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**BEFORE THE**  
**COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS**  
**UNITED STATES SENATE**  
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Good morning Madam Chairman and Members of the Committee.

Thank you for the opportunity to be here today to discuss recommendations for improving the national emergency response system in the wake of Hurricane Katrina. It is our hope that the lessons learned from the response to Hurricane Katrina will form the foundation for critical improvements necessary for the nation to prepare for and respond to any disaster – natural or man-made.

As noted in recent reports issued by the House Select Bipartisan Committee to Investigate the Preparation For and Response to Hurricane Katrina and the White House report, the federal response to Hurricane Katrina identified many weaknesses and shortcomings that had a direct effect on our citizens. Unfortunately, as my testimony indicates, many of these weaknesses were not unique to Hurricane Katrina, but have been identified in Inspector General reports as far back as 1992, when Hurricane Andrew devastated Southern Florida.

Today, I would like to focus my remarks on five critical areas where improvements are needed:

- Command and Control
- Coordination of Federal Government Response Efforts
- Visibility of Deployed Assets
- Reliability of Communication Systems
- Media Relations

Finally, I will discuss concerns we have with the White House report. Above all, our goal is to turn lessons learned into problems solved.

Over the past few years, my office has completed a number of reviews related to preparedness and response operations by the Department of Homeland Security (DHS) that disclosed serious deficiencies in the national emergency response system, including:

- An audit on the deficiencies with existing information technology used by the Federal Emergency Management Agency (FEMA), *Emergency Preparedness and Response Could Better Integrate Information Technology with Incident Response and Recovery*;
- An evaluation of the April 2005 Top Officials 3 exercise, *A Review of the Top Officials 3 Exercise*, which highlighted issues with command and control as well as roles and responsibilities under the National Response Plan; and,
- A soon to be released report, *A Performance Review of FEMA's Disaster Management Activities in Response to Hurricane Katrina*, which details FEMA's responsibilities for three of the four major phases of disaster management—Preparedness, Response, and Recovery—during the first five weeks of the federal response. Additionally, we evaluated FEMA's preparedness and readiness efforts over the past ten years to determine its organizational capability and posture prior to Hurricane Katrina.

My testimony will provide details on each of these deficiencies and recommendations for the critical areas mentioned above.

### **Command and Control**

In February 2003, Homeland Security Presidential Directive-5, "Management of Domestic Incidents," required the Department of Homeland Security (DHS) to develop the National Incident Management System (NIMS). NIMS is a framework to help emergency managers and responders from different jurisdictions and disciplines work together more effectively during disasters and emergencies. In most disasters, local emergency response personnel are capable of managing the majority of calamities. However, some incidents require multiple jurisdictions or levels of government to provide an adequate response. In addition, initially some incidents can be handled locally but grow in size or complexity and require additional assistance and support. The NIMS standardizes the concepts and processes for incident command and management and provides an efficient and effective coordination system to enable multiple entities from different jurisdictions to conduct incident management activities.

#### **Incident Command System**

The NIMS defines a command and control structure for domestic incident management using two levels of management structures: an Incident Command System (ICS) and Multiagency Coordination Systems. An ICS is a standard on-scene, all-hazard incident management system that allows users to establish an integrated organizational structure to respond to single or multiple incidents. The ICS structure is widely applicable to a variety of emergencies from small and basic to large and complex, whether natural or man-made. It applies across all levels of government, the private sector, and nongovernmental organizations, as well as across multiple functional disciplines. Key ICS characteristics include:

- Use of common terminology;
- Scalable, top-down modular system based on the size, complexity, and nature of the incident;
- Incidents managed by objectives established by the incident command;
- Use of incident action plans to communicate strategic objectives and operational and support activities to the incident command organization;
- Span of control ranging from three to seven subordinates;
- Clear employee-supervisor reporting relationships;
- Clear chain of command and authority within the organization; and,
- Use of communication plans and interoperable communications systems.

The ICS structure includes five major functional areas: Incident Commander, Operations Section, Planning Section, Logistics Section, and Finance/Administration Section. Depending on the size and complexity of the incident, additional functional or geographic branches or divisions can be included within one or more of the major functional areas.

The Incident Commander establishes either a single command or a unified command to manage an incident. Under a single command, the Incident Commander develops incident objectives,

approves the incident action plan, and approves all requests involving resources. For incidents involving multiple agencies or jurisdictions, a unified command is established. Designated members of each agency work together to develop a common set of objectives and strategies for the entire incident and jointly plan support activities under a single incident action plan. As a result, unified command improves information flow, communication, coordination, and reduces duplication of efforts.

Natural disasters and other incidents occur without regard for geographical, functional, or other jurisdictional divisions--disasters create damage with no heed for state or county lines. Additionally, federal, state, and local agencies divide themselves into geographical or functional territories or regions that differ depending on the agency. Even different components within DHS divide differently into regions, sectors, or other divisions. Therefore, establishing a unified command within an ICS structure enables multiple agencies or jurisdictions to work together effectively without compromising their different legal, geographic, and functional authorities and responsibilities.

The ICS structures and unified command were implemented with varying levels of success in Mississippi, Alabama, and Louisiana during the response to Hurricane Katrina. Mississippi immediately implemented a comprehensive ICS structure and integrated federal, state, and local personnel at all levels in a unified command. Alabama implemented an ICS structure, but on a smaller scale because Hurricane Katrina did not cause the level of damage in Alabama that it did in Mississippi and Louisiana. Louisiana had difficulty fully implementing an ICS structure and establishing a unified command with federal, state, and local officials.

FEMA's Federal Coordinating Officer (FCO) and Mississippi's State Coordinating Officer immediately established a unified command with a comprehensive ICS structure to manage response efforts in Mississippi. FEMA and state officials told us that after landfall, federal, state, and local counterparts integrated and worked side-by-side to manage the response. Due to the magnitude of the damage, the Operations Section established three geographic branches, each containing multiple divisions, within Mississippi. In comparison to Mississippi, Alabama's ICS structure was much smaller and less complex, showing the flexibility and scalability of the ICS system. For example, Alabama did not need to establish branches or divisions in order to adequately coordinate a response.

In contrast, Louisiana had great difficulty establishing an ICS structure, and never fully achieved a unified command with FEMA. FEMA and state personnel were unable to co-locate due to space limitations at Louisiana's Emergency Operations Center (EOC), causing FEMA to establish an interim operating facility for most FEMA personnel at a separate location until the Joint Field Office (JFO) was established on September 12, 2005. Even then, state operations personnel remained at the state EOC rather than co-locating with FEMA at the JFO. FEMA immediately established positions based on an ICS structure; however, FEMA and state officials told us that because Louisiana had a limited number of trained emergency management staff, the state was not able to provide a counterpart to all federal positions. Louisiana's ICS structure did not include geographic branches or divisions within the Operations Section. At the local level in the affected parishes, federal and local counterparts did not coordinate to establish a unified command in most cases, according to FEMA officials in Louisiana.

In Mississippi, joint incident action planning meetings with federal and state counterparts from all response sections facilitated planning joint objectives, priorities, and operations for each operational period. FEMA and Alabama Emergency Management Agency personnel worked from the beginning to establish joint objectives and priorities, and developed joint incident action plans in Alabama as well. However, FEMA's FCO and Louisiana's State Coordinating Officer did not establish joint priorities and objectives for the response until September 11, 2005, and did not develop the first joint incident action plan until September 14, 2005.

In addition, FEMA and state emergency management officials in Mississippi recognized early on that a forward location in the disaster area would be necessary, so an Area Field Office was established in Biloxi. Federal, state, and local personnel were moved into the disaster area, and they were empowered to act. Division supervisors within the affected area determined their requirements and requests that could not be filled by the state were passed to the Branch. The requests were then passed to the JFO if they could not be filled at the Branch level, and sent forward within the ICS structure until filled. In Alabama, the FCO recognized that Department of Defense (DOD) assistance would not be required and, two days after landfall, released the Defense Coordinating Element so it could move to Mississippi for future support operations.

A forward operational area was not established in New Orleans until September 5, 2005, when the Deputy Principal Federal Official (PFO) arrived in Louisiana. According to FEMA officials, the PFO cell, which later became an Area Field Office, operated as a satellite of the JFO in Baton Rouge. While the Area Field Office was assigned an area of responsibility covering several parishes in the New Orleans area, personnel on the ground were not delegated authority, as was the case with division supervisors in Mississippi. In contrast to Mississippi, the New Orleans Area Field Office received its action plans and operations from Baton Rouge rather than determining its own needs for the area and sending requests for assistance through the JFO.

The ICS structure established in Mississippi included geographic branches and divisions, and authority was delegated to personnel at the division level. In addition to establishing a unified command with federal, state, and local response personnel, the structure allowed FEMA, state, and local emergency management officials to manage Hurricane Katrina response efforts even though existing resources were overwhelmed according to FEMA and state officials. The limited ICS structure and lack of unified command in Louisiana significantly undercut its response efforts.

### **Multiagency Coordination Systems**

Multiagency Coordination Systems provide a common framework to coordinate and support incident management policies and priorities, facilitate logistics support and resource tracking, make critical resource allocation decisions, coordinate incident related information, and coordinate interagency and intergovernmental issues regarding incident management policies, priorities, and strategies. Operational responsibility for incident management activities remains with the on-scene incident commander.

Both EOCs and multiagency coordination entities could be part of a multiagency coordination system. EOCs, usually established at the state or local level, are the physical location where core functions of coordination, communications, resource dispatch and tracking, and information collection are executed. Personnel from multiple jurisdictions or functional disciplines may staff EOCs. Multiagency coordination entities support and facilitate incident management, coordinate policy, and provide strategic guidance and direction to support incident management activities. These entities usually include representatives from agencies or organizations with direct incident management responsibility or significant support and resource responsibilities.

For Hurricane Katrina, each affected state activated and staffed its EOC following basic ICS positions and elements. This facilitated coordination between federal and state counterparts, and ultimately, integration when the incident command organization was established in each state's JFO. The Homeland Security Operations Center (HSOC) executed the core EOC functions at the federal level for Hurricane Katrina. Several multiagency coordination entities were used during the Hurricane Katrina response, including FEMA's National Response Coordination Center (NRCC), FEMA's Regional Response Coordination Centers (RRCC) in Atlanta, Georgia, and Denton, Texas, and FEMA's Emergency Response Teams. Also, the Interagency Incident Management Group (IIMG) was activated. This is a federal, headquarters-level, multiagency coordination entity created under the National Response Plan (NRP) to assemble on an as-needed basis to provide strategic incident management planning, coordination, and decision-making support for the DHS Secretary and White House.

The NRCC, RRCCs, and Emergency Response Teams have the same organizational structure. As issues developed, all three entities began working to resolve the issue rather than allowing the issue to be worked at the field level first by the Emergency Response Teams, and then elevated to the regional or national level as necessary. Instead, efforts were duplicated, resulting in the need for multiple conference calls among the three entities to resolve an issue.

The HSOC and the IIMG also duplicated efforts during the Hurricane Katrina response. Co-located with the HSOC, during Hurricane Katrina the IIMG established operational hours, fulfilled requests for situational information, and created routine reports. IIMG members said that the senior officials on the IIMG served as a reporting cell to DHS leadership and the White House, running parallel functions with the HSOC. Doubling the headquarters-level information collection effort to include both the HSOC and the IIMG burdened response operations at the JFO and the NRCC, which began hiring contractors to manage information requests.

Given the complexity of the response effort and issues presented by Hurricane Katrina, DHS headquarters and FEMA must establish a defined use for multiagency coordination entities that expedites the resolution of issues, facilitates incident management, coordinates policy, and provides strategic guidance and direction to support incident management activities at the most appropriate operation level. Doing so will avoid the unnecessary and time-consuming coordination that resulted in response to Hurricane Katrina.

## Clarification of Principal Federal Official's Role

The NRP describes several key leadership positions during a disaster response. In addition to the role of DHS' Secretary, the President designates an FCO as the lead federal official to coordinate federal resource support for each emergency or major disaster declared under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (the *Stafford Act*).<sup>1</sup> The DHS Secretary serves as or formally appoints a PFO to facilitate federal support to the established incident command structure and coordinate overall federal incident management and assistance to officials such as the FCO acting under their disaster response authorities. The PFO does not direct or replace the incident command structure. When the President issues an emergency or major disaster declaration under the *Stafford Act*, FEMA Regional Directors designate Disaster Recovery Managers to administer the financial aspects of assistance authorized under the *Stafford Act*.

The response to Hurricane Katrina was the first operational use of the PFO. On August 30, 2005, DHS' Secretary designated the Under Secretary of Emergency Preparedness and Response (EP&R) as the PFO for Hurricane Katrina. The majority of state and federal officials we interviewed said that the Under Secretary's execution of the PFO role matched the non-directive, coordination duties described in the NRP. However, when the Secretary appointed Vice Admiral Allen as PFO on September 9, 2005, the PFO took a greater role in directing the federal response, which was contrary to the PFO's role as outlined in the NRP.<sup>2</sup>

As the PFO assumed a greater role in the response operations, the new lines of command and authority created confusion. For example, a state official told us the PFO was coordinating directly with local government officials without the knowledge of the state. In addition, the PFO duplicated planning and reporting activities in the JFO. Also, the PFO cell issued action request forms directly to emergency support function (ESF) leads, in conflict with the JFO operations section. In Louisiana, the JFO staff and PFO cell spent a significant amount of energy establishing and clarifying respective roles and responsibilities.

Effective September 21, 2005, the Acting Under Secretary for EP&R designated the PFO as FCO for the states of Alabama, Mississippi, and Louisiana.<sup>3</sup> Several officials commented that the eventual blending of PFO and FCO authorities suggests an unnecessary division within the NRP. Others added that the FCO's statutory authorities as the representative of the President fully encompass the PFO role. Further, if one justification for a PFO is to reduce the non-operational burden of the FCO, such as public and media relations, combining the roles defeats the purpose.

## Command and Control Issues Are Not New for Domestic Incident Management

During the response to Hurricane Andrew in 1992, the Federal Response Plan provided the command and control structure for federal response assistance within the Disaster Field Office.

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<sup>1</sup> 42 U.S.C. §5143, Coordinating Officers.

<sup>2</sup> We also observed a gravitation of the PFO towards a more operational rather than coordination role during the *Top Officials 3* exercise.

<sup>3</sup> 70 Fed. Reg. 57308 and 57309 (September 30, 2005).

However, the structure was not implemented entirely as described in the Federal Response Plan. This was in part because top-level officials in the federal government were unfamiliar with the Plan. In addition, a Presidential Task Force and a DOD Joint Task Force were added, which created initial confusion and uncertainty when they joined the response. Working relationships, roles, chain of command, and authority were not well defined between personnel in the Disaster Field Office, the Presidential Task Force, and the Joint Task Force. Many of the command and control problems that existed following Hurricane Andrew were a “result of inadequate pre-disaster planning, training, and exercising” of large-scale disaster scenarios.<sup>4</sup>

Similar command and control problems arose during the Top Officials 3 exercise in April 2005 following the implementation of the NRP. For example, confusion existed among top-level officials over roles and responsibilities of the PFO and FCO. This exercise “highlighted – at all levels of government – a fundamental lack of understanding for the principles and protocols set forth in the NRP and NIMS.”<sup>5</sup> The command and control problems and confusion had not been resolved when Hurricane Katrina struck.

In addition, as a result of the Hurricane Katrina’s magnitude, and subsequent levee breaches in New Orleans, a large number of Urban Search and Rescue (US&R) resources were needed quickly within the area. Because US&R task forces came from locations across the United States, ESF-9, Urban Search and Rescue phased in FEMA US&R deployments; full strength was reached in Louisiana on August 31, 2005, and in Mississippi on September 1, 2005. Also, the majority of search and rescue personnel were not provided through ESF-9. In addition to state and local first responders and volunteers, U.S. Coast Guard, Department of Defense, National Guard, and Emergency Management Assistance Compact (EMAC) resources augmented search and rescue efforts in the affected area. The U.S. Coast Guard performed 32,967 rescues as of September 6, 2005.

Many US&R resources were not coordinated with or by FEMA in its role as ESF-9 coordinator. When providing ESF-9 status reports for DHS situation reports, FEMA reported only information concerning FEMA national US&R task forces. In addition, the FEMA’s National Response Coordination Center Operations Section Chief tasked the U.S. Coast Guard with rescue missions directly, rather than going through ESF-9 to coordinate rescue operations.

Lack of coordination resulted in duplicative searches. FEMA US&R task forces conducting secondary building searches found symbols indicating US&R resources in the area through EMAC had already searched the buildings. US&R officials indicated they had very little coordination with the EMAC resources in the field. EMAC was an extremely useful resource; however, FEMA and EMAC resources need better coordination among search and rescue task forces to avoid duplicative efforts. We need to address, train, and exercise command and control issues before disasters occur to prevent confusion and duplication of efforts.

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<sup>4</sup> FEMA OIG, *FEMA’s Disaster Management program: A Performance Audit After Hurricane Andrew*, January 1993, p. 71.

<sup>5</sup> DHS OIG, *A Review of the Top Officials 3 Exercise*, November 2005, p. 2.



## Coordination of Federal Government Response Efforts

Under the NRP, 32 federal departments and service agencies agreed to supporting NRP concepts, processes, and structures and carrying out their assigned functional responsibilities, including designating representatives to staff interagency coordinating structures, as required.

Under the authorities of the *Stafford Act* and the NRP, FEMA is responsible for providing the necessary emergency management leadership to other federal departments, agencies, and other organizations when responding to incidents of national significance. This includes coordinating ESFs for emergency management; mass care, housing, and human services; urban search and rescue; long-term recovery; external affairs; and providing disaster assistance to individuals and communities. FEMA is also responsible for providing resources such as generators, US&R teams, and National Disaster Medical System teams.

However, as a coordinator of emergency activities and functioning as a coordinating or primary agency of an ESF, FEMA is largely dependent on other agencies and outside resources in executing much of the activities that take place. For example, while FEMA should address asset visibility, a number of factors outside of FEMA's control affect its ability to deliver requested commodities, including the reasonableness of field requests, supplier inventories, and the availability of transportation resources.

In addition, when FEMA issues mission assignments to other federal agencies to perform work in support of FEMA or the state, FEMA is dependent upon those agencies and departments to perform those tasks in an expeditious manner. Such tasks include sourcing, procuring and transporting food, water, and ice to distribution points or shelter locations. For example, in order to fulfill its logistics mission, FEMA may require the support of the following emergency support functions:

- ESF-1, Transportation: The Department of Transportation (DOT) maintains a national transportation contract capable of providing ground, rail, marine, or aviation assets. If necessary, DOT has the capability to contract for additional transportation resources. If commercial transportation is not available, DOT may request Department of Defense support.
- ESF-3, Public Works and Engineering: The U.S. Army Corps of Engineers (USACE) maintains commodity contracts for ice and drinking water.
- ESF-7, Resources Support: The General Services Administration (GSA), as the central procurement authority for the federal government, provides additional contracting support.

Because the NRP assigns coordinating and primary ESF roles to other federal agencies in addition to DOT, USACE, and GSA, those agencies must be able to effectively coordinate their activities with additional federal agencies.

The need for top federal government officials to plan, train, and exercise together was stressed in a 1998 Senate Report. Aware that numerous exercises were conducted each year to practice operations in the event of a terrorist incident, the U.S. Senate understood that few of the top officials of agencies and departments had ever fully participated in those exercises. The Senate, therefore, directed in fiscal year 1999 that an exercise be conducted to include all key personnel who would participate in the consequence management of an actual terrorist event. This led to a national bi-annual series of Top Official (TOPOFF) exercises. The first was conducted in 2000.

We reviewed the most recent TOPOFF exercise, conducted in April 2005, and produced a report, *A Review of the Top Officials 3 Exercise* (November 2005) that contained recommendations for corrective action. We determined that the exercise highlighted at all levels of government a fundamental lack of understanding regarding the principles and protocols set forth in the NRP and NIMS. Guidance and procedures to define how each function interrelates within the NRP were absent. We recommended that FEMA consult with federal departments and agencies to develop operating procedures that clearly define individual and organizational roles and responsibilities under the NRP, and continue to train NRP and NIMS with all levels of government.

It is imperative that every federal agency and department, especially those that have committed to supporting the concepts, processes, and structures of the NRP, maintain a readiness posture consistent with their responsibilities under the plan. As the White House report on Hurricane Katrina lessons learned points out:

“Each primary department or agency for each ESF and support annex should develop a detailed operations plan on how they will become operational and coordinate with other annexes and ESFs during a major incident. These operational plans should conform to NIMS and be consistent with the recommended reconfiguration of the ESF structure. These plans should be exercised yearly through either National, departmental, or agency exercises.”

Departments and agencies should be afforded both personnel and funds to train, exercise, plan, and detail staff to disaster response activities to enable better execution of their roles and responsibilities and plans and procedures. Specific contingency plans must be developed and integrated so that capabilities and gaps are identified and addressed.

The TOPOFF 3 exercise provided DHS and other federal planners and participants with an opportunity to exercise decision making within the framework of the newly implemented NRP, NIMS, and the operating procedures of the IIMG and the HSOC. The scope of the exercise involved establishing incident scenes and required first responders to perform actions usually associated with an initial response to a terrorist incident. Those actions included victim rescue, triage, treatment, decontamination, hazard identification, site security, crowd control, render-safe procedures on devices or weapons, monitoring for contamination, contamination control, and device recovery and packaging.

A major undertaking in TOPOFF 3 was integrating DOD participation, as it had not traditionally played an active role in domestic responses to acts of terrorism. Although engagement of DOD

was for the most part successful, the exercise identified integration issues that require further discussion and analysis at both federal and state levels of government.

We observed that DOD and DHS planners struggled to develop a scenario to facilitate and integrate DOD's participation in the exercise. TOPOFF 3 was to provide DOD with an opportunity, in conjunction with civil authorities under the newly implemented NRP, to test its role in the national strategy for domestic emergency preparedness and response. Historically, DOD had asserted that civil agencies should lead domestic emergency preparedness and response efforts. DOD considered its domestic emergency response role as providing only supplemental support or assistance, following the exhaustion of federal, state, and local resources. In addition, concerns about the *Posse Comitatus Act* and possible misunderstandings of its scope also tended to restrict deployment of DOD forces.<sup>6</sup>

As Hurricane Katrina proved, DOD's role in future domestic emergency preparedness and response efforts may no longer be as limited as previously thought. Ironically, after Hurricane Andrew, the FEMA's Inspector General reported that FEMA needed to clarify with the DOD under the Federal Response Plan their use of the Joint Task Force concept in response operations, and the relationships with the Defense Coordinating Officer role and the DOD support roles in each of the ESFs.

In our TOPOFF 3 report, we encouraged DHS as a part of its planning process for future exercises, to survey federal departments and agencies and their components to identify the events and mechanisms necessary for DOD activation and the operating procedures that govern its participation. By working in partnership with other federal departments and agencies, DHS could facilitate interagency cooperation and integration into the TOPOFF exercise series better. Further, we emphasized the need for DOD participation in NRP and NIMS training to solidify its role and responsibilities for homeland security and to facilitate an enhanced understanding among federal, state, and local agencies of DOD's role.

Further, we highlighted the concerns expressed by other federal agencies that federal departments and agencies must use funds from their base operating budgets to plan and participate in the exercise, which may have resulted in limiting the resources they could commit. In effect, they have to cannibalize from other programs to find resources for their planning and participation efforts. Grants from DHS can be used by state and local governments for exercising, which dramatizes the plight of federal agencies, most of which are not in the responder business ordinarily and need such funding as they would for other purposes. We must construct a better mechanism to line item/earmark funding expressly for response exercising by federal agencies and perhaps place more priority in grants to states for the same purpose. This could also serve as a better way for FEMA to assess a state's capabilities rather than the current "self-assessments" process. It has become increasingly important that federal departments and

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<sup>6</sup> Congress passed the *Posse Comitatus Act*, 18 U.S. Code, Section 1385, after the Civil War to prohibit the use of the Army in civilian law enforcement. The Act embodies the traditional American principle of separating civilian and military authority and currently forbids the use of the Army, Air Force, Navy, and Marine Corps to enforce civilian laws. See 10 U.S. Code, Section 375. The prohibitions do not apply to the U.S. Coast Guard in peacetime. Generally supportive and technical assistance (e.g., use of facilities, vessels, aircraft, intelligence, technical aid, surveillance, etc.) is permitted while direct participation of military personnel in law enforcement (e.g., search, seizure, and arrests) is prohibited.

agencies institutionalize their participation in planning, training, and exercise activities; account for the costs associated with their participation; and, undertake planning, training, and the commitment of resources in future exercise opportunities. Regardless, TOPOFF 3 involved various levels of participation from 27 federal agencies and departments.

Furthermore, to effectively address disaster response, recovery, and oversight, federal interagency data sharing and collaboration are a must. However, data-sharing arrangements between FEMA and other federal agencies to safeguard against fraud and promote the delivery of disaster assistance are not in place. Critical tasks, from locating missing children and registered sex offenders to identifying duplicate assistance payments and fraudulent applications, have all been hindered because mechanisms and agreements to foster interagency collaboration did not exist prior to Hurricane Katrina.

Just this past week an agreement was reached between the Department of Justice and FEMA to allow the Hurricane Katrina Fraud Task Force direct access to DHS/FEMA's "Disaster Assistance Recovery Files." This agreement will go a long way in helping the Katrina Fraud Task Force identify and pursue fraudulent claims of disaster relief assistance. The FBI also believes direct access to FEMA data would significantly assist its efforts in locating missing persons and sexual predators. A significant number of children are still sought by relatives in the aftermath of Hurricane Katrina and the whereabouts of previously registered sex offenders remain unknown. Presently, the process in place for law enforcement to obtain information from FEMA's disaster assistance files is inadequate because of FEMA's rigorous guidelines.

Currently, the FBI must go through an extensive, multi-tiered process before it can acquire necessary data. The process begins with a request made by the FBI to FEMA's Office of Counsel and then forwarded to FEMA's data specialists where the information is collected and subsequently provided to the FBI. The FBI has indicated that the quickest response it has received was within 48 hours, though fulfillment of the requests customarily takes significantly longer. The FBI notes that due to technical issues, limited staffing, and coordination issues, acquiring data has often been a protracted process. As of today, an agreement allowing the FBI direct access to FEMA's disaster recovery files still has not been reached.

In other data-sharing initiatives, the U.S. Department of Housing and Urban Development (HUD) and FEMA are presently working to establish a computer-matching program to detect excessive or insufficient housing assistance. We believe that similar arrangements with the Social Security Administration, Small Business Administration, Internal Revenue Service, Postal Service, and others, would be beneficial to detecting fraud and facilitating the delivery of disaster assistance to eligible applicants, particularly if the data can be shared in real-time. We are currently reviewing data sharing processes and procedures that can be enhanced to promote effective interagency collaboration. We believe agencies should put in place data sharing agreements to facilitate response, recovery, and oversight in conjunction with an emergency declaration. This would not only facilitate the delivery of assistance to disaster victims, but also would be a major factor in preventing fraud, waste, and abuse in FEMA's disaster relief programs.

## Visibility of Deployed Assets

FEMA is responsible for supplying commodities, equipment, personnel, and other resources to support emergency or disaster response efforts of affected states. Therefore, FEMA's ability to track resources is key to fulfilling its mission.

In response to Hurricane Katrina, state officials expressed frustration with the lack of asset visibility in the logistics process. Officials indicated they had ordered water, ice, and Meals-Ready-To-Eat in quantities far greater than what was delivered. Yet, when they attempted to determine where additional quantities were in the delivery process, they were told the commodities were "in the pipeline." According to FEMA field officials, on average, Mississippi received less than 50 percent of the commodities it requested between August 27, 2005, and September 5, 2005. Similarly, during the 2004 hurricane season, when asked about the delivery status of requested ice and water, federal logistics personnel could only tell requesting state officials that the commodities were en route.

In our review of FEMA's performance following Hurricane Katrina, we looked at the process for ordering and filling resource requests. We determined an inconsistent process was used. It involved multiple, independent computer and paper-based systems, many of which generated numerous, unique tracking numbers and few of which were cross-referenced. Similarly, the White House report revealed a highly bureaucratic federal supply process that was not sufficiently flexible or efficient to meet requirements, and that failed to leverage the private sector and 21st Century advances in supply chain management. FEMA must develop a means to standardize and streamline its resource ordering and tracking process.

In our report, *Emergency Preparedness and Response Could Better Integrate Information Technology with Incident Response and Recovery* (September 2005) we stated that FEMA Logistics Inventory Management System (LIMS) provides no tracking of essential commodities, such as ice and water, needed by disaster victims. As a result, FEMA cannot readily determine its effectiveness in achieving DHS' specific disaster response goals and whether or not there is a need to improve. LIMS is essentially an inventory system used to manage equipment and accountable property, such as cell phones or pagers. However, once the items are identified for deployment, LIMS does not indicate when they will be shipped or when they should arrive. To compensate, emergency personnel said that they tracked items on a spreadsheet and spent a significant amount of time calling trucking companies to determine the status and projected arrival times of in-transit goods. This also required the assignment of additional personnel to obtain the status of deployed commodities and complicated emergency response planning and coordination.

Further we noted that FEMA's disaster response culture has supported the agency through many crisis situations, such as the 2004 hurricanes. However, FEMA's reactive approach encourages short-term systems fixes rather than long-term solutions, contributing to the difficulties it encountered in supporting response and recovery operations. Without taking the time to fully define and document systems requirements, it is difficult for FEMA to evaluate viable alternatives to its custom-designed systems. Also, the reactive manner in which information

technology systems are funded and implemented has left little time for proper systems testing before they are deployed.

The White House report makes similar observations in stating, “FEMA’s lack of a real-time asset-tracking system – a necessity for successful 21st Century businesses – left Federal managers in the dark regarding the status of resources once they were shipped.” While a number of factors outside of FEMA’s control affect its ability to deliver requested commodities, including the reasonableness of field requests, supplier inventories, and the availability of transportation resources, the effectiveness of a response depends upon the ability to anticipate and address potential shortfalls through adequate contingency planning.

Interestingly, the White House Report states, “DOD should have a contingency role and a requirement to assist DHS with expertise in logistics, planning, and total asset visibility.”

In 2004, FEMA Logistics received approval from its headquarters to pilot an asset visibility system, which involved putting tracking units on selected trucks to monitor their movement. Once surge funds became available in anticipation of Hurricane Katrina making landfall, it was estimated that 25 to 33 percent of the trucks were equipped with tracking units. FEMA logistics officials said that budgeted funds were simply not available to purchase the number of tracking units needed to equip all of the trucks used. However, due to software limitations of the tracking equipment, FEMA was unable to determine whether a truck had been offloaded or had changed cargo once it left its point of origin. Additionally, FEMA had to retrieve the tracking units from trailers that were not FEMA-owned. Once testing of the asset visibility system is complete, FEMA advised that a decision would be made as to whether the system will be pursued. In our opinion, it is absolutely essential that FEMA possess the capability to track assets real-time, across federal, state, and local organizations, otherwise, federal managers will continue to operate “in the dark.”

### **Reliability of Communication Systems**

#### **Consolidation of Reporting**

DHS had difficulty obtaining, verifying, and reporting disaster information during Hurricane Katrina. Physical damage to the communications infrastructure and an inadequate structure for collection and dissemination hampered DHS’ ability to obtain complete, timely, and accurate information. This included timely notification of key events such as the levee breaches and spontaneous sheltering of victims at the New Orleans Convention Center. It also included management reporting, such as the status of commodity deliveries and the number of victims in shelters. Unreliable information directly impacted the speed of the response and constrained the information DHS Public Affairs could provide to disaster victims, the public, and the media.

Part of the challenge in obtaining better disaster information involves adapting to the new structures created by the *Homeland Security Act* of 2002 and the NRP. Prior to these changes, under the Federal Response Plan, FEMA led an ESF-5 focused on information and planning duties. With the creation of DHS, the HSOC assumed a central role in gathering and analyzing

disaster information. The NRP further altered the structure by assigning new information processing and decision-making support roles to the IIMG and ESF-15, External Affairs. The relationship between the HSOC, National Response Coordination Center, FEMA's Operations Center, and IIMG needs clarification to streamline duplicative efforts and ensure rapid distribution of information.

These four groups were part of a larger network of responding entities that generated thousands of reports related to Hurricane Katrina. Despite the multiple levels of reporting, critical, timely, and accurate information did not consistently reach FEMA and DHS leadership. A second part of the challenge in obtaining better disaster information involves funding and applying existing information technology to manage this volume of reporting. During Hurricane Katrina, disaster information was fragmented and dispersed among many systems. These systems included the HSOC's Homeland Security Information Network, and sites with incident reports published by single federal departments and subcomponents, several DOD entities, and the American Red Cross. At the state level, incident, resource, and planning data was stored in commercially available software, which is not compatible for exchange with FEMA information software. No single, complete repository existed for data verification and analysis. Further, many of the incident reports contained contradictory information, creating challenges for staff that attempted to synthesize them, such as External Affairs staff developing public information on the progress of the response.

DHS should establish a common information management system to consolidate and publish disaster information including incident reports, contact information, duty logs, and resources. This recommendation is similar to the one that FEMA's Office of Inspector General made in 1993 after Hurricane Andrew, when it recommended that FEMA develop an online information system to consolidate disaster information. In April 2005, we again observed FEMA (and DHS) difficulties in compiling and analyzing disaster information during the TOPOFF 3 exercise, and, again, we recommended that DHS develop such a system. Information management is a recurring problem that requires a long-term solution.

### **Communications Interoperability**

Another widely reported problem during Hurricane Katrina was the operability of telecommunications equipment. Others have testified before this committee about the magnitude of destruction Hurricane Katrina wreaked on telecommunications lines, towers, antennas, and call centers. We support the recommendations made by the White House Task Force to improve the planning and strategy for communications restoration and to develop a deployable communications capability within DHS. We also support strengthening FEMA's Mobile Emergency Response Support teams to surge for catastrophic disasters.

However, when we look at communications operability, we need also to remember the issue of communications interoperability. During Hurricane Katrina, the need for interoperable communications equipment was overshadowed by basic operability. But during previous disasters, particularly the September 11<sup>th</sup> terrorist attacks, the inability of first responders to communicate across disciplines and jurisdictions led to tragic loss of life.

The *Homeland Security Act* of 2002 provided DHS' Science and Technology (S&T) directorate with the authority to adopt standards for interoperable communications equipment. The *Intelligence Reform and Terrorism Prevention Act* of 2004 requires that agencies including DHS accelerate the development of voluntary consensus standards for public safety interoperable communications.

Our forthcoming report, *A Review of DHS' Progress in Adopting and Enforcing Equipment Standards for First Responders*, shows that DHS has adopted no standards for interoperable communications equipment as of March 2006. The 12 standards S&T adopted to date are for personal protective and detection equipment, and no new equipment standards have been adopted since February 2004. S&T needs to improve its tracking of the status of standards being considered for adoption and to establish performance measures for timely completion of its standards adoption process.

In addition, we note that S&T has no regulatory authority to compel first responders to purchase equipment that conforms to the standards it adopts. Instead, S&T relies upon DHS' Office of Grants and Training to ensure, through grants management activities, that first responders procure equipment that conforms to S&T-adopted standards. However, S&T does not consistently advise the Office of Grants and Training on whether equipment it authorizes for purchase conforms to S&T-adopted standards. Further, grant guidance does not uniformly require that first responders purchase equipment listed on the Authorized Equipment List. For example, the Assistance to Firefighters Grant Program does not issue this guideline. DHS needs to improve the coordination between the S&T and Preparedness Directorates.

### **Media Relations**

ESF-15, External Affairs, serves as the primary means of sharing information and developing a unified message for the government, disaster victims, and the public. This function is new under the NRP, but combines the efforts of six FEMA components that had informally coordinated with each other during past incidents – Public Affairs, Community Relations, Congressional Affairs, International Affairs, Intergovernmental Affairs, and Tribal Affairs.

Prior to Hurricane Katrina, the TOPOFF 3 exercise was the only full activation of ESF-15 with FEMA components under DHS coordination. In a review of the exercise, we determined public information and media relations efforts to be effective, both within the exercise and in DHS' external communications about the exercise with the media and the general public. By contrast, in 1993 FEMA's Inspector General observed that the local media in Florida were not kept informed of FEMA's response efforts immediately following Hurricane Andrew, leading to a public perception of no substantial federal presence in the disaster area.

During Hurricane Katrina, many of the problems observed during Hurricane Andrew had been rectified, but new ones emerged. Trained External Affairs personnel were deployed to the Gulf Coast prior to landfall, but communications problems across the region – with large-scale outages of power, telephones, and radios – limited the capabilities of External Affairs in the



initial weeks. While local and national media were updated, many victims had no access to this information because of the level of infrastructural damage.

Difficulties in obtaining complete, timely, and accurate information on response efforts and the lack of trained staff for a disaster of Hurricane Katrina's magnitude also created obstacles for External Affairs. A number of DHS and FEMA staff complained of having to repeatedly figure out which response data were the most reliable, since information from a variety of incident reports was conflicting. While DHS was still able to produce a daily messaging template to help coordinate the Joint Information Centers, there is little doubt that the process could have been more effective and efficient.

Staffing issues, common across FEMA, also impeded the capabilities of External Affairs. While the rosters for each component contain highly skilled and trained people, the numbers were simply inadequate for a disaster of Hurricane Katrina's magnitude. In addition, overlaying DHS Public Affairs with FEMA's traditional External Affairs operation created its own unique challenges. DHS and FEMA have been working together on standardizing the External Affairs operation, but issues had not been fully resolved prior to landfall. Confusion over organization and hierarchy had to be sorted out in the midst of the largest response ever conducted by External Affairs.

The White House report recommended that a unified external affairs office be created within DHS, combining public affairs, legislative affairs, and intergovernmental affairs and headed by an Under Secretary for External Affairs. This type of organization would match day-to-day operations with those during a response. We observed that FEMA could benefit from a similar reorganization.

External Affairs managed to set up a unified operation with officials in Alabama and Mississippi. On the other hand, Louisiana officials, after a verbal altercation on August 31, 2005, between FEMA's Director and a communications staff member from the Louisiana Governor's office, elected not to conduct external affairs jointly with ESF-15. Both federal and Louisiana officials felt they could have provided a more positive and unified image to the press and the public had they combined their efforts from the beginning. In particular, FEMA officials noted that the visible lack of cooperation helped to undermine public confidence in FEMA operations and diverted media attention from FEMA's victim assistance efforts.

Ultimately, the combination of problems – communications, staffing, organization, and lack of coordination with Louisiana – created a situation where External Affairs was not as effective as it could have been, and those obstacles inhibited DHS' ability to be proactive in its messaging. Instead, the public heard the constant drumbeat that "FEMA failed," and messaging was reactive and never performed as envisioned. Efforts to manage the expectations of the media and the public by educating them on FEMA's responsibilities and programs, were overshadowed. The message that DHS and FEMA are responsible for making victims whole continues to be widely accepted.

FEMA needs to do a better job of engaging, or partnering with the national media in getting critical and potentially life-saving and life-sustaining information to victims in the affected area

and victims dispersed across the country. Both FEMA and DHS must work more aggressively and in partnership with the media to provide accurate and timely information. One alternative is to follow the lead of DOD and allow embedded reporters to participate in the response and recovery efforts.

### **Other Critical Concerns**

The White House report, *The Federal Response to Hurricane Katrina Lessons Learned February 2006*, identifies deficiencies in the federal government's response and presents lessons learned and recommendations for corrective action. We agree with and endorse the 17 critical challenges identified in the report.

However, we have concerns with two of the report's recommendations affecting human services and housing:

1. "The Department of Health and Human Services should coordinate with other departments of the Executive Branch, as well as state governments and nongovernmental organizations, to develop a robust, comprehensive, and integrated system to deliver human services during disasters so that victims are able to receive federal and state assistance in a simple and seamless manner. In particular, this system should be designed to provide victims a consumer oriented, simple, effective, and single encounter from which they can receive assistance."(Page 49)
2. "Using established federal core competencies and all available resources, the Department of Housing and Urban Development, in coordination with other departments of the Executive Branch with housing stock, should develop integrated plans and bolstered capabilities for the temporary and long-term housing of evacuees. The American Red Cross and DHS should retain responsibility and improve the process of mass care and sheltering during disasters." (Page 50)

The report correctly identifies these two critical challenges as deficiencies in the federal response to Hurricane Katrina. However, the accompanying lessons learned and recommendations, as proposed, may create a greater bifurcation in the timely and consistent provision of assistance to victims of disaster.

As proposed, FEMA will retain its responsibility along with the American Red Cross for mass care and sheltering during disasters. In this role, FEMA is directly positioned to coordinate with state governments and nongovernmental organizations to assist victims as they transition to more temporary, interim, and longer-term housing. FEMA has longstanding and established relationships with states and with voluntary agencies that provide disaster housing assistance. Transferring this responsibility to another federal agency could hinder rather than help victims with their housing needs.

Also, FEMA authorities allow for the provision of financial assistance and, if necessary, direct services to eligible individuals and households who, as a direct result of a major disaster, have necessary expenses and serious needs and are unable to meet such expenses or needs through

other means.<sup>7</sup> FEMA administers the Individual and Households Program to provide this assistance and funds 100 percent of the housing assistance component and co-administers with states the other needs assistance component under a 75/25 percent cost share. This program is FEMA's primary mechanism to assist individuals and households recover from damages or losses sustained as a direct result of a disaster.

In our opinion, transferring FEMA's housing and human services programs to other federal entities could significantly affect the continuity of assistance to disaster victims. Rather than defining FEMA's role as only responsible for mass care and sheltering, we believe more attention and resources needs to be focused on FEMA's coordination and case management activities with other federal and nongovernmental partners to facilitate and expedite a disaster victim's recovery.

### **Turning Lessons Learned into Problems Solved**

The White House, Congress, DHS, FEMA, the Offices of Inspector General, the Government Accountability Office, the media, and others have invested much work in critiquing the federal response to Hurricane Katrina. FEMA in particular has a routine process of facilitator-led discussions, or "hotwashes," to identify lessons for future disasters based on past catastrophes such as Hurricanes Katrina and Andrew, and based on the hundreds of smaller-scale disasters that occurred in between. But those "lessons learned" are really nothing more than "lessons recognized" until solutions are put in place. However, implementing changes to transform lessons into solutions occurs for only a fraction of lessons learned, which allows problems to recur as much as a decade after they were first recognized. Stronger mechanisms are needed to ensure that changes are implemented.

FEMA implemented several significant changes based on the lessons learned from Hurricane Andrew, and these improved the response to Hurricane Katrina. For example, the Federal Response Plan, which became effective in 1992, did not provide adequately for mobilizing and deploying resources in advance of the storm. Throughout the 1990s, FEMA built up a logistics structure to support early deployment of equipment and commodities such as generators, water, and meals. For Hurricane Katrina, FEMA pre-positioned commodities at 16 sites around the Gulf Coast, in greater quantities than for any previous natural disaster. While the quantities were not sufficient, given the scale of Hurricane Katrina's devastation, the repositioning was nevertheless a significant increase in FEMA logistics efforts since Hurricane Andrew. In a second example, the Federal Response Plan lacked provisions for security and coordination of federal and local law enforcement. The NRP added ESF-13, Public Safety and Security, to integrate and coordinate federal law enforcement support. During Hurricane Katrina, ESF-13 coordinated the work of over 2,800 federal law enforcement officers in Louisiana and Mississippi.

Two other examples of FEMA changes to resolve lessons learned from Hurricane Andrew involve processes for supporting disaster victims. FEMA's Inspector General made multiple recommendations that FEMA revise how it obtains basic information to register victims. During

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<sup>7</sup> 42 U.S.C. §5174 and 44 CFR Part 206, Subparts D and F.

Hurricane Andrew, FEMA had difficulty establishing sites for registering victims in person; and its telephone registration process was slow and overwhelmed by caller volume. As a result of lessons identified from Hurricane Andrew, FEMA developed a Mobile Disaster Recovery Center capability for registering victims in person; 24 of these mobile centers deployed to Texas, Alabama, Louisiana, and Mississippi for the Hurricane Katrina response. FEMA boosted its capacity for registering applicants over the telephone. Further, FEMA developed the capacity to register victims via the internet; over 46 percent of registrations for Hurricane Katrina used online applications during the two weeks after landfall.

However, many other lessons learned from Hurricane Andrew and subsequent disasters have led to recurring problems rather than solutions. The following are some examples of lessons that Hurricane Katrina demonstrated we have only recognized, but not resolved:

- Expectations of State and Local Capabilities. Hurricane Andrew overwhelmed state and local capabilities to respond, and many of the state and local officials could not specify their needs for federal assistance. Since the federal responders expected state requests, this led to delays in assisting victims. During Hurricane Isabel, in 2003, federal expectations again differed from state and local capabilities. In that case, FEMA expected the affected states to support themselves with basic provisions for the first 72 hours, but states required federal assistance sooner. In 2003, it was recommended that FEMA communicate closely with the states regarding their mutual expectations. However, during Hurricane Katrina, FEMA remained unable to determine the point at which states will become overwhelmed and require federal assistance. FEMA's awareness of state capabilities is now based on state self-assessments and a third-party review conducted and compiled by a nongovernmental organization, which does not include 21 states and territories and has no requirement that state assessments be kept current. DHS should develop a stronger system to assess state capability to respond to a disaster.
- Federal Command and Control. During Hurricane Andrew, the command and control structure did not clearly define working relationships to encompass a Presidential Task Force, emergency managers from the FCO down to the local level, and the incorporation of DOD support. The recent changes under the NRP, including the creation of the PFO, did not resolve the confusion during exercises such as TOPOFF 3 and did not resolve the confusion during the response to Hurricane Katrina. DHS still needs to figure out how to synthesize these elements, in advance of disasters, in order to prevent delays and duplication of efforts on the ground.
- Need for Greater use of Information Technology. FEMA is not yet making full use of available technology and data sources to verify property losses. Hurricane Andrew established that the process of individual inspections to determine property damage was inefficient. FEMA's Inspector General recommended that FEMA arrange access to databases for verifying ownership or residency prior to a disaster, especially in disaster-prone areas. Thirteen years later, FEMA is not yet making full use of this information. FEMA's Inspector General also recommended that new technologies be established to expedite the loss verification process. Based on our observations of Hurricane Katrina

operations, much more still needs to be done. FEMA should place priority on its efforts to use new methods and technology to verify damage, occupancy, and ownership, when traditional methods of inspection are not responsive in the timely provision of assistance.

In a second example, FEMA needs to make greater use of available information technology to manage reporting information. After Hurricane Andrew, FEMA's Inspector General recommended FEMA develop an automated system to synthesize and adapt federal and state operational reports to produce needed management information and statistics. FEMA's Inspector General also recommended then that the system provide online access to federal officials. DHS' HSOC has assumed much of the responsibility for information management, but this automated system is still needed.

What mechanisms should be used to ensure that lessons result in solutions? FEMA's primary accountability mechanism was enacted in 2003 and needs to be strengthened. The Remedial Action Management Program, or RAMP, combines the essential components of a lessons learned system: collecting issues from hotwashes around the country, consolidating issues into a single report, assigning responsibility for fixing problems, and monitoring the progress of those solutions. However, the program does not have consistent high-level oversight or support, and it does not have strong mechanisms to ensure completion of assigned remediation tasks. FEMA omitted monthly RAMP reports for September through December 2005 due to hurricane response demands. The August 2005 monthly RAMP report showed four action plans overdue and five remediation completion dates missed.

Further, the system does not require interim solutions when remediation plans are long-term. As of December 2005, RAMP contained eight outstanding remedial action issues that have a remediation completion date greater than one year from the time the issue was assigned. We observed no interim remediation measures in RAMP for these long-term solutions. For example, in December 2004, FEMA added a remedial action in RAMP for improving visibility of logistics assets. FEMA began implementing a total asset visibility program in the summer of 2005, but during Hurricane Katrina FEMA remained unable to track most state requests through to order fulfillment. FEMA staff revised this action's completion date twice, extending it to October 2009. Since the majority of disasters to which FEMA responds recur on a yearly cycle, such as hurricanes, long completion dates will allow the problems and issues to recur. FEMA should implement interim solutions to lessen the impact of known problems.

Beyond FEMA, the mechanisms to ensure the implementation of lessons learned are weaker. DHS' primary lessons learned repository, the Lessons Learned Information Sharing website, consolidates lessons learned in a single site and makes them accessible to emergency response providers and homeland security officials throughout the country. However, it does not include mechanisms for pushing new lessons learned to appropriate parties, for assigning responsibility for implementing the lessons, or for monitoring the progress of lesson implementation. We endorse the White House Task Force's recommendation for DHS to help extend Remedial Action Management Programs throughout the federal government, creating a comprehensive system to ensure that lessons recognized become problems solved. This recommendation needs to be accompanied by a funding mechanism to bridge the gap between identified solutions and the resources required to implement them.

Let me end my statement with reiterating our goal and intention, which is to take the lessons learned from the response to Hurricane Katrina and assist DHS to form the foundation for critical improvements necessary for the nation to prepare for and respond to any disaster – natural or man-made.

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Madam Chairman that concludes my prepared statement. I would be happy to answer any questions you or the members may have.

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