

EXECUTIVE SUMMARY OF FINDINGS

The Select Committee identified failures at all levels of government that significantly undermined and detracted from the heroic efforts of first responders, private individuals and organizations, faith-based groups, and others.

The institutional and individual failures we have identified became all the more clear when compared to the heroic efforts of those who acted decisively. Those who didn't flinch, who took matters into their own hands when bureaucratic inertia was causing death, injury, and suffering. Those whose exceptional initiative saved time and money and lives.

We salute the exceptions to the rule, or, more accurately, the exceptions that proved the rule. People like Mike Ford, the owner of three nursing homes who wisely chose to evacuate his patients in Plaquemines Parish before Katrina hit, due in large part to his close and long-standing working relationship with Jesse St. Amant, Director of the Plaquemines Office of Emergency Preparedness.

People like Dr. Gregory Henderson, a pathologist who showed that not all looting represented lawlessness when, with the aid of New Orleans police officers, he raided pharmacies for needed medication and supplies and set up ad hoc clinics in downtown hotels before moving on to the Convention Center.

But these acts of leadership were too few and far between. And no one heard about or learned from them until it was too late.

The preparation for and response to Hurricane Katrina show we are still an analog government in a digital age. We must recognize that we are woefully incapable of storing, moving, and accessing information – especially in times of crisis.

Many of the problems we have identified can be categorized as “information gaps” – or at least problems with information-related implications, or failures to act decisively because information was sketchy at best. Better information would have been an optimal weapon against Katrina. Information sent to the right people at the right place at the right time. Information moved within agencies, across departments, and between jurisdictions of

government as well. Seamlessly. Securely. Efficiently.

Unfortunately, no government does these things well, especially big governments.

The federal government is the largest purchaser of information technology in the world, by far. One would think we could share information by now. But Katrina again proved we cannot.

We reflect on the 9/11 Commission's finding that “the most important failure was one of imagination.” The Select Committee believes Katrina was primarily a failure of initiative. But there is, of course, a nexus between the two. Both imagination and initiative – in other words, *leadership* – require good information. And a coordinated process for sharing it. And a willingness to use information – however imperfect or incomplete – to fuel action.

With Katrina, the reasons reliable information did not reach more people more quickly are many, and these reasons provide the foundation for our findings.

In essence, we found that while a national emergency management system that relies on state and local governments to identify needs and request resources is adequate for most disasters, a catastrophic disaster like Katrina can and did overwhelm most aspects of the system for an initial period of time. No one anticipated the degree and scope of the destruction the storm would cause, even though many could and should have.

The failure of local, state, and federal governments to respond more effectively to Katrina — which had been predicted in theory for many years, and forecast with startling accuracy for five days — demonstrates that whatever improvements have been made to our capacity to respond to natural or man-made disasters, four and half years after 9/11, we are still not fully prepared. Local first responders were largely overwhelmed and unable to perform their duties, and the National Response Plan did not adequately provide a way for federal assets to quickly supplement or, if necessary, supplant first responders.

The failure of initiative was also a failure of agility. Response plans at all levels of government lacked flexibility and adaptability. Inflexible procedures often

delayed the response. Officials at all levels seemed to be waiting for the disaster that fit their plans, rather than planning and building scalable capacities to meet whatever Mother Nature threw at them. We again encountered the risk-averse culture that pervades big government, and again recognized the need for organizations as agile and responsive as the 21st century world in which we live.

One-size-fits-all plans proved impervious to clear warnings of extraordinary peril. Category 5 needs elicited a Category 1 response. Ours was a response that could not adequately accept civilian and international generosity, and one for which the Congress, through inadequate oversight and accounting of state and local use of federal funds, must accept some blame.

In crafting our findings, we did not guide the facts. We let the facts guide us. The Select Committee's report elaborates on the following findings, which are summarized in part here, in the order in which they appear:

The accuracy and timeliness of National Weather Service and National Hurricane Center forecasts prevented further loss of life

The Hurricane Pam exercise reflected recognition by all levels of government of the dangers of a catastrophic hurricane striking New Orleans

- Implementation of lessons learned from Hurricane Pam was incomplete.

Levees protecting New Orleans were not built for the most severe hurricanes

- Responsibilities for levee operations and maintenance were diffuse.
- The lack of a warning system for breaches and other factors delayed repairs to the levees.
- The ultimate cause of the levee failures is under investigation, and results to be determined.

The failure of complete evacuations led to preventable deaths, great suffering, and further delays in relief

- Evacuations of general populations went relatively well in all three states.
- Despite adequate warning 56 hours before landfall, Governor Blanco and Mayor Nagin delayed ordering a mandatory evacuation in New Orleans until 19 hours before landfall.
- The failure to order timely mandatory evacuations, Mayor Nagin's decision to shelter but not evacuate the remaining population, and decisions of individuals led to an incomplete evacuation.
- The incomplete pre-landfall evacuation led to deaths, thousands of dangerous rescues, and horrible conditions for those who remained.
- Federal, state, and local officials' failure to anticipate the post-landfall conditions delayed post-landfall evacuation and support.

Critical elements of the National Response Plan were executed late, ineffectively, or not at all

- It does not appear the President received adequate advice and counsel from a senior disaster professional.
- Given the well-known consequences of a major hurricane striking New Orleans, the Secretary should have designated an Incident of National Significance no later than Saturday, two days prior to landfall, when the National Weather Service predicted New Orleans would be struck by a Category 4 or 5 hurricane and President Bush declared a federal emergency.
- The Secretary should have convened the Interagency Incident Management Group on Saturday, two days prior to landfall, or earlier to analyze Katrina's potential consequences and anticipate what the federal response would need to accomplish.
- The Secretary should have designated the Principal Federal Official on Saturday, two days prior to landfall, from the roster of PFOs who had successfully

completed the required training, unlike then-FEMA Director Michael Brown. Considerable confusion was caused by the Secretary's PFO decisions.

- A proactive federal response, or push system, is not a new concept, but it is rarely utilized.
- The Secretary should have invoked the Catastrophic Incident Annex to direct the federal response posture to fully switch from a reactive to proactive mode of operations.
- Absent the Secretary's invocation of the Catastrophic Incident Annex, the federal response evolved into a push system over several days.
- The Homeland Security Operations Center failed to provide valuable situational information to the White House and key operational officials during the disaster.
- The White House failed to de-conflict varying damage assessments and discounted information that ultimately proved accurate.
- Federal agencies, including DHS, had varying degrees of unfamiliarity with their roles and responsibilities under the National Response Plan and National Incident Management System.
- Once activated, the Emergency Management Assistance Compact enabled an unprecedented level of mutual aid assistance to reach the disaster area in a timely and effective manner.
- Earlier presidential involvement might have resulted in a more effective response.

DHS and the states were not prepared for this catastrophic event

- While a majority of state and local preparedness grants are required to have a terrorism purpose, this does not preclude a dual use application.
- Despite extensive preparedness initiatives, DHS was not prepared to respond to the catastrophic effects of Hurricane Katrina.
- DHS and FEMA lacked adequate trained and experienced staff for the Katrina response.
- The readiness of FEMA's national emergency response teams was inadequate and reduced the effectiveness of the federal response.

Massive communications damage and a failure to adequately plan for alternatives impaired response efforts, command and control, and situational awareness

- Massive inoperability had the biggest effect on communications, limiting command and control, situational awareness, and federal, state, and local officials' ability to address unsubstantiated media reports.
- Some local and state responders prepared for communications losses but still experienced problems, while others were caught unprepared.
- The National Communication System met many of the challenges posed by Hurricane Katrina, enabling critical communication during the response, but gaps in the system did result in delayed response and inadequate delivery of relief supplies.

Command and control was impaired at all levels, delaying relief

- Lack of communications and situational awareness paralyzed command and control.
- A lack of personnel, training, and funding also weakened command and control.
- Ineffective command and control delayed many relief efforts.

The military played an invaluable role, but coordination was lacking

- The National Response Plan's Catastrophic Incident Annex as written would have delayed the active duty military response, even if it had been implemented.
- DOD/DHS coordination was not effective during Hurricane Katrina.
- DOD, FEMA, and the state of Louisiana had difficulty coordinating with each other, which slowed the response.
- National Guard and DOD response operations were comprehensive, but perceived as slow.

- The Coast Guard’s response saved many lives, but coordination with other responders could improve.
- The Army Corps of Engineers provided critical resources to Katrina victims, but pre-landfall contracts were not adequate.
- DOD has not yet incorporated or implemented lessons learned from joint exercises in military assistance to civil authorities that would have allowed for a more effective response to Katrina.
- The lack of integration of National Guard and active duty forces hampered the military response.
- Northern Command does not have adequate insight into state response capabilities or adequate interface with governors, which contributed to a lack of mutual understanding and trust during the Katrina response.
- Even DOD lacked situational awareness of post-landfall conditions, which contributed to a slower response.
- DOD lacked an information sharing protocol that would have enhanced joint situational awareness and communications between all military components.
- Joint Task Force Katrina command staff lacked joint training, which contributed to the lack of coordination between active duty components.
- Joint Task Force Katrina, the National Guard, Louisiana, and Mississippi lacked needed communications equipment and the interoperability required for seamless on-the-ground coordination.
- EMAC processing, pre-arranged state compacts, and Guard equipment packages need improvement.
- Equipment, personnel, and training shortfalls affected the National Guard response.
- Search and rescue operations were a tremendous success, but coordination and integration between the military services, the National Guard, the Coast Guard, and other rescue organizations was lacking.

The collapse of local law enforcement and lack of effective public communications led to civil unrest and further delayed relief

- A variety of conditions led to lawlessness and violence in hurricane stricken areas.
- The New Orleans Police Department was ill-prepared for continuity of operations and lost almost all effectiveness.
- The lack of a government public communications strategy and media hype of violence exacerbated public concerns and further delayed relief.
- EMAC and military assistance were critical for restoring law and order.
- Federal law enforcement agencies were also critical to restoring law and order and coordinating activities.

Medical care and evacuations suffered from a lack of advance preparations, inadequate communications, and difficulties coordinating efforts

- Deployment of medical personnel was reactive, not proactive.
- Poor planning and pre-positioning of medical supplies and equipment led to delays and shortages.
- New Orleans was unprepared to provide evacuations and medical care for its special needs population and dialysis patients, and Louisiana officials lacked a common definition of “special needs.”
- Most hospital and Veterans Affairs Medical Center emergency plans did not offer concrete guidance about if or when evacuations should take place.
- New Orleans hospitals, Veterans Affairs Medical Center, and medical first responders were not adequately prepared for a full evacuation of medical facilities.
- The government did not effectively coordinate private air transport capabilities for the evacuation of medical patients.

- Hospital and Veterans Affairs Medical Center emergency plans did not adequately prepare for communication needs.
- Following Hurricane Katrina, New Orleans Veterans Affairs Medical Center and hospitals' inability to communicate impeded their ability to ask for help.
- Medical responders did not have adequate communications equipment or operability.
- Evacuation decisions for New Orleans nursing homes were subjective and, in one case, led to preventable deaths.
- Lack of electronic patient medical records contributed to difficulties and delays in medical treatment of evacuees.
- Top officials at the Department at Health and Human Services and the National Disaster Medical System do not share a common understanding of who controls the National Disaster Medical System under Emergency Support Function-8.
- Lack of coordination led to delays in recovering dead bodies.
- Deployment confusion, uncertainty about mission assignments, and government red tape delayed medical care.

Long-standing weaknesses and the magnitude of the disaster overwhelmed FEMA's ability to provide emergency shelter and temporary housing

- Relocation plans did not adequately provide for shelter. Housing plans were haphazard and inadequate.
- State and local governments made inappropriate selections of shelters of last resort. The lack of a regional database of shelters contributed to an inefficient and ineffective evacuation and sheltering process.
- There was inappropriate delay in getting people out of shelters and into temporary housing – delays that officials should have foreseen due to manufacturing limitations.

- FEMA failed to take advantage of the Department of Housing and Urban Development's expertise in large-scale housing challenges.

FEMA logistics and contracting systems did not support a targeted, massive, and sustained provision of commodities

- FEMA management lacked situational awareness of existing requirements and of resources in the supply chain. An overwhelmed logistics system made it challenging to get supplies, equipment, and personnel where and when needed.
- Procedures for requesting federal assistance raised numerous concerns.
- The failure at all levels to enter into advance contracts led to chaos and the potential for waste and fraud as acquisitions were made in haste.
- Before Katrina, FEMA suffered from a lack of sufficiently trained procurement professionals. DHS procurement continues to be decentralized and lacking a uniform approach, and its procurement office was understaffed given the volume and dollar value of work.
- Ambiguous statutory guidance regarding local contractor participation led to ongoing disputes over procuring debris removal and other services.
- Attracting emergency contractors and corporate support could prove challenging given the scrutiny that companies have endured.

Contributions by charitable organizations assisted many in need, but the American Red Cross and others faced challenges due to the size of the mission, inadequate logistics capacity, and a disorganized shelter process



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“We were abandoned. City officials did nothing to protect us. We were told to go to the Superdome, the Convention Center, the interstate bridge for safety. We did this more than once. In fact, we tried them all for every day over a week. We saw buses, helicopters and FEMA trucks, but no one stopped to help us. We never felt so cut off in all our lives. When you feel like this you do one of two things, you either give up or go into survival mode. We chose the latter. This is how we made it. We slept next to dead bodies, we slept on streets at least four times next to human feces and urine. There was garbage everywhere in the city. Panic and fear had taken over.”

Patricia Thompson
New Orleans Citizen and Evacuee
Select Committee Hearing, December 6, 2005¹