

City of Seattle After Action Report Aurora Avenue Bus Collision



September 24, 2015



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I. Event Overview

On September 24, 2015 at approximately 11:00 AM Seattle Police and Fire Dispatch Centers began receiving calls about a collision between a charter bus and a Ride the Duck vehicle on the Aurora Bridge. Callers were reporting mass injuries and a complete blockage of the bridge. Seattle Fire activated their Mass Casualty Incident (MCI) Plan, deploying the MCI team who arrived at the scene 11:15 AM. Seattle Police arrived on scene to provide traffic control as the MCI team addressed the injured passengers.

Upon arriving at the scene, investigators learned the bus was chartered by North Seattle College's International Program and was carrying 45 students and staff, who were on their way into the city for a day of sightseeing. The Ride the Duck vehicle is an amphibious vehicle (originally used as landing craft by the U.S. military during WWII to deliver cargo from ships at sea directly to shore) that is operated by "Ride the Duck", a popular tourist attraction. While the number of passengers on the vehicle was never verified, it had a seating capacity of 38.

Soon after arriving, Seattle Fire noted that four passengers had been pronounced dead on the scene. Patients were transported to 7 hospitals and one urgent care center, with the most critical patients admitted to Harborview Medical Center (HMC), the area's Level I Trauma Center.

This event posed some unique circumstances that added to the level of complexity. Because the vast majority of individuals on the charter bus and a few on the Ride the Duck vehicle were foreign nationals, the State Department and various consulates became involved in the process. North Seattle College (NSC) was also a critical link in identifying and providing information regarding the students involved and making contact with families and friends. In total, the victims came from 14 different countries. English fluency and social support systems varied widely from person to person.

The National Transportation Safety Board (NTSB) was deployed because the two vehicles involved were commercial transportation vehicles. The NTSB has a legislative mandate to investigate accidents that have a significant impact on the public's confidence in highway transportation safety, generate high public interest and media attention, or highlight national safety issues. The NTSB also provides support to victims and their family members impacted by major transportation disasters.

1.1 EOC Objectives

The objectives of the Emergency Operations Center (EOC) focused on five (5) major themes:

- Patient Identification and Tracking
- Traffic Impacts
- Identifying and Providing Services to Support Victims and Families
- Multi-Agency Coordination
- Donations Management

Each of these themes will be reviewed in detail in the follow pages.

1.2 EOC Activity

The chart below captures a summary of EOC products including Consolidated Actions Plans (CAP), Situation Reports and Snapshot reports. It also reflects the Mayor's Emergency Executive Board meeting.

Emergency Operation Center (EOC) hours	EOC Activity Summary					
	Thursday	Friday	Saturday	Sunday	Monday	Total
	9/24/15	9/25/15	9/26/15	9/27/15	9/28/15	
	1130-2400	0000 – 1900	0800 – 1700	0800 – 1700	0800 – 1800	
Consolidated Action Plan (CAP)	1		1	1	1	4
Situation Reports		1			1	2
Snap Shot Reports	12	8	2	2	3	27
Emergency Executive Board Meeting	1					1
EOC Shifts Filled	66	76	29	26	30	227
Press Conference	2	2	1	1		6

1.3 EOC Responders

A total of 227 shifts were filled in the EOC over the 5-day activation by various departments and agencies. The planning cycle used in the EOC was to set operational objectives as the needs and focus of the event changed. Each Operational Period these were re-evaluated and changed to meet the current situational issues.

Departments and organizations represented in the EOC over the five day activation were:

City of Seattle Departments

- Seattle Fire
- Seattle Police
- Seattle Department of Transportation
- Seattle Human Services Department
- Office of Emergency Management
- Department of Planning & Development
- Mayor's Office
- Department of Information Technology
- Office of Immigrant and Refugee Affairs

- Office of Intergovernmental Relations
- Office of Economic Development
- Seattle City Light
- Seattle Public Utilities
- Finance & Administrative Services
- Law Department
- Seattle Public Libraries
- Northwest Healthcare Response Network
- American Red Cross
- U.S. Department of State
- The Washington State Governor's Office
- National Transportation Safety Board
- North Seattle College
- Seattle Colleges
- King County Office of Emergency Management
- Renton Office of Emergency Management

Partner Agencies

- King County Department of Transportation – Metro Transit
- Public Health - Seattle & King County

In total 227 shifts were filled during the activation. On average each shift represents 8 hours of work so over the course of the activation, city staff worked 1,816 hours. To calculate the cost to the city, an average hourly wage of \$40 was used. This rate was multiplied by 1,816, bringing the estimated cost of city staff time to \$72,640.

2. EOC Objectives

2.1 Patient Identification and Tracking

There were three objectives set on September 24th to identify where patients had been transported after they had been triaged. They were:

1. Establishing situational awareness including patient counts and location.
2. Reconcile the vehicle manifests from the Ride the Duck and charter bus vehicles.
3. Coordinate information between the scene and the Joint Information Center (JIC).

Identifying the passengers on the two vehicles and their status was a major priority in the early hours of the activation. This was complicated by the lack of a passenger manifest for the Ride the Duck vehicle, and a delay in getting the manifest of the Charter Bus to the scene.

The Ride the Duck vehicle did not have a passenger manifest, only a record of who had purchased tickets. There was no way to know who exactly was on the vehicle; thus, locating passengers was made even more difficult.



Seattle Fire Department MCI team providing treatment to passengers

While the Charter Bus did have a manifest there was confusion about who actually had the physical document, with the first responders thinking the College had it, while the College believed first responders found it leading to a delay in getting the information to the EOC. In addition, once EOC received the manifest, the College could not confirm its accuracy.

Further complicating response efforts were charter bus passengers who were initially released by EMS on scene. Upon returning to NSC from the Woodland Park Zoo where they gathered for rides back to the college, some students subsequently required medical assistance and were transported to area medical facilities. This added to the difficulty in compiling an accurate number of passengers involved in the accident.

As with most mass casualty incidents, the injured were transported to a number of different medical facilities. Decisions on patient destination were based on triage status and bed availability; in some cases this meant that victims of the same families were transported to different hospitals.

By 1:00 PM the Seattle Fire Department was able to provide a preliminary summary of the number and location of patient transports. They also confirmed that four passengers had been pronounced dead on the scene. The breakdown of medical facilities along with triage status provided by SFD was as follows:

With this information the EOC focused on Objective #2 – reconciling the vehicle manifests with the patient information. Critical to this was our partnership with the Northwest Healthcare Response Network (NWHRN), the region’s emergency preparedness and response healthcare coalition, and Public Health-Seattle & King County (PHSKC). WATrac, a state-wide online healthcare communication and resource tracking system, was an extremely helpful tool. One of the functions of the system allows for tracking of patients in mass casualty incidents. However in the greater Seattle area, the system had not yet been fully implemented. As a result, not all of the hospitals had taken the training that would allow them to use it. To address this, NWHRN worked with the healthcare facilities to implement “just in time” use of the patient tracking system to collect the needed information. Of the seven hospitals and one urgent care center receiving patients that day, half of the facilities, which had received prior training, populated patient information into WATrac themselves. NWHRN worked with the remaining healthcare facilities to coordinate essential patient tracking information and managed the WATrac data on their behalf. The strong partnership between the NWHRN and local healthcare facilities enabled effective information sharing between key partners, which were critical to ultimately identifying patient destinations. A call center was established with 2-1-1 on the first day to take some of the burden off the hospitals by sharing patient destination information from WATrac with family members and loved ones seeking information on victims.

Seattle Police Department played an important role in the days following the crash, reconciling and compiling the information from the vehicle manifests, WATrac and other victim information into one list. It is recommended they support this type of coordination in future events since missing persons and victim support is a role they play day-to-day.

As with any large incident the media was immediately on scene and began reporting. To this end, objective #3 - coordinating information between the scene and the Joint Information Center was critical.

The Mayor, along with the Fire and Police Chiefs and the Director of Seattle Department of Transportation responded to the scene to begin providing information to the media. Due to the large number of foreign nationals it was not only local media who were interested, but media from across the world. Providing consistent and accurate information especially in the early hours of the event was difficult due to some of the complexities outlined above.

During the After Action meetings it was brought up that there was some confusion on the part of the college regarding who was responsible for contacting and notifying the families of those students that had died, especially when the State Department and Consulates are involved. The Medical Examiner's Office is the designated death notification agency and they routinely coordinate notifications with consulates and the State Department when foreign nationals are involved. It is recommended that existing protocols and processes be followed during mass casualty events and the Medical Examiner is consulted if there are any questions regarding the notification process.

2.1.1 What worked well?

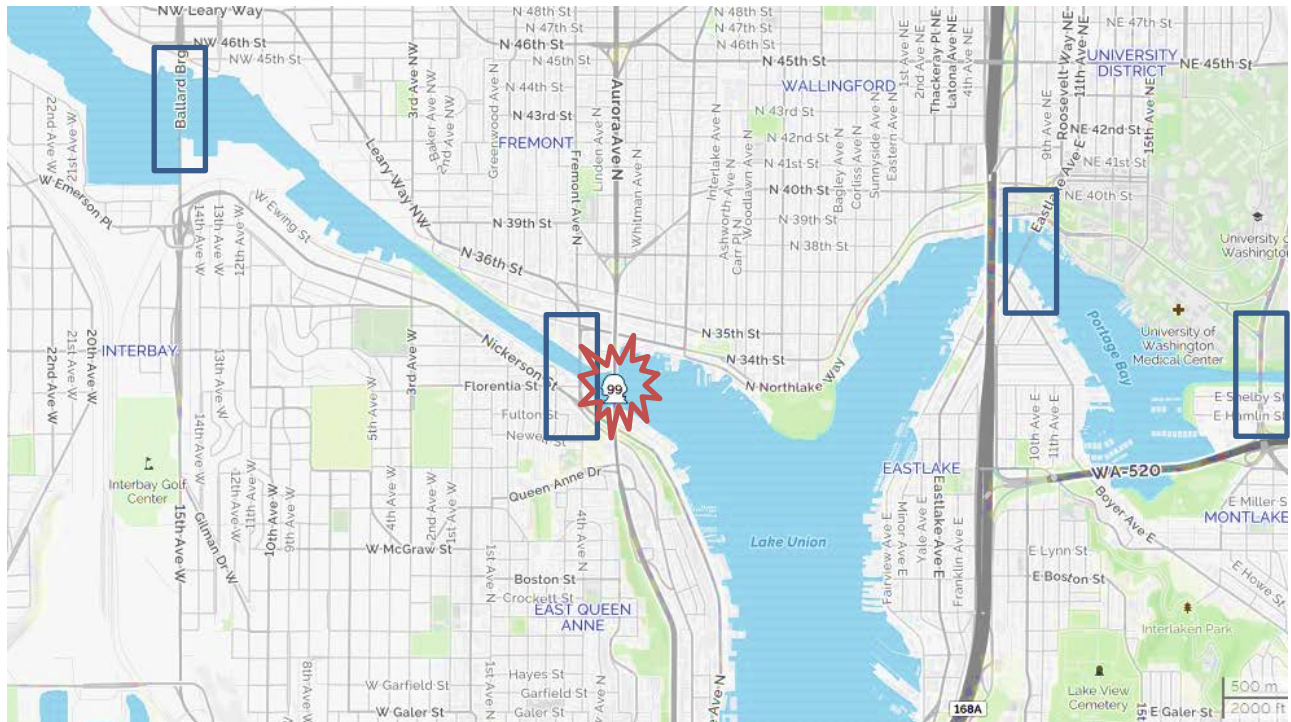
- Pre-existing relationships with Northwest Healthcare Response Network and Public Health-Seattle & King County were instrumental in obtaining and sharing information with and between regional healthcare organizations.
- Use of WATrac to assist in patient tracking. (Improvement Plan tracking number **I-014**)
- Information from Seattle Fire Department and Seattle Police Department during EOC stand up briefings.

2.1.2 What needs improvement?

- Hospitals were inundated with calls from City agencies/departments, consulates, media, and patient families. While well-intentioned, these information requests were often duplicative of other requests and consisted of unconfirmed caller/requester identification. Better coordination and synchronization of responding agency/department information requests is needed by the EOC, as well as a discussion of a single healthcare point of contact where appropriate. (Improvement plan tracking number **I-011**)
- The Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA) were not thoroughly understood by all agencies regarding what patient/student information can or cannot be shared among response partners. For example, the Office of Intergovernmental Relations sought patient information in order to notify consulates. (Improvement Plan tracking number **I-012**)
- Uninjured passengers from the bus were not provided transportation to a safe location. Many walked to Woodland Park Zoo, where staff from North Seattle College picked them up. When they arrived at the school, many needed medical care, so additional resources had to be deployed to assist. (Improvement Plan tracking number **I-009 & I-010**)
- Emergency contact information needs to be gathered and continually updated for permanent and advisory consulates in the Seattle area. (Improvement Plan tracking number **I-013**)

2.2 Transportation Impacts

Aurora Avenue is a major thoroughfare that runs north to south the entire length of the city. According to the Seattle Department of Transportation's *2014 Traffic Report*, the average week day traffic on Aurora Avenue N. is 37,950, making it one of the City's top 10 arterials by volume. The collision occurred on the bridge that connects the north end of the city to the central core. The map below shows the area, highlighting the bridges that span the waterway that connects Lake Washington to Puget Sound. One of the reasons this roadway is such a vital transportation route is that it is only one of two bridges that are not impacted by marine traffic (I-5 being the other). Because of the extent of the accident, it was clear very early in the event that this route would be shut down for a significant period of time.



Two objectives were established to address traffic impacts. They were:

- Establish alternate routes for the evening commute.
- Provide support to the accident investigation as needed.

Seattle Department of Transportation (SDOT), along with King County Metro immediately began developing a traffic plan to mitigate impacts of the road closure. At approximately 2:00 PM the Seattle Fire Department closed down the MCI operation and released the scene to the Seattle Police Department to begin the Accident Investigation. As the evening commute was approaching, the US Coast Guard (USCG) was contacted and agreed to establish a safety zone around the collision site, which kept the Fremont and Ballard Bridges closed to maritime traffic for six hours to facilitate traffic flow on the rerouted streets. SDOT also contacted construction companies that had projects on the north-south corridor of the traffic re-routes asking them to suspend their work and clear their equipment from the

road to, again, facilitate the flow of traffic during the evening commute. Lighting cycles were re-programmed to keep traffic moving at a steady pace. The EOC Joint Information Center sent messages through a variety of traditional and social media outlets informing the public about the re-routes and requesting patience in their commute home. In addition, the new public notification system, AlertSeattle was used to send messages to those individuals who opted in, providing ongoing

information about the road closures.



Aerial view of the Aurora Bridge following crash of vehicles

As the accident investigation process came to a close, the EOC began planning for clearing the roadway, ensuring the structural integrity of the bridge was not compromised, finding an adequate storage facility for the two vehicles and establishing a route to the facility that accommodated the oversized vehicles. All of this was accomplished and the street re-opened

by 11:00 PM. The vehicles were taken to the Seattle Public Utilities site at the former Sunny Jim factory to await the arrival of the NTSB who were scheduled to arrive in Seattle on September 25th.

2.2.1 What worked well?

- Following Incident Command System (ICS) within the agencies.
- Close partnerships between SDOT, King County Metro and WSDOT.
- Good communication to inform public.
- Requesting that USCG establish “safety zone” to keep the bridges down during evening commute.

2.2.2 What needs improvement?

- It was challenging through the first evening of the event (and outside of normal business hours) to find a facility capable of providing secure, covered, heated, lit space for the vehicles to be stored for investigation purposes. (Improvement Plan tracking number **I-018**)

2.3 Identifying and providing services to victims and family

There were nine objectives established over the five day activation that addressed identifying and providing services to victims and their families. They were as follows:

1. Stand up a 24-hour Call Center for patient information.
2. Account for all victims and their arriving families.
3. Enlist the support of Consulates.
4. Support the needs of the Consulates.
5. Ensure the needs of patients and families are identified and met, including translation and survivor assistance.
6. Establish and support a Family Services Center (FSC).
7. Coordinate the return of personal belongings left at the accident scene.
8. Address how to repatriate remains and who pays for it.
9. Transition from Family Services Center to Case Management services provided by the Salvation Army.

Early in the activation it was clear that identifying and providing services for the victims and their families would require coordination with a number of regional and federal agencies. With the number of foreign nationals involved in the accident, families from across the world were coming into Seattle to be with their loved ones. The countries of origin represented were as follows:

- Austria
- Brazil
- China
- Germany
- Indonesia
- Japan
- Korea
- Kyrgyzstan
- Netherlands
- Saudi Arabia
- Switzerland
- Taiwan
- United Kingdom
- United States
- Vietnam



Early in the activation Office of Intergovernmental Affairs created a Passenger Information Sheet that was distributed to the Consulates, family members, hospitals, and others who were coming into contact with passengers. The information sheet was updated regularly and providing important information about such things as insurance, reclaiming personal property and key contact numbers.

The Port of Seattle was enlisted on the first day to provide a family care program; they met family members at their arrival gate at Sea-Tac Airport, assisted them in getting their bags, made sure there were language and interpretation services available, helped them through customs, and provided transportation to hotel or hospitals. Both Delta and Alaska Airlines provided flights at no charge for family members and the Seattle Hotel Association quickly identified hotels close to area hospitals that

could accommodate family members (many of these rooms were provided free of charge) as they arrived. Much of this work would continue throughout the week-end with the help of the NTSB's Family Support Team, who arrived in Seattle on 9/25/15.

North Seattle College was overwhelmed with requests from media, students, and family members. Immediately the EOC reached out to the University of Washington and Seattle Pacific University, both of whom have very robust Emergency Management programs to offer support and guidance.

Because of the number of different languages spoken, the Office of Immigrant and Refugee Affairs (OIRA) was instrumental in identifying interpretation and translation services, contacted and confirmed that the identified interpreters would be on-call to address needs that could arise over the next few days. While they did an outstanding job, it was clear that in a bigger event, the current capacity would be quickly overwhelmed.

This allowed the Joint Information Center to have their messages announcing the number for families to call regarding the incident translated into seven (7) languages. These translations were then posted on the City of Seattle website. Throughout the activation providing information in a variety of languages and securing interpreting services for family members remained a high priority.

Public Health-Seattle & King County coordinated with 211 to establish a call-in line that could provide information regarding the victims and their hospital location to families and loved ones. The Call Center line was activated at 4:00 PM Thursday, September 24th and stayed in place through 8:00 AM Saturday, September 26th. The Call Center phone number was disseminated through the Joint Information Center. A total of 75 calls were received during the time it was operational, including international calls. The Call Center Line was closed when the call volume no longer necessitated 211 staffing a call center line.

The Family Service Center was located in the Washington State Convention Center and operated Saturday & Sunday, (9/26 – 9/27) from 8:00 AM to 8:00 PM and Monday, (9/28) from 10:00 AM – 4:00 PM. Due to our pre-existing relationship with the Convention Center the EOC was able to secure the site when several other locations had turned down the request. Public Health-Seattle & King County staffed the center on Saturday and Sunday. Seattle Human Services Department took over staffing on Monday, 9/28. Over the course of the weekend four people visited the center (one person was representing two (2) different families from the same country). Having a fixed location that was not situated closely to the hospitals may have contributed to the low number of people accessing the FSC. Additionally a phone line was set up at the FSC and switched to at night to a number that was staffed by an EOC responder.



Woman pauses to honor the victims

North Seattle College set up a “comfort center” on their campus for students and family members to meet and provide support to each other. Executive level staff members from the City were on site to

answer questions regarding the event and provide support to personnel from the college, who were also dealing with personal losses based on their relationships with the students.

The Consulates played an important role in providing information and access to the family members who were arriving to care for their loved ones. Seattle Office of Intergovernmental Relations (OIR) did a good job coordinating with the identified consulates to ensure that our response was addressing the actual needs and that our approach was culturally sensitive. This also extended to the State Department and the Governor's Office. OIR is required to make contact with consulates when a death of one of their citizens occurs in Seattle. Consulates are helpful in arranging for notifications and services for their constituents while they are in the United States, in coordination with the Medical Examiner's Office. OIR had some difficulty in contacting some consulates, especially those that do not have a permanent consulate in the City. This was also complicated when the foreign national did not want the assistance of the Consulate and the varying degrees of authority that Advisory Consuls have.

While the overall work with consulates and the State department were very positive there was some confusion about the role each had, especially in regards to death notifications. Day-to-day notifications occur in coordination with the State Department, Consulates and Medical Examiner's Office.

Repatriation of the victim's remains was necessary and details including payment needed to be worked out. It was determined that the insurance company covering the students would cover the cost, as long as the families worked through the Insurance Company's designated provider. NTSB provided guidance



Memorial at the crash site

and the Medical Examiner's Office followed established protocol for processing the remains and provided information on the funeral homes that can support repatriation. Since individuals began processing what had occurred; calls began to come in regarding how to get personal property that was left on the vehicles back. The loss of personal cell phones was especially troublesome to many of the victims. Office of Economic Development in coordination with NSC identified a foundation that could receive funds to buy phones. Finance & Administrative Services (FAS) also worked to identify vendors that could get phones programmed (including the ability to make

international calls) and ready for distribution. For this population of victims, cell phones were the one link they had to contacting their families in their home countries. Our increased reliance on cell phones makes losing them a much more impactful issue than it was just a few years ago. Recognizing that in events such as this, the need to find cell phones will oftentimes present as a major priority for individuals.

The Seattle Police Department (SPD) took pictures of all the property that was taken from the vehicles and the accident scene allowing victims and their families to look through what was in the property room prior to making a trip down to pick up belongs. SPD also staffed the property room with additional officers to ensure that families who came down to pick up belongs did not have an inordinate wait. Some commented that when people arrived at the Evidence Section they were put off by the "bars and

security” and that some of the photographed property had been destroyed because of bio-hazard contamination.

2.3.1 What worked well?

1. Pre-existing relationships with 211 and their ability to rapidly set up a call in number.
2. Using multiple media outlets to publicize the call in number.
3. The NTSB Family Assistance Team members were very helpful.
4. PHSKC early identification of need for Family Services and taking the lead to establish.
5. Relationship with Northwest Healthcare Response Network.
6. Various agencies contributing to a Victim tracking list that was maintained by OIR.
7. OIRA reach out to Community Based Organizations (CBO) to assist in translations.
8. Having photos of property for families to look at prior to traveling to property room.

2.3.2 What needs improvement?

1. Grow our capacity to locate qualified interpreters and translators and provide crisis intervention training to those who may be called upon to respond. (Improvement Plan tracking number **I-017**)
2. Explore options for delivering family services outside of one centralized location. Options include a virtual FSC and healthcare sites. (Improvement Plan tracking number **I-016**)
3. Logistics needs to be involved in discussions about resource needs and purchasing from the beginning. (Improvement Plan tracking number **I-015**)
4. Decision about the level of services the City is going to extend and if there is external funding available to assist.
5. Emphasize at the EOC briefings the importance of using the WebEOC resource request forms and processes. (Improvement Plan tracking number **I-027**)
6. Follow established Medical Examiner’s Office protocols for death notifications for foreign nationals.
7. There was confusion and hesitation in properly ordering supplies and services necessary to provide logistical support to the operation and disaster relief services for the survivors and families. (Improvement Plan tracking number **I-024**)
8. There was a delay in acquiring Low Org and Project Activity Codes. (Improvement Plan tracking number **I-028**)
9. Operations Section was requesting resources verbally, however not documenting the request in WebEOC. This created an administrative workload for Logistics to document the request. (Improvement Plan tracking number **I-027**)

2.4 Multi-Agency Coordination

There were a large number of agencies responding to a variety of issues throughout the event. Coordination between all became a very important component of the overall management of the event. There were five objectives established that were used to help achieve this coordination. They were:

1. Provide resource support to North Seattle College by establishing a multi-departmental city team to be available at the college over the weekend to provide communication and coordination.
2. Coordinate with the NTSB Disaster Assistance Division to ensure additional resources are made available to victims.
3. Coordinate public information with the NTSB, North Seattle College and all healthcare organizations to ensure messages are uniform and consistent.
4. Coordinate information sharing between healthcare organizations, Consulates, Family Service Center and those impacted by the collision.
5. Identify and coordinate long-term storage for the vehicles involved in the collision.

This event created some unique challenges and opportunities in terms of multi-agency coordination. Representatives from Federal, State, and local organizations were all part of the EOC activation. North Seattle College was overwhelmed in the immediate aftermath of the collision and the City offered the support of several executive level city staff to assist them. This took the form of physically locating these staff members at the college, providing guidance and access to city services.

The NTSB's Disaster Assistance Team provided a level of expertise and understanding that was invaluable to the EOC. They were able to provide timely and concise information regarding the NTSB processes and provide information to the passengers and their families. Because they have very specific protocols, it was mentioned that it would have been helpful to have an idea of what they would be doing and need prior to their arrival.



National Transportation Safety Board investigators at work

Sharing information and developing a coordinated public message is one of the major priorities of the EOC. The Joint Information Center (JIC) becomes the hub of that coordination and because of the complex nature of this incident and the multi-agency response, the JIC was activated immediately. Throughout the course of the five days they supported the various agencies in regards to public messaging which was consistent and assessable to all. Overall the coordination between players was very good.

Finding long term storage for the two vehicles that were involved in the collision proved to be somewhat challenging. Because of their size the options for where they would be stored were limited. It was noted that there was no centralized directory that provided storage facilities (either owned by the

city or privately) with dimensions for garage entrances and ceiling heights. Because of this sites that were being considered required that staff respond to take measurements to ensure that once the vehicles arrived they could actually get them into the facility. This ultimately slowed the clearing of the roadway as the vehicles could not be moved until an adequate storage facility was located.

2.4.1 What worked well?

1. Multi-Agency coordination is practiced and part of the routine business practices of the EOC.
2. NTSB expertise and collaboration.
3. Key department and agencies were in the same room solving problems together.
4. Having City Staff at North Seattle College.
5. Well defined missions with Mayoral support.
6. Standing up a call center in the early hours of the activation.
7. Having a Fire Department representative at Harborview Medical Center's Disaster Medical Control Center.
8. Ongoing coordination following demobilization of the EOC.

2.4.2 What needs improvement?

1. More consistent communications between North Seattle College and the EOC. (Improvement Plan tracking number **I-021**)
2. Lack of understanding of insurance issues. (Improvement Plan tracking number **I-023**)
3. Start searching for long term storage early in the incident and establish a database that provides storage options with building dimensions included. (Improvement Plan tracking number **I-018**)
4. Establish Memorandum of Understandings (MOU's) with vendors prior to the incident (Improvement Plan tracking number **I-019**)
5. Some in the EOC were unaware of the services the Office of Intergovernmental Relations can play in an emergency. (Improvement Plan tracking number **I-022**)



Ride the Duck vehicle being loaded on tow truck

2.5 Donations Management



Managing donations for disasters, big and small, is always a challenge. Knowing this the Office of Emergency Management has worked to establish partnerships with agencies such as the United

Way of King County, as well as a city policy that allows City of Seattle employees to donate the cash value of unused vacation time to disasters that have been approved by City leaders. In this event, donation management was identified early in the activation as something that needed to be addressed sooner rather than later. On the first day of the activation, the following objectives were established:

1. Establish an on-going non-profit agency to collect donations.
2. Establish an ongoing donations management procedure through non-profit partners.
3. Utilize Seattle Shares for city employees to make donations.

Donations were made through a number of different agencies. United Way of King County agreed to act as the on-going nonprofit recipient agency and the Mayor urged the community to make donations to support the victims of this incident. A Seattle Shares Campaign was approved which allowed city employees to donate the cash value of a portion of their unused vacation time. North Seattle College received a donation from Real Networks within 24 hours of the collision. The Foundation for Seattle Colleges also accepted donations on behalf of the students involved in the accident. The following table shows the final accounting for financial donations made to support the victims in this collision.

Agency	# of Donations	Donation Amount
Seattle Shares	80	\$16,987
United Way	84	\$24,310
Foundation for Seattle Colleges	61	\$5,904
North Seattle College (Ed Fund)	1 Real Networks	\$10,000
Total		\$57,201

It is important to note that the table above only reflects the monetary donations; much credit needs to be given to the Office of Economic Development, the Finance and Administrative Services Department, and the Human Services Department who were instrumental in working with their established partners. The following chart highlights the in-kind donations made as a result of the outreach done by OED:

Company	Donation	Estimated value
T Mobile	10 Cell Phones + Service	\$4,304
Seattle Hotel Association	Rooms from 16 local hotels	\$4,000
Delta Airlines	Airfare	
Alaska Airlines	Airfare	
Various Businesses	Gift Cards	
	Total	

2.5.1 What worked well?

1. Pre-existing relationship with United Way King County.
2. Identifying early in the activation the need to have objectives addressing donation management.
3. Using Seattle Shares to allow city employees to donate.
4. OED's relationships with Hotel and Airline Companies; FAS relationship with cell phone providers.
5. Money donated early by Real Networks.

2.5.1 What needs improvement?

1. In-kind donations in addition to cash contributions (i.e. eyeglasses) were not systematically well managed. (Improvement Plan tracking number **I-020**)
2. Managing the data regarding donations in a large scale event.
3. Review of the draft Donations Management Plan in light of this event. (Improvement Plan tracking number **I-020**)

3. Demobilization and Follow up

The EOC began preparing to demobilize on Monday, September 28th with an agreement that OEM would host a daily conference call to address the remaining issues associated with the incident. At the time of demobilization three objectives remained, they were:

1. Continue to provide support to survivors and victims and their families.
2. Implement Donations Management Process.
3. Complete plan for long-term storage for both vehicles involved in crash.

Daily conference calls continued throughout the week of September 28th. By Friday, October 2nd, Objective #2 and #3 had been completed and Objective #1 was being coordinated by the Case Management Task Force. It was agreed that the daily conference calls would be replaced with a weekly conference call.

The conference calls continued through the week of October 23rd when it was agreed that the City had completed all of the outstanding issues that remained. The Case Management Taskforce would continue to host weekly conference calls through November 18, 2015.

4. Case Management Task Force

Over the course of the EOC Activation, it was clear that a number of passengers would need ongoing support as they recovered from their injuries. Among the services identified were, airline flights for families who had not yet made it to the area to support their injured family members; hotel rooms for the families in the area; transportation, ongoing support at the airport as families arrived; interpretation services; and for those who had more serious injuries, long-term housing as their loved ones moved from a hospital to a rehab facility. It was clear as the EOC demobilized that some passengers would require inpatient care and ongoing support for an extended period. Establishing a case management system would be the best means to help support both the injured and their families.

In a meeting with a number of community based organizations, The Salvation Army (TSA) offered and was selected to take on the case management responsibilities with the support of several community based organizations.

Seattle Human Services Department (HSD) served as the liaison and overall point of coordination to the TSA. A case management task force was formed to support TSA's case management efforts. Aside from the City representatives from HSD and OEM, other task force members included representatives from North Seattle College, American Red Cross, Catholic Community Services, & Asian Counselling and Referral Service. The task force convened weekly via phone to provide updates.

Case management services were extended to all who were involved in the accident, as well as another chartered bus from North Seattle College that witnessed the accident. TSA set up an office on the campus of North Seattle College to provide more accessibility to students. Services were restricted to needs related to the accident. Because of privacy issues required by TSA, the City was not involved in service delivery or individual outcomes of the case management process.

Case management costs were initially absorbed the TSA, with the understanding that a memorandum of agreement would be signed between TSA and United Way, allowing the United Way to transfer donations, which would then be used to support the case management services. North Seattle College also received donations to their foundation for support. They worked directly with TSA to use the funds in the manner the donors designated.

4.1 Case Management Activity

The following table shows the current number of individuals still receiving in-patient rehabilitative services as of November 17, 2015. The official case management task force held its last conference call on November 18, 2015, however a monthly report will be done by the Human Services Department until all of the remaining 3 patients have been released from rehab facilities.

Client Status	NSC Students	Ducks	Totals/Comments	
			#	Countries
Hospital	0	0	0	
Rehab Facility	3*	0	3	Japan (1) Vietnam (1), Brazil (1) 11/9:UK (Ducks) removed from count, declined TSA services and was anticipated to have been discharged
Totals	3	0	3	2 families remain in the area -(1 family with student in rehab, 1 family with out-patient rehab student)

Case Management Activity	# of Individuals Served (Includes duplicated services)							Total
	Oct 1-7	Oct 8-12	Oct 13-15	Oct 16-22	Oct 23-Nov 2	Nov 3-10	Nov 11-17	
Week								
#Client Interviews	17	13	8	16	17	9	4	84
Cases Opened	14	5	3	0	0	1		23
Cases Closed	0	0	0	0				0
Referrals to other agencies	41	63	9	14	0	4		131
Individuals assisted	49	17	12	23	24	9	5	139

4.2 Services Provided

The following table represents the case management services the Salvation Army provided to individuals who were involved in the Aurora Bridge Bus Crash from October 1, 2015 through November 17, 2015. Due to privacy issues not all of the services provided by TSA are reflected. These numbers do not reflect services that were provided prior to the Salvation Army taking on case management responsibilities or services provided through other community based organizations.

Case Management Services provided 10-1-15 through 11-17-15		
Prepared Meals (hot & cold)		8
Vouchers provided		
	Gift Cards / Debit Cards	57
	Groceries	4
	Housing (rent/mortgage)	2
	Short term lodging	1
	Transportation	108
Emotional & Spiritual Care		
	Spiritual Care (prayer)	149
	Mental Health Care (CISM)	304
	Memorial Services	3
Nights of Lodging (includes long term leases)		292
	Extended Stay Hotel	1
	Apartment Lease	2
In-Kind Distribution		
	Comfort Kits	50
	Clothing (estimated value)	\$50
	Furniture (estimated value)	\$3,000
	Groceries/Food boxes (estimated value)	\$300

5. After Action Survey

Each time the City activates the Emergency Operations Center, we have an opportunity to test our plans, protocols and tools. The nature of this event, a no-notice, mass casualty, multi-agency response, provided us with a number of challenges.

Immediately following the demobilization of the EOC, OEM staff sent out an After Action Survey to all of the people who responded to the EOC over the course of the five days. The survey asked respondents to rate how well they felt the objectives of the operational period(s) they worked in the EOC were met. A five point scale was provided with **1 being Objective Met and 5 being the Objective was not met.**

The following table shows the average rating for the overarching objectives identified in the overview of the event. They are:

Objective Area	Average rating
Locating and accounting for passengers	2.21
Traffic Management	1.43
Identifying and providing services to support victims and families	1.77
Multi-Agency Coordination	1.82
Donations Management	1.62

A summary of the full survey results can be found in Attachment 1.

In addition to the survey, two after action meetings were held to receive input from those who responded to the incident. Participants were asked to provide information about what they thought worked well during the activation and what we needed to improve upon for future events. Those answers, along with the survey results were incorporated into the review of each of the objective areas.

Lastly, the NTSB responders were unable to attend any of the in-person after action meetings, so OEM hosted a conference call to debrief the incident. The NTSB responders specifically complimented Seattle on several aspects of the activation. Included in those were:

- The decision to activate the EOC and stay activated after the Life/Safety issues and traffic impacts had been resolved. They noted that often EOC's are shut down too early in the process and the multi-agency coordination is hampered by this decision.
- Accounting for victims is always a difficult task in these types of incidents. Despite this, they felt that Seattle was able to accomplish this in a relatively quick timeframe.

- The interagency coordination was noted as a critical factor that made their jobs much easier. They were impressed with the openness with which they were met. In past deployments they stated that it is not uncommon for jurisdictions to see their presence as a nuisance or being intrusive. They were impressed with the collaboration they experienced.
- They specifically called out the manner in which the personal effects were managed and the care that was taken in returning them.
- The idea of setting up a Family Support Center was a good idea, even though they noted that FSC are not always fully utilized depending on the type of event.

6. Improvement Plan

Several Areas of improvement were identified through the survey and two in-person After-Action meetings. The following improvement plan highlights action items that have been identified and assigned to specific departments or Emergency Support Function for follow up.

Tracking Number	Issue Overview	Proposed Action	Dept./Lead	Due Date
I-001	Individuals from outside the City, working in the EOC, cannot access the Seattle-EOC account limiting their ability to take on certain tasks.	Revisit the feasibility of changing the set up to a position specific rather than individual with Department of Information Technology.	OEM – TJ McDonald	11/30/2015
I-002	Auxiliary Communication Services (ACS) volunteers are being asked to support EOC operations both in the Planning and Administration Sections. Need for additional training and formal process for obtaining the training.	Liaison with Mark Sheppard to identify interest and training needs	OEM – Ken Neafcy	12/1/2015
		Develop and distribute survey seeking input on the types of positions ACS and EOC support team are interested in for planning and admin sections.	OEM – Ken Neafcy	12/1/2015
		Develop skill requirements, interview process, and assessment criteria necessary for individual to be assigned a position.	OEM – Ken Neafcy	1/6/2016
		Develop training for those interested in identified positions.	OEM – Ken Neafcy	2/28/2016
1-003	Planning Section staffing should allow for OEM staff assigned to planning table to take a more prominent role in facilitation and problem solving around specific issues that arise during activation.	Provide additional training on facilitation and the expectations associated with the OEM facilitation during activations. Each staff member will be provided a facilitation opportunity.	OEM – Laurel Nelson	1/4/2016
		Provide 15 minute skill building exercises for SDO training to enhance facilitation skills.	OEM – Laurel Nelson	Ongoing through 2016
		Tie to IP #003 to provide additional staffing at the planning table.	OEM – Laurel Nelson	2/28/2016

I-004	The Consolidated Action Plan format cumbersome and there was a lack of clarity about what should be included in the CAP (i.e. organizational charts.) Discussed alternative formats that might make it easier to produce CAP.	Provide a list of recommendations for alternative formats that can be used for the CAP. Included in the recommendations should be an analysis of the benefits and challenges along with a ranking of the options.	OEM – Operations Coordinator	12/15/2015
		Present the recommendations to Planning, Operations, Exercises & Training Team for their action.	OEM – Operations Coordinator	1/4/2016
I-005	There were a number of people responding to the EOC that had no experience or any training. Someone had to walk them through setting up a WebEOC account, logging in and other basics. There is a written protocol that might not have been shared with all responding to the EOC.	Develop a list of topics that individuals typically need assistance with when they respond to EOC.	OEM – Operations Coordinator	12/4/2015
		Identify ways that orientation/training for those topic areas could be provided (assign to watch someone sitting at same table, etc.).	OEM – Operations Coordinator	12/4/2015
		Update EOC Activation checklist adding task directing that hard copies of the WebEOC User Guide are put out on all tables at the beginning of all activations.	OEM – Operations Coordinator	12/4/2015
		Assign more people (possibly ACS) to Admin Section and assign "concierge" to assist at next activation.	OEM – Operations Coordinator	Complete
I-006	need phone chargers for the EOC	Purchase spare charging cords and have them available in EOC	OEM – Operations Coordinator	12/11/15
I-007	Signing in and out of EOC was inconsistent	Add item to Administration Section Chief Checklist reminding people to log in at beginning of shift.	OEM – Operations Coordinator	12/4/15
		Add item to Administration Section Chief to create and put signs around EOC reminding people to sign in.	OEM – Operations Coordinator	12/4/15
I-008	No way to send AlertSeattle from the EOC User computers using standard sign-in	Remind Staff Duty Officers' about the emergency login site that can be used from EOC.	OEM – Cathy Wenderoth	Complete

		Test the login from the EOC floor when doing the weekly notification test of AlertSeattle.	OEM – Cathy Wenderoth	Complete
I-009	Students not injured in the accident self-evacuated to Woodland Park Zoo, where they were met by NSC staff, who took them back to college.	Develop protocol for first responders to provide safe spot to stage "uninjured" victims while arrangements are being made to have transportation brought to them. (i.e. metro bus, sheltered area)	Planning Operations, Exercise & Training (POET) & Fire	12/11/15
I-010	Some students brought back to the college because they were not initially injured ended up needing medical assistance. Also some students needed mental health support.	Set up a secondary triage station to make sure that "green" patients do not decompensate prior to releasing them from the scene. Provide resources to help them process the event.	POET & Fire	12/11/15
I-011	Hospitals were inundated with requests for information on patient status and ongoing coordination regarding patient and family needs patients from City agencies & departments, consulates, media, families.	Review any relevant City plans as necessary. Discuss at SWG and Disaster Management Committee opportunities for better EOC coordination on information requests and how information can be streamlined.	NWHRN, PHSKC, SWG	DMC Meeting in 2016
I-012	The Health Insurance Portability and Accountability Act (HIPAA) was not thoroughly understood by all agencies regarding what patient information can or cannot be shared among response partners.	Develop a job aid on HIPAA to be included in EOC procedures manual. Work through SWG to define access and how information will be obtained	PHSKC, Seattle City Attorney, NWHRN, OEM	12/11/15
	FERPA - which protects students (+18) information also was not fully understood	Provide training to the same group of individuals on the regulations regarding FERPA. Keep a reference document in the EOC outlining important information learned in the training. Work through SWG to define access and how information will be obtained	Seattle Colleges, OEM	DMC training in 2016
I-013	OIR needed to make contact with permanent and advisory consulates after ordinary business hours	Emergency contact information needs to be gathered and continually updated for permanent and advisory consulates in the Seattle area.	OIR/Carlton Vann	12/15/15

I-014	WATrac was an effective patient tracking tool; it is important to note WATrac is only a piece of the overall victim accounting and family reunification process.	Facilitate a more detailed discussion regarding sharing patient information with appropriate response partners. Work through SWG to define access and how information will be obtained.	NWHRN, OEM, PHSKC	Completed See in I-012
I-015	There was confusion and hesitation in properly ordering supplies and services necessary to provide logistical support to the operation and disaster relief services for the survivors and families.	Include Logistics Section Chief in setting EOC objectives and clearly identify (if only preliminary advice) city authorization of funding.	OEM	Complete
I-016	The Family Services Center may have been more effective in offering support services had it been located somewhere else or offered virtually.	Explore both the concept of and delivery of services to families following a mass casualty event than just one centralized location.	ESF-6 & ESF-8	SWG meeting 12/14/15
I-017	While the Office of Immigrant and Refugee Affairs did a great job finding and providing translators and interpreters, there were not enough people to meet the need. We need to grow the capacity for larger events that affect more people and have a way to identify level of proficiency each person has.	OIRA's current work plan includes the development of a strategy for language assistance.	OIRA	
I-018	It was challenging through the first evening of the event (and outside of normal business hours) to find a facility capable of providing secure, covered, heated, lit space for the vehicles to be stored for investigation purposes.	Develop an inventory of facilities that could be used for various purposes and create a database of storage facilities that includes the building size, door dimensions and other facility information.	ESF-7	End of 2016

I-019	North Seattle College deeply appreciated Woodland Park Zoo's willingness to use their property as a staging area for College staff and students involved in the accident who were not in need of EMS transport. Memoranda of Agreement would benefit the City with organizations such as the Zoo	Develop MOA's with Woodland Park Zoo and the Department of Defense for the use of Fort Lawton.	ESF-7	End of 2016
I-020	In-kind donations in addition to cash contributions (example: eye glasses) were not systematically well managed. The City's Donation Management Plan was not trained upon at the time of the event and therefore not used.	Develop a concept of operations to deal with in-kind donations; identification/assignment of a team, process, checklist and tracking mechanism. Review Donations Management Plan to ensure any needed changes are incorporated.	ESF-7	End of 2016
I-021	North Seattle College was unfamiliar with how the City's Joint Information Center worked and may have assigned their PIO to the Center had they known.	Explain the JIC concept to the college district who can share that with the other local colleges.	OEM	Complete
I-022	Some representatives in the EOC were unaware of the services the Office of Intergovernmental Relations can play in an Emergency.	Schedule a presentation about OIR's services for the Disaster Management Committee.	OEM – Laurel Nelson	DMC Meeting in 2016
I-023	Questions regarding insurance issues that were not easily answered	Invite a representative from the Insurance Commissioner's Office in the EOC when dealing with complex insurance related issues	OEM	Complete

I-024	There was confusion and hesitation in properly ordering supplies and services necessary to provide logistical support to the operation and disaster relief services for the survivors and families.	Convene an interdepartmental group to develop policy guidelines and document directions for; 1. When it is appropriate for City funds to be used; 2. What the criteria or thresholds should be for use of those funds; 3. Where the expenditures will come from; and 4. Outlining the accepted method for tracking and accounting for the expenditures.	OEM – Erika Lund & CBO	1/20/16
I-027	Operations Section was requesting resources verbally, however not documenting the request in WebEOC. This created an administrative workload for Logistics to document the request.	Refresher training for using WebEOC should be provided annually. Instructions at the beginning of the incident should include communicating to EOC command to use the Resource Request for, and just-in-time training should be provided to new personnel responding to the EOC.	OEM – Ken Neafcy	Include in WebEOC training scheduled in January 2016
I-028	There was a delay in acquiring Low Org and Project Activity Codes	At the onset of an incident, contact Director's Office to obtain appropriate Low Org and Project Activity Code to be used. Document appropriate procedures and include in ESF-7 Annex.	ESF-7	1/20/16

7. Conclusion

This event provided EOC responders an excellent opportunity to practice many of our processes and plans in a very demanding environment. Coming on the heels of the Chinese Presidential visit and amidst a National Accreditation process, the activation stretched many of the responders and OEM staff.

In true Seattle fashion, the community stepped up to the challenge presented by this event. From the Canlis Restaurant serving meals to first responders on scene, to the generous donations made by the airlines, hotels, service providers, city employees and the community at large, this incident reinforced that we live in a compassionate and caring community.

This activation has forged new partnerships with the National Transportation Safety Board, local Consulates, and the State Department, as well as strengthened existing ones. We have identified areas that we need to improve, but overall the services provided over the course of the activation and the ongoing case management services were well planned, coordinated and implemented.

The Office of Emergency Management will continue to monitor and support the work yet to be done to ensure that action items identified are completed and our EOC responders are provided with training and practice to make sure that we improve in the areas we identified.

For information regarding this report or any ongoing activities please feel free to contact the Office of Emergency Management at 206-233-5076 or email us at Seattle-EOC@seattle.gov.

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Attachment 1

Summary of After Action Survey

Seattle OEM distributed a survey to everyone who responded to the EOC throughout the five days. The survey went out to over 150 individuals with 40 of those responding.

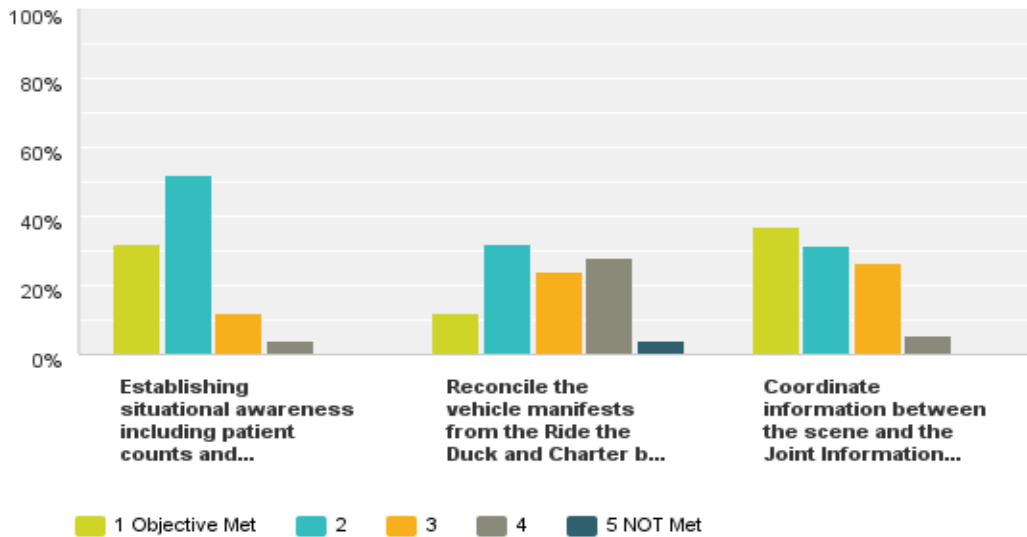
The following summary provides an overview of the survey results. The comments reflect individual responses. It was not uncommon to find that individuals had different perspectives on the same issue with responses to “what worked well” and “what needed improvement” sometimes containing the same answer.

The survey is organized around the five themes outlined at the beginning of the report. It also contains a question regarding the new City Notification System AlertSeattle.

Theme 1 – Patient Identification and Location

Q6 Over the course of the activation, the identification and tracking of individuals who were on the two vehicles was a major objective. On a scale of 1 -5 (1=met objectives; 5=did not meet objectives) please rate how well the following objectives were accomplished.

Answered: 31 Skipped: 6



Objective	Rating 1=met/5=not met
Establishing Situational awareness including patient counts and transportation destination	1.93
Reconcile the vehicle manifests from the Ride the Duck & Charter Bus with patient information received from the hospitals	2.78
Coordinate information between the scene and the Joint Information Center (JIC)	2.00
Average	2.21

Comments:

On Scene Information

Worked Well

- Manifests that were provided by college and bus company
- SFD reporting of patient transportation information at EOC briefings

- Unified Command of Fire, Police, SDOT and AMR

Need Improvement

- Getting information regarding riders on both vehicles was very difficult some ideas include
 - Requiring all riders of public transportation to have ID on their person & full double check manifests at boarding
 - Require manifests for all multi-passenger vehicles
 - Corrected manifests physically on the vehicles
- Better sharing of information and who is doing what
- Transportation for students with minor injuries and those not injured back to the college. Students had to walk to Woodland Park Zoo and picked up by NSC employees in their personal vehicles.

Patient & Hospital Information

Worked Well

- One representative from each hospital
- NWHRN ability to access hospital personnel and provide information. Having NWHRN in the EOC to help streamline the process of identifying patients.
- WATRAC
- Utilizing social workers at hospital (HMC specifically mentioned)
- HMC Situational awareness outstanding

Need Improvement

- Hospitals have point person identifying patients and providing that to a central contact point.
- HIPAA & FERPA:
 - Understanding of the legal requirements under HIPAA and whether they are applicable in emergency situations.
 - Non-healthcare responders need an orientation on the rules about releasing patient information
 - Understanding of FERPA (Federal Educational Rights and Privacy Acts)
- Tracking needs to include everyone, not just the injured.
- Relying on Hospital social workers and manifests is information collected at scene and can that be shared?

Coordinate information between Scene and JIC

Worked Well

- Having Fire, Police & SDOT representative in EOC to communicate the situation
- Regular emails between the Family Services Center and the EOC updating Information

Need Improvement

- Report out on all patients, media only reporting out on HMC numbers
- Lack of communication between EOC and the college on “the list”
- Use of SharePoint so mobile devices could have worked

Other

Worked Well

- Being able to refer reporters to the appropriate hospital and ME’s contacts for information

- SPD id outstanding job at victim accounting

Need Improvement

- Closer coordination with Hospitals and Medical Examiner: pre-emptive outreach to these groups to establish protocols
- Efforts to track family members, next of kin, etc., went way beyond what is reasonable to expect in these situations. Hospitals and ME have a way to collect and do that, we shouldn't expect this to be centrally tracked in EOC
- Having Subject Matter Experts in HIPAA and FERPA available
- Training for College and improved cooperation between the parties that had the information

Use of Pre-existing documents, processes and/or partnerships

80% of respondents indicated they used some type of pre-existing document, process or partnership to help them achieve this objective. They included:

- WATrac
- Pre-existing professional contacts
- Northwest Healthcare Response Network

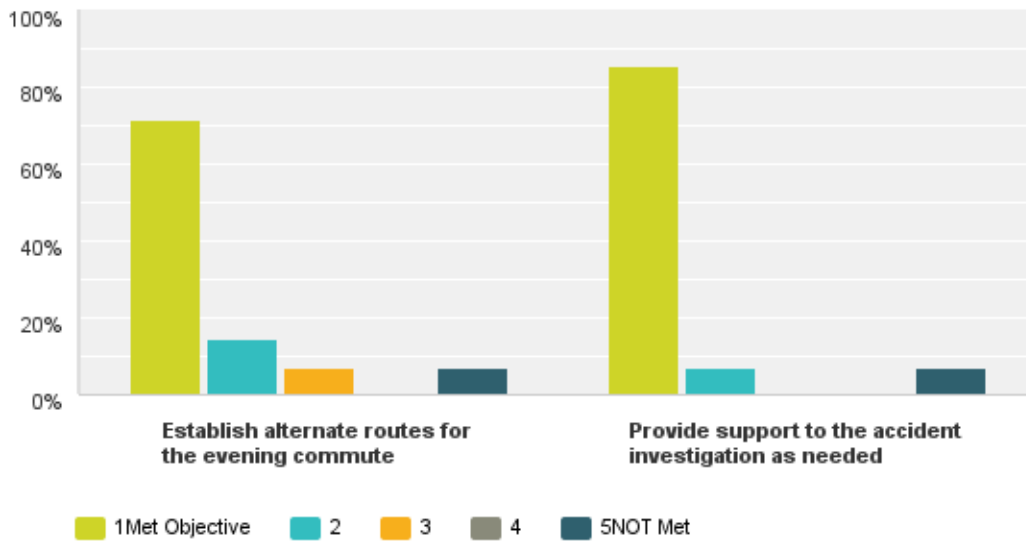
Respondents were asked what types of documents, processes and/or partnerships would have helped, answers included:

- Emergency contact list for consulates
- Contact list for hospital social workers
- Accurate information on HIPAA and FERPA
- Master Victim Accounting list

Theme 2 – Traffic Management

Q12 This event created a major traffic disruption that extended into the evening commute. On a scale of 1 to 5 (1=met objectives; 5=did NOT meet objectives), please rate how well the following objectives related to traffic management were met.

Answered: 31 Skipped: 6



Objective	Rating 1=met/5=not met
Establish alternate routes for the evening commute	1.53
Provide support to the accident investigation	1.33
Average	1.43

Comments

Establishing Alternate Routes

Worked Well

- Following ICS within the agencies and rapid communication
- EOC did a good job working with partners to ensure other bridges were kept open during evening commute
- Alter system worked well to redirect traffic to different routes
- The work done by SDOT, Metro and requests from Fire Department made a huge difference in getting routes set up quickly

- Close partnership with SDOT, Metro and WSDOT

Need Improvement

- Divert traffic father away from the incident
- AlertSeattle messages didn't identify detour routes

Communicating Alternate Routes

Worked Well

- Broadly announced through all media
- AlertSeattle message
- SDOT active on Twitter

Need Improvement

- Alert Seattle notifications got a little excessive
- Greater advertising that the route was closed and what alternate routes were suggested
- Better communication that on board GPS systems might not be reliable

Other

Need Improvement

- There was significant delay in obtaining the information on the vehicles involved in the accident, hindering the removal of the vehicles off the roadway. To improve efficiency, early in the investigation phase the following information should be obtained and shared with those stakeholders involved with removing the vehicles: Year, make model, dimensions, investigation requirements for towing, and specific hazardous conditions to note.

Pre-existing Documents, Processes and/or Partnerships

40% of survey respondents indicated they used pre-existing documents, processes and/or partnerships to help them achieve this objective. They were:

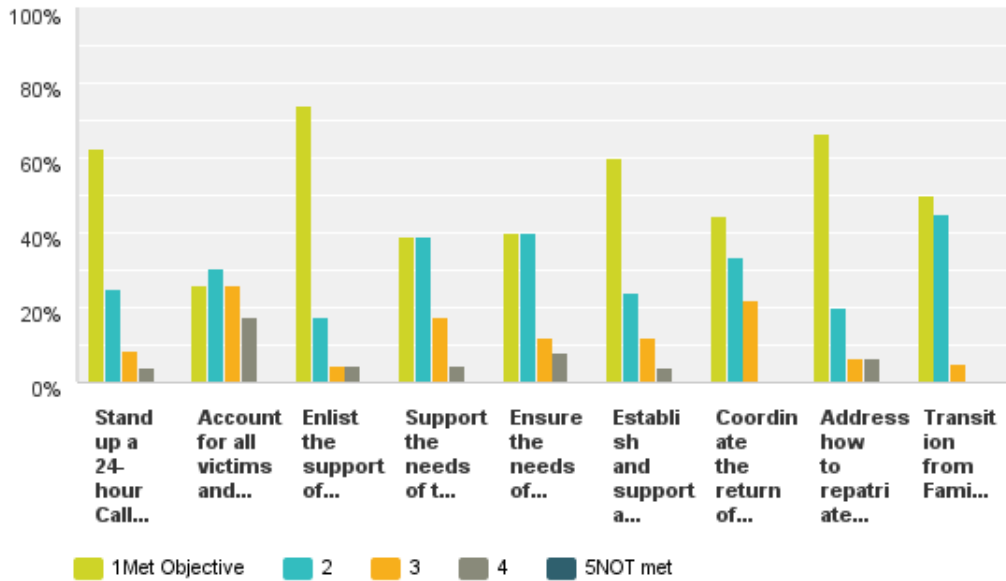
- Three person taskforce to develop bus re-route strategy
- Use of blanket contracts for towing
- AlertSeattle Management Team

There was no identified document, process or partnership listed that would have improved the ability to meet this objective.

Theme 3 – Identifying and providing Services

Q18 Throughout the activation there were a number of objectives that focused on identifying and meeting the needs of the people involved in the collision and coordinating service delivery for family members. On a scale of 1 to 5 (1=met objective; 5=did NOT meet objective) please rate how well the following objectives related to victim needs were accomplished.

Answered: 27 Skipped: 10



Objective	Rating 1=met/5=not met
Stand up a 24 hour Call Center for patient information	1.56
Account for all victims and their arriving families	2.38
Enlist the support of Consulates	1.44
Support the needs of the Consulates	1.92
Ensure the needs of patients & families are identified and met, including translation and survivor assistance	1.92
Establish and support a Family Services Center	1.65

Objective	Rating 1=met/5=not met
Coordinate the return of personal belongings left at the accident scene	1.78
Address how to repatriate remains and who pays for it	1.88
Transition from Family Services Center to Case Management services provided by the Salvation Army	1.55
Average	1.77

Comments

Setting up 24-hour Call Center

Worked Well:

- Pre-existing relationship with 211 and their ability to rapidly set up a number
- Broadcasting both 211 and the North Seattle College numbers via multiple media systems

Need Improvement

- While people responded to make this happen there was a concern about having adequate staffing and capabilities. This seemed like not the best time to try to figure out how people would be found to staff a line and who was going to financially support the service.
- Establishing triggers both for when to establish call center (possibly tie to SFD MCI call out protocol) and when to transition from a 24-hour operation.
- Identify what department should be taking “after hours” call
- Translation issues need to be identified early in the process

Accounting for all victims and their families

Worked Well

- Excel spreadsheet produced by OIR
- WATrac System
- Working with a smaller group of “can-do” individuals
- OIR’s coordination with ESF 6 partners

Need Improvement

- Getting access to the manifest early in the process
- Streamline the process
- Establish protocol that makes it easier to get information from hospitals in emergency situations
- Assign to proper authority (law enforcement)
- Remember to maintain contact with the “uninjured”

Enlist Support of Consulates

Worked Well

- OIR did a great job
- Medical Examiner provided high level of service to consulates for deceased foreign nationals
- Good Partnership with State Department

Need Improvement

- Need contact information for all consulates/honorary consulates in Seattle and add to AlertSeattle system
- More education for responders on roles/protocols of Consulates and State Department for incidents involving foreign nationals
- More education on Consulate process of working with families

Establishing and operating a Family Service Center

Worked Well

- Public Health taking lead and establishing the Center
- City's relationship with Washington State Convention Center
- American Red Cross's flexibility and creativity in meeting the need for Disaster Mental Health services

Need Improvement

- Location – Families didn't want to go to off-site location to get information
 - Consider setting up at hospitals and/or hotels
 - Did physical location need to be established – could have continued to provide services through phone
 - All the services needed to be offered at site and managed by City of Seattle
- Establish clarity of roles and responsibilities with regards to this service
- Pre-existing MOU's with locations that might be used
- Transferring to HSD on Sunday night put extra strain on Health and Human Services Branch

Identifying needs and coordinating services

Worked Well

- Tactical planning in EOC
- Proactive outreach to community service providers
- Information sheet for families

Need Improvement

- Identify missions early in the process
- There was a disconnect between the hospitals and EOC, should leverage hospital social workers and provide a central point of contact for them
- Logistics not always included in securing resources
- Need for system or spreadsheet for tracking services

Repatriating remains

Worked Well

- Having a single entity work on this issue
- Medical Examiner's Office was quick & responsive
- OIR, CAO and State Department worked well together

Need Improvement

- Fact sheet of issues would have helped
- Better system to coordinate with ME's office so that bodies are not released until we know which funeral home to use as provided by insurance company

Coordination of return of personal belongings

Worked well

- Having photos of the items
- SPD did a great job

Need Improvement

Consider co-locating with Family Service Center

Transition from Family Service Center to Case Management

Worked Well

- Case management continued throughout process with FSC being one of the outreach mechanisms

Need Improvement

- Establish triggers for transitioning from FSC to a phone line

Other

Worked Well

- Utilizing the Salvation Army for ongoing Disaster Case Management, the early concept of this was excellent and process done at record speed.

Need Improvement

- Identify early on who was paying for services being requested for families and victims
- Establish standard protocols for involvement of tour bus company, Ride the Duck and other transportation providers would be helpful

Use of Pre-existing documents, processes and/or partnerships

68% of survey responders indicated they used some type of pre-existing document, process or partnership to help them reach this objective. Included in those were:

- The Mass Fatality Plan
- Pre-existing relationships with hospital social workers
- Professional contacts with the Consular Corps.
- Blanket Contracts
- American Red Cross guidelines and forms
- WATrac
- Crisis Clinic MFI/FAC plans

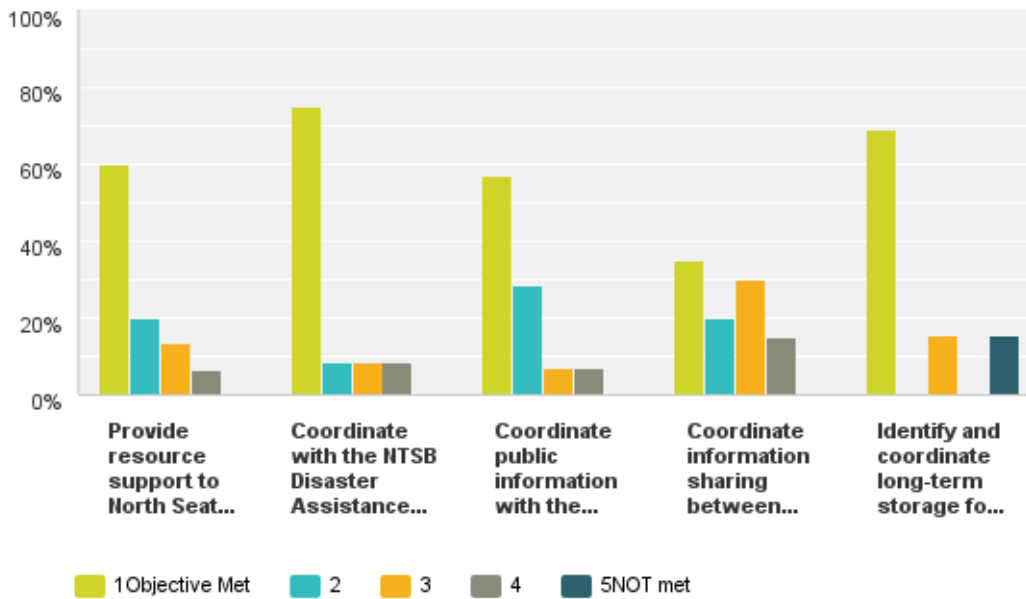
Response to the question about what plans, processes or partnerships would have been helpful included:

- Disaster Assistance Center Plan
- Better coordination with Medical Examiner's Office and Funeral Homes
- MOU with Washington State Convention Cent
- Citywide Disaster Assistance Service Center Plan

Theme 4 – Multi-Agency Coordination

Q24 This event required coordination across city, county, state and federal agencies. On a scale of 1 to 5 (1=met objectives; 5=objective not met) please rate how well the following objectives pertaining to multi-agency coordination were met.

Answered: 26 Skipped: 11



Objective	Rating 1=met/5=not met
Provide resource support to North Seattle College (NSC) by establishing a multi-departmental city team to review and assist in implementing their response plan	1.67
Coordinate with the NTSB Disaster Assistance Division to ensure additional resources are made available to victims	1.54
Coordinate public information with the NTSB, NSC and all hospitals to ensure messages are uniform and consistent	1.64
Coordinate information sharing between Hospitals, Consulates, Family Service Center and those impacted by the collision	2.29
Identify and coordinate long term storage for vehicles involved in the collision	1.92
Average	1.82

Comments

Support and Coordinate with North Seattle College

Worked Well

- Quick response when NSC got overwhelmed

Need Improvement

- Regular update meetings would have helped
- Having consistent contact from NSC

Support to NTSB Victim Support Team

Worked Well

- Great to have them in the EOC
- NTSB expertise and perspective was very helpful
- NTSB vital part of the EOC Team

Need Improvement

- NTSB could provide a “to-do” list to impacted jurisdiction so they can begin working as soon as NTSB has made a decision to activate.

Coordination to ensure public messaging is consistent

Worked Well

- Clear messages
- Mayor’s Office communications team was regularly briefed

Need improvement

- None listed

Coordinate information sharing

Worked Well

- Updates to the Consulates

Need Improvement

- Healthcare overwhelmed with requests. A single or smaller number of organizations should act as liaison(s) to healthcare partners.

Identifying and coordination of long term storage

Worked well

- SPD, SDOT, Metro and FAS were all in the same room together

Need Improvement

- Start process earlier in the day, by the time process was started many people that were needed to be contacted had already gone home
- Precise measurements were to slow to come
- Move back to “normal” operations sooner rather than later, allows for City Departments who handle these things routinely to do their job, rather than a groups that does not have the history.

- There is a lack of covered warehousing and storage options available for long term storage. Set up a MOU with Army National Guard in the interim for use of Fort Lawton

Other

Worked Well

None listed

Need Improvement

- Additional training for those new to the EOC
- Clear understanding at the department level about who are the designated EOC responders and the responsibilities associated with that
- Ongoing training for EOC responders

Use of Pre-existing documents, process and/or partnerships

50% of survey respondents indicated they used some type of pre-existing document, process or partnership to help them reach this objective. Included in those were:

- NWHRN Healthcare Emergency Coordination Center
- EOC 101 and login/remote access training documents
- Seattle Disaster Case Management Draft Plan
- HMAC liaison protocol

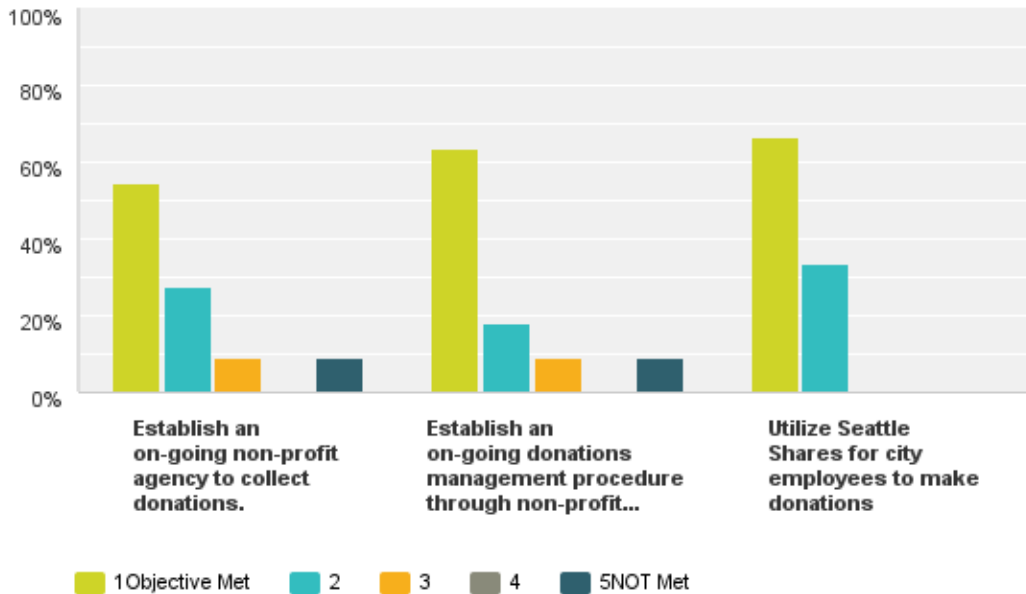
Response to the question about what plans, processes or partnerships would have been helpful included:

- Database for City-owned building with room and door dimensions
- Vertical clearances under bridges (SDOT is currently working with WSDOT to develop)
- Emergency contact list for Consulates

Theme 5 – Donations Management

Q30 This event generated offers of money, services, and "things" to assist those impacted. On a scale of 1 to 5 (1=objective met; 5=objective not met) please rate how well the following objectives were met in regards to donations management.

Answered: 24 Skipped: 13



Objective	Rating 1=met/5=not met
Establish an on-going non-profit agency to collect donations	1.82
Establish an on-going donations management procedure through non-profit partners	1.73
Utilize Seattle Shares for city employees to make donations	1.33
Average	1.62

Comments

Establish ongoing non-profit agency to collect donations

Worked Well

- Relationship with United Way King County
- Addressing this early in the process

Need Improvement

- Move forward with setting up MOU with United Way

Establish an ongoing non-profit donations management process through non-profit

Worked Well

- None listed

Need Improvement

- Identify appropriate non-profits to support different aspects of the donation management process
- Set up MOU's for non-profits in coordination with King County Emergency Management

Utilize Seattle Shares

Worked Well

- Good to offer way for City employees to donate
- Human Resources does a great job managing

Need Improvement

- Send out more than one message about how to donate

Other

Worked Well

- None listed

Need Improvement

- Is this an appropriate role for the City to take on?
- Did donations process follow the existing plan or was it created during the response?

Use of Pre-existing documents, process and/or partnerships

16% of survey respondents indicated they used some type of pre-existing document, process or partnership to help them reach this objective. Included in those were:

- Established relationship with United Way and Seattle Shares
- Draft of the Seattle Disaster Case Management Plan

There were no responses to the question about what plans, processes or partnerships would have been helpful.

AlertSeattle Notification

52% of the respondents received an AlertSeattle notification about this event. Of those all found the notification to be helpful

When responders were asked if they saw opportunities to use AlertSeattle in ways that were not taken in this event 38% responded yes. Included in those responses were:

- Notification to response partners that Seattle EOC was activated.
- The notifications seemed a little too 'generic' (especially when we had already used "Major Traffic Disruption" multiple times over the previous two days). Also, including an estimated duration might be helpful (even if it is "More than x hours / days").
- Maybe traffic alerts/notifications. Is it possible to do limited alerts to the consular corps through AlertSeattle? If so, it would help.
- If an alert was not sent, this would have been a good opportunity to use the system.

- It could have been used to share that traffic was going to be rerouted off of the Aurora bridge for a long time.
- Initial use of AlertSeattle to notify EOC support teams
- Perhaps traffic re-routing notifications?

Other Comments:

- Computers in the EOC are slow and some do not work, need updating
- Resource request process needs to be reviewed by all, consider adding an Administrative position to all the Operational Branches
- Consider computer needs when setting up Family Service Center. Convention Center was difficult to get computers up and running.