance of preparedness is properly acknowledged within West Warwick's government chambers. Although many volunteers are ham radio operators assigned to the communications group, others have completed training offered by the American Red Cross (ARC) in basic lifesaving skills, mass casualty support, and damage assessment. West Warwick has a rudimentary EOC in the basement of the Town Hall and an alternative EOC at the West Warwick Civic Center.

Executive and Agency-Level Briefings

A successful business executive in the manufacturing industry, Governor Donald L. Carcieri took the oath of office on January 6, 2003, approximately 6 weeks before the West Warwick Station club fire. Most members of the governor's executive staff were also new to executive-level government operations. It is customary that before assuming office, newly elected governors and their staff receive briefings from leaders of Rhode Island's key organizations and agencies. On December 19, 2002, Major General Reginald A. Centracchio and Mr. Albert Scappaticci described to the governor and his staff the concept of Statewide emergency management operations, including the use of Emergency Support Functions (ESFs). They also described the capabilities of RIEMA and its staffing shortfalls. That briefing also included a graphic depiction of State and local roles and responsibilities under the Federal Response Plan (FRP) (see **Figure D-2**). The governor also toured the National Guard Command Readiness Center, which houses RIEMA headquarters (HQ).

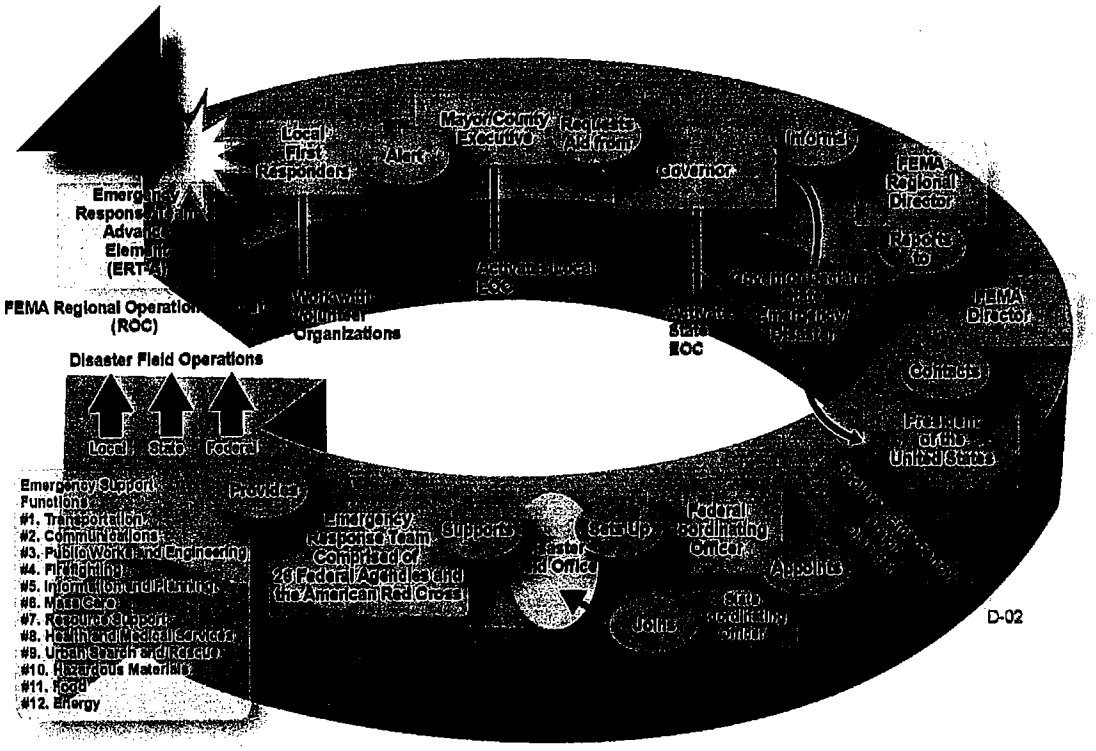


Figure D-2. Briefing chart of State and local roles and responsibilities under the Federal Response Plan for Governor Carcieri.

On January 14 and 15, 2003, Governor Carcieri, his executive staff, and cabinet directors participated in a policy-oriented workshop at the Alton Jones campus of the University of Rhode Island in West Greenwich. Emergency management was one of the topics discussed at the workshop. General Centracchio talked about the need for additional resources to meet the demands of terrorism and the new risk environment. Several cabinet directors stressed concerns about the need for better interagency coordination. Mr. Jan Reitsma, director of the Department of Environmental Management, also expressed his concerns about preparedness deficiencies, noting a general lack of capacity to operate beyond the first 24 hours in an emergency. On February 17 and 18, just days before the Station club fire, a winter blizzard with

nearly record snowfall brought with it the first instance for the new administration to view some of Rhode Island's emergency management mechanisms set in motion.

The remainder of this annex describes the observations, findings, and recommendations related to Rhode Island's emergency management system and operations, organized into the following six sections:

- Section 1 – Initial Response
- Section 2 – Command, Control, and Coordination
- Section 3 – Policies, Plans, and Procedures
- Section 4 – Facilities and Technology
- Section 5 – Organization and Staffing
- Section 6 – Training and Exercises

SECTION 1 – INITIAL RESPONSE

Observations

Alert and Notification

Under normal emergency management system protocols, in the wake of a catastrophic mass casualty event, one would expect certain planned actions to occur within the context of an established emergency management system. Key personnel would be contacted using cascading telephonic notification schemes or similar communications protocols and devices. The designated level of alert would dictate the location to which individuals would report and the initial actions to take. In the case of the West Warwick Station club fire, such protocols for initial notification were not implemented. The magnitude of the event, its toll in human lives and suffering, the proliferation of cellular telephones, and the pervasiveness of public media combined to rapidly spread the news to responders and citizens alike that a catastrophic life-threatening fire was in progress.

WPRI-TV Channel 12

Disoriented burn victims, patrons who had managed to exit the club safely, and bystanders look on as fire engulfs the Station club.

Mr. Senerchia, the West Warwick emergency management director, was at home on the night of February 20, 2003. A ham radio operator, he was monitoring the local police dispatch channel. Shortly after 11:00 p.m., he heard the initial report that there was a fire at the Station club. By 11:20 p.m., Mr. Senerchia was at the scene, which was crowded with emergency vehicles, disoriented burn victims, other patrons who had managed to exit the club safely, and growing numbers of bystanders. Observing that victims were receiving medical treatment at the Cowesett Inn across the street from the Station club, he made his way in that direction and reported to Captain Greg Johnson of the West Warwick Police Department (WWPD). He did not want to interfere with Fire Chief Charles Hall, who was directing fire and rescue operations from a location near the entrance to the club.

Scene at the Cowesett Inn

The Cowesett Inn had already become a gathering place for burn victims and family members and friends searching for others who might have survived. With the aid of Mr. Todd Manni and other emergency management team members from nearby Smithfield, Mr. Senerchia helped establish the initial victim information hotline in a relatively quiet room on the second floor of the Cowesett Inn. Local radio and television stations immediately began broadcasting the Cowesett Inn telephone number. He also made a joint decision with Captain Johnson to call RIEMA. A WWPD officer radioed and asked the dispatcher to call RIEMA. By 1:00 a.m., volunteers from the ARC, The Salvation Army, and members of the clergy were helping with the hotline, offering comfort to victims and family members, and providing food for the first responders and others gathered at the scene.

RIEMA Alert

Mr. Scappaticci, executive director of RIEMA, learned about the fire when he received a telephone call from his daughter. Mr. Scappaticci followed the situation on local television as it was unfolding, and engaged in telephone conversations with Mr. John Aucott, RIEMA terrorism/ weapons of mass destruction (WMD) program manager. Shortly after midnight, Chief Randy Parrott, an Emergency Medical Services (EMS) officer from Coventry, one of the mutual-aid units working at the incident, called Mr. Scappaticci, briefed him on the situation, and asked that local hospitals be contacted to determine the availability of beds to receive burn victims. Additionally, body bags and communications capabilities were needed at the incident site. Mr. Scappaticci called Mr. Aucott and directed him to call Chief Parrott at the scene. Mr. Aucott next called the Cranston Fire Alarm dispatch center and asked that they activate the hospital communications system and determine available capacity. He was told that it was unnecessary because all victims would be sent to Rhode Island Hospital.

Mr. Scappaticci also notified General Centracchio of the incident and called Mr. Wayne Farrington, the Rhode Island Department of Health's (RI Health's) on-call representative, to inform the Rhode Island medical examiner of the gravity of the situation. His next telephone call alerted Ms. Diana Arcand, RIEMA operations chief, of the possibility that West Warwick responders may need to use RIEMA facilities and instructed her to await further instructions.

Notifying the Governor's Office

At about midnight, General Centracchio telephoned Mr. Kenneth McKay, Governor Carcieri's chief of staff, and told him about the fire. Governor Carcieri was in Florida at the time. After a brief discussion, the adjutant general recommended that Mr. McKay go to the incident site. Mr. McKay called Mr. Clark Greene, the deputy chief of staff, who had already learned about the fire from Rhode Island State Fire Marshal Jesse Owens. Mr. Greene worked with the previous administration. The policy under the previous governor designated the deputy chief of staff as the emergency point of contact (POC) with the Governor's Office, so it was Mr. Greene's telephone number that Fire Marshal Owens carried. Mr. McKay picked up Mr. Greene and proceeded to the fire scene where the governor's communications director, Ms. Laurie White, joined them.

Notifying the Lieutenant Governor

About 1:15 a.m., General Centracchio telephoned Lieutenant Governor Charles Fogarty and briefed him on the situation. He told Lieutenant Governor Fogarty that the governor had been advised of the incident and was making arrangements to return to Rhode Island as quickly as possible. General Centracchio advised him to wait a few hours before coming to the incident site because of the turmoil of ongoing rescue operations.

Discussions at the Fire Scene

Mr. Scappaticci met Mr. Aucott at RIEMA HQ and loaded the body bags and 40 Nextel telephones in his car. They proceeded to West Warwick, along with Mr. Nathan Rodgers, a RIEMA domestic preparedness planner. By the time Mr. Scappaticci arrived at the incident site, around 1:45 a.m., the fire was extinguished. He reported to Chief Hall that he had with him the additional cache of body bags. Along with Mr. Aucott, he then joined Fire Marshal Owens, Governor Carcieri's Chief of Staff McKay, Deputy Chief of Staff Greene, Governor's Communications Director White, Mr. Senerchia from West Warwick, and others who were conferring

upstairs in the Cowesett Inn. Mr. McKay called Governor Carcieri in Florida and briefed him on the situation.

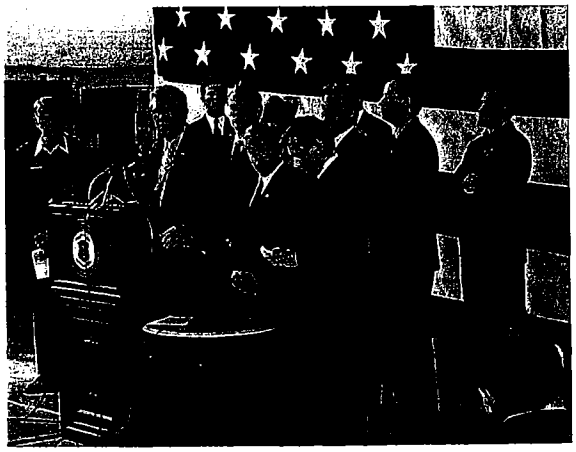
As it became increasingly apparent that this tragedy was even more extensive than originally perceived, Mr. Scappaticci reports that he called Dr. Elizabeth Laposata, the chief medical examiner, at her home twice in the early hours of Friday morning and recommended the need for more senior OME personnel on site.

Decisions Regarding Extended Support Operations

RIEMA had participated at the Family Assistance Center (FAC) established by the ARC following the crash of EgyptAir flight 990 approximately 50 miles off the coast of Nantucket in October 1999. Based on that experience, Mr. Aucott facilitated a forward planning discussion at 2:30 a.m. at the Cowesett Inn about how operations in response to the Station club fire might proceed. As a result Mr. Nick Logothets of the American Red Cross of Rhode Island (ARC RI) and Mr. Scappaticci decided to move the family support activities away from the incident site. The group also decided to relocate the victim information hotline to RIEMA HQ and to expand its operations. Mr. Aucott asked Mr. Greene to contact the Crowne Plaza Hotel, which was a convenient distance from the site, believing that a call from the Governor's Office might carry more weight. The on-duty night auditor called the hotel general manager, Mr. Rudi Heater, at 2:36 a.m. After checking on other facility commitments, he readily volunteered the Crowne Plaza Hotel facilities for the FAC. RIEMA offered to activate a hotline capability that had been included in operations plans and previously exercised. West Warwick accepted the offer. Ms. Arcand at RIEMA HQ was told to prepare to host the West Warwick victim information hotline. Both the FAC and hotline support began operations at their new locations at 5:00 a.m. on Friday, February 21.

Media Management

Media equipment and journalists began converging on the scene shortly after the fire was reported. Police managed to contain most of the press vehicles and broadcast equipment in the parking lot of a nearby Texaco Station, which became the initial location for the release of information to the public. Town Manager Wolfgang Bauer and others, including Lieutenant Governor Fogarty, who had arrived at the site around 6:00 a.m., met periodically with the press throughout the early morning. At a 7:00 a.m. news conference at the Texaco Station, Fire Chief Hall spoke directly to the press for the first time since the fire erupted.



Governor Carcieri briefs the media.

Joint Information Center

Governor Carcieri returned from Florida at about 10:00 a.m. on Friday, February 21, and went directly to the incident site. After touring the remains of the Station club, the governor was briefed at the Cowesett Inn by several members of the response community. At about 11:00 a.m., he met with the press at the Texaco Station. The governor spent the remainder of the day shuttling between the West Warwick fire scene, the FAC at the Crowne Plaza Hotel, and

the Rhode Island medical examiner's facilities gathering information, giving instructions to responsible officials, and attempting to comfort relatives of victims. Media representatives followed Governor Carcieri from site to site as he assumed the role of incident spokesperson. Periodically, the governor's staff announced when and where he would next meet with the press. To better manage the release of public information, Ms. White, the governor's communications director, assisted by Lieutenant Colonel Mike McNamara of the Rhode Island National Guard, established a Joint Information Center (JIC) on Saturday morning, February 22. Located at Schofield Armory, adjacent to the National Guard Command Readiness Center and RIEMA HQ, the JIC remained in operation during recovery activities.

Activities at RIEMA Headquarters

Ms. Arcand, RIEMA operations officer, arrived at RIEMA HQ at about 2:45 a.m. on February 21 and began contacting key staff members. At 3:30 a.m., she received a call from Mr. Scappaticci at the incident site instructing her to prepare to host the West Warwick victim information and tracking operations, including the information hotline, at RIEMA HQ. It was emphasized that this would be a West Warwick operation using RIEMA facilities and staff support. Ms. Arcand immediately contacted the Rhode Island Department of Corrections (RI DOC), which provides telephone support to the RIEMA HQ complex. The RI DOC responded immediately, dropping additional telephone lines into the RIEMA work area. At 5:00 a.m., the hotline operation was transferred from the Cowesett Inn to RIEMA HQ. As RIEMA staff members arrived for work that morning, they joined ARC volunteers from the Korean War veterans organization answering hotline telephone calls. By 8:30 a.m., the hotline was fully functional. It was eventually staffed at 35 workstations after expanding into the EOC planning area at about 1:00 p.m.

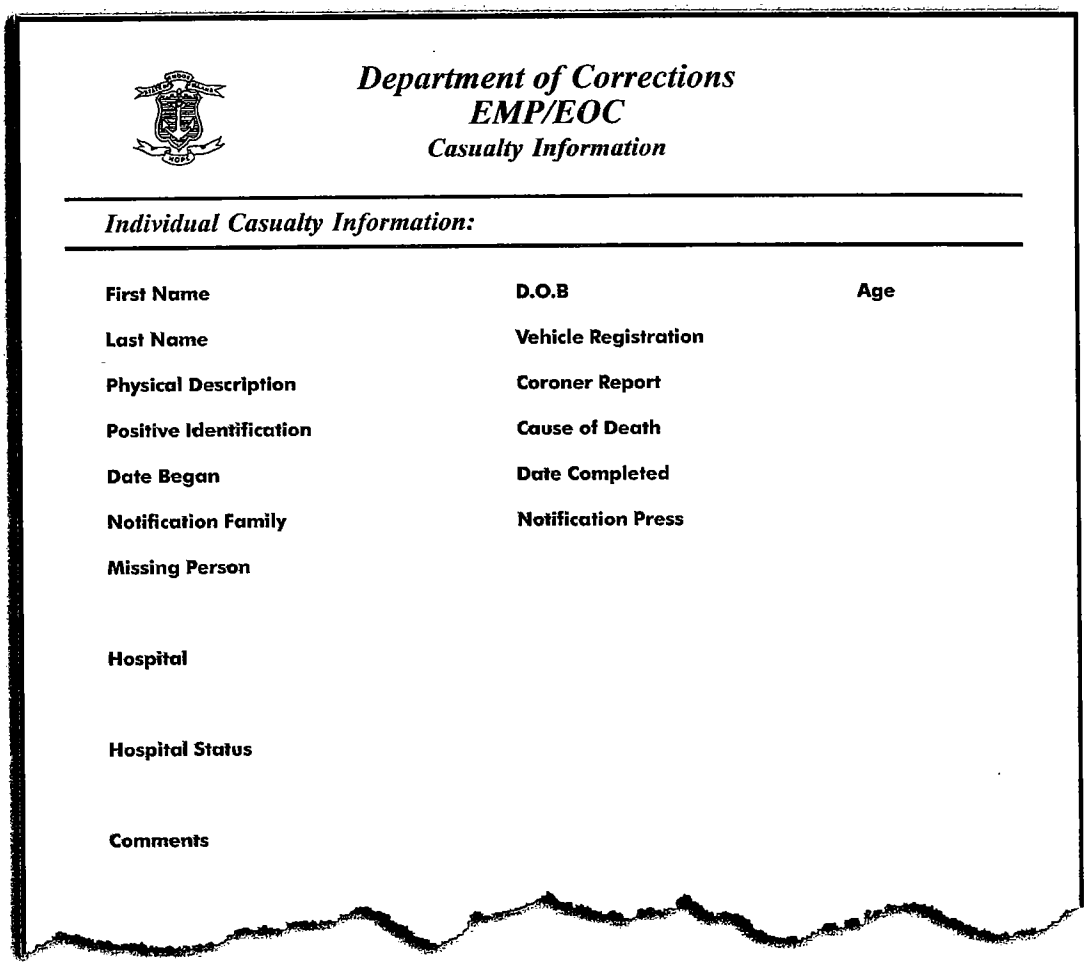
Gathering Victim Information

Initially, the task of hotline operators was to collect the names of possible victims based on telephone calls from family members and friends. As operations continued, it became a more proactive information-gathering activity. Governor Carcieri appeared on television to ask anyone who had been present at the Station club to call the hotline, where operators recorded their names and asked about others with whom they might have traveled or who they might have seen at the club. This was combined with other information gathered by the WWPD based on missing person reports and on registration data belonging to the automobiles found in the Station club parking lot. Mr. Armand Randolph and Mr. Rodgers, both RIEMA contract employees at the time, compiled and disseminated the accumulating victim information.

Victim Information Database

Mr. James Berard, the RI DOC associate director of management information systems, arrived at RIEMA HQ at about 7:00 a.m. on Friday morning. Mr. Berard had been authorized by RI DOC Director Ashbel T. Wall to offer any assistance needed to help respond to the tragedy. Surveying the situation, he noted that RIEMA was not using any form of emergency management software. Additionally, HQ was not connected to the Rhode Island State computer network. He offered to bring in the software used in the RI DOC EOC and to develop an information-tracking system for the data being collected and tabulated at HQ (see **Figure D-3**). The tracking system database produced 20 different information tables, 23 reports, and supported 16 different queries. The RI DOC technical staff quickly discovered that the RIEMA desktop computers were incompatible with the EOC software. As an alternative, they brought in RI DOC computers and built the database from scratch, working nonstop for nearly 24 hours, then transferred it to the workstation of Mr. Randolph, replacing the initial Microsoft Excel

spreadsheets developed and used by Mr. Randolph and Mr. Rodgers to maintain the data for RIEMA.



Department of Corrections
EMP/EOC
Casualty Information

Individual Casualty Information:

First Name	**D.O.B**	**Age**
Last Name	**Vehicle Registration**	
Physical Description	**Coroner Report**	
Positive Identification	**Cause of Death**	
Date Began	**Date Completed**	
Notification Family	**Notification Press**	
Missing Person		
Hospital		
Hospital Status		
Comments		

Figure D-3. Sample victim information report format.

Family Assistance Center

Concurrently, Ms. Barbara McGann, executive director of the ARC RI, and Mr. Aucott of RIEMA established the FAC at the Crowne Plaza Hotel, beginning operations at 5:00 a.m. on Friday morning, February 21, 2003. A unified ARC-RIEMA command center was the focal point of the FAC. Governor Carcieri visited the FAC frequently and briefed the waiting families. As additional victims were identified or individuals reported missing were found in area hospitals, updated victim information reports were transmitted by fax from RIEMA HQ to the Crowne Plaza Hotel. Family members of deceased victims were identified and notified in private by a team of three or more persons, usually from RI Health, ARC, and WWPD, as well as a clergy member. Grief counseling and other forms of family support were immediately available, including spiritual care offered by volunteer faith groups. The Crowne Plaza Hotel management and staff provided everything that the ARC and RIEMA requested to support the FAC, including three meals each day for every family member.

Transition to the Family Resource Center

On Monday morning, February 24, trained grief counselors replaced the volunteers and RIEMA staff members answering hotline telephones at RIEMA HQ. By Tuesday almost all of the victims had been identified and families informed of their fate. Plans were made to transition to a recovery phase. A Family Resource Center (FRC) was established at a former Daewoo automobile dealership about 2 miles from the incident site. In coordination with the West Warwick Emergency Management Agency (WWEMA) and West Warwick Department of Human Services (WW DHS), Ms. Jane Hayward, director of the Rhode Island Department of Human Services (RI DHS), and Mr. Aucott assembled representatives of every agency and organization that could offer assistance to the surviving family members. Mr. Peter Todd of RIEMA transformed the large, empty automobile showroom into a working office complex, again with support from several vendors and from the RI DOC, which provided furnishings, partitions, and other items. The FAC at the Crowne Plaza Hotel shut down at about 6:00 p.m. on Tuesday, February 25, and the FRC opened at the former car dealership at 10:00 a.m. the following morning. Staffed by more than a dozen organizations, the FRC provided a complete range of administrative, legal, educational, and counseling services for survivors. The RI DOC also constructed a family support management database using parameters defined by RIEMA's Ms. Michelle San Souci and Mr. Paul Lupoli and provided on-site data entry and technical support. Eventually this system contained 12,986 records.

West Warwick Photo

A Family Resource Center was established at a former Daewoo automobile dealership.

Closing Out the Hotline

The victim information hotline began phasing out on February 26 and was shut down at 4:30 p.m. on February 28, with an announcement referring further inquiries to the FRC. RIEMA HQ resumed normal operations on that same date. In 8 days, the hotline received 18,313 calls. Additionally, the ARC RI received 4,500 cellular telephone disaster welfare inquiries. The FRC continued to function until March 14, after which family support has been provided directly by each responsible organization. Detailed information about the operations of the FAC and FRC can be found in Annex F – Family Services and Support.

Findings and Recommendations

EMSO-001 RIEMA and WWEMA accomplished a limited response to this incident in a timely manner, but not through planned and established alert, notification, and response procedures. Systems to alert key agencies and officials and to activate preestablished rapid response teams were not in place at the time of this incident. RIEMA, like other Rhode Island government agencies, uses a commercial answering service for after-duty notification rather than having a 24-hour on-duty presence. Although emergency management agencies are not first response organizations, systems should be in place to accomplish rapid and organized responses to support on-scene operations.

RIEMA should establish a 24-hour watch and communications center to serve as the primary entry point for all non-law enforcement emergency communications to State government. Adequate plans for alert, notification, and response should be developed and regularly exercised.

EMSO-002 Existing EOPs did not guide operations during the initial response at State or local levels. Although this was a very localized incident, the complexity of response and recovery actions and the probable extent of outside agency involvement were apparent early during the response and rescue phase and would most likely have justified EOP implementation at State and town levels.

State and local EOPs, properly maintained and frequently exercised, should be used early to support all emergency and disaster operations involving multiple jurisdictions and agencies.

EMSO-003 Governor Carcieri and his executive staff were new to government service and had only brief exposure to the emergency responsibilities associated with State government. Fortunately, Mr. Greene, assistant to the Governor's Chief of Staff, had served in the same position during the previous administration and was a familiar figure to many key officials responding at the incident scene. Other members of the executive staff had to introduce themselves and, at the same time, develop working relationships with officials from other parts of the State government and from other jurisdictions.

Each time a new administration assumes office, the governor, key executive staff members, and newly appointed cabinet officers must receive a thorough and detailed emergency management indoctrination. Notification procedures should be updated immediately and distributed throughout the emergency management community. This should be the responsibility of the RIEMA director.

EMSO-004 The lack of interoperable communications systems posed substantial challenges for all responding agencies. Although cellular telephone and Nextel communications were used to contact key emergency management individuals and agencies, these systems are inadequate substitutes for integrated interoperable public safety voice and data communications systems. Mr. Scappaticci, RIEMA executive director, and Mr. Aucott reported to the incident scene with critical resources, specifically body bags and Nextel radios. The 40 Nextel radios, delivered to the site and offered to Incident Command by RIEMA, were not distributed or used, despite the prevailing communications deficiencies.

Rhode Island should establish and maintain a Statewide interoperable voice and data communications system for use by all State and local public safety and emergency response agencies.

EMSO-005 Neither the West Warwick EOC nor the Rhode Island EOC was activated during this event. Although State EOC activation procedures exist, they are outdated, describing RIEMA EOC facilities and capabilities that were in place at the Rhode Island State House before relocating RIEMA in 1996.

RIEMA should update the EOC activation procedures so that they are consistent with existing facilities and capabilities as long as RIEMA occupies those facilities.

EMSO-006 There are no established policies for classifying levels of disaster based on the disaster intelligence (e.g., minor, major, catastrophic) that would automatically trigger EOC activation.

RIEMA should develop and coordinate with local governments an EOC activation protocol based on escalating levels of disasters and emergencies.

EMSO-007 The Rhode Island Mass Casualty Disaster (MCD) Plan was not implemented. It specifically calls for the "activation of the EOC in the affected community" to "serve as the emergency management point of operations management, offering communications and coordinating services."

Rhode Island should establish provisions or trigger mechanisms for the timely implementation of the MCD Plan.

EMSO-008 RIEMA had developed a Nextel-based hospital communications network for use during mass casualty events, which was intended to be a complementary and redundant communications asset to the Hospital Emergency Administrative Radio (HEAR). These systems were not used, even though RIEMA requested activation by the Cranston Fire Alarm dispatch center. Failure to facilitate communications between the State's hospitals resulted in unnecessary confusion and ineffective use of critical medical resources.

The Nextel-based hospital communications system should be used any time that an incident involving significant casualties occurs. Even if the bed capacity appears to be adequate, the nature of injuries and required treatment may not be immediately obvious. The system should be used not only to notify hospitals about an emergency circumstance but also to apprise them regularly of evolving medical developments.

EMSO-009 Information about surviving burn victims was obtained from area hospitals, both by direct telephone calls from RIEMA HQ and through RI Health. Initial attempts to obtain patient treatment information directly from the hospitals by telephone were stymied because hospital staff were unfamiliar with RIEMA personnel, could not verify their identity, and, in the absence of an official emergency declaration, faced stringent privacy barriers.

Protocols should be developed that permit the judicious dissemination of patient treatment information during emergency situations to legitimate government authorities, including designated RIEMA officials.

EMSO-010 Governor Carcieri was particularly concerned about the length of time it was taking to identify those who died in the fire. Mr. Gary Kleinman, the U.S. Department of Health and Human Services (HHS) regional coordinator for Rhode Island, who was already present at the Rhode Island medical examiner's facilities, advised Mr. Andy

Hodgkin, the governor's executive counsel, that a request for help from HHS could be quickly acted on. At about 6:00 p.m. on February 21, Governor Carcieri called Assistant Secretary Jerome Hauer at HHS and requested that a Disaster Mortuary Operational Response Team (DMORT) be dispatched to help the Rhode Island medical examiner. It arrived the following day. Usually such a request would have been made through RIEMA to the Federal Emergency Management Agency (FEMA) Regional HQ.

A formal process should be established to determine requirements and request emergency support assets from the State and from the Federal Government, as well as from private organizations that provide disaster services.

EMSO-011 In this situation, it is possible that the early deployment of a mobile command post, along with a trained and equipped mass causality team, might have been beneficial. However, with limited staff resources, RIEMA did not have a qualified rapid response team and its mobile command post, a 1988 Ford box truck badly in need of replacement, was not deployed. An adequate capability might have been available from elsewhere through the Emergency Management Assistance Compact (EMAC) or other mutual-aid arrangements. However, there is not an established process for determining support that might be needed from other organizations and agencies.

RIEMA should establish trained rapid response teams to deploy to incident scenes or to local EOCs and support impacted communities during emergencies or disasters.

EMSO-012 Mutual-support agreements between neighboring jurisdictions in Rhode Island, except for fire department mutual aid, are informal and based largely on personal and professional relationships, not on official written protocols. The advantage of Rhode Island's small size is that interpersonal relationships are extensive, particularly within professional disciplines. The disadvantage is that these relationships tend not to be recorded in written documents. They are therefore not regularly reviewed and tested. Arrangements based primarily on personal relationships depend entirely on the availability and cognizance of the responsible parties at the time that an incident occurs.

The State, in coordination with local governments and appropriate private organizations, should develop a comprehensive Statewide mutual-aid compact to facilitate rapid intra-State mutual aid for all hazards among all jurisdictions and emergency functions.

EMSO-013 Rhode Island has enacted, and is a signatory to, EMAC. EMAC is a mutual-aid agreement approved by Congress in 1996 that enables member States to seek help from other member States during an emergency for which they are subsequently reimbursed. Currently 48 States, the District of Columbia, and two Territories have ratified EMACs. In this instance, Rhode Island submitted two requests for EMAC assistance. One resulted in obtaining the services of Mr. Alex Amparo from Florida, a qualified donation management coordinator. The second request was for an

Incident Management Assistance Team. Ms. Joan Roche and a five-member team from Massachusetts, which worked at both the FAC and FRC, filled this requirement. However, Rhode Island has not developed and institutionalized operational procedures to quickly identify requirements for outside support and fully use EMAC provisions. The current outdated RIEMA EOP contains a generic critical resource list, but Rhode Island does not have established and clearly understood processes for identifying, requesting, and tracking the locations and use of emergency support resources.

RIEMA should develop operational procedures to determine requirements and for requesting and receiving inter-State mutual-aid assistance through the EMAC. These procedures should be incorporated in the Rhode Island EOP.

SECTION 2 – COMMAND, CONTROL, AND COORDINATION

Observations

Command, Control, and Coordination Expectations

Emergency exercises that test MCD response usually follow a predictable sequence. Key officials are notified of the simulated event. First responders establish an Incident Command Post (ICP) at the site of the emergency. EOCs are activated at the host and possibly at supporting jurisdictions. A forward EOC is often deployed to the incident site to better coordinate support for the response force. In many cases this is a mobile command post. Information is gathered at each level and transmitted among the command entities. Situation and status reports are routinely posted and leadership briefings conducted regularly. Decisions are made and instructions disseminated. The responsible chief executive officer (CEO) (the mayor or city manager, county manager, governor, or president) uses this emergency management system to direct recovery operations and, to the extent possible, restore pre-emergency conditions.

Localized But Tragic Event

During the early morning following the fire at the Station club, its magnitude and ultimate impact were uncertain. The area of physical impact was small and self-contained, literally within a space of about 90,000 square feet. The sirens of arriving fire apparatus and departing ambulances could be heard throughout the surrounding neighborhood, but community services were never interrupted. It was clearly a tragic but localized event in which the surrounding area was physically unaffected. The initial fatality reports were startling, but not staggering. Approximately 15 people were confirmed dead by 11:30 p.m.

From the beginning, RIEMA leadership viewed this as a local West Warwick event that would require resource support from the State, but over which West Warwick would retain direct control. As a result, the Rhode Island EOC was never activated. The facilities were opened and staffed, but not in the context of an EOC. Instead, RIEMA office space and the EOC planning area functioned as a center for collecting and tabulating victim information under the leadership of the WWPD.

Communications from the Incident Site

Mr. Scappaticci, RIEMA's executive director, spent the first several hours at the incident site, but primarily in a liaison capacity to the West Warwick leadership team at an informal command post established at the Cowesett Inn. RIEMA has a mobile command post but it was not deployed. Cellular telephones were used as the primary means of communications.

RIEMA mobile command post.

Opening RIEMA Headquarters

When Ms. Arcand, RIEMA operations chief, arrived at RIEMA HQ to prepare the facility for operations, the first staff members she telephoned were Mr. Todd and Mr. Larry Macedo. She did so not because their job titles implied specific responsibilities during emergency operations or because of call-up instructions in a RIEMA plan or standard operating procedure (SOP). According to the outdated RIEMA staff titles, Mr. Macedo is a civilian protection relocation

specialist and Mr. Todd is the Rhode Island radiological defense officer. Ms. Arcand contacted Mr. Todd and Mr. Macedo because she knew they had the knowledge to assist in setting up the additional telephone lines.

As RIEMA staff members arrived at HQ to begin the workday on Friday, February 21, 2003, they discovered much ongoing activity. RI DOC staff, under direction of Mr. Clarence Burrius, continued adding additional telephone lines to expand the victim information hotline, which was already operational. Some members of the RIEMA staff were immediately assigned to join the Korean War veterans already answering hotline telephone calls. The WWPD was researching data about the automobiles that had been towed from the Station club parking lot. In general, there was a great deal of activity but little visible organization or leadership.

Multiple Command and Control Activities

Command and control functions were exercised by different organizations at different locations throughout the response and recovery operations. The West Warwick Fire Department (WWFD) maintained the ICP until fire and rescue operations were concluded. The WWPD controlled access to the site and subsequently commanded the crime scene. The WWPD also directed victim information collection efforts at RIEMA HQ and participated in next-of-kin notification. The ARC RI participated with RIEMA in a highly effective Unified Command at the FAC. Subsequently, the RI DHS and RIEMA collaborated in directing the FRC operations. On Friday, RI Health activated its own command post to coordinate hospital information dissemination and manage department support for the OME and the FAC.

Executive Leadership

Governor Carcieri was new in office and would have benefited from a more structured and rigorous process for obtaining operational information and advice from experienced practitioners. The governor brought a hands-on style to the scene and collected information in real time as he traveled from site to site. On two occasions, because the governor had more current information, families at the FAC, awaiting news regarding loved ones, watched as he announced a different fatality count on television than what had been most recently posted at the FAC. This was corrected by ensuring closer coordination between the governor's staff and the FAC.

Traveling from one location to the next, the governor asked questions of individuals, taking notes on 3" x 5" cards. He used this information when he met with the press and to guide follow-up discussions with the officials who provided him with the information. In this manner, he imposed a degree of discipline over the otherwise disparate components of the Rhode Island emergency management system.

In a telephone conversation with Governor Carcieri at about 6:00 p.m. on Friday, February 21, HHS Assistant Secretary Hauer agreed to immediately dispatch a Federal DMORT to Rhode Island. He also asked one of his assistants to travel to Rhode Island and offer the governor whatever assistance was needed in response to the tragedy. Mr. Tim Brown, a former New York City firefighter and a survivor of the September 11, 2001, World Trade Center attack, arrived in Rhode Island on Friday night. He seldom left the governor's side during the following 10 days.

Findings and Recommendations

EMSO-014 The Rhode Island General Laws state that "an executive order or proclamation of a state of disaster emergency shall activate the state and local disaster emergency plans applicable to the political subdivision or area in question and shall be authority for the deployment and use of any forces to which the plan or plans apply and for the use or distribution of any supplies, equipment, and materials and facilities assembled, stockpiled, or arranged to be made available." Neither the town of West Warwick nor the State of Rhode Island issued an emergency proclamation, although Governor Carcieri did request that President George W. Bush declare the State of Rhode Island a disaster area, which would therefore make it eligible for presidential disaster funds.

Rhode Island government leaders at State and municipal levels should use the lessons learned from this experience to assess the circumstances under which the declaration of emergency conditions is prudent and beneficial. It is possible that situations will occur in the future that might similarly challenge government leaders and will not necessarily have readily apparent and easily measurable trigger mechanisms.

EMSO-015 There are important implications of not issuing a formal emergency declaration. Without these declarations, there could be a presumption that West Warwick and Rhode Island had the capacity to manage the response to, and recovery from, this event without seeking external aid.

Rhode Island should initiate a detailed review, in conjunction with FEMA, of the factors bearing on decisions regarding declarations of a disaster emergency at State, local, and Federal levels and the implications of those decisions.

EMSO-016 Although the Incident Command System (ICS) was used at the incident scene by the WWFD and most capably executed by Chief Hall, an integrated Unified Command was not evident. The ICP and the informal West Warwick command post at the Cowesett Inn were in close proximity to each other, resulting in general coordination and exchange of information. However, they lacked the necessary systems to effectively collect, analyze, and manage critical information regarding victim tracking, resource management, and validation of information to support public information requirements.

Rhode Island should require State and local government emergency organizations to adopt the principles of an Incident Management System and integrate a commonly accepted concept of operations into all EOPs, procedures, and policies.

EMSO-017 West Warwick did not activate its EOC at the Town Hall. Requests for external assistance were made either from the ICP or West Warwick command post, both of which were located in the immediate proximity of the incident. This approach limited the opportunity to organize and conduct future operations planning and to consolidate information and produce situation reports for decisionmakers.

RIEMA should develop and institute scalable EOC activation procedures to simplify and standardize decisionmaking regarding the use of State and local EOCs.

EMSO-018 In the first several hours, news of the event precipitated an extraordinary response from local agencies and volunteer organizations that arrived at the town of West Warwick to provide assistance. Coupled with the mutual-aid assistance requested from neighboring jurisdictions, this produced an exceptionally large pool of response and humanitarian relief resources. These resources could have been more effectively used across the entire spectrum of the response and recovery phases if there had been a State Forward Emergency Operations Center (FEOC) and if a Unified Command had been established.

RIEMA should develop rapid response teams, procure a modern deployable command post, and institute procedures for routinely establishing an FEOC to better support disaster response operations.

EMSO-019 When Governor Carcieri returned from Florida and arrived at the incident scene, he found many people and agencies involved in response and recovery activities, but no one in charge. Written status reports were not regularly generated and provided to the governor. There was no single individual to whom the governor could turn for information and there was not a representative of the Governor's Office at RIEMA.

RIEMA is responsible for serving as the governor's principal source of advice and information during emergency response and recovery operations. Even if the RIEMA EOC is not activated, RIEMA should take the lead in providing the governor and other senior officials with regular, coordinated information briefings and written status reports. This would also ensure a State-level record of events after the emergency is contained.

EMSO-020 Public information management was accomplished in a fragmented manner during the first several hours following the fire. Impromptu media demands frequently plagued State and local officials who were not always completely informed of the entire scope of the operation. Delays in establishing a JIC, which opened on Saturday, February 22, compounded this common challenge.

As soon as evidence suggests a high level of sustained media interest in an unfolding emergency event, the JIC should be established. All State agencies should be immediately appraised of the JIC location and the schedule for press briefings and conferences.

EMSO-021 Information was being collected from area hospitals at different locations, specifically at RIEMA HQ and also at the Crowne Plaza Hotel FAC. On Saturday morning, February 22, a member of the governor's staff visited both locations and noted significant discrepancies in the numbers of patients reported being treated at area hospitals. Governor Carcieri was advised not to talk about hospitalized victims until these discrepancies were resolved. The data accumulated from hospitals by the RI Health staff at the FAC proved more up-to-date than the data received at RIEMA HQ.

A single agency should be held accountable for the accuracy of all information provided to decisionmakers so that conflicting data is not released to the public or presented to distressed family members.

EMSO-022 Resource management requests and tracking were accomplished in an ad-hoc fashion. Some resources, such as the 40 Nextel telephones that were delivered to the incident site by RIEMA, were never used and interoperability among responding agencies was never achieved.

RIEMA should develop a resource management system to include a State maintained critical resource database, procedures for requesting and tracking needed resources, and the integration of supplied resources into local operations.

EMSO-023 There has not been a systematic and comprehensive internal assessment of command, control, and decisionmaking responsibilities and procedures associated with the Station club fire response and recovery operations.

RIEMA should conduct an internal detailed multiagency review of command and control activities at State and municipal jurisdictions after major operational events to ensure deficiencies are identified and improvements implemented.

SECTION 3 – POLICIES, PLANS, AND PROCEDURES

Observations

Risk of Disaster

We live today in an increasingly risky environment. Many communities face the recurring periodic threat of large-scale natural disasters. Residents and visitors to coastal areas take special precautions during hurricane season. Those who live in "tornado alley" have more precise weather-tracking systems today that offer earlier warning of dangerous conditions and greater opportunity to escape harm's way. Earthquakes are less predictable, though potentially high-risk areas are well known and safety precautions well publicized and frequently practiced. Technological accidents are still less predictable, but the source of potential danger is sometimes relatively apparent—the nearby nuclear power plant, oil refinery, or chemical manufacturing facility. Frequent inspections of environmental and regulatory compliance reduce the likelihood of technological accidents, but do not eliminate them. None of us, however, can predict the random occurrence of a purely accidental and unintended catastrophic event that claims large numbers of lives, destroys property, and damages critical infrastructure. Moreover, every community must now be alert to an entirely new threat, the intentional coordinated execution of a terrorist attack on a target chosen simply because of its symbolic value or because it is densely populated with unsuspecting innocent citizens.

Need for Coordinated Planning

When a significant disaster occurs, regardless of its cause, local governments with jurisdictional authority are first to respond. But in the aftermath of many major disasters, State and Federal resources are required to supplement those available to local governments. Neighboring communities and adjacent States may also be asked for help. Therefore, all levels of government must develop and maintain coordinated emergency policies, plans, and procedures to perform integrated emergency response and recovery activities when required.

Rhode Island Statutory Provisions

Title 30 of the Rhode Island General Laws charges the governor with responsibility of preparing a comprehensive program for disaster response and recovery. This program is to be integrated into, and coordinated with, those of other States and the Federal Government to the fullest extent possible. Emergency preparedness plans and programs of the political subdivisions of the State are also to be integrated into and coordinated with the State disaster plan and program.

The Rhode Island General Laws further provide that the governor may delegate any administrative authority vested in him. The lieutenant governor chairs the RIEMAC. RIEMAC is charged with advising the governor and the adjutant general on all matters pertaining to disaster and emergency preparedness. RIEMA, headed by the adjutant general, has been designated by the governor to carry out the program for disaster preparedness. The adjutant general is responsible for coordinating the emergency preparedness activities of all organizations within the State, and for maintaining liaison and cooperating with disaster agencies and organizations of other States and of the Federal Government. RIEMA has developed, and is charged with maintaining, the Rhode Island EOP and its supporting policies and procedures. RIEMA is also responsible for coordinating the development of complimentary municipal EOPs. RIEMA administers Federal

emergency management planning grant funding to help municipalities develop and maintain EOPs.

Findings and Recommendations

EMSO-024 The existing Rhode Island statutory provisions that define the governor's emergency preparedness authorities and responsibilities do not reflect current circumstances and requirements. The Rhode Island General Laws establish the governor's authority to issue regulations related to emergency management. However, regulations containing specific emergency management guidance for State agencies and municipalities are not in place.

The Rhode Island Governor's Office and the Rhode Island Legislature, in coordination with RIEMA and the U.S. Department of Homeland Security (USDHS), should review all statutes relating to emergency powers and emergency management in Rhode Island and modernize the existing provisions of law related to these areas.

EMSO-025 RIEMA does not have a written emergency management policy statement that describes its enabling authority, management policies and procedures, strategic planning requirements, budgetary process, and administrative practices to ensure program continuity and viability.

In coordination with RIEMAC, RIEMA should prepare a comprehensive emergency management policy statement that provides a broad overview of associated authorities, responsibilities, programs, planning requirements, budgetary process, and administrative practices.

EMSO-026 The Rhode Island EOP does not reflect current operational circumstances. It was promulgated by former Governor Lincoln Almond on January 25, 1995, and last officially revised on August 20, 1996. It describes key missions and functions of designated agencies but does not use the generally accepted concept of ESFs, which are incorporated in the FRP. The FRP was adopted by 25 Federal agencies in April 1992. The ESF concept is the foundation of many State and local EOPs throughout the country. A new National Response Plan (NRP) is under development and changes are anticipated, some of them fundamental. However, anticipating change is not a valid reason for failing to update and modernize obsolete emergency preparedness plans. The draft Terrorism Annex, which was added to the Rhode Island EOP on January 9, 2002, better reflects currently accepted emergency preparedness planning standards.

RIEMA should develop an aggressive emergency management planning initiative in coordination with State agencies that have primary roles in emergency management and with all 39 local jurisdictions to address EOP revisions. Consideration should be given to adopting the planning principles embodied in the FRP and its successor, the NRP. The RIEMA draft Terrorism Annex may serve as a useful model for revising other annexes of the current EOP.

EMSO-027 The current status of Rhode Island State and municipal emergency plans, policies, and procedures is emblematic of a serious deficiency in emergency preparedness oversight and review. RIEMA is committed to a thorough update of the Rhode Island EOP. Unless an effective review process is concurrently implemented, the new EOP is destined to erode and eventually become obsolete. The activities of RIEMAC as specified by law include reviewing emergency plans.

RIEMAC should consider instituting procedures for regular reviews of EOPs at each jurisdictional level. Although RIEMA might reasonably be tasked to review municipal EOPs, an independent entity should be charged with the regular review of the Rhode Island EOP to ensure it is routinely updated and synchronized with other State agencies and Federal emergency preparedness programs.

EMSO-028 Physical security was problematic for several hours after operations began at RIEMA HQ. Located inside the National Guard Command Readiness Center, there was already a large constituency with legitimate access to the building, but who didn't need to know the highly sensitive victim-related information that was collected, discussed, and openly displayed in the RIEMA office complex. Locks on the two office area doors provided the only protection from inadvertent disclosure, but the frequent traffic in and out lessened their effectiveness. It was not until late on Friday afternoon that an access roster was established and an identification badge system instituted. Even then, security breaches occurred. For example, on Saturday morning, a member of the governor's staff entered the offices unchallenged and walked around until finally encountering a person who appeared to be in charge, Lieutenant Albert Giusti of the WWPD. Additionally, sensitive victim-related information was routinely transmitted by fax to the front desk of the Crowne Plaza Hotel, an unsecured area readily accessible by hotel employees.

Until such time as RIEMA has independent facilities that can be properly isolated and secured, special provisions need to be developed to safeguard sensitive emergency operational information within its HQ complex. Policies must also be instituted to prohibit the electronic transmission of such information to unsecured areas.

EMSO-029 The RIEMA EOP does not address the subject of donation management. The RIEMA staff person responsible for donation management retired in December 2002 and had not been replaced. Compared with many other major disasters, donation management was a relatively minor challenge in this incident; however, because it was not anticipated, it became a significant distraction, resulting in the necessity for EMAC support.

RIEMA, in coordination with the ARC RI and the Rhode Island Voluntary Organizations Active in Disaster (VOAD), should develop a comprehensive donations management program that is scalable to address the requirements of all disasters and emergencies.

EMSO-030 The West Warwick EOP is generally consistent in design with the State EOP and was last officially revised in 1988. Emergency preparedness planning is particularly challenging for municipalities. Most municipal emergency management leadership positions are part-time and, except for the part-time director, WWEMA staff engagement is entirely voluntary. Even if a planning grant is available, municipalities must provide matching funds. That can be an insurmountable challenge for the smaller Rhode Island towns. In past years, before suffering significant staff and budget cuts, RIEMA planners worked directly with each of the municipalities to help them develop and maintain local EOPs.

Adequate funding should be provided to RIEMA so it can resume the practice of assisting municipal emergency management staff to develop and maintain EOPs that are consistent and coordinated with the Rhode Island EOP.

EMSO-031 Neither RIEMA nor the WWEMA has maintained current EOC SOPs to support emergency operations.

RIEMA should develop new EOC SOPs at the State level and provide technical assistance to all local jurisdictions in the development of local EOC SOPs.

EMSO-032 The process of identifying hazards and conducting risk assessments has not been embraced by RIEMA. As a result, RIEMA does not conduct risk-based planning.

RIEMA should coordinate the development of a Statewide hazards analysis and risk assessment program to serve as the basis for future planning and resource allocation.

SECTION 4 – FACILITIES AND TECHNOLOGY

Observations

Impact of Technology

The fast pace of technological advances that have occurred during the past decade, particularly in computer and communications fields, continues unabated. Today, functions previously associated with multiple, large devices reside side-by-side in a single handheld instrument, as computer and communications technology enters into what is sometimes referred to as the new age of "computications." It is therefore understandable that automation in government organizations and in other large enterprises naturally lags behind the latest available capabilities emerging in the commercial marketplace. This technological proliferation has also driven down the cost of technology, making it possible to acquire more capability for less money.

Modern Emergency Management Systems

As elsewhere, the impact of technological advances is evident in the field of emergency management. Modern EOCs have ample contiguous workspace that supports all essential emergency management functions and enables decisionmakers to rapidly assess the evolving situation and direct appropriate response and recovery actions. The EOC staff has access to workstations that operate on a local area network (LAN), share databases, work collaboratively, and connect via wide area networks (WANs) to external databases. Imagery is acquired by rapid response teams directly from the incident site in near-real time and displayed using embedded EOC projection devices. Suites of available off-the-shelf emergency management software provide fingertip access to a full range of standard applications such as notification and recall rosters, checklists, journals, action-tracking records, and many more. Rapid response teams deploy in modern mobile command vehicles similarly equipped in scaled-down fashion. A Forward Emergency Operations Center (FEOC) is often established near the incident site to better support the local responders and to acquire and transmit timely information to decisionmakers at the EOC. In the event that the primary EOC is not accessible for any reason, a backup site is available and equipped with similar capabilities. These are not the circumstances that prevailed in Rhode Island at the time of the Station club fire.

Findings and Recommendations

EMSO-033 RIEMA EOC located in the National Guard Command Readiness Center is not adequate in size or design and is not properly equipped to effectively manage emergency response and recovery activities. The only space that is fully dedicated to EOC activities is far too small to serve as more than a modest meeting and planning area. The larger EOC expansion space is a noncontiguous multipurpose classroom shared by RIEMA and the National Guard. It must be reconfigured and equipped to support EOC operations. It is reported that funding has been requested to construct a new RIEMA EOC but has been regularly pushed to the out years. This is not an acceptable arrangement for a State EOC.

The State should take steps to immediately develop and equip an adequate State EOC facility.

EMSO-034 The State EOC is only marginally equipped with computer automation. The EOC planning area and the expansion operations area have dial-up access so that State agency representatives can connect to their base work area over the Internet, but the RIEMA LAN is not connected to the Rhode Island State network. This severely impedes the ability to communicate effectively with other critical State agencies and limits access to critical agency-specific data by State agency representatives at the EOC. This is not a technically insurmountable problem.

RIEMA should act immediately to establish connectivity to the State computer network to afford supporting agencies critical connectivity to their primary agency systems from the EOC.

EMSO-035 RIEMA has not deployed generally available crisis management software solutions to support its EOC. This is a limiting factor during complex multijurisdictional operations involving large numbers of requests for emergency assistance, multiple concurrent mission assignments, resource acquisition, deployment and tracking, and general emergency messaging. Moreover, when the RI DOC offered to install its emergency management software at the EOC, it determined that the limitations of the outdated and undersized hardware were prohibitive.

RIEMA should immediately acquire and deploy a crisis management software solution for the State EOC through available Web-based technologies and provide access to this system to all 39 municipal EOCs.

EMSO-036 Current technologies are not integrated into the Rhode Island emergency management system. The most obvious weaknesses are in communications and information management systems. RIEMA and Rhode Island public safety agencies are operating without the benefit of state-of-the-art radio frequency communications systems, resulting in interoperability impediments that adversely impact operations. This will only be partially addressed with the deployment of the new 800 MHz system, which apparently will be used only for alert and notification.

The State should explore all available avenues to establish a Statewide public safety voice and data interoperable communications system, and RIEMA should fully integrate this system into all EOCs.

EMSO-037 Basic Geographic Information System (GIS) capabilities are available in the EOC, but RIEMA staff are not familiar with or trained on the use of this system. The State GIS is robust and should be used, along with other presentation software, to support decisionmaking during emergency operations. Projection systems to display status charts, situation reports, maps, and other critical graphic information are not available in the EOC.

GIS training should be provided to key RIEMA operations and planning staff to afford better use of this valuable asset in emergency planning and actual response operations. Emergency management software and related training should also be acquired to compliment the GIS capability, and the EOC should be equipped with

electronic projection systems to display critical information for use during emergency operations.

EMSO-038 RIEMA has a 1988 Ford box truck that serves as its mobile command post. The vehicle and its equipment need to be replaced with a modern state-of-the-art capability. Cellular telephones and Nextel communications are powerful tools, but not adequate substitutes for a properly configured deployable capability.

Rhode Island should proceed without delay to complete the acquisition of a state-of-the-art mobile command post.

EMSO-039 Title 30 of the Rhode Island General Laws requires that all Rhode Island State agencies have an alternative site for agency operations in the event that the primary site is unavailable. This is a prudent requirement to ensure Continuity of Government (COG) and Continuity of Operations (COOP). The Zambarano Hospital is the designated alternative operating site for RIEMA. The RI DOC has installed a telephone switchboard at the hospital, but it is otherwise not equipped or configured for this purpose.

Steps should be taken to ensure the Zambarano Hospital, or another suitable location, is configured as an alternative RIEMA facility and EOC. That facility should be regularly activated and tested.

EMSO-040 Almost all of the findings related to the Rhode Island emergency management system facilities and technology also apply to West Warwick. Its rudimentary EOC, located in the basement of the Town Hall, is not well-equipped and it does not have modern computer and communications technology. West Warwick had a mobile command post vehicle at the time of the Station club fire, but it was deemed not to be roadworthy. To its credit, West Warwick subsequently managed to acquire a Navy surplus vehicle that has been equipped with radios donated by the volunteer ham radio operators of the WWEMA Communications Team. An alternative West Warwick EOC is located at the West Warwick junior and senior high school complex, which is also the designated emergency population shelter location.

RIEMA should assist West Warwick and other Rhode Island cities and towns to upgrade their emergency management facilities and technology. Web-based solutions should regularly be extended to municipal entities.

SECTION 5 – ORGANIZATION AND STAFFING

Observations

Responsibility for Emergency Management

The Rhode Island adjutant general, subject to the direction and control of the governor, is designated the executive head of RIEMA. In that capacity, he is responsible to the governor for carrying out the program for disaster preparedness in the State. He is also required to coordinate the disaster preparedness activities of all organizations within the State, and to maintain liaison and cooperate with the emergency management agencies and organizations of other States and of the Federal Government. The adjutant general also serves as the Rhode Island Homeland Security Advisor and uses RIEMA staff to support this Statewide responsibility.

Several States assign responsibility for emergency management to the adjutant general and others assign that responsibility to a director of emergency management who reports directly to the governor. Rhode Island's situation is unique in that there are no intermediate political jurisdictions between the State government and local municipalities. Elsewhere in the country, county emergency management staffs direct initial support to threatened local communities. In Rhode Island, local leaders turn directly to the State for help. There is no intermediate recourse.

Rhode Island Emergency Management Advisory Council

RIEMAC is established by Rhode Island General Law 30-15-6 and is charged with advising the governor and adjutant general on all matters pertaining to disaster and emergency preparedness. The lieutenant governor chairs RIEMAC and the adjutant general serves as vice chair. The Council consists of 16 ex officio members and 15 members appointed by the governor. RIEMAC has several functional area subcommittees and working groups that provide subject matter advice and direction. One of the most active has been the Domestic Preparedness Subcommittee, which is charged with coordinating Rhode Island homeland security efforts (see **Figure D-4**).

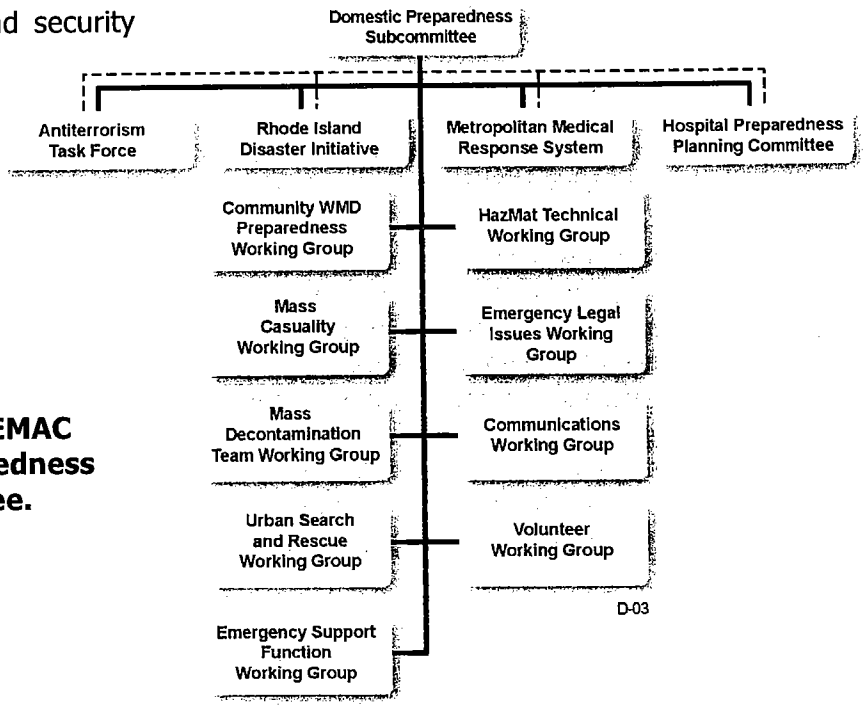
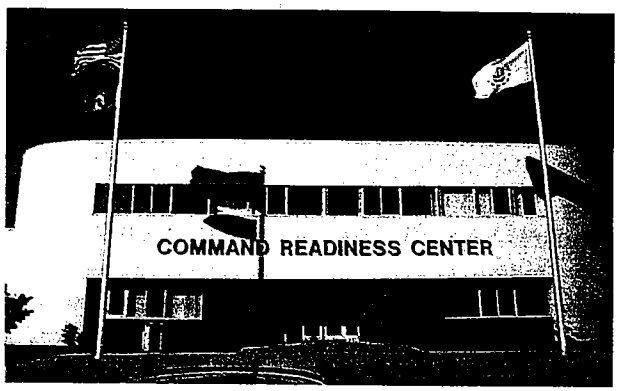


Figure D-4. RIEMAC Domestic Preparedness Subcommittee.

Rhode Island Emergency Management Agency

At the heart of its emergency management system is RIEMA. Once a key agency in the Governor's Office, RIEMA staff had dwindled from 29 persons in 1974 to 13 employees at the time of the Station club fire. For much of that same period of time, RIEMA was located in the State House and functioned routinely as part of the Governor's Office, even while the adjutant general was the designated director. In 1996, RIEMA was relocated to its current location at the National Guard Command Readiness Center in Cranston, RI.



Rhode Island National Guard Command Readiness Center in Cranston, RI.

RIEMA has been understaffed and underfunded for decades, which has contributed to its inability to maintain current planning documents that reflect Federal policies and also to aid municipalities in developing similar plans and capabilities. This has eroded confidence in RIEMA by some State agencies and other response organizations.

Local Emergency Management

Each Rhode Island municipality is required to establish, through local ordinance, a comparable agency to RIEMA, headed by a director with powers and duties similar to those of the RIEMA director. Local emergency management agencies are required to cooperate with and assist RIEMA and are authorized to act jointly with similar municipal agencies. Municipal chief executive officers have emergency management powers and duties within their jurisdictions similar to those of the governor at the State level.

WWEMA consists of 40 citizen-volunteers led by a part-time town employee who is paid to work 10 to 15 hours per week. About 25 volunteers are ham radio operators assigned to the WWEMA Communications Team. The remaining volunteers are trained in more general emergency assistance skills. Mr. Senerchia, the WWEMA director, conducts a monthly Monday evening meeting. The Communications Team meets on its own initiative on Wednesday evenings at the EOC and for breakfast on Saturday mornings. This collegial group of citizen-volunteers donated the communications equipment to outfit a refurbished Navy surplus vehicle that now serves as West Warwick's mobile EOC.

Investing in Preparedness

Historically, Rhode Island has been relatively free from major disasters. The only occasion when a presidential disaster declaration pertained to Rhode Island was during Hurricane Bob in 1991. This relative tranquility is reflected in the failure to invest in improving Rhode Island's emergency preparedness for many years. Despite this extended resource deprivation, RIEMA staff have accomplished some important improvements. It manages an active and robust training program, an aggressive hazards mitigation program, and a proactive domestic preparedness program. Many dedicated and hard working emergency management professionals have done more than would normally be expected within the organizational environment of the past several years.

Findings and Recommendations

EMSO-041 It is apparent that RIEMA is not held in high regard by some Rhode Island cabinet departments and other response organizations. In some cases, it is viewed as a relatively inconsequential subordinate organization of the Rhode Island Military Department. From that perspective, critics presume incorrectly that it has immediate access to all of the Rhode Island National Guard assets and, therefore, should not look elsewhere for support. Others question the capabilities of RIEMA to effectively perform its role, noting that it is technically disconnected from the Statewide computer network and that supporting agencies summoned to work at the Rhode Island EOC are similarly isolated from their resident databases. RIEMA's mission to protect life and property through a program of mitigation, preparedness, response, and recovery is uniquely different from that of the National Guard. Some respondents likened the placement of RIEMA within the Rhode Island Military Department to placing FEMA inside the Department of Defense.

After careful review of existing independent reports, the Emergency Management Accreditation Program Report, the Rhode Island Department of Administration Emergency Management Agency Performance Audit, and this After-Action Report, the governor should take immediate steps to explore alternatives to organizational and fiscal limitations impacting on RIEMA and the entire emergency management system. Such a review should consider, but not be limited to, the appropriate placement of RIEMA within Rhode Island State government. This assessment should also address staffing levels within RIEMA to ensure it has the necessary resources to perform effectively all assigned missions.

EMSO-042 RIEMA has had inadequate resources for many years, and, while other elements of the Rhode Island State government have modernized to face the challenges of the 21st century, RIEMA has consistently fallen behind. Since the Station club fire, RIEMA staffing has increased by five full-time positions, accommodating the need to add a homeland security component. Even with 20 staff members, RIEMA is hard-pressed to perform the full range of its responsibilities and would find great difficulty operating 24 hours a day for an extended period of time in the event of a catastrophe. There were no arrangements in place to augment RIEMA staff from other Rhode Island government agencies during the Station club fire.

RIEMA should devise and coordinate a staff augmentation plan that provides additional administrative support from other State organizations during emergencies, freeing RIEMA staff for direct disaster response and recovery assignments.

EMSO-043 RIEMA has not developed an adequately trained and supported State emergency response team that includes other State agencies to fully staff key positions when the EOC is activated. As a result, some State agencies have created independent emergency operations cells to accomplish specific agency functions without considering the pivotal role of the EOC in achieving a fully coordinated response.

Concurrent with solving the EOC facility limitations described in Section 4 of this annex, RIEMA should establish an orientation and training program for designated

representatives of key Rhode Island government organizations that will relocate to the EOC when it is activated.

EMSO-044 It is impossible to look at a RIEMA organization chart and determine the day-to-day responsibilities of staff members. Staff titles and position descriptions are antiquated and do not relate to the actual duties routinely performed by the incumbents. Position descriptions and titles of RIEMA staff still reflect the requirements of a cold war long past, rather than the current emergency management environment. Many RIEMA professional staff positions are inappropriately classified and position descriptions do not provide essential information for assigning an appropriate job function, title, or pay grade. It is therefore impossible to identify essential functions based on job-specific competencies and to convey to staff members a clear understanding of assigned duties. This failure to update staff positions is reportedly caused, at least in part, by the reluctance to change on the part of the State government employees' union.

The governor should direct a complete evaluation of RIEMA titles and position descriptions to ensure they reflect contemporary emergency management conditions. This assessment should be accomplished in close coordination with union officials so that the rights and benefits of State employees are protected.

EMSO-045 Morale within the agency is generally low. Many staff members view the organization as an unwanted tenant in the Rhode Island National Guard complex, beholding to a reluctant landlord for the facilities and support needed to do their job. Although this may not be the case, the perception is very real and its effect on the organization debilitating. Additionally, some staff members believe that certain components of RIEMA are favored over others, fragmenting RIEMA staff and further lowering overall effectiveness. The lack of modern technology and access to automated tools, which are common elsewhere in support of emergency management, reinforces the general malaise within the organization.

By its very nature, RIEMA is an organization that performs absolutely essential, but highly stressful, work. Over time this takes its toll on staff morale. Regular off-site staff retreats allow members to engage in meaningful communications and relieve dysfunctional pressures. At least once each year, RIEMA, with assistance of an outside facilitator, should conduct an all-hands management retreat.

EMSO-046 During the early hours of the Station club fire response, Mr. Senerchia, the director of WWEMA, worked closely with Mr. Manni, his counterpart from Smithfield, RI, and other members of the Smithfield Emergency Management Agency. It was Mr. Manni who alerted the ARC RI of the disaster minutes after the fire began. Such spontaneous cooperation between neighboring communities, without the benefit of a formal mutual-aid agreement, is admirable. A more structured relationship would be even more beneficial.

RIEMA should conduct a detailed review to determine creative ways to recognize and support municipal emergency management organizations. These citizen-volunteer groups provide the baseline for initial intervention on behalf of the Rhode Island first response community.

EMSO-047 RIEMA did not conduct an immediate internal after-action review of its performance during the Station club fire response and recovery operations. Such immediate assessments capture ideas while they are fresh and lead to immediate operational improvements.

RIEMA should be required to conduct an immediate "Hot Wash" performance assessment at the end of every emergency management engagement. This assessment should be completed within 2 weeks of ending operations, should involve all participating organizations, and the written results should be reviewed by RIEMAC.

SECTION 6 – TRAINING AND EXERCISES

Observations

Importance of Training

Unlike some other disciplines, it is inadvisable to learn the intricacies of emergency management exclusively from personal experience. To effectively implement EOPs, responders and support organization staff members must thoroughly understand their plan's overall concept, roles, and responsibilities of organizations and key individuals and the operational procedures set forth in the EOP as well as supporting SOPs. This understanding is gained through recurring training in the functions needed to respond to and recover from disasters and in the skills required to perform those functions. A staff member who is usually engaged in one set of activities may be assigned far different duties under emergency conditions. For example, a staff member might be assigned to manage donations. In that capacity, he or she will be faced with a myriad of tasks quite different from day-to-day responsibilities. It is virtually impossible to learn the intricacies of donation management at the same time that truckloads of donated materials are accumulating at the incident site. A robust and recurring training program is a critical component of every sound emergency preparedness program.

Emergency management training programs should be multidimensional. The USDHS training courses sponsored by FEMA and the Office for Domestic Preparedness (ODP) should be an integral part of an emergency management training program. However, those offerings should be complemented by courses specifically tailored to the needs of the State and local communities. Training should not be provided only to response agencies, but in some cases to the general public as well. Community education must be a high priority.

Rhode Island Emergency Management Training

Training has been a RIEMA priority for many years. Emergency management training courses are offered free throughout the State and its 39 municipalities. It is aimed at helping the response community attain and maintain proficiency in mitigating, preparing for, responding to, and recovering from all types of emergencies, including those attributable to hazardous materials (HazMat). In addition, independent-study courses are offered for individuals who seek professional training but are unable for personal or professional reasons to engage in a full standard classroom curriculum. RIEMA also coordinates admission to resident courses offered at ODP-supported training centers and FEMA at the national Emergency Management Institute (EMI) and elsewhere.

The ARC also offers a variety of relevant emergency response training courses at times that are often more convenient for volunteers who can only train in the evening or on weekends. This has been an important factor in developing Rhode Island's Community Emergency Response Teams (CERTs).

Testing Emergency Management Systems

Exercises are the primary method of testing an emergency management system to evaluate its various system components, including the EOP. Adequate system evaluation is best accomplished through a progressive exercise program that includes issue-oriented tabletop sessions, functionally specific exercises, and full-scale field exercises. These exercises should address

traditional emergency response roles and functions as well as immediate and long-term disaster recovery operations. A viable exercise program tests the integration of all public and private organizations and allows participants to practice together the activities essential to successful disaster response and recovery.

In addition to emergency management exercises that test government organizations, external facilities such as hospitals, industrial complexes, and airports are also required to conduct periodic exercises to maintain licenses and accreditation. Such exercises have become increasingly important since September 11, 2001. Integrating these public and private exercise requirements benefits all participants and adds significant realism to the portrayal of simulated events.

The value of such exercises was clearly demonstrated by the performance of EMS and other first responders during the Station club fire. In a *New York Times* article published last March, Captain Peter Ginaitt of the Warwick Fire Department cited the importance of ODP-sponsored exercises offered and executed by RIEMA, saying, "There was never one responder who second-guessed the organizational system. Everybody followed the plan and, as a result, were able to get a large number of severely injured people to the appropriate hospitals very, very quickly."

The true benefit of an effective exercise program comes from rigorous impartial performance evaluation and the resulting corrective action plans that address weaknesses and deficiencies. Post-exercise debriefings of all key participants immediately following each exercise provides a starting point for quick fixes to problematic areas. A more extensive written critique usually includes a detailed description and analysis of systemic problems along with recommended solutions.

Findings and Recommendations

EMSO-048 RIEMA conducts and coordinates an active Statewide training program. Nearly 4,000 first responders and public safety personnel have completed more than 200 homeland security-related courses since September 11, 2001. This training is valuable and must be continued; however, it generally does not adequately address all critical training needs identified by Rhode Island emergency management professionals. For example, emergency management leadership development, State-specific training for professional staff assigned to work in the EOC, and training regarding use of RIEMA basic information management technology are all cited as critical missing components.

RIEMA, in coordination with a Rhode Island academic institution, should develop a management and leadership training program for RIEMA staff and for local emergency management organizations. RIEMA should also develop State-specific training courses to address requirements unique to Rhode Island, such as the Rhode Island EOP, EOC operational procedures, and Rhode Island emergency communications systems.

EMSO-049 RIEMA staff members have had little opportunity to take regularly scheduled training courses in basic office automation systems. Every organization needs regular access to standard training courses on evolving office automation tools and on newly deployed software applications.

RIEMA should take full advantage of State-sponsored technology training courses to enhance staff competencies with current and evolving information management technologies.

EMSO-050 RIEMA establishes the State emergency management training schedule based on the availability of instructors, budgetary factors, and the schedule of contract trainers who deliver ODP-sponsored courses. These training courses are routinely offered during regular working hours at area hotels convenient to the attendees. Many Rhode Island response community members are volunteers with weekday career commitments that preclude them from attending these regularly scheduled training classes. Thus, an important segment of the Rhode Island emergency management population is excluded from much of the available training.

To the extent possible, training courses should also be scheduled in the evenings and on weekends to accommodate the emergency management volunteer community.

EMSO-051 ODP-sponsored exercises based on chemical, biological, radiological, nuclear and high-yield explosive (CBRNE) scenarios serve as the basic platform for the RIEMA exercise program. RIEMA has successfully leveraged the ODP CBRNE exercise program and related funding to improve State and local capabilities to manage terrorism, including incidents involving WMD. However, endemic staff shortages and funding limitations have curtailed all-hazard exercises, once the core of that program.

All-hazard emergency management training courses should be continued and offerings further expanded to address the basic training needs of all individuals who comprise the emergency management system.

EMSO-052 The level of participation of key State agencies and local governments in RIEMA-sponsored CBRNE exercises varies widely. Several EOP-designated agencies with emergency operations functions and many of the 39 local jurisdictions have not actively participated in exercises.

ODP CBRNE exercises should be continued and increased in number as funding permits. The frequency of local exercises should be increased to better evaluate and improve CBRNE incident management capabilities in all 39 local jurisdictions.

EMSO-053 A common challenge for exercise planners is that elected and appointed executive officials rarely participate in Rhode Island emergency management training and exercises. This level of participation is critical to developing a clear understanding among senior public leaders of the emergency management system, as well as the roles and responsibilities of government executives during emergency operations.

Training of key officials and early engagement in simulated emergencies is particularly important after a change of administrations.

Executive-level exercise participation should be mandatory and is particularly important because of the direct reliance of Rhode Island municipalities on State leaders and resources. RIEMA should conduct executive-level training and tabletop exercises for State and local elected and appointed officials shortly after an administration change and regularly thereafter.

EMSO-054 As demonstrated by Exercise Team Hope in June 2002, hospitals and other medical facilities are often incorporated in RIEMA-sponsored exercises. This WMD exercise afforded an excellent opportunity to involve and evaluate medical disaster response capabilities.

RIEMA should continue to include private organizations such as area hospitals and airports in the emergency exercise program.

EMSO-055 The Exercise Team Hope evaluation report identified several important areas needing improvement. Some corrective actions have been implemented but other deficiencies noted during the exercise remain unchanged.

RIEMA should consistently use an exercise after-action reporting process and implement a corrective action system to capture lessons learned and to implement recommended system improvements. The Homeland Security exercise and evaluation program guidance and criteria should be used to ensure State compatibility with Federal programs.

ANNEX E
PUBLIC HEALTH, HEALTHCARE FACILITIES, MENTAL HEALTH, AND MASS FATALITY MANAGEMENT

PART I
PUBLIC HEALTH

INTRODUCTION

Rhode Island has a long and distinguished history of public health leadership and excellence. In 1854, the city of Providence reeled under its second epidemic of cholera in 5 years. Dr. Edwin Snow pioneered efforts to document and analyze the incidents of cholera and, using his own patients to track the disease, devoted himself to tracing its source and preventing its reoccurrence. When Providence established a permanent city health department in 1856, Dr. Snow was appointed the first superintendent. A State Board of Health was created 22 years later with three mandates: prevent the spread of disease, collect vital statistics, and implement a sanitation program.

Today the mission of the Rhode Island Department of Health (RI Health) is to prevent disease and promote the health and safety of the people of Rhode Island. To accomplish this mission, the department is organized into seven programs: Central Management, Office of the Medical Examiner, Family Health, Health Services Regulations, Disease Prevention and Control, Environmental Health, and Health Laboratories (see **Figure E-1**).

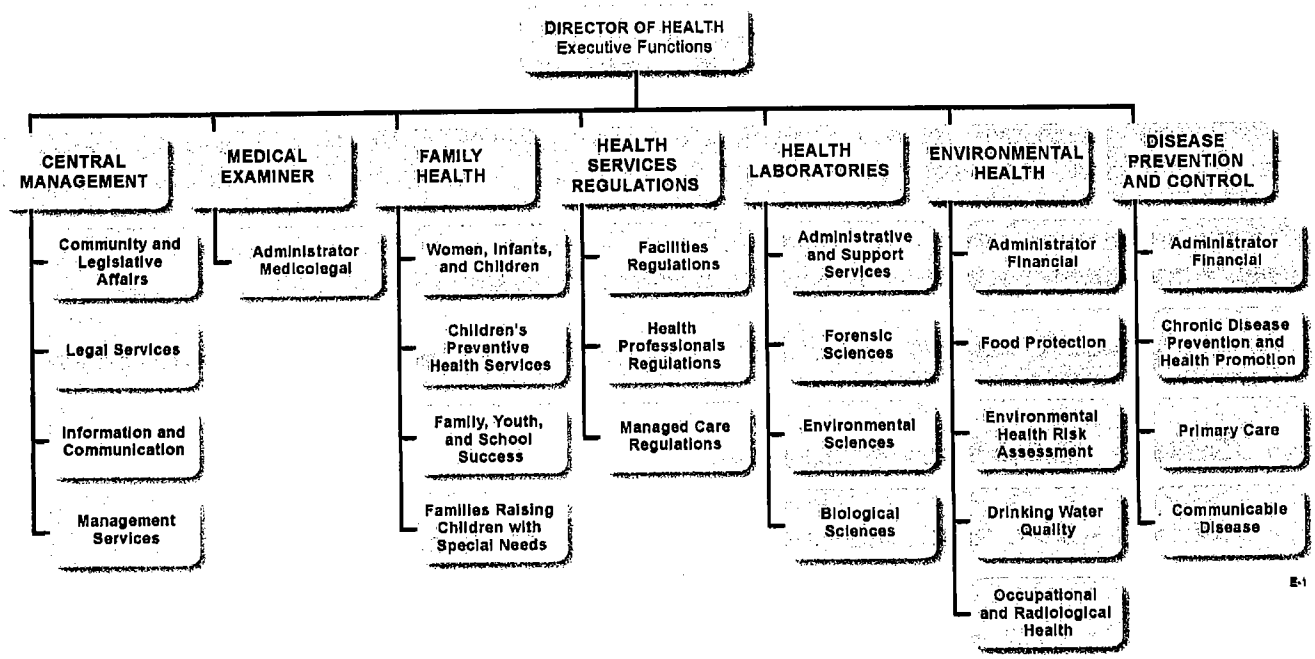


Figure E-1. Rhode Island Department of Health organization.

The RI Health director is Dr. Patricia Nolan MPH. Her cabinet level appointment is for 5 years. She is currently 3 years into her second term. Dr. Nolan and the seven senior department administrators lead a staff of 550 personnel dedicated to promoting lifestyle changes, environmental health, the delivery of health services, and disease prevention. The 2003 RI Health budget was $97,755,807.

Dr. Patricia Nolan

Recently, the department has undertaken two particularly important initiatives. First, it has embraced a U.S. Department of Health and Human Services (HHS) "Healthy People 2010" initiative. The overarching goal of this important program is to increase the quality and length of healthy life while eliminating health disparities among Rhode Islanders. At present, initiatives are under way in the following areas: physical activity, overweight and obesity, tobacco use, substance abuse, responsible sexual behavior, mental health, injury and violence, environmental quality, immunization, and access to healthcare.

The second initiative is to enhance and intensify RI Health emergency preparedness efforts as a result of the terrorist attacks of September 11, 2001. RI Health has been designated the lead agency for the State's bio-preparedness response efforts. The department has received several Federal grants to assist with improving the recognition, identification, and management of bioterrorist incidents and has added infrastructure support and personnel. Newly adopted policies and procedures address medical surveillance, sophisticated testing of laboratory specimens, smallpox, surge capacity planning, and public risk communications. In the past year, RI Health planned and executed one of the Nation's largest Strategic National Stockpile bioterrorism exercises. The lessons learned have been shared with health departments, emergency management agencies, and other professional groups throughout the United States.

Part I of Annex E is organized into the following sections and each section contains observations, findings, and recommendations:

- Section 1 – Initial Department Response
- Section 2 – General Disaster Response
- Section 3 – Demobilization and Department Activity Restoration

SECTION 1 – INITIAL DEPARTMENT RESPONSE

Observations

RI Health Notification

Mr. Wayne Farrington, associate director for Central Management, was on-call for RI Health on the night of February 20, 2003. He received a telephone call at home sometime after midnight from Mr. Albert Scappaticci, executive director of the Rhode Island Emergency Management Agency (RIEMA), advising that a bad fire with casualties at the Station club in West Warwick was in progress and that the Office of the Medical Examiner (OME) had been notified. RIEMA did not request any further action on the part of RI Health at that time. Mr. Farrington immediately called Mr. Jay Kingston, the OME investigator on duty, and discussed the situation. At that point, Mr. Kingston understood that there were as many as 15 to 20 fatalities. Mr. Kingston departed for the scene. Mr. Scappaticci called Mr. Farrington again at about 3:00 a.m. and stated that the incident was even larger than first suspected. He sought reassurance that the OME would be prepared for larger numbers of deceased victims. In a follow-up conversation with Mr. Carl Zambarano with OME, Mr. Farrington was assured that the OME was "gearing up." Subsequent conversation between Mr. Farrington and Mr. Scappaticci established that RIEMA was setting up a command communication center at the Cowesett Inn.

RI Health Leaders

Dr. Nolan learned about the fire after she awoke on Friday morning and heard the story on the 6:00 a.m. radio news. She proceeded directly to the OME and met with Dr. Elizabeth Laposata to learn more about what had happened. At that time, the estimated death count was between 35 and 40 persons and growing. Dr. Nolan and Dr. Laposata discussed the assistance that OME might require in responding to the emerging situation.

Mr. Don Williams, the RI Health associate director for Health Services Regulation and a State employee for 26 years, was about to begin his daily swim at 6:10 a.m. when he heard a radio report about the fire. He curtailed his exercise and went to his office. Once there, he began activating the RI Health command post in the director's office suite. Early activities focused on needs assessment and OME support.

Mr. Peter Leary, the Rhode Island Emergency Medical Services (EMS) director, learned of the fire from televised news at 5:30 a.m. He immediately went to his office and began contacting area hospitals to find out how many patients had been seen, admitted, transferred, or discharged.

Twenty-five-year RI Health employee Dr. Walter Combs Ph.D., the executive director of Environmental Health and the department's bioterrorism grant manager, encountered Mr. Williams in the command post at midmorning and began helping where he could. He spent most of the next 4 days working at the Family Assistance Center (FAC).

The RI Health associate director for Disease Prevention and Control, Dr. John Fulton Ph.D., also joined in the intensive effort at the command post to ascertain patient information. Later that day, he was assigned an administrative role supporting Dr. Laposata and the OME staff.

Dr. Colleen Caron Ph.D., the RI Health health communications chief, learned of the incident from news reports on Friday morning. That afternoon she was assigned to the FAC at the Crowne Plaza Hotel to help console family members and participate in family notification of the deaths of loved ones.

Mr. Greg Banner, the RI Health emergency response preparedness coordinator, learned about the fire from a friend at Rhode Island Hospital who called his home at 3:00 a.m. on Friday morning, reporting that the hospital had received a number of badly injured victims. Mr. Banner performed his normal duties on Friday and was sent to the FAC on Saturday night, where he worked until it closed on Tuesday evening, February 25. He then spent the next 2 days working at the RIEMA headquarters (HQ).

Dr. Bill Waters Ph.D., the RI Health deputy director, was in New York for an extended weekend and saw news reports about the fire on television. He returned home on Saturday and was asked by Mr. Williams to help at the Crowne Plaza Hotel FAC.

The RI Health hospital bioterrorism planner, Mr. Tom Kilday, was also on vacation. Early on Thursday evening he had turned off his pager and cellular telephone. As a result, he missed efforts by Mr. Tom Lawrence from Rhode Island Hospital to reach him during the night to tell him about the fire. He first learned of the fire at 6:00 a.m. from television news reports. He called Mr. Williams and reported to work, performing a variety of activities in support of the FAC, Dr. Nolan, and Governor Donald L. Carcieri.

Mr. Leonard Green, the RI Health chief of vital records, was in Atlanta, GA, for a meeting at the Centers for Disease Control and Prevention (CDC) when the fire occurred. He saw stories about the fire on television and realized that his office would be involved in issuing death certificates. He returned to Rhode Island on Friday evening and was assigned to work at the FAC beginning on Saturday.

Findings and Recommendations

PH-001 At the time of the fire, there was no alert and notification procedure for the on-call administrator or other department members to use in the event of a mass casualty incident (MCI).

Alert and notification procedures for mass casualty events should be established, including instructions for contacting RI Health leadership. These procedures should be regularly tested.

PH-002 Even though the OME learned of the event as early as 11:30 p.m. on Thursday, no one in the OME notified the director of RI Health or any of her leadership or staff. Even after the executive director of RIEMA called the on-call RI Health officer, who then obtained additional details from the OME investigator, no one called Dr. Nolan. Although it was increasingly apparent during the early morning hours of Friday morning that a significant tragedy had occurred, neither the chief medical examiner nor a member of the RI Health senior staff contacted the director. In this instance, fundamental professional courtesies were not extended. Governor Carcieri was

notified of the event, but the cabinet officer responsible to him for a critical response activity was not.

Alert and notification procedures and instructions within the RI Health organization as a whole and at RIEMA need to be fully reviewed. Plans and processes need to be developed and included in overarching State and RI Health plans. Exercises and tests of the processes and system must be regularly exercised.

PH-003 Although the RI Health has an area designated to serve as its command post during an emergency, it does not have communications capabilities to simultaneously notify department leaders when an emergency occurs.

RI Health leaders should be equipped with dependable two-way communications devices and use them in accordance with established communication procedures.

PH-004 An "on-call administrator's bag" contains only limited operational materials for this type of event.

Contact numbers for department and nondepartment personnel, response procedures for various situations that are likely to occur, and appropriate reference texts should be added to the on-call administrator's bag for use during a mass casualty event.

PH-005 The need for an off-site Incident Command capability did not exist at the time of this incident, but is recognized as a capability needed.

The RI Health should develop an Incident Command capability that can be used at off-site locations when needed.

SECTION 2 – GENERAL DISASTER RESPONSE

Observations

Organizing the Response

As the details of the fire became clear on Friday morning, the RI Health leadership team began to identify what needed to be done and assign responsibilities to staff members. Mr. Williams served as the principle coordinator at the command post while Dr. Nolan and one staff person assumed that role at the Crowne Plaza Hotel FAC. Despite the lack of a written plan, the longstanding personal and professional relationships among the various participants facilitated communications and cooperation.

RI Health Volunteers

As word of the fire spread, RI Health personnel, like others throughout Rhode Island, wanted to do something to help. By Friday afternoon, a volunteer sign-up list was posted. Scores of persons signed up to work that day and over the weekend helping at the RI Health command post, OME, and the FAC. These volunteers, like their supervisors, put in long hours of hard work and sacrificed personal and family time to contribute to the response.

Supporting OME Operations

Support provided to the OME took several forms. Senior- and mid-level RI Health administrators, including two who had past OME experience, were assigned to assist Dr. Laposata beginning Friday afternoon. Their initial focus was responding to telephone inquiries, completing paperwork, and locating special equipment, such as bone saws and refrigerator trucks.

The activities taking place at the OME included body preparation, identification investigations, autopsies, and producing extensive documentation (see Part IV – Mass Fatality Management). One of the RI Health volunteer administrators filled a temporary staffing vacancy by helping prepare several bodies for examination. Other RI Health personnel collated victims' files that included dental records, autopsy results, and missing persons information. Work schedules were arranged so that support was available 24 hours a day.

It appeared to everyone involved at the State morgue that there was a seamless integration of regular OME staff, other RI Health personnel, and the scores of dentists, funeral directors, and other volunteers. The sensitive nature and urgency associated with this work resulted in considerable scrutiny and external pressure. However, everyone involved described the experience as unique and gratifying.

Family Assistance Center Support

As the OME operation became more efficient during the weekend, some of the RI Health personnel were reassigned to the FAC. At the FAC, the RI Health played several roles. Seven RI Health personnel, including Dr. Nolan, were involved in the actual family death notification process (see Part IV – Mass Fatality Management). Others played important behind-the-scenes roles, including staffing telephone banks, entering victim information data, providing support to the governor, and providing general support to the waiting families (see Annex F – Family Services and Support).

Information Management
To assist with data collection and information management, four RI Health information technology (IT) personnel established an automated support system that included a department laptop computer, two desktop computers, and three printers. By Saturday, the IT personnel devised a computer-based victim registry. This evolving Microsoft Excel database eventually included critical pieces of information such as each victim's name and age, the date of OME identification, when the autopsy was completed, and the date of family notification.

After Friday afternoon, technical personnel were present during each shift to perform data entry and troubleshoot technical problems.

Protecting Sensitive Information
RI Health staff at the OME and at the FAC were constantly challenged to protect the confidentiality of the victims' records while sharing selected items of information. It was also important that the FAC data correspond with data at the OME. Problems such as dealing with several victims who shared the same name and identifying misspelled first or last names required extraordinary attention to detail by the data entry staff and administrators. Mr. Green, RI Health chief of vital records and the IT section director, provided data system oversight at both locations. On Wednesday, February 26, a comprehensive set of fatality data was compiled and presented to Dr. Laposata.

Information Acquisition
RI Health was also challenged to acquire timely and accurate information about the injured survivors of the Station club fire. EMS personnel at the incident scene did not record the destinations of patients evacuated to area hospitals. Thus, each hospital had to be called by telephone. Some facilities refused to share patient information because of confidentiality concerns, and others offered only limited information. This situation was further exacerbated because RIEMA personnel assigned to accumulate victim information were also calling area hospitals seeking the same information. This duplicative effort annoyed hospital personnel and led some to question the competency of those in charge.

These efforts were further hampered because different hospital personnel sometimes answered the telephone when someone called seeking patient information, negating progress made during previous discussions. This led to delays and raised questions about the accuracy of the information. These problems were largely overcome through the combined efforts of RIEMA and RI Health.

By Saturday afternoon, RIEMA and RI Health effectively joined efforts and began producing a consolidated list that was continuously updated and provided to the governor twice daily. This collaborative effort helped solidify the data and eventually resulted in a master list containing information about hospitalized victims, patients sent home from the hospital, patients transferred to other facilities, and those who had expired. This information was used by response leaders for planning purposes and was also reviewed by Governor Carcieri before meeting with victims' families and with the media.

Neither RIEMA nor RI Health attempted during the response to regularly determine resource deficiencies encountered by all area hospitals. For their part, hospitals were unaware that RI Health and RIEMA were available to help obtain additional equipment or personnel.

By Wednesday, February 26, the FAC had closed and most RI Health personnel had been released to assume normal duties.

Findings and Recommendations

PH-006 Senior RI Health administrative personnel responded effectively to the challenges confronting them in the wake of the Station club fire. However, the absence of a written mass casualty response plan added to the confusion and required those in charge to make some decisions that were not coordinated or adequately communicated.

RI Health should expedite efforts to develop a disaster response plan. This plan should address the management of RI Health resources and activities as well as its responsibilities at the Emergency Operations Center (EOC) and other off-site locations, such as the FAC.

PH-007 The RI Health administrator should ensure the development of a disaster plan that addresses the use of the Incident Management System.

RI Health personnel should be trained on the Incident Management System as well as the provisions of the new disaster response plan, once completed.

PH-008 It was difficult for those not already familiar with the RI Health chain of command to determine who was in charge at the department command post or at the FAC.

The RI Health disaster response plan should describe how personnel assigned to a leadership position will be visibly identified, along with their radio call signs.

PH-009 Despite the nature and magnitude of this incident, area hospitals felt bound by established safeguards regarding patient confidentiality and the release of patient information.

Legal issues and protocol surrounding patient confidentiality and the release of patient information during a disaster or public health emergency should be reviewed and clarified. This review should be conducted in concert with the Rhode Island Attorney General, RI Health, and hospital attorneys.

PH-010 Some staff expressed disappointment that a more effective communications system was not established to keep personnel apprised of department activities in the days that followed the fire and inform them of ways in which they might be able to assist.

Every effort should be made to inform all personnel of activities related to an ongoing disaster response. This should include frequent staff meetings, e-mail updates, and electronic and fabricated bulletin boards.

PH-011 The opportunity for RI Health personnel to volunteer to assist in the response was viewed as very important personally and professionally by those who participated.

RI Health disaster planning should take into account that department personnel will volunteer to assist when given an opportunity. Work assignments should consider the skills and experience of the volunteers.

PH-012 Because RIEMA did not activate the EOC, RI Health representatives were not invited nor did they have the opportunity to be integrated into a State emergency management system of operations. This was the case despite the fact that this was a mass casualty and mass fatality incident. This lack of coordination resulted in uncertainty among public health officials and the hospitals as to what the RI Health role should be during this disaster.

The activation of the EOC should be considered for all mass casualty events. Thresholds for the activation and levels of activation of the EOC should be defined. RIEMA and RI Health officials need to mutually outline their respective roles during a disaster and their duties at the EOC.

PH-013 All RI Health personnel involved in the response gave unselfishly of their time and expertise. However, providing qualified staff for an extended operation with a variety of work sites and job requirements proved to be problematic.

RI Health should attempt to identify the number of personnel likely to be needed for various major events and the duties they might be assigned to ensure sufficient numbers of trained staff will be available.

PH-014 RI Health did not have a dedicated readily available and accurate inventory of computer equipment that could rapidly be deployed to off-site locations.

A cache of computers, printers, and peripherals should be available for use during emergencies. The computers should have appropriate software applications, local area network (LAN) connections, and support materials.

PH-015 There was no Internet connection established for RI Health personnel to use at the FAC. Access to the Internet would have been helpful.

RI Health should have an Internet connection capability when field computer workstations are established.

PH-016 Although there were landlines in use at the time of the fire, there was no computer link between the OME and the RI Health command post. Initially, all transactions were done on paper and faxed to the other location.

A computer link between the OME and RI Health command post should be established and a redundant system should be in place.

PH-017 There currently is no IT person assigned to the OME.

RI Health should evaluate the need for an IT-trained individual assigned to support the OME.

PH-018 The duplicative efforts of RIEMA and RI Health to establish a victim list proved counterproductive, inefficient, and frustrating to everyone concerned.

RIEMA and RI Health should determine areas of responsibilities for the development of a patient-tracking procedure based on the experience of the Station club response. EMS and Rhode Island hospitals should be involved in this process to establish a procedure that is acceptable to all parties and complies with pertinent health laws.

PH-019 Area hospitals acted independently to transfer patients to other facilities, including burn centers in Massachusetts. These actions ensured patients received the specialized care they needed. However, the lack of a central coordinating authority made it difficult for State officials to track patient locations and obtain incident management information.

RI Health and RIEMA should meet with hospital officials to develop a patient-transfer coordination procedure for use during a disaster. The system should address the responsibility for acquiring patient beds, arranging for transportation, and maintaining documentation.

PH-020 Establishing a single victim list was difficult in part because multiple agencies and personnel were collecting information. In addition, some were hesitant to share information.

RIEMA, RI Health, OME, area hospitals, Rhode Island State Police (RISP), and the American Red Cross (ARC) should develop a formal plan for how victim information will be collected, recorded, and shared. A database should be devised that will serve as the template for obtaining information.

PH-021 RI Health did not attempt to regularly obtain situation updates from area hospitals or to identify resource acquisition assistance that might be needed.

During a disaster, RI Health should regularly communicate with area hospitals to obtain situation updates and determine if any resource acquisition assistance is required.

PH-022 While RI Health personnel spent time assisting at OME and at the FAC, their regular responsibilities often went undone. Thus, when they returned from their temporary assignments, they found themselves several days behind.

While personnel are on temporary assignment, critical aspects of their normal duties should be continued. RI Health should be sensitive to these issues and assist individuals whenever possible.

PH-023 At one point, while RI Health personnel were busy updating patient records at the FAC, the media entered the command operations area and could overhear and record personal information while filming.

Filming and tape recording should not be allowed at any time when personal information about victims is being discussed, recorded, or displayed. Adequate notification of media visits should be made so that personnel can take appropriate steps to safeguard sensitive patient information.

PH-024 Because there was no access control, visiting dignitaries frequently came into the FAC command operations center. In addition to unintentionally interrupting ongoing activities, they had access to sensitive information.

A procedure should be established early into the FAC that restricts dignitaries and other visitors access to the command center.

SECTION 3 – DEMOBILIZATION AND DEPARTMENT ACTIVITY RESTORATION

Observations

Reacting to Stress

Once the deceased had been identified and the FAC closed, most RI Health personnel resumed their normal duties. However, some personnel experienced difficulty because of the physical and emotional fatigue associated with the long stress-filled days of the Station club fire response. The department Employee Assistance Program (EAP) provided mental health assistance for some personnel, while others participated in the post-incident service offered by the Rhode Island Critical Incident Stress Management (CISM) Team. In other cases, personnel relied solely on family support to help them cope and recover from the experience.

Defining Lessons Learned

Recognizing the importance of identifying lessons learned, several RI Health small group sessions discussed what happened and the department's response to the event. In general, there was a very positive feeling and a sense of pride throughout the department. However, several areas in need of additional planning and training were identified.

Research Challenge

The unique nature of this incident, which involved mass casualties and mass fatalities, presents an opportunity for important research projects by government and private researchers. The CDC sought, in collaboration with RI Health, to enroll victims of the fire in a long-term morbidity and fatality survey. However, the project was deferred because of Attorney General concerns about creating new records in the midst of an ongoing criminal investigation.

Interagency Commitment to Improved Readiness

The incident reinforced the importance of being better prepared to respond to a variety of potentially devastating emergencies. RI Health leaders recognize that some of the problems encountered, such as confusion about roles and responsibilities, communications difficulties, and fatality management planning deficiencies, were significant and need to be fixed immediately. Increasing the RI Health emphasis on disaster preparedness and placing higher priority on various preparedness-related projects will help. However, many RI Health officials believe that a new sense of urgency and commitment to change must be shared by other State agencies as well. In particular, although RI Health and RIEMA are mutually respectful, this incident highlighted areas where working relationships need to be further improved.

Findings and Recommendations

PH-025 Despite attempts to notify everyone via e-mail twice, not all RI Health personnel who participated in the response were aware of the availability of mental health support after the incident. Had they known about such support, more would have sought these services.

Mental health support is important in helping personnel manage the emotional and psychological distress caused by such tragic events. Thus, multiple strategies

should be employed to inform and encourage personnel to participate in stress management programs.

PH-026 Although no specific problems were encountered, RI Health officials expressed concern about the failure to plan for verifying the credentials and properly using medically trained personnel.

RI Health, in coordination with RIEMA, should investigate the issues related to volunteer medical personnel and devise a plan to maximize their use in disasters.

PH-027 Although post-incident critique meetings were held, not all pertinent personnel had a chance to participate in the process.

All RI Health personnel who participate in an emergency response should be encouraged to attend post-incident critiques and share opinions on what went well and what obstacles were encountered, as well as to suggest improvements.

PH-028 Some post-incident discussions that identified problems and lessons learned were apparently not documented.

All after-action discussions should be documented so corrective action plans can be devised and executed.

PH-029 To date, there has not been a comprehensive health and medical after-action meeting involving RI Health personnel, other medical response agencies, and Rhode Island hospitals. Some believe such a meeting is still important.

RI Health, working with RIEMA, should co-sponsor an after-action discussion of the Station club fire and invite all appropriate organizations to participate.

PH-030 The Rhode Island Emergency Management Advisory Council (RIEMAC) work group efforts to improve disaster preparedness have been under way for several months. However, several RI Health administrators view the current decisionmaking process as too slow and inconclusive.

In view of lessons learned from the fire and the importance of being prepared for all emergencies, the current disaster planning process should be reviewed to ensure a timely decisionmaking process is being employed.

PH-031 The circumstances surrounding this fire produced an opportunity to learn important health and medical information as well as other valuable lessons. The CDC sought, in collaboration with RI Health, to enroll victims of the fire in a long-term morbidity and fatality survey. The project was deferred because of Rhode Island Attorney General concerns relative to creating new records in the midst of an ongoing criminal investigation.

RI Health should initiate discussion with the Rhode Island Attorney General to ensure the identification of a process that will, whenever possible, ensure important health surveys can be conducted in a coordinated and timely manner.

PART II
HEALTHCARE FACILITIES

INTRODUCTION

Rhode Island Hospitals

There are 16 hospitals located throughout Rhode Island, ranging in size from 100 to 719 licensed beds. Eleven are acute care facilities capable of treating adult and pediatric victims of sudden illness or injury (see **Figure E-2**).

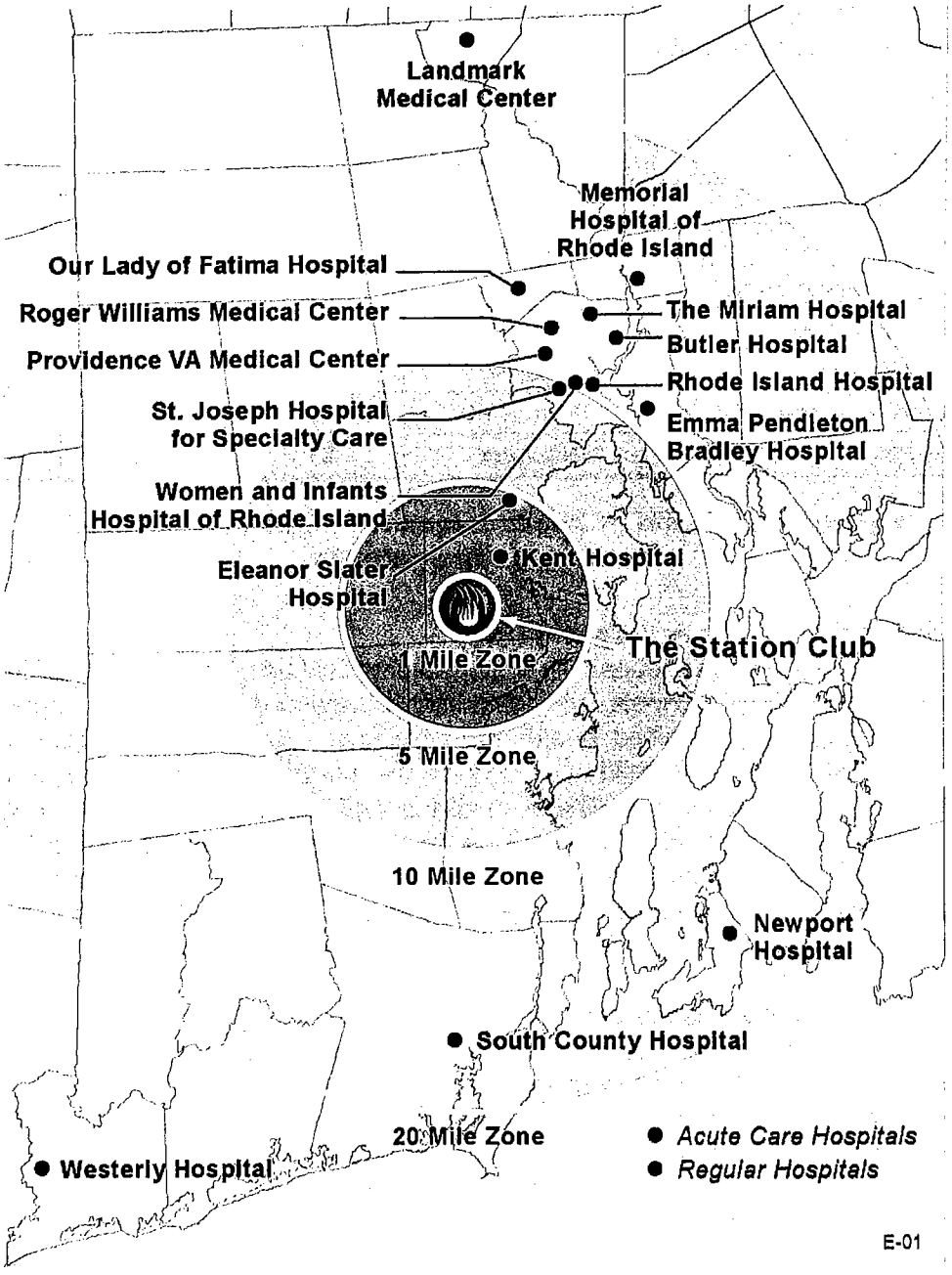


Figure E-2. Locations of Rhode Island hospitals.

In 2002, Rhode Island hospitals received 435,966 emergency department (ED) visits, an average of nearly 1,200 each day, the equivalent of nearly half of the State's entire population. 122,282 patients were admitted to hospitals that year, staying an average of 5 days. Doctors performed more than 150,000 surgeries, including 114,000 outpatient procedures. On average, 60 percent of the licensed beds in Rhode Island hospitals are occupied each day (see **Figure E-3**).

Hospital	Location	Miles from the Fire	Number of Beds	Number of ICU Beds
Kent Hospital	West Warwick	3	359	15
Rhode Island Hospital	Providence	12	719	61
Our Lady of Fatima Hospital	North Providence	17	386	15
South County Hospital	Wakefield	21	100	8
The Miriam Hospital	Providence	16	228	47
Roger Williams Medical Center	Providence	14	220	14
Landmark Medical Center	Woonsocket	24	250	16
The Westerly Hospital	Westerly	34	80	8
Memorial Hospital of Rhode Island	Pawtucket	18	294	16
Newport Hospital	Newport	23	148	10

Figure E-3. Profile of Rhode Island hospitals that received Station club fire patients.

Additional Medical Services and Specialties

In addition to inpatient and outpatient services, several facilities have formal affiliations with medical, nursing, and dental schools, providing highly regarded educational opportunities to future physicians, nurses, and allied health professionals. Many hospitals also offer select specialty services for adults and children. Despite the State's diminutive size, Rhode Island hospitals have nationally recognized clinical medicine and research programs. Rhode Island Hospital, located 12 miles from West Warwick, is the only Level 1 Trauma Center in the State. Currently, no Rhode Island hospital has met the criteria to be designated a burn center. That criteria is established by the American College of Surgeons in collaboration with the American Burn Association and set forth in *Guidelines for the Operation of Burn Units*.

Rhode Island Healthcare Economics

The Rhode Island healthcare industry employs 25,000 people, however, as is the case elsewhere, Rhode Island hospitals face growing concerns about serious shortages in healthcare professionals, high facility usage, and aging physical plants. All of the hospitals in the State operate on a not-for-profit basis and a community-based board of trustees governs each hospital. A combination of charging insufficient fees, coupled with the Nation's lowest insurance reimbursement rate, has resulted in systemic annual operating losses. Each year, Rhode Island hospitals provide more than $100 million in free care to low-income citizens or uninsured patients.

Hospital Association of Rhode Island
The Hospital Association of Rhode Island (HARI) is a trade organization that acts proactively as an advocate for member hospitals. HARI is a national leader in promoting healthcare facility quality improvement and accountability through public reporting. Members of HARI developed and implemented the Rhode Island Health Quality Performance Measurement and Reporting Program (RIHQPMRP), one of the first such programs in America. This initiative annually reports on clinical performance and patient satisfaction for all licensed healthcare facilities in the State.

Station Club Fire Response
There is general agreement that all hospitals in Rhode Island and Massachusetts that received and treated the 186 patients evacuated from the Station club fire responded to the needs of the victims in a swift, efficient, and professional manner. The professional medical staff at each of these facilities rendered the highest quality care to the victims and extended compassionate support to their families under very stressful circumstances. However, this event revealed a number of lessons learned and areas where recommendations for improvements should be considered.

Part II of Annex E consists of the following sections, each of which conveys observations, findings, and recommendations:

- Section 1 – Planning, Training, and Preparedness
- Section 2 – Initial Response
- Section 3 – Communications
- Section 4 – Disaster Operations
- Section 5 – Patient Care in Emergency Departments
- Section 6 – Hospital Inpatient Care
- Section 7 – Extended Operations
- Section 8 – System Recovery and Restoration

SECTION 1 – PLANNING, TRAINING, AND PREPAREDNESS

Observations

Disaster Response Planning

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) describes within its guidelines the expectation that each healthcare facility has a comprehensive disaster response plan. In addition, hospital preparedness efforts are to be integrated effectively with the other response agencies in the community, including the use of a common Incident Management System. In response to this expectation, many hospitals have embraced the Incident Management System developed in California and known as the Hospital Emergency Incident Command System (HEICS). JCAHO also stresses the importance of alert and notification procedures, internal and external communications, resource management, surge capacity planning, patient tracking, documentation, and extended operations, along with system recovery and restoration. JCAHO requires annual training exercises to provide staff a realistic opportunity to use the plan and evaluate its appropriateness.

Mass Casualty Disaster Plan

Rhode Island's Mass Casualty Disaster (MCD) Plan was written in the 1990s by RIEMA. It is intended to provide a framework for response to incidents of all types. It does not contain detailed information about the specific roles and responsibilities of each responding entity, nor does it describe communications, mutual aid, and resource management procedures for patient care and family support. Additionally, although the Rhode Island Emergency Operations Plan (EOP) includes a health and medical section, it does not incorporate the provisions of Emergency Support Function (ESF) #8 – Health and Medical Services, which is the basis for medical emergency management throughout the Nation.

The large number of critically injured patients evacuated from the Station club fire provided a formidable test for all of the hospitals' disaster plans, especially those receiving the most patients—Kent Hospital, Rhode Island Hospital, Our Lady of Fatima Hospital, South County Hospital, and The Miriam Hospital.

Findings and Recommendations

HF-001 At the time of the Station club fire, there was not a current, comprehensive mass casualty plan available for local use or at the State level. Public health, emergency management, and hospital personnel relied on individual hospital plans and procedures, personal relationships, and familiarity with nearby facilities to make critical lifesaving decisions.

The current Rhode Island MCD Plan should be reviewed and updated by RIEMA, in coordination with a multidisciplinary committee, composed of agencies and institutions that will be expected to use it. The plan should effectively address in a comprehensive manner the variety of response issues that are likely to be seen in mass casualty events.

HF-002 The majority of Rhode Island hospital personnel were unaware of the current Rhode Island MCD Plan at the time of the fire. Those who were knowledgeable of the plan believe that it does not adequately address all of the critical response issues, including those associated with terrorism. HARI and RI Health officials commented that RIEMA has not acted on expressions of concern raised previously regarding the MCD Plan content and format.

Once a new MCD Plan is completed, hospital personnel should be given training to ensure desired familiarization with the plan. Cable television, the Internet, compact discs (CDs), and similar delivery media should be considered to optimize the availability of the instruction and reduce some of the associated costs for the hospitals. Local, regional, and periodic Statewide exercises should be employed to allow personnel to employ and gain confidence in the plan.

HF-003 Although the staff at most Rhode Island hospitals are personally familiar with many officials at RIEMA and RI Health, there is general unawareness of their roles and responsibilities during response to disasters. Furthermore, there is only limited understanding of the Rhode Island EOP. This overall lack of understanding diminishes the importance of these agencies, complicates the performance of their duties, and contributes to inappropriate or unrealistic expectations.

The failure to understand the roles and responsibilities of RIEMA and RI Health during a disaster should be fully discussed in meetings involving all parties. These discussions should identify and resolve response issues that arise in day-to-day operations and during real or simulated disasters.

HF-004 HARI and the Hospital Preparedness Planning Committee have increasingly endeavored to take a leadership role in promoting collaboration among Rhode Island hospitals. Although meetings have led to meaningful discussions, significant preparedness issues remain.

HARI and the Hospital Preparedness Planning Committee should continue to play a leadership role in promoting collaborative response planning among hospitals. Consideration should be given to developing response-oriented planning templates addressing such areas as external communications, security, patient tracking, and resource management. Planning on these subjects should be done with representatives from RI Health and RIEMA. Other specialty-oriented discussions, such as triage, personal protective equipment (PPE), and patient decontamination, should include fire, EMS, hazardous materials (HazMat), and law enforcement officials.

HF-005 Hospital mutual-aid agreements are informal arrangements that have not yet been codified in writing.

A Statewide comprehensive hospital mutual-aid agreement should be developed for use in future disasters.

HF-006 Hospital personnel appear to enjoy good day-to-day relationships with their EMS colleagues. However, there is no forum that brings representatives from each group together to regularly discuss response-related issues. In addition, State, local, and Federal officials do not consider hospitals to be frontline first responders alongside fire, police, and EMS organizations.

Meetings involving all hospitals and EMS response community members should be regularly scheduled. Participants should discuss matters of mutual interest concerning routine situations and disaster operations. The results of these discussions should be recorded and distributed to all parties.

HF-007 Rhode Island hospitals were able to meet the challenge of receiving 186 seriously injured victims transported by EMS as well as a reported additional 40 or more patients arriving by other means. However, there is little evidence of written surge capacity expansion plans at area hospitals. The absence of tiered response plans increases the pressure on the staff and increases the chance that some part of the response will prove unsatisfactory. Thus, it is important that each facility have a written plan for increasing its patient care capacity using a variety of approaches, including staff reassignment and call back, use of hallways for patient staging, canceling elective admissions and surgeries, and similar measures. Moreover, in the event that a hospital is unable to expand beyond its existing capacity under extraordinary circumstances, there is no regional or Statewide contingency plan.

RI Health, working in conjunction with the hospitals, RIEMA, and other appropriate agencies, should prepare a written plan for supplementing the local capability in a timely fashion by drawing on State and/or regional resources, Emergency Management Assistance Compact (EMAC), or Federal assistance. Periodic exercises of these respective plans must be held if they are to be successfully used during an actual emergency.

HF-008 Hospital personnel identified a need for more training on disaster response issues, including the Incident Command System (ICS). Current fiscal constraints at most Rhode Island hospitals dictate pursuing creative training solutions to minimize the cost and logistical implications.

RIEMA and RI Health should work with the hospitals to provide ICS training, using cable television, the Internet, or CDs to maximize the availability of the training and minimize the cost.

HF-009 Since the events of September 11, 2001, Rhode Island has reorganized many of its planning committees. Currently, hospital representation exists on the RIEMAC, the Hospital Preparedness Planning Committee, and the Healthcare Emergency Preparedness Group. However, they are not included on other critical committees and work groups such as the Communications Working Group, the Radio Work Group, Mass Decontamination Working Group, Mass Casualty Working Group, Community Weapons of Mass Destruction (WMD) Working Group, or the ESF Working Group. Absence from these organizations limits the ability of Rhode Island hospitals to provide important input on issues that will impact on healthcare operations.

Hospitals should be represented on all State committees where patient care issues are addressed.

HF-010 All Rhode Island hospitals that engaged in the Station club fire medical treatment response should be commended for conducting internal after-action discussions that assessed performance and identified areas needing improvement.

Rhode Island hospitals should review the lessons learned derived from their internal and external reviews following the Station club fire response, along with the recommendations in this report, and make needed changes to disaster plans.

HF-011 Although they were held several months after the fire, the two general sessions facilitated by HARI were important and productive.

All hospitals should meet together soon after an incident to review response efforts and identify needed response changes.

SECTION 2 – INITIAL RESPONSE

Observations

Alert and Notification

Rhode Island hospitals learned about the fire through a variety of means. Kent Hospital, the closest to the incident scene, received a brief alert from a West Warwick rescue unit shortly after 11:00 p.m. that there was a "fire at the Station," followed by a second message stating there might be more than 100 victims. The person who received the initial call presumed that the fire occurred at the fire station and, therefore, the prospect of so many casualties had been exaggerated. Twenty minutes later, the first victim of the Station club fire walked through the door, transported to the hospital by automobile.

Rhode Island Hospital staff first learned of the fire from television news reports. A short time later, Lieutenant Ray Medeiros of the North Providence Fire Department (NPFD), called Mr. Lawrence at the Rhode Island Hospital Emergency Department (ED) seeking authority to administer morphine to critical burn patients at the scene. Earlier attempts to contact a medical control agent and obtain permission had been unsuccessful.

Subsequently, Rhode Island Hospital contacted the Incident Command Post (ICP) at the scene and stated that it could receive all of the critically injured victims. This information was relayed to EMS personnel onsite and also to the Cranston Fire Alarm Office. It influenced some of the subsequent patient distribution decisionmaking.

An inbound rescue unit contacted Our Lady of Fatima Hospital shortly after 11:30 p.m. The first burn victim arrived at Our Lady of Fatima Hospital in a private car a short time later, followed quickly by the EMS unit with two additional patients. Kent Hospital personnel called The Miriam Hospital's Emergency Department trying to gather information about critical beds. Media reports were the primary source of information for all hospitals as they attempted to understand the magnitude of the calamity and determine what was needed and what response steps to initiate.

Preparatory Steps

The closest facilities to the incident began clearing beds in the ED and in the intensive care units (ICUs). Because the fire began at the time of the 11:00 p.m. shift change, additional medical and support staff were immediately available and were directed to remain on duty. Others who had just left to go home returned to work, while many of those who had been off duty and heard the media reports reported to work in case they might be needed. More distant facilities took some of these same precautions, not knowing whether they would receive patients.

Blood stocks and medication inventories were verified and other aspects of hospital disaster plans were reviewed in anticipation of receiving a substantial but undefined number of seriously injured patients. All of the hospitals were able to make additional beds available in the EDs and elsewhere. Rhode Island Hospital arranged to quickly transfer eight patients to Landmark Hospital to free up beds while simultaneously evacuating all ED patients to the nearby Hasbro ED. These aggressively implemented preparatory actions proved important because within

45 minutes of receiving the first walk-in patient, 55 other seriously injured victims were received at Kent Hospital alone.

Assessing the Situation
There was little communication between staff at the receiving hospitals and emergency response personnel on the scene or, for that matter, between en route ambulance staff and the hospitals to which the victims were transported. EMS crews delivering patients to hospitals shared some information about what was transpiring at the incident site, as did arriving patients who were able and willing to speak. But, for the most part, hospital staff, particularly at Kent Hospital and Rhode Island Hospital, knew only that there was a steady and seemingly endless stream of ambulances transporting badly burned patients. Some hospitals called RIEMA HQ seeking information but reported reaching only the after-hours answering service.

At the suggestion of one of the emergency medical technicians (EMTs), Dr. Robert Baute, the chief executive officer (CEO) of Kent Hospital, went to the scene of the fire in a rescue vehicle, arriving at about midnight. By then many patients, especially the most critically injured, had already been transported to hospitals or were being loaded into ambulances. He was able to provide first-hand information to the Kent Hospital staff via cellular telephone and influence the distribution of some of the patients remaining at the scene to other Rhode Island hospitals.

Findings and Recommendations

HF-012 Rhode Island hospitals did not receive official notification that a fire had occurred at the Station club or information from the scene identifying the probable number of victims and the nature and severity of injuries. Despite the deficiencies in the alert and notification process, all of the hospitals responded in a commendable fashion.

It is important that all hospitals receive preliminary size-up information about an incident as soon as possible. Such information should include the nature and location of the incident, an estimate of the number injured and type of injuries, a description of care given at the scene, and an estimate of the arrival time of patients being evacuated to area hospitals. This preliminary information should be regularly updated for the duration of the incident.

HF-013 There was no attempt to ascertain the capacity of Rhode Island hospitals to accept patients with injuries of varying criticality, thus impeding the ability of command staff on the scene to make sound decisions regarding patient distribution.

Immediately upon notification of an incident, each potential receiving hospital should be asked to quickly determine the number of critical and noncritical patients it can receive. The ambulance loading officer at the scene should consider this information when determining patient destinations. Periodic status reports from the hospitals should also be sought and considered in routing decisions.

HF-014 As patients suddenly began to arrive at Rhode Island hospitals either on their own initiative or via EMS transport, the hospitals did not contact their local Fire Alarm

Offices to inform them of what was transpiring and to seek information about the incident.

Once a hospital begins to receive patients from an incident about which they were unaware, hospital staff should notify the appropriate regional Fire Alarm Office, apprise them of the situation, and seek additional information about the incident. They should also provide dispatchers with a situation report.

HF-015 Incorrect contact information, including inaccurate telephone and pager numbers, delayed notification of some hospital personnel.

Hospitals should regularly review and test internal disaster plans, including the notification and mobilization sections to ensure contact numbers are current and personnel can be reached by telephone and pager when needed.

HF-016 Once contacted at home, personnel called the hospitals in response to the pager notifications, placing a further workload on the ED secretary and hospital telephone operator. The ED secretary manages all direct incoming and outgoing calls from that location.

Hospitals should consider giving key personnel two-way pagers so that calling in for more information is unnecessary. This type of pager might also prove useful for communication among personnel once at the hospital.

HF-017 The ED secretaries at several facilities were overwhelmed with telephone calls and sometimes had difficulty managing the workload. Hospital communications is minimally staffed at this time of night and also encountered similar difficulties.

Upon determining that there will be an unusually large number of critically injured patients, additional personnel should be assigned as soon as possible to supplement the ED secretary and hospital telephone operators.

HF-018 When a physician from Kent Hospital responded directly to the incident site, he did so at the request of an EMT who had delivered a patient to the hospital without communicating with Incident Command personnel. He was able to assist briefly with triage and also provide situation updates to Kent Hospital by cellular telephone. There are currently no protocols in place for physicians and other hospital staff to deploy to a mass casualty site nor instructions regarding their presence at the site.

Rhode Island should consider adapting an on-scene medical practitioner policy. Such a policy should outline how volunteer physicians and other healthcare professionals who come to an incident are used and the conditions under which they would be allowed to render patient care.

SECTION 3 – COMMUNICATIONS

Observations

Initial Communications

Communication is always a major challenge for the healthcare community during major incidents. The West Warwick Station club fire was no exception. Under ideal circumstances, all potential receiving hospitals would immediately be notified of the event. In Rhode Island, this notification would normally be initiated by the responsible local Fire Alarm Office acting on the request of the Incident Commander's (IC's) emergency medical staff or RIEMA. In this incident, a formal notification did not occur.

Hospitals ideally would also be quickly surveyed to determine the capacity and capability to receive patients with varying degrees of critical injuries. This would occur over the Nextel hospital radio system, which connects all responsible parties and is regularly tested with roll calls three times each day. When Mr. John Aucott of RIEMA called the Cranston Fire Alarm Office and asked that area hospitals be surveyed using the Nextel system, he was told that it was unnecessary because Rhode Island Hospital would receive all evacuated victims.

The Nextel system would also be used among the receiving hospitals to coordinate patient status as victims are received and to exchange other important information. During this incident, the hospital Nextel system was not used because personnel were not adequately trained or familiar with it or sufficient staff were unavailable to use it.

The EMS loading officer at the incident site would use hospital status information in making patient disposition decisions. The Rhode Island Interagency Nextel Hospital Communications Network Plan specifies that the participating facility nearest to an incident site should initiate and coordinate Nextel calls among receiving hospitals. During the Station club fire response this would have been Kent Hospital. In this incident there was no coordination of Nextel calls among receiving hospitals.

Inbound EMS Communications

EMS personnel transporting patients to area hospitals often radio ahead and inform the ED of the nature and severity of injuries and the estimated time of arrival. Both parties view this routine practice as important. It is especially important during a mass casualty situation, although it may need to be modified to avoid problems such as channel crowding and to accommodate short travel times by a large number of ambulances.

Internal Communications

Hospitals use internal communications capabilities and procedures to prepare for arriving patients. Various treatment facilities would be realigned to free up space in the ED and other critical care facilities. Physicians and other medical and support staff would be contacted, apprised of the situation, and prepared to receive and treat patients. Elective medical activities might be canceled, postponed, or transferred to other facilities and the hospital communications staff would transmit this information to all affected parties. In anticipation of a surge in telephone inquiries from patients' families, others searching for possible victims, and media

representatives seeking information, the hospital communications staff would be augmented with personnel from other departments trained for such situations.

Findings and Recommendations

HF-019 During the Station club fire, there was very little communication between en route EMS units and the receiving hospitals. In the absence of patient prearrival information, hospital staff often scrambled to find beds and match the injuries of arriving patients with appropriate medical specialists.

The Rhode Island MCD Plan should clearly outline the expected communications between an in-bound EMS crew and a receiving hospital. It should describe the mandatory baseline information to be provided, such as the number of patients, their priority, and basic injuries along with the estimated time of arrival.

HF-020 Rhode Island does not have one single EMS communications system. Thus, each jurisdiction has devised a system that works within a particular community but can become problematic when providing mutual aid or delivering patients to hospitals that are outside the normal response area. During the response to the Station club fire, some EMS crews were unfamiliar with hospital locations and correct radio contact numbers.

The current Rhode Island Communications Committee's and Hospital Preparedness Planning Committee's work on developing a Statewide communication system is vitally important and should proceed without delay. Committee deliberations should take into account not only the daily need for a dependable and redundant communications system but a system that can be expanded or otherwise modified as needed during a disaster. The system should effectively integrate all hospitals with both public safety and private sector EMS agencies.

HF-021 Some hospitals reported that the location of the Nextel radio was a problem. In some cases, it is located in an administrative area to facilitate the daily roll calls and, therefore, not readily accessible to those directly engaged in emergency response. Others reported that placing the Nextel radio amid the noise and frantic activity of the ED made it difficult to hear and also unlikely that someone nearby would have time to answer a call.

Rhode Island should consider placing two Nextel radios in each hospital. This would allow one to be kept in the ED and a second to be maintained in the Hospital Command Center or other appropriate location. An audible visible alarm notification should be included with the Nextel radio.

HF-022 The Rhode Island Interagency Nextel Hospital Communications Network Plan also calls for first responders to use the Nextel system to relay vital information to the hospitals and obtain information from the hospitals with the assistance of one of the five regional Fire Alarm Offices. That was not done by Metro Control, the

facility closest to West Warwick. This lapse reportedly occurred because of limited personnel on duty.

The successful implementation of a vital communications system requires that every component embrace its use. The RIEMAC Communications Working Group should review the use of the Nextel system during the Station club fire response and endorse and mandate its use in future emergencies or replace it.

HF-023 One of the purposes of the Nextel hospital radio system is to enable hospitals to routinely coordinate bed availability and the status of diverting patients under extraordinary circumstances. Coupled with the daily roll calls, one would expect these regular uses would ensure adequate staff familiarization with the system. However, in the Station club fire response, it was clear that many of the hospital staff were not trained in the system and did not know how to answer or initiate calls. When Kent Hospital initiated a call to coordinate with other hospitals in accordance with the Rhode Island Interagency Nextel Hospital Communications Network Plan, other hospitals failed to answer. Subsequently, Rhode Island Hospital tried to call other receiving hospitals on the Nextel system and had the same results. Our Lady of Fatima Hospital also made repeated attempts to contact several hospitals with disappointing results.

All hospital staff working in the general proximity of a Nextel radio should be trained in its use. Participation in the thrice-daily roll call should be rotated among hospital staff members so that they are comfortable with the system. It should also be periodically exercised under simulated disaster circumstances.

HF-024 The failure of the Nextel system to work as planned severely limited communications, coordination, and information sharing among hospitals and between hospitals and other key response agencies. RIEMA did not attempt to use the Nextel system at all during the incident.

The current Rhode Island Interagency Nextel Hospital Communications Network Plan should be reviewed and changes made to better ensure the system works effectively on a daily basis and during disasters. Regular use of the Nextel system during routine operations, coupled with frequent testing during exercises and better staff training, will make it a more useful tool during emergencies.

HF-025 Some hospitals reported difficulty making timely internal notifications because of technical communications problems. As a result, some key personnel and certain areas of the hospital did not receive timely and accurate information about the incident.

Each hospital should regularly evaluate the effectiveness and dependability of communications technology such as overhead pagers, standard pagers, and radios to ensure they will function properly when needed.

HF-026 During the Station club fire response, no Rhode Island healthcare facility or other agency assumed a coordination role during initial response or over the next several

days of extended operations. As a result, information sharing among hospitals was random or nonexistent.

The Hospital Preparedness Planning Committee, RI Health, and RIEMA should revise the current host hospital concept and designate a single facility and backup facility to serve as a hospital coordination center. This facility would be activated to serve as an information clearinghouse for hospitals. It would assist, as necessary, with obtaining and relaying information from the scene while at the same time coordinating information sharing among receiving hospitals during emergencies.

HF-027 Communication between hospital EOCs was limited and yet the need for information sharing among hospitals was vital. The Nextel system could be used for this purpose but it was felt it was not appropriate.

A reliable system for communication between hospitals to command centers should be mandated early into an incident and used continuously.

HF-028 A disaster that causes mass casualties is likely to strain hospital capabilities and resources. During the response to the Station club fire, receiving hospitals with limited information performed valiantly and with great flexibility. Had there been a pressing need for outside assistance or emergency supplies, the Rhode Island EOC was unavailable to offer assistance because it had not been activated. Hospital staff also reported that, in some cases, they did not have correct contact information for the State EOC had it been activated.

Hospitals should be advised when a State or local EOC is opened and they should be provided correct contact information. In the absence of an active EOC, hospitals should maintain current emergency contact information for their local emergency management agency, RIEMA, and RI Health.

HF-029 The Rhode Island healthcare community continues to rely exclusively on traditional telephone and radio communications, although computer-based communications and resource management software are increasingly available. The Internet, with high-speed connectivity and real-time messaging, coupled with the portability of handheld devices and portable keyboards, offers immediate expanded communications possibilities.

The use of the Internet as a valuable communications tool for hospitals, public health, and emergency management should be made a priority. RI Health should explore further the use of the Internet as a means of providing information to the public.

HF-030 Because of concerns related to security or patient confidentiality, incident-related information must be carefully compiled and prudently shared. Some hospitals voiced concerns regarding the transfer of patient information via telephone or radio. In addition, although the fax machine proved to be a valuable means of information transfer, some hospital and public health personnel appropriately worried that sensitive patient information was accessible to persons who did not

have a legitimate need for it. Additionally, when telephone requests for patient information were received from persons identifying themselves as RIEMA staff members, their identities could not be readily verified.

The current practice used by hospitals to share patient information should be reviewed to determine if there are confidentiality concerns and, if so, those concerns should be addressed. In addition, public health and emergency management personnel should review with hospital staff and HARI officials how patient information is best obtained from hospitals during disasters, and institute procedures to validate those individuals and agencies to which information can be released.

SECTION 4 – DISASTER OPERATIONS

Observations

Initial Surge of Patients

Because of the sudden and unanticipated arrival of seriously injured patients, Rhode Island hospitals quickly recognized the need to expand capacity to receive and treat the critically injured patients. For example, in a period of less than 45 minutes, Kent Hospital received 55 victims of the Station club fire. The large influx of patients with little prior notice placed a premium on effective and timely actions on the part of the ED staff and hospital leaders.

Hospital Emergency Incident Command System

The majority of hospitals in Rhode Island use the Hospital Emergency Incident Command System (HEICS), originally developed in California. Most hospital command posts were operational for less then 12 hours during the Station club fire; however, administrative coordination of the hospital response went on long after the last patient was discharged.

Expanding Capacity

Each ED immediately released patients who could be discharged and limited admissions to those who needed immediate critical care. Wherever possible, on-duty hospital staff were reassigned to the ED and back-filled by off-duty personnel who were recalled or reported on their own volition. The fact that the incident coincided with the evening shift change was fortunate. For example, Kent Hospital had 15 ED staff going off duty and 10 reporting for duty. Thus they had a total of 25 trained ED personnel immediately available.

Additional beds were also needed for this surge in emergency admissions, and steps were taken to find as many as possible. In some cases, arrangements were made to send patients home where appropriate. Others were transferred to nearby rehabilitation facilities or nursing homes. Rhode Island Hospital was able to move already hospitalized patients to an unoccupied floor, thus freeing up beds for incoming patients.

Queuing Up for Treatment

There was a continuous stream of seriously injured patients arriving at area hospitals. In the absence of communications from the incident site, ED staff presumed that the most seriously injured were being evacuated first, followed by those less seriously injured. However, this was not necessarily the case. Some of those who suffered the worst burns were among the last rescued from the fire.

AP Photo

A continuous stream of seriously injured patients arrive at area hospitals.

With the unanticipated arrival of so many patients, it was impossible to always assign physicians to patients based on medical specialties. Physicians were assigned to arriving patients on a first-come, first-served basis.

After the initial retriage and stabilization, treatment was to a certain extent based on the judgment and experience of the assigned physician and not subject to an overarching standard established, for example, by a surgeon who specialized in burn victims. There was also no apparent end to the constant flow of casualties, as ambulances followed one right after another. It was only when one ambulance crew member commented that he thought just about everyone had been evacuated that Kent Hospital suspected the worst might finally be over.

Hospital Staff-Patient Bonding
Bonding among physicians, hospital staff, and patients occurred quickly under these circumstances. In some cases, when patients were transferred to other healthcare facilities better able to treat their injuries, the attending physician or nurse accompanied the patient by mutual request.

Unprecedented Teamwork
The Rhode Island emergency medical community responded with outstanding teamwork and camaraderie to the challenges of this horrific event. Physicians rushed to area hospitals offering their services. Police officers offered to drive ambulances to free up EMTs to remain at the scene and perform triage. The NPFD usually delivers patients to Our Lady of Fatima Hospital. Its personnel are familiar with the hospital's layout and ED functions. It seemed natural, therefore, for the personnel of North Providence Fire and Rescue to respond on their own, organize themselves into teams, and assist Our Lady of Fatima Hospital staff with triage, patient information collection, and general patient care.

Caring for Families
Families of victims and missing family members quickly began to congregate at area hospitals, adding to the congestion and presenting healthcare challenges of a different nature. Clergy came to minister to the victims and to console distraught family members. In many cases, these were the same clergy who made frequent rounds visiting hospitalized members from their own congregations. Families of other patients and even non-Station club fire patients provided comfort and solace to the Station club fire victims and their families.

Findings and Recommendations

HF-031 This incident reinforced the importance of the hospital disaster plans and the Incident Management System. It also pointed out the need for more training on HEICS and various aspects of the response plan itself.

Each hospital should ensure personnel expected to fill leadership roles are familiar with the hospital disaster plan and the principles of the HEICS.

HF-032 All of the hospitals did an outstanding job of finding beds and providing care for the injured in the absence of formal plans calling for expanded emergency surge capacity. Several facilities subsequently identified additional steps they could have taken that were not considered during the response.

Each hospital should develop a written surge capacity plan that can be used in any type of disaster. This plan should include methods of using its own staff and resources along with regional, State, and Federal assistance as well.

HF-033 Rhode Island does not have a uniform Statewide approach to hospital surge capacity planning. Each hospital is left to determine its own requirements and develop ways to satisfy them. This leads to an uncoordinated situation and possible conflicting reliance on the same resources.

The RI Health and Hospital Preparedness Planning Committee should develop a surge capacity and capability planning template. It should outline objectives for hospitals to meet extraordinary demands using on-duty and call-back staff, supplemented when required by State and regional resources and, if needed, Federal assistance. This plan should be applicable for any type of disaster and to all patient constituencies, including adults, children, and persons with special needs.

HF-034 Several hospitals reported that the surge of medical volunteers was almost overwhelming. Some were off-duty staff members who could be immediately engaged; others were highly qualified volunteers unfamiliar with the hospital and ED layout and procedures. Still others had qualifications that needed to be determined or validated. The physical presence of so many volunteers added to the congestion and noise in already crowded EDs and treatment areas.

Consideration should be given to having a personnel staging area away from the ED and other areas of critical activity. The plan should also address how lay volunteers and medical personnel who usually do not work at the facility will be used during a disaster.

HF-035 In some cases, in the rush to return to the hospital, personnel left their identification badges at home, resulting in challenges by the security staff and delays in reporting for duty.

It is important for reasons of security and identity verification that all hospital staff and attending physicians have proper credentials with them at all times. Hospitals should be prepared to identify all personnel entering and, in some situations, exiting the building.

HF-036 Had this incident been more protracted, hospitals would have had to sustain surge activities for an indefinite period of time. Some hospitals reported that current plans do not provide for extended personnel staging or infrastructure support for long-term emergency response operations.

In recalling healthcare facility personnel, consideration should be given to the extended nature of certain types of disasters and the need for supplemental personnel over long periods of time. Extended operations planning should also address other issues, such as infrastructure support and documentation.

HF-037 Several hospitals reported many generous acts of kindness from the surrounding neighborhoods and the community in general. Donations of prepared foods, flowers, money, gifts intended for victims, and other expressions of support were keenly appreciated. Such donations, however, must also be properly managed, adding yet another challenge to the hospital staff.

As part of the disaster response plan, hospitals should comprehensively address how they will manage donations of food, materials, and money.

SECTION 5 – PATIENT CARE IN EMERGENCY DEPARTMENTS

Observations

Initial Patient Surge

EMS personnel quickly mobilized the staff and ambulances to transport approximately 186 seriously injured persons from the incident site to Rhode Island hospitals in less than 2 hours after the fire erupted.

None of the patients received a triage tag (see **Figure E-4**) before or during transport, and Ambulance Run Reports were completed on fewer than 23 percent of the patients. Triage tags would usually convey information about the patient's identification, the nature of injuries, and treatment provided at the incident site. The Ambulance Run Report would contain information about care given during transport and changes in the patient's condition. Upon arriving at a hospital, the transport crew quickly rendered a verbal report of the patient's identity and condition. An ED physician or surgeon serving as the triage officer then decided which treatment area would receive patients for further evaluation and preliminary care. All of the EDs reported using an Incident Management System to direct department activities. Key leadership positions were filled by on-duty personnel or persons recalled from home. In some cases, the limited number of available staff with sufficient skill sets made it difficult to initially fill all of the command positions, so one person sometimes assumed multiple roles.

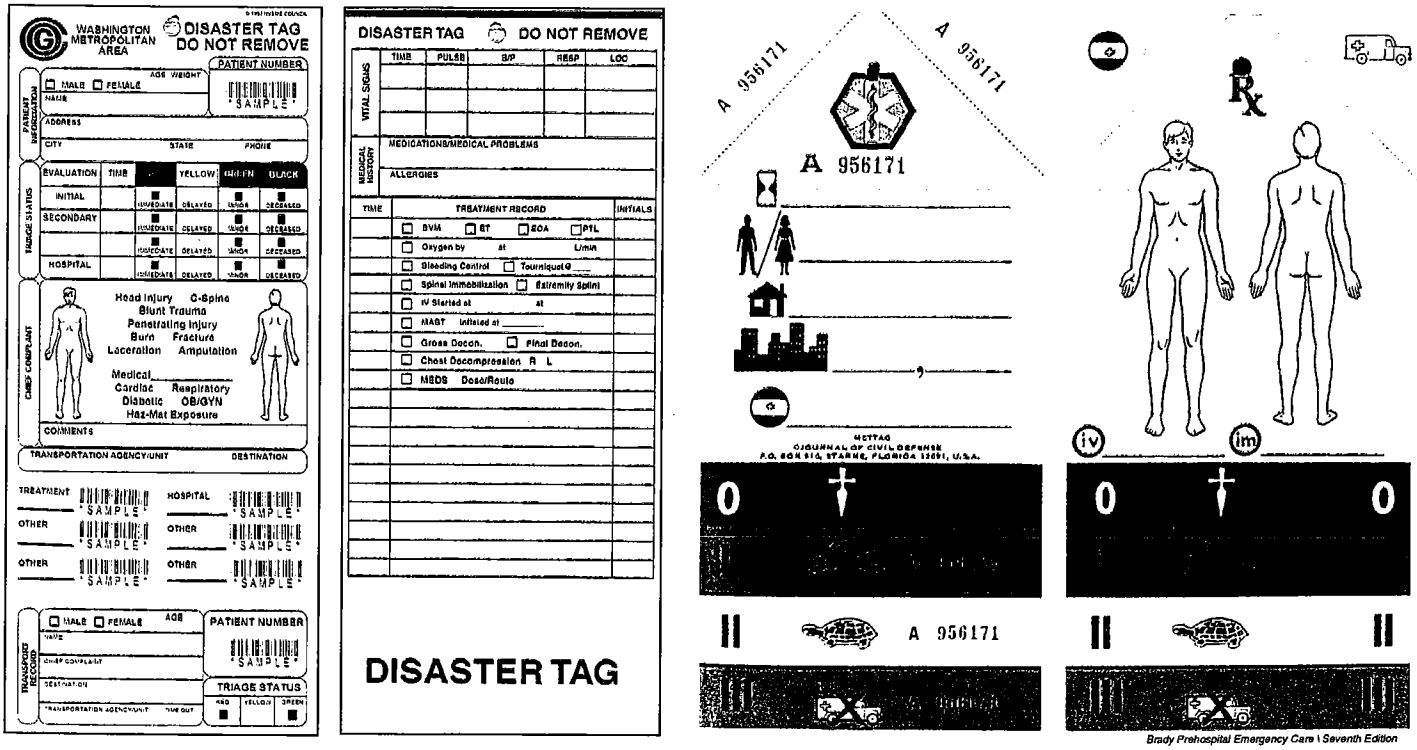


Figure E-4. Samples of the types of triage tags used in the United States.

There are no standard Statewide triage criteria or procedures used by all Rhode Island hospitals. Hospitals reportedly used either the American College of Surgeons trauma criteria or that of the American Burn Association to perform triage. None of the hospitals reported placing a triage priority identifier such as a ribbon, card, or forehead marker on the patient once triage was completed. Hospital staff reported that the failure to use triage tags by EMS did not negatively impact on their patient care efforts. However, it did limit the patient information that was immediately available.

Organizing Emergency Department Resources

The hospitals closest to the fire (Kent, Our Lady of Fatima, The Miriam, South County, and Rhode Island) received patients sooner and in larger numbers than most of the remaining facilities (see **Figure E-5**). Without adequate information from the incident site, it was difficult for hospitals to decide whether to keep patients in the ED or transfer them to auxiliary treatment areas in accordance with their disaster plan. At Rhode Island Hospital, Dr. William Cioffi, the chairman of the surgical department and a burn physician by training, along with the director of nursing, Dr. Jane Metzger Ph.D., examined each arriving patient and gave instructions on patient disposition and treatment. Critical burn victims were taken within 15 to 20 minutes of arrival to the ICU or to a temporary burn ward to allow space in the ED for less critical patients. Injuries ranged from nearly 100 percent body surface burns and smoke inhalation to broken bones, cuts and abrasions, and emotional trauma. Airway management, starting intravenous (IV) lines, and maintaining hemodynamic stability were major challenges posed by many patients and tested the expertise of the most experienced clinicians.

Hospital	Patients Received	Treated and Released	Transferred	Air Transfers	Ground Transfers	Admitted
Kent Hospital	82	43	18	4	14	21
Rhode Island Hospital	68	17	8	3	5	43
Our Lady of Fatima Hospital	18	13	2	2	0	3
South County Hospital	17	16	1	0	1	1
The Miriam Hospital	12	4	2	0	2	8
Roger Williams Medical Center	10	4	6	1	5	0
Landmark Medical Center	6	5	0	0	0	1
The Westerly Hospital	2	1	1	0	1	0
Memorial Hospital of Rhode Island	1	1	0	0	0	0
Charlton Memorial Hospital	1	1	0	0	0	0
Newport Hospital	3	3	0	0	0	0
St. Luke's Hospital	2	1	0	0	0	1
South County Hospital	1	1	0	0	0	0
Massachusetts General Hospital/ Shriners Hospital for Children	17	0	0	0	0	17
UMass Memorial Medical Center	4	0	0	0	0	4
Brigham and Women's Hospital	8	0	0	0	0	8

Source: Dr. Selim Suner, Rhode Island Hospital

Figure E-5. Patient distribution.

The availability of significant numbers of medical staff early in the emergency permitted EDs to accommodate the initial patient surge. In some cases, teams of personnel were created to care for each critically injured patient. ED physicians or surgeons examined the patient, while anesthesiologists and respiratory therapists monitored the airways. Nurses administered medications, maintained treatment charts, and dressed and bandaged wounds. ED technicians and others assisted with patient care and moved patients between various treatment areas. In the first couple of hours, overcrowding and noise were issues in the busiest hospital EDs.

Although the majority of Station club fire victims sought immediate medical care, others reported to area hospitals throughout the next 48 to 72 hours. Even though some of these patients had serious burn injuries, they had delayed seeking medical care until the most seriously injured had received treatment.

Other Patients Awaiting Emergency Treatment
There were already patients awaiting emergency care in some receiving hospitals when the Station club fire occurred. Some left voluntarily, planning to return for care later. Others remained and, in some cases, provided emotional support to the burn victims and comforted their family and friends.

Medical Supplies
Receiving hospitals made arrangements for supplemental ED equipment, medications, and supplies. Items that were used in large quantities included dressings and bandages (including burn packs), burn cream, IV fluids, oxygen masks, and analgesics, chiefly morphine sulfate. One hospital used the equivalent of a 3-month supply (3 grams) of morphine in the first 24 hours after the fire. Ventilators were also used on many badly burned victims.

Impact on Support Operations
Laboratory staff played an important supporting role in the initial evaluation of the critically injured victims. There was a much higher-than-normal volume of routine and specialized ED testing because of the number of patients and the nature of their injuries. The radiology department was also impacted as scores of x-rays, CAT scans, and other radiographic studies were required.

Patient registration was affected as well. In some cases, the sheer volume of patients exceeded the ability of the registration staff to keep up. At Kent Hospital and Rhode Island Hospital, the number of unconscious patients was especially high. Identification of unconscious victims was very difficult because, in many cases, their personal identification had been removed, burnt, or otherwise lost. Thus, "John and Jane Doe" identifications were used. Keeping accurate track of patients, their names, and treatment status was problematic for the busiest hospitals, especially during the first hour into the incident.

Findings and Recommendations

HF-038 The absence of triage tags applied at the incident site by EMS personnel reduced the hospital ED staff's ability to fully understand the initial assessment and preliminary treatment given to arriving patients. EMS technicians did not always have time to give a complete report before returning to the scene. In other cases, the

absence of a triage tag also precluded initial hospital triage priority identification, delayed initial documentation, and made patient tracking more difficult. There are no standard Statewide triage criteria or procedures used by all Rhode Island hospitals.

EMS personnel should endeavor to routinely use the triage tag during all mass casualty incidents (MCIs) as described in State and local guidelines. Rhode Island should establish a standard Statewide triage procedure for hospital use.

HF-039 Several hospital staff members reported they were unfamiliar with the triage tag and with the triage process used by EMS.

The staff at all hospitals should be trained in EMS triage principles and know how to properly use the State disaster triage tag.

HF-040 Although all receiving hospitals adhere to the principals of the ICS, with the hectic pace and congestion of busy ED operations during the Station club fire response, it was not always clear who was in charge. Although each hospital implemented the Incident Management System according to its plan, few used command vests or other distinctive markings or provided personnel with reminders of command roles and responsibilities.

Command vests should be made available for each leadership position in the ED, auxiliary treatment areas, and the hospital command post. Descriptions of command roles and responsibilities, radio title identifiers, and critical contact reminders should also be distributed to key hospital staff.

HF-041 Hospitals reported difficulty in reaching some staff members because contact numbers proved incorrect. Despite this problem, each hospital was able to quickly supplement ED and support service staff through holdover, reassignment, and selective call-back. Had this incident not occurred at shift change, it would have taken longer to achieve the staffing levels required in this emergency.

All hospitals should regularly review and periodically test staff call-back procedures. Projecting the relative staff reporting times will help hospital command personnel determine the order in which people should be contacted.

HF-042 The unsolicited assistance that Our Lady of Fatima Hospital received from the NPFD proved both valuable and gratifying. This came about because of the long-standing and often practiced working relationships between Our Lady of Fatima Hospital and the NPFD (Engine, Truck, and Rescue). NPFD personnel were familiar with ED staff, facilities, and operating procedures. Our Lady of Fatima Hospital ED staff had confidence in the NPFD basic and advanced lifesaving skills and with EMS triage principles. North Providence Police Department (NPPD) assisted with patient identification and parking lot security.

All hospitals should consider under what circumstances, and in what manner, to engage local fire department and EMS (public safety and private sectors) in disaster

response efforts. Regular meetings, along with periodic training sessions, are necessary to ensure such participation will go according to plan.

HF-043 Hospitals conducted some form of inventory assessment of equipment, medications, and other supplies. The time required and accuracy of the results depended on the knowledge of available staff, the use of automated or manual procedures, and the availability of prior inventory data.

Each hospital should be prepared to perform a rapid assessment to determine on-hand inventory of critical items at the outset of an incident. Hospitals should be prepared to share this information with RIEMA if requested.

HF-044 Our Lady of Fatima Hospital and The Miriam Hospital used auxiliary treatment areas for less severely injured patients. Other hospitals reported leaving their express call areas open beyond normal closure times to accommodate the influx of patients. These additional treatment sites proved useful in freeing up ED space; however, the absence of standard patient treatment areas and computer terminals resulted in unanticipated patient processing adjustments.

The hospital disaster plan should include the use of auxiliary treatment areas as necessary during the disaster. The plan should comprehensively address topics such as area location, setup, staffing, equipment and supplies, technology support, and patient processing.

HF-045 Resource management is a vital part of hospital disaster response. The critical nature of many injuries will likely require a variety of specialized medical equipment such as laryngoscopes, endotracheal tubes, warm IV fluids, electrocautery units, and burn treatment kits. Such items must be readily available in ample supply. The number of patients needing these items exceeded the initial quantity on hand in some of the EDs. Attempts to obtain these items in a timely manner sometimes proved difficult.

ED staff should ensure equipment and supply inventories are regularly performed and include items needed to care for multiple critical burn and trauma victims. Resource management planning should address how to rapidly obtain such items after hours and ensure each treatment area has all required items to meet its patient care responsibilities.

HF-046 There are fewer laboratory and radiology technicians on duty at night than during the day. In addition, the number of supervisory personnel and specialized staff to do testing is often less. Despite the exceptional efforts of available personnel, some hospitals experienced delays in performing and obtaining results of various tests and x-rays.

Hospitals should develop a priority system for performing laboratory and radiological examinations during MCIs. ED and other clinical areas would use this system until such time as sufficient support personnel are available to handle the increased workload.

HF-047 The sudden influx of large numbers of seriously injured patients requires modifying the normal registration practice. Some hospitals reported difficulty in quickly registering patients because of a shortage of trained administrative personnel during the late night shift. Others encountered technical difficulties such as pre-programmed computer system downtime or the lack of a means to electronically register patients located in auxiliary treatment areas within the hospital. The inability to rapidly register patients occasionally delayed clinical evaluation and medication administration.

Hospital disaster plans should provide one or more strategies to rapidly register mass casualties, including those who are unconscious or otherwise unable to provide necessary admission information. Such strategies might include using the EMS triage tag numbering system or special disaster patient records until the normal system can be used. Registration support technology should be available at each patient care area.

HF-048 All moderately and seriously injured patients required some level of blood testing. Collecting such a large number of specimens in a compressed period of time resulted in delays in labeling specimen vials and contributed to difficulties in test processing by ED staff.

Hospital disaster plans should describe how laboratory specimens will be collected and labeled using temporary or permanent patient identification numbers. Adequate numbers of trained staff should be included on call-back rosters to ensure specimen labeling and processing can be accomplished in a timely fashion using computer terminals or manual methods.

HF-049 During peak periods, the ED staff was sometimes challenged to completely document on standard patient-care charts the procedures performed as well as laboratory tests and x-ray results. Incomplete information has important clinical and billing implications.

Hospitals should consider using handheld tape recorders or modified patient records as an alternative to the standard handwritten charts to capture and later transcribe treatment data during peak patient treatment periods.

HF-050 Hospital staff also noted that the standard patient-care chart is not designed to include treatment information specifically related to burn patients, rendering it somewhat burdensome to use during circumstances similar to those presented by the Station club fire.

ED disaster patient charting should accommodate recording and diagramming burn injuries as well as ongoing care. Digital or Polaroid photography should be used to assist with wound documentation where possible.

HF-051 Some fire victims failed to seek immediate medical help because of concern for others whom they considered more seriously injured. Some had significant burn

injuries, including to their hands. This delay in some cases contributed to clinical management difficulties and impeded long-term recovery.

Public announcements should emphasize that persons injured during an incident seek immediate medical attention either at the closest ED or from their private physicians.

SECTION 6 – HOSPITAL INPATIENT CARE

Observations

Initial Patient Disposition

Ten Rhode Island hospital EDs received more than 200 patients following the Station club fire. In addition to the reported 186 victims transported by EMS within the first 2 hours after the fire, others found their own way to hospitals at various times throughout the day. Kent Hospital, the closest to the incident scene, received a total of 82 patients and Rhode Island Hospital received 68. 110 patients were treated and released. 107 patients were admitted to the receiving hospitals. 38 patients were transferred to burn centers in Worchester or Boston, MA, directly from the receiving ED or following a brief admission for further stabilization and preliminary treatment in Rhode Island. Ten of the transfers used aeromedical evacuation services offered by the Northeast Aeromedical Alliance. The remaining transfers used municipal or private ground ambulance services. Most transfers were completed by 8:00 a.m. on Friday morning, February 21 (see **Figure E-5** on page E-35).

Rhode Island Inpatient Care

The care given to patients remaining in Rhode Island hospitals posed challenges that were met through the dedication and teamwork of the medical professionals involved. Wound care and dressing changes were time consuming, labor intensive, and posed the dual risk of potential infection and excruciating pain for the patient. Nurses from all treatment areas frequently spent their discretionary time helping the ICU nurses perform these difficult, but crucial, services.

Not all of the Rhode Island hospitals had all of the specialized equipment they would like to have had to treat complex burn injuries, such as burn showers. Ventilators were in high demand and their daily use provided a constant challenge to respiratory therapists.

Pharmaceutical Sharing

Early fears that hospitals might not have adequate medicinal supplies produced an unintended benefit. In addition to inventorying their own stocks, hospital pharmacies shared this information and, although sufficient supplies were generally on hand, medical supplies were also shared when it was beneficial. For example, Rhode Island Hospital's pharmacy sent racemic epinephrine to Kent Hospital.

Our Lady of Fatima Hospital's pharmacy made special arrangements with Brooks and Rite Aide pharmacies, as well as pharmaceutical vendors, for analgesics and burn creams. Rhode Island Hospital contacted its pharmaceutical supplier for similar supplies and also for medication to prevent tetanus. Although blood was not needed, hospitals automatically checked on-hand supplies.

Therapeutic Services

Physical and occupational therapists provided daily bedside patient assistance followed by long-term rehabilitation services. They also fabricated splints and other devices that aided burn victim rehabilitation. The work was especially intense during the first 3 weeks, when continuous intervention is critical to restoring function to badly burned extremities.

Other Services
Even support services such as food services were hard pressed to meet the special nutritional needs of burn patients while simultaneously offering meals and snacks to large numbers of visiting family members and friends.

The hospital security staff, often at minimal levels during the late night hours, was confronted with a surge in nighttime medical staff, growing numbers of family members, and media representatives seeking first-hand information. Environmental services were critical to keeping facilities clean and the rapid turnover of treatment areas for new patients.

Rhode Island hospitals worked with local police, the Office of the Medical Examiner (OME), and the Family Assistance Center (FAC) in an attempt to correctly identify all of the patients. In some cases this took several days.

Documentation Challenges
Inpatient documentation went more smoothly in many cases than what occurred in many EDs; nonetheless, some problems did occur. Revising the patients' charts and other medical records from the ED was challenging, especially for patients whose identity was still unknown.

Patient Tracking
All hospitals experienced difficulty tracking the numbers of patients and their locations. Compounding this problem was the deluge of telephone calls from government agencies, the press, and the general public seeking patient information. It was not until Sunday, February 23, that hospitals began reporting patient data on a regular basis to a single authority, RIEMA. Patient tracking was especially problematic for those who had been transferred to other hospitals. It was difficult to obtain follow-up status information over the telephone because of patient confidentiality concerns, especially from hospitals in Massachusetts.

Confidentiality
In the eyes of the medical community, because of the absence of a State disaster declaration, hospitals were required to comply with existing State and Health Insurance Portability and Accountability Act (HIPAA) patient confidentiality requirements. Hospital personnel were especially guarded about releasing patient information for fear of inadvertently violating these requirements.

Federal Burn Treatment Resources
On February 25, Dr. Joseph Amaral, president and CEO of Rhode Island Hospital, along with Dr. Cioffi, chief of surgery, and Dr. Metzger, chief nursing officer, met with Mr. Gary Kleinman and Mr. Mark Libby, emergency coordinators for HHS, and with other Federal officials. They asked for assistance to operate an expanded outpatient burn clinic and for clinical staff support. Specifically, Rhode Island requested 12 burn care nurses, two respiratory therapists, a nutritionist, and four social workers with grief counseling experience.

U.S. Air Force Major Linda Cashion, who was on military assignment to the U.S. Department of Homeland Security (USDHS) Office of Emergency Preparedness (OEP), was chosen to lead the Rhode Island task force. Major Cashion is an ED nurse with extensive MCI experience.

The 12 burn care nurses were selected from a list of volunteers maintained by the OEP in conjunction with the American Burn Association. The four respiratory therapists were members of an OEP-coordinated Disaster Medical Assistance Team (DMAT). The U.S. Public Health Service provided the nutritionist, two social workers, and two psychiatrists.

Major Cashion arrived in Providence on February 27, and the entire team was in place for extensive briefings and orientation the next day. The Federal burn treatment team began twice-daily, 12-hour shifts at Rhode Island Hospital on February 29, working side-by-side with local hospital personnel for 10 consecutive days. Mutual trust and professional respect quickly flourished and the new colleagues routinely shared experiences and best practices. While the primary focus was on the patients, considerable time and attention was devoted to family members. A joint debriefing and a modest celebration marked the end of the 10-day deployment, along with an unsolicited and highly emotional testimonial from a relative of a hospitalized burn victim broadcast over a Providence radio station.

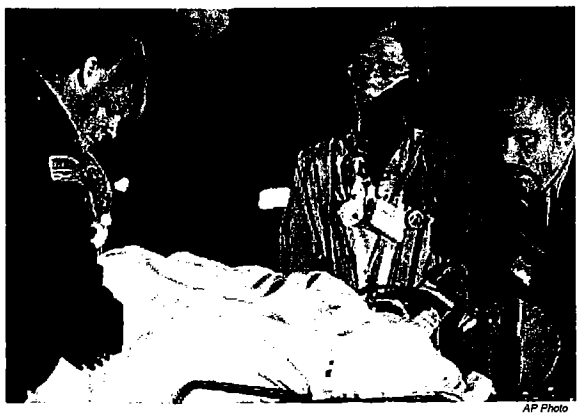
Patient Discharge

In the days, weeks, and months after the Station club fire, four victims who were evacuated to area hospitals succumbed to the devastating injuries they had suffered. This, alone, is proof of the monumental achievement of the hundreds of medical professionals who provided timely prehospital triage, transport, inpatient treatment, rehabilitation, and loving care to the victims of the fire and to their families.

The last Station club fire victim at a Rhode Island hospital was discharged to a rehabilitation center on May 8, 2003.

Care of Patients Transferred to Massachusetts Burn Centers

Just after midnight on Friday, February 21, Dr. Cioffi, chief of surgery at Rhode Island Hospital, called and spoke to Dr. Robert Sheridan, an attending burn surgeon at Massachusetts General Hospital. He discussed with him the severity of the injuries and the need to transfer the most critically burned patients to fully recognized burn centers. Dr. Sheridan directed that as many ICU beds as possible be made ready. He also called the Shriners Hospital Corporate Office in Florida and asked if the Shriners Hospital for Children in Boston, with its special pediatric burn care capabilities, could accept some patients. This was the second time that Shriners Hospital had been asked to accept adult patients. A similar request was honored following the September 11, 2001, terrorist attack on the World Trade Center. Permission was quickly forthcoming.



During the early morning hours on Friday, February 21, critically burned patients were transferred by ground and air units to Massachusetts Burn Centers.

During the early morning hours on Friday, February 21, 12 critically burned patients were transferred by ground and air units to Massachusetts General Hospital, three to Shriners Hospital, eight to Brigham and Women's Hospital, and four to University of Massachusetts (UMass) Memorial Medical Center in Worchester. Dr. Dennis Orgill at the Brigham and Women's Hospital and Dr. Ray

Dunn at UMass Memorial Medical Center led the burn team efforts at their respective institutions. All three physicians periodically communicated with one another in the days and weeks following the fire.

Shortly after 1:00 a.m., the transferred patients began arriving at Massachusetts General Hospital. They were met at the ED by one of two burn teams standing by to perform a preliminary assessment of injuries. After the initial examination, patients were assigned rooms at Massachusetts General Hospital or were transferred across the roadway to Shriners Hospital. As patients continued to arrive, Dr. Sheridan called burn centers in New York, NY, and Philadelphia, PA, and arranged for additional beds in the event they were needed.

The burn center staff at the receiving hospitals was taken back both by the extreme severity of the burns and smoke inhalation and by the number of patients with multiple trauma injuries. Trampling during the chaotic attempt to escape the Station club caused many trauma injuries. Several patients had limbs amputated during their hospitalization. Because of these critical injuries, many patients remained in ICUs longer than most burn patients.

The pediatric burn nurses at the Shriners Hospital had to be especially resourceful in adapting pediatric equipment to meet the needs of their adult patients as well as adjusting medication doses and nutritional supplements. There was some early discussion of transferring patients from Massachusetts General Hospital and Shriners Hospital to other verified burn centers designed for adult care, but it was determined that the patients were too unstable for transport.

Despite the commitment and expertise of the physicians, nurses, respiratory therapists, physical therapists, and nutritionists, four badly burned patients eventually succumbed to the injuries received in the fire. The others eventually were able to return home. Most are still undergoing weekly outpatient care in the burn clinics affiliated with the four Massachusetts burn facilities.

Findings and Recommendations

HF-052 Each Rhode Island hospital addressed the need for surge capacity to some degree. Those hospitals receiving the most patients implemented disaster plans. None of the hospitals thought that its ultimate capacity was exceeded. However, this incident reinforces the importance of surge planning both for the ED and to provide sustained inpatient services and outpatient care.

Hospitals should include inpatient services and outpatient follow-up care for extended periods of time in their surge capacity planning.

HF-053 Each hospital provided the best expertise available to care for the Station club victims. Patients were often treated by more than one physician in the ED and after admission. In some cases, physicians inadvertently directed conflicting treatment instructions, which proved frustrating to the nurses and counterproductive to good patient care.

Hospital disaster plans should provide guidance for assigning an attending physician as well as the coordinated use of consulting services in a fashion that minimizes potential confusion in treatment plans.

HF-054 Four helicopter programs used to transfer patients to burn centers proved invaluable. These programs were UMass Memorial LifeFlight, Hartford Hospital's LIFE STAR, Boston MedFlight, and Westchester Medical Center's StatFlight. However, the absence of a written plan for using helicopters during a disaster caused delays as some hospitals did not receive timely support. There was not a coordinated effort to find both specialty care hospital beds and aeromedical patient transport for all of the hospitals. Each hospital made its own arrangements, which sometimes proved inefficient and was potentially counterproductive.

The Northeast Aeromedical Alliance, in collaboration with the States they serve, should develop a comprehensive plan for helicopter response to disasters. The plan should address the process for requesting, coordinating, and using civilian and military aeromedical resources for incident scene evacuations and facility transfers. The use of helicopters for other purposes, such as incident site reconnaissance and ferrying personnel or supplies, should also be addressed in the plan.

HF-055 Individual hospitals attempted to coordinate burn center beds and helicopter transport without fully understanding the gravity of the entire situation on the healthcare system. This first-come, first-served approach was not ideal for ensuring the most advantageous use of valuable resources.

RI Health, HARI, and RIEMA should consider designating a central coordinating authority to engage with designated burn centers and with aeromedical dispatch and communications centers to arrange for specialty care beds and helicopter transport.

HF-056 Rhode Island does not have a burn center that meets criteria established by the American College of Surgeons in collaboration with the American Burn Society. Each of the hospitals that received victims of the Station club fire ensured patients received the very best medical care available. However, the care of critically injured burn patients requires personnel with specialized training and resources. There is no substitute for burn teams composed of physicians, nurses, respiratory therapists, physical and occupational therapists, nutritionists, pharmacists, and mental health professionals who are trained and equipped to meet the special needs of burn patients. Such resources are generally only available at recognized burn centers.

Rhode Island Hospital, RI Health, and other appropriate State officials should consider acquiring the capabilities to meet the criteria for a burn center as specified in Guidelines for the Operation of Burn Units.

HF-057 Rhode Island health community leaders, Federal officials, and other burn specialists raised the question of whether moderate and critical burn patients should remain at local hospitals or be transferred to a distant burn center, a practice that takes

patients away from their home and deprives them of local community support. Alternatively, Rhode Island Hospital requested and received the assistance of a Federal burn team. This practice raises a related question about sending burn specialists to an unfamiliar setting rather than transferring patients to a burn center that has qualified staff as well as other needed resources.

Rhode Island should urge further national discussion on the best approach to providing medical care to burn victims so that planning guidance can be provided to State and local authorities as well as to burn centers.

HF-058 Rhode Island Hospital's decision to request Federal assistance apparently was not initially coordinated with RIEMA or with State public health officials. This caused some delay in obtaining the formal written request, which was signed and sent to HHS on February 26.

Procedures for requesting Federal assistance must be clearly established and well understood so as not to cause unnecessary delays and confusion in requesting and obtaining critical support. This should be addressed in the Rhode Island EOP and regularly practiced in training and exercises.

HF-059 The National Disaster Medical System (NDMS) burn team did an outstanding job providing patient care at Rhode Island Hospital during its 10-day deployment. It demonstrated the critical importance of having an experienced clinical person as the team leader; the value of an orientation program for team members before beginning work; and the importance of close working relationships between the team leader, other members of the team, the host hospital staff, and its leadership. The NDMS burn team leader had a strong clinical and administrative background, coupled with previous deployment experience, and was deployed in advance of team members to coordinate with Rhode Island Hospital. A formal day-long detailed orientation was provided to team members before commencing work. Team members were encouraged to spend as much time as possible with patients' families. Team members stayed at a nearby hotel that was not also hosting families of burn victims. Mental health support was available everyday, and a joint debriefing involving hospital staff and team members proved a fitting way to conclude the deployment.

The Rhode Island Hospital NDMS burn team deployment is a model for other communities to emulate when confronted with mass casualty conditions involving large numbers of burn victims.

HF-060 The work schedule planned for burn team members was 12 consecutive days of 12-hours shifts. The physical and psychological intensity of the work involved with critical burn victims makes this schedule unrealistic and ill-advised.

Federal officials should revise the current work schedule concept for burn teams in view of the lessons learned from this deployment.

HF-061 Under the prevailing conditions of receiving and admitting a large number of seriously injured patients in a short period of time, accurately tracking patients within hospitals as they moved from the ED to various treatment areas was challenging.

Hospitals and local EMS agencies should develop a method of collecting patient information, including name, age, and physical description, as well as current and final location. It should take into account the possibility that some patients may not be identified until sometime later; therefore, records and patient location data must be regularly updated. Ideally, this information can be electronically maintained and be accessible to all appropriate administrators.

HF-062 Hospitals were deluged with requests for patient information. Family members and friends telephoned or visited hospitals searching for missing loved ones. Media representatives sought any new piece of information for their next deadline. State and local officials called repeatedly in efforts to compile a complete and accurate account of all Station club fire victims.

Public safety, HARI, public health, RIEMA, and ARC officials should develop a comprehensive plan for coordinating the acquisition, maintenance, and release of patient information.

HF-063 Concerns with violating privacy laws seemed to influence hospital staff response to inquiries emanating from legitimate authorities as well as more questionable sources. It is uncertain under what circumstances relief from such constraints can be obtained.

RI Health, the Hospital Preparedness Planning Committee, and RIEMA officials should review the implications of State and local disaster declarations as well as declaring a public health emergency on releasing patient information, including the implications of HIPAA.

HF-064 Some hospitals treated patients for 2 or 3 days before they were identified, while family and friends desperately searched for missing loved ones. This was psychologically troubling for families and hospital staff alike and reinforced the importance of early police assistance in identifying disaster victims.

Patient identification, including the use of forensic investigation techniques, should be a high priority. Hospitals unable to identify patients must immediately notify the local law enforcement agency and seek assistance.

HF-065 It is vital that critically burned patients are taken as quickly as possible to a recognized burn center or a Level 1 trauma center. Rhode Island State and local protocols fail to specify that this practice should be followed by EMS command personnel when evacuating multiple badly burned patients. Direct transport to a burn center from the Station club fire incident site was best done by helicopter, which was not feasible because of the unavailability of helicopters. Rhode Island Hospital is a Level 1 trauma center, and many of the most seriously injured victims

were taken there directly. Other patients were evacuated to nearby hospitals for initial treatment and stabilization, then transferred to a more appropriate treatment facility.

State EMS protocols should make clear but flexible recommendations to EMS personnel on where and by what means critically injured patients should be transported to a designated specialty center.

HF-066 Several persons interviewed thought that the Station club fire highlighted the continuing need for national guidance on how State and local health and medical authorities should respond to such situations and the role of the Federal Government in providing resource support.

Rhode Island health officials should urge the American Burn Association, in conjunction with other State and Federal public health, healthcare facilities, EMS, and emergency management officials, to develop guidelines on burn care for mass casualty victims. These guidelines should address issues such as sending as Federal clinical burn specialists to work in local hospitals rather than transferring patients to recognized burn centers, the number of patients burn centers should be expected to receive in a 24-hour period of time, and reimbursement for burn centers providing clinical care to uninsured patients.

HF-067 The ability of the burn center clinical staff to establish an effective working relationship with patients is vitally important to the recovery process. Developing meaningful relationships with the victims' families is also important. The burn center staff reported that, because of the large number of critically injured patients, there was sometimes insufficient time available to spend with families.

Communications with a burn patient's family should occur daily, led by a staff member who assumes the primary liaison role. This individual should coordinate meetings between the family and appropriate medical staff throughout the period of hospitalization. Hospitals and burn centers should be prepared to increase designated liaison staff when an MCI occurs to ensure the personal and psychological needs of each family member are met with compassion and understanding.

HF-068 The intense daily routine of patient rounds, surgery (hundreds of surgical procedures were done on the patients), and clinic appointments was greater and more demanding than any of these seasoned physicians and nurses had previously experienced. As a result, less time than usual was available for them to document certain aspects of the care they were providing patients. The absence of complete medical documentation reduced the amount of reimbursement the hospital and burn surgeons subsequently received.

Hospitals and burn center staff should be prepared to enhance clinical staff documentation preparation when confronted with a large influx of patients by using scribes, handheld tape recorders, and personal digital assistant (PDA)-based medical patient records.

HF-069 A number of the victims had severe facial burns that rendered identification difficult. Forensic investigation to identify these victims did not occur as quickly as anticipated. Transferring the victims out of Rhode Island to receive their definitive care further complicated the identification process.

To aid in patient identification, hospitals and burn centers should immediately seek forensic assistance from State and local law enforcement agencies and from the OME because of its particular forensic expertise.

HF-070 Several hospitals had difficulty obtaining follow-up information on patients transferred to burn centers in Massachusetts because of concerns about patient confidentiality.

MCIs routinely present problems related to communicating patient information. Clearly, patient confidentiality and HIPAA regulations cannot be disregarded. However, potential latitude exists, especially in declared State, local, or Federal emergencies. Legal counsel should be sought by RIEMA and Rhode Island healthcare facilities, including specialty facilities in adjacent States, to establish standard practices concerning patient information release.

HF-071 Security personnel at all hospitals did an admirable job of addressing the challenges posed by the Station club fire. However, response needs in some cases had not been adequately addressed in disaster planning.

Disaster planning should address the myriad of response issues that security personnel will likely face.

SECTION 7 – EXTENDED OPERATIONS

Observations

Continuing Support After Initial Response

Although ED operations concluded within hours after the fire, other aspects of hospital response continued for weeks and, in some cases, months. Clinical staff hours were often lengthened and time off cancelled. Hospital security staff were tasked early into the incident with maintaining building security as well as parking and traffic control because of the increased numbers of visitors and media representatives. Food service personnel prepared extra meals for staff and visitors as well as special nutritional supplements for the patients. Operating room schedules were busier than usual because of the large number of special procedures that were needed to treat burn wounds and repair for orthopedic injuries. Social workers, psychologists, and clergy provided mental health support for patients, their families, and hospital staff.

Managing the Media

Hospital public information officers (PIOs) were confronted with numerous requests for information concerning patient status and hospital operations. Early in the response and for days afterward, hospitals were deluged with requests from local, national, and international media. Reporters called nursing units and, in some cases, arrived at hospitals with film crews to do live news shows. Hospitals recognized the legitimate right of the media for information, but also recognized patients' rights to privacy and confidentiality. Information was only released after obtaining a patient's permission. Media representatives were particularly interested in interviewing surviving patients. Different strategies were sometimes taken regarding patient interviews. The Miriam Hospital prohibited such interviews, while other hospitals allowed them if the patient approved.

Law Enforcement Integration

Hospitals generally had little interaction with law enforcement agencies. In one case, local police assisted hospital security for a brief period. Requests by police investigators to interview patients did not interfere with patient care priorities and were easily accommodated.

Post-Hospitalization Treatment

Discharged patients with burn wounds often were sent to rehabilitation facilities or referred to outpatient clinics to continue treatment for physical and psychological injuries. These continuing services were coordinated by hospital clinical and administrative staff until the last patient was discharged. In some cases, that care continues today.

Findings and Recommendations

HF-072 Rhode Island hospital disaster plans, like those of many hospitals, focus primarily on the immediate response and less on the extended operational and system recovery and restoration phases. The hospitals did a remarkable job in meeting the requirements of extended operations, generally without benefit of planning guidance.

Rhode Island hospitals should ensure disaster plans address extended operations as well as system recovery and restoration. Such plans should address the following:

- *Staffing pattern adjustments*
- *Staff scheduling modifications*
- *Patient transfers to other hospitals and nursing homes*
- *Mental health support for patients and their families*
- *Mental health support for staff and their families, if needed*
- *Maintaining inventories of medical equipment and supplies*
- *Greater then usual food and water inventories and more frequent vending machine resupply*
- *Press and media management*
- *Requests from attorneys for information, pictures, and interviews*

HF-073 Despite generally good working relations with members of the local press and media, hospital staff sometimes were faced with protecting patient privacy against media intrusion, while a few patients actively sought out the media to tell their story, sometimes without informing hospital staff. This created a difficult challenge.

Hospital administrators, PIOs, and other appropriate officials should develop press and media management policies regarding victims and hospital staff interviews. Such policies should also address requests by family members and attorneys to speak to reporters at the hospital. Patients and their families should be informed of these policies as early as possible following admission.

HF-074 In some cases, hospital administrators had to decide whether the patient or the medical staff made decisions regarding media access. The large number of reporters covering the Station club fire presented administrative burdens as well. Hospitals had to provide parking, refreshments, communication connectivity, interview rooms, and knowledgeable personnel to meet with the media. National news representatives proved to be more problematic than the local media representatives.

Hospitals should review press and media policies to ensure they effectively address the problems likely to occur during a disaster. Policies should identify the hospital spokesperson and the frequency and location of news conferences as well as the methods for transmitting information, telecommunications connectivity, and administrative support requirements.

HF-075 RIEMA activated a Joint Information Center (JIC) on Saturday, February 22. There was little communication or coordination among the various hospitals PIOs before opening the JIC.

In the absence of a JIC, hospital PIOs should regularly converse and formulate standard approaches to media activities.

HF-076 Hospital PIOs did not initially have critical contact information available to refer media inquiries to the JIC.

Once a JIC becomes operational, hospitals should be advised of critical contact information and make qualified personnel available to assist in developing public information statements.

HF-077 Hospitals were generally aware of the operation of the FAC, however, there was insufficient communications between hospitals and the FAC in the first few days after the fire.

Once the FAC and, subsequently, the Family Resource Center (FRC), become operational, hospitals should be notified and provided contact information. Daily teleconferences between the receiving hospitals and the FAC or FRC would ensure consistent communications.

HF-078 In an effort to support victims' families, many hospitals waived parking fees and offered other free amenities, such as cafeteria food service. This kindness was costly and the practice sometimes questioned by other patients and their families who were not involved with the fire.

When hospitals change regular operating practices, even with good cause, caution must be taken to ensure such actions are not viewed as prejudicial in any form.

SECTION 8 – SYSTEM RECOVERY AND RESTORATION

Observations

Cost Reimbursement

Patient care provided by the 10 receiving facilities in Rhode Island and the four Massachusetts burn centers continued for periods of time ranging from 5 days to more than 3 months after the fire. Hospital administrators made decisions regarding the return to normal operations based on the specific circumstances of each facility. A common situation facing all hospitals was the recovery of the monumental costs of treatment for the Station club victims. Many victims were uninsured. Rhode Island has a high percent of uninsured citizens. In cases where patients had insurance, hospitals were unable to recover the full cost of treatment. For example, the average unreimbursed cost per patient at the Massachusetts General Hospital Burn Center was more than $57,000 or a total of nearly $1 million. This does not include hundreds of thousands of dollars of unreimbursed professional fees.

One complicating factor effecting reimbursement was the lack of complete documentation resulting from the intense workload, the absence of practical ways to capture costs during a mass casualty situation, and incomplete patient medical records. Some questioned whether the families of those who succumbed to their injuries while hospitalized should be billed for the treatment rendered.

Post-Event Assessments

After returning to normal operations, each hospital held a critique involving the various departments that were engaged during the Station club fire disaster. Many hospitals have taken important steps to improve the capability of responding to future mass casualty events. For example, Kent Hospital and the Rhode Island Visiting Nurses Association sent several nurses to receive intensive burn treatment training at Massachusetts General Hospital. HARI also sponsored a post-incident debriefing in May and a debriefing survey was distributed to each hospital as part of the recovery process. State committees tasked with improving disaster preparedness are now addressing the results of these initiatives.

All of the participating Rhode Island hospitals believe they responded effectively to the Station club fire, and most believe they could have treated additional patients had it been necessary. Those hospitals that prepared for, but did not receive, patients were not able to be part of this valiant and successful lifesaving effort. This was further exacerbated when they learned belatedly that site evacuation was complete. They had remained on standby without cause.

Expressions of Gratitude

Governor Carcieri visited several Rhode Island hospitals as well as the burn centers treating victims in Massachusetts. He expressed his support to the patients and their families and he thanked the hospital staff for their continuing efforts during these tragic circumstances. Local communities also sent expressions of appreciation to the hospitals in the form of notes, cards, flowers, and home-baked goods.

Findings and Recommendations

HF-079 The Rhode Island hospitals and Massachusetts burn centers reportedly lost hundreds of thousands of dollars in unreimbursed costs, due in part to inadequate documentation by the ED and incomplete records kept by hospital command post staff.

It is imperative that patient treatment during a disaster is thoroughly documented. Laborsaving automated methods should be used to minimize the time that ED personnel devote to recordkeeping. Additionally, command post documentation procedures should clearly delineate the forms to be used, the types of information to be recorded, and how financial data is to be tabulated.

HF-080 The costs of caring for burn patients often exceeds the reimbursable rates paid by third-party insurance carriers or government coverage programs. The difference between incurred expenses and allowable reimbursement increases with the severity of the burn injuries. The number of critically injured patients resulting from the Station club fire made treatment particularly costly. This reimbursement problem threatens the financial viability of general hospitals and specialty healthcare facilities, including burn centers.

The Hospital Preparedness Planning Committee and RIEMA should work with State and local elected representatives to maximize the financial support hospitals receive during a disaster and take steps to ensure hospital administrators are trained on how to seek reimbursement.

HF-081 There was no discussion among hospitals aimed at formulating a coordinated position regarding billing for services rendered to patients who did not survive. In one instance, the ED billing company invoiced a family despite a decision by hospital administrators not to do so.

The Hospital Preparedness Planning Committee should recommend a position on whether the families of the deceased victims, especially those without insurance, should be billed for services rendered at the hospital. Additionally, hospitals should decide whether individual departments should bill the families of deceased patients independently for their services.

HF-082 Hospital media coverage failed to convey how widespread and important the response was and how each hospital successfully managed the challenges.

The JIC, working with hospital PIOs, should ensure each hospital's contribution to the response effort is recognized. In the absence of a JIC, individual hospital PIOs should take the steps collaboratively to inform the press and media of their continuing efforts on behalf of the victims and the community.

HF-083 There was not a Statewide special occasion at which all participating hospitals were recognized for their efforts in response to this tragedy. This was disappointing to many of the medical community.

State and local officials should be aware of the importance of formally recognizing the contributions of all the responders to a disaster, including those of each healthcare facility.

HF-084 The post-incident debriefing meetings held by each hospital are viewed as an important part of closing out the incident as well as preparing for the next one. For the most part, these meetings included only hospital personnel. In addition, there has never been a response communitywide debriefing involving representatives of all participating organizations.

Following a response to a major incident, each hospital staff should meet as soon as possible to capture important lessons learned. Rhode Island hospitals did this very well. However, similar critical discussions need to include other important organizations, especially first responders and State and local emergency managers. The results of these discussions should be recorded and corrective actions planned.

PART III
MENTAL HEALTH

INTRODUCTION

Physical Injuries Are Not the Only Source of Scars


AP Photo

In addition to the physical injuries suffered by the surviving victims of the Station club fire, the psychological impact of this tragic event affected a much larger community. The victims and their families, the families of the deceased, the first responders and their families, and the staff members of the hospitals that treated the victims were all subject to significant psychological stress. Early intervention by trained personnel able to assist those suffering from critical incident stress reactions, disaster psychosis, and survivor's grief is a critical aspect of the recovery process. Many communities struggle to handle the daily requirements for treatment of emotional and psychological disorders. The number of trained personnel, budget reductions, and insurance constraints limit the mental health services that can be routinely provided to the general public. Disasters exacerbate the need for this important component of healthcare, which in some severe cases may be required for many months after the event. The Department of Mental Health, Retardation and Hospitals (MHRH) is responsible for ensuring mental health services are available to Rhode Island citizens to meet the psychological challenges of daily life, as well as those caused by unplanned tragic events with broader impact.

Responders and Caregivers Are Not Invulnerable

Responding to disasters takes an emotional toll on the response community, including the public safety and hospital staff. To meet the acute psychological support needs of first responders (police, fire, and EMS) and others who request assistance, the Rhode Island CISM Team was established in 1988. The team includes 27 peer support personnel from area police, fire, and EMS organizations who have been trained by the International Critical Incident Stress Foundation (ICISF). The Rhode Island Association of Fire Chiefs provides funding for the Rhode Island CISM Team. Its services are free to the end user. Team members are required to participate in periodic continuing education and can be deployed to incident scenes, firehouses, and police stations, as well as other locations to perform services aimed at restoring or preserving the mental health of the response community. The Rhode Island CISM Team is a separately chartered organization and is independent of the MHRH.

Rhode Island hospitals generally apply in-house expertise (social services, pastoral care, psychiatrists, and psychologists) to provide mental health assistance to patients, their families, and to staff members. However, nearly 2 years ago, Kent Hospital formed its own ICISF trained CISM team, composed of volunteer staff members who underwent stress management training to meet this recurring challenge.

The Station club fire tested Rhode Island's ability to rapidly expand its daily capability while sustaining an expanded response to meet the acute and long-term community psychological and mental health requirements. In some cases, this assistance is still ongoing.

Part III of this annex includes the following three sections:

- Section 1 – Mental Health Support for the Patients and Their Families
- Section 2 – Mental Health Support for Fire and Emergency Medical Services Personnel
- Section 3 – Mental Health Support for Healthcare Facility Personnel

SECTION 1 – MENTAL HEALTH SUPPORT FOR THE PATIENTS AND THEIR FAMILIES

Observations

Immediate Need for Mental Health Support

Even as ED staff performed initial assessments of the physical injuries of Station club fire victims, the receiving hospitals began mobilizing mental health resources. Social workers, pastoral care personnel, psychologists, and psychiatrists were contacted at home and advised of the impending need for their services. As the first victims began arriving, family members and friends of those not yet accounted for also converged on area hospitals.

Hospital staff worked diligently to provide the information sought by relatives and friends of victims, specifically whether their loved ones had been evacuated to that facility or to another Rhode Island hospital and, if so, the extent of injuries and prognosis for recovery. However, given the hectic pace of ED operations, and in the absence of an effective centralized patient-tracking system, such information was often not readily available, causing frustration and increased anguish.

Comfort and Counseling for Waiting Relatives

In the designated family waiting areas, some hospitals provided free food and beverages, while clergy members and other mental health professionals consoled the waiting family members and friends. Relatives of patients who were not victims of the Station club fire but who happened to be at the hospital also offered comfort to victim's families.

Psychological support and counseling for patients and their families continued throughout the course of each individual's hospitalization. At some facilities, daily conferences with family members allowed them to ask questions and obtain information from members of the medical team taking care of their family member.

Continuing Patient and Family Support

Once discharged, local mental health agencies such as the Kent County Mental Health Center took the lead in providing individual and group mental health support for patients and their families. Special counseling sessions were designed to help children deal with the loss of one or both parents or another family member. Bradley Hospital and The Phoenix Society for Burn Survivors, Inc. hosted individual and group recovery sessions and provided training to burn victims and their families. For many surviving victims, their families, and the families of those who died, the healing process and the need for mental health support will continue well into the future.

Findings and Recommendations

MH-001 Some hospitals failed to anticipate the implications of providing mental health support for the fire victims and their families. It proved to be much more long-term and labor intensive than they had expected.

Hospital disaster planning should address the need to provide short-term and long-term mental health services for patients and their families, including individual and group support before and after discharge.

MH-002 Hospital personnel at several facilities expressed concern about the adequacy of mental health support provided to patients who were injured but did not require admission. In some cases, discharged victims returned not because their physical injuries had worsened, but because they had become emotionally dysfunctional.

Hospital personnel need to be sensitive to the fact that patients with only minor physical injuries could harbor significant psychological and emotional stress from undergoing such a tragic experience. At a minimum, they should be offered an opportunity to speak with a counselor before discharge, and telephone follow-up would be appropriate in the days and weeks following physical treatment.

MH-003 The importance of being able to contact all members of the mental health team after-hours was highlighted during this response. In some cases, notification was delayed because of incorrect or incomplete contact information.

Mental health staff should be included on disaster call-back lists and their contact information kept current. Staff recall should be regularly tested.

MH-004 Hospital planning for disaster mental health support services had not been seamlessly integrated with the plans of the MHRH. This lack of collaborative planning complicated the efficient delivery of mental health support.

MHRH, HARI, and the Rhode Island CISM Team should develop a comprehensive disaster response plan that clarifies the roles and responsibilities of each party. The comprehensive disaster plan should include inpatient and outpatient support services for victims and their families and support for all response personnel.

MH-005 MHRH requested that mental health personnel from Our Lady of Fatima Hospital and Butler Hospital assist at the incident scene and at the FAC. Some hospital mental health staff are also under contract to one of the MHRH affiliated regional mental health centers. This double counting of some mental health resources could reduce the mental health staff available to meet hospital inpatient needs.

MHRH administrators should meet with hospital mental health personnel to devise a response plan that will ensure on-scene mental health care is provided without depriving hospitals of required staff support.

MH-006 Rhode Island hospitals did not formally evaluate the adequacy or effectiveness of mental health care provided to fire victims and their families. The absence of this information limits insight into what went well and what areas need improvement.

In coordination with State and local mental health officials, Rhode Island hospitals should develop a sensitive and constructive way for disaster victims and their families to provide feedback on mental health services. Identified weaknesses should be addressed and plans revised accordingly.

SECTION 2 – MENTAL HEALTH SUPPORT FOR FIRE AND EMERGENCY MEDICAL SERVICES PERSONNEL

Observations

Recognizing the Need for Critical Incident Stress Management

Following the 1982 Air Florida crash in Washington, DC, Dr. Jeffrey Mitchell Ph.D. studied the mental health effects of the aircraft disaster on emergency responders. Since that time, fire, police, and EMS agencies throughout the United States have developed strategies to combat critical incident stress, including instructional material on sustaining good mental heath during a response and the use of CISM teams during and immediately afterward.

Stressful Impact of the Station Club Fire

The hundreds of firefighters, police officers, and EMS personnel who responded to the Station club fire were immediately confronted with extraordinary sensory and emotional circumstances. Upon arrival, the responders were confronted with a building already immersed in flames, burned and burning occupants clamoring to escape through windows and doors, cold weather, and large crowds of frightened and concerned people, including family members of those injured and killed. These horrific circumstances complicated the tasks and heightened the tension and stress for all of those who responded to the event. The fire had to be suppressed while scores of victims were pulled free from the wreckage and nearly 200 seriously injured were treated and evacuated from the scene. All of these activities transpired simultaneously within a timeframe of less than 2 hours. The grim task of recovering the dead continued for several more hours.

A Painful Environment

EMS personnel converted the neighboring Cowesett Inn into a temporary medical care center where the injured were quickly assessed and then transported to one of the receiving hospitals. While awaiting triage and transport, EMS personnel, supported by four volunteer nurses, dressed wounds, administered oxygen, and gave words of encouragement to the injured. Once en route to the hospital, compassionate care was blended with lifesaving skills by the EMS transport teams. The physical disfigurement from the burns, the smell of smoke and burning flesh, and the frustration of not being able to do more affected experienced and inexperienced responders alike.

Body Recovery Plan

Once the fire was extinguished and there were clearly no more survivors that could be saved, efforts turned to the gruesome and emotionally charged task of recovering the bodies of the deceased. Incident Command personnel, believing at the time that the number of dead was fewer than 30, devised a plan to minimize the emotional impact of removing the dead. The plan called for four-person teams, each operating under the direction of a senior command officer, to make one entry, quickly remove the deceased, and immediately report to the rehabilitation sector at the Cowesett Inn. However, many unanticipated and complicating factors were encountered that added to the emotional toll.

Recovery and Extraction of Remains

Inside the smoldering ruins, many victims' bodies were found in areas leading to windows and doorways or jammed into small passageways. Some had been severely trampled as well as burned. Because of the placement of the bodies, considerable exertion and a variety of extraction techniques had to be employed. Despite compassionate handling by the firefighters, the badly burned bodies sometimes proved difficult to load intact into the body bags after investigators took pictures. As the building was gradually cleared of debris, more and more bodies were discovered. The initial intent of having individuals engaged in only one extraction proved unrealistic. In some cases firefighters performed five or more recoveries before all 96 bodies were recovered.

Reuters \ Jim Bourg

Firefighters carry out the bodies of victims.

CISM Support at the Incident Scene and Offsite

The Rhode Island CISM Team was contacted by Cranston Regional Fire Alarm and activated at 12:10 a.m. Dr. Anne Balboni, the Rhode Island CISM Team coordinator, reported to the IC at the incident site at 12:30 a.m. The team remained onsite until 11:40 p.m. on Friday, February 21, providing clergy presence for body recovery, counseling support for employees of the Cowesett Inn and others, and conducting demobilization briefings for 27 fire and EMS units as they disengaged. They used three small areas in the front of the Cowesett Inn, while the ARC assisted the families in the back of the building. Two of the Rhode Island CISM areas were used to meet with the responders while the third was used as a waiting area where water, coffee, and light refreshments were available.

Dr. Anne Balboni

Because of the intensity and length of the CISM activities, Dr. Balboni requested CISM mutual-aid assistance from Massachusetts. Five Massachusetts CISM Teams responded. These additional personnel were onscene before 12:00 noon on Friday, February 21. CISM personnel from the various teams remained onscene until the last piece of apparatus left nearly 23 hours after the fire had started.

Fire department Incident Command staff, concerned about the emotional intensity of the situation and the impact it could have on the responders, ordered every firefighter and EMS provider to speak with a CISM team member before leaving the scene. Police command staff did not mandate that their personnel participate, but several officers chose to do so. The fire department demobilization sessions were usually done with each complete crew as it went off shift.

At the West Warwick HQ fire station, Rhode Island CISM Team members also found an area to meet with returning firefighters. In both locations, all of the responders had the option of seeking out CISM team members to discuss how they were feeling. CISM team members also walked around the incident scene to observe the impact of activities on responders.

Near-Term Follow Up
On the days immediately following the incident, steps were taken by many of the fire departments, EMS agencies, and police departments to provide follow-up support to their personnel. Several fire department senior staff called or visited with personnel to offer support and appreciation for their extraordinary effort. Fire department chaplains visited stations to check on personnel and converse with them.

On Saturday, February 23, Dr. Balboni, working with representatives of the Rhode Island Association of Fire Chiefs, developed a list of all the agencies that responded to the fire. A similar effort was initiated with the Rhode Island Association of Police Chiefs. The Rhode Island CISM Team, with assistance again from the Massachusetts' CISM Teams, worked with the leadership of each response agency to schedule "defusing" sessions (small group discussions of what happened and information about critical incident stress and proper mental health preservation techniques). After several more days, debriefing sessions were scheduled with those agencies to attain psychological closure. Each defusing session was facilitated by two or more CISM peer support members, and the debriefings were led by one or more peer support person(s) and a mental health professional. Some senior department leaders participated in the entire debriefing session. Others left near the near the end of the session, so that front-line personnel could conclude their CISM discussions without intimidation. The senior staff then had a chance to finish their discussion among themselves with another CISM team member. During a 3-week period following the fire, CISM personnel conducted 37 defusing and 29 debriefing sessions, made 42 station visits and 11 follow-up station visits, and engaged in 119 individual counseling sessions.

Follow-On Responder Assistance
Personnel needing follow-up mental health assistance were referred to the department's EAP or other local qualified mental health providers. In a few cases, personnel were admitted to residential treatment centers. This series of defusing and debriefing sessions were followed up in some situations with CISM members continuing to check on the progress of personnel who were particularly affected by the events of February 20.

Support for Responders' Families
CISM team members also held evening sessions for responders and their families. In some sessions, the department members stayed for part of the session but later left so the families could talk among themselves. Small group sessions were also planned and conducted for children. This was the first time that the CISM team offered family sessions to such a large group of people. By all accounts, it appears to have been well-received and helpful.

CISM Support for the Office of the Medical Examiner and Others
Through the intervention of Mr. Kleinman, the HHS regional coordinator, the Rhode Island CISM Team was also asked to provide support to the OME. Beginning on the Saturday, February 22, CISM team members were available to talk with the regular OME staff, as well as the scores of volunteer medical and dental personnel who had been mobilized to assist with identifying the dead, conducting autopsies, and preparing death certificates. Because these personnel were on their feet working for prolonged periods of time, the CISM team arranged for a massage therapist to come to the OME and treat personnel during work breaks.

Members of the Rhode Island Critical Incident Stress Management Team.

The CISM team also visited the State Fire Marshal's Office, State Department of Public Health, and the Rhode Island Visiting Nurses Association, which was responsible for in-home healthcare for the burn victims once they were discharged.

Continuing Support

CISM support activities continued for nearly 3 weeks after the fire and concluded with the CISM members themselves being debriefed by one of the CISM teams from Massachusetts. Rhode Island CISM Team members and their colleagues from Massachusetts devoted hundreds of hours of service at no cost to the responders, their agencies, or the government.

Findings and Recommendations

MH-007 Command officials recognized early the impact this incident was going to have on personnel and took deliberate, well-thought-out steps to ensure the CISM team was onscene and available to provide assistance.

CISM should be an integral part of the response to any MCI. All first response organizations should develop close relations with CISM support resources and encourage all personnel to make use of their services so that they are readily accepted after a disaster.

MH-008 The Rhode Island CISM Team lacks communication equipment for rapid team alert notification and for members to talk to one another once they are deployed.

The Rhode Island CISM Team should be provided with communication equipment such as Nextel radios or two-way pagers that will enable dependable notification and communications once team members have been mobilized.

MH-009 The Rhode Island CISM Team lacks personal equipment to respond safely once onscene, regardless of the weather and environmental conditions.

Funding should be given to the Rhode Island CISM Team to provide all members with personal response gear such as a protective weather coat, boots, and a flashlight.

MH-010 Although the CISM team did avail themselves of mental health support, insufficient attention was put to their physical health while working.

CISM personnel should ensure they take the time to eat and attend to other physical needs while working.

MH-011 At the rehabilitation sector, there were times when victims' families entered areas where response personnel were resting. This proved uncomfortable for everyone concerned.

The rehabilitation sector should be situated an appropriate distance away from on-site activities and security personnel should be positioned to prevent uncontrolled visits from the media or the public.

MH-012 In coordination with command personnel, the Rhode Island CISM Team arranged to station a clergy member at the body staging area to offer a nondenominational prayer as each body was recovered. Response personnel viewed this spontaneous decision as important.

During large-scale incidents involving mass fatalities, command personnel should consider having clergy available on the scene to ensure the dignified and respectful handling of deceased victims.

MH-013 Because a complete list of all responders was not kept at the ICP, the Rhode Island CISM Team leaders asked for assistance in compiling a list of responding agencies and personnel. This list was completed 2 days after the fire.

Incident Command should maintain a complete list of all agencies responding to an incident and share that list with CISM team leaders.

MH-014 Despite a lack of written procedures, the command staff of several fire departments initiated personal or telephone follow-up with their personnel during the days following the fire. This personal interest in the well-being of department members was keenly appreciated.

All response agencies should have a written procedure describing what post-incident mental health support will be provided to responders, how it will be executed, and by whom.

MH-015 The Rhode Island CISM information sessions provided to the families (including children) of the first responders were helpful, well received, and appreciated.

Response agencies, working with the Rhode Island CISM Team, should continue to hold family information sessions following major incidents. Sessions for children should be included.

MH-016 The therapeutic massages provided to the staff at the Rhode Island morgue were very much appreciated. However, such services may be difficult to obtain because a process to organize and coordinate therapeutic massage resources is lacking.

Rhode Island CISM officials should continue to work with massage therapists willing to respond to disasters and help them organize into a recognized response resource.

MH-017 The various emotions associated with an incident of this magnitude can lead to the delayed onset of post-traumatic stress.

Each response agency should monitor personnel for early signs of critical incident stress and post-traumatic stress disorder (PTSD). Particular attention should be paid to higher-than-normal absenteeism, increased alcohol use, and changes in personality or work ethic.

MH-018 Some responders who did not respond to the fire because they were not dispatched or available on the night of the fire experienced feelings of guilt and despair over not having been there when they were needed.

Disaster planning should address the possibility that personnel not directly involved with the response may need assistance to work through their feelings.

MH-019 The anniversary of the Station club fire will potentially serve as a catalyst for renewed responder emotions that will range in type and severity.

Response agency leaders, in coordination with the CISM team and other mental health officials, should review planned recognition events commemorating the Station club fire and prepare to mobilize mental health resources if needed.

MH-020 Unlike the fire command, the police leaders did not mandate that all personnel speak to a CISM team member before leaving the scene.

Police leaders should encourage all personnel to speak with a CISM team member before their departure from the scene.

MH-021 Non-Rhode Island sanctioned peer personnel operated as freelancers in offering their assistance to several police departments, resulting in confusion regarding their affiliation and standard of care.

All volunteer peer support personnel should be a coordinated component of the State CISM Team and not be allowed to act independently.

SECTION 3 – MENTAL HEALTH SUPPORT FOR HEALTHCARE FACILITY PERSONNEL

Observations

Mental Health Self-Help

Providing mental healthcare to hospital staff members is not always addressed in hospital disaster plans. If an individual staff member is confronted with a particularly disturbing situation, he or she has the opportunity to approach one of the hospital social workers or psychiatrists and ask for help. Generally speaking, however, tragedy is viewed as "part of the job." Adding stress management intervention may be seen as complicating an already busy day in the ED or other treatment area, taking time away from patients or intruding on badly needed personal and family time. Although it may be generally true that tragedy and grief are part of the healthcare business, even the most experienced practitioners found the injuries suffered in the Station club fire among the worst they had ever encountered. Coupled with the sheer number of badly burned victims and the emotional displays of grief-stricken family and friends, the Station club fire presented extraordinary conditions. These conditions challenged the psychological tolerance level of even the most stoic medical staff members.

Caring for the Caregivers

In some cases, to better cope with the stress, hospital staff members were afforded over the ensuing days and weeks access to formal defusing and debriefing sessions conducted by fellow staff members or CISM-trained consultants. In other cases, simply talking with colleagues during work or going out for coffee provided the opportunity to discuss the tragedy with others and to share personal experiences and feelings. Family members became the alternative for some hospital staff to vent their feelings. Those who had no such outlet reported experiencing some traditional signs of critical incident stress, including fatigue, sleep disorders, and appetite changes. Long work hours and seemingly endless days of handling painful dressing changes, performing physical therapy, and listening to patients questioning the very reason to live took a heavy emotional toll. The Station club fire truly had many victims.

Findings and Recommendations

MH-022 Several hospitals reported dissatisfaction with attempts to meet the mental health needs of hospital staff.

Hospitals should review disaster plans to ensure they adequately address the acute and long-term mental health support necessary to meet the needs of their staff and their families.

MH-023 The provision of hospital mental health services is usually the domain of staff psychologists, psychiatrists, social workers, or clergy members. However, helping the victims and caregivers cope with the emotions associated with disasters requires specialized training that is beyond routine counseling. Several hospitals reported they did not have sufficient trained mental health resources to meet their needs.

Hospital planning should include the identification of qualified staff to provide mental health support during and following a disaster to victims, their families, and hospital staff. The plans should include procedures for supplementing these personnel with external resources.

MH-024 Kent Hospital has a trained CISM team comprised of volunteers from the hospital staff who are available to serve patients or other staff members.

Other hospitals should consider this approach and obtain ICISF CISM training for their staff.

PART IV
MASS FATALITY MANAGEMENT

INTRODUCTION

The Rhode Island Office of the Medical Examiner

The Rhode Island OME was consolidated at its present Providence facility in the 1970s. The chief medical examiner is Dr. Laposata, a pathologist with nearly 25 years of experience, including 8 years in her current position. Dr. Laposata reports to the director of RI Health, Dr. Nolan. The 19-person OME staff includes four pathologists, five investigators, three autopsy assistants, two case managers, one administrator, one budget analyst, and two front office staff (see **Figure E-6**). An investigator is on duty 24 hours a day. Investigators answer death-related telephone calls and deploy from the office to conduct on-scene investigations related to sudden deaths and to direct body removal using a contracted transport service. The Rhode Island OME performs between 700 and 800 autopsies each year and receives more than 5,000 death calls annually. The current facility is designed to perform up to four autopsies simultaneously if adequately staffed. Thirty bodies can be kept in refrigerated storage. That number can be increased somewhat if bodies are placed on the refrigerator floor. The Forensic Toxicology Section of the State Laboratory provides laboratory support for death investigations.

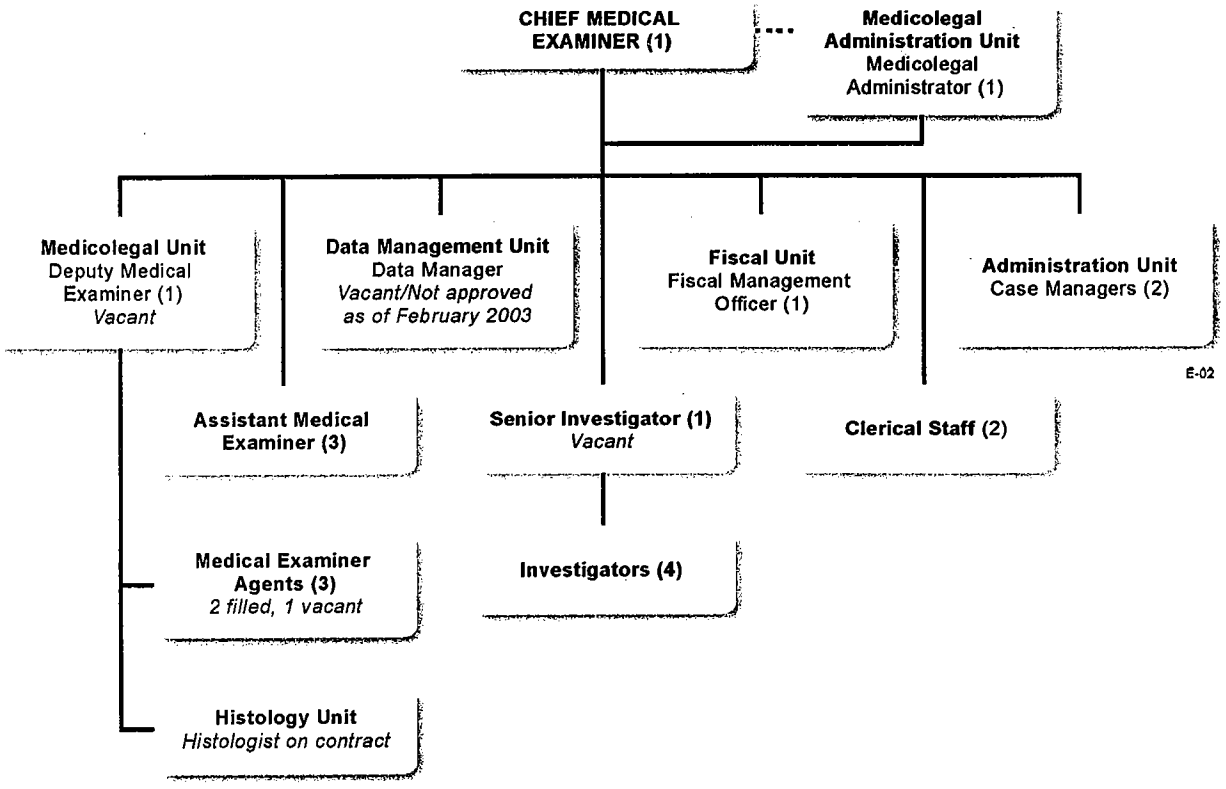


Figure E-6. OME organization chart.

Past Experience
Although Rhode Island had not previously suffered a significant mass casualty incident (MCI), the OME played a lead role following the EgyptAir flight 990 crash into the Atlantic Ocean off the coast of Massachusetts on October 31, 1999. Assisted by a Federal Disaster Mortuary Operational Response Team (DMORT) and Statewide volunteers, the OME examined more than 6,000 personal effects and performed 217 autopsies during an investigation that lasted nearly 2 years. The investigation was conducted in collaboration with the Federal Aviation Administration (FAA), National Transportation Safety Board (NTSB), National Disaster Medical Assistance System (NDMAS), and Federal Bureau of Investigation (FBI).

Remarkable Results
Although the OME staff competently and compassionately deals with death everyday it became evident very early that this was no ordinary incident. Working around-the-clock over the course of the next 5 days, the OME completed positive forensic identification investigations and performed autopsies on all 96 bodies recovered from the ruins of the Station club. This phenomenal accomplishment required the complete commitment of the OME staff, a Federal DMORT, and scores of volunteers, including funeral directors, dentists, and administrative personnel.

Annex E, Part IV includes the following four sections:

- Section 1 – Initial Notification and Response
- Section 2 – On-Scene Activities
- Section 3 – Death Investigation at the Office of the Medical Examiner
- Section 4 – Family Notification of the Death of a Loved One

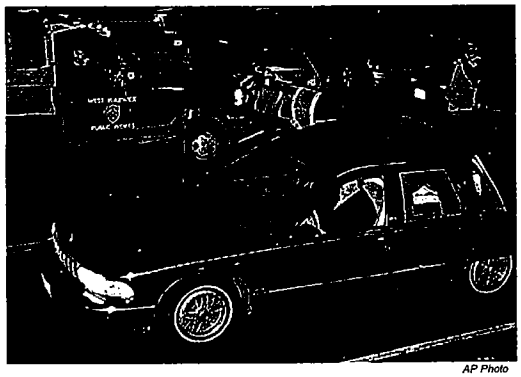
SECTION 1 – INITIAL NOTIFICATION AND RESPONSE

Observations

OME Notification

The OME investigator on duty the evening of February 20 was 9-year veteran Mr. Kingston. He received a telephone call sometime after 11:30 p.m. from the West Warwick police dispatcher informing him of a fire at the Station club. This initial report stated that as many as 15 to 20 persons might be dead. Following regular office procedure, he called the police dispatcher back to confirm the information. He then called Dr. Laposata at home while turning on the television news, seeking more information. Mr. Kingston next contacted the Ocean State Livery Transfer Service, the company contracted by the OME to assist with body removal. He asked them to double the regular number of response crews, providing a total of two vehicles and four personnel. This was the extent of OME resources deployed to the scene until recovery operations were completed on Friday night. Based on his previous experience, Mr. Kingston decided to add more plastic gloves, extra 35mm Polaroid film, and three additional boxes of body bags (20 bags per box) to his already stocked response vehicle. OME vehicles are usually stocked with one box of gloves, one box of body bags, and film.

Shortly after midnight, following notification from the West Warwick police dispatcher that the Incident Commander considered it safe for the OME to commence work, Mr. Kingston and the two crews from the Ocean State Livery Transfer Service proceeded to the scene. Mr. Kingston's OME vehicle is not equipped with a radio. His cellular telephone was the only possible means of communicating with responders at the scene to receive situation updates while en route. Without a list of contact numbers, communication was not possible.



AP Photo

Findings and Recommendations

MFM-001 Rhode Island did not have a written mass fatality management plan at the time of the Station club fire. As a result, staff members at the OME had to rely on past personal experience to guide response activities.

The chief medical examiner should work with other elements of RI Health, the Rhode Island State Association of Fire Chiefs, the Rhode Island Hospital Preparedness Planning Committee, RIEMA, and officials from State and local law enforcement agencies to develop a comprehensive mass fatality management plan. The plan should address the variety of fatality-related issues created by natural and manmade disasters.

MFM-002 The absence of a radio or computer-based communications system in OME response vehicles precluded communicating with on-scene units to obtain update reports and later enter scene data that could be useful to OME response personnel and to RIEMA.

Funding should be secured to equip OME response vehicles with two-way radios and computers that will allow integrated communications with State and local response agencies, healthcare facilities, and RIEMA.

SECTION 2 – ON-SCENE ACTIVITIES

Observations

Initial Circumstances Confronting the OME

Upon arriving at the incident site at approximately 1:00 a.m. on Friday morning, the OME investigator and Ocean State Livery Transfer Service personnel were briefly held in a staging area until the Incident Commander determined it was safe for them to enter the fire scene. Once authorized to proceed, Mr. Kingston planned to implement the regular OME investigative process. This process includes locating the deceased, photographing them from several angles, making notations about their location on a note pad, affixing an identification tag to the body, placing the body in a bag, and having it removed to a body staging area or awaiting van.

Prevailing circumstances, however, quickly made this routine practice impractical. Some bodies had already been removed to a body staging area to allow rescuers to reach other trapped persons who were still alive. The initial victims were brought to a body staging area located in the parking area adjacent to the right front side of the Station club, where the bodies were covered by tarps. These were the first to be examined, tagged, and placed in body bags by Mr. Kingston. There was also a large concentration of bodies at the Station club front door area that had to be removed before access could be gained to the interior of the building. Once the bodies were removed from the doorway, the search for bodies inside the building began.

Problems Photographing Bodies

Structural frames of reference for picture taking were often limited because of the extent of damage to the facility. Mapping the location of the deceased became more difficult as firefighters began tearing down walls and clearing debris to reach trapped bodies. In a few cases, firefighters spontaneously removed bodies before the OME investigator photographed them and made notations concerning the bodies' locations.

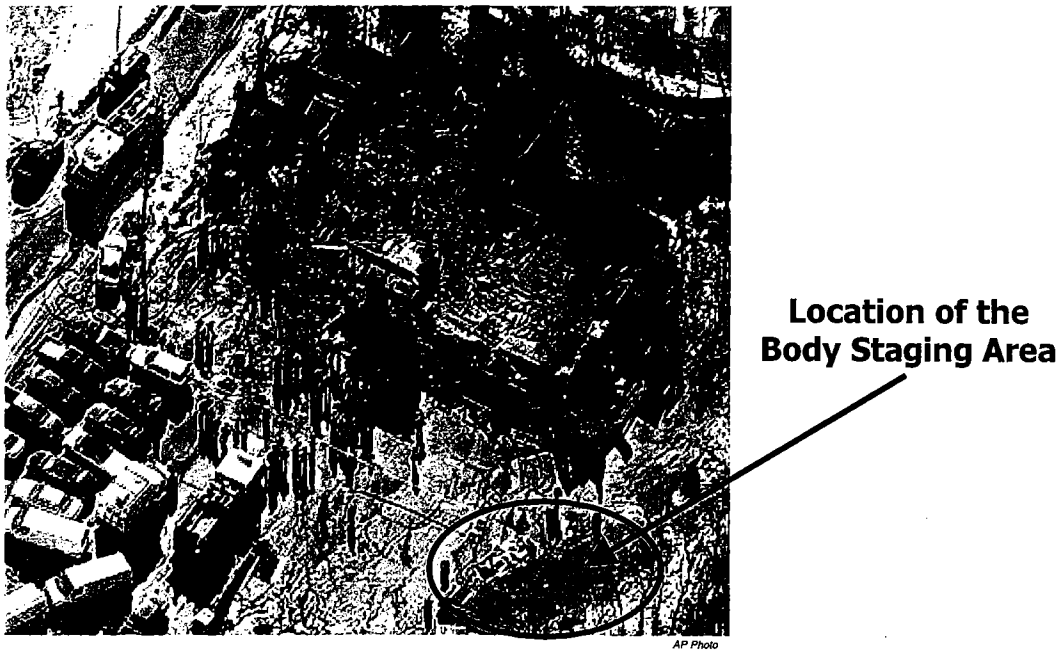
Mr. Kingston's camera eventually became inoperable during the early morning hours because of the bitterly cold weather. Fortunately, police investigators and fire marshals had more advanced equipment and continued taking pictures. However, their interests were somewhat different than that of the OME investigator, focusing primarily on victims' faces rather than the entire bodies and their locations.

West Warwick Police Department

Firefighters began tearing down walls and clearing debris.

Difficulties Recovering Bodies

Because of the cramped quarters, bodies sometimes were moved outside of what remained of the Station club before they could be placed in body bags. In these situations, decedents were placed on extrication devices, such as backboards, and covered with a sheet before being moved to the body staging area.



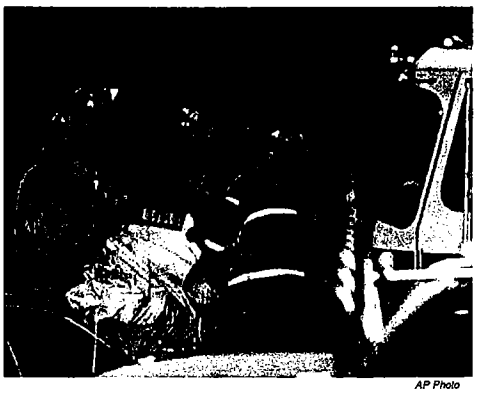
Location of the body staging area.

Communicating with Incident Command

Communications between Mr. Kingston and Incident Command staff were infrequent. He was not integrated into the ICS nor was a liaison officer appointed to work closely with him. Body removal efforts were sometimes complicated because fire department officers gave instructions to personnel without consulting Mr. Kingston. None of these chiefs wore a vest or other identifier that indicated responsibility for coordinating the recovery activity.

The Challenge Continues to Grow

A police officer standing in the Station club entrance area assigned each body a number as the body was removed and noted in an informal journal the location in the building from which each body was recovered. As time passed, additional bodies were found intertwined and stacked one on top of another. Rescue belts and other extrication equipment sometimes had to be used to extricate a body. This process proved time consuming, as well as physically and emotionally exhausting. The smell of burned bodies was noticeable even to recovery teams wearing surgical masks with an odor distracter. The growing number of dead and the degree of injuries to so many victims took an emotional toll on everyone engaged in the recovery process, including Mr. Kingston and his assistants.



Outside the burned-out shell of the Station club, bodies were placed on tarps at a body staging area site while awaiting assignment to a transport vehicle. Other tarps were hung to provide a modicum of privacy. Several emergency vehicles were repositioned to preclude press and media from entering and filming the body staging area. As temperatures continued to plummet during the night, body bags became stiff from the cold and zippers began freezing. As a result, bags were sometimes left partially open and covered with a sheet in the body staging area. Wind gusts sometimes blew away the sheets or toppled the tarps that had been hung. Nearby personnel quickly reacted to restore the area. In one instance, an Ocean State Livery Transfer Service employee attempted to place an already bagged body into a second bag. A fire service officer who thought this was unnecessary and inappropriate stopped him.

A chaplain associated with the Rhode Island CISM Team was assigned to the body staging area and offered a nondenominational prayer as each body arrived in the area.

A fire chaplain leads firefighters in a prayer over the remains of a victim.

Resource Constraints Prevail

Incident Command planned to limit the number of times response personnel working in teams of four or five persons with a supervising officer had to be involved in recovering remains to one rotation. However, the number of fatalities eventually required multiple extractions for each team.

At one point during the recovery, the West Warwick police dispatcher relayed to Incident Command an offer from the military to send additional body bags to the scene. This offer was accepted without consulting the OME investigator, who had already made arrangements for more body bags.

As the body count rose and other information was learned, Mr. Kingston periodically called Dr. Laposata and Mr. George Ducharme, the OME administrative officer, and apprised them of the situation. Mr. Albert Scappaticci, executive director of RIEMA, reported that he called Dr. Laposata at home twice between 3:00 a.m. and 5:00 a.m. urging that she come to the scene or send a senior staff member. West Warwick Police Department (WWPD) Chief Peter Brousseau stated that he made a similar telephone call at around 3:30 a.m. Dr. Laposata does not recall receiving those telephone calls.

Mr. Ducharme and a scene investigator state that he arrived at the OME between 12:30 a.m. and 1:00 a.m. Mr. Kingston left the incident site at about 2:00 a.m. to transport the first bodies. He arrived back at the site at about 3:00 a.m. Mr. Kingston's temporary absence interrupted the OME recovery process onsite.

The original transport plan employed by Mr. Kingston used his OME van and the two Ocean State Livery Transfer Service vehicles. After a few hours, it became evident to Incident Command that additional transport vehicles would be needed. Incident Command assigned four ambulances with volunteer crews to the transport fleet. Each ambulance made two trips in convoy to the OME in Providence, each carrying two bodies. Early on Friday morning, non-emergency vehicles replaced the ambulances. A Warwick Fire Department bus and vans from the West Warwick Department of Public Works were pressed into service to supplement the Ocean State Livery Transfer Service vehicles and remained in service until the final body was transferred to the morgue late Friday afternoon. Each vehicle carried four or five bodies and traveled unescorted to the OME morgue, where Providence Fire Department personnel unloaded them. Personnel untrained in body transport and not accustomed to the distressing circumstances of this event drove these vehicles.

Transporting remains from the scene.

Closing the Air Space Over the Incident Site

As the sun began to rise, helicopters appeared with crews filming the incident site from above, including the body staging area. Their intrusive presence quickly resulted in a request that the FAA close the airspace in the vicinity of the Station club. The area was quickly cleared of aircraft.

Throughout the recovery operations, the State Fire Marshal and members of the RISP were performing their own search of the debris, photographing victims, and taking notes. Once the last living victim was rescued, fire command personnel viewed law enforcement as responsible for the body recovery effort. However, there appeared to be limited coordination and communications between police and fire command personnel and the OME investigator.

The OME on-scene investigation and body recovery efforts continued until about 5:00 p.m. on Friday, February 21. At that time, Mr. Kingston returned to OME HQ and began completing paperwork before being sent home. The last fire department units left the scene by 11:15 p.m. Friday night.

Boston Globe \ Tom Landers

The last fire department units departed the scene of the Station club fire by 11:15 p.m. Friday night.

Findings and Recommendations

MFM-003 The OME on-scene response was inadequate to meet the requirements of this tragic event. As a result, firefighters and EMS personnel were pressed into service to help recover and remove deceased victims.

Firefighters, EMS, and public works personnel are not usually employed to transfer dead bodies. When they are asked to do so, they are not available to perform the duties for which they are trained; therefore, using them to perform this task should be avoided whenever possible.

MFM-004 Because the OME deployed with insufficient resources, ambulances and commercial vehicles were used to transport bodies to the State morgue. Funeral homes and other body transfer companies were not mobilized.

Mass fatality planning should address the use of sufficient body transport companies and funeral homes to assist with body recovery and transport.

MFM-005 The responsibilities for coordinating the on-scene OME activities, conducting the investigation, and communicating with Incident Command, law enforcement personnel, and the State Fire Marshal's Office was clearly beyond the capabilities of

one OME investigator. None of the other OME investigators were directed to report to the scene.

The scope and complexity of a mass fatality incident demands that multiple investigators be notified and directed to respond to the scene. This requirement should be specified in a Rhode Island mass fatality management plan.

MFM-006 Although there were telephone calls between the OME investigator, the chief medical examiner, and other OME staff during the body recovery operations, neither the chief medical examiner nor one of the other pathologists came to the scene.

The chief medical examiner or a pathologist should deploy very early to the scene to size up the magnitude of the event. The presence of the chief medical examiner or another pathologist would have added investigative expertise. Additionally, the chief medical examiner would have immediately understood the magnitude of the incident and been able to commit more investigative and transport resources.

MFM-007 The OME had only four investigators at the time of the fire. Mr. Kingston remained on the scene without relief until the investigation was completed, more then 17 hours after the fire was extinguished.

The chief medical examiner should develop a staffing plan that maximizes on-scene efficiency and ensures the ability to place adequate staff and resources onscene. Every effort should be made to mitigate the need to exceed reasonable work periods for the personnel involved.

MFM-008 The absence of frequent substantive conversations between Incident Command staff and the OME investigator contributed to misunderstandings regarding the body removal process.

OME personnel should be fully integrated into the Incident Management System.

MFM-009 Communications problems were exacerbated by a lack of understanding of the roles and responsibilities of all parties during a mass casualty and mass fatalities.

OME and State and local public safety, public health, and healthcare facilities staff should regularly train together on managing a mass fatality incident. Fatality management should also be included in future Statewide exercises.

MFM-010 Incident Command was very sensitive to the need for victim privacy. However, the lack of a protected body staging area prohibited complete environmental protection and privacy.

Once onscene, OME personnel should work with Incident Command to establish a body staging area that provides protection, privacy, and transportation access. If a fixed facility is not available, consideration should be given to using tents similar to those used by HazMat teams for decontamination.

MFM-011 There appeared to be confusion among Incident Command personnel and the OME investigator concerning the need for additional body bags and where to obtain them.

The mass fatality management plan should identify what equipment and supplies will be needed at an incident scene. OME personnel should be responsible for determining their need for additional resources and obtaining them through appropriate channels, including the ICS Logistics Branch if activated.

MFM-012 The photographic equipment used by OME investigators was not sufficiently rugged for the weather and environmental conditions.

The OME should be provided with funding to acquire Polaroid and digital cameras designed to operate in extreme environmental conditions.

MFM-013 The OME investigator's handwritten notes were later transferred to another document back at the office. This proved time consuming and inefficient.

The OME should acquire laptop computers or other portable technology for investigators to use that can download data and pictures directly from the scene.

MFM-014 The plastic gloves worn by the OME investigator were not suitable for conducting the investigation and removing bodies in the blustery cold weather that occurred on the night of the Station club fire. The cold temperatures quickly numbed his fingers and made his job more difficult.

Investigators should be issued a variety of gloves suitable for a range of weather and environmental conditions. Chemical hand-warmers that can be slipped inside shoes and gloves should be available as well.

MFM-015 Surgical masks treated with petroleum jelly provided only limited benefit to those using them under the prevailing conditions at the Station club fire.

More effective methods for limiting or eliminating troubling odors associated with decaying or burned bodies should be found. Consideration should be given to using air-purifying respirators or N-95 masks treated with spirits of wintergreen.

MFM-016 Many persons involved in recovery operations did not have any form of respiratory protection.

Incident Command should require the use of respiratory protection during the recovery operations. In addition to the odor associated with the deceased victims, other noxious fumes were present.

SECTION 3 – DEATH INVESTIGATION AT THE OFFICE OF THE MEDICAL EXAMINER

Observations

Previous Experience Was Helpful, but with Important Differences

At 8:00 a.m. on Friday, February 21, Dr. Laposata assembled key OME staff members and began crafting a plan to perform autopsies and identification procedures on the bodies of the Station club fire victims, which now numbered 60. Several of the OME staff had participated in the 1999 EgyptAir investigation, which proved to be valuable experience, despite some important differences between these two tragic events. The EgyptAir flight crashed approximately 50 miles off the coast of Massachusetts, and the shattered remains of passengers from around the world were scattered across a vast ocean floor. It took weeks to recover the body parts and even longer to gather thousands of personal effects that were the primary evidence in identifying the victims. The Station club fire left most victims intact but burned beyond recognition. All of the victims were local citizens from Rhode Island, Massachusetts, and Connecticut. Unlike the EgyptAir situation, most anticipated a speedy autopsy and victim identification process rather than one drawn out for several weeks and beyond.

The OME staff organization at the time of the EgyptAir investigation was also different from that in place during the Station club fire. Dr. Laposata had a deputy chief medical examiner during the earlier incident. This freed her to spend a great deal of time helping families of victims at the FAC understand the deliberate investigative process required to confirm the identity of the deceased. That position had been eliminated long before the Station club fire, leaving Dr. Laposata to concentrate on her administrative, operational, and pathology responsibilities. Communicating with the families of victims at the FAC became the shared responsibility of Dr. Nolan, the RI Health director, Ms. Barbara McGann of the American Red Cross of Rhode Island (ARC RI), and Mr. Aucott of RIEMA. However, by Friday afternoon, Governor Carcieri personally assumed this critical responsibility, which he performed with great care and compassion. Family members and friends of the victims greatly appreciated the governor's sincere and heartfelt support during this painful ordeal.

Twenty-Four Hour Operations

Preliminary plans called for the OME staff to work 12-hour shifts until all autopsies were completed. This was not acceptable to Governor Carcieri, who made victim identification and family notification his first priority and promised to secure whatever resources were needed to support that effort. It was the governor's desire that the OME operate 24-hours a day starting immediately and continue that schedule until these objectives had been met. Thus, the need for outside assistance was recognized and the Disaster Mortuary Operational Response Team (DMORT) was requested by the governor.

Two OME pathologists returned early from vacation to join in the effort and two retired OME investigators also reported for duty (the OME was down one full-time investigator because of a retirement in January). They had learned of the incident on television and called offering to help. The OME staff established the process for identifying the bodies, standardized procedures for performing a directed autopsy, and decided on terminology for data entry. The patient identification system established by Mr. Kingston, which used standard case numbers in

conjunction with other State cases, at the fire scene was changed to a separate numbering sequence unique to the Station club fire. By 2:00 p.m. on Friday afternoon, the first victim identification efforts and autopsies were under way.

Expanding Storage Space

To expand the available body storage space, the OME requested two refrigerator trucks. One of two senior RI Health administrators assigned to support Dr. Laposata contacted RIEMA, and the trucks arrived later in the day. They were parked near the rear loading dock of the morgue but, because of the height of an overhang, the trucks could not back directly up to the building. RIEMA arranged for carpenters from the U.S. Department of Transportation to construct ramps that allowed easy ingress and egress while protecting these activities from public view. Security of the entire area was provided by Rhode Island State Police Department (RISP).

Help from Funeral Directors and Dentists

Also at about 2:00 p.m. on Friday afternoon, Dr. Laposata met with Mr. Steve Carpenter, the chairman of the Rhode Island Funeral Director's Association's Mass Fatality and Disaster Committee, and with Dr. David Puerini, chairman of the Rhode Island Dental Association's Disaster Committee. They were asked to provide around-the-clock volunteer assistance. The 12-hour shifts would begin that night and continue until victim identification and autopsy activities were completed. Both of these groups had worked with Dr. Laposata and her staff on the EgyptAir crash and were familiar with much of what needed to be done and the procedures used by the OME staff. Arrangements were made for five licensed Rhode Island funeral directors and embalmers to be on duty beginning Friday night at 6:00 p.m. By Saturday night, the number grew to 12 each shift. The funeral director's role included assisting with body handling and preparation, specimen collection, and completing required paperwork.

Three volunteer dentists were assigned to the day shift and two at night. They performed the antemortem and postmortem dental examinations using records provided by family dentists. These records were obtained on Saturday and Sunday following a public appeal by Governor Carcieri asking that dentists quickly respond to any request for the dental records of their patients. RI Health volunteers drove as far as Massachusetts and Connecticut to pick up these records.

Assistance Offered from Neighboring State

On Friday afternoon, February 21, a team of forensic experts arrived from Massachusetts and offered their assistance to the Rhode Island OME. The chief medical examiner was unaware of anyone asking the Massachusetts forensic team to deploy. She determined that their help was not needed at the morgue and declined their offers of assistance.

Documentation and Testing

RISP assisted with fingerprinting the victims and also provided security at the morgue. RI Health provided several personnel, including senior-level administrators to help coordinate OME activities. Information technology specialists set up computers and created software programs to aid in documenting the process. The Forensic Toxicology Laboratory, part of the State Laboratory, modified its regular work schedule to accommodate the unusually high testing requirements associated with this investigation, examining for the presence of alcohol, illegal drugs, carbon monoxide, and cyanide in addition to routine specimen examination.

Planning for Federal Assistance
After conferring with Dr. Nolan and Dr. Laposata, Governor Carcieri decided to ask for Federal assistance in the form of a DMORT. Mr. Kleinman and Mr. Libby, emergency coordinators for HHS, had arrived earlier that afternoon and had offered HHS assistance. Dr. Laposata and Mr. Ducharme concluded that the Federal resources OME needed included three pathologists, three autopsy assistants, three x-ray technicians, three clerks, and one forensic odontologist.

Anticipating a request for assistance from Rhode Island, at approximately 4:15 p.m. on Friday, the HHS OEP asked Mr. Craig Caldwell to serve as the DMORT leader, with Ms. Carol Gregory as the OEP medical support team leader. Both Mr. Caldwell and Ms. Gregory had worked with Dr. Laposata and her staff during the EgyptAir investigation.

At approximately 6:00 p.m. on Friday, February 21, Governor Carcirei telephoned HHS Assistant Secretary Jerome Hauer and asked for DMORT support. Mr. Hauer approved the deployment order by 7:00 p.m. that evening.

DMORT Assistance Arrives
Nineteen DMORT personnel were selected and notified later Friday evening to report to the Rhode Island OME as early as possible on Saturday. The personnel chosen were from DMORTs located in the eastern part of the United States, and many of them were already gathered in Pittsburgh, PA, for the funeral of one of the founders of the DMORT system. Mr. Caldwell arrived in Rhode Island early Saturday morning and, along with Ms. Gregory, met with Dr. Laposata, Mr. Kleinman, Mr. Libby, and Mr. Mark Russo from the HHS OEP. They planned the integration of DMORT personnel into the body identification and autopsy effort that was already under way.

With the DMORT augmentation in place by Saturday at 2:00 p.m., the OME was able to accelerate the process by employing up to four teams each during the day and night shifts. Each shift was 12 hours long. While each team of four or five persons worked independently, they performed the same directed investigation outlined in the Friday morning meeting by Dr. Laposata. Alternative procedures enabled the investigating teams to overcome occasional problems, such as difficulties obtaining panorex x-rays of the mouth because of equipment limitations. Dr. Laposata, Mr. Ducharme, Mr. Caldwell, the DMORT team leader, Mr. Carpenter of the Rhode Island Funeral Director's Association, Dr. Puerini of the Rhode Island Dental Association, and others met daily to identify and resolve operational problems, set work objectives, and plan activities for the day. Either Dr. Laposata or Mr. Ducharme was always present at the morgue to provide administrative oversight and offer assistance. By Sunday, significant progress had been made and the pace of victim identification had substantially quickened.

Conveying Results to the Family Assistance Center
Once a body was positively identified and the autopsy completed, Dr. Laposata reviewed the entire record and then called the RI Health contact person at the FAC and conveyed the victim information. The family notification process would then commence (see Annex F – Family Services and Support).

DMORT Support at the Family Assistance Center
Although most of the DMORT personnel worked at the morgue, six team members with expertise in working with families and conducting victim identification interviews were sent to the

FAC. Despite some initial difficulty integrating them into the support system already in place, they were able to contribute substantially to the assistance offered to the grieving families. They brought with them to the FAC a DMORT Victim Information Profile (VIP) form that proved more useful than the WWPD Missing Person Report that had been used since the opening of the FAC on Friday morning (see Appendix 4 – Forms).

Leadership Visits to the Office of the Medical Examiner

Governor Carcieri and other elected officials visited the OME each day, sometimes more than once, receiving status briefings and commending the hard-working staff. The Rhode Island CISM Team provided around-the-clock peer support to the OME investigative teams and arranged for a therapist to offer seated massages during periodic breaks. Local businesses and citizens delivered prepared food and other gifts over the weekend and throughout the following week.

Completing the Effort and Demobilizing

With an average of 35 persons working around-the-clock, the autopsies of all 96 deceased victims were completed by 7:00 p.m. on Monday, February 24. All body identification was completed by 8:00 p.m. on Tuesday night. The successful use of dental records and fingerprinting for victim identification precluded the need for DNA testing, speeding the process by reducing special laboratory testing and its associated costs.

Except for two information specialists, all DMORT personnel were demobilized and sent home on Wednesday morning, February 26. The DMORT information specialists remained for an additional 36 hours, working closely with RI Health information specialists to ensure all DMORT victim data was transferred to OME computers. Two laptop computers purchased by the HHS representatives with a government credit card were left for the OME to use in its continuing investigation efforts.

The volunteer dentists and the Rhode Island Funeral Director's Association personnel were released on Tuesday evening, February 25, after having made an enormous contribution to the effort. The Funeral Director's Association immediately turned its attention to staffing a booth at the FRC, which remained open until March 14, 2003 (see Annex F – Family Services and Support).

Findings and Recommendations

MFM-017 The Station club fire was a huge tragedy with exclusively local impact on a uniquely compressed population. From the outset, there was pressure from every direction to release information about the fatality count, the identity of deceased victims, and the number and names of those injured. Families and friends of persons suspected to have been at the Station club, media representatives, elected and appointed officials, and others wanted detailed information much faster than it could be accurately and conclusively produced. During the course of performing autopsies and conducting victim identification investigations, the OME sometimes received duplicate or inappropriate requests for sensitive information.

A Rhode Island mass fatality management plan should include an information-sharing strategy regarding deceased victims that satisfies all appropriate constituencies in a manner consistent with the resources and time available to the chief medical examiner.

MFM-018 The process by which Rhode Island officials requested DMORT assistance from the Federal Government seemed to some to be disjointed and lacking the integrated involvement of the chief medical examiner, public health officials, emergency management personnel, and the governor's staff. Standard methods for requesting Federal resources were not followed.

Requests for Federal assistance should clearly specify the exact needs of State and local officials, which should be accurately conveyed through appropriate channels.

MFM-019 On Friday afternoon, February 21, a team of forensic experts from Massachusetts arrived at the OME offering its services. It is unclear whether someone other than the OME had requested assistance. The OME concluded that their help was not needed at the morgue; therefore, the offer was declined. They subsequently supported victim identification efforts at the FAC on Friday and Saturday, returning to Massachusetts after the DMORT personnel arrived.

The new mass fatality management plan should address the process for obtaining help and how volunteers will be used onscene and at the OME during a disaster. Requests for expert services to assist with mass fatality investigations and examinations should originate at, or be coordinated with, the chief medical examiner.

MFM-020 The chief medical examiner wanted to maintain the identification and autopsy procedures used everyday as much as possible. It was also her desire to use the State morgue as the only location for conducting victim identification and performing autopsies. Therefore, Dr. Laposata recommended against requesting that the National Disaster Medical System (NDMS) portable morgue be deployed to Rhode Island. Others outside of OME thought such a step was reasonable and prudent given the prevailing circumstances. The NDMS portable morgue was requested and deployed to Rhode Island. The trailer and its accompanying crew were positioned at a RISP barracks to serve as a back-up facility for the Station club investigation and to support any other concurrent incident that might occur. It was returned, unused, to Rockville, MD, on Tuesday, February 25.

The NDMS portable morgue should only be requested when there is a clearly defined need. It is a valuable and expensive Federal resource that should be requested only when it will fulfill a proven need. Among other factors that should be considered is the capacity of available resources to handle a second mass casualty event while engaged in ongoing mass fatality operations.

MFM-021 The absence of a qualified health professional serving as deputy medical examiner forced Dr. Laposata to work extraordinarily long hours for an extended period of time and was identified as a factor that prohibited her from spending time with victims' families at the FAC.

Consideration should be given to restoring the deputy medical examiner position to the OME.

MFM-022 The chief medical examiner is the last physician to see a deceased individual. The death of a loved one often leaves lingering questions in the minds of family members that need to be answered for complete closure. OME staffing constraints contributed to Dr. Laposata's decision to not meet with victims' families each day as she would have liked. Some families expressed disappointment and frustration because Dr. Laposata was unavailable.

The chief medical examiner should ensure there is sufficient infrastructure available to enable meeting with the families on a regular basis, brief them on what is occurring, and answer questions.

MFM-023 Individual records had to be created for each victim that included a variety of information not always available at the same time. Several personnel, including staff from RI Health, were assigned the responsibility of collecting, collating, and assembling the information and placing it in a folder for the chief medical examiner's review and approval. This was a tedious chore that required diligence, precision, and methodical attention to detail. At times there were insufficient qualified personnel available for this task.

Sufficient numbers of trained personnel should be assigned to create victim records using a prescribed format.

MFM-024 There were insufficient quantities of special equipment, such as bone saws, available for the OME to process the large number of victims of the Station club fire. Additionally, laptop computers to record victim information at various morgue locations were not available. Emergency procurement procedures to meet such needs were not in place. Autopsy equipment was borrowed from several hospital pathology departments, and HHS emergency coordinators used government credit cards to purchase two laptop computers from a local office equipment supplier.

Emergency procurement procedures should be in place for use by the OME during emergencies. There should also be a written agreement by which Rhode Island hospitals provide personnel and equipment to OME during a mass fatality incident.

MFM-025 The OME staff was not familiar with all of the features of the refrigerator trucks used to expand body storage at the morgue and did not initially monitor storage temperatures. The temperature inside one vehicle did not initially reach the desired level because a thermostat switch had not been activated. Although no harm occurred to the deceased, it reinforced the need for equipment familiarization and performance monitoring.

Personnel should be thoroughly briefed on all refrigeration equipment and an individual should be assigned to monitor temperatures.

MFM-026 Governor Carcieri's public appeal for dental records produced immediate results and proved to be an effective step in obtaining victim identification information.

Mass fatality management planning should address using the media as a means of notifying health professionals when their cooperation is needed.

MFM-027 The four victims who eventually succumbed to their injuries died at burn centers in Massachusetts, where the most seriously injured were treated. Rather than return the bodies to Rhode Island for identification and autopsy, the Massachusetts medical examiner, Dr. Robert Evans, and Dr. Laposata agreed on how the situation would be handled. Massachusetts pathologists conducted a directed autopsy examination consistent with those performed in Rhode Island. All of the information needed to prepare the death certificate was then transferred to the Rhode Island OME.

In mass fatality incidents involving victims from multiple States, the respective medical examiners should collaborate in developing a death investigation process that is standard and ensures the timely return of the remains to the families.

MFM-028 The chief medical examiner had previously worked with the DMORT leaders. These previously established relationships proved invaluable and enabled immediate and seamless resource integration.

NDMS and DMORT officials should continue to ensure State medical examiners are familiar with DMORT personnel and capabilities and how this expertise can be integrated into a mass fatality response. Exercises are a particularly valuable tool to develop and reinforce healthy relations.

MFM-029 The information recorded on the missing person report is not as complete or germane as that needed to identify badly disfigured persons. As a result, some families had to be asked on three or four separate occasions for additional personal information. The VIP form used by DMORT proved much more helpful in expediting the victim identification process.

Medical examiners should consider using the DMORT VIP form from the outset of a mass fatality incident to collect information from victims' families.

MFM-030 At the FAC, some inexperienced staff members were asked to obtain vital victim identification details and provide emotional support to the grief-stricken families.

Personnel assigned to an FAC should be well trained to perform these sensitive roles. Volunteers from groups such as the Rhode Island Funeral Director's Association should be considered.

MFM-031 Using DMORT personnel at the FAC added important expertise. However, some ARC officials seemed unaware of their skills and experience in dealing with disaster victims.

NDMS and DMORT officials should work with ARC officials to ensure there is adequate familiarity among ARC chapters regarding the total expertise resident in a DMORT.

MFM-032 The Rhode Island Funeral Director's Association responded in sterling fashion despite the absence of a written response plan. The lack of a written response plan sometimes slowed their efforts and required developing ideas as they went along. The Rhode Island Funeral Director's Association had not previously been invited to participate in any State or local disaster planning effort.

The Rhode Island Funeral Director's Association should devise a written mass fatality response plan. The plan should be periodically exercised to ensure association members are familiar with and prepared to employ it. The Rhode Island Funeral Director's Association should routinely be invited to participate in State and local mass casualty planning and exercises.

MFM-033 The Rhode Island Funeral Director's Association discovered during the response that its personnel notification list was outdated.

The Rhode Island Funeral Director's Association should continue recent efforts to update and maintain an accurate notification list, which should be regularly tested.

MFM-034 There were a number of lessons learned by the funeral directors and dentists who responded to the chief medical examiner's request for help. However, the Rhode Island Funeral Director's Association did not conduct a critique to discuss or document lessons learned.

The Rhode Island Funeral Director's Association and the Rhode Island Dental Association should conduct their own post-incident response discussions and identify lessons learned.

MFM-035 Processing 96 death certificates required that information be recorded accurately, reviewed for completeness, and then approved by the chief medical examiner. The OME lacked the computers and software to accomplish this task and used the equipment brought by DMORT.

The OME should acquire and maintain the resources needed to compile and maintain a computerized database of information for daily and disaster-related responses.

MFM-036 Some, but not all, OME staff and volunteers were directed to see CISM personnel before leaving at the end of their shift. Some reported that these discussions only delayed their departure after a long shift and thought there was no benefit from the meeting. Others reported that they would have liked a final CISM session after the incident ended.

The meeting with CISM personnel at the end of each shift should be encouraged. Once the incident is over, consideration should be given to holding one final defusing session and arrange for a subsequent debriefing session if requested.

MFM-037 The demonstrations of appreciation from the governor and other elected and appointed officials as well as the gifts of prepared foods meant a great deal to the staff and volunteers at the morgue. However, all of these occurred during the day shift. The night staff only heard about the visits.

Recognition by elected officials and others should be extended to those on the night shift whenever possible.

MFM-038 The OME, DMORT, the Rhode Island Funeral Director's Association, and the Rhode Island Dental Association performed 96 identification investigations and autopsies in less than 5 full days. These efforts were not publicly recognized.

All those who participate in a mass fatality response working long hard hours to help bring closure to the victims' families should be recognized after the event is concluded.

MFM-039 The OME did not conduct a critique following the event involving all of the organizations engaged in activities at the State morgue.

Following a mass fatality incident, the chief medical examiner should convene a meeting of all volunteer groups and others to discuss lessons learned and identify improvements to response practices.

SECTION 4 – FAMILY NOTIFICATION OF THE DEATH OF A LOVED ONE

Observations

Family Assistance Center Role

RI Health employees were at the FAC from the outset of its opening on Friday morning, February 21. One of their principal roles was to serve as a liaison between the chief medical examiner and the victims' families. Family members were asked to register upon entering the FAC and sign out when leaving the area. (For detailed discussion of FAC operations, see Annex F – Family Services and Support.)

Notification Linkage

Once a definitive identification was concluded at the State morgue, Dr. Laposata telephoned the designated RI Health point of contact (POC) at the FAC, who recorded the victim identification information on administrative records created by FAC personnel. A designated RI Health member then met with the other members of the notification team while another FAC staff member escorted the family to a private meeting area. Once the family was notified of the confirmed identification of a loved one, mental health professionals and clergy were available for those who wanted such support.

On the rare occasion that a family was not at the FAC when the identity of a victim was confirmed, the WWPD contacted the appropriate hometown law enforcement agency, which went to the family's home to make the death notification. By the time the FAC closed on Tuesday evening, February 25, all but two families had been notified about the death of their loved one. Final notifications were made by telephone on Wednesday at the families' request.

Concluding the Process

Once the family of a deceased victim selected a funeral home, bodies were released using procedures that are standard at the OME. The Rhode Island Funeral Director's Association agreed to provide their services at no cost to the families. Donations to the Rhode Island Station Nightclub Fire Relief Fund (SNFRF) covered the nominal burial expenses. Caskets were also provided free, as were the services of the Moshassuck Crematorium. The Caron Rock of Ages granite company provided headstones up to a value of $1,000, and Catholic cemeteries throughout Rhode Island offered burial plots. By Friday, March 1, all of the remains of the deceased had been released and death certificates issued to all of the families.

The personal effects of the deceased had been collected and, where identification was clear, were returned to the victims' families. Unidentified items were cleaned and photographed. Forensic Archeology Recovery (FAR), a team of volunteer archeologists organized after the World Trade Center terrorist attack and called in by law enforcement, assisted in recovering evidence from the incident site. A personal effects catalog will be produced and provided to the families of the deceased for identification of remaining personal effects. At the time of this report, Dr. Laposata plans to meet with the families of victims to answer any lingering questions.

Findings and Recommendations

MFM-040 RI Health played an important role at the FAC, where questions frequently arose about who was in charge of coordinating the various activities. FAC personnel did not wear command vests or other unique forms of identification.

The roles and responsibilities of participating organizations at the FAC should be clearly defined and those in leadership positions readily identifiable.

MFM-041 Seven senior RI Health administrative officials were assigned to the family notification teams at the FAC. The notification teams performed this difficult responsibility in a professional and compassionate manner, despite the lack of previous experience and with little in the way of instruction.

Personnel responsible for telling families about the death of a family member should preferably have clinical backgrounds and experience in making death notifications. In any case, notification team members should periodically reflect on the process and share their thoughts on carrying out this very difficult responsibility.

MFM-042 The policy of reviewing all available information about the victim before seeking out the family was time consuming but essential. In at least one situation, incorrect information was identified and corrected before family notification.

The Station club fire reinforced the importance of using a formal system of information preparation that includes double-checking all details before the family notification.

MFM-043 The notification teams frequently met with several families during a single work shift. In some cases, RI Health personnel participated in more than five notifications each per shift. The members of the notification team completed this assignment with great emotional investment.

Personnel assigned to serve on the notification team should be rotated frequently and their mental health closely monitored by trained personnel.

MFM-044 The composition of the family notification team included a RI Health representative, who actually told the family about the confirmed identification, a representative from the ARC RI, and a member of the clergy. However, the personnel fulfilling these roles were not assigned to specific teams. This lack of continuity and familiarity among notification team members sometimes made it difficult for them to comfortably interact with the families.

Whenever possible, death notification teams should be composed of two or three persons who are assigned to a specific team and not rotated randomly.

MFM-045 RI Health records maintained at the FAC were not planned. The database was created onsite as the specific requirements were defined, a process that took some time. Several people raised concerns about the lack of documentation planning for this important aspect of FAC operations.

Planning for a mass fatality incident should include redundant records to be completed and maintained at the FAC during the incident. Automated family notification records should be established as soon as an FAC becomes operational, and all data entry information should be double-checked for accuracy.

MFM-046 There were concerns about the security of the victim records created by RI Health at the FAC.

Victim record security must be a high priority at all times. They should not be accessible except by personnel who need the information.

MFM-047 Waiting family members at the FAC wore nametags bearing the name of the missing loved one. The absence of the wearer's name made it difficult at times for notification team members to personalize discussions. In addition, some families chose not to wear nametags and other nametags were lost or eventually became illegible.

At the FAC registration desk, family members should be asked to put their own name and that of the loved one on a name tag of durable quality and to wear it at all times while in the FAC.

MFM-048 The physical area where families learned about the death of a family member was a modest-sized room that lacked complete privacy. Others could inadvertently enter the area during a notification.

Areas that are used for family notification should be private, quiet, comfortable, and sufficient in size to accommodate all family members. Individual rooms should be used when more than one notification is being made simultaneously.

MFM-049 The system of cleaning, photographing, and cataloging unidentified personal effects for identification by family members worked well during the EgyptAir response. Similar results are expected once the personal effects catalog is presented to families of the Station club fire victims.

Identifying personal effects of the victims should include a catalog of photographs that can be shown to family members.

ANNEX F
FAMILY SERVICES AND SUPPORT

INTRODUCTION

The Nature of Mass Casualty Events


The Providence Sunday Journal

DAYS OF GRIEF

The rescue phase of a mass casualty incident (MCI) is often intense but short-lived. Those who are able to escape do so quickly. Those who are less fortunate often perish in the first few minutes. Heroic efforts are required by first responders to save seriously injured victims who barely escape alive. This was the case in the West Warwick Station club fire on the night of Thursday, February 20, 2003. According to most reports, only those able to exit the building within the first few minutes survived. In less than 2 hours, first responders treated and evacuated to area hospitals 186 seriously injured victims, every one of whom reached a care facility alive. Only four of those evacuated eventually succumbed to the injuries incurred in the fire. This in itself is a stunning accomplishment. The fire was largely extinguished in that same brief period of time, but the response and recovery phases of this operation were only beginning.

Wide-Ranging Effects

In addition to caring for those who were physically injured, a much broader community required immediate, near-term, and long-term services and support. The firefighters, emergency medical personnel, and law enforcement professionals who dealt firsthand with the horrors of this tragic event received special critical incident stress management (CISM) intervention, which is vital to preserving and restoring the psychological well-being of first responders. More traditional mental health comfort and counsel was provided to family members and friends suffering the agony of uncertainty and then the devastation of losing a loved one, as well as advice and assistance in dealing with the consequences of unexpected death. The caregivers who tend to the vital needs of the stricken families often are also in need of support and counseling.

A Large and Dedicated Community

This annex describes the family services and support provided to those affected by the Station club fire by more than 27 State, local, and Federal government entities, and community and nonprofit organizations. Support resources were also drawn from three adjacent States—Connecticut, Massachusetts, and New York—and from as far away as Florida. More than 1,000 volunteers and professional caregivers engaged in support activities during the first 3 weeks after the fire.

Some family support services were provided at the Cowesett Inn in the immediate aftermath of the fire. Early on Friday morning, February 21, those services were transitioned to a Family Assistance Center (FAC) established at the Crowne Plaza Hotel in Warwick, RI. The American Red Cross of Rhode Island (ARC RI) and the Rhode Island Emergency Management Agency (RIEMA) shared responsibility for opening and operating the FAC. The purpose of opening the FAC early was to meet the immediate and short-term needs of the victims and their families. The FAC operated for 5 days and closed on the evening of February 25. To meet intermediate and long-term needs, a Family Resource Center (FRC) was established on February 26 at a vacant car dealership in West Warwick, RI. The Rhode Island Department of Human Services (RI DHS) and RIEMA shared responsibility for the FRC until it transitioned to the RI DHS on March 14 for approximately 6 weeks, then Family Services of Rhode Island assumed responsibility for the FRC operations.

The following paragraphs briefly describe the responsibilities of the key organizations that participated in these critical support activities.

The Rhode Island Emergency Management Agency (RIEMA) is responsible for developing and maintaining the Rhode Island Emergency Operations Plan (EOP) and for coordinating all Rhode Island response and recovery activities. For a detailed discussion of RIEMA, see Annex D – Emergency Management System and Operations. Major General Reginald A. Centracchio is the RIEMA director. Mr. Albert Scappaticci is the executive director.

The American Red Cross of Rhode Island (ARC RI) was chartered in 1917. As part of the national ARC structure, it is a humanitarian organization lead by volunteers and guided by its charter and by the International Red Cross Fundamental Movement. It provides relief to victims of disasters and helps people prevent, prepare for, and respond to emergencies. Because of its compact size, Rhode Island has only one ARC chapter. By contrast, Texas has 36 chapters. The ARC RI provides a full range of services to the citizens of Rhode Island and is considered a first response resource for all disasters that occur within the State. It works closely with State and local government agencies, business entities, labor unions, religious and community organizations, and numerous other volunteer organizations. This coordinated effort ensures all of these groups work together to meet the needs of whomever might be affected by a disaster. Ms. Barbara McGann was the chief executive officer (CEO) of the ARC RI.

Barbara McGann
Rear Admiral, USN (Ret.)

The American National Red Cross (ANRC) was chartered by Congress in 1905 to serve as a national humanitarian relief organization. When a disaster occurs in a local chapter's jurisdiction, and the magnitude of that disaster exceeds the capability of the local chapter and the resources of the host State, the national organization provides additional financial, personnel, and material resources to meet the needs of victims affected by the disaster. Because of the number of fatalities resulting from the Station club fire, ANRC assigned a Disaster Response Operation number to the operation (DR 406) and provided personnel and resources to assist ARC RI with the response. Ms. Becky Szymcik from Leominster, MA, was the designated job director.

The Rhode Island Department of Mental Health, Retardation and Hospitals (MHRH) has an operational budget of $400 million and provides services to the citizens of Rhode Island who have disabilities that limit autonomy. Services offered include hospitalization, housing, vocational programs, in-patient and out-patient treatment, counseling, rehabilitation, and transportation. These services are provided through contracts with 36 private, nonprofit hospital programs and agencies. The mental health plan divides the State into eight regional catchment areas. Immediately after the fire, the MHRH mental health professionals offered grief counseling to victims and victims' families. These mental health professionals also provided some support to first responders during the early phase of the response effort. The continuing major concern of the MHRH is the long-term mental health of the citizens of Rhode Island who were affected by the Station club fire. The director of MHRH at the time was Ms. A. Kathryn Power.

A. Kathryn Power

The Rhode Island Department of Health (RI Health) is charged with preventing disease and promoting the health and safety of the people of Rhode Island. RI Health provided staff to assist in notifying next of kin on verification of a victim's death by the Rhode Island Office of the Medical Examiner (OME). It also coordinated with area hospitals regarding patient distribution and status. For additional details on the operations and organization of RI Health, see Annex E – Public Health, Healthcare Facilities, Mental Health, and Mass Fatality Management. Dr. Patricia Nolan is the director.

The Rhode Island Department of Human Services (RI DHS) provides financial and health services to individuals and families within Rhode Island. The RI DHS is the primary source of medical and financial aid, food stamps, and social services to more than 175,000 Rhode Island citizens. A comprehensive life cycle service provider, the RI DHS services begin with prenatal Medicaid programs, including food, shelter, child, and senior citizen care programs. The RI DHS also operates the 240-bed Rhode Island Veterans Home and manages the Veterans Cemetery. The RI DHS has an operating budget of $1.4 billion and its objective is to assist individuals and families to achieve self-sufficiency, self-care, and a stronger family life. The RI DHS also provides a comprehensive array of training and educational opportunities aimed at maximizing the potential for independence. In coordination with RIEMA, the RI DHS established and operated the FRC, a one-stop shop where victims and families of victims obtained assistance in acquiring a comprehensive array of support services. The RI DHS also provided caseworkers to guide people through the FRC process, ensuring each family received all appropriate entitlements. The director of RI DHS is Ms. Jane A. Hayward. Ms. Hayward also currently serves as the director of MHRH.

Jane A. Hayward

The Rhode Island State Council of Churches is an ecumenical body comprised of 11 Protestant denominations, four affiliated church organizations, and eight Orthodox denominations and congregations. These groups have more than 100,000 members in 300 congregations. They collaborate with 75 civic and human services agencies, and affiliate with the National Council of Churches and the World Council of Churches. The organization has an annual operating budget of nearly $300,000. The Reverend John Holt is the executive minister of the council.

Reverend John Holt

The West Warwick Department of Human Services (WW DHS) is a private, nonprofit organization that is under contract to provide social services to the citizens of West Warwick. The WW DHS provides food, housing, and other social services. It is notified when any type of disaster occurs within West Warwick and responds as appropriate. Mr. Tom Iannitti is the director of WW DHS.

Dennis Murphy

The United Way of Rhode Island (UWRI) traces its roots to the Providence Community Fund started in 1926 in response to a number of private agencies that were raising funds individually. The Providence Community Fund was organized on the belief that a combined effort would give Rhode Islanders the opportunity to have a more positive impact on the lives of their neighbors in need. The organization went through many name and structure changes and, in 2002, adopted the new name, the United Way of Rhode Island. Its mission is to mobilize the caring power of the community to improve the lives of people in need. The organization is led by its president and CEO, Mr. Dennis Murphy.

This annex consists of the following four sections:

- Section 1 – Initial Response
- Section 2 – Family Assistance Center Operations
- Section 3 – Family Resource Center Operations
- Section 4 – Volunteers, Donations, and Funds Management

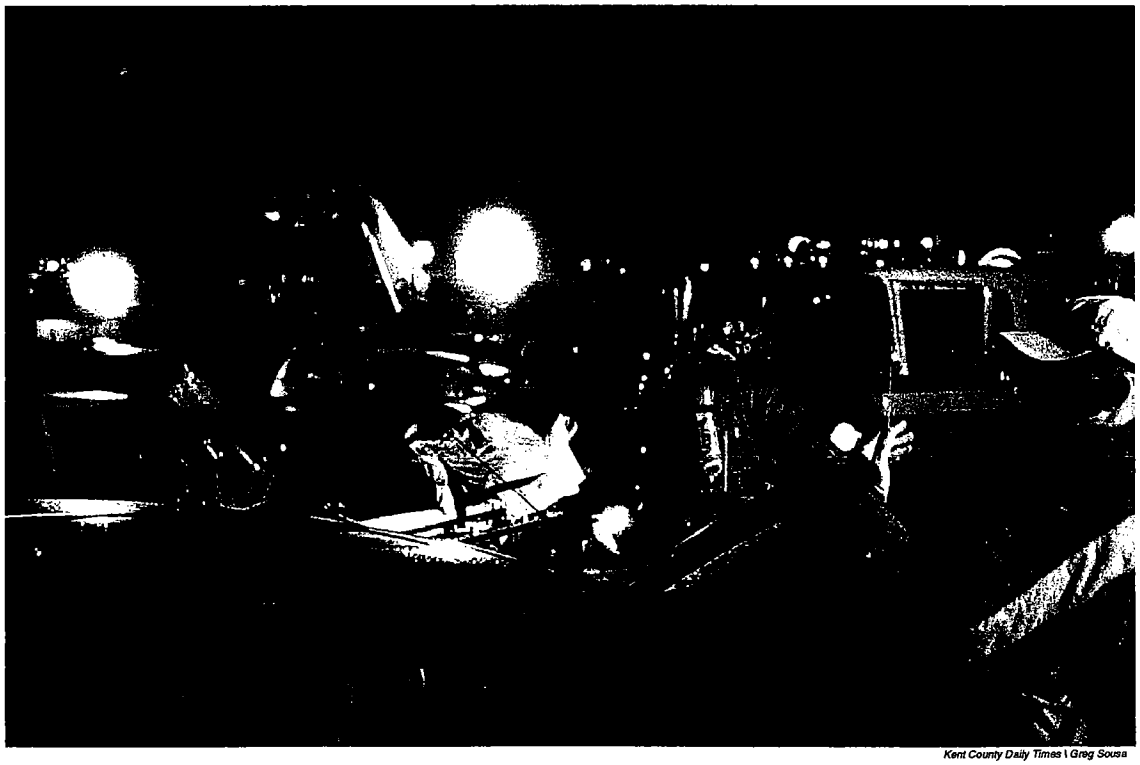
SECTION 1 – INITIAL RESPONSE

Observations

Scene at the Station Club and the Cowesett Inn

Minutes after the media broadcast news of the Station club fire, neighborhood bystanders, family members, and friends of people believed to have attended the Great White performance began assembling in front of the Cowesett Inn, a restaurant directly across the street from the Station club. Most of the restaurant's regular customers had left an hour earlier, and the remaining seven employees were cleaning up the restaurant in preparation for closing. Mr. Jimmy Paolucci, the restaurant's owner, was en route to the Cowesett Inn when his wife called his cellular telephone and told him about the fire.

As Mr. Paolucci entered the Cowesett Inn parking lot, he noted that the area around the restaurant was crowded with emergency vehicles and firefighting apparatus. The weather was bitter cold and large snowbanks surrounded the areas where the parking lot had been cleared following the massive Presidents' Day weekend snowstorm. In addition to the growing crowd of observers wandering throughout the area, he noted that some burn victims were meandering toward the Cowesett Inn's entrance. He immediately opened the restaurant's doors and rearranged tables and chairs for the burn victims and Emergency Medical Services (EMS) personnel who would tend to them. Offering them ice and cold drinks, Mr. Paolucci instructed his staff to brew coffee for the fire, police, medical, and emergency management personnel. He then called in additional staff to prepare breakfast for all first responders.



Kent County Daily Times \ Greg Sousa

The area around the Cowesett Inn crowded with emergency vehicles and firefighting apparatus.

Mr. Paolucci was extremely supportive throughout the incident. He relinquished his entire business for 48 hours to establish a central location to coordinate the response effort, offering a gathering place for victims, family members, and personnel from responding agencies, and providing them with food and beverages. The value of his generous contribution is estimated at $50,000, including direct costs and lost business. Mr. Paolucci was the first of several business owners and managers who, without hesitation, immediately met the challenges of this communitywide tragedy.

American Red Cross of Rhode Island

The ARC RI was first notified of the incident when Mr. Nick Logothets, director of disaster services, received a Nextel call at 11:17 p.m. from Mr. Todd Manni, the emergency management director from Smithfield, a community neighboring West Warwick. Mr. Logothets immediately activated and deployed a Disaster Assistance Team led by Mr. Joe Farrington, which arrived at the incident scene at 11:22 p.m. Mr. Farrington reported back to Mr. Logothets describing the severity of the circumstances. In continuous communication with Ms. McGann, Mr. Logothets activated the West Warwick shelter team and also sent Ms. Sarah Bilofsky, the ARC RI public relations person, to the scene. By 12:30 a.m., ARC RI had a functioning command cell onsite prepared to coordinate extensive mental health counseling, disaster welfare inquiries, and possible mass care activities. Mr. Logothets had alerted several mental health care providers, including the Rhode Island MHRH. At 12:42 a.m., Mr. Logothets received a call from Mr. Scappaticci of RIEMA stating that he was en route to the site to offer support and that this was a local West Warwick emergency; it was not a Statewide emergency. Mr. Scappaticci called again at 1:10 a.m. and at 1:40 a.m., first asking for help locating 50 body bags, then asking if the ARC RI could help staff the victim inquiry hotline if RIEMA decided to activate it.

Cowesett Inn Command Post

Most of the activity not directly aimed at fire suppression and rescue operations occurred at and around the Cowesett Inn. On the first floor, emergency medical treatment was provided to surviving burn victims while counselors from MHRH and the Rhode Island CISM Team offered support to victims, family members, and first responders. West Warwick police officers interviewed survivors and eyewitnesses, collecting information about others who had been in the Station club when the fire began.

Kent County Daily Times \ Greg Sousa

Most of the activity not directly aimed at fire suppression and rescue operations occurred at and around the Cowesett Inn.

West Warwick town officials met on the second floor in what became an informal command post. It was quickly inundated by the surge of responders from other organizations, including representatives of the Governor's Office, RIEMA, ARC RI, and other volunteer agencies and leaders from neighboring communities.

The growing crowd outside the Cowesett Inn increasingly intermingled with first responders and others engaged in supporting the rescue efforts, often overhearing details of the continuing operations. It was clear that family support activities should be moved away from the incident site.

Following a group discussion at about 2:30 a.m. facilitated by Mr. John Aucott of RIEMA, he and Mr. Logothets asked Mr. Clark Greene, the governor's deputy chief of staff, to help find suitable space, recommending the nearby Crowne Plaza Hotel. Mr. Greene contacted Mr. Rudi Heater, general manager of the Crowne Plaza Hotel, through the on-duty night auditor at the hotel and made arrangements to open the FAC. The FAC became operational at 5:00 a.m., February 21, under the Unified Command of RIEMA and the ARC RI.

Findings and Recommendations

FSS-001 The process of notifying essential personnel that a disaster had occurred and that their organization's assistance was needed in response to the event was ad hoc and did not function effectively. This caused delays in getting information to all appropriate personnel. For example, when Mr. Logothets of the ARC RI initially attempted to contact MHRH, his telephone calls went unanswered. He subsequently reached an after-hours answering service, which responded that it might not be able to contact the proper personnel.

RIEMA should maintain and regularly test a master contact list with 24-hour notification information relating to key personnel in government agencies and other response organizations. The use of contract answering services should not be relied on in emergency situations.

FSS-002 Under most notification protocols, key personnel have prescripted instructions regarding reporting and initial actions. The ARC RI first learned of the Station club fire from Mr. Manni, the emergency management director of nearby Smithfield, RI. Coincidentally, Mr. Manni had added the ARC RI to the Smithfield Nextel network the day before the fire and he called Mr. Logothets via that network. Individuals from other organizations were not notified through any planned or formal call-down process but, instead, they learned of the event from media reports or other sources and responded. The members of Voluntary Organizations Active in Disaster (VOAD) were notified of the disaster but did not activate as an organization.

All Rhode Island government agencies and other critical response organizations should include reporting instructions in standard operating procedures or EOPs that instruct personnel where to report in an emergency, regardless of the means of notification, unless overridden by specific instructions from a competent authority.

FSS-003 Many support agency representatives and volunteers went directly to the incident site rather than to a planned location such as an agency Emergency Operations Center. Personnel from the various State agencies, volunteer organizations, local officials from West Warwick and from other neighboring communities, and volunteers arrived on the scene. This overwhelming response and the subsequent lack of direction caused unnecessary congestion at the site and added to the confusion regarding lines of authority.

RIEMA should coordinate the establishment of policies and procedures so that support organizations and volunteers arriving at an incident site are quickly organized and brought under a central coordinating authority and do not inadvertently complicate rescue operations.

FSS-004 Even as the West Warwick fire chief was implementing the Incident Command System for fire suppression and rescue operations, there was confusion during the initial response regarding which government organization or agency was in charge of the overall operation. West Warwick town leaders assumed they were in charge because the fire occurred in their jurisdiction. Many organizations believed that RIEMA was in the lead because of the many responding State and voluntary organizations and the potentially large number of fatalities. Mr. Scappaticci, RIEMA executive director, clearly deferred to West Warwick. However, in decisions relating to establishing and subsequently managing the FAC, Mr. Aucott assumed a leadership role on behalf of RIEMA. It was apparent in the early morning hours of February 21 that the scope and magnitude of responding to this tragedy was beyond the management capacity of the town of West Warwick.

In the absence of intermediate political jurisdictions, RIEMA should act quickly and decisively on behalf of the State to organize resources outside the span of control of the impacted municipality. It is easier to relinquish external control when the situation merits than to assert it during an atmosphere of confusion and uncertainty.

FSS-005 The Rhode Island CISM Team is responsible for debriefing first responders and offering them counseling. Led by Dr. Anne Balboni, the Rhode Island CISM Team uses a peer approach, with retired fire, police, or emergency medical personnel leading intervention teams. This affords a degree of credibility and increased receptiveness among the first response community. All CISM team members have completed certification CISM training. In contrast, mental health staff from MHRH are not licensed or certified. Their qualifications are based on formal education and a degree, usually graduate level, in an appropriate academic discipline.

Rhode Island should strive to achieve a common certification standard for mental health counselors regardless of their organization's affiliation.

FSS-006 Although the role of MHRH counselors is midterm and long-term mental health care, they are also available to help first responders when specifically requested. During the response to the Station club fire, law enforcement officials at the site asked MHRH counselors to meet with some responding police officers while CISM

team members were working with firefighters, emergency medical personnel, and police. MHRH is preparing a plan that better integrates all mental health resources.

Rhode Island should act expeditiously to ensure multiple sources of mental health expertise can be obtained as needed during extraordinary circumstances such as prevailed at the Station club fire.

FSS-007 The involvement of clergy members early during this event was problematic at the Cowesett Inn and FAC. It is natural for members of the clergy to offer comfort to those suffering from the effects of tragedy. However, many clergy members seemed to be unaware that a plan exists to accommodate spiritual care. Thus, many well-intentioned clergy appeared at the incident site or at the FAC who had no training or previous experience in grief counseling, particularly as it relates to a situation involving mass casualties. By late Saturday, February 22, 2003, this situation was resolved. The ARC RI asked the Rhode Island State Council of Churches to assume responsibility for spiritual care support. Six chaplains with the requisite skills were assigned to the FAC and continued to provide support at the FRC.

The Rhode Island State Council of Churches or another religious organization with Statewide responsibility should develop and maintain a list of clergy qualified through training and experience to comfort and counsel the grief stricken in a mass casualty situation. Only these individuals should be issued credentials stipulating their qualifications.

SECTION 2 – FAMILY ASSISTANCE CENTER OPERATIONS

Observations

Acquiring Space for the Family Assistance Center

At 2:45 a.m., Mr. Heater, the general manager, learned that RIEMA wanted to occupy the Crowne Plaza Hotel at 4:00 a.m. He instructed the night auditor to inspect the ballroom and determine if it was cleared and ready for use or still set up for the previous day's meetings. He called his executive chef and pastry chef, asking them to report to work and prepare to serve breakfast. The second call Mr. Heater received provided some insight into the scope of the operations estimated by RIEMA. A large room would be needed for 50 to 75 people with clustered seating areas using covered round tables. One smaller room would be used to inform family members of a verified fatality. When Mr. Heater learned later that this would be a combined RIEMA and ARC RI operation, the space requirements expanded significantly.

Organizing the Family Assistance Center

By approximately 7:00 a.m., more than 200 family members and friends had gathered in the Crowne Plaza Hotel ballroom, which served as the primary FAC gathering area. The four adjacent salons provided additional workspace. One served as the Unified Command Post from which activities were coordinated and directed by RIEMA and ARC RI. The governor's staff also shared this space, as well as the West Warwick Police Department (WWPD). Other salons were used as workspace for RI Health, MHRH, and a delegation from the Massachusetts Medical Examiner's Office (33 victims were from Massachusetts). Private space was also set aside to notify families upon verification of the death of a loved one and to serve as a quiet place for grief counseling and spiritual care.

Crowne Plaza Hotel Photo

More than 200 family members and friends gathered in the Crowne Plaza Hotel, which served as the primary Family Assistance Center gathering area.

The main entrance to the ballroom was closed, and the FAC could be accessed only through a side door secured by the WWPD and the Rhode Island State Police (RISP). This prohibited unrestricted access to family members by media representatives. Some journalists from out of State were able to obtain guest rooms and attempted to enter the FAC under false pretenses, but were detained and evicted from the hotel. The Crowne Plaza Hotel also strengthened its security staff to help isolate the FAC. Family members were directed to register at a sign-in station on entering the grand ballroom and to sign out if they left the FAC area (see **Figure F-1**).

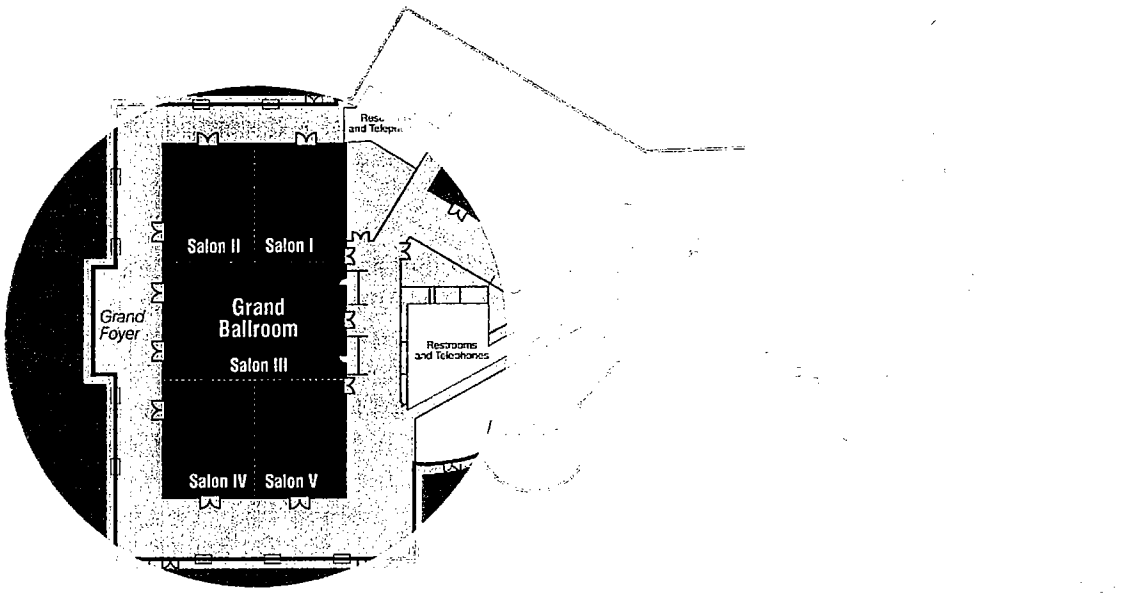


Figure F-1. Crowne Plaza Hotel ballroom where the Family Assistance Center was located.

The WWPD immediately established a work area in the ballroom where they interviewed family members, collecting information that would help in the victim identification process, such as the types of clothing and jewelry victims had worn and any distinguishing marks or conditions. They also asked for access to dental records and completed missing person reports as appropriate.

Victim Information Management

Victim information management and dissemination was a major function at the FAC. Information about confirmed and suspected victims came from several sources. The victim information hotline at RIEMA headquarters (HQ) generated substantial data and RIEMA staff also called area hospitals to gather information about the distribution and condition of patients. Without a formal emergency declaration, stringent privacy laws restricted hospital staff from revealing patient treatment information to RIEMA representatives.

Additionally, the WWPD, which was also directing activities at RIEMA HQ, researched the registration records of automobiles towed from the Station club parking lot and accumulated data from missing person reports filed with area police departments. All of this information was tabulated in a report format and regularly sent from RIEMA HQ to the Crowne Plaza Hotel by fax. The hotel's front desk staff notified the FAC to pick it up.

RI Health representatives at the Crowne Plaza Hotel were also in contact with area hospitals and accumulated their own patient disposition and treatment data. This was particularly important because of the unwillingness of some hospitals to release information directly to RIEMA. ARC RI established a cellular telephone-based disaster welfare inquires system to gather information on potential victims and to answer calls from concerned families. During the 5-day period the FAC was open, 4,500 calls were received and processed. The victim information hotline at RIEMA responded to 18,000 calls. Each time the identity of a deceased victim was verified, the Rhode Island OME contacted an RI Health representative at the FAC.

Providing Information to Families

As family members and friends gathered at the FAC, it became apparent to Mr. Aucott and Ms. McGann that providing accurate information about the victim identification process on a regular basis was imperative. Mr. Aucott called Dr. Elizabeth Laposata, the Rhode Island chief medical examiner, and urged that she visit the FAC to describe the victim identification process to the waiting families. Dr. Laposata did not feel this was possible because of the workload and the limited staff at the OME morgue. On Friday around 7:30 a.m., Mr. Aucott conducted the first briefing for family members. It included only definite information about the numbers of victims who were confirmed dead and whose families had already been notified as well as victims who were known to have survived and were being treated at local hospitals.

Family briefings were repeated throughout the day and were always conducted by the most senior person available and appropriate to the task. Governor Donald L. Carcieri presented the vast majority of these information updates. He spent a great deal of time consoling families and keeping them informed.

Support from an Elected Local Official

Mr. Leo Constantino was a newly elected West Warwick Council member at the time of the fire. After briefly visiting the incident site, he went to the FAC seeking an appropriate and useful role for a local public official. He noted that families and family groups tended to form clusters, each with its own gathering space in the Crowne Plaza Hotel ballroom. He began circulating among the groups, introducing himself and quietly seeking opportunities to be of service. Under the prevailing circumstances, small things that might otherwise be considered trivial became extremely irritating to the distressed families. Working with Mr. Iannitti, the director of the WW DHS, Mr. Constantino focused on eliminating these problems, a role he continued to perform after the transition to the FRC. For example, one family became agitated about the inability of local authorities to find the car that had been driven to the Station club. It was not with other cars that had been towed from the parking lot. Mr. Constantino telephoned his son, described the car, and asked him to drive throughout the surrounding area. He found the car on a neighboring side street. Mr. Constantino then discovered that many cars were locked and their keys destroyed in the fire. Through Mr. Iannitti, he located a West Warwick locksmith who opened the cars and also made replacement keys.

Family Member Notification

The task of notifying family members following the verification of the identity of a deceased victim was treated with the utmost sensitivity. Many waiting family members already knew with some degree of certainty that their loved ones were among the deceased. Most survivors of the fire were accounted for in a fairly short time. Thus, family notification was a critical step toward closure following this tragic event.

Once the Rhode Island OME notified the RI Health representative at the FAC of a confirmed identification, a strategy meeting was quickly convened at the FAC command center. The notification team was comprised of a staff member from RI Health, a counselor from the ARC or MHRH, a clergy member serving under the auspices of the Rhode Island State Council of Churches, and a West Warwick police officer.

Family members, on their own initiative, had chosen to identify themselves with name tags specifying the missing person's identity, not their own. A member of the notification team sought out the family and guided them to a private counseling area where they learned of the identity confirmation. Grief counseling and spiritual care were immediately available. Only after notification was completed were names released to the public through the regularly scheduled Joint Information Center (JIC) press conferences. And only after the name of a deceased victim was published in the newspaper was it added to the RIEMA victim information report.

Touring the Incident Site

One of the activities planned by RIEMA, ARC RI, RISP, the Governor's Office, and West Warwick town leaders was a carefully orchestrated tour of the incident site for family members on Sunday, February 23. More than 400 family members and close friends of victims were transported by bus from the Crowne Plaza Hotel along a carefully designed route to the site of the fire. A mental health counselor, a Rhode Island State trooper, an ARC representative, and a member of the clergy joined the passengers on each bus. At the site, family members walked a planned route, protected from public view, and then returned to the Crowne Plaza Hotel.

West Warwick Photo

Family members tour the incident site.

Providing for Continuing Support

The pace of victim identification, slow in the beginning, accelerated on Sunday, and a meeting was convened to plan the next step in the family and victim support phase. Mr. Aucott of RIEMA and Ms. Hayward, director of the RI DHS, jointly hosted the meeting. Governor Carcieri had pledged to the family members that help would be available to them. With encouragement from the Governor's Office and from Rhode Island congressional delegations, representatives of every State and Federal organization and members of the major nonprofit organizations that were able to offer some form of assistance to survivors and to family members of deceased victims attended this planning meeting, which set the stage for opening the FRC. West Warwick town officials began searching for adequate space to establish a FRC.

At 6:00 p.m. on Tuesday, February 25, the FAC transitioned to the RI DHS. All but one of the victims had been identified. Special provisions were made to accommodate the family still awaiting confirmation. During 5 days of operations, the FAC provided for the physical, emotional, mental, and spiritual needs of more than 300 family members and friends with a staff of 460 professionals and volunteers. The Crowne Plaza Hotel, in coordination with the ARC, served more than 7,500 meals, using its own resources and items donated by area caterers and restaurants. The Crowne Plaza Hotel absorbed costs estimated at $168,000 in support of the FAC.

Findings and Recommendations

FSS-008 Establishing a centrally located FAC for family members to wait and receive information relating to loved ones proved to be extremely effective. Government and volunteer organizations collaborated at one location to provide needed services.

All mass casualty plans should provide for a FAC to concentrate and safeguard victim information management and family notification activities.

FSS-009 The Crowne Plaza Hotel was an ideal choice to serve as the FAC. Its proximity to the fire scene, the size and composition of its facilities, and the availability of trained professional staff and management rendered it an exceptional operational HQ and family safe haven.

Plans should contain detailed descriptions of the desired attributes of a FAC so potential FAC locations near an incident site can be quickly identified.

FSS-010 Collecting, processing, coordinating, and disseminating information about missing, injured, or deceased personnel was inefficient. With no single agency in charge, responsibility was fragmented among RIEMA, ARC RI, RI Health, RISP, and WWPD. This duplication of effort created unnecessary opportunities for error in the notification process. There was only one instance of erroneous notification, when a family was told that the two missing members were hospitalized, only to learn later that they had been among the missing and were subsequently identified as deceased.

One agency should be tasked with compiling and disseminating victim-related information. All sources of such information should coordinate directly and expeditiously with the responsible agency.

FSS-011 If Rhode Island had issued a formal emergency declaration, Governor Carcieri would have been empowered to suspend some privacy restrictions that otherwise hampered the flow of patient treatment information. This would have facilitated a smoother process for acquiring information from area hospitals.

RIEMA, in coordination with the Governor's Executive Council, should prepare and maintain a detailed composite of all benefits and encumbrances associated with a State emergency declaration and a list of regulations that might be suspended under different scenarios. This should be a regular decision point in State emergency management exercises and the basis for frequent executive tabletop exercises.

FSS-012 Sensitive victim status information was transmitted over a fax line from RIEMA HQ to the front desk of the Crowne Plaza Hotel. Hotel staff then notified the FAC and the fax was retrieved. This procedure posed a serious risk of compromising sensitive information.

Because of its sensitivity, victim information must be handled with caution and security. If it is to be transmitted electronically, procedures must be instituted at each end to safeguard such information. In work areas where such information is tabulated, it must not be carelessly displayed and should be accessible only to authorized officials.

FSS-013 There was no data link established between the FAC at the Crowne Plaza Hotel and the State offices in Providence and Cranston, RI. This hampered coordination between agency representatives at the FAC and their home offices.

Communications support plans for operating a FAC should include all necessary connectivity to function efficiently, including access to supporting government networks.

FSS-014 Accounting for family members at the FAC was not completely effective. As family members entered the facility, they were asked to sign in. When they left the facility they were asked to sign out. Many failed to follow this procedure and notification was sometimes delayed because family members could not be found.

Policies established to expedite the family notification process must be firmly implemented. If a sign reminding people to sign out is ineffective, the police guarding the entrance should remind those leaving to do so.

FSS-015 Governor Carcieri did an outstanding job keeping families informed of the continuing victim identification process. He conducted many briefings for the waiting families and reassured them that resources would be made available to help them. His hands-on leadership and personal involvement guided efforts throughout this

ordeal. At these briefings he committed to the families that survivor groups would be formed.

Frequent information briefings for family members conducted by senior government and ARC RI officials are important to ensure every effort is being made to expeditiously identify victims and share all relevant status information.

FSS-016 The Rhode Island medical examiner did not have the time or the resources to participate in explaining to waiting family members the procedures involved in victim identification. There is no other person as qualified to properly describe such procedures.

RI Health plans should provide for augmenting the Rhode Island OME with sufficient staff to ensure the medical examiner can carry out all assigned responsibilities regarding victim identification and family notification.

FSS-017 The incident site tour planned and conducted by West Warwick officials, ARC RI, RISP, and RIEMA was very important to the families of deceased and missing victims. It was done in a manner that enabled family members to understand the destructive force that had claimed so many lives, while protecting their privacy and respecting their dignity. The event was greatly appreciated by the grieving relatives of victims.

Rhode Island should share with others the extraordinary preparations and precautions that made the response to this event successful.

FSS-018 Mental health care provision to first responders, victims, and victims' families by Rhode Island agencies and organizations was not fully integrated and coordinated. Lines of responsibility were unclear, causing some confusion and misunderstanding among agencies. The CISM program for first responders is not integrated into a Statewide plan for delivery of mental health. The Statewide plan for mental health support currently under development by MHRH has not yet been finalized and distributed. Mental health care is a continuing requirement and long-term support must be made available.

The Statewide mental health services plan under development by MHRH should be completed, coordinated, published, and disseminated without delay.

FSS-019 The mental health support provided to victims and their families by ARC RI and MHRH and their contract regional agencies was effective and appreciated. Mental health counselors established a "compassionate presence," through which they were quietly available to step in when circumstances required, rather than the more traditional approach to counseling.

Other communities should emulate the "compassionate presence" model used in Rhode Island for making available counseling services in a low-key fashion during periods of intense suffering.

FSS-020 For the most part, the Unified Command exercised by ARC RI and RIEMA at the FAC was effective overall. However, an immediate and comprehensive post-event review of FAC operations was not conducted to capture areas for improvement in future events.

Other communities should learn from the successful Unified Command in place at the FAC. A comprehensive review would yield important lessons for others to follow.

SECTION 3 – FAMILY RESOURCE CENTER OPERATIONS

Observations

Acquiring Space for the Family Resource Center

At 10:00 a.m. on Sunday, February 23, Mr. Iannitti, the director of the WW DHS, called Mr. Phil Cascalenda Jr. who, along with his father, owned an empty building that formerly housed an automobile dealership and was located close to the incident site. He asked Mr. Cascalenda if the town could rent the facility for a few weeks to serve as a center for processing aid to victims and families. Mr. Cascalenda replied that renting the building would not be possible. Mr. Iannitti persisted, assuring him that West Warwick would find some means of paying a fair market price for its use. Mr. Cascalenda explained that renting was unnecessary because West Warwick could use the facility at no cost. He and his father spent the next 2 days (and approximately $30,000) reactivating the winterized building's infrastructure and preparing it to be the FRC.

Logistics Challenge

On Monday, February 24, Mr. Aucott assigned RIEMA's Mr. Peter Todd the task of equipping the vacant automobile showroom located on Highway 2, about 2 miles from the fire scene, to serve as the FRC. It was to be a one-stop shop where survivors and families of survivors and deceased victims would obtain all of the available assistance, entitlements, and social services. Implicit in this ambitious plan was the involvement of more than a dozen State, municipal, and Federal agencies, as well as volunteer and nonprofit organizations.

With the FRC scheduled to open on Wednesday morning, Mr. Todd faced a formidable challenge. The former Daewoo car dealership had been vacant for more than a year and the cavernous 25,000-square foot facility was empty except for a single antique automobile. He called an acquaintance at Verizon and told him that he needed 50 to 60 telephones and a T-1 line immediately. Next he called Mr. James Berard at the Rhode Island Department of Corrections (RI DOC), who in turn contacted prison industries. Within hours, RI DOC trucks began delivering room dividers, desks, chairs, filing cabinets, and other office equipment. Volunteer engineers, electricians, and plumbers swept through the dealership as RI DOC technicians installed a local area network connecting a dozen computers provided by the Rhode Island National Guard. A database built from scratch by RI DOC technical staff was installed to track progress as families negotiated the resource support and entitlement application process.

Mr. Todd contacted the various organizations that would occupy the FRC to determine specific or unique requirements. For example, the Social Security Administration (SSA) wanted a direct telephone line to dial into its system to expedite claims. Mr. Todd made those arrangements. Staples, Office Depot, BJ's Warehouse, Wal-Mart, and other area businesses donated reams of paper, writing pads, pens and pencils, staplers and paper clips, copy machines, shredders, and other office supplies and equipment. The floor-to-ceiling showroom windows were covered with sheets of plastic to provide privacy. The plastic sheets were affixed to the glass using the artwork of local elementary school children. Dunkin' Donuts committed to delivering coffee and doughnuts every morning for the volunteer custodial crew from the Rhode Island Department of Children, Youth, and Families managed training school.

Volunteers preparing for the opening of the Family Resource Center.

Opening the Family Resource Center

The FRC opened at 10:00 a.m. on Wednesday, February 26, under the unified direction of RI DHS and RIEMA (see **Figure F-2**). Ms. Hayward, the director of RI DHS, specified two operating ground rules for the FRC. First, families were to be protected from media exposure throughout the process. Second, egos were to be checked at the door. The purpose of the FRC was to expeditiously meet as many of the legitimate needs as possible of the victims' families, not to advance individual or agency agendas.

Welcoming the Victims' Families

When family members first arrived at the FRC, they were met in the reception area by a RI DHS caseworker. The caseworker remained with the family, offering assistance and counsel throughout each step of the FRC process. The RI DHS caseworker made the "good faith" determination of needs required by the Internal Revenue Service (IRS) so that donated monies would not be taxable. Additionally, those making contributions could count this as a donation. The RI DHS used a registration form produced from a model developed by The Salvation Army following the terrorist attack on the World Trade Center. It enabled caseworkers to perform an individual initial assessment of support needed by arriving families. A second form, developed by the RI DOC technical staff, related family needs to entitlement programs and other support sources available at the FRC. RI DOC volunteers entered the information from the completed form into a database that eventually contained nearly 1,300 records. (See Annex E, Part IV – Mass Fatality Management for more information.)

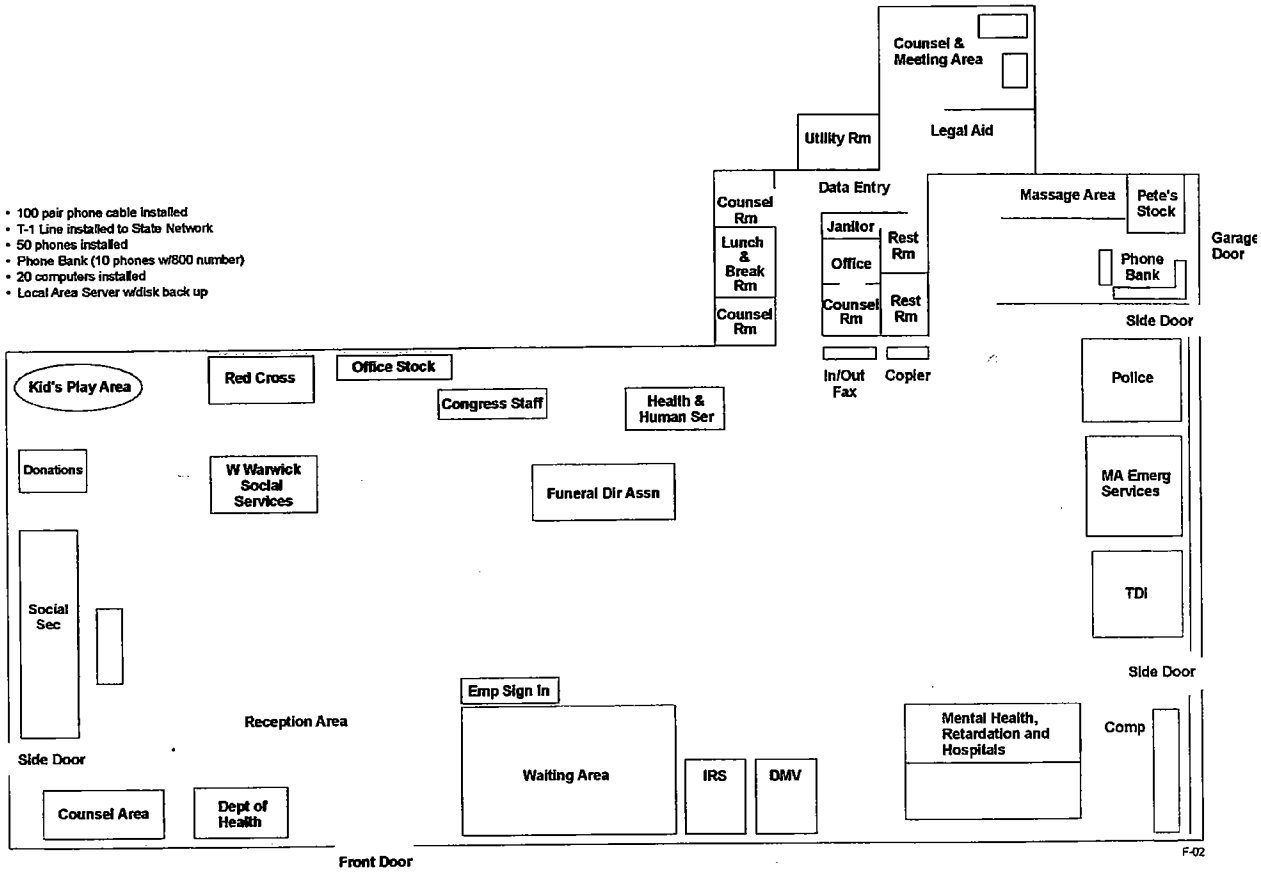


Figure F-2. Family Resource Center floor plan.

Challenges Faced by Families

The challenges faced by surviving victims and family members of deceased and hospitalized victims were far-ranging and immediate. Mortgage, rent, utility bills, insurance premiums, and car payments had to be met. People had to be transported to funerals and memorial services and, in some cases, adequate clothing provided for family members to attend services. Relatives traveling from distant locations needed transportation and lodging. Surviving single parents sought legal advice and assistance, as did grandparents seeking custody of orphaned children. Others required childcare or counseling services. Petty cash was needed to pay for bandages used to dress the wounds of recovering burn victims. Automobiles had to be retitled and new keys had to be made to replace those lost in the fire. Children attending local parochial schools needed temporary tuition assistance or faced transfer in mid-winter to neighborhood public schools. Funeral arrangements had to be made and memorial services scheduled. These and a myriad of other challenges faced the distressed population that sought help at the FRC.

Meeting the Challenges

Based on the initial needs assessment, the caseworker first guided the family to each of the State, municipal, and Federal agencies available to offer assistance and aided them in completing the various applications along the way. Many of the seriously burned victims did not have health insurance or, if they were insured, the copayment provisions were prohibitive. SSA representatives, with direct access to the SSA automated system, processed survivor benefit

applications at the FRC and issued disability checks to burn victims based on a presumptive eligibility for disability. The IRS helped families apply for income tax extensions for the approaching tax season. The Rhode Island Department of Labor and Training processed claims for temporary disability insurance. The Rhode Island Department of Motor Vehicles issued replacement drivers' licenses and retitled automobiles. In addition to coordinating all services offered at the FRC, the RI DHS also managed Medicaid applications, food stamps distribution, child and dependent care, and other Rhode Island general public assistance services. The Massachusetts Office of Victim Assistance and the Massachusetts Counseling Network supported families of victims from that State; however, all services at the FRC were available to everyone seeking help, regardless of place of residence. After exploring available government programs, caseworkers escorted the families to the various charitable agencies and organizations to determine additional support that might be available.

Support from the Community

Family members met with representatives of the Rhode Island Funeral Director's Association, which had agreed to provide burial services at a greatly reduced cost paid by the Rhode Island Station Nightclub Fire Relief Fund (SNFRF). Catholic cemeteries throughout Rhode Island, whose population is about 70 percent Roman Catholic, donated burial plots for the deceased victims and the Caron Rock of Ages granite company of Pawtucket, RI, donated headstones.

Having exhausted all programmatic support sources, families next met with donations management staff to help fill remaining needs. For example, a family might have wanted a particularly close cousin living on the West Coast to attend a planned memorial service and spend time with grieving relatives. If that person did not meet the definition of "immediate family member" or qualify for ARC travel funds, it was possible that donated frequent-flier miles might be available. If not, as a last resort, money from the SNFRF might be expended to purchase an airline ticket.

No one at the FRC understood the West Warwick community as well as its own town leaders and elected officials. Thus, the WW DHS performed an important step in the review process to ensure every possible need faced by those suffering from this tragedy had been adequately met. When appropriate, Mr. Iannitti and his colleagues, including Council Member Constantino, made adjustments spontaneously. West Warwick officials ran errands or provided their own transportation for those in need. A call to a local limousine service produced transportation for a hospital visit and then a ride home. Bus tickets that would require a 4-day trip by a grieving aunt were exchanged for airline tickets, extending her stay with her distressed sister.

Keys to Success

The FRC remained open for 16 days, providing resource support to 326 victims and family members, 186 of whom met concurrently with Rhode Island behavioral network grief counselors. The FRC succeeded because of the ingenuity, generosity, and compassion of what one newspaper referred to as "the neighborhood known as Rhode Island." Local businesses provided for many of the needs of those serving and those served. Rhode Island State public servants warmly embraced the public they served. State, local, and Federal government employees and the volunteers and staff members of charitable organizations worked side by side with a remarkable display of cooperation, dedication, and sensitivity toward the victims' families and one another.

Continuing Support After Closing the Family Resource Center

Longer term support continues in many forms. RI DHS counselors maintain contact with many of their clients. The Kent County Mental Health Center provides meeting space for families and survivor support groups. Bradley Hospital conducted an educational forum at West Warwick High School on "Helping Children and Their Families Deal with Tragedy and Loss." The Phoenix Society for Burn Survivors, Inc., a national organization for seriously burned survivors, has visited with Rhode Island victims and hosts support meetings at the Shriners Hospital in Boston, MA. The Phoenix Society has also proposed a training program for Rhode Island clergy, mental health counselors, and visiting nurses working with Station fire burn survivors. At the request of the American Lung Association, Family Services of Rhode Island has initiated an assessment of the long-term lung damage of victims and first responders caused by the fire. Additionally, MHRH has received nearly $500,000 in Federal grants from the Substance Abuse and Mental Health Services Administration (SAMHSA). These funds provide victim support training to clinicians, clergy, educators, and other natural helpers. Additionally, they continue to operate the FRC from a different location and provide continuing required services.

Findings and Recommendations

FSS-021 The concept of using one location to accomplish the documentation necessary for clients to receive available services from the State and Federal government proved efficient. It was important to separate these necessarily administrative activities from the prevailing traumatic focus on victim identification at the FAC. It was fortunate that a local business owner generously made available a vacant automobile dealership with ample floor space and adequate parking areas.

The FRC, as it functioned in response to the West Warwick Station club fire, is a model that others should emulate when confronted with a mass casualty or mass fatality situation. This independent freestanding activity brought together in one place all of the available support services from every jurisdictional level and every public and private source. The personal care and assistance that characterized the treatment of each client throughout the FRC operation could not have been achieved by following a decentralized approach or by piggybacking support services on top of the victim identification and notification function at the FAC. The use of a FRC should become the norm for future mass casualty plans.

FSS-022 The practice of assigning a caseworker from the RI DHS to each client entering the FRC ensured continuity throughout the process. These caseworkers served as advocates providing essential information to the 326 family members who used the services offered at the FRC.

The personal relations established between caseworkers and family members, even in a relatively brief encounter, proved to be highly beneficial in helping families negotiate the necessary administrative processes associated with the unanticipated death of a loved one. This should become standard practice in mass fatality situations.

FSS-023 A data link installed by the RI DOC ensured the ability to coordinate support and entitlement applications among the agencies represented at the FRC and with their parent State and Federal organizations. Neither the FAC nor RIEMA HQ had the advantage of similar interconnectivity.

Communications interconnectivity should be an integral part of every plan calling for a FRC. Entitlement agencies and other resource benefactors need immediate access to home databases to expedite the application process.

FSS-024 Forty percent of the Station club fire fatalities were residents of Massachusetts and Connecticut, yet there was only minimal presence at the FRC of service representatives from those States. Although no victim or family member suffered because of this absence of representation, greater involvement from the neighboring States would likely have been beneficial.

When a disaster affects people from more than one jurisdiction, support services from all appropriate government agencies and jurisdictions should be easily accessible to the victims and their families.

FSS-025 West Warwick town officials were empowered to participate along with State, Federal, and nonprofit organizations. If these agencies could not provide needed support, the SNFRF paid for the needed services.

Although many recovery resources come from State and Federal programs, local leaders are critical to the proper and judicious distribution of those resources within the community. All components of a successful FRC operation must be identified in advance in EOPs. They must also be trained and regularly exercised.

FSS-026 The steps taken to obtain, equip, and organize the FRC facility, and coordinate the representatives of participating organizations, have not yet been captured and institutionalized for future reference in Rhode Island or elsewhere. Such information is perishable and should not be retained exclusively in the memories of individual participants and their handwritten notes. The UWRI is conducting an after-action review to assess the process of fundraising and the role of the nonprofit agencies in disaster response.

In coordination with RI DHS, RIEMA should conduct an after-action review with all agencies and organizations that were engaged at the FRC and document the lessons learned during the response to the Station club fire.

SECTION 4 – VOLUNTEERS, DONATIONS, AND FUNDS MANAGEMENT

Observations

In everyday life we might argue, criticize one another with disparaging remarks, crowd court calendars with frivolous litigation, and otherwise behave in an uncivilized manner. But when disaster strikes, we rush to the aid of those at risk. If our Nation, our community, or our neighbor is threatened, we rally to the challenge. When terrorists struck the World Trade Center on September 11, 2001, the citizens of our largest and most diverse metropolis revealed a depth of kindness and generosity rooted in a shared commitment to comfort each other and help their city. Although smaller in magnitude, the West Warwick Station club fire was no less tragic an event for the close-knit population of Rhode Island. And their response was equally remarkable. Americans are blessed with an apparently boundless capacity to pull together in adversity.

Volunteering Time and Talent

The first manifestation of volunteerism is the spontaneous offering of personal time and talent to aid in response and recovery efforts. Citizens from every walk of life abandon regular schedules, volunteering to help meet even the most mundane legitimate need. The associate director for administration of the RI DOC, Ms. Ellen Alexander, answered telephone calls over the victim information hotline, working from 12:00 midnight to 8:00 a.m., alongside other volunteers from the RI DOC and other places. Mr. Richard Frechette, the RI DOC chief financial officer, volunteered as a data entry clerk at the FRC. Hundreds of citizens of West Warwick and the surrounding communities contributed countless hours of service to those who suffered directly or indirectly from this tragedy.

National Voluntary Organizations Active in Disaster (NVOAD) was established in 1970 to coordinate response and communications among voluntary disaster response organizations. More than 20 national charitable organizations participate in NVOAD, including most prominent faith-based charities. State-level VOAD components include many of the same organizations if they have a significant presence in that particular State. Leadership of VOAD components rotates among member organizations. Once convened, VOAD coordinates the response activities of its members and also manages the use of spontaneous volunteers.

Donating Goods and Services

The second manifestation of volunteerism is the outpouring of goods and services from individuals and local businesses. In the words of one responder in the aftermath of the Station club fire, it was virtually impossible to pay for anything. Just minutes after the fire erupted, the proprietor of the Cowesett Inn, Mr. Paolucci, opened his doors to victims, their families, friends, and rescuers. The cost of his generosity during the critical initial response is calculated to be $50,000. That was not a factor in his spontaneous and generous decision. Similarly, Mr. Heater, the general manager of the Crowne Plaza Hotel, readily agreed to provide a safe haven for the distraught families of those missing in the fire, an estimated $168,000 commitment on behalf of the hotel's owners. Restaurants and caterers prepared and delivered food and beverages to every location where responders worked and others waited.

Mr. Todd, who furnished and equipped the empty automobile showroom that served as the FRC, calculates that the total cost to the government after 2½ weeks of operations was less than $5,000. The space, furnishings, office equipment, supplies, food, and everything needed to operate the FRC was donated by area businesses, civic organizations, citizen groups, and individuals. He kept his own records of goods donated to the FRC, returned all unused items to the donors, sent thank you notes to everyone who volunteered and, when the FRC closed, sent a list of donors to General Centracchio, the Adjutant General, recommending proper recognition by the governor. Eventually, help with donation management was acquired through the Emergency Management Assistance Compact (EMAC), a program administered by the National Emergency Management Association (NEMA). Mr. Alex Amparo, a qualified donation management coordinator, arrived from Florida and, supported by two experienced ARC logistics specialists, implemented an effective donation management system.

More than 60 companies made in-kind donations during the response to the Station club fire. Florists donated flowers for funerals and memorial services. Toys, stuffed animals, personal hygiene products, and first aid items were donated. One organization brought therapy dogs to help comfort the grieving families. On one particularly busy day, Mr. Ed Sneesby of the RI DHS observed that there was not enough food on hand at the FRC to serve lunch to everyone. He called a local pizza delivery restaurant and ordered pizzas, giving the street address of the former Daewoo dealership. When the pizzas arrived and the delivery staff realized where they were, they refused to accept payment. A short time later they returned with 10 more pizzas.

Financial Generosity

The final manifestation of our natural generosity during challenging times is the outpouring of financial help for the survivors and families of the victims. Many Americans are willing to share the financial burden of those directly affected, but only with the assurance that gifts serve their intended purpose. The Station club fire occurred at a time when our largest national charitable organizations were under some scrutiny. People had become aware that funds donated to the ARC, in the wake of a specific disaster, went into a general recovery fund and not to the community directly affected by the immediate event. Controversy also surrounded the United Way amid accusations regarding the response to the September 11, 2001, terrorist attack on the World Trade Center. The environment was not conducive to raising money to help victims of the Station club fire.

However, the UWRI is unique in that its administrative and management costs are sustained through a trust established in the 1930s. As a result, the proceeds of UWRI fundraising activities go directly to the beneficiaries.

Station Nightclub Fire Relief Fund

Governor Carcieri called Mr. Murphy, president of the UWRI, to discuss establishing a single agency to receive and manage donated funds. After clearing this request with his board of directors, Mr. Murphy agreed that the United Way would provide this service at no cost, up to an amount of $2 million. The fund was established as the Station Nightclub Fire Relief Fund (SNFRF).

SNFRF Oversight Committee

Governor Carcieri asked the Reverend Holt, executive minister of the Rhode Island State Council of Churches, to serve as chairman of an independent council comprised of elected officials,

community leaders, and heads of numerous nonprofit agencies (see **Figure F-3**). The committee was established to oversee the disbursement of donated funds that would be administered by the United Way. The council was clear that this fund was not an "entitlement" automatically due every victim. It would be used exclusively to address immediate financial needs of victims and their families that could not be otherwise met.

Name	Organization
Reverend John Holt, Chair	Rhode Island State Council of Churches
Dennis Murphy	United Way of Rhode Island
Bill Allen	United Way of Rhode Island
Barbara McGann	American Red Cross
Major Robert Pfeiffer	The Salvation Army
Joy Messinger	Volunteer Organizations Active in Disaster
Catherine Avila	Office of the General Treasurer
John Aucott	Rhode Island Emergency Management Agency
Jeff Grybowski	Office of the Governor
Jane Hayward	Department of Human Services
Mark Adelman	Governor's Office
Barbara Cottam, Vice Chair	Citizen's Bank
Matthew Brown	Secretary of State
Nathan Rodgers	Rhode Island Emergency Management Agency
Christine Rossi (ex officio)	Office of the Attorney General
Reverend Wesley Smith	Liaison to Families
Norm Landroche	State Representative from West Warwick
Cate Roberts	Textron Inc.

Figure F-3. SNFRF coordinating council.

The council defined who would be classified as a victim and the relationships that constituted family membership. It established initial limits for financial assistance but gave authority to the chair, the Reverend Holt, to exceed those limits on a case-by-case basis. It also defined the criteria for distributing funds and established four guiding principles from which it never strayed:

- Retain accountability to donors and to the community at large
- Minimize trauma to victims and their families
- Maximize coordination, collaboration, and communications
- Respond as quickly as possible and do it well

With a jump start led by local philanthropists and a public appeal by Rhode Island Secretary of State Matthew Brown, more than $200,000 was raised within 48 hours. The UWRI was able to disburse the first financial assistance check on Thursday, February 27, 1 day after the FRC opened. Daily reports on the amount of donations and disbursements kept the public informed of the status of the fund.

With few exceptions, payments were made to third-party vendors and not directly to victims or their families. Almost $500,000 was spent on funeral expenses for deceased victims. Mortgages, rent, car payments, and other basic costs accounted for another $280,000. In selected cases, the SNFRF paid for travel, lodging, and food when other funding sources were unavailable so that relatives from distant areas could join family members during the grieving process or could be with hospitalized victims.

When the fund reached the $2 million mark, management responsibility was transferred to the Rhode Island Foundation (RIF). RIF performs this function at a cost of 1 percent of the principal, while investing it at the rate of 3 percent. Before transferring responsibility, the Reverend Holt, Mr. Murphy, and Secretary of State Brown met with some major donors to obtain their approval of the arrangement, which ensures all donated money is expended on behalf of the victims while the modest management fees are paid from accruing interest. The management fee pays for full-time caseworkers employed by a private provider, Family Services of Rhode Island. To date, approximately $3 million has been donated to support the victims and families of victims of the Station club fire.

Family Services of Rhode Island continues to provide exceptional follow-up casework service to victims and family members. They are currently completing an assessment of the long-term needs of those affected by the fire. Although responsibility for oversight of the funds moved to a new agency, the quality of the service continues to be outstanding.

Findings and Recommendations

FSS-027 A large number of volunteers assembled at the operations HQ and offered their assistance. There was no method to verify that these volunteers had the requisite skills to assist in the response effort. In one instance, a hotline volunteer released the names of some deceased victims to the media before their families had been notified.

NVOAD or another broad-based charitable organization with Nationwide responsibilities should undertake an initiative to establish some uniform manner of ascertaining the qualifications of volunteers in disciplines commonly needed during an emergency.

FSS-028 The Rhode Island VOAD did not convene its members to consider the long-term needs of the victims and their families in the wake of the Station club fire, even when encouraged to do so by the Federal Emergency Management Agency (FEMA) Regional HQ. Some VOAD member organizations participated as independent entities, but not under the VOAD banner.

The Rhode Island VOAD should work closely with the voluntary agency liaison at FEMA Region I HQ and with its member organizations to strengthen its response capability.

FSS-029 Reportedly, the Rhode Island VOAD organization does not have a disaster response plan, nor has it conducted coordinated response training for its members. Many important charitable organizations in Rhode Island do not participate in VOAD.

The Rhode Island VOAD should develop a disaster plan to address the unmet needs of those who suffer the effects of mass fatality events. It should also consider establishing a full-time staff position to facilitate planning and training, and to work with Rhode Island communities to establish local VOAD entities.

FSS-030 The ARC spiritual care coordinator did well coordinating clergy participation in the family notification process but, because he did not know the local clergy members, less structured spiritual care initially suffered. Effective VOAD involvement might have averted this situation. The Rhode Island State Council of Churches subsequently assumed responsibility for this function and ensured only trained, experienced clergy were admitted to the FAC.

RIEMA should coordinate the function of volunteer management with the Rhode Island VOAD and other prominent charitable organizations, including the ARC RI and the Rhode Island State Council of Churches. If the Rhode Island VOAD is willing and able to accept responsibility for this important function, it should put in place appropriate plans and procedures. Otherwise, the responsibility should be assigned elsewhere. In either case, volunteer management should be addressed in the Rhode Island EOP.

FSS-031 For the first few days, there was no system in place to solicit, receive, store, disburse, and account for donated goods. As a result, some items were delivered to the wrong locations, some donated items were simply not needed, and perishable goods often spoiled. Donation management is not addressed in the current Rhode Island EOP.

Donation management is an important and totally predictable function that, if ignored, can quickly produce serious debilitating conditions. RIEMA should designate in the EOP responsibility for managing in-kind donations. Individuals must be trained to perform this function and management tools acquired to support it.

FSS-032 Rhode Island is unique in that its United Way organization is sustained by a trust established in the 1930s that pays for all management and administrative costs. Consequently, all funds raised by the UWRI are spent directly on the cause at hand.

With a separate trust available to pay operating expenses, the UWRI is able to accept and manage money for disaster recovery without using any of the donated funds for overhead costs. That is a powerful tool in the constant struggle for public confidence. The ARC, other United Way chapters, and other large charitable organizations should consider adopting this approach.

FSS-033 The flexibility with which the SNFRF was managed ensured financial needs were promptly met. The daily reporting and detailed recordkeeping, as well as monitoring by an external council, guaranteed accountability.

The UWRI should develop a plan to manage donated funds in future emergencies. It should also share this model with other communities and organizations Nationwide.

APPENDICES

APPENDIX 1
GOVERNOR'S LETTER

State of Rhode Island and Providence Plantations
State House
Providence, Rhode Island 02903-1196
401-222-2080

Donald L. Carcieri
Governor

June 13, 2003

Fire Chief, Town of West Warwick
1176 Main St.
West Warwick, RI 02893

Dear Chief Hall:

The Office for Domestic Preparedness of the United States Department of Homeland Security, in cooperation with the Governor's Office for the State of Rhode Island, has retained the services of Titan Corporation to compile the West Warwick Station Nightclub Fire After Action Report (WWSNFAAR). Titan Corporation is the same firm that recently completed the After Action Report for the September 11, 2001 attack on the Pentagon. This report will enable the State of Rhode Island to gather and review information on how key components of the State, Local and Federal governments, as well as the private sector, responded and coordinated assets *during and after* the West Warwick Station Nightclub Fire. This effort is a great opportunity for us to identify all of the elements of the response that, due to our training and preparedness, worked well and to also identify where we may collectively target areas for enhancement and improvement.

This endeavor *is not an investigation* as to cause, or a report intended to place blame. It *is* an "after-action report" intended to point out our strengths and weaknesses and to assist us in developing a road map for improvement. We expect this program to take six months.

Tim Brown from my office and Grant Peterson's team from the Titan WWSNFAAR team will contact you in the coming weeks and months. They will explain in detail the project parameters.

I thank you for your agency's outstanding effort in supporting the families during this difficult time and look forward to your cooperation and support for this worthwhile effort.

Sincerely,

Donald L. Carcieri
Governor

APPENDIX 2
PARTIAL LIST OF RESPONDING AGENCIES

This list is not meant to be a complete representation of every agency that responded to the incident. Rather it is an attempt to reconstruct a list of those that responded based on available information.

Rescue

Attleboro (Massachusetts) Fire Department

Barrington Fire Department

Burrillville
- Harrisville Fire Department
- Oakland-Mapleville Fire Department

Coventry Fire Department
- Anthony Fire District
- Central Coventry Fire District
- Harris Fire District
- Hopkins Hill Fire District
- Tiogue Fire District
- Washington Fire District
- Western Coventry Fire District

Coventry Police Department

Cranston Fire Department
Cranston Police Department

Cumberland Rescue

East Greenwich Fire Department
East Greenwich Police Department

East Providence Fire Department
East Providence Police Department

Exeter Rescue Corps

Foster Ambulance Corps

Glocester Harmony Rescue

Johnston Fire Department
Johnston Police Department

Lincoln Rescue 4

Narragansett Rescue 1

Newport Rescue 1

North Attleboro (Massachusetts) Fire Department

North Kingstown Fire Department

North Providence Police Department
North Providence Rescue 1 and Rescue 2

North Smithfield Fire and Rescue, Inc.

Norton (Massachusetts) Fire Department

Pawtucket Police Department
Pawtucket Rescue

Plainville (Massachusetts)

Portsmouth Rescue 1 Firefighters

Providence Fire Department
Providence Police Department

Raynham (Massachusetts) Rescue

Rehoboth (Massachusetts) Ambulance Committee
Rehoboth (Massachusetts) Rescue 7

Scituate
- Hope-Jackson Fire Department
- Potterville Fire Department

Scituate Ambulance Corps
Scituate Police Department

Seekonk (Massachusetts) Fire Department
Seekonk (Massachusetts) Police Department

Smithfield Medic 3

Somerset (Massachusetts)

Swansea (Massachusetts) Ambulance Corps

Tiverton Rescue 2

Warren Rescue 2, Engine 1, Special Hazards

Warwick Fire Department
Warwick Police Department

West Greenwich
- Lake Mishnock Fire Company

West Greenwich Police Department

West Warwick Fire Department
West Warwick Police Department

Medical

Boston Shriners Hospital
Brigham and Women's Hospital
Charlton Memorial Hospital (in Fall River)
Kent County Memorial Hospital
Landmark Medical Center
Massachusetts General Hospital (in Boston)
Newport Hospital
Our Lady of Fatima Hospital
Rhode Island Hospital
Roger Williams Medical Center
South County Hospital
St. Luke's Hospital (in New Bedford)
The Miriam Hospital
UMass Memorial Medical Center (in Worcester)
Westerly Hospital

Private Ambulance Services

Alert Ambulance Service, Inc.
American Medical Response
Charlestown Ambulance Service
MedTech
New England Ambulance Service
Universal Ambulance

Other Agencies

Boston Police Department CIS Team
Cape and Island Critical Incident Support Team
Concord Area CISM Team
Montachusett Area CISM Team
Pawtuxet Valley Bus Lines
Plymouth County CISM Team
Professional Firefighters of MA CISM Team
Providence Salvation Army Canteen
Rhode Island Airport Corporation (Theodore F. Green State Airport)
Rhode Island Chapter of the American Red Cross
Rhode Island Critical Incident Stress Management (CISM) Team
Rhode Island Public Transit Authority (Ride Bus)
Smithfield Emergency Management Agency
West Warwick Department of Public Works

APPENDIX 3
AFTER-ACTION REPORT
PROJECT TEAM

Mr. Grant C. Peterson led the project team. Mr. Peterson, a Titan Corporation (Titan) vice president for Homeland Security Planning and Preparedness, is a former Presidentially appointed U.S. Senate-confirmed associate director at the Federal Emergency Management Agency (FEMA) under Presidents Ronald Reagan and George H. W. Bush. While assigned to FEMA, he coordinated the Federal response to 190 Presidential Disaster Declarations. Mr. Peterson led the Titan project team that prepared the After-Action Report (AAR) following the September 11, 2001, terrorist attack on the Pentagon. Mr. Peterson also served for 5 years as an elected county commissioner in Washington State.

Nationally recognized experts served as lead analysts for each of the annexes presented in this AAR. Project team members were chosen because of their acknowledged subject matter expertise and national recognition in their fields; independent of political influence; and none were involved in any fashion in the response to the Station club fire.

Mr. Stan McKinney led the analysis of Rhode Island's Emergency Management System and Operations (Annex D). Mr. McKinney has more than 20 years of State and local government public safety and emergency management service, including 9 years as South Carolina's director of emergency management.

Mr. John Lee Cook led the analysis of Fire Department Operations (Annex A). Mr. Cook has more than 30 years of firefighting experience, beginning his career as a volunteer, transitioning into the career field, and rising through the ranks to serve as chief in a number of communities over a period of 17 years. He is an adjunct instructor at the National Fire Academy and the author of numerous articles and other publications on the subject of fire protection.

Mr. Craig DeAtley served as lead analyst for Emergency Medical Services (Annex B) and for Public Health, Healthcare Facilities, Mental Health, and Mass Fatality Management (Annex E). Mr. DeAtley has more than 30 years of experience in emergency health and medical services. He is a certified physician's assistant and an emergency medical supervisor with the Fairfax County, VA, Fire and Rescue. Over the past 12 years he has consulted with the Centers for Disease Control and Prevention (CDC), the U.S. Department of Health and Human Services (HHS), and the Office for Domestic Preparedness (ODP), U.S. Department of Homeland Security (USDHS).

Mr. Brad L. Spicer was the Law Enforcement (Annex C) lead analyst. Mr. Spicer has been a member of the Missouri State Highway Patrol since 1993, following 4 years of service as a U.S. Army intelligence analyst. He is a certified first responder, serving 4 years on the Missouri Special Emergency Response Team, including 2 years as the team leader. Mr. Spicer is also a member of the Missouri governor's protection detail.

Mr. Don Jones led the analysis of Family Services and Support (Annex F). Mr. Jones retired from the U.S. Army as a Lieutenant General after 35 years of service. His final Army assignment was as Deputy Assistant Secretary of Defense for Military Manpower, where he oversaw all military support to civil authorities. Mr. Jones then spent 9 years as a senior vice president with the national headquarters (HQ) of the American Red Cross (ARC). In that capacity he coordinated ARC support during the response to 86 major disasters.

Mr. Edward F. McGushin was responsible for the integration of information collected in each of the functional annexes. Mr. McGushin is a business consultant with more than 30 years of experience in the fields of crisis management and emergency preparedness. He has served as a technical report writer and speechwriter for senior government officials and business leaders. Mr. McGushin performed a similar role in the preparation of the *Arlington County After-Action Report on the Response to the September 11 Terrorist Attack on the Pentagon.*

APPENDIX 4
FORMS

This appendix contains the following forms:

- VIP Personal Information Form (DMORT Victim Information Profile)
- VIP/DMORT Program Form
- Missing Person Report Form (Rhode Island State Police)
- Death Notification Form (Town of West Warwick)

VIP Personal Information

Name _____ / _____ / _____ **Gender** ○ Male ○ Female
Last First Middle Maiden/Birth name _____

Address _____ **Phone** (H) _____

City _____ **State** ____ **Zip** _____ **Phone** (W) _____

Res County _____ **Res Country** _____ **Phone** (O) _____

Live Inside City Limits ○ Yes ○ No **Race:** ○ African American ○ Hispanic ○ Asian/Pacific Islander ○ Caucasian ○ Native American ○ Other _____

Social Security # / Other _____ **Date of Birth** _____ **Age** _____
(MM/DD/YYYY)

Citizenship (1 or more) _____ **Highest Education Level:**

Naturalization Card ○ Yes ○ No **Religion** _____ **Elem/Second (0-12):** _____

College (1-5+): _____

Birth Hospital _____ **Birth City** _____ **State/Country** _____

Alias 1 _____ _____ _____ **2** _____ _____ _____
Last First Middle Last First Middle

Group Status: ○ Traveling Alone ○ Group such as family, company, sports team or school

Group Type: _____ **Fam/Grp Name:** _____

If family group, please list other family members below:

Related to _____

Marital Status ☐ *Married* ☐ *Never Married* ☐ *Widowed* ☐ *Divorced* ☐ *Separated* ☐ *Unknown* **Wedding Date** _____
(MM/DD/YYYY)

Spouse _____ _____ _____ _____ ☐ *Living* ☐ *Deceased* ☐ *Unknown*
Last Maiden/Birth name First Middle

Father _____ _____ _____ ☐ *Living* ☐ *Deceased* ☐ *Unknown*
Last First Middle

Mother _____ _____ _____ _____ ☐ *Living* ☐ *Deceased* ☐ *Unknown*
Last Maiden/Birth name First Middle

Legal Next of Kin _____ **Phone** _____
Last First Middle

Address: _____ **On Site Phone** _____

City _____ **State** ____ **Zip** _____

Relationship: ☐ Wife ☐ Father ☐ Brother ☐ Son ☐ Employer ☐ Other _____
☐ Husband ☐ Mother ☐ Sister ☐ Daughter ☐ Friend

Informant 1: Name _____ _____
Last First

Address _____ **Phone** _____

City _____ **State** ____ **Zip** _____ **On Site Phone** _____

Relationship ○ Wife ○ Father ○ Brother ○ Son ○ Employer ○ Other
○ Husband ○ Mother ○ Sister ○ Daughter ○ Friend
_____
Please place other here

Informant 2: Name _____ _____
Last First

Address _____ **Phone** _____

City _____ State ____ Zip _____ **On Site Phone** _____

Relationship ○ Wife ○ Father ○ Brother ○ Son ○ Employer ○ Other
○ Husband ○ Mother ○ Sister ○ Daughter ○ Friend
Please place other relationship here

Coroner/ME/Lead Agency _____

Incident Location _____ **Incident Name** _____

VIP Personal Information

Name _____ / _____ / _____ ○ Male ○ Female
Last First Middle

Dentist Name _____

Address _____

City _____ **State** ____ **Zip** _____

Phone _____

- ☐ Extensive Dental Work
- ☐ Most/all teeth
- ☐ Lower dentures
- ☐ Dental Films
- ☐ Upper dentures
- ☐ Bridge
- ☐ Upper & Lower
- ☐ Other
- ☐ Partial Plate
- ☐ Braces _____
- ☐ No teeth

Dentist 2 _____

Address _____

City _____ **State** ____ **Zip** _____

Phone _____

Medical Radiographs?
○ Yes
○ No

Physician(s) _____

Address _____

Medical Radiographs Location	Potential Type of Radiographs - and dates taken if known

Objects in Body: ☐ Pacemaker ☐ Steel plate ☐ Shrapnel ☐ Bullets ☐ Needles ☐ Other _____
Please place other objects here

Old Fractures: ○ Yes ○ No Description: _____

Surgery ☐ Gall Bladder ☐ Laparotomy ☐ Breast Implants ☐ Appendectomy ☐ Caesarean ☐ Open heart ☐ Tracheotomy ☐ Mastectomy ☐ Other _____
Please place other surgery here

Unique Characteristics ○ Yes ○ No
Description of: Scars, Operations, birthmarks, burns, missing organs, amputations, other special characteristics _____

Prosthetic
○ Yes
○ No

Prosthetic Location/Description _____

Prints on File:
○ Yes ○ No
☐ Fingerprints
☐ Footprints

Prints Located _____

Employer & Address Please list last employer if retired - Information on additional employers should be placed on page 6 _____

Type of Business _____

Occupation _____

VIP Personal Information

Name _____ / _____ / _____ ○ Male ○ Female
Last First Middle

Height inches ○ Less than 24 ○ 24-36" ○ 37-48" ○ 49-60" ○ 61-72" ○ 73-84" ○ 85-96" ○ Over 96"

Weight in Pounds ○ less than 10 ○ 41-60 ○ 101-120 ○ 161-180 ○ 221-240 ○ 281-300
○ 11-20 ○ 61-80 ○ 121-140 ○ 181-200 ○ 241-260 ○ Greater than 300
○ 21-40 ○ 81-100 ○ 141-160 ○ 201-220 ○ 261-280

Eye Color ☐ Blue ☐ Green ☐ Grey ☐ Brown ☐ Hazel

Eye Status ☐ Missing R ☐ Glass R ☐ Cataract R ☐ Blind R ☐ Missing L ☐ Glass L ☐ Cataract L ☐ Blind L

Optical ☐ Glasses ☐ Contacts ☐ None **Description** _____

Hair Color ☐ Auburn ☐ Brown ☐ Gray ☐ Salt & Pepper ☐ Other _____ ☐ Blonde ☐ Black ☐ Red ☐ White Please place other here

Hair Colored ○ Yes ○ No ○ Unknown **Color** _____ **Hair Style** _____

Hair Accessory ☐ Wig ☐ Toupee ☐ Hair Piece ☐ Hair Transplant

Hair Length ○ Short 1-3" ○ Medium 4-8" ○ Long 8-12" ○ Very Long 12-24" ○ Over 24" ○ Bald

Hair Description _____

Facial Hair Color ○ Blonde ○ Brown ○ Black ○ Gray ○ Red ○ Salt & Pepper ○ White ○ N/Applicable

Facial Hair Type ○ Beard ○ Beard & Moustache ○ Moustache ○ Clean Shaven ○ Goatee ○ N/Applicable

Facial Hair Style ○ Fu Manchu ○ Mutton Chops ○ Handle Bar ○ Pencil Thin Upper Lip ○ Whiskers Under Lower Lip ○ Full Upper Lip

Facial Hair Notes _____

Ear Lobes ○ Attached ○ Unattached ○ Unknown **Circumcision** ○ Yes ○ No ○ Unknown ○ NA

Fingernail Type ○ Natural ○ Artificial ○ Unknown **Length** ○ Extremely Long ○ Long ○ Medium ○ Short

Fingernail Color _____ **Fingernail Characteristics** ☐ Bites ☐ Mishapen ☐ Decorated ☐ Stained

Description _____

Toenail Color _____ **Toenail Characteristics** ☐ *Bites* ☐ *Mishapen* ☐ *Decorated* ☐ *Stained*

Toenail description _____

Complexion: ○ Light ○ Medium ○ Dark ○ Acne ○ Tanned ○ Olive ○ Ruddy

Tan Mark Description _____

Tattoo(s ○ Yes ○ No **Description/ Body Location** _____

Can family draw a picture?

Tattoo Photos ○ Yes ○ Unknown ○ No ○ NA **Tattoo Photo Location** _____

Body Piercing(s)? ☐ Yes ☐ No

Body Piercing Location(s) _____

Body Piercing Description _____

VIP Personal Information

Name _____ / _____ / _____ ○ Male ○ Female

Last First Middle

A= Data not available B= Photo C= Further information available on page 6

#	Clothing Items	Material	Color	Description	Size	A	B	C
01	Hat					☐	☐	☐
02	Overcoat					☐	☐	☐
03	Scarf					☐	☐	☐
04	Gloves					☐	☐	☐
05	Jacket					☐	☐	☐
26	Suspenders/Braces					☐	☐	☐
14	Sweater					☐	☐	☐
09	Vest					☐	☐	☐
07	Tie					☐	☐	☐
08	Shirt					☐	☐	☐
15	Blouse					☐	☐	☐
06	Undershirt					☐	☐	☐
18	Chemise/Camisole					☐	☐	☐
19	Bra					☐	☐	☐
11	Underpants					☐	☐	☐
20	Girdle					☐	☐	☐
17	Slip					☐	☐	☐
10	Trousers/Slacks					☐	☐	☐
23	Shorts/walking					☐	☐	☐
13	Dress					☐	☐	☐
16	Skirt					☐	☐	☐
12	Socks					☐	☐	☐
21	Hose/Stockings					☐	☐	☐
22	Tights					☐	☐	☐
24	Belt					☐	☐	☐
25	Belt Buckle					☐	☐	☐
27	Other 1					☐	☐	☐
28	Other 2					☐	☐	☐
29	Other 3					☐	☐	☐
30	Other 4					☐	☐	☐

VIP Personal Information

Name _____ / _____ / _____ ○ Male ○ Female
Last First Middle

Shoes

A= Data not available B= Photo C= Further information available on page 6

#	Material	Color	Description	Label	Size US	Size cm	A	B	C
01 Shoes							☐	☐	☐

Watch

A= Data not available B= Photo C= Further information available on page 6

#	Type	Material	Color	Description	Make	Inscription			
01	Digital						☐	☐	☐
02	Analog						☐	☐	☐
03	Other						☐	☐	☐

04 Worn ☐ Right Wrist ☐ Left Wrist ☐ Finger ☐ Pin On ☐ Pocket Watch

05 Band ☐ Leather ☐ Metal ☐ Other Specify Other Band Color

Jewelry

A= Data not available B= Photo C= Further information available on page 6

#	Jewelry	Material Color	Stone Color	Description	Inscription	Where Worn			
01	Wedding Ring						☐	☐	☐
02	Finger Rings						☐	☐	☐
03	Ear Rings						☐	☐	☐
04	Earclips						☐	☐	☐
05	Neck Chains						☐	☐	☐
06	Pendant Chain						☐	☐	☐
07	Other Chains						☐	☐	☐
08	Bracelets						☐	☐	☐
09	Medic Alert						☐	☐	☐
10	Other2						☐	☐	☐
11	Other3						☐	☐	☐
12	Other4						☐	☐	☐
13	Other5						☐	☐	☐

Use this space for more info regarding jewelry:

VIP Personal Information

Name _____ / _____ / _____ ○ Male ○ Female
Last First Middle

Wallet: Description _____

Contents _____

Purse: Description _____

Contents

Other Personal Effects

Ever in Armed Forces? ○ Yes ○ No ○ Unknown Military Branch _____

Military Service Number _____ Nation Served _____

Approximate Service Date _____

Additional Data

VIP Personal Information

Name _____ / _____ / _____ SS# _____

Last First Middle

○ Male ○ Female

Potential Living Biological Donors

Mother/Father of Missing Individual

Name	Age	Address	Phone	DNA Collected	Consent Form Signed
				○ Yes ○ No	○ Yes ○ No
				○ Yes ○ No	○ Yes ○ No

Brother and Sisters of Missing Individual

Name	Age	Address	Phone		
				○ Yes ○ No	○ Yes ○ No
				○ Yes ○ No	○ Yes ○ No
				○ Yes ○ No	○ Yes ○ No
				○ Yes ○ No	○ Yes ○ No
				○ Yes ○ No	○ Yes ○ No
				○ Yes ○ No	○ Yes ○ No
				○ Yes ○ No	○ Yes ○ No
				○ Yes ○ No	○ Yes ○ No

Spouse of Missing Individual

Name	Age	Address	Phone		
				○ Yes ○ No	○ Yes ○ No

Children of Missing Individual

Name	Age	Address	Phone		
				○ Yes ○ No	○ Yes ○ No
				○ Yes ○ No	○ Yes ○ No
				○ Yes ○ No	○ Yes ○ No
				○ Yes ○ No	○ Yes ○ No
				○ Yes ○ No	○ Yes ○ No
				○ Yes ○ No	○ Yes ○ No
				○ Yes ○ No	○ Yes ○ No
				○ Yes ○ No	○ Yes ○ No

Primary donor for Nuclear DNA Analysis

An "appropriate family member" for **nuclear DNA Analysis** is someone that is biologically related to and only one generation removed from the deceased. The following are the family members who are appropriate donors to provide reference specimens, and in the order of preference (family members highlighted in bold print are the most desirable):

1. Natural (Biological) **Mother and Father**, OR
2. **Spouse** and Natural (Biological) **Children**, OR
3. A Natural (Biological) Mother or Father and victim's biological children, OR
4. Multiple Full Siblings of the Victim (i.e., children from the same Mother and Father

VIP Personal Information

Name _____ / _____ / _____
Last First Middle

Interview Location _____ Interview Date _____ Interview Time _____
(MM/DD/YYYY)

Interviewer Info:

Interviewer Name _____ _____
First Last

Interviewing Organization _____

Interviewer **Home** Information

Interviewer Address _____
Street, City State, Zip

Interviewer home phone _____

Interviewer cell phone _____

interviewer work phone _____

Interviewer **On-Site** Information

interviewer onsite address _____
Street, Hotel, Room #

interviewer onsite phone _____

interviewer onsite cell _____

Reviewer Info:

Reviewer Name _____

Reviewer Signature _____

Reviewing agency _____

Coroner/ME/Lead Agency _____

Incident Location _____ **Incident Name** _____

VIP/DMORT Program

Requested Records List

Victim Last/First/Middle

Case #

Informant LAst/First/Middle

Address

Informant phone

On Site Phone

Dental

Type	Location	Contact	Phone	Date Ord	Date Rec

Prints

Radiographs

Medical Records

Photo Requests

Requested Records Notes

MISSING PERSON REPORT

Rhode Island State Police

CASE #_____ Date of Report _____

Message Key (See definitions on page 1) (MKE) ☐ Disability (EMD) ☐ Juvenile (EMJ) ☐ Endangered (EME) ☐ Victim (EMV) ☐ Involuntary (EMI) ☐ Caution	Name (NAM)					Race (RAC) ☐ Asian or Pacific Islander (A) ☐ Unknown (U) ☐ Black (B) ☐ White (W ☐ American Indian/Alaskan Native (I)	
Place of Birth (POB)	Sex (SEX) ☐ Male (M) ☐ Female (F)	Date of Birth (DOB)	Date of Emancipation (DOE)	Height (HGT)	Weight (WGT)	Eye Color (EYE) ☐ Black (BLK) ☐ Hazel (HAZ) ☐ Blue (BLU) ☐ Maroon (MAR) ☐ Brown (BRO) ☐ Multicolored (MUL) ☐ Gray (GRY) ☐ Pink (PNK) ☐ Green (GRN) ☐ Unknown (XXX)	
Hair Color (HAI) ☐ Black (BLK) ☐ Brown (BRO) ☐ Red/Auburn (RED) ☐ White (WHI) ☐ Blonde/Strawberry (BLN) ☐ Gray/Partially Gray (GRY) ☐ Sandy (SDY) ☐ Unknown (XXX)			Hair Description (MIS) ☐ Wavy ☐ Curly ☐ Straight ☐ Treated				
Hair Length (MIS)	Hair Style (MIS)	Skin Tone (SKN) ☐ Albino (ALB) ☐ Fair (FAR) ☐ Olive (OLV) ☐ Black (BLK) ☐ Light (LGT) ☐ Ruddy (RUD) ☐ Dark (DRK) ☐ Lt Brown (LBR) ☐ Sallow (SAL) ☐ Dk Brown (DBR) ☐ Medium (MED) ☐ Yellow (YEL) ☐ Med Brown (MBR)		Scars, marks, tattoos, and other characteristics (SMT) (See check list)			
Has the missing person ever been fingerprinted? ☐ No ☐ Yes If so by whom?			Fingerprint Classification (FPC)		Other Identifying Numbers (MNU)		
Social Security Number (SOC)	Operator's License Number (OLN)	Operator's License State (OLS)	Operator's License Year of Expiration (OLY)	Date of Last Contact			
Originating Agency Case Number (OCA)	Blood Type (BLT) ☐ A Positive (APOS) ☐ B Positive (BPOS) ☐ AB Positive (ABPOS) ☐ O Positive (OPOS) ☐ A Negative (ANEG) ☐ B Negative (BNEG) ☐ AB Negative (ABNEG) ☐ O Negative (ONEG) ☐ A Unknown (AUNK) ☐ B Unknown (BUNK) ☐ AB Unknown (ABUNK) ☐ O Unknown (OUNK)			Has missing person ever donated blood? ☐ No ☐ Yes Where?			
Has the missing person been circumcised? (CRC) ☐ Was circumcised (C) ☐ Was not circumcised (N) ☐ Unknown (U)		Are footprints available? (FPA) ☐ Yes (Y) ☐ No (N)					
Are body x-rays available? (BXR) ☐ Full (F) ☐ Partial (P) ☐ None (N)	Does the missing person have corrected vision? ☐ Glasses ☐ Con Lenses	☐ Yes ☐ No (SMT)	Corrective vision prescription (VRX)				
Type of Contact Lenses and Color (MIS) ☐ Hard ☐ Longwear ☐ Blue ☐ Gray ☐ Clear ☐ Soft ☐ Semi ☐ Green ☐ Brown	Jewelry Type (See check list (JWT)		Jewelry Description (JWL)				
Handedness ☐ Left ☐ Right (MIS)	Build (MIS) ☐ Very thin ☐ Medium ☐ Heavy/Stocky ☐ Thin ☐ Muscular ☐ Obese						
Any other miscellaneous information (MIS)							

Below is a list of clothing and personal effects. Please indicate those items the missing person was last seen wearing. Include style, type, size, color, condition, labels, or laundry markings. (MIS)

Item	Style/Type	Size	Color	Markings	Item	Style/Type	Size	Color	Markings
Head Gear					Shoes/Boots/Sneakers				
Scarf/Tie/Gloves					Underwear				
Coat/Jacket/Vest					Bra/Girdle/Slip				
Sweater					Stockings/Pantyhose				
Shirt/Blouse					Wallet/Purse				
Pants/Skirt					Money				
Belts/Suspenders					Glasses				
Socks									

LICENSE PLATE AND VEHICLE INFORMATION

License Plate Number (LIC)	State (LIS)	Year Expires (LIY)	License Plate Type (LIT)				
Vehicle Identification # (VIN)	Year (VYR)	Make (VMA)	Model (VMO)	Style (VST)	Color (VCO)		
Aliases	Reporting Agency	Reporting Officer					
Complainant's Name	Complainant's Address	Complainant's Telephone Number					
Relationship of Complainant to Missing Person	Missing Person's Address	Missing Person's Occupation					
NCIC # (NIC)	Places missing person frequented (MIS)						
Close friends/relatives	Possible destination						
	Complainant's Signature	Date					

- Attach current photo, if available.

If additional space is needed, attach additional sheets.

All dental information should be recorded on the dental report and entered in NCIC as a supplemental record.

ORIGINAL — STATE POLICE
YELLOW — LOCAL POLICE

Peter T. Brousseau
CHIEF OF POLICE

Town of West Warwick
Police Department • 1162 Main Street
West Warwick, Rhode Island 02893-4829
Phone: (401) 821-4323 Fax: (401) 822-9206

To: _____

From: **West Warwick Police Incident Command Center @ The Crown Plaza Hotel, Warwick , RI**

Date: **February 24, 2003**

Re: **Death Notification**

_____**dob ( ), age** _____ has been positively identified and pronounced deceased by the State Medical Examiners Office.

Please attempt to make this death notification to the following next of kin:

Next of Kin: _____

If notification has been made please inform the family that they can contact a funeral home of their choosing, who will make arrangements with the Medical Examiners Office (401.222.5500) to release the body. Also, if a member of the clergy or grief counselor is needed by the family it can be obtained by calling the State Emergency Management Agency @ (401) 738-2901.

Lastly, will the family give permission to the Governor to release the victim's name to the media at this time Yes☐ NO☐. In the event they do not wish to have it made public at this time , we will attempt to withhold this release for eight (8) hours.

Upon completion of the notification, please contact the West Warwick Police Department (401.821.4323). Subsequently, fax this form with the families request pertaining to media release to the West Warwick Police Incident Command Center @ (401.738.1238).

Thank-you for your assistance in this matter.

"Courage - Sacrifice - Devotion"

APPENDIX 5
LIST OF ACRONYMS

AAR	After-Action Report
ALS	Advanced Life Saving
AMR	American Medical Response
ANRC	American National Red Cross
ARC	American Red Cross
ARC RI	American Red Cross of Rhode Island
BLS	Basic Life Saving
CAT	Computed Axial Tomography [Scan]
CBRNE	Chemical, Biological, Radiological, Nuclear and High-Yield Explosive
CD	Compact Disc
CDC	Centers for Disease Control and Prevention
CEO	Chief Executive Officer
CERT	Community Emergency Response Team
CISM	Critical Incident Stress Management
CNN	Cable News Network
COG	Continuity of Government
COOP	Continuity of Operations
CPD	Coventry Police Department
CPR	Cardiopulmonary Resuscitation
DMAT	Disaster Medical Assistance Team
DMORT	Disaster Mortuary Operational Response Team
DMV	Department of Motor Vehicles
DNA	Deoxyribonucleic Acid
DOA	Dead on Arrival
DOT	U.S. Department of Transportation
EAP	Employee Assistance Program
ED	Emergency Department
EMAC	Emergency Management Assistance Compact
EMI	Emergency Management Institute
EMS	Emergency Medical Services
EMSC	Emergency Medical Services for Children
EMT	Emergency Medical Technician
EMT-B	Emergency Medical Technician-Basic
EMT-C	Emergency Medical Technician-Cardiac Rescue Technician
EMT-P	Emergency Medical Technician-Paramedic
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
ESF	Emergency Support Function
FAA	Federal Aviation Administration
FAC	Family Assistance Center
FAR	Forensic Archeology Recovery
FAST	Firefighter Assist and Search Team
FBI	Federal Bureau of Investigation

FEMA	Federal Emergency Management Agency
FEOC	Forward Emergency Operations Center
FRC	Family Resource Center
FRP	Federal Response Plan
GIS	Geographic Information System
HARI	Hospital Association of Rhode Island
HazMat	Hazardous Material(s)
HEAR	Hospital Emergency Administrative Radio
HEICS	Hospital Emergency Incident Command System
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HQ	Headquarters
IC	Incident Commander
ICISF	International Critical Incident Stress Foundation
ICP	Incident Command Post
ICS	Incident Command System
ICU	Intensive Care Unit
IRS	Internal Revenue Service
IT	Information Technology
IV	Intravenous
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JIC	Joint Information Center
JPD	Johnston Police Department
LAN	Local Area Network
MCD	Mass Casualty Disaster [Plan]
MCI	Mass Casualty Incident
mg	Milligram
MHRH	Department of Mental Health, Retardation and Hospitals
MHz	Megahertz
MPH	Masters in Public Health
NDMAS	National Disaster Medical Assistance System
NDMS	National Disaster Medical System
NEMA	National Emergency Management Association
NFPA	National Fire Protection Association
NPFD	North Providence Fire Department
NPPD	North Providence Police Department
NRP	National Response Plan
NTSB	National Transportation Safety Board
NVOAD	National Voluntary Organizations Active in Disaster

ODP	Office for Domestic Preparedness
OEP	Office of Emergency Preparedness (USDHS)
OME	Office of the Medical Examiner
PAR	Personnel Accountability Roll Call
PDA	Personal Digital Assistant
Ph.D.	Philosophiae Doctor (Doctor of Philosophy)
PIO	Public Information Officer
POC	Point of Contact
PPE	Personal Protective Equipment
PTSD	Post-Traumatic Stress Disorder
RI DHS	Rhode Island Department of Human Services
RI DOC	Rhode Island Department of Corrections
RI Health	Rhode Island Department of Health
RIEMA	Rhode Island Emergency Management Agency
RIEMAC	Rhode Island Emergency Management Advisory Council
RIF	Rhode Island Foundation
RIHQPMRP	Rhode Island Health Quality Performance Measurement and Reporting Program
RISP	Rhode Island State Police
RN	Registered Nurse
SAMHSA	Substance Abuse and Mental Health Services Administration (HHS)
SNFRF	Station Nightclub Fire Relief Fund
SOP	Standard Operating Procedure
SSA	Social Security Administration
START	Simple Triage and Rapid Transport
SWAT	Special Weapons and Tactics
UCP	Unified Command Post
UMass	University of Massachusetts
USDHS	U.S. Department of Homeland Security
UWRI	United Way of Rhode Island
VIP	Victim Information Profile
VOAD	Voluntary Organizations Active in Disaster
WAN	Wide Area Network
WFD	Warwick Fire Department
WMD	Weapon(s) of Mass Destruction
WPD	Warwick Police Department
WW DHS	West Warwick Department of Human Services
WWEMA	West Warwick Emergency Management Agency
WWFD	West Warwick Fire Department
WWPD	West Warwick Police Department

NGER
RUGGED
WARWICK