

# IMPLICATIONS

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- Communications Failures
- Situation Reports
- Organizing Using ICS
- Exercise
- Wrap-Up

## COMMUNICATIONS FAILURES

- We make the mistake of looking at disasters from after the event.
- “We screwed up here” describes the consequences of our decisions.
- Before the incident, consequences were often implied.
- We need to be better at understanding the implications of what we see and do.

## COMMS FAILURE

- A characteristic of EVERY disaster and most large-scale emergencies.
- Not just a characteristic, but a DEFINING characteristic.
- Often the first tipping point from a large emergency to a true disaster.
- Unrecognized as a tipping point.

## COMMS FAILURE

- How many types are there?
- Implication #1 – if we can't identify what is going wrong, we can't fix it.
- Implication #2 – if there is more than one type, fixing one might not fix the next.
- Implication #3 – Saying we can fix all communications failures may be setting us up for failure.

## DEFINITIONS

- Mode – the means by which we pass traffic.
- Information – a one-way flow of facts (and sometimes fiction)
- Communications – a two-way flow of information

# COMMUNICATIONS FAILURES

## Examples of Various Failures

### MODE FAILURES (mode doesn't work)

1. Equipment Failure / Damage – infrastructure damage
2. System overload – inability to get on frequency, get dial tone
3. No interoperability – unable to connect various modes
  - a. No transfer point – absolutely no connection between modes.
  - b. Inefficient transfer point – for example, a human operator
  - c. Encryption (no transfer point?)
4. Mode too slow – NTS messages are accurate but SLOW

### OPERATION ERRORS (mode does work)

5. System works but operator doesn't know how to work the equipment
6. System works, but nobody at other end (fax into a locked room)
7. System works, but person has left other end (turned off, coffee break)

### INFORMATION FAILURES (mode still works)

8. Information Incorrect
9. Information not received by appropriate
  - a. Person
  - b. Location
  - c. Organization
10. Information not received in time – time sensitive
11. Lack of information – unable to make good decisions
12. Information overload – unable to make good decisions

### HUMAN ERROR – THE TWO EARS PROBLEM

13. Information misunderstood – info correct but not heard
14. Information missed (listening to two radios)
15. Context missed – water and PowerBars example
16. Conflicting messages (multiple spokesperson)
17. Black hole problem – scope unknown.
18. Exaggeration or Under-Reporting
19. Over-sending Information – “Hey! If you see Bill...!”

## **IMPLICATIONS**

- While we recognize mode failure #1 (telephones / radios down), we miss most of the others.
- We fail to recognize mode failure in our own efforts (# 4 mode too slow)
- We may not be able to fix information errors
- We may not be able to fix all human errors

## **SITUATION REPORTS**

- A key source of information
- Keep everyone “on the same page”
- Communications fail – no situation reports during a major evacuation
- Communications fail – we don’t do it often enough
- Communications fail – we don’t have a structure to our sitreps

## **EMERGENCY PUBLIC WARNING & EMERGENCY PUBLIC INFO**

### **ACCURACY**

- Information will be incomplete and inaccurate at the start
- The situation will be constantly changing
- The disruption to the community creates tremendous information demand
- You will need to be concise and accurate

### **STANDARDIZED FORMAT**

- allows quick assembly of facts
- concise presentation
- identifies missing information
- allows quick verification
- allows fast creation of newspaper stories, warning messages, additional information

## **STANDARDIZED FORMAT**

- WHO
- WHAT
- WHEN
- WHERE
- WHY
- HOW

## **INITIAL FACTS**

- if not verified, use “initial reports”, “approximately”, “estimated”
- verification by asking “EXACTLY”
- addition of information as it comes in
- creation of multiple situation reports
- get authorization to release!

## **SITUATION REPORTS**

- We assume we know how to do it on the fly.
- Most are too long
- Given too rarely
- Implication: We waste time trying to create them.
- Implication: We waste valuable radio frequency trying to give them
- Implication: We don't have everyone on the same page because they are too rare

## ICS

- How many are trained in ICS?
- Group ICS versus Incident ICS
- ICS is more than just an organization chart.
- You must adopt ALL principles of ICS, not just the ones you like.
  
- ICS was specifically created for disasters.
- Unique in identifying EVERYTHING that went wrong, then trying to fix it.
- Unique in building a system rather than just fixing the problems
- Unique in lasting for nearly 40 years.
- Tweaks have generally not worked.

## WHAT DO WE NEED?

- In most events, what ICS positions do we need?
- Which one is filled first, which one is second, third, fourth, fifth...
- Setting the objectives
- Importance of spares

## SPARES

- A crisis for the organization if you don't have them.
- Temporary net control
- Safety
- Where do you place them?
  - Evacuation: Reception Centre
  - Mass Casualty: Hospital
  - Not sure: Frequency

# CREATING A BRIEF SITUATION REPORT

A situation report tells a story. Keep the story short and accurate.

The more accurate the report, the more people will have the right information to work with.

The shorter the report, the more often you can put it onto the air without interfering with other communications and messaging.

A short sit-rep can be used to speed up callout of members.

In addition to the key “Who, What, When, Where, Why and How”, include

- Your name / authority to establish credibility
- Safety message
- Objectives of your response
- Is the situation getting better or worse? Never say “It’s the same”
- If given on air, provide instructions for checking-in. For example, “If you are not immediately available, stand by for check-in at the half-hour”

Don’t mix the incident with the emergency response with the desired group response. Each of the three must be kept entirely separate.

Improve the report by redoing it using the additional word **“EXACTLY”**:  
Exactly who, EXACTLY where, exactly when...

If unable to verify information, use caution words such as “approximately”, “expected”, “initial reports”, “unverified”, “appears”

Spend the most time / detail on the desired group response, especially where, why and how.

This is: ARES Net Control VE6ACD

	INCIDENT	RESPONSE	ARES
WHO	Edmonton	Emergency Service	ARES members
WHAT	Tornado reported	Responding	Stand by / check in
WHEN	(NOW!)	(NOW!)	(NOW!)
WHERE	Millwoods	Millwoods / EOC	146.940
WHY		Possible casualties	Possible deployment
HOW			Clear family / work
			Grab & Go
			3 minutes

Our objectives are: Support the City of Edmonton EOC / Staff all trauma hospitals

Safety Message: Do not go to incident site unless ordered. Watch sky

Situation better / worse: At this point, with unknown casualties, the situation is worse.

This is:

	INCIDENT	RESPONSE	ARES
WHO			
WHAT			
WHEN			
WHERE			
WHY			
HOW			

Our objectives are:

Safety Message:

Situation better / worse



