

*Leadership During Crisis:  
Isn't Everyday a Bit Challenging?*



**Bruce J. Moeller, PhD**



# Public Safety / Public Service Background





# Opportunity

Illinois to Florida

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# Hurricane Andrew



# Gasoline Tanker vs. Amtrak Train

- March 17, 1993
- Six deaths





# FIRE INVESTIGATION REPORT

**Board and Care Facility Fire  
Broward County, Florida**

**December 1, 1994**

Prepared by  
**Michael S. Isner**  
Fire Protection Engineer  
National Fire Protection Association

## Assisted Living Facility Fire

- Six Fire Fatalities
- December 1, 1994



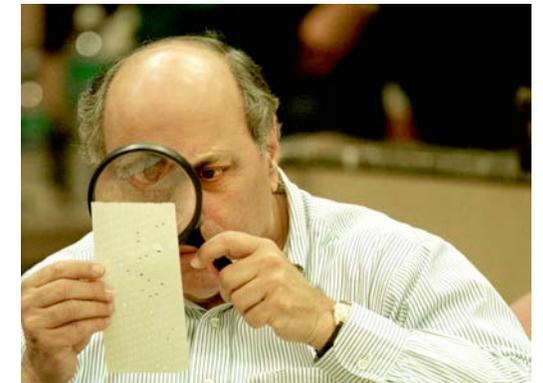
# ValuJet Flight #592

- May 11, 1996
- DC-9 with 110 souls
- MIA -> ALT
- Crashed 10 minutes after taking off as a result of a fire in cargo compartment



# 2000 Presidential Recount

- Space
  - Logistical Support
    - Food / Water / Facilities
    - Breakout / Administrative Space
    - Current Technology
- Security





Hurricane Katrina

# HURRICANE WILMA

OCT 15-25, 2005

63 KILLED

## One-Two Punch

DAMAGE TO FLORIDA  
\$29.1 BILLION (2005 USD)

- Hurricane Wilma – October 2005
  - Approx. 800 condos destroyed
- Chinese Drywall – 2008-2010



●●● HURRICANE  
●●● TROPICAL STORM  
●●● TROPICAL DEPRESSION



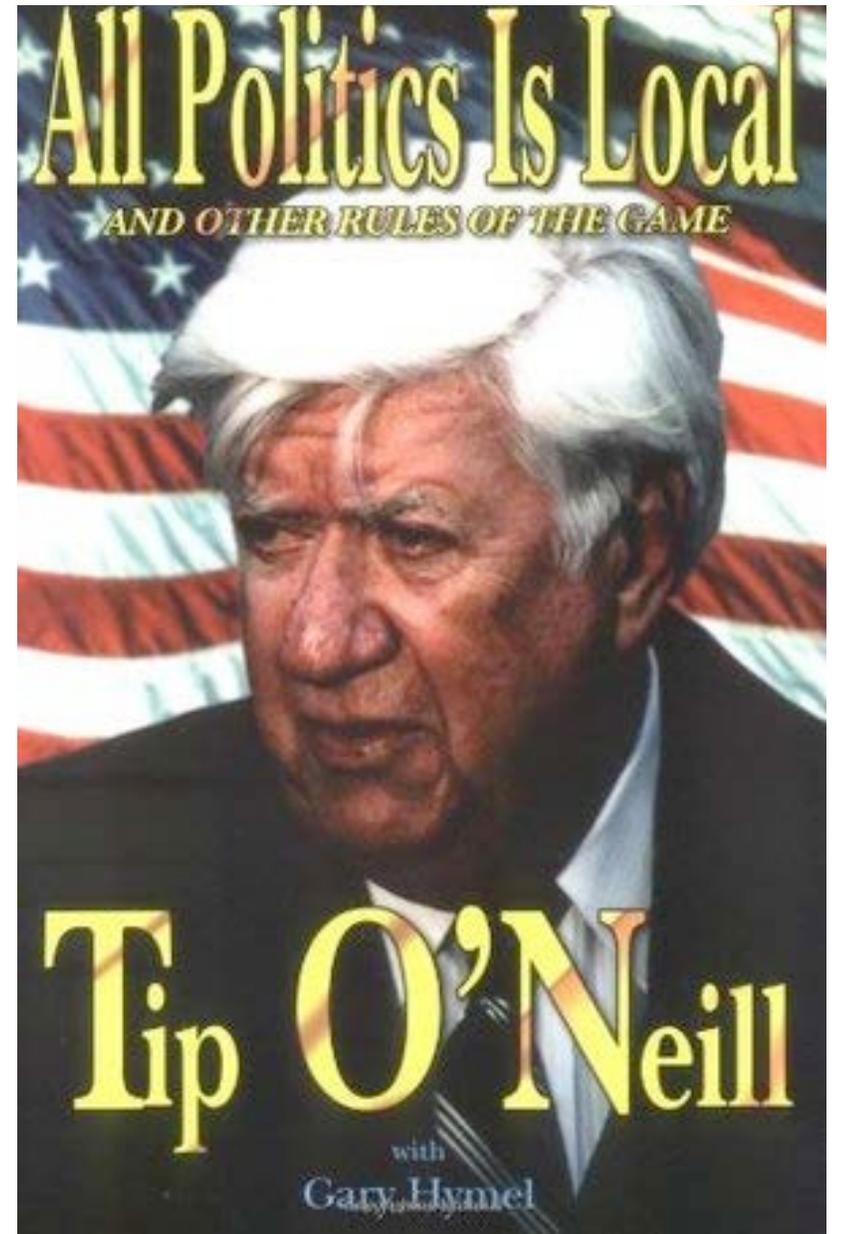
Mistakes

Don't Worry

The State or Federal Government  
Will Handle This . . . Maybe

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Residents expect those governmental leaders  
closest to them will help . . . .

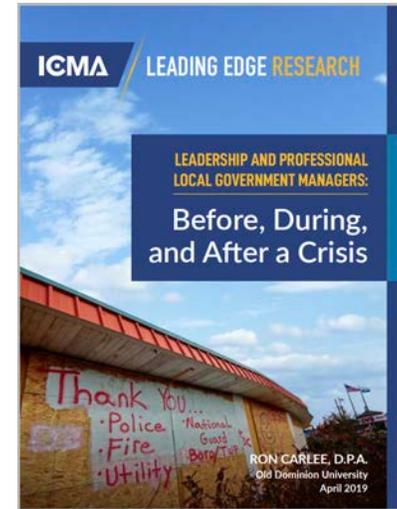


# Leadership During Crisis

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*Part II. Lessons Learned.* This section integrates the observations, lessons, and recommendations from city managers across the following areas with key takeaways:

- **Leadership.** In a crisis, city managers must be leaders, setting the tone for the responses, coordinating their roles with the elected officials, playing appropriate operational roles with city departments, and ensuring effective relationships with community and governmental partners.
- **Preparation and Response.** City managers must ensure that a city is prepared when a crisis hits, know its risks and operational capacity, and be prepared to improvise in response to unique and unexpected circumstances.
- **Employee Support.** City managers must ensure the health and safety of employees during and after a crisis event and be prepared to support employees who may themselves be victims of a disaster.
- **Media Management.** For a major event with national or international attention, city managers must have a plan to secure the communications resources needed to protect the reputation of the city, to keep its residents informed, and to combat rumors and misinformation.
- **Recovery.** City managers must ensure that recovery planning starts immediately, is highly focused, and returns the community to normalcy as quickly as possible.

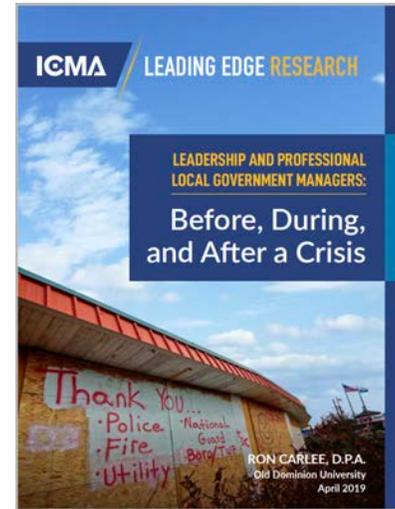


Timely Topic

# Leadership During Crisis

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Timely Topic

“You only have to be [smart] within your circle of competence. The size of that circle is not very important; knowing its boundaries, however, is vital.” *Warren Buffet, 1996*

“I’m no genius. I’m smart in spots – but I stay around those spots.” *Tom Watson, Sr. – Founder of IBM*

# How Not to Be Stupid

## 7 Factors Forcing Smart People to Make Mistakes

- *Outside Your Area of Competence*
- *Stress*
- *Rushing or Urgency*
- *Fixation on an Outcome*
- *Information Overload*
- *Group Think*
- *Presence of an “Authority.”*

# Avoiding Mistakes

- ***Outside Your Area of Competence***
- *Stress*
- *Rushing or Urgency*
- *Fixation on an Outcome*
- *Information Overload*
- *Group Think*
- *Presence of an “Authority.”*



# Avoiding Mistakes

- *Outside Your Area of Competence*
- **Stress**
- **Rushing or Urgency**
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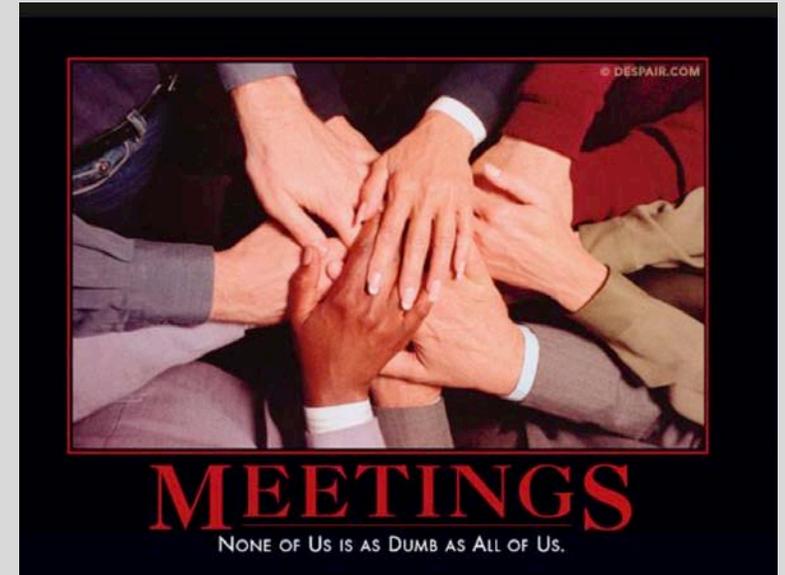
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# Avoiding Mistakes

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# Command

(a.k.a. Leadership)

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## Lessons We Don't Learn: A Study of the Lessons of Disasters, Why We Repeat Them, and How We Can Learn Them

Posted on July 2006

Amy Donahue and Robert Tuohy

**ABSTRACT:** Emergency responders intervene before and during disasters to save lives and property. The uncertainty and infrequency of disasters make it hard for responders to validate that their response strategies will be effective, however. As a result, emergency response organizations use processes for identifying and disseminating lessons in hopes that they and others will be able to learn from past experience and improve future responses. But the term "lessons learned" may be a misnomer. Anecdotal evidence suggests mistakes are repeated incident after incident. It appears that while identifying lessons is relatively straightforward, true learning is much harder – lessons tend to be isolated and perishable, rather than generalized and institutionalized. That we see problems persist is a serious concern; as emergency response missions expand to include broader homeland security responsibilities, the ability to capitalize on experience is ever more important. This article reports the results of a qualitative study of both the lessons themselves and the efficacy of the processes by which responders hope to learn them.

### SUGGESTED CITATION:

Donahue, Amy, and Robert Tuohy. "Lessons We Don't Learn: A Study of the Lessons of Disasters, Why We Repeat Them, and How We Can Learn Them." *Homeland Security Affairs* 2, Article 4 (July 2006). <https://www.hsaj.org/articles/167>



On February 23, 2006, in a press conference to release the White House report on lessons learned from Hurricane Katrina, Assistant to the President for Homeland Security and Counterterrorism Frances Townsend said "[The president] demanded that we find out the lessons, that we learn them and that we fix the problems, that we take every action to make sure America is safer, stronger and better prepared." The lessons Townsend called out in her briefing concerned planning, resource management, evacuation, situational awareness, communications, and coordination. No one in the emergency response community was surprised. We know these are the problem areas. We knew they would be before Katrina ever hit the Gulf coast. Why? Because we identify the same lessons again and again, incident after incident.

In fact, responders can readily predict the problems that will arise in a major incident and too often their predictions are borne out in practice. Even a casual observer can spot problems that recur: communications systems fail, command and control structures are fractured, resources are slow to be deployed. A quick perusal of the reports published after the major incidents of the past decade quickly shows this to be true. Consider the following:

*Hurricane Katrina, 2005* In terms of the management of the Federal response, our architecture of command and control mechanisms as well as our existing structure of plans did not serve us well. Command centers in the Department of Homeland Security (DHS) and elsewhere in the Federal government had unclear, and often overlapping, roles and responsibilities that were exposed as flawed during this disaster...This lack of coordination at the Federal headquarters-level reflected confusing organizational structures in the field...Furthermore, the JFO [Joint Field Office] staff and other deployed Federal personnel often lacked a working knowledge of NIMS [the National Incident Management System] or even a basic understanding of ICS [Incident Command System] principles.  
– From *The Federal Response to Hurricane Katrina Lessons Learned, 2006*: 52

*September 11 attack, 2001* It is a fair inference, given the differing situations in New York City and Northern Virginia, that the problems in command, control, and communications that occurred at both sites will likely recur in any emergency of similar scale. The task looking forward is to enable first responders to respond in a coordinated manner with the greatest possible awareness of the situation...Emergency response agencies nationwide should adopt the Incident Command System (ICS).When multiple agencies or multiple jurisdictions are involved, they should adopt a unified command. Both are proven frameworks for emergency response.  
– From *The 9/11 Commission Report, 2004*: 315, 397

*Oklahoma City bombing, 1995* The Integrated Emergency Management System (IEMS) and Incident Command System (ICS) were weakened early in the event due to the immediate response of numerous local, state and federal agencies, three separate locations of the Incident Command Post (ICP), within the first few hours, and the deployment of many Mobile Command Posts (MCPs), representing support agencies.  
– From *the After Action Report: Alfred P. Murrah Federal Building Bombing, 2003*: 3

*Hurricane Andrew, 1992* The Committee heard substantial testimony that the post-disaster response and recovery to Hurricane Andrew suffered from several problems, including: inadequate communication between levels of government concerning specific needs; lack of full awareness of supply inventories and agency capabilities; failure to have a single person in charge with a clear chain of command; and inability to cut through bureaucratic red tape.  
– From *the Governor's Disaster Planning and Response Review Committee Final Report, 1993*: 60

As these statements reveal, we repeatedly confront command and control issues in large incidents. These are but a few examples from dozens of reports that cite the need for sound command structures. Somehow, though, we fail to *learn* this and other crucial lessons that have been identified in after-action reports for decades. The central concerns of this paper are why that is so and how we can improve. We report here on an exploratory investigation that targets six research questions.

1. Is it true that lessons recur?
2. What lessons are persistently identified?
3. Why do these lessons continue to be identified as important?
4. Why are these lessons so hard to learn? (That is, why do agencies have difficulty devising and implementing corrective actions once lessons are identified?)
5. How do lessons-learned processes work?
6. How can they be improved?

We believe that by explicitly identifying persistent challenges, responders may be better attuned to these challenges and more able to address them in their planning and training processes. Likewise, by better understanding why these challenges remain unresolved, responders may be able to adapt their lessons-learned processes to better support behavioral change and improvement. To these ends, we have conducted a qualitative analysis of response organizations' perspectives on lessons and learning. The next section describes the context of emergency response learning. We then explain our investigative approach. Following that we present and discuss our findings about what lessons responders struggle with most and what learning approaches they use. We conclude with recommendations for improving these processes.

Lessons We Don't Learn: A Study of the Lessons of Disasters

Lessons Learned Issues	Anthrax Attacks	Columbia Recovery	Columbine	Hurricane Katrina	Oklahoma City Bombing	SARS	September 11th	Sniper Investigation
Communications			•	•	•		•	•
Leadership	•	•	•	•	•	•	•	•
Logistics	•	•		•	•	•	•	
Mental Health					•		•	•
Planning	•	•	•	•	•	•	•	•
Public Relations	•	•	•	•	•	•	•	•
Operations		•	•	•	•	•	•	•
Resource Management	•	•	•	•	•	•	•	•
Training & Exercises	•	•	•	•	•		•	

**Table 1: Common Categories of Lessons.**

Correlation between After Action Reports from selected major incidents and significant issues addressed.

“The failure to learn from the lessons starts with the leadership of and management of the organization.”

# Lessons Not Learned . . .

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*“In fact, responders can readily predict the problems that will arise in a major incident and too often their predictions are borne out in practice.*

*Even a casual observer can spot problems that recur: communications systems fail, command and control structures are fractured, resources are slow to be deployed.*

*A quick perusal of the reports published after the major incidents of the past decade quickly shows this to be true.”*

Lesson  
Repeatedly  
Identified

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Uncoordinated Leadership

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Failed Communications

---

Weak Planning

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Resources Constraints

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Poor Public Relations

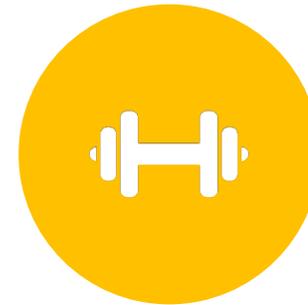
# Why Don't We Learn ?



MOTIVATIONS FOR  
CHANGE



LEARNING &  
TEACHING



EXERCISING (A.K.A.  
DOING!)

# Leadership – Pulse Nightclub (aka Command)

... during the first hour of the incident there was no one who assumed command outside the club to manage the overall operation as well as the staging and deployment of personnel and resources as they arrived on the scene.

Once the unified command center (UCC) was established, decision-making, strategies, and assignments were generally well coordinated and effective.

As the incident progressed, some agencies such as the Orlando Fire Department (OFD) established their own incident command posts, which negatively impacted information and resource sharing, coordination, and overall situational awareness.

MARJORY STONEMAN  
DOUGLAS HIGH SCHOOL  
PUBLIC SAFETY  
COMMISSION



# Parkland School Shooting

- One of the challenges of this investigation has been the numerous and diverse topics . . .
- With respect to law enforcement, the complicated Parkland 911 system, radio and other communications systems in Florida and Broward County; law enforcement policies; the law enforcement response itself on February 14, **including command and control; and access to information and data sharing among agencies were evaluated**, as well as medical response and aid rendered to MSDHS victims . . .
- Further contributing was the unsatisfactory law enforcement response, which includes the **flawed City of Parkland 911 system and the flawed and failed Broward County law enforcement radio system**. The Broward Sheriff's Office's inadequate active assailant response policy, the abysmal response by the school's SRO, a failed response by some law enforcement officers and supervisors and BSO's **flawed unified command and control of the scene** were also identified as areas that need to be addressed. [emphasis added]





# Leadership

- Nature – and organizations – abhor a vacuum
- Corollary: managing organizations during crisis requires leadership!
- If you don't provide the leadership, an “outsider” – somebody without the knowledge – will attempt to fill the vacuum

# Leadership

“The day the [staff] stop bringing you their problems is the day you stopped leading them. They have either lost confidence that you can help them or concluded that you do not care. Either case is a failure of leadership.”

*General Colin Powell*

“A leader is the man who has the ability to get other people to do what they don't want to do and like it.”

*President Harry S. Truman*



# Situational Awareness

## Perception

- Gathering Information

## Comprehension

- Understand / Interpret

## Projection

- Think Ahead / Anticipate Future

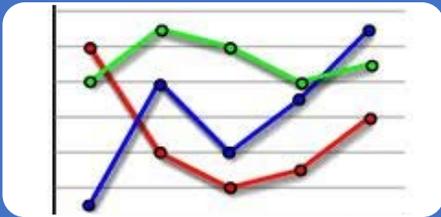
# Situational Awareness

Derived from: Endsley, M. (2000). Theoretical underpinnings of situation analysis: A critical review. In M. Endsley & D. Garland (Eds.), *Situation Awareness Analysis and Measurement*. Mahwah, NJ: Lawrence Erlbaum Associates.



## LEVEL I

- Identify Relevant Data



## LEVEL II

- 'Make Sense' of the Information



## LEVEL III

- Anticipate Future State

Situational Awareness

# Pattern Recognition – Conscious (Intentional)



- **Perceptual Recognition** – comparing incoming stimulus information with stored knowledge in order to categorize the information.

# Pattern Recognition – Unconscious (Gut Feeling)



- An ancient Greek statue was purchased by Getty Museum for just under \$10 million, after a 14 month investigation, concluded the thing was genuine.
- Three different art historians, upon each seeing the statue, sensed 1) somehow it lacked the “appropriate spirit”; 2) felt a wave of “intuitive repulsion”; and 3) believed it was “fake”.
- Further testing revealed the 14 month investigation failed to see what 3 experts saw in seconds – it was a forgery.

# News Feeds

- National & State Associations
- Professional Conferences
- Governmental Alerts / Feeds
- News aggregators
- Google Alerts

☆ FEMA (Federal Emergency Management Agency)  
FEMA Daily Operations Briefing for Sunday May 26, 2019  
To: Bruce J. Moeller Ph. D.,  
Reply-To: fema@service.govdelivery.com

**Significant Events:**

- Flooding & Tornado – Central U.S.

**Tropical Activity:**

- Atlantic: No significant activity affecting U.S. interests
- Eastern Pacific: Disturbance 1: Low (30%)
- Central Pacific: No significant activity affecting U.S. interests
- Western Pacific: No significant activity affecting U.S. interests

**Significant Weather:**

- Flooding - Central U.S.
- Critical and Elevated Fire Weather – AZ, NM and TX

**Declaration Activity:**

- Emergency Declaration Approved - Oklahoma
- Request for Emergency Declaration – Louisiana
- [FEMA Daily Ops Briefing 5-26-2019.pdf](#)



# Lessons Learned – Situational Awareness

Leadership must have a clear understanding of *what is happening . . .*

- If 'understanding' is not in place, you must proactively go get the information
  - Talk to those 'on the ground'
  - Verify what you are told / the perceptions that have been shared
  - Go assess the situation personally
  - Seek input from those that can 'make sense' of current conditions

You must prepare for *what is coming next . . .*

- Gain perspective on what others are thinking
- Talk with colleagues & peers (internal & external) regarding future events
- Talk with those to your North to seek their guidance and/or provide guidance to them



NIMS

# How Do You Prepare to Win ?

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# Strategy vs. Tactics

Strategy without tactics is  
the slowest route to  
victory.

Tactics without strategy is  
the noise before defeat.

*Sun Tzu*  
*The Art of War*

Strategy	Tactics
Why	How
Planning	Doing
Large-scale	Small-scale
Long Time-horizon	Short Time-horizon
Hard to replicate	Easy to copy



# National Incident Management System

*Third Edition  
October 2017*



**FEMA**

## Bringing Order to Chaos

---

### C. NIMS Guiding Principles

Incident management priorities include saving lives, stabilizing the incident, and protecting property and the environment. To achieve these priorities, incident personnel apply and implement NIMS components in accordance with the principles of flexibility, standardization, and unity of effort.

#### **Flexibility**

NIMS components are adaptable to any situation, from planned special events to routine local incidents to incidents involving interstate mutual aid or Federal assistance. Some incidents need multiagency, multijurisdictional, and/or multidisciplinary coordination. Flexibility allows NIMS to be scalable and, therefore, applicable for incidents that vary widely in terms of hazard, geography, demographics, climate, cultural, and organizational authorities.

#### **Standardization**

Standardization is essential to interoperability among multiple organizations in incident response. NIMS defines standard organizational structures that improve integration and connectivity among jurisdictions and organizations. NIMS defines standard practices that allow incident personnel to work together effectively and foster cohesion among the various organizations involved. NIMS also includes common terminology, which enables effective communication.

#### **Unity of Effort**

Unity of effort means coordinating activities among various organizations to achieve common objectives. Unity of effort enables organizations with specific jurisdictional responsibilities to support each other while maintaining their own authorities.

# Special Events



- July 4<sup>th</sup> Celebration
- Arts Festival
- Larger Sporting Events
- 1<sup>st</sup> Day of School
- Spring Break
- Graduations

## Special Events Contingency Planning

Job Aids Manual

*March 2005*



FEMA

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## Coordination in Crises: Implementation of the National Incident Management System by Surface Transportation Agencies

Posted on March 2017



by Nicholas B. Hambridge, Arnold M. Howitt, & David W. Giles

### Abstract

For more than a decade, the National Incident Management System (NIMS) has served in the United States as the mandated framework for coordinated organization, operational command, and implementation of response to emergencies nationwide. This article examines whether surface transportation agencies are developing the capabilities necessary to fit effectively into NIMS. It reviews the literature on NIMS, focusing on its implementation in "second and third circle responder"



# Unified Command

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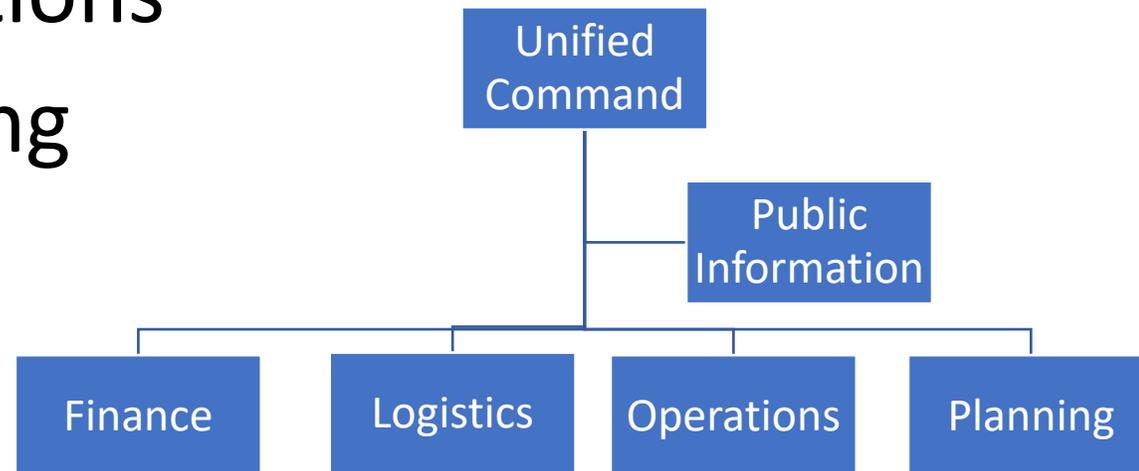
# National Incident Management System

Third Edition  
October 2017



# FLOP

- Finance
- Logistics
- Operations
- Planning



# Flexible Organizational Structure



Figure 1. Basic Incident Command System (ICS) Structure<sup>11</sup>

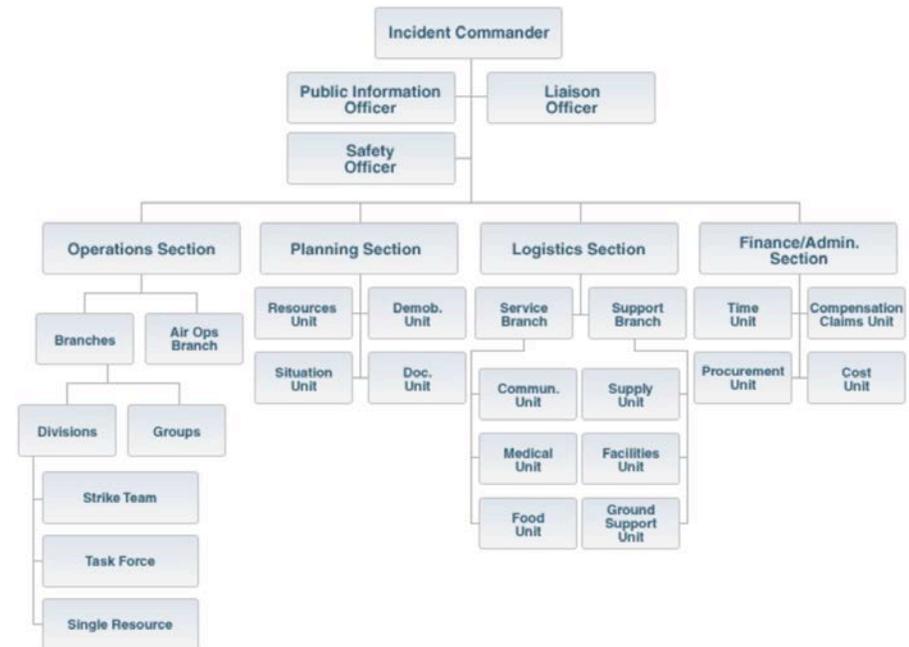


Figure 2. Expanded Incident Command System (ICS) Structure<sup>12</sup>

# Practice

“If you fail to plan, you are planning to fail.”

*Benjamin Franklin*

“Those who fail to learn from the past are doomed to repeat it.”

*Sir Winston Churchill*

The downloadable, fillable pdf forms available on this page have been modified to comply with the Section 508 requirement that website content be accessible to people with disabilities.

Description	Size	File Type
<b>ICS Forms</b>		
ICS Form 201_Incident Briefing (v3).pdf	131.1KB	.pdf
ICS Form 202_Incident Objectives (v3).pdf	57.4KB	.pdf
ICS Form 203_Organization Assignment List (v3).pdf	62.3KB	.pdf
ICS Form 204_Assignment List (v3).pdf	51.5KB	.pdf
ICS Form 205_Incident Radio Communications Plan (v3).pdf	61.1KB	.pdf
ICS Form 205A_Communications List (v3).pdf	58.9KB	.pdf
ICS Form 206_Medical Plan (v3).pdf	111.9KB	.pdf
ICS Form 207_Incident Organization Chart (v3).pdf	38.1KB	.pdf
ICS Form 208_Safety Message-Plan (v3).pdf	29.6KB	.pdf
ICS Form 208HM_Site Safety and Control Plan (v3).pdf	461.8KB	.pdf
ICS Form 209_Incident Status Summary (v3).pdf	307.5KB	.pdf
ICS Form 210_Resource Status Change (v3).pdf	78.1KB	.pdf
ICS Form 211_Incident Check-in List (v3).pdf	83.2KB	.pdf
ICS Form 213_General Message (v3).pdf	27.3KB	.pdf
ICS Form 213RR_Resource Request Message (v3).pdf	48.4KB	.pdf
ICS Form 214_Activity Log (v3).pdf	80KB	.pdf
ICS Form 215_Operational Planning Worksheet (v3).pdf	63.4KB	.pdf
ICS Form 215A_Incident Action Plan Safety Analysis (v3).pdf	40.4KB	.pdf
ICS Form 217A_Comm Resource Avail Worksheet (v3).pdf	187.9KB	.pdf



**ORGANIZATION ASSIGNMENT LIST (ICS 203)**

1. Incident Name:		2. Operational Period: Date From: _____ Date To: _____	
		Time From: _____ Time To: _____	
<b>3. Incident Commander(s) and Command Staff:</b>		<b>7. Operations Section:</b>	
ICM/CS		Chief	
		Deputy	
Deputy		Staging Area	
Safety Officer		Branch	
Public Info. Officer		Branch Director	
Liaison Officer		Deputy	
<b>4. Agency/Organization Representatives:</b>		Division/Group	
Agency/Organization	Name	Division/Group	
		Deputy	
		Division/Group	
		Deputy	
		Division/Group	
		Branch	
		Branch Director	
		Deputy	
<b>5. Planning Section:</b>		Division/Group	
Chief		Division/Group	
Deputy		Division/Group	
Resources Unit		Division/Group	
Situation Unit		Division/Group	
Documentation Unit		Branch	
Demobilization Unit		Branch Director	
Technical Specialist		Deputy	
		Division/Group	
		Division/Group	
		Division/Group	
<b>6. Logistics Section:</b>		Division/Group	
Chief		Division/Group	
Deputy		Air Operations Branch	
Support Branch		Air Ops Branch Dir	
Group			
Supply Unit			
Facilities Unit		<b>8. Finance/Administration Section:</b>	
Ground Support Unit		Chief	
Service Branch		Deputy	
Director		Time Unit	
Communications Unit		Procurement Unit	
Medical Unit		Comp/Claims Unit	
Food Unit		Cost Unit	
Prepared by: Name _____		Position/Title _____ Signature _____	
ICS 203		IAP Page _____ Date/Time: _____	

**INCIDENT OBJECTIVES (ICS 202)**

1. Incident Name:		2. Operational Period: Date From: _____ Date To: _____	
		Time From: _____ Time To: _____	
3. Objective(s):			
4. Operational Period Command Emphasis:			
General Situational Awareness			
5. Site Safety Plan Required? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Approved Site Safety Plan(s) Located at:			
6. Incident Action Plan (the items checked below are included in this Incident Action Plan):			
<input type="checkbox"/> ICS 203	<input type="checkbox"/> ICS 207	Other Attachments _____	
<input type="checkbox"/> ICS 204	<input type="checkbox"/> ICS 208	<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> ICS 205	<input type="checkbox"/> Map/Chart	<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> ICS 205A	<input type="checkbox"/> Weather Forecast/Tides/Currents	<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> ICS 206		<input type="checkbox"/> _____	<input type="checkbox"/> _____
7. Prepared by: Name _____		Position/Title _____ Signature _____	
ICS 202		IAP Page _____ Date/Time: _____	

# Lessons Learned – Leadership (a.k.a. Command; Control; NIMS)

## Staff must have clear expectations of how a 'crisis' will be managed

- Ensure a clear understanding of who has 'Command' – and what role each team member is playing
- Stay in your lane !!! Don't manage the event – manage the process
  - Keep everyone – including elected officials – in their lanes
- Ensure you have situational awareness
  - What information do we have?; what does it mean?; what do we anticipate?

## Integrating your 'command & control' expectations into frequent (?) routines will build 'muscle memory'

- Your 'system' must be Flexible, Standardized, and ensure a Unity of Effort
- Your system must be used in daily operations – or it will fail !
- Who are the SMEs (subject matter experts) – both internal & external

## Plan / anticipate the 'crisis's' your team must be adept in managing

- Undertake a community risk assessment
- Ensure the team has plans for the 'high risk' scenarios
- Provide the resources to train everyone – then train again !

Lesson  
Repeatedly  
Identified –  
Lessons  
Learned

Uncoordinated  
Leadership

Command

NIMS

Failed  
Communications

NIMS

Practice, practice, practice

Weak Planning

Situational Awareness

SMEs

Resources  
Constraints

Situational Awareness

SMEs

Poor Public  
Relations

## The Big 3

- Command
- Situational Awareness
- NIMS  
... or whatever system you need to use!



Bruce J. Moeller, PhD

