

FINDINGS

“HURRICANE KATRINA: A NATION STILL UNPREPARED”

EMERGENCY MANAGEMENT ALONG THE GULF COAST: FEDERAL, STATE AND LOCAL – LOUISIANA

1. First responders in Louisiana played an indispensable role in the response to Katrina.
2. The Louisiana state government failed to provide sufficient resources to the Louisiana Office of Homeland Security and Emergency Preparedness (LOHSEP). Its planning, preparedness and response to Katrina suffered as a result.
3. The Louisiana Office of Homeland Security and Emergency Preparedness failed to ensure that state agencies adequately understood their emergency-response obligations.

EMERGENCY MANAGEMENT ON THE GULF COAST: STATE AND LOCAL – MISSISSIPPI

4. First responders in Mississippi played an indispensable role in the response to Katrina.
5. Mississippi's use of the EMAC interstate mutual-aid arrangement was vital to its response to Hurricane Katrina.
6. Many residents found shelter conditions quite difficult because of shortages of food and water and sanitation problems. Though their challenges regarding mass care were formidable, state and local governments and the American Red Cross could have prepared better for a catastrophic disaster on the scale of Hurricane Katrina. In addition, state and local governments in Mississippi could have been better prepared to shelter the special needs population on the Mississippi Gulf Coast.

HURRICANE PAM: KATRINA IS PREDICTED

7. Hurricane Pam was an elaborate planning exercise that anticipated many of the challenges of responding to Katrina.
8. Hurricane Pam and other planning exercises put federal, state and local officials on notice of the potential consequences of a hurricane of the magnitude of Katrina.
9. Louisiana should have given greater consideration to filling gaps in federal funding of the Pam exercise.

LEGACY EFFECTS OF ENVIRONMENTAL, ENGINEERING CHANGES

10. Changes in Louisiana's coastal landscape, including wetlands loss and subsidence, have made New Orleans and coastal Louisiana more vulnerable to hurricanes and may have contributed to damage from Hurricane Katrina. These changes are in large part an unintended consequence of human activities that have altered the natural flow of the Mississippi River and other coastal processes.
11. Until addressed, the continued subsidence, loss of wetlands, and other changes to the coastal landscape will make New Orleans and other regions of the Louisiana deltaic plain increasingly vulnerable to hurricanes.
12. The building of the Mississippi River Gulf Outlet (MRGO) and the combined Gulf Intracoastal Waterway (GIWW)/MRGO channel resulted in substantial environmental damage, including a significant loss of wetlands which had once formed a natural barrier against hurricanes threatening New Orleans from the east.
13. MRGO and the combined GIWW/MRGO provided a connection between Lake Borgne and Lake Pontchartrain that allowed the much greater surge from Lake Borgne to flow into both New Orleans and Lake Pontchartrain. These channels further increased the speed and flow of the Katrina surge into New Orleans East and the Ninth Ward/St. Bernard Parish, increasing the destructive force against adjacent levees and contributing to their failure. As a result, MRGO and the combined GIWW/MRGO resulted in increased flooding and greater damage from hurricane Katrina.

LEVEES: WHO'S IN CHARGE?

14. Confusion, ambiguity and uncertainty characterized the perception of the Army Corps of Engineers, the local levee boards, and other agencies with jurisdiction over the levee system of their respective responsibilities, leading to failures to carry out comprehensive inspections, rigorously monitor system integrity, or undertake needed repairs.
15. Louisiana law imposes on local levee boards the responsibility to protect their respective jurisdictions from flooding and gives them extraordinary taxing authority to carry out that duty.
16. Congress tasked the Army Corps of Engineers with designing and constructing a levee system in and around New Orleans, but that responsibility does not diminish the Orleans Levee District's statutory duty to protect its jurisdiction from flooding.
17. The Orleans Levee District performed modest maintenance of the levees – such as mowing the grass. Nevertheless, ambiguities, confusion, and disputes between the Orleans Levee District and Army Corps of Engineers over responsibility led to inadequate maintenance of the levee system and to a lack of effective emergency plans

and preparations.

18. Local levee districts, including the Orleans Levee District, did not have the engineering expertise or diagnostic equipment to ensure that the hurricane-protection systems within provided the level of protection for which they were designed.
19. The Louisiana Department of Transportation and Development failed to fully carry out its responsibilities under state statutes such as the need to: (a) train levee-board members and their appointed inspectors or watchmen on how to care for and inspect levees; and (b) review the emergency plans of local levee districts to ensure that the levee districts could adequately respond to emergency situations.
20. The Orleans Levee District focused time, attention and resources on business interests unrelated to levees, such as casinos, restaurants, a karate club and a beautician school, to the detriment of flood protection.
21. Inspections of the Lake Pontchartrain Project administered jointly by the Army Corps and the Orleans Levee District failed to ensure that the project provided the level of protection for which it was designed and constructed.

PREPARING FOR THE STORM: STATE AND LOCAL GOVERNMENTS

22. Governor Blanco and Mayor Nagin failed to meet expectations set forth in the National Response Plan to coordinate state and local resources “to address the full spectrum of actions” needed to prepare for and respond to Hurricane Katrina. Funding shortages and inadequacies in long-term planning doomed Louisiana’s preparations for Katrina.
23. Governor Blanco submitted an inadequate and erroneous request for assistance to the President and generally failed to ask the federal government for sufficient assistance before the storm.
24. The Louisiana National Guard prepositioned too many resources at Jackson Barracks in the lower Ninth Ward, where many of them were lost to flooding.

PREPARING FOR THE STORM: FEDERAL GOVERNMENT

25. DHS, the agency charged with preparing for and responding to domestic incidents, whether terrorist attacks or natural disasters, failed to effectively lead the federal response to Hurricane Katrina.
26. In advance of landfall, Secretary Chertoff failed to make ready the full range of federal assets pursuant to DHS’s responsibilities under the National Response Plan (NRP).

27. DHS leaders failed to bring a sense of urgency to the federal government's preparation for Hurricane Katrina.
28. Secretary Chertoff failed to appoint a Principal Federal Official (PFO), the official charged with overseeing the federal response under the NRP, until 36 hours after landfall.
29. The Interagency Incident Management Group (IIMG), intended to coordinate the federal response to a catastrophe, was not activated until the day after landfall, and then added little value to the federal response effort, leaving federal agencies without an intermediate inter-agency dispute resolution mechanism.
30. Secretary Chertoff failed to activate the Catastrophic Incident Annex of the NRP, which could have led to a more proactive federal response.
31. Secretary Chertoff appointed a field commander, Michael Brown, who was hostile to the federal government's agreed-upon response plan and therefore was unlikely to perform effectively in accordance with its principles. Some of Secretary Chertoff's top advisors were aware of these issues but Secretary Chertoff has indicated that he was not. Secretary Chertoff should have known of these problems and, as a result, should have appointed someone other than Brown as Principal Federal Official.
32. Although the Hurricane Pam exercise, among other things, put FEMA on notice that a storm of Katrina's magnitude could have catastrophic impact on New Orleans, Michael Brown and FEMA leadership failed to do the necessary planning and preparations
 - a) to train or equip agency personnel for the likely needed operations;
 - b) to adequately prearrange contracts to transport necessary commodities;
 - c) to preposition appropriate communications assets; or
 - d) to consult with DOD regarding back-up capability in the event a catastrophe materialized, among other deficiencies.
33. National Hurricane Center and National Weather Service warnings—including a video conference appearance by NHC Director Max Mayfield— put FEMA on notice as of August 26 for Katrina's catastrophic potential as the hurricane moved toward the Gulf Coast. DHS notified the White House of that potential.
34. FEMA did not adequately preposition critical personnel and equipment before landfall.
35. Despite prepositioning unprecedented amounts of relief supplies, FEMA's efforts were inadequate.
36. FEMA's inadequate preparations for Katrina were in part a consequence of insufficient long-term catastrophic planning.

37. Before landfall, it does not appear that FEMA asked the Department of Defense to employ its assets.

DHS'S ROLES AND RESPONSIBILITIES

38. Statutory authorities and presidential directives establish the Department of Homeland Security (DHS) as the central federal entity for preparedness for and response to disasters.
39. The Secretary of Homeland Security has a clear duty to lead and manage the federal response to disasters such as Katrina.
40. When effective response is beyond the capabilities of the state and the affected local governments, the Stafford Act provides for federal assistance upon the request of the state and local governments.
41. Under our system of federalism, state and local governments bear the primary responsibility for responding to emergencies. As such, they generally manage the response to an incident in the first instance.
42. Following a catastrophic disaster, the traditional mode of operation may not work if state and local governments are so overwhelmed that they can't effectively make specific requests for assistance. In such circumstances the National Response Plan's Catastrophic Incident Annex provides for a more proactive federal response.
43. The United States Coast Guard distinguished itself during the Hurricane Katrina emergency by protecting its vessels and aircraft from the initial attack of the storm, by anticipating the critical missions it would need to conduct, by immediately moving in as soon as conditions allowed, and by heroically sustaining a massive effort that rescued more than 33,000 people from danger of death.

FEDERAL EMERGENCY MANAGEMENT AGENCY

44. FEMA was unprepared—and has never been prepared—for a catastrophic event of the scale of Katrina.
45. FEMA had been operating at a more than 15 percent staff-vacancy rate for over a year before Katrina struck.
46. FEMA's senior political appointees, including Director Michael Brown and Deputy Director Patrick Rhode, had little or no prior relevant emergency-management experience before joining FEMA.
47. FEMA's emergency-response teams were inadequately trained, exercised and equipped.

48. FEMA failed to adequately develop emergency-response capabilities assigned to it under the National Response Plan.
49. FEMA had budget shortages that hindered its preparedness.
50. Michael Brown, FEMA's director, was insubordinate, unqualified and counterproductive, in that he:
 - a) sent a single employee, without operational expertise or equipment and from the New England region to New Orleans before landfall;
 - b) circumvented his chain of command and failed to communicate critical information to the Secretary;
 - c) failed to deliver on commitments made to Louisiana's leaders for buses;
 - d) traveled to Baton Rouge with FEMA public affairs and congressional relations employees and a personal aide and no operational experts;
 - e) failed to organize FEMA's or other federal efforts in any meaningful way; and
 - f) failed to adequately carry out responsibilities as FEMA's lead official in the Gulf before landfall and when he was appointed as the Principal Federal Official after landfall.

GOVERNMENT RESPONSE: THE ROLE OF THE WHITE HOUSE

51. The White House knew or should have known that Katrina could turn into the long-feared "New Orleans Scenario," and could wreak devastation throughout the Gulf Region. The White House also may have been aware that FEMA was not prepared for such a catastrophe.
52. The President did take extraordinary steps to prepare for the storm – such as issuing an emergency declaration in advance of landfall – but could have done more to marshal federal resources.
53. Despite receiving information from multiple sources on the extent of the damage in New Orleans, the White House does not appear to have been aware that levees had broken and the city was flooding on the day of the storm and, indeed, appears to have been under the misimpression, for some time, that the levees did not break until the day after Katrina made landfall.
54. The initial response to Katrina was halting and inadequate, in part due to poor situational awareness. Ultimately, the President and his team brought the full resources of the federal government to bear on the catastrophe.

EVACUATIONS: PRE STORM

55. Before landfall, Louisiana successfully evacuated people with vehicles who wanted to leave.
56. Prior to Katrina, New Orleans officials did not fulfill a commitment in their emergency plan to provide transportation for people without vehicles.
57. Mayor Nagin wasted time in waiting to order a mandatory evacuation until Sunday morning, while his staff worked out details of the order that should have been settled long before the crisis.
58. The City of New Orleans, the state of Louisiana, and the federal government failed to retain drivers for the pre-landfall evacuation, even though city officials informed state and federal officials of this need over a month before landfall.
59. Governor Blanco missed opportunities to ask the federal government to help evacuate New Orleans before landfall. For example, she failed to ask for transportation assistance in her request for an emergency declaration, which was promptly granted by the President.
60. The State's lead agency for transportation, the Louisiana Department of Transportation and Development, failed to meet its responsibility under the State's emergency operations plan as lead agency for identifying, mobilizing, and coordinating transportation to assist with a pre-landfall evacuation.
61. The Louisiana Office of Homeland Security and Emergency Preparedness did not exercise sufficient oversight to ensure that the Louisiana Department of Transportation and Development would fulfill its responsibilities under the State's April 2005 plan.
62. The federal government did not engage state or local authorities about transportation alternatives for those lacking means for pre-landfall evacuation.
63. The federal government could have offered assistance with pre-landfall evacuation without waiting for requests from state and local government.
64. Hurricane Katrina revealed that consideration of the needs of those with pets should be a factor in emergency planning for evacuations and sheltering.

WHY THE LEVEES FAILED TO PROTECT NEW ORLEANS

65. The forensic teams investigating the flooding have concluded that: (a) the flood walls along the 17th Street and London Avenue Canals failed in that they did not withstand the forces for which they were supposedly designed or constructed; and (b) flooding was exacerbated as many levees and floodwalls were breached because of design and

construction deficiencies, including not having protection against the scour and erosion caused by overtopping.

66. In designing, constructing and maintaining the hurricane-protection system, the Corps did not adequately address: (a) the effects of local and regional subsidence of land upon which the protection system was built; and (b) then-current information about the threat posed by storm surges and hurricanes in the region.
67. For several years, the Corps has inaccurately represented to state and local officials and to the public the level of protection that the hurricane system provided. The Corps claimed the system protected against a fast-moving Category 3 storm even though: (a) there was no adequate study or documentation to support this claim; and (b) information known to or provided to the Corps demonstrated that the claim was not accurate.

COMMUNICATIONS VOIDS

68. Hurricane Katrina resulted in a pervasive and widespread breakdown in communications significantly affecting the ability of first responders and government officials in their rescue and response efforts.
69. The National Communications System failed to develop plans to support first responder communications, assess the damage to the communications systems, and maintain awareness of the federal government's available communications assets. Local governments either had inadequate plans or were unable to rapidly repair damage to their first responder communications systems.
70. The response to Katrina was also hampered by the lack of data interoperability – that is responders' inability to electronically share data – including patient medical records, information needed to track missing children and adults – coordinate search and rescue operations, and verify eligibility for benefits.
71. During Katrina, many of the 9-1-1 systems citizens call first during emergencies failed. Because of widespread destruction of call centers, many calls could not be rerouted; when they were rerouted, there were no systems in place to share critical data, for example, about the call's point of origin. Officials also had no plans to provide additional 9-1-1 operators needed to field thousands of calls for help.
72. When terrestrial-based communications networks were damaged or destroyed, some responders were able to use satellite phones for limited communications capabilities. For example, the Mississippi Emergency Management Agency provided satellite phones to all of its employees in the field; it also had a mobile communications unit with satellite capability.

73. The private sector deployed massive resources to restore their communications infrastructure, but their efforts were hampered because (1) government did not provide repair workers with uniform credentials to gain access to devastated areas; (2) government sometimes diverted fuel resources needed for generators; and, (3) industry was justifiably reluctant to go into some areas without security, a principal responsibility of the government.

LACK OF SITUATIONAL AWARENESS

74. Michael Brown willfully failed to report key information directly to DHS leadership, instead reporting straight to White House officials.
75. The Homeland Security Operations Center (HSOC) failed to take timely steps to create a system to identify and acquire all available, relevant information.
76. The HSOC failed in its responsibility under the National Response Plan to provide “general situational awareness” and a “common operational picture,” particularly concerning the failure of the levees, the flooding of New Orleans, and the crowds at the Convention Center.
77. On the day of landfall, senior DHS officials received numerous reports that should have led to an understanding of the increasingly dire situation in New Orleans, yet they were not aware of the crisis until Tuesday morning.
78. Louisiana was not equipped to process the volume of information received by its emergency operations center after landfall.
79. Lack of situational awareness regarding the status of deliveries created difficulties in managing the provision of needed commodities in Louisiana and Mississippi.

CRITICAL INFRASTRUCTURE; ESF 15 PUBLIC AFFAIRS

80. Hurricane Katrina demonstrated that it is an enormous and complex task for government to assess damage to critical infrastructure and work with the private sector to coordinate its restoration. At the time Katrina struck, the Department of Homeland Security had not completed its planning and assessment work to prioritize the protection of critical infrastructure; this plan might have been helpful in coordinating the restoration of critical infrastructure.
81. Federal and state officials failed to fulfill their responsibilities under federal and state plans to disseminate timely and accurate information to the public.

SEARCH AND RESCUE

82. Federal, state and local agencies rescued approximately 60,000 people in the aftermath of Katrina. Of this 60,000, the Coast Guard missions alone accounted for 33,000 rescues. The Louisiana Department of Wildlife & Fisheries (W&F), along with the out-of-state agencies that assisted the department through the EMAC process, accounted for 21,000 rescues. The Coast Guard, Department of Defense and the National Guard conducted an extensive helicopter search and rescue mission.
83. The National Response Plan (NRP) does not adequately address the organizational structure and the assets needed for search and rescue in a large-scale, multi-environment catastrophe. Under the NRP, Emergency Support Function 9 (Urban Search and Rescue) is focused on missions to rescue people in collapsed structures. Emergency Support Function 9 gives the U.S. Coast Guard a support role for water rescue. However, the NRP does not provide a comprehensive structure for water and air rescues, which constituted a significant portion of the necessary search and rescue missions in the Katrina response.
84. The lack of a strategic intergovernmental plan to address search and rescue in a disaster environment that required tactical planning and organization, communications, air traffic control, and the reception of victims, led to inefficient employment of resources, hazardous flight conditions, and protracted waits by victims in need of rescue.
85. The City of New Orleans left the New Orleans Fire Department (NOFD) and the New Orleans Police Department (NOPD) unprepared to conduct water search and rescue missions by repeatedly denying budget requests by those departments for watercraft. Consequently, the NOFD entered Katrina with no boats, and the NOPD entered Katrina with five boats.
86. The Louisiana National Guard stationed many boats and high water vehicles at Jackson Barracks, one of the lowest points in the city. Jackson Barracks flooded during Katrina and rendered many of these assets unavailable for search and rescue missions.
87. The individuals working on behalf of federal, state and local agencies to rescue victims worked in chaotic situations often at great risk to themselves. Yet search-and-rescue resources, including boats and helicopters, were insufficient despite their accelerated deployment through the first week of landfall.
88. Even though thousands were stranded in imminent jeopardy, FEMA only had 45 helicopters by Tuesday after landfall. The state failed to ask for enough helicopters for FEMA and FEMA failed to ask the Department of Defense for additional helicopters beyond the state's request, and even though additional helicopters could have been made available, DOD did not offer them.

89. Regarding the need for additional boats, the state asked for rubber rafts but FEMA did not provide them because FEMA decided rubber rafts would not be sturdy enough to maneuver in debris laden water. However, state officials disagree and believe these rafts would have been valuable for such things as towing groups of rescued victims behind regular boats.
90. Planning and coordination by the designated lead federal and state agencies, FEMA and the Louisiana Department of Wildlife & Fisheries, were inadequate and impaired the overall effectiveness of the search and rescue mission.
91. The Hurricane Pam exercise predicted flooding in New Orleans and called for boat-and helicopter-based rescues, but emergency planners at all levels of government did not anticipate before landfall the need for large scale rescue operations.
92. FEMA did not equip or train its SAR teams for water search and rescue. FEMA SAR teams did not begin search and rescue missions until Tuesday morning.
93. Communications failures abounded at the local, state and federal level exacerbating the ability of agencies and their rescuers to coordinate their work.
94. The Emergency Management Assistance Compact proved to be a valuable resource for Louisiana to obtain necessary equipment and teams. However, bureaucracy related to and confusion over the approval process delayed its utility to the State of Louisiana.
95. Concerns about lawlessness forced some FEMA and NOFD search and rescue teams to pull back their operations temporarily because they lacked security.
96. The Department of Homeland Security was slow to deploy equipment that could have assisted in the response to Katrina. For example, the Department did not deploy, until nearly a week after the storm, pre-positioned equipment “pods,” each of which was capable of providing lifesaving equipment to 150 first responders. DHS waited until at least two days after landfall to advise either Louisiana or Mississippi of their availability.

Search and Rescue for Mississippi

97. The number of communities and the geographic area affected by Katrina created manpower and logistical difficulties for search and rescue operations, especially given the time-sensitive nature of the work.
98. The amount of debris hindered search and rescue operations. Mississippi National Guard engineering unit and others often had to clear debris before rescuers could access areas to conduct operations.

99. The collapse of communications along the Gulf Coast made coordination difficult from the start and presented challenges for the duration of search and rescue missions.
100. Despite the many challenges, search and rescue operations proceeded successfully along the Mississippi Gulf Coast, with operations beginning even before the flood waters had receded. Search and rescue responders and assets were effectively marshaled from the ranks of Mississippi communities, FEMA, EMAC states, the Coast Guard, Mississippi National Guard, and other sources.

POST-LANDFALL EVACUATION

101. The failure to effect a complete pre-landfall evacuation amplified the challenges of the post-landfall evacuation.
102. While the need for post-landfall evacuation of New Orleans was foreseeable, no level of government took the steps necessary to prepare for it.
103. FEMA Director Michael Brown failed to follow through on his promise to Louisiana officials to arrange for speedy delivery of buses to evacuate New Orleans.
104. Lack of communication among city officials resulted in the missed opportunity to use as many as 200 safely positioned city buses to begin the evacuation of New Orleans shortly after Katrina passed.
105. The Louisiana Department of Transportation and Development's lack of preparedness contributed to the delay in locating in-state buses to evacuate New Orleans.
106. Delays in arranging transportation to evacuate New Orleans led to unnecessary suffering of people stranded there.
107. Provisions for sheltering were inadequate, and the state of Louisiana was at least partially responsible.
108. Concerns about security slowed the post-landfall evacuation.
109. No level of government addressed the evacuation of the Convention Center until Friday, two days after large numbers of people began congregating there.

LOGISTICS

110. DHS leaders knew or should have known that FEMA's logistics system suffered from significant and long standing problems, yet, they did not take sufficient steps to fix the system.

111. Prior to landfall, FEMA failed to pre stage enough commodities in either Mississippi or Louisiana.
112. FEMA's logistics system failed out of the box, but with revisions and assistance from DOD logistics specialists, the FEMA system began to improve in the second week after landfall.
113. Louisiana's failure to adequately prioritize its requests to FEMA wasted FEMA's time and limited resources.
114. Louisiana Office of Homeland Security and Emergency Preparedness failed to effectively coordinate the distribution of commodities.
115. The ARF and E Team methods by which response resources were requested were incompatible and ill equipped to handle a disaster of this magnitude.
116. FEMA lacked the ability to track the shipment of commodities. The lack of visibility disrupted the ability to respond effectively to the aftermath of Katrina.
117. Fuel is a crucial commodity during the response to any disaster. In Katrina's immediate aftermath, a shortfall in the fuel supply hindered the response as early attempts to mitigate the disruptions appear to have been inadequate.
118. The Louisiana National Guard (LANG) failed to anticipate and adequately plan for the large scale commodity distribution necessitated by Katrina. LANG did not have enough manpower and equipment available to complete its distribution mission.
119. During approximately the first ten days following the storm, the federal logistics system was unable to provide the requested level of Meals Ready to Eat (MRE) rations, water, and ice in Mississippi.
120. The commodity pipeline Florida set up to bring supplies into south Mississippi was crucial to alleviating additional suffering in that area.
121. Early in the response, Mississippi recognized how severely Katrina had disrupted the state's infrastructure and the resulting inability of many residents of south Mississippi to travel to the Points of Distribution to acquire life-saving supplies. The resulting "push" of supplies by the National Guard to residents was crucial to preventing additional hardship in south Mississippi.

MEDICAL ASSISTANCE

Federal

122. The federal government's medical response suffered from a lack of planning, coordination, and cooperation, particularly between the U.S. Health and Human Services and the Department of Homeland Security.
123. Despite its lead role as the primary agency in charge of coordinating the federal medical response, the Department of Health and Human Services did not deploy its on scene response-coordination teams as rapidly as it should have, and lacked adequate emergency-coordination staff and resources.
124. The federal agencies involved in providing medical assistance did not have adequate resources or the right type or mix of medical capabilities to fully meet the medical needs arising from Katrina, such as meeting the needs of large evacuee populations, and were forced to use improvised and unproven techniques to meet those needs.
125. Unlike Disaster Medical Assistance Teams, the U.S. Public Health Service is not organized or equipped to serve as medical first responders and have no pre established, readily deployable teams, personnel practices, transportation and other logistical difficulties.
126. Although FEMA eventually deployed virtually all of its National Disaster Medical System resources – having started with only a single team – there was a greater need for such teams than could be filled, and those teams that did deploy experienced difficulties in obtaining necessary logistical, communications, security, and management support.
127. Despite efforts by both FEMA and HHS to activate federal emergency-health capabilities of the National Disaster Medical System (NDMS) and the U.S. Public Health Service as Katrina approached the Gulf Coast, only a limited number of federal medical teams were actually in position prior to landfall to deploy into the affected area, of which only one (the Oklahoma – 1 Disaster Medical Assistance Team) was in a position to provide immediate medical care in the aftermath of the storm.
128. Although a shipment of medical supplies was dispatched from the Strategic National Stockpile to Louisiana late on Sunday, August 28, in response to a last-minute request from the City of New Orleans, it was not possible to get it to Louisiana before landfall, and no other federal medical supplies were pre-positioned in the Gulf region.

Louisiana

129. The State of Louisiana failed to ensure that nursing homes and hospitals were incorporated into the State's emergency-planning process, and as a result failed to ensure that they had effective evacuation plans or were genuinely prepared to shelter their critical care patients in place, causing loss of life and avoidable suffering.
130. Louisiana failed to plan for known emergency medical-response needs, such as post storm evacuation of patients from hospitals or moving large numbers of patients to medical treatment facilities.
131. Louisiana State University failed to carry out its responsibilities under the state emergency-operations plan to ensure adequate emergency preparedness for health-care facilities, and the Louisiana Office of Homeland Security and Emergency Preparedness failed to ensure that its functions were implemented.

PUBLIC SAFETY AND SECURITY

132. Actual and perceived lawlessness hampered the emergency response during Katrina.
133. In statements to the media, New Orleans officials perpetuated unsubstantiated rumors about violent crimes that had not occurred.
134. The NOPD was overwhelmed by Katrina. Under extraordinarily difficult circumstances, most of its officers performed their duties.
135. The NOPD failed to adequately provision personnel or coordinate fully the pre-staging and pre-positioning of its assets, which reduced its effectiveness.
136. DHS and DOJ's failure to understand, plan for and implement their ESF-13 responsibilities in natural disasters prior to Katrina led to delays in providing law enforcement assistance.
137. Neither DHS nor DOJ planned for or coordinated their joint ESF-13 roles and responsibilities relating to a natural disaster.
138. The lack of advanced planning by DHS and DOJ delayed the deployment of Federal law enforcement into the Gulf region and New Orleans, in particular.

139. Inadequate planning by local officials for the evacuation of detention facilities and the identification of back-up facilities for new arrests contributed to the public safety problems in New Orleans.
140. There was insufficient coordination of the processes that procured and deployed National Guard and civilian law enforcement assistance.

MILITARY OPERATIONS

Overall

141. The National Guard and active-duty military troops and assets deployed during Katrina constituted the largest domestic deployment of military forces since the Civil War. The National Guard and active-duty military response saved lives; provided urgent food, water, shelter, and medical care to many hurricane victims; and helped restore law and order, re-establish communications, and rebuild damaged roads.
142. Although the Department of Defense's preparations for Katrina were consistent with its procedures and prior practices in civil-support missions, they were not sufficient for a storm of Katrina's magnitude. Additional preparations in advance of specific requests for support could have enabled a more rapid response.
143. The deployments of National Guard and active-duty forces were not well coordinated. A major cause of this was that there was no pre existing plan or process for the large scale deployment of National Guard forces from multiple states in response to a catastrophic disaster. NORTHCOM did not have full and timely information on the capabilities of National Guard troops deploying to the Gulf Coast.
144. In part because of the lack of a pre existing plan for large scale deployments, some National Guard units arrived before there was established an adequate command-and-control structure for the number of forces deployed, resulting in a failure to efficiently employ all available troops.
145. While some active-duty and National Guard units are designed and structured to deploy rapidly as part of their military missions, the Department of Defense is not organized, funded or structured to act as a first-responder for all domestic catastrophic disasters.
146. The dual military-command structure in Katrina exposed a fundamental tension – inherent in our system of government – between the principles of unity of command and federalism.

147. DOD has unique resources and capabilities to provide humanitarian relief in a catastrophe. FEMA's failure to request these assets sooner delayed the Department's delivery of these critical assets.

Pre-Landfall Preparation

148. The Department of Defense prepared for Hurricane Katrina in a manner consistent with its interpretation of DOD's role under the National Response Plan, which is to respond to requests for assistance from FEMA. However, this approach was inadequate to prepare for a catastrophe of the magnitude of Katrina.
149. The Department of Defense's preparations prior to landfall largely consisted of deploying Defense Coordinating Officers and Defense Coordinating Elements, identifying staging bases, identifying some assets and units for potential disaster support, participating in conference calls and meetings led by FEMA, monitoring the progress of the storm, and identifying available commodities.
150. Based on their previous experience in hurricanes, prior to landfall a number of commanders took additional actions to prepare assets for deployment in advance of any specific request or order for those assets.
151. Northern Command and First Army commanders requested that certain DOD assets be identified before landfall in anticipation of requirements, but the Joint Directorate of Military Support failed to respond in a timely manner.
152. Because the Department has denied the Committee access to Northern Command's plans for its preparation for and response to domestic catastrophes, even though they are not classified, the Committee is unable to assess their status and adequacy. The Committee has received directly contradictory testimony as to whether these plans are complete, so it is unclear to what extent the Department, especially Northern Command, had planned its response to Katrina or whether the plans would have addressed the problems of coordination identified by this investigation.

Initial Response after Landfall

153. During the initial 24 hours after landfall, the Department of Defense lacked timely and accurate information about the immediate impact of Hurricane Katrina. DOD and DHS did not coordinate adequately for the use of DOD assets to make such assessments during this period.

154. During this initial period after landfall, a number of military commanders within the services were proactive, identifying, alerting, and positioning assets for potential response, prior to receiving requests from FEMA or specific orders. Many of these preparations proved essential to the overall response; however, they reflected the individual initiative of various commanders rather than a pre-planned, coordinated response as is necessary for a disaster of this magnitude.
155. During this initial period after landfall, the office of the Joint Director of Military Support took the position that DOD should provide support or mobilize assets only after DOD had received, evaluated, and approved a specific request for assistance from FEMA. As a result, DOD did not act quickly to process and approve the first request it received from FEMA for two helicopters for rapid needs assessment.
156. On Tuesday, August 30, as DOD officials became concerned about the extent of the damage, DOD prepared and mobilized many assets to be able to respond quickly to requests for assistance and provide military support to the hurricane response. The Acting Deputy Secretary of Defense gave direction that eliminated much of the internal review and approval process, and encouraged the deployment of assets that commanders deemed potentially necessary prior to receiving requests for such assets. The Chairman of the Joint Chiefs of Staff provided guidance to the Service Chiefs on Tuesday to exercise their own judgment in pushing assets forward. The services followed this guidance. Some commanders moved quickly to mobilize and position assets for potential deployments in advance of formal requests or approvals.
157. Not all deployments were fully coordinated among the services, NORTHCOM, and the Joint Task Force. NORTHCOM did not have a complete picture of the movement of troops and resources within its area of responsibility.

Responses to FEMA's Requests for Assistance

158. DOD's normal, "21 step" process for accepting assignments from FEMA to assist in responding to a disaster is cumbersome and unlike the processes followed by all other federal agencies. It also caused tension between DOD and FEMA and slowed certain of DOD's initial efforts in the response.
159. On Tuesday, August 30, in an effort to speed DOD's response, the Acting Deputy Secretary of Defense suspended the regular approval process, including the requirement that formal written approval by the Secretary of Defense precede the actual execution of a mission. Following this decision, DOD appears to have responded quickly to FEMA requests for assistance.
160. Despite the assignment of numerous DOD liaison officers, some FEMA officials still did not have a good understanding of the assets and resources that DOD could provide.

Similarly, some FEMA officials did not have a good understanding of the DOD's processes for responding to FEMA requests for assistance.

161. In many instances, discussions between FEMA or DHS officials and DOD officials were necessary to clarify requests for assistance or to ensure that DOD would be providing the most effective resources in response to the request. Some FEMA officials believed that these discussions and DOD's approval process took too long.

National Guard Troop Deployments

162. There is no established process for the large scale, nationwide deployment of National Guard troops in response to a governor's request for large scale deployment of troops for civil support.
163. During Katrina, neither the state of Louisiana, the state of Mississippi, nor the Emergency Management Assistance Compact was able to manage the large scale deployments of National Guard troops from all 50 states and 4 other jurisdictions.
164. The National Guard Bureau solicited the rapid deployment of National Guard troops from all 50 states and four other jurisdictions. Although this process successfully deployed a large number of National Guard troops, it did not proceed efficiently, or according to any pre existing plan or process.

Federal Troop Deployments

165. Some active-duty units, including elements of the 82nd Airborne Division and the Second Marine Expeditionary Force, are maintained on alert for rapid deployment, and were placed on higher alert on Wednesday, August 31. These forces could have deployed sooner into Louisiana had the President or the Defense Department made a decision to deploy them.
166. Due to the restrictions placed by the White House and DOD on the Committee's ability to interview White House and senior civilian and military officials within DOD about deployment decisions, the Committee has been unable to conclude why the President ordered the deployment of federal active-duty troops on Saturday, September 3, including reasons why the President did not order the deployment of federal active-duty troops sooner. However, the Committee has been able to make findings about DOD officials' views on these topics.
167. The deployment of National Guard forces before active-duty troops was consistent with the DOD Strategy for Homeland Defense and Civil Support, which relies on the National Guard in the first instance for civil support.

168. The large numbers of National Guard troops that were deploying into Louisiana were a major factor in the Department of Defense's decision not to deploy additional active-duty troops prior to Saturday, September 3. DOD officials said that the choice to deploy National Guard troops first was correct because the Guard is designated as the first military responder under the DOD Strategy for Homeland Defense and Civil Support, and because National Guard forces, unlike active duty troops, are not restricted from performing law-enforcement duties under the federal Posse Comitatus Act.
169. Federal and state officials did not coordinate well the requests and consideration of requests for National Guard and active-duty troop deployments. The Governor of Louisiana asked for 40,000 troops, but federal officials did not interpret this as a specific request for active-duty troops.
170. Local, state, and federal officials had differing perceptions of the numbers of federal troops that would be arriving and the appropriate command structure for all troops, causing confusion and diverting attention from response activities. In Louisiana, a stronger unified command might have avoided this confusion and diversion of attention.

POOR CONTROLS AND DECISIONS IN FEMA SPENDING

171. Taxpayer dollars meant for relief and recovery were lost to waste and fraud.
172. Wasteful practices and program control weaknesses that FEMA indicated it had identified and was addressing after the 2004 Florida hurricanes were not remedied prior to Katrina.
173. Due to a lack of planning and preparation, much of FEMA's initial spending was reactionary and rushed, resulting in costly purchase decisions and utilization of no-bid, sole source contracts that put the government at increased risk of not getting the best price for goods and services.

FAILURES IN DESIGN, IMPLEMENTATION, AND EXECUTION OF THE NATIONAL RESPONSE PLAN

174. DHS did not effectively implement the National Response Plan, although it was released in January 2005 and required to be implemented in April 2005.
175. The NRP lacked clarity on a number of points, including the role and authorities of the Principal Federal Official and the allocation of responsibilities among multiple agencies under the Emergency Support Functions, which led to confusion in the response to Katrina. Plan ambiguities were not resolved or clarified in the months after the NRP was issued, either through additional operational planning or through training and exercises.

176. Although DHS was charged with administering the plan and leading the response under it, DHS officials made decisions that appear to be at odds with the NRP, failed to fulfill certain responsibilities under the NRP on a timely basis, and failed to make effective use of certain authorities under the NRP.
177. By not implementing the NRP's Catastrophic Incident Annex (NRP CIA) in response to Hurricane Katrina, the Secretary of DHS did not utilize a tool that may have alleviated some of the difficulties with the federal response. The Secretary's activation of the NRP CIA could have increased the urgency of the federal response and led the federal government to respond more proactively rather than waiting for formal requests from overwhelmed state and local governments.
178. DHS had not completed the Catastrophic Incident Supplement referred to in the NRP CIA, had not engaged in adequate catastrophic planning, and had not developed regional or situation specific plans that could have improved the usefulness of the NRP in a catastrophe.
179. In the absence of additional operational planning and without adequate implementation, the NRP was insufficient to address this catastrophic event.
180. The Incident Command System doctrine includes the concept of Unified Command, which is designed to allow all agencies with responsibility for an incident to work together effectively. It establishes a process through which strategies and objectives are determined collectively so that agencies under different jurisdictional control can work under a single incident action plan toward common objectives.
181. FEMA, as well as other federal agencies, did not have an adequate number of personnel familiar with and trained in the Incident Command System and the principles of unified command to be able to respond to a catastrophe of the magnitude of Katrina.
182. The Louisiana Office of Homeland Security and Emergency Preparedness suffered problems such as inadequate funding; not enough staff; insufficient training, (demonstrated by the need of Louisiana officials to hire consultants to train EOC participants and National Guard members in basic NIMS ICS courses two days after Katrina made landfall); widespread lack of understanding of NIMS ICS and unified command; an overall lack of preparation, and a lack of emergency-management capacity to respond effectively to Katrina. Together, these were the primary reason for the failure to establish unified command and establish an incident command structure in Louisiana.
183. Mississippi established a unified command with FEMA, conducted joint planning prior to landfall, and was able to broaden the unified command and establish an incident command structure after a short period of chaos following Katrina.

184. Senior leaders and individuals in Mississippi with responsibilities for emergency management had been given extensive prior training on NIMS ICS, and FEMA's senior personnel in Mississippi possessed a very high level of knowledge and understanding of NIMS ICS.

185. Where and when personnel with experience and training on NIMS ICS were in control with an adequate number of trained support personnel, coupled with the discipline to adhere to the doctrine of NIMS ICS, it made a positive difference in the quality and success of implementing an incident command structure, establishing a unified command, and the response.