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Homeland Security Exercise and Evaluation Program (HSEEP)  
After Action Report/Improvement Plan  
(AAR/IP)

Operation Green Light

# Operation Green Light

August 17-19, 2012



## AFTER ACTION

# REPORT/IMPROVEMENT PLAN

September 15, 2012

Nevada Division of Emergency Management  
2478 Fairview Drive  
Carson City, Nevada 89701

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After Action Report/Improvement Plan  
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## EXECUTIVE SUMMARY

The NDEM Search and Rescue (SAR) Full Scale Exercise (FSE) *Operation Green Light* was developed in conjunction with eight Nevada counties, the Nevada Air and Army National Guard, and several federal agencies to test NDEM EOC Management, jurisdictional SAR capability, and communications capability throughout the various agencies involved. The exercise planning team was composed of representatives of each agency involved in the FSE. The exercise planning team discussed the best way to test specific ESF functions that would be necessary to work with ESF-16 (Military) and assist the National Guard to meet its objectives for its FE.

Based on the exercise planning team's deliberations, the following objectives were developed for Operation Green Light:

- Objective 1: Land Based Search and Rescue (SAR) – Test activation of jurisdictional SAR teams, management of SAR tactical operations, stabilization and transport of injured subjects, multi-jurisdictional mutual aid.
- Objective 2: EOC Management - Test ability of State EOC to provide resource support and coordination, upon request, through the Duty Officer function.
- Objective 3: Communication – Test alert and dispatch procedures at jurisdictional and state levels, determine interoperability in multi-jurisdictional operations involving county, state, and military resources.

The purpose of this report is to analyze exercise results, identify strengths to be maintained and built upon, identify potential areas for further improvement, and support development of corrective actions.

### Major Strengths

The major strengths identified during this exercise are as follows:

- This exercise demonstrated the ability of multiple jurisdictions and levels of government to cooperatively provide search and rescue services when mutual aid becomes necessary.
- This exercise allowed the State EOC to provide resource support and coordination upon the request of county jurisdictions.
- This exercise, based on the demands of each scenario, demonstrated the depth of SAR capability throughout northern Nevada..

### Primary Areas for Improvement

See Attachments I-IV, Scenario reports.

## SECTION 1: EXERCISE OVERVIEW

### Exercise Details

**Exercise Name**

Operation Green Light

**Type of Exercise**

Functional Exercise

**Exercise Start Date**

August 17, 2012

**Exercise End Date**

August 19, 2012

**Duration**

50 hours over three (3) days, including five (5) individual scenarios at various locations..

**Location**

State Emergency Operations Center, 2478 Fairview Drive, Carson City, NV 89701, Douglas, Elko, Carson City, Lyon, Storey, Pershing, Humboldt, and Washoe counties.

**Sponsor**

N/A

**Program**

N/A

**Mission**

Response

**Capabilities**

Land Based Search and Rescue (SAR), EOC Management, Communication

**Scenario Type**

Search and Rescue

### Exercise Planning Team Leadership

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Controller, Overdue Rancher  
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Controller, Trespassing Bikers  
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## Participating Organizations

Nevada National Guard (JOC, ESF-16, etc.)  
Nevada Division of Emergency Management  
Nevada Army National Guard  
Nevada Air National Guard  
National Weather Service  
Air Force Rescue Coordination Center (AFRCC)  
Fallon Naval Air Station  
Civil Air Patrol (CAP), Nevada Wing  
Carson City County Sheriff SAR

## Participating Organizations (cont.)

Douglas County Sheriff SAR  
Elko County Sheriff SAR  
Humboldt County Sheriff SAR  
Lyon County Sheriff SAR  
Pershing County Sheriff SAR  
Storey County Sheriff SAR  
Storey County Fire Department  
Storey County Communications  
Storey County Emergency Management  
Washoe County Sheriff SAR  
Comstock Mining, Inc.

## Number of Participants

- Players: 100 +/-
- Controllers: 5
- Evaluators: 10
- White Cell: 3

## SECTION 2: EXERCISE DESIGN SUMMARY

### Exercise Purpose and Design

*Green Light* is a Full Scale Exercise (FSE) designed to be coordinated with several other jurisdictions in an exercise series comprised of numerous exercises, drills, and other preparedness activities utilizing a progressive approach. These activities include participation by local, state, and federal agencies that would support response efforts during a real severe weather incident in Nevada.

In addition, the exercise will allow State and Local agencies to interface and integrate response activities that would support response efforts during an actual event.

Furthermore, the exercise will demonstrate the capability of regional operational coordination and critical communications.

**Green Light will further develop and strengthen regional partnerships and enhance emergency preparedness, response, and prevention capabilities.**

### Exercise Objectives, Capabilities, and Activities

Capabilities-based planning allows for exercise planning teams to develop exercise objectives and observe exercise outcomes through a framework of specific action items that were derived from the Target Capabilities List (TCL). The capabilities listed below form the foundation for the organization of all objectives and observations in this exercise. Additionally, each capability is linked to several corresponding activities and tasks to provide additional detail.

Based upon the identified exercise objectives below, the exercise planning team has decided to demonstrate the following capabilities during this exercise:

- Objective 1: Land Based Search and Rescue (SAR) – Test activation of jurisdictional SAR teams, management of SAR tactical operations, stabilization and transport of injured subjects, multi-jurisdictional mutual aid.
- Objective 2: EOC Management - Test ability of State EOC to provide resource support and coordination, upon request, through the Duty Officer function.
- Objective 3: Communication – Test alert and dispatch procedures at jurisdictional and state levels, determine interoperability in multi-jurisdictional operations involving county, state, and military resources.

## Scenario Summary

See Scenario Reports, Attachments I-IV.

## SECTION 3: ANALYSIS OF CAPABILITIES

This section of the report reviews the performance of the exercised capabilities, activities, and tasks. See Attachments I-IV for analysis.

### Capability 1: Land Based Search and Rescue (SAR)

**Capability Summary:** Coordinate and conduct search and rescue (SAR) response efforts for all hazards, including searching affected areas for victims (human and, to the extent no humans remain endangered, animal) and locating, accessing, medically stabilizing, and extricating victims from the damaged area. Specific objectives include:

1. Conduct search and rescue operations to locate and rescue persons in distress, based on the requirements of state and local authorities.
2. Initiate community-based search and rescue support operations across a wide geographically dispersed area.
3. Ensure the synchronized deployment of local, regional, national, and international teams to reinforce ongoing search and rescue efforts and transition to recovery.

### Capability 2: EOC Management

**Capability Summary:** Emergency Operations Center (EOC) Management is the capability to provide multi-agency coordination (MAC) for incident management by activating and operating an EOC for a pre-planned or no-notice event. EOC management includes EOC activation, notification, staffing, and deactivation; management, direction, control, and coordination of response and recovery activities; coordination of efforts among neighboring governments at each level and among local, regional, State, and Federal EOCs; coordination public information and warning; and maintenance of the information and communication necessary for coordinating response and recovery activities. Similar entities may include the National (or Regional) Response Coordination Center (NRCC or RRCC), Joint Field Offices (JFO), National Operating Center (NOC), Joint Operations Center (JOC), Multi-Agency Coordination Center (MACC), Initial Operating Facility (IOF), etc.

### Capability 3: Communications

**Capability Summary:** Agencies must be operable, meaning they must have sufficient wireless communications to meet their everyday internal and emergency communication requirements before they place value on being interoperable, i.e., able to work with other agencies. Communications interoperability is the ability of public safety agencies (police, fire, EMS) and service agencies (public works, transportation,

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hospitals, etc.) to talk within and across agencies and jurisdictions via radio and associated communications systems, exchanging voice, data and/or video with one another on demand, in real time, when needed, and when authorized. It is essential that public safety has the intraagency operability it needs, and that it builds its systems toward interoperability.”

Many activities listed under the **Communications** target capability address communication systems and networks, and their ability to adequately function. These align to the **Operational Communications** core capability definition and include:

1. Ensure the capacity to communicate with both the emergency response community and the affected populations and establish interoperable voice and data communications between Federal, state, and local first responders.
2. Re-establish sufficient communications infrastructure within the affected areas to support ongoing life-sustaining activities, provide basic human needs, and transition to recovery.

## SECTION 4: CONCLUSION

The NDEM Search and Rescue Full Scale Exercise Exercise (FSE) *Operation Green Light* successfully tested the State EOC and the many entities that took part. The realistic injects and communications from the White Cell helped make this exercise a successful testing of internal processes. The outcome of this exercise for the State EOC helps to demonstrate that we are on the right track with regard to planning, training, and exercising for improvement. We have built upon previous exercises and real-world incidents and are becoming more effective and efficient in supporting County jurisdictions in their requested needs.

The purpose of this report was to analyze exercise results, identify strengths to be maintained and built upon, and identify areas for further improvement. Results from this exercise report will impact NDEM multi-year training and exercising plans and efforts.

## APPENDIX A: IMPROVEMENT PLAN

This IP has been developed specifically as a result of SAREX 2012: Operation Green Light conducted on August 17-19, 2012. These recommendations draw on both the After Action Report and the After Action Conference. This IP has been formatted to align with the *Corrective Action Program System*.]

Capability	Observation Title	Recommendation	Corrective Action Description	Capability Element	Primary Responsible Agency	Agency POC	Start Date	Completion Date
1: Land Based Search and Rescue (SAR)	3. SAR Responder Training	3.1 Conduct civilian SAR responder training..	3.1.1 Train volunteer personnel to SAR initial response best practice level.	Training	County Sheriff	County Sheriff	Dec 1, 2012	Nov. 30, 2013
			3.1.2 Train volunteer personnel to SAR management response best practice level.	Training	County Sheriff	County Sheriff	Nov. 30, 2013	Jun 30, 2014
2. Communications	1. Inter-county SAR communications	1.1 Develop an inter-county SAR communications plan which identifies and integrates county specific SAR frequencies.  1.2 Exercise the Inter-County SAR communications plan.	1.1.1 Task the NV SAR Board Training Committee	Planning	NDEM	Paul Burke 775-687-0423	Dec 1, 2012	Mar. 1, 2013
			1.2.2 Design and conduct inter-jurisdictional SAR exercise utilizing the SAR communications plan	Training	County Sheriff	County Sheriff	Mar. 1, 2013	Jun. 30, 2013

## APPENDIX A: IMPROVEMENT PLAN

This IP has been developed specifically as a result of SAREX 2012: Operation Green Light conducted on August 17-19, 2012. These recommendations draw on both the After Action Report and the After Action Conference. This IP has been formatted to align with the *Corrective Action Program System*.]

Capability	Observation Title	Recommendation	Corrective Action Description	Capability Element	Primary Responsible Agency	Agency POC	Start Date	Completion Date
1: Land Based Search and Rescue (SAR)	1. Helicopter Hoist Operations	1.1 Conduct joint training with civilian ground SAR and Army National Guard (USARNG) helicopter resources.	1.1.1 Conduct and exercise hoist protocols	Training	USARNG	Cpt. Andrew Wagner 775-972-2703	Dec 1, 2012	Nov. 30, 2013
			1.1.2 Establish ground to air communication protocols.	Systems/ Equipment	USARNG	Cpt. Andrew Wagner 775-972-2703	Dec 1, 2012	Mar 1, 2013
	2. Unified Command	2.1 Conduct multi-agency Unified Command table top exercises.	2.1.1 Table Top (TTX) to refine the use of ICS Unified Command	Training	NDEM	Paul Burke 775-687-0423	Dec 1, 2012	Sep. 1, 2013
			2.2.2 Establish Unified Command communication protocols.	Planning	NDEM	Paul Burke 775-687-0423	Dec 1, 2012	Sep. 1, 2013

## APPENDIX B: PARTICIPANT FEEDBACK FORM

**Exercise Name:** Operation Green Light

**Exercise Date:** August 17-19, 2012

**Participant Name:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Agency/Jurisdiction:** \_\_\_\_\_

### Part I – Recommendations and Action Steps

1. **Based on your participation, please share what went right from your point of view and how beneficial this exercise was:**

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2. **Based on your participation, please share what improvement is needed for better inter-jurisdictional coordination:**

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**Part II – Exercise Design**

**1. What is your assessment of the exercise’s design and conduct?**

*Please rate, on a scale of 1 to 5, your overall assessment of the exercise relative to the statements provided below, with 1 indicating strong disagreement with the statement and 5 indicating strong agreement.*

<u>Assessment Factor</u>	<b>Rating of Satisfaction with Exercise</b>				
	<i>Strongly Disagree</i>				<i>Strongly Agree</i>
a. The exercise was well structured and organized.	1	2	3	4	5
b. The exercise gave enough time for collaborative team effort	1	2	3	4	5
c. If I had questions, others provided answers to my satisfaction.	1	2	3	4	5
d. Periodic exercises are needed on a regular basis with different, but probable scenarios we may face	1	2	3	4	5
e. Participants included the right people in terms of position	1	2	3	4	5

**2. What changes would you make to improve future Exercises we may have?**

*Please provide any recommendations on how this could be improved or enhanced.*

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## APPENDIX C: ACRONYMS

Acronym	Meaning
AAR/IP	After Action Report/Improvement Plan
AFRCC	Air Force Rescue Coordination Center
ARF	Action Request Form
CAP	Civil Air Patrol
CCCSO	Carson City County Sheriff's Office
DCSO	Douglas County Sheriff's Office
DEM	Nevada Division of Emergency Management
DPS	Department of Public Safety
ECSO	Elko County Sheriff's Office
EOC	Emergency Operations Center
ESF	Emergency Support Function
FSE	Full Scale Exercise
FOUO	For Official Use Only
FNAS	Fallon Naval Air Station
HCSO	Humboldt County Sheriff's Office
HSEEP	Homeland Security Exercise and Evaluation Program
ICS/EOC	Incident Command System/Emergency Operations Center (Interface)
JOC	Joint Operations Center
LCSO	Lyon County Sheriff's Office
NIMS	National Incident Management System
NVANG	Nevada Air National Guard
NVARNG	Nevada Army National Guard
NVNG	Nevada National Guard
NWS	National Weather Service
PCSO	Pershing County Sheriff's Office
SOP	Standard Operating Procedures
SCEM	Storey County Emergency Management
SCSO	Storey County Sheriff's Office
TTX	Tabletop Exercise
WCSO	Washoe County Sheriff's Office

**ATTACHMENT I**

**LYON COUNTY SCENARIO REPORT**

**OPERATION GREEN LIGHT**

**August 17-18, 2012**

**(ELT/Plane Crash Site – Sunrise Pass, Lyon County)**

**Evaluator: Lt. Bryan Veil, Lyon County SAR Coordinator**

**OBJECTIVE OF EVALUATOR:**

**Evaluate Lyon County Sheriff's Office Search and Rescue personnel in the overall handling/operations of Operation Green Light. Evaluation covers mainly Command Post/ Incident Command operations, as well as field work from staff.**

**HOW CALL INITIATED:**

**8-17-12**

**1300 Hours – Controller Polish called Rob Loveberg, Lyon County Assistant Emergency Manager, to determine if the weather event email had been sent out. It had not as Loveberg thought it was for information only. Controller Polish requested he forward the email that was sent by Kirsten Shreve at 0824 hours.**

**1306 Hours - Rob Loveberg sends out exercise weather message.**

**1615 Hours - Lyon County Sheriff's Office (Lyon) Dispatch received a call from the Nevada Department of Emergency Management (DEM) regarding the incident. The phone call was followed with the comment, "This is an Exercise." Lyon Dispatch took it as just a notification and didn't do anything with the information. This delayed proceedings and response from Lyon County Sheriff's Search and Rescue (Lyon SAR) personnel by approximately one-half an hour.**

**1643 Hours – Controller Polish called Lyon Dispatch and determined they had not done anything with the information received from DEM at 1615 hours. Controller Polish explained that this information should have been given to the Lyon Watch Commander to act upon and that dispatch needed to follow normal procedures regarding this incident.**

**1652 Hours- Lyon SAR Assistant Coordinator McDaniel was notified by me and advised to contact dispatch for info regarding the incident.**

**1659 Hours – Controller Polish called the Lyon Watch Commander, Lt. Pattison, and determined he had not done anything with the information. Lt. Pattison didn't pass on the**

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**information as he normally would as he was told it was an exercise and believed it was just a notification. This further delayed normal procedures in the activation of Lyon SAR.**

**1704 Hours – Lyon Dispatch paged out Lyon SAR personnel to stage at the Dayton Substation with ATV's. This was nearly 45 minutes after the initial call came in.**

**1706 Hours – Lyon Dispatch was contacted by Controller Polish who changed the staging area to Luzier Lane and US095 and cancelled ATV's. The initial staging area in Dayton would have been OK if the area could be accessed thru Eldorado Canyon but it cannot.**

**1710 Hours – Lyon County Amateur Radio Emergency Services (LCARES) activated due to possible communication problems in the area of the incident.**

**1712 Hours – Lyon SAR Assistant Coordinator McDaniel contacted me requesting Douglas County Sheriff's Search and Rescue (Douglas SAR) and Carson City Sheriff's Search and Rescue (Carson SAR.) I told him do what he needed to do. He contacted dispatch and requested Douglas SAR and Carson SAR. Controller Polish cancelled the request for Mutual Aid at that time for training purposes.**

**1820 Hours – Controller Polish notified Lyon Dispatch that if mutual aid or additional resources are requested to please make the request thru the DEM Duty Officer at 775-687-0498.**

**1857 Hours – Carson Dispatch contacted directly by Lyon Dispatch for mutual aid by Carson SAR**

**1858 Hours – Douglas Dispatch contacted directly by Lyon Dispatch for mutual aid by Douglas SAR**

**1903 Hours – Carson SAR called Lyon Dispatch to get contact information for Lyon SAR**

**1933 Hours – Controller Polish informed by Shuan Thomas that the request for Douglas County thru DEM was toned out as a search for a missing person in the area of Sunrise Pass Road.**

**1935 Hours – Controller Polish checked with Hourihan at the DEM SIMCEL and he indicated that the initial call by Lyon Dispatch to Douglas dispatch was not acted upon and that the call from DEM was regarding a downed aircraft not a search for a missing person.**

**1950 Hours – Lyon SAR personnel arrived at Sunrise Pass Road.**

**2000 Hours – Incident Commander Maginot requested that Douglas SAR stage at the foothills on Sunrise Pass Road and that Carson SAR stage at Brunswick Canyon in Carson City.**

**2015 Hours – Controller Polish reminded Incident Commander Maginot to establish command with Lyon Dispatch and Douglas SAR and Carson SAR**

**2018 Hours – Lyon SAR established “Sunrise ELT Command” with Lyon Dispatch but not with Douglas SAR or Carson SAR**

**2030 Hours – LCARES on frequency 440.050**

**2030 Hours – Corey Perman of Douglas SAR arrived at the Command Post. Controller Polish believed that Perman was there for the Unified Command or as a Liaison Officer if a Unified Command was not established.**

**2106 Hours – Rod Hogan of Douglas County SAR said they were staging at Lebo Springs. Controller Polish questioned why Rod Hogan was in charge of the Douglas SAR personnel when he had been involved in the initial planning meeting and knew where the initial GPS coordinate would be and where the crash site might be located based on discussions at the planning meeting.**

**2115 Hours – Controller Polish requested a status of Carson SAR but they could not be reached by Command**

**2133 Hours – Controller Polish notified by Hourihan at the DEM SIMCEL that Douglas SAR had located the crash site.**

**2143 Hours - Corey Perman of Douglas SAR confirmed that the crash site and three victims were found at approximately 2130 hours and Douglas SAR had not notified Lyon SAR.**

**2156 Hours – Lyon SAR notified Lyon Dispatch of found “Crash site.”**

**2208 Hours – Lyon SAR dispatched search team, F-2, to crash site**

**2250 Hours – Radio communications were poor between Lyon Command and Lyon Search Teams. In addition Douglas staging (Douglas Command) would not communicate information to Lyon Command. Lyon Command would have to request information on numerous occasions from Douglas. (This was the biggest problem throughout the exercise.) Controller Polish informed me that Lyon’s SO1 Bald was the frequency that would be the primary channel as pre-arranged with Shuan Thomas of Douglas SAR.**

**2306 Hours – Lyon Command was informed that Douglas SAR had located 8 victims. That was up from 3 that they had reported initially. This info came into Lyon Command well after the fact as confirmed by Corey Perman of Douglas SAR.**

**2323 Hours – Lyon SAR search team, F-2, advised going to “Base Camp” per Douglas SAR. Lyon Command never created a “Base Camp.”**

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**2330 Hours – Continued radio problems. Not able to reach Lyon SAR personnel on numerous occasions. The amateur radios would have helped but there were not enough personnel to accomplish this task.**

**2337 Hours – Lyon Command was advised, well after the fact, that Douglas SAR assigned a Lyon SAR search team, F-2, to a Douglas SAR team. Lyon SAR search team, F-1, on foot and on HT.**

**2347 Hours – Radio communications still poor. Search tactics not being done correctly. Lyon Command not being advised by Douglas SAR what the search teams were doing.**

**2352 Hours – Lyon SAR Human Remains Detection (HRD) team arrived at Douglas staging.**

**8-18-12**

**0014 Hours – Lyon Command was advised by Douglas SAR well after fact that 9 live bodies located. HRD team en route to site where victim jumped out of plane.**

**0015 Hours – HRD team on scene.**

**0020 Hours – Lyon SAR Team Leader, Emily Castle-Hukill, called via a cell phone and stated that Douglas SAR had released Carson SAR and Lyon SAR, however, Lyon SAR requested permission to stay with the HRD team.**

**0034 Hours – Lyon SAR search team, F-1, to go to high ground on Sunrise Pass Road and establish a relay for the other Lyon SAR teams.**

**0229 Hours – received information that a member of Lyon SAR search team, F-2, had an asthma attack at the crash scene several hours earlier and Lyon Command was never informed.**

**0302 Hours – HRD team at Douglas staging**

**0311 Hours – All Lyon search teams back at Command**

**OVERVIEW AND OPINION OF EVALUATOR:**

**Next time we need to advise Dispatch and the Watch Commander prior to the exercise and inform them that their participation is needed to make the exercise more real. They would also be advised that they are part of the evaluation and they need to follow agency policy and procedures for that incident.**

**Assistant SAR Coordinator McDaniel needs to familiarize himself with the Sunrise Pass area and know the roads. He also needs to be familiar with other events taking place (Best in the Desert Race). This will help in his planning of an initial staging area.**

**McDaniel initially did well by requesting Douglas SAR and Carson SAR. If the incident were real that would have happened immediately.**

**It took an extended amount of time for Lyon SAR to arrive at Sunrise Pass. Command wasn't established for nearly 30 minutes after arrival.**

**Dispatching of teams into the field took quite a while for Lyon SAR.**

**Douglas SAR Command didn't communicate well with Lyon Command. (Biggest Problem). It seemed as if Douglas SAR wanted to get through the exercise as fast as possible. They didn't treat the crash site as a crime scene and released personnel and security of the site. Evidence processing wasn't done at all until the Lyon SAR HRD team arrived.**

**Carson SAR didn't communicate with Lyon Command very well. In fact we did not even know where Carson was until we were informed that Carson SAR had arrived at the crash scene about the same time as one of our search teams.**

**It is my opinion that Assist. SAR Coordinator McDaniel and Lyon SAR Incident Commander Dennis Maginot should have been more aggressive addressing the communication and operations aspect with Carson SAR and Douglas SAR, especially with the incident being in Lyon County. Unified Command in my opinion was never established and no one really took charge.**

**One thing that I observed at times was when questioned by an evaluator / controller, Lyon Incident Commander became defensive. Assist. SAR Coordinator McDaniel expressed when he made suggestions to Incident Commander Maginot that he felt as if he was being "blown off" and his suggestions were never looked into or considered.**

**After "Several Hours" Lyon Command was finally advised by Douglas SAR that they had to treat a Lyon SAR member for asthma related issues. This notification should have been immediate.**

**My overall opinion of the incident is that a lot of individuals involved in the exercise didn't treat it as if it were real. At points there was no urgency when there should have been and at other points there was rushing when it should have been slower.**

**In debriefing with Lyon SAR members it is my opinion that due to the exercise their morale was very low. Communication was the biggest complaint and not knowing who was in charge. Their man tracking skills weren't utilized. Douglas SAR told Lyon SAR the**

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**ground was too hard to find anything, therefore, do a line search for the last victim.**

**Individuals involved in the planning process should not be involved in the exercise other than as a role player, evaluator, or coordinator. It is apparent that this created an earlier than expected find from Douglas County due to their staging area.**

**The aircraft was hooked up and ready to depart when the HRD team arrived on scene. There were human remains in the plane for the dogs to find. It once again appeared that some were in a hurry to get off the hill.**

**There were good points and low points throughout the exercise. It is my opinion that Lyon SAR train more frequently with Douglas SAR and Carson SAR in Unified Command situations, so we can iron out differences and train on what is expected. Communication must be better executed.**

**Lyon County Sheriff's Office SAR Coordinator Lt. Bryan R. Veil**

## ATTACHMENT II

### ELKO COUNTY SCENARIO REPORT

**AFTER ACTION REPORT: OPERATION GREEN LIGHT**  
Controller

August 17-18, 2012

#### **OBJECTIVES**

Operation Green light was effective in achieving the field operations goals of Elko County as outlined in the Controller and Evaluator Handbook, Chapter 1: General Information, Exercise Summary, Target Capabilities, Tasks Addressed.

Under the preceding heading 'Purpose' the hand book states "... for radiological incident response." I had no knowledge that this had anything to do with radiological incident response and it was not played that way in any shape or manner.

#### **PARTICIPANTS**

WCSO Sgt. Dom LeBlanc was professional, maintained pre and ongoing event communications addressing safety and logistical issues, and utilized the considerable experience of the Hasty Team leader Bill McCauley to complete a very effective multi operational search and rescue response to completion. He was a pleasure to work with and I look forward to future opportunities to do so.

The Hasty Team was an efficient, professional, relaxed and well coordinated team of responders. As a whole and as individuals I found them to be an incredible resource.

Elko County Sheriff's Office is fully supporting the continued development of its Search and Rescue unit and SAR Commander Det. Cpl. Jimmy Carpenter is eagerly and actively layering SAR skills on his many years of LE experience. He was a calm leader who prepared for the event and integrated command functions smoothly with Sgt. LeBlanc to let the teams do what they were trained for.

ECSO field teams operated as expected and completed their assignments effectively.

ECSO SAR field team evaluators Josh Anderson and Brian Burgess maintained effective communications on their observations as the scenario progressed as did staging evaluator Duane Jones.

We did not identify or train an evaluator in the mobile communication station however the personnel maintained spontaneous documentation on their own and it is enclosed.

#### **KEEP**

- Communications with and through the mobile base station for relay was essential for the success of this mission.
- The Elko field team communicated well with Hasty team guiding them into the 'crash site' from the next ridge. Both teams worked well together and functioned as needed.

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- Functions at Staging with IC were fully supported with command trailer, cots, lavatory and meals which provided comfort and the ability to extend well into a multi day operation.
- Integration of approximately 30 people from two teams, a new communications system and personnel who all focused on the mission without egos interfering.

**POLISH**

- Development of individual SAR skills and team efficiency within ECSO SAR. Primarily navigation and deployment strategies.
- Is being addresses with continued scheduled training.
- ECSO is actively recruiting new members.
- Prioritizing functional deployments and time lines.

**ELIMINATE**

- ⊕ Transportation is best addressed at the individual working level and through mutual aid between counties. The State DEM was unable to meet its pledge to secure reliable transportation both to and from the exercise. This delayed response times, reduced field deployment times and reduced the overall efficiency of teams.
- ⊕ At the county level this also reduced efficiency by holding field teams until all the equipment could be brought into play. This delayed response times and reduced efficiency of teams.

I very much appreciated the opportunity to be a controller on this exercise. It was my first exposure to both a MSEL and table top and I gained valuable knowledge working at this level. Staging, and not having an 'active roll', I found myself feeling left out watching teams work in the field and being reminded of the anticipation and excitement that draws us in to get involved in the first place.

Cheryl Cuthbertson

ECSO SAR K9 Handler  
EMT  
SARTECH II

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**PREPLANNING (ELKO)**

- Logistics planning was evident based on the preparedness of the group to support the host team as well as the Washoe County Hasty Team through a superb kitchen unit.
- Equipment preparedness was adequate. Use of the Sheriff's Department Command unit was helpful for command, shelter and sleeping areas. Personnel were prepared and equipped to sustain themselves for the operational period.
- Preventative maintenance on equipment may need improvement. The light generator plant was unable to be used due to a bad battery, and a light cover was broken.
- Recommended fix- establish a second training day each month to include equipment checks and services, as well as a scheduled maintenance program for motorized equipment.
- Communication was enhanced by the use of the local HAM radio club in support of the operation. The capabilities to relay information between the command post and search teams increased the efficiency of the search operations. Pre-established frequencies were known, used and communicated with all supporting groups.
- Establishing a secondary or administrative frequency may be a good idea to eliminate cross traffic of tactical operations and administrative information. (note: I did not observe message logs or notes)
- Incident Command System was established and utilized to the extent required for the operation.
- The establishment of policies and procedures as well as assigning duties and responsibilities for functional areas outside of emergency operations may increase the comfort level and understanding of ICS.

**PREPLANNING (WASHOE)**

- Preplanning is proven by being prepared for the mission. The HASTY team was very well prepared to accomplish the mission they were asked to accomplish.
- It was very evident the team has well established procedures and protocols and that all members are aware and trained to the established guidelines.
- All personnel were prepared to sustain themselves for an extended operational period to include remaining in the backcountry if asked.
- Team equipment was ready and available on scene. There was no equipment requested from the host team, as the HASTY team again was well prepared to accomplish the search as well as the technical rescue portion of the exercise.

**NOTIFICATION OF TEAM AND MEMBERS**

- ECSO SAR team notification seemed to be quite effective and simple. The use of text messaging and established response guidelines ensured that the team knew where, when, why and how to respond. The text back gave the Incident Commander the ability to begin his/her planning based on the resources they knew were available.
- Team members were given assignments upon arrival at the staging area and began to accomplish their assignments in a timely manner.

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→ In larger settings/operations it may be a good idea to track the team assignments and treks on a status board in the CP.

### **PLANNING AND STRATEGY**

- Given little information, the incident commander was able to establish search priorities and determine how to effectively use his/her limited resources. Using an apparent track-line pattern with the one initial search team beginning from the LKP, the IC was able to clear two POA ridgelines in a short amount of time using a fast search team. This fast team was able to locate debris as well as survivors.
- Search team mapping was effective. The Incident Command was able to maintain the treks of the fast team on the map using GPS/UTM coordinates and elevations. Maps were printed and provided to the search teams.
- Upon arrival of the Washoe Hasty Team, the team leaders were briefed by the IC. The team leaders and the IC jointly established team strategies and plans.
- Good coordination between Host team and Hasty Team. Once new information was injected into the scenario the Incident Command and the search teams were able to redirect their plans into the new POA increasing the POS in a short amount of time.
- Arrival of the mutual aid or supporting entities should include an incident action plan briefing from the IC as well as a safety briefing regarding the local conditions and hazards.

### **OPERATIONS AND TACTICS**

- Initial operations and tactics maximized the POS in a minimum amount of time with the given resources available.
- Upon locating the accident scene teams quickly responded, assessed patient conditions, treated patient injuries accordingly, interviewed the victims to determine if there was other victims not with those located.
- While moving to the location identified by the initial search team as the crash site, Search team 2 (HASTY) maintained good communications with Search team 1 (ELKO) and was able to make their way directly to the scene.
- HASTY team sent a Fast Team with medically qualified persons ahead of the main body to quickly assess the victims and report conditions, actions and needs to the main search team.
- While moving into the scene teams used several signals such as whistles, and yelling to help locate the missing persons.
- Hasty team members had good communication and decision making skills. Communications were clear, concise and team members followed directions as well as made recommendations.
- Hasty team members established good rapport with the victim's; they used the victim's first names and had a basic knowledge of each individual prior to beginning extraction.
- Once the HASTY team determined there was a possibility of two additional victims they determined the need to conduct a secondary search of the area. The team decision to conduct a reconnaissance search during night operations demonstrates their willingness to perform to the best of their ability.

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- The determination to suspend search operations after a thorough grid search gave up no additional victims was a wise decision. Team members were able to rest and regroup for the next morning.
- Teams were debriefed and a plan of attack was decided upon for the next morning.
- GPS treks were reviewed and the search patterns were assigned to two search teams from the HASTY team in the POA. Within fifteen minutes of beginning the search, team 2 located the missing subject, relayed the location to the other team and command and made access to the victim.
- Team Leaders made the decision to keep two rescuers with the victim while the remaining team members returned to retrieve equipment. The two remaining rescuers assessed the victim, stabilized the patient's medical condition, and determined equipment requirements for transporting the victim to safety.
- Plan A and Plan B were established by the two rescuers remaining.
- Plan C was implemented after the rest of the team had returned with the equipment.
- Technical rescue systems were kept simple. Identifying hazards and mitigation the risks were accomplished by the entire team.
- Good communications among all team members.
- Extraction and Transportation of the victim was accomplished in a safe and timely manner.

**OVERALL OBSERVATION**

The technical response by the Washoe County Sheriff's Department HASTY team was very well conducted. The professionalism of the team was evident by their ability to see around the fact that this was only a drill. They approached all aspects as though this was the real thing starting with the timely response with sufficient personnel to transporting the simulated victim back to the base camp.

The ability of both teams to work together and share knowledge made Operation Green Light a success.

Milton Burgess

ECSO SAR  
EMT-I

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Staging AAR – Operation Green Light

August 17-18, 2012

**TIMELINE**

- 8:00 Start of Exercise
- 9:25 Notification and call out of ECSO SAR, via mass email to cellular phones of players.
- 10:30 Incident Command trailer, Communications truck, light generator trailer and players vehicles are lined up at the gate ready for deployment.
- 10:45 Briefing by Undersheriff C. Morris  
Sign in of all participants.  
Aircraft down and approximate location, but limited information.  
Washoe County Hasty Team Requested.  
Establish location of IC at terrace above Spring Creek Camp Ground.  
Approximates, Accessibility, Area size  
Communications anticipates problems with IC site selection.  
Decision for a remote communications site elsewhere in the valley below.  
Logistical support for meals and sleeping  
Safety Briefing
- 11:00 Players depart Elko Country Sheriff Office.
- 12:00 Players arrive at designated staging site, Spring Creek Camp Ground.  
Communications established, frequency testing, maps posted, white board set up and field kitchen set up, while additional Elko SAR team arrives.
- 14:20 Elko SAR Team assigned a search area and is deployed.
- 17:55 Washoe County Hasty Team arrives at staging area.  
ECSO and WCSO verify information; they have and planned expansion of search area West of IC.
- 18:50 A civilian report of aircraft debris to the East of IC.
- 18:55 Elko SAR Team reports visual on downed aircraft site.
- 19:00 Washoe Hasty Team deployed to Crash area, guided in by Elko SARS observation site.
- 20:00 Survivors located and extricated. Search for missing pilot continues under darkness.
- 23:00 Stand down of search until morning.
- 24:00 All searchers return to IC.

**KEEP**

- The exercise was taken seriously at all times by the players. Players worked well with the information and resources that were available during the exercise.
- I observed cooperation and professionalism from all of the players without exception throughout the exercise.

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- The Communication Team was a high point for Elko County Incident Command Operations during the exercise. There was a poor line of site communication between the IC and the SAR Teams. The ability to relay information through the Communications Team site resolved the problem.

**POLISH**

- Some training on radio protocol would be useful for the ECSO SAR.
- The ECSO SAR needs map and compass review. I feel the skills are there, but some practice and confidence building would be helpful. A state of the art GPS tracking system for the ECSO SAR is needed.
- Even though the exercise went well and all the bases were covered, I feel Incident Command Training is needed for everyone, top to bottom, in order to make the ECSO SAR even more efficient and effective.

**OVERALL OBSERVATION**

This training exercise was especially valuable for ECSO Team players who observed the WCSO Hasty Team organization and control during their night search in rugged steep terrain of rock ledges and cliffs intermixed with thick brush.

Duane H. Jones

ECSO SAR  
SARTECH II

Search Evaluation AAR – Operation Green Light

August 17-18, 2012

**OBJECTIVES**

First search to locate possible downed Helicopter crash.  
Second search to locate 4<sup>th</sup> victim who was ejected during the crash.

**KEEP**

- Crash site found in the first operation period, with luck on our side. Initial search team defined an area and executed a search. Half way thru the execution plan was changed based on information from a bystander hiker. Near the end of the modified search area addition information inject information help guide search to the right area.
- Communication was excellent, with team checking in and sharing of available information.
- First search team also did an excellent job of spreading out and covered as much ground as possible given their limitation.
- They used verbal visual techniques to help locate crash site. After crash site was located 2 hasty teams where guided into site with the assistance of the initial search team high ground position.

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- Patients from crash were extricated in a timely manner and proper medical care was given which resulted in information about another missing subject.
- Hasty team did an excellent job covering the second search area for the 4<sup>th</sup> victim. Tracks downloaded at end of first operational period indicated holes in their pattern that were covered first thing in the second operation period. This resulted in successful location of 4<sup>th</sup> victim early on.

**POLISH**

- Limited number of search team for such a large search area.
- Assumption made based on staging location that crash site would be above LKP.
- Timing of first team departure, delayed due to crew availability.
- Number of available search teams early in the search.
- Hasty team had lots of duplicated coverage on second search during the first operation period, but terrain difficulty and darkness was probably to blame. Better coverage occurred in the daylight during the second operation period.

Josh Anderson

ECSO SAR  
SARTECH II  
EMT-I

Mobile One / Controllers Time line Operation Green Light

August 17, 2012

07:55 Wx event notification

07:59 Cadets Hiking in

08:40 Cadets in place as AC survivors at scene of crash

09:22 Notification of SAR team by SO of AC crash- initiates call out

09:25 Text for responders – immediate and almost complete response by established team members

10:40 Inject - DEM request for additional responders

11:42 Responders arrive and set up staging

12:45 ELT location identified and checked no AC found

13:00 Security check of cadets

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14:00 Searchers arrive

14:20 Field team deploys one Elko team- Team 1

14:47 Team 1 radio in, negative contact

15:17 Team 1 radio in, negative contact

15:50 Team 1 radio in, negative contact

16:36 Team 1 radio in, negative contact. Location N 40 39 536 W 115 30 611 – Hiker in the area interviewed with no sightings up canyon.

16:54 Team 1 radio in, negative contact, Code 4, Headed East

17:00 WC Tasty Team Arrives

17:38 Inject- Cowboy calls 911 with information of observation on hill “Saw something shiny where road and burn meet between the campground and Seitz Canyon on the ridge.”

17:55 WC deploys

17:59 Team 1 spots wreckage, gives their location as N 40 39 886 W 115 30 462 with AC at a bearing of 244 dm, this is identified as a back azimuth and corrected

18:38 Clear talk: This is an exercise by Mobil 1 (comm. station)

18:45 WC radio check

18:57 WC deploys first team to make contact, Team 1 stays in place to guide WC via radio from across the ridge

19:00 WC makes contact 3 live subjects with injuries requests additional resources. Location N 40 39 972 W 115 29 988

19:45 Team 1 leaving location headed back to base

19:51 Second search or missing subject begins

20:00 N 40 39 900 W 115 29 891

20:14 Team 1 still enroute to base

20:19 N 40 39 834 W 115 29 852

20:20 Team 1 at base

20:32 N 40 39 834 W 115 29 852

20:57 Subjects (cadets) secure at waiting ambulance

21:13 N 40 39 940 W 115 28 886

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21:15 N 40 39 907 W 115 29 787

21:28 GPS unit located

23:13 WC at gear cache recommend stop for night

24:00 All teams at base

00:00 Operations suspended

Mobile One timeline -- Operation Green Light

August 18, 2012

07:48 Mobile 1 radio check

08:20 Team 1 begins search

08:55 WC begins search

09:08 IC radio check

09:17 WC located a badger

09:17 Contacted made with badger determined to be alive -- strong pulse

09:23 Location N 40 40 098 W 115 30 06

09:56 Assessment of patient

10:57 Patient secured at waiting ambulance

11: 25 All teams returning to staging

11:27 Team 1 arrives at staging

## ATTACHMENT III

### STOREY COUNTY SCENARIO REPORT

#### SAREX Operation Greenlight Exercise- American Flat, AUG. 18, 2012 AFTER ACTION NOTES AND REPORT

*The Storey County portion of this multi-county exercise was developed and documented by Storey County Emergency Management personnel and a team of personnel representing each of the disciplines; Emergency Management, Fire Department, Sheriff's Department, Communications and Private industry (Comstock Mining.)*

#### **Agencies involved:**

Storey County Emergency Management: Coordination, Control and Evaluation  
Storey County Fire Department: Response, EMS  
Storey County Sheriff's Department: Response, LE & Search  
Storey County Sheriff's Jeep Posse: Response & Search  
Storey County Communications  
Comstock Mining Inc. (CMI), private industry: Response, initial EMS  
Fallon Naval Air Station, Longhorn SAR Helicopter unit (LtC Tim Simonson)

#### **OBSERVATIONS AND EVALUATION:**

*In preparation for this exercise the Fallon NAS Longhorn search and rescue helicopter brought a victim/survivor simulated (real person) to the site of the rescue at 0730 this date and dropped them on the side of the mountain to be the victim. That person remained there on the hillside from 0730hrs till approximately 1100hrs this date when NAS Longhorn arrived back on scene to "rescue" the victim based on being found by ground SAR units.*

#### **Comstock Mining Inc (CMI):**

Initial response to the vehicle accident on their property was quick. They were able to exercise their emergency response team and deploy their equipment for victim stabilization. This allowed their newly formed team to function as a unit and deploy their equipment. They identified some minor points of coordination and their Safety Director was able to demonstrate to the team the functions and needs of an emergency response. It served as an effective first learning experience for their team. Future exercises with the Fire Department will be planned.

#### **Storey County Fire Department:**

Pre staged, response to initial medical call of motorcycle versus 18 wheeler dump truck on the CMI site was effective and appropriate. This was routine for them but the

interaction with the CMI response team allowed for opportunity to work together and get to know each other on a semi-stress setting.

The intent of the exercise however was to have the FD EMS respond to the site of the injured person up the canyon at the base of McClellan Peak to provide medical assistance. This was not able to be conducted due to the FD having to respond to an actual real time medical call during the course of the exercise.

Also, however, they were not requested by the SAR unit (Jeep Posse) that located the victim up in the canyon on "suicide hill".

Fire Dept personnel remained on the scene at the ICP as part of the unified command that was set up by the SO and FD.

**Storey County Sheriff's Department and Jeep Posse:**

The SCSO responded to the initial incident as they would normally and set up their command function with a Sergeant. As the exercise incident expanded in scope to include a possible search event up into the hills to the west of the initial incident in American Flat. The SCSO then requested their SAR unit (Storey County Sheriff's Jeep Posse) to respond to the command post for briefing to prepare for their search function. Prior to the arrival of their Jeep Posse personnel the initial responding Sergeant detailed a two person Sheriff's unit to proceed up the most likely canyon to the west to attempt to locate the second individual.

Unfortunately, due to a leakage of information, this unit was told exactly where the individual was located prior to the portion of the exercise that was to identify a GPS location for the person. This would have normally precluded the use of the Sheriff's SAR unit so that SO unit was then removed from play so as to give the Jeep Posse the opportunity to actually go out and find the survivor victim.

Jeep Posse units were briefed by a Sheriff's Sgt using topographic maps and sent on their way.

It was noted that they should assign a singular unit number to each vehicle as opposed to dealing with two call numbers in each vehicle. However each person did have a handheld radio and their own call number and were directed to remain together as a team at all times.

A better listing of the persons in each vehicle should be kept and provided to all other SO and FD units prior to dispersing the Jeep Posse units into the field.

I never heard any responses back from any of the other posse units that were sent into the field except for the one that eventually located the victim/survivor. There were no reports from the units as to their progress in searching sent back to the command post. They should be reporting back to command on an assigned time basis to advise their location and where they have searched and what has been accomplished and the status of their condition.

There was a singular SAR ground unit in a small all terrain vehicles that was not part of the actual jeep posse response that was later sent up the canyon as a search unit by command. It was not identified by a unit number and on arrival in the area it was unknown what it was doing in the area until they identified themselves as an advance

ground posse unit.

**Jeep Posse:**

On arrival of the Jeep Posse units in the area it was noted that as they progressed down roads in the area that they never left the confines of their vehicle. No attempt to call out to a possible victim in the area, honk horns or use other means of trying to make contact with a victim were used. Once in the area where the victim was identified, they did not attempt to go to the victim to determine the need for medical assistance. They did not call command to request EMS assistance to go to the victim. One of the ground SAR units later did climb up to the top of a lower hill top from where the victim was but did not proceed to the victim.

Some yelling back and forth occurred but the victim's (simulated) injuries were such that he was not able to yell back due to the nature of his assigned injuries. He was left there till the Fallon NAS helicopter arrived on scene approximately 1.5 hours later.

The Sheriff's Office two person unit that had come into the area initially then was removed from the scenario was then re-inserted into the scenario and went to a location where they could go partially up the hill and make some verbal contact with the victim. The victim had to be told that it was now alright to end his silence mode and state the nature of his injuries to the SO and Jeep Posse units. That information was then relayed to command.

It is unknown what other areas ground SAR units were sent to for searching as no reports came over the radio as to alternate search locations.

**Fallon Naval Air Station Longhorn Search and Rescue Helicopter**

After location of the victim by the ground SAR units there was a significant delay in making a request for the NAS SAR helicopter. FD command personnel in the unified command post made the suggestion to command that such a request should be made.

That request was then made to Storey Dispatch who then called (per procedure) State Department of Emergency Management Duty Officer to request the NAS SAR helicopter. Upon the state making that phone call to Fallon NAS they received only voice mail and could not make contact with them. Storey County Dispatch had the same result. Upon notification to exercise control we then called direct to the Longhorn helicopter unit commander. Lt. Commander Tim Simonson via cell phone to request the unit per the exercise plan. He was advised of the voice mail problem. This will have to be researched as to why this happened when calling the NAS SAR unit. Apparently the wrong numbers were used for making the call and fortunately exercise control on scene had a direct cell phone number for calling Lt Cmdr Simonson.

The NAS SAR helicopter arrived on scene within about 35 minutes once we finally made contact with the Commander, direct.

Communication between ground (exercise control) and the helicopter were

accomplished via Fire Department communications equipment. (See communications section below).

NAS FALLON SAR Longhorn then conducted its normal rescue functions and procedures by dropping lines and depositing two rescuers down to the victim, prepping the victim for retrieval via winch line up to the helicopter hovering above then landing in an adjacent area and simulating transferring personnel to the ground, returning for the other rescuer that had been left on the rescue site to simulate weight concerns for the helicopter due to above sea level and temperature density altitude concerns in the area. They then retrieved their other personnel on the ground at lower altitude and left the area at approximately 1150 hrs in simulated route to Renown Hospital in Reno.

Overall the interaction with the NAS FALLON Longhorn SAR helicopter unit went perfectly and effectively. The minor communications hiccup will be examined for future fixing but at least we know we can talk to them from ground to air.

#### **OVERALL OBSERVATIONS:**

The entire exercise unfolded on the time schedule that was planned for and was only about 20 to 30 minutes behind schedule when completed.

Overall the exercise went quite well. As an initial SAR exercise for the county it was quite effective in identifying both our strengths and weaknesses as is the intent of an exercise. Participation in the event was very good and well intentioned. All participants took the exercise seriously and conducted themselves in professional manner as if it were the real thing.

The minor glitches that appeared only go to demonstrate the reality of how things do not always go according to a plan. The ability to "bob and weave" as it were is always going to appear even in the best of events, real or exercise.

Everyone in all county organizations is commended for their efforts and volunteer participation.

Storey County Communications (Dispatch) performed very well in their handling and distribution of information from the field.

The participants with the CMI are also well commended for their performance and willingness to participate so as to increase their knowledge of their function within private industry.

#### **Communications:**

##### **Command and ground communications channels**

Communication with all ground units (SO, FD, Posse, Storey Dispatch & control) via White 2 was always clear and effective. The channel performed perfectly in the hilly country.

##### **Communications with the Fallon NAS Helicopter**

Communications with the Fallon NAS Longhorn SAR helicopter was conducted effectively but with significant limitations. For reasons unknown (we will have to research) we could only hear the helicopter on the Storey County Fire channel using the

FD pagers on monitor mode. Then we could only talk back to the NAS helicopter on the FD Local channel. It would not work using any of the repeater channels for the FD. This denied any other units on scene from monitoring the NAS SAR helicopter communications. So all communications with the NAS helicopter had to be then relayed via the command channel (White 2) to command thereby allowing all other units on the net to hear the status of things with the NAS SAR helicopter.

We have known of this communications problem for some time as we have tried to get the communications matter fixed or clarified but have been unable to make communications work properly between the Fallon NAS Longhorn helicopter and the FD ground units.

At least we can talk back and forth; we just have to do it in a convoluted manner.

**Ground (Jeep Posse) SAR units**

Coordination and communication with ground SAR units needs to be tightened up a bit. We need to help our Jeep Posse become more functional with their mission. The ground SAR units are in need of a significant amount of SAR training

*A NOTE OF THANKS GOES OUT TO THE NAS FALLON LONGHORN SAR HELICOPTER UNIT FOR THEIR PARTICIPATION IN THE EVENT AS THAT REALLY MADE THE EXERCISE A BIG SUCCESS.*

***END OF AFTER ACTION OVERVIEW REPORT***

Joe Curtis, Director, Storey County Emergency Management

## ATTACHMENT IV

### PERSHING COUNTY SCENARIO REPORT

ALCON,

These four pictures are from the SAREX last weekend. Scenario: "Nigel" experienced a mishap due to road washouts from a bad storm. Me, the owner, was stuck in the middle of the Dun Glen area and had to be found as well as a horse extricated. He fell over in the trailer and could not get up due to being tied in and could not get his balance with his head because he was tied in and lying on the trailer floor and flopped around which resulted in injuries that required the use of a rescue glide to get him to the vet. At 0900, Civil Air Patrol flew over and found me, by 0915, the CAP/SAR folks showed up. I acted like an hysterical owner and got into the trailer with the horse begging the responders to help me while comforting the horse standing amongst his legs. Someone removed me when he recognized the potential danger of the "fish flop", good job. I stepped out of the way to evaluate and stay out of the way at that point. One responder did, however, crawl into the trailer for which I immediately designated as injured from the flopping, downed horse. She became a casualty with a concussion and had to be rescued as well. No comment was made regarding a veterinarian to respond once the horse emergency was identified. Sedation is detrimental to the safety of all involved. The teams (Humboldt and Pershing County SAR) did a good job of creating their own rescue gear as well as utilizing it. The attached pictures reflect the events. The incident commander (IC) the safety officer were assigned initially. The IC did not appear to be in charge as people were reacting and acting on their own. Also, the IC was very hands-on instead of directing. Perhaps due to extensive technical rescue knowledge. The rescue glide built by one of the teams worked well and creativity was used in the hobbling and tying down the animal to the glide. Kudos to the team. The training trailer also doubled as the rescue trailer, however, nobody mentioned bringing in a trailer to move the downed animal to vet care until the evaluator brought it up. I felt that all aspects should have at least been discussed with the responders. Exercises should be taken seriously.

SFC Michael Connell  
NV JOC Battle NCO NVARNG  
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Classification: UNCLASSIFIED  
Caveats: FOUO

## ATTACHMENT V

### WASHOE COUNTY SCENARIO REPORT

#### Greg Felton, Evaluator, Report

All,

Below are the observations, in no particular order, I made at the Sunday SAREX rope rescue scenario. Note that their intent is not to criticize individuals but to highlight what went well, as well as what could have gone better, ALL FROM MY PERSPECTIVE (which could be incomplete or wrong) in the interest of ensuring our real rescues are as safe and efficient as possible. A bit of background is included to put all of this in perspective for those who were not present. Times are included where I noted them.

I'd be more than happy to clarify any of this content if it's not clear.

Best, Greg

#### **OVERALL OBSERVATIONS:**

- The operation likely would have been faster, with less communication lapses, with less people
- Leadership changes must be explicit, and should include a reassessment of the scene and plan by the new leader, especially when initial leadership is unclear or a change is unexpected (e.g. when a team called in to provide mutual aid expects to "support" but ends up in charge)
- Respecting the ICS chain of command (e.g. for communications) is vital.
- Safety is not a part-time occupation. The safety officer must focus only on that and always remain vigilant. All team members must also watch for safety issues and be willing to call "stop" if they observe any issues. And all members must respect safety standards (e.g. donning helmets) or they put others at risk and should not be on the team.

#### **TIMING:**

10:05 – Arrival of team with rope rescue and medical equipment at top of rock  
10:18 – All stop called by Rescue Group leader for briefing on big picture, helicopter requested  
10:42 – Subject on rescue rope system  
10:50 – 2<sup>nd</sup> rescuer moving to edge with litter  
11:10 (approx) – Helicopter told to expect the subject to be ready for transport in 20 minutes  
11:20 – "Convert to raise" requested by rescuers  
11:25 – Raised 2' to take load off of subject's system, then stopped to better secure

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subject to litter

11:35 – Slack in 1<sup>st</sup> rescuer's belay line requested to untangle ropes, told "that's all he gets"

11:40 – Rescue Group lead asked edge "what's going on?" and got "Don't know..." from edge

11:50 – 1<sup>st</sup> rescuer climbed out. 2<sup>nd</sup> rescuer moved to position above the litter to transition lip

11:55 – Rotated litter into recess and transitioned to vertical orientation

12:10 – Litter to point of edge transition

**DETAILED OBSERVATIONS:**

- DCSAR initial response and communications:
  1. Douglas SAR responded to Washoe mutual aid call, Mt. Rose Hwy @ Fairview, with 10 personnel in 5 vehicles (including Tech 12 as this was dispatched as a technical rope rescue).
  2. The command structure within DCSAR was clearly established before departure from the station, and good communication was maintained between the inbound teams. Cell phones and texting were used in areas where radios were ineffective. NOTE: Having cell phone numbers for all other SAR members preprogrammed made this possible.
  3. It was not clear while en route how, and with whom in Washoe, DCSAR should communicate. A cell phone discussion with OL Thomas, who was on scene, clarified this. NOTE: On real incidents, we likely wouldn't have a DCSAR member on scene in advance of the team so the method of communication, and identification of key personnel, should be clear at the time of dispatch.
  4. Upon arrival of DCSAR resources, 2 hasty teams of 2 Washoe members each were just leaving the command post. It's not clear how long Washoe resources were on site before deployment, but I was surprised that our arrival was apparently so soon after Washoe's.
  5. Upon arrival at the command post and check-in with the IC, we determined that:
    1. Douglas SAR radios contain several Washoe frequencies, one of which we selected which proved effective for all ground communications between teams (see note later re: communication issues with the Raven helicopter crew).
    2. Douglas SAR team would prepare to back up the hasty teams with medical and technical rope equipment.
  6. A command change on the DCSAR team was necessary (because I was tapped as a judge). This was clearly communicated to the team members and IC to eliminate potential confusion and happened seamlessly.
- The subject was located by hasty teams in approximately 15 minutes, hanging unresponsive approximately ½ way down a 75' rock face.
  1. The IC acknowledged the find and had to request coordinates of the subject several times. I don't know the reason for the delay. Ultimately, the UTM coordinates in abbreviated form as well as a plain-English description of the best ingress route were passed on but the delay slowed the response of follow-on teams. NOTE: To date, the DCSAR team has not abbreviated UTM coordinates when relaying over the radio. This is

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- something which should be considered (to align with other teams and reduce radio traffic).
- The hasty team accessed the rock above the subject. The leader of this team indicated "I would immediately put on a piggy back (meant redundant anchor) on climber's rope." Great idea, and clearly he had a solid handle on rope rescue techniques...but several comments:
    1. Response to my query re: what would be used as the anchor was vague ("one of these rocks").
    2. When I said, effectively, "don't just talk about it, do it" the system was set up with three critical flaws:
      1. The prussic wasn't dressed and wasn't set tight (thus was not grabbing the rope)
      2. The tensionless hitched webbing was never tied off but was held by a member of the team until she had to move to other tasks after which the tail was left loose
      3. The webbing was not tight and thus there would have been a huge shock load had this back-up come into play
    3. An excellent safety culture was demonstrated when another member questioned the available rock anchors and said "None of these is bigger than me" which led to the permanent anchors being to a distant tree, the best answer in this case.
  - Rescue Group management:
    1. When the DCSAR team with all technical gear (ropes, litter, etc) arrived at the top of the rock, a handoff of leadership took place but this wasn't formal. My observation was that Washoe deferred rather than a conversation taking place between the former and new leader.
    2. Because DCSAR was called out on a mutual aid to back up Washoe, the DCSAR leader didn't expect to be in charge. This resulted in an incomplete assessment of the scene and lack of objective assessment of the approach (for instance, how to access the subject and generally where to place anchors).
    3. The entire rescue operation was more complicated, and took longer than it could have, because of the selection of the approach path. The Rescue Group leader recognized this before the litter went over but judged the operation to be too far along to change gears. NOTE: As some people observed, handling the worse egress path was a great training exercise!
    4. Rescue Group leader backed up (13 minutes after arrival) and took command of several elements that likely would have been handled earlier had there not been a fuzzy handoff:
      1. Called for a helicopter. NOTE: I did not hear any discussion at this time about potential LZ's. Later discussion revealed the plan to pick-off the top of the rock.
      2. Called for all stop and gave the entire team a brief on the big picture (2 rescuers, c-spine precautions necessary, clarified the purpose of each rope, etc).
  - The overall safety system was not sufficient:
    1. A safety officer was assigned but he ended up assisting with rigging (which there was certainly a temptation to do, but it was not necessary since there were plenty of other personnel). This resulted in him not being objective when looking at systems he'd worked on AND him being distracted and therefore not focused on checking other systems.
    2. Great idea to set up safety lines for edge personnel with critical issues:

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1. The line was set up parallel to the rock face to which rescuers could clip. If a rescuer had fallen, enormous loads would have been placed on the anchors. The line(s) should have been perpendicular to the face.
  2. The rescuers attached to the line did not use prussics but instead used either biners or girth hitches. If the line had failed, they would have run right off of the end (and likely would have taken other rescuers with them).
  3. At least one person working near the edge didn't lock his biner (which made clear no one had done a safety check on him)
  4. During the safety line setup process, some rescuers were very close to the edge without being tied into anything. NOTE: The DCSAR leader left 2 observers at the base of the rock and, in the interest of safety, they called this out on the radio. This was outstanding...both having these observers AND their willingness to speak up.
3. See safety issues noted elsewhere in these notes (e.g. 1<sup>st</sup> rescuer not checked before moving to edge, personnel near edge without locked biners or safety checks, back-up system on subject's anchor a good idea but poorly executed, etc).
  4. Two rescuers who arrived late proceeded to the rescue site without helmets (and just before the arrival of the helicopter). The rescue team members posted at the bottom of the rock informed these individuals that they needed helmets but these warnings were ignored and they proceeded in anyway.
- First rescuer:
1. First rescuer selected based on depth of medical skills.
  2. Initial decision was to send him over the edge on a single line, self-rappel using existing sport climbing anchors. This was overruled. A belay line was put on him.
  3. The rescuer was not safetied before preparing to go over the edge. Judge had to call stop.
  4. The rappel line was thrown down where the subject could reach it (rather than the tail being carried by the rescuer). The problem with this was made obvious when the rescuer was mid-rappel and the subject pulled on the rope to lock him up. Only cooperation by the subject allowed the rescue to continue.
  5. The rappel line was not long enough to reach the ground. If it was necessary to change the game plan (to access then raise), the rescuer would have been stuck.
  6. Subject was secured to the rescuer's main rappel line. The rappel line system (e.g. sport climbing anchors) was selected because it was not expected to carry rescue loads...bad assumption!
  7. First rescuer had very limited medical equipment with him (e.g. didn't have Oregon until 2<sup>nd</sup> rescuer descended with the litter which delayed the initiation of application).
  8. The Oregon splint application was sloppy (e.g. started with the head instead of the torso, resulted in a lot of movement of the subject) and took a very long time.
  9. Disconnected completely one of his two connection points to straighten out tangled ropes. Should have put a 3<sup>rd</sup> connection point in place first.
  10. Tied webbing around main bar of litter when securing subject. This exposed it to abrasion on the wall. Had to undo and retie.
  11. Not equipped or prepared to ascend. In this case, the terrain allowed climbing the rock but if it had not, he would have been stuck. As noted above, his rope didn't go to the ground so he couldn't go up OR down! Always should be ready to self-rescue!

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- Edge management:
  1. Rollers were put in place to protect the ropes. A tag line was tied to these but they were set on the edge before the tag line was tied into an anchor (so they could have fallen).
  2. Because of the notch selected as the evacuation route, protecting and preventing overlap of the ropes was difficult. This was an ongoing problem during the rescue.
  3. There were two people at the edge. This, and a long rescue, resulted in loss of concentration (discussion of backgrounds, etc). There were communication issues between the rescuers and topside as a result (e.g. the message was passed to the Rescue Group leader and subsequently to command that the subject was on the rescue system well before this was really the case, the second rescuer asked for a 1-foot lower which the edge personnel did not hear, the rescuers asked for the system to be converted to a raise but the first request didn't get past the edge leading to a delay of approximately 5 minutes before the rescuers asked for an ETA to raise, at which point the conversion began).
  4. Once load was off of subject's rope, redundant anchor system was untied. The order of equipment removal resulted in biner being loose and potentially dropped on rescuers and subject. Should have left biner attached to anchor so only prussic would have been loose.
- Rigging:
  1. One rescue member set up webbing around a tree as a wrap-3-pull-2. A member of another team thought that this was a mistake and started to change it to a wrap-3-pull-3. This was unsafe not only because the system would have been weaker but members must communicate when changing each others' systems.
  2. It's OK to use one anchor (e.g. huge rock, significant tree, etc) for more than one line if necessary, but in this case two ropes were put on one webbing system around the same anchor. It wasn't clear that it was necessary to share the same webbing, and even if it were that there was forethought about which ropes would be best to share (e.g. we wouldn't want the main line and belay for the same system on one piece of webbing....one weak link).
  3. The large quantity of people appeared to be more of a liability than an asset in this case.
  4. Excellent idea and execution to pretension the anchor system.
  5. Rescue system ended up in the same notch as the subject's rope
- Second Rescuer:
  1. Good preparation before going over the edge and arriving at the subject (e.g. the C-collar was presized).
  2. The path taken during the descent, even though there was discussion with the edge personnel about this, resulted in rope tangling which later resulted in the first rescuer disconnecting one of his two connection points to get straightened out.
  3. Good instruction provided to the first rescuer re: the Oregon splint (to overcome lack of familiarity with that device) though it was the subject who got this ball rolling (e.g. "attach the device to the torso before the head").
  4. Excessive gear caused multiple snags (e.g. GoPro camera on the helmet, lots of gear on his belt).
  5. Good awareness of whole subject when moving (e.g. used feet to manipulate subject's legs when maneuvering into litter...though one leg did end up outside the bridle and had to be moved later).

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6. Rock features (ledges) existed which could have been used earlier to make movement more fluid (rather than remaining suspended on ropes the entire time).
  7. When ascending, moved to position above the litter when going from a flat face into a recess. Should have remained below the litter to have feet on the wall. The time to be above the litter is when going from recess to flat wall.
  8. Very solid manipulation of litter into recess then progressively to vertical position. Several straps were hanging out of the litter. It didn't happen in this case, but they could have become fouled on rock while ascending and would have required lowering or extra movement by the rescuer to descend and free them.
  9. Good question for edge personnel before reaching the edge transition, "Are you ready for pike and pivot?"
  10. When litter at point of edge transition (top of litter projecting approximately 1' above edge), the stresses on the ropes were significant and movement by the rescuer resulted in bouncing in the system (which made the subject very nervous...he was reaching outside the litter to hold onto the rock). The litter provides a large moment arm to magnify rope stresses. Extreme care must be taken during these transitions.
- Medical:
    1. There was no subject medical assessment provided to the Rescue Group leader (and therefore none given to the IC, personnel topside who might have prepared to administer additional aid, incoming helicopter, etc).
    2. There were clearly issues, inefficiency and proper handling of the subject, due to lack of familiarity with the medical and rescue equipment of other teams (e.g. jigger to allow adjustment of litter angle, Oregon splint, scarabs). The subject ended up in a position of considerable discomfort (back hyperextended) when suspended in Oregon from his ropes rather than supported by rescue system. NOTE: This problem was limited because personnel from each team were a part of each operation, but if gear from one team were provided to personnel from another team, this might have become a major problem. Cross training on equipment would be wise.
  - Communications:
    1. USARNG was not provided with the PL tone for the Washoe frequency being used thus, while they could receive ground-based communications, the rescue team could only receive them on one radio (that held by the Washoe team leader, and only when he turned off the squelch).
    2. There were incidents of communication outside the normal chain of command (e.g. one of the edge personnel contacting the IC directly on several occasions to provide updates). This was all clearly well intentioned but is not appropriate.
    3. Communication with the subject was intermittent. When done, it was appropriate, but long periods went by with no communication. No one was assigned the role of communicating with the subject prior to the rescuer going over the side. Though the subject was unresponsive in this case, this role is important (even if the subject is not talking to us, we must assume he/she can still hear and understand).
  - Transport:
    1. USARNG arrived on scene shortly after the subject was reached. The crew was told to expect 20 minutes to pick-off and to circle away from the area to reduce noise. The subject was not ready for pick-off for over an hour.

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2. As noted above, had one member of the team not had a radio on which the squelch could be disabled, communication from the helicopter would have been impossible.
3. The medic who lowered from the helicopter immediately removed his helmet and handed it to a bystander which: 1) Eliminated protection he would have from the helmet, and 2) Eliminated his ability to communicate with the helicopter.
4. The subject, in a reclined position, was instructed to slide onto the penetrator before the shoulder strap was ready to deploy and when the cable to the helicopter was relatively tight. Shortly thereafter the helicopter rose and the penetrator was pulled upward. Had the subject sat on the penetrator when instructed, he would have been thrown backward, potentially off of the rock. NOTE: Never climb on a penetrator before the shoulder strap is ready AND there's slack in the cable...remember who is #1 and protect yourself. Also note that devices lowered from helicopters should be allowed to touch the ground to disperse electrical charge...do not reach up and grab them.

-end-