Virginia Polytechnic Institute and State University

The Washington Navy Yard Shooting, 2013

Analytical Paper

Joshua Slaughenhoupt

PAPA 5354: Policy Systems Management Homeland Security, Response & Recovery

Jeffrey Glick, Ph.D.

April 16th, 2018

Executive Summary

The 2013 Washington Navy Yard (WNY) active shooter incident resulted in over twenty casualties and culminated as the second deadliest shooting to occur on federal property since the Fort Hood Shooting in 2009.[1] The increasing prevalence for Active Shooter incidents in the United States (U.S.) present an acute threat to our critical infrastructure, which introduces new challenges for our approach in all-hazard response. As outlined through OPNAVINST 3440.17, protocol aims to deter, detect, and disrupt potential attacks through revitalized training and drills, while also establishing mutual aid agreements with external agencies.[2]

Internal reviews following the WNY incident determined that many of the installation's emergency management procedures served as a detriment for incident response. The Department of Navy (DON) cited the inefficiency in response was largely attributed to the failure to implement protocols outlined in the Department of Defense (DoD) Installation Emergency Management Program. Specifically, the DON provided recommendations in four key principles that encompassed: 1) Command & Control, 2) Planning, 3) Training & Exercises and 4) Program Oversight. These recommendations are intended to be a staple for incident response among all federal installations.

[1] Department of Defense. (2010). DoD Independent Review Related to Fort Hood. Retrieved: https://www.defense.gov/Portals/1/Documents/pubs/DOD-ProtectingTheForce-Web_Security_HR_13Jan10.pdf

[2] Department of the Navy. (2013). Report of the Investigation into the Fatal Shooting Incident at the Washington Navy Yard on September 16, 2013 and Associated Security, Personnel, and Contracting Policies and Practices. Retrieved: http://archive.defense.gov/pubs/Navy-Investigation-into-the-WNY-Shooting_final-report.pdf

Introduction

On Monday, September 16th, 2013, Aaron Alexis, an independent contractor with Experts, Inc. and former service member with the U.S. Navy, routinely entered the WNY to join a diverse workforce of more than 17,000 military, civilian and contractor personnel. After momentarily entering the Naval Sea Systems Command building (NAVSEA), Alexis engaged in an active shooter incident that lasted approximately 69 minutes before he was neutralized by law enforcement officers. Though over 117 officers from various agencies and departments engaged in incident response, Alexis still fatally shot twelve people and injured eight others throughout the course of the attack.[3]

The 2013 WNY active shooter incident is representative of the increasing prevalence of active shooter incidents in the U.S., which emphasizes the critical performance gaps that exist in even the most effective response strategies.[4] The complex and dynamic nature of active shooter incidents impose an acute threat shared among our key critical infrastructure and federal facilities. A critical analysis for the WNY event revealed discrepancies between the Installation's response for this incident, relative to the guidelines recommended through the Navy Installation Emergency Management protocol referred as OPNAVINST 3440.17, for addressing all-hazard emergency responses.

[3] Ibid.

[4]As instructed by Glick (2018), Response refers to the "capabilities necessary to save lives, protect property and environment, and meet basic human needs after an incident occurred."

Prevalence

Active shooter incidents refer to situational-based threats in which a shooting is still in progress and a certain aspect of the incident may affect the protocols used for response.[5] While active shooter incidents are relatively rare, the random and un1predictable nature of these threats, including the operating area which they occur, presents many complex challenges for incident response. [6]

Characterization

The most commonly recognized definition for active shooter incidents is referred to as "an individual or individuals who actively engages in killing or the attempt to kill people in a populated area".[7] More contemporary definitions have excluded the term "confined" to admit the potential for these incidents to occur both inside and outside of a facility.[8] Furthermore, active shooter situations are generally differentiated from other illustrations of gun violence due to the unique characteristics attributed to these events, whereas 69% of active shooter incidents conclude in five minutes or less. Often, these events conclude before authorities even arrive on scene.[9]

---

[5] Interagency Security Committee. (2015). Planning and Response to an Active Shooter: An Interagency Security Committee Policy and Best Practices Guide. Retrieved: https://www.dhs.gov/sites/default/files/publications/isc-planning-response-active-shooter-guide-non-fouo-nov-2015-508.pdf

[6] The Bureau of Justice Statistics reports that active shooter incidents make up less than 1% of all gun related offenses.

[7] Interagency Security Committee. (2015). Planning and Response to an Active Shooter: An Interagency Security Committee Policy and Best Practices Guide. Retrieved: https://www.dhs.gov/sites/default/files/publications/isc-planning-response-active-shooter-guide-non-fouo-nov-2015-508.pdf

[8] Ibid.

[9] To seek a better understanding of these threats, the FBI evaluated all active shooter incidents between the years 2000-2013, which included the incident at the WNY in the analysis. Continuum of the studies have included datasets

After an extensive analysis for all incidents, the Federal Bureau of Investigation (FBI) reported that it is difficult to provide an accurate characterization for perpetrators, who display no particular pattern for their motives or victims.[10] Taken together, the difficulty in characterizing an archetypical perpetrator contributes to the haphazard disposition of these incidents which are considered "unpredictable". The datasets obtained through the FBI indicate these events are alarmingly becoming more common. Table 1. depicts over 220 active shooter incidents have occurred between 2000 through 2016 collectively, which culminated in over 661 fatalities.[11] More precisely, 134 incidents, (resulting in 378 fatalities) were concentrated between 2010 and 2016 alone, which correlated to an average of 19.4 incidents annually with at least one incident every three weeks in this time frame.[12]

concerning the years 2014-2016, based off the same methodology from the initial study. As well, 2016 is the last available dataset.

[10] Schweit, Katherine W. (2017). Active Shooter Incidents in the United States from 2000-2016. Federal Bureau of Investigation, U.S. Department of Justice, Washington D.C. 2017.

[11] Ibid.

[12] Ibid.

Active Shooter Incidents Per Annum, 2000-2016

Year	Incidents	Fatalities	Wounded	Total Casualties
2000	1	7	0	7
2001	6	12	31	43
2002	4	11	18	29
2003	11	29	22	51
2004	4	14	6	20
2005	9	24	27	51
2006	10	23	23	46
2007	14	69	57	126
2008	8	29	34	63
2009	19	65	78	143
2010	26	37	49	86
2011	10	32	52	84
2012	21	90	118	208
2013	17	44	42	86
2014	20	36	61	97
2015	20	56	78	134
2016	20	83	129	212
Total	220	661	825	1,486

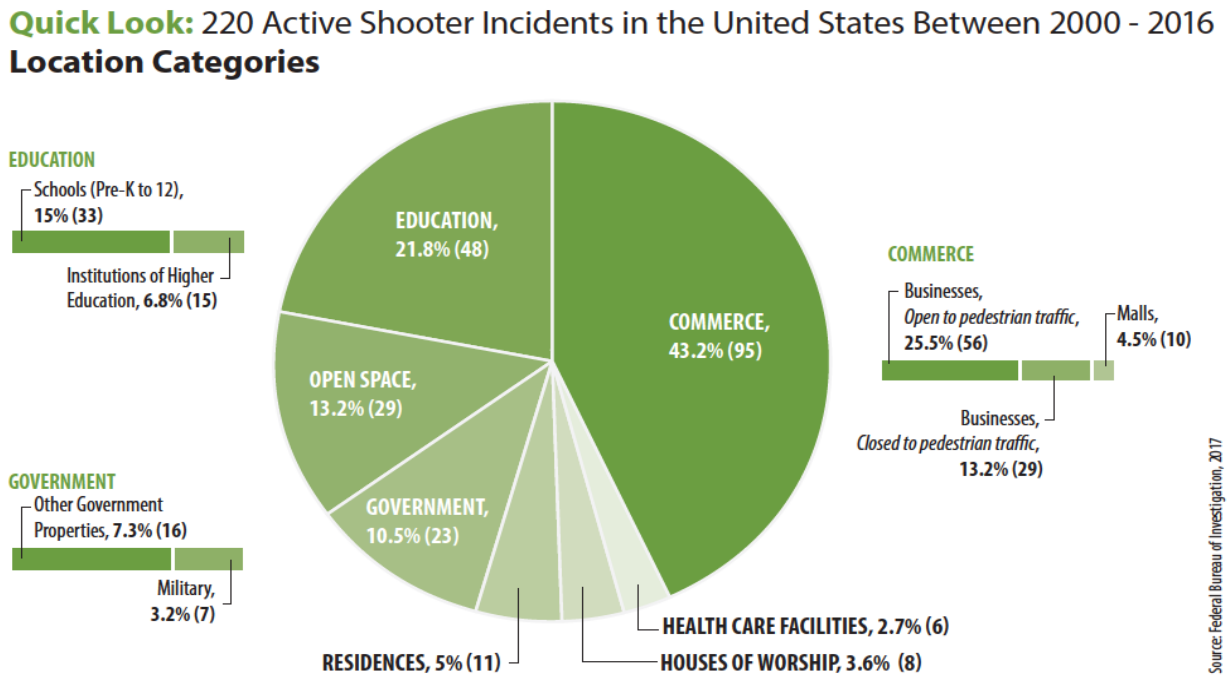
Table 1. Source: Federal Bureau of Investigation, 2017

Government Property

Datasets also depicted critical infrastructure such as our federal facilities and military bases share this danger as well, which accounted for over 10% of the active shooter incidents in the analysis. Examples included both the WNY event and the Fort Hood Shooting in 2009. In particular, the Fort Hood Shooting was one of the initial focusing events to challenge the

threshold for response on federal properties.[13] Internal reviews and investigations that followed the incident questioned many of the base's procedures at the time and called for emergency management reform among all federal installations.[14]

Active Shooter Incidents by Location



Graph 1. Source: Federal Bureau of Investigation, 2017

As such, emergency management programs such as the DoD's Installation Emergency Management Program, evolved to better express the principles of the National Response Framework (NRF) and National Incident Management System (NIMS) to provide stronger counterintuitive action plans to include active shooter incidents.[15]

[13] Ibid.

[14] Occurring on November 5th, 2009, the Fort Hood Shooting resulted in 13 fatalities and 32 additional casualties as a consequence to an active shooter incident within the military installation.

[15] Department of Defense. (2010). DoD Independent Review Related to Fort Hood. Retrieved: https://www.defense.gov/Portals/1/Documents/pubs/DOD-ProtectingTheForce-Web_Security_HR_13Jan10.pdf

Background

Washington Navy Yard

Located in the southeast side of Washington, D.C., the WNY encompasses 68 acres along the Anacostia River and is naturally situated in close proximity to other key federal properties such as the U.S. Capitol Building. Dating back to October 2, 1799, the WNY serves as the Navy's oldest military installation still in use today, with nearly 17,000 military, civilian, and contractor personnel reporting daily.[16] Contemporary use for the facility includes its role as the administrative center for the U.S. Navy, home to the Chief of Naval Operations, and the headquarters for NAVSEA. In addition, the WNY hosts an additional 67 tenants inside the installation.[17]

Location of the Incident

Colloquially known as building 197, NAVSEA is the largest tenant in the installation where over 3,000 of the WNY's personnel are concentrated. Among the 3,000 personnel included the perpetrator Aaron Alexis, who frequently operated within the confines of NAVSEA when visiting the WNY to conduct work assignments. The building encompasses 638,000 square feet and five floors, with what is described as a "maze like" interior. The layout consists of various cubicles, training facilities, conference rooms, and auditoriums with pathways that offer a few feet of clearance. Furthermore, long narrow hallways also stretch the entire length of the

[16] Department of the Navy. (2013). Report of the Investigation into the Fatal Shooting Incident at the Washington Navy Yard on September 16, 2013 and Associated Security, Personnel, and Contracting Policies and Practices. Retrieved: http://archive.defense.gov/pubs/Navy-Investigation-into-the-WNY-Shooting_final-report.pdf

[17] Ibid.

building. As depicted in Figure 1., NAVSEA's physical location is on the west side of the complex by Isaac Hull Avenue, directly south of the closest entrance off of the 6th Street Gate.[18]

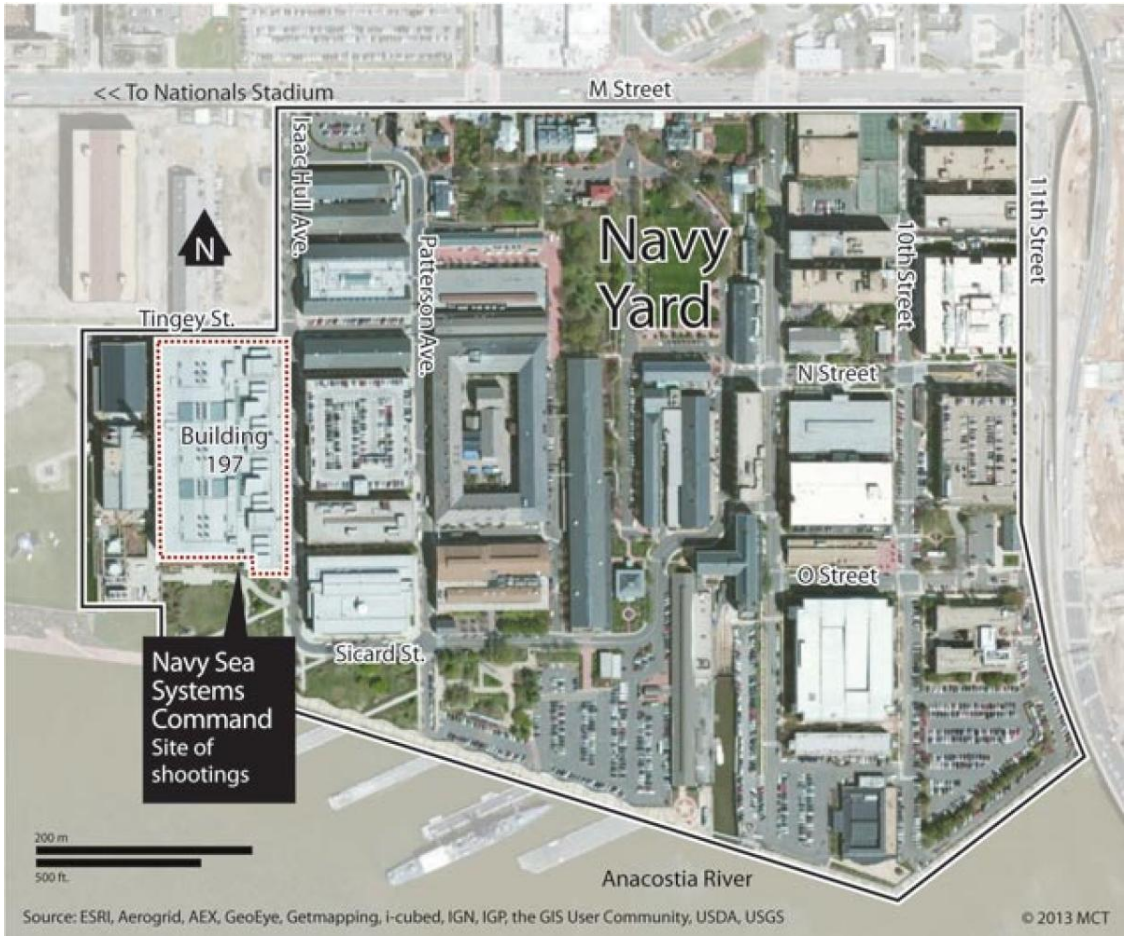


Figure 1. Source: New York Daily News, 2013

NAVSEA[19] serves a multitude of functions, some of which occur within Sensitive Compartmented Information Facilities (SCIFs), also housed in the facility. Generally, employees who enter NAVSEA are only required to scan an identification badge at the main entrance, but no metal detector or other sophisticated security measures exist for entry. However, the presence

[18] Ibid.

[19] NAVSEA's primary mission in the WNY is ship designing, constructing, and maintenance, in addition to installing weapons systems.

for SCIFs in the facility introduced extra security measures. As a result, personnel were prohibited from having their mobile phone device in their possession when entering the SCIF, a common practice enforced among SCIF's due to Physical and Technical Security Standards implemented by the Obama Administration.[20]

Instead, these employees would store their mobile devices in lockers designated at the front lobby. Regardless of the nature of an employee's work assignment, everyone was instructed to call the WNY's internal emergency contact in the event an emergency occurred. The four-digit dial would route the caller to the Naval District Washington police (NDW) Emergency Region Dispatch Center on base in lieu of the city's emergency call center in D.C. [21]

Naval Support Activity Washington

The purpose behind the practice was to allow operators to automatically identify the address of the caller to decrease emergency response time. This was particularly useful due to the fact WNY is patrolled by its own internal police and operated its own emergency services through Naval Support Activity Washington (NSAW). Additional security present within the installation included armed Military Police personnel and contracted security officers.[22]

Though the Navy Yard installation shares jurisdiction among Washington's First Police District of the Metropolitan Police Department (MPD), it was not a common practice for MPD

[20] Exec. Order No. 13526, 75 FR 705 (December 29, 2009).

[21] In response for the Fort Hood Active Shooter incident in 2009, the Department of Defense's internal review (2010) following the event recommended military facilities established their own internal emergency call-taking and dispatch centers like witnessed at the WNY.

[22] Department of the Navy. (2013). Report of the Investigation into the Fatal Shooting Incident at the Washington Navy Yard on September 16, 2013 and Associated Security, Personnel, and Contracting Policies and Practices. Retrieved: http://archive.defense.gov/pubs/Navy-Investigation-into-the-WNY-Shooting_final-report.pdf

officers to regularly patrol the grounds and only intervened when requested by NSAW. Given the close proximity of the base and the culmination of internal police, fire and emergency medical services readily available for the facility, this was considered an effective practice for small scale incidents. For more severe incidents, protocol calls for mutual aid from supporting agencies as instructed in OPNAVINST 3440.17.[23]

Summary of Events[24]

At approximately 0744 on Monday, September 16th, 2013, Aaron Alexis was approved access to enter the WNY. Afterwards, Alexis then continued his projection towards NAVSEA, where he also possessed access through his credentials awarded by the Personnel Security Program. After visiting a restroom momentarily on the fourth floor, Alexis re-appeared revealing an 870 tactical pump-action shotgun and then initiated the active shooter incident by striking his first casualty at 0815. Though first responders were dispatched as early 0817, law enforcement such as the MPD and even the Navy Criminal Investigative Service (NCIS) did not penetrate NAVSEA until 0827.[25]

While various officers continued pursuit of Alexis, others secured the perimeter for building 197 as Unified Command was established through the MPD at the 11th and O Street

[23] Navy Installation Emergency Management, OPNAVINST 3440.17A. Department of the Navy, Washington D.C. 2014.

[24] Many of the events offered in a chronological narrative format, occurred concurrently rather than sequentially. The times, when noted, are based on information, communications, and records provided by the thorough investigations of the DON, FBI, and the MPD.

[25] Department of the Navy. (2013). Report of the Investigation into the Fatal Shooting Incident at the Washington Navy Yard on September 16, 2013 and Associated Security, Personnel, and Contracting Policies and Practices. Retrieved: http://archive.defense.gov/pubs/Navy-Investigation-into-the-WNY-Shooting_final-report.pdf

entrance gate; approximately at 0839. Overall, pursuit for Alexis would exhaust 69 minutes until finally, an U.S. Park Police officer also assisting the response, shot and killed Alexis at 0925 on the third floor of the complex. In the course of the incident, Alexis fatally shot twelve people and injured eight others (including four officers), 10 of the fatalities occurred within the first 6 minutes.[26]

The response was overwhelmed with uncertainty, as external resources such as the MPD had inadequate resources and knowledge of the installation. Disorientation stemmed from Unified Command, where responders struggled to locate NAVSEA, including examples of Officers converging on the opposite side of base. At Unified Command, MPD and other resources heavily relied on NCIS to attain critical intelligence, such as building 197 floor plans and CCTV footage. Conversely, NCIS was just primarily a tenant in the Installation and these requests had to be channeled through NSAW instead.[27] As a result, MPD received intelligence only gradually, meanwhile being forced to make decisions with the absence of key information.

Generally, much of the installation's inherent security measures served as a detriment for response as well. The mobile phone policy for building 197 eliminated many victims from having the ability to call for help. Meanwhile, the reports authorities did receive were skewed, due to vital information being received by two separate emergency call centers depending if the caller directed their call to the D.C. dispatch or Navy Yard's internal emergency number like mentioned previously. At no point, did the city dispatch or NDW directly communicate with each other.[28]

[26] Ibid.

[27] Ibid.

[28] Specifically, the OUC received 61 calls concerning the shooting. Initial calls reported a homicide versus an active

More noticeably, when the shooting was initially reported at 0817, the WNY followed a traditional military 'lockdown' procedure of enclosing the installation and then abandoning the checkpoints to aid in response. As a result, initial first responders who reported at the north gates (6th and M Streets) were barred access to the facility. Officers instead had to locate an alternative passage through the visitor entrance on the east side of the installation (east gates at 11th and O Streets) in a foot race, since the entrance gate was not open wide enough for vehicles to pass through.[29]

Overall the incident reflected a large-scale and multi-agency response which included over 117 police, fire, and emergency medical personnel from various agencies outside the resources of NSAW.[30] In particular, the Department of Navy (DON) concluded NSAW was overwhelmed by the threat and struggled to coordinate resources appropriately. Consequently, NSAW was highly scrutinized by DON for their limited role in the incident. An internal review and investigation highlighted the installation's failure to abide by the comprehensive emergency management procedures instructed by OPNAVINST 3440.17 that could have mitigated much of the friction that impeded response.

Navy Installation Emergency Management Program

As mentioned previously, OPNAVINST 3440.17 serves as the Navy installation Emergency Management Program for DON facilities. Accompanied with the Navy Installation Emergency Management Program Manual, CNIINST 3440.17, the program prescribes elements

shooter incident.

[29] Ibid.

[30] Specifically, representatives from D.C. Metropolitan Police Department, U.S. Park Police, Naval District of Washington Police, Naval Criminal Investigative Service, Metropolitan Washington Airports Authority, U.S. Marshals Service, Navy Contract Security Guards, U.S. Navy, Department of Defense all participated in the incident response for the WNY active shooter incident.

to coordinate responsibilities and establish structure to address all-hazards emergencies, including small-scale local emergencies to large-scale natural disasters and violent criminal activity.[31] Stemming from principles shared among the DoD and NIMS, these resources are comprehensive with the expectation each installation tailors to the local mission, conditions, and hazards specific for their jurisdiction.[32]

In its entirety, OPNAVINST 3440.17 and CNIINST 3440.17 primarily focuses on deterring, detecting and disrupting potential attacks on the installation through heavy physical security measures that demonstrates a "robust security posture", for the purpose to advert malicious activity. Like witnessed with the PSP, additional preventative measures include general Access Control, which refers to the ability to restrict and control entry for visitors. As a result, all personnel who wish to operate on the WNY must receive the proper credentials to do so after being subjected to prior screening.[33]

In the event these preventative measures fail, DON requires a response force to contain and neutralize all-hazard threats.[34] To coordinate this response, OPNAVINST 3440.17 invokes the six key principles:

[31] Navy Installation Emergency Management, OPNAVINST 3440.17A. Department of the Navy, Washington D.C. 2014.

[32] Department of Defense. (2017). DoDI 6055.17: DoD Emergency Management (EM) Program, February 13, 2017. Retrieved: https://www.hsdl.org/?view&did=798849

[33] Department of the Navy. (2013). Report of the Investigation into the Fatal Shooting Incident at the Washington Navy Yard on September 16, 2013 and Associated Security, Personnel, and Contracting Policies and Practices. Retrieved: http://archive.defense.gov/pubs/Navy-Investigation-into-the-WNY-Shooting_final-report.pdf

[34] Navy Installation Emergency Management, OPNAVINST 3440.17A. Department of the Navy, Washington D.C. 2014.

1. Command and Control
2. Planning
3. Training and exercises
4. Communications Management
5. Equipment
6. Program Oversight

The DON determined deficiencies existed in all six principles for incident response for the WNY shooting, specifically highlighting discrepancies for NSAW's incident response in comparison to the recommendations outlined through the Command & Control, Planning, and Training & Exercises, and Program Oversight principles shared with NIMS.[35]

Command and Control

Most visibly, much of the fog for incident response during the WNY Shooting was emanated in the operations of Command and Control. Specifically, OPNAVINST 3440.17 states Command and Control is intended to:

> Allow the commander to coordinate and adapt the overall response, including situations beyond the planned responses. Command and Control establishes the response structure including trained responders, resources, effective communications, and information management. Unified Command provides guidelines to enable agencies with different legal, geographic, and functional responsibilities to coordinate, plan, and interact effectively.

[35] Department of the Navy. (2013). Report of the Investigation into the Fatal Shooting Incident at the Washington Navy Yard on September 16, 2013 and Associated Security, Personnel, and Contracting Policies and Practices. Retrieved: http://archive.defense.gov/pubs/Navy-Investigation-into-the-WNY-Shooting_final-report.pdf

Although the MPD is a capable resource to facilitate Unified Command, they did not possess the internal knowledge for the installation to solely direct incident response.[36]

In accordance with the Command and Control construct of NIMS, NSAW is required to establish an appropriate interface and integrate with external agencies to conjoint Unified Command. DON determined NSAW did not achieve this at the operational level, as a result, NSAW did not adequately communicate and coordinate actions with the MPD until after the threat had been neutralized at 0925. As such, NSAW did not perform a meaningful role in the incident, which was reflected in MPD's dependency for NCIS to acquire essential resources and intelligence.

Planning

Prior to an incident, OPNAVINST 3440.17 and CNIINST 3440.17 also required the development of risk-based pre-planned procedures that include the integration for both external and internal resources. The DON determined the lack of clarity concentrated within Unified Command also attributed from the failure to cooperate with external agencies such as the MPD to form prearrange agreements and response plans referred as "mutual aid".

Encouraged by the DHS, mutual aid agreements are applicable for a wide variety of agencies and organizations for aiding across jurisdictional boundaries when local resources are overwhelmed. Assistance derives in the form of essential services, specialized teams, equipment, and even advanced technologies when appropriate.[37]The intentions for these agreements is to

[36] Metropolitan Police Department Washington D.C. (2013). After Action Report Washington Navy Yard September 16, 2013. Retrieved: https://www.policefoundation.org/wp-content/uploads/2015/05/Washington-Navy-Yard-After-Action-Report.pdf

[37] Navy Installation Emergency Management, OPNAVINST 3440.17A. Department of the Navy, Washington D.C. 2014.

facilitate rapid, short-term deployment for emergency support prior to, during, and/or after an incident when needed.[38]

Despite this being a common practice among emergency management, it was determined that NSAW and NDW did not adequately established mutual aid agreements with civil and emergency responders, including local resources. At the time of the incident, only one prearranged agreement existed, which was executed in 1990 and neglected all applicable agencies present for the 2013 WNY Shooting.[39] The finding was discouraging, for agreements of this nature were a strong recommendation in the aftermath of the Fort Hood Shooting.[40]

Training and Exercises

As an extension for the risk-based pre-planned procedures mentioned previously, the training and exercise principle exists to validate the readiness for personnel to respond to the all-hazards response mission. Though the response for the 2013 WNY Shooting was considered "swift and heroic" upon review, DON revealed that critical performance gaps existed in response primarily for Navy Yard personnel not actively performing training and exercises beforehand. Prior to the incident, NSAW was neglecting these procedures for all emergencies, though no training and exercise drills were exhibited specifically for active shooter threats.[41]

---

[38] National Response Framework Second Edition dated May 2013.

[39] Department of the Navy. (2013). Report of the Investigation into the Fatal Shooting Incident at the Washington Navy Yard on September 16, 2013 and Associated Security, Personnel, and Contracting Policies and Practices. Retrieved: http://archive.defense.gov/pubs/Navy-Investigation-into-the-WNY-Shooting_final-report.pdf

[40] Department of Defense. (2010). DoD Independent Review Related to Fort Hood. Retrieved: https://www.defense.gov/Portals/1/Documents/pubs/DOD-ProtectingTheForce-Web_Security_HR_13Jan10.pdf

[41] Department of the Navy. (2013). Report of the Investigation into the Fatal Shooting Incident at the Washington Navy Yard on September 16, 2013 and Associated Security, Personnel, and Contracting Policies and Practices. Retrieved: http://archive.defense.gov/pubs/Navy-Investigation-into-the-WNY-Shooting_final-report.pdf

Incorporating active shooter drills in all-hazards response was also a strong recommendation following the Fort Hood Shooting.[42]

Program Oversight

Ultimately, the investigation highlighted deficiencies were mainly attributed to the Program Oversight, which failed to detect the faults listed above for NSAW's emergency management procedures. The deficiencies developed through NSAW neglecting annual "independent vulnerability" assessments, as instructed in OPNAVINST 3440.17 and CNIINST 3440.17. Instead, no reviews occurred between July 24, 2009 until the aftermath of the WNY incident. An ideal Emergency management oversight would be intentional to ensure emergency management programs remained flexible to acclimate to the ever-evolving threats for the installation. Instead, DON distinguished that no program to develop, execute, and track an emergency management training plan for either the NDW or NSAW emergency management programs were being conducted. As a result, the deficiencies noted above were not being tracked nor corrected. This was subjected to an immediate revision following the incident.[43]

[42] Department of Defense. (2010). DoD Independent Review Related to Fort Hood. Retrieved: https://www.defense.gov/Portals/1/Documents/pubs/DOD-ProtectingTheForce-Web_Security_HR_13Jan10.pdf

[43] Department of the Navy. (2013). Report of the Investigation into the Fatal Shooting Incident at the Washington Navy Yard on September 16, 2013 and Associated Security, Personnel, and Contracting Policies and Practices. Retrieved: http://archive.defense.gov/pubs/Navy-Investigation-into-the-WNY-Shooting_final-report.pdf

Conclusion

An analysis of the FBI database revealed that Active Shooter Incidents are an increasing phenomenon in the U.S. with over 220 incidents between 2000 through 2016. Specifically 134 incidents have occurred since 2010 alone, resulting in an alarming rate of at least one active shooter incident every three weeks. Like scrutinized in the 2013 WNY Shooting, the increasing prevalence for these threats are shared among our key critical infrastructure and federal properties as well.

The 2013 WNY event is the second deadliest attack on a military base in US history, which resulted in twelve deaths and eight additional casualties. The attack illustrated the dynamic and haphazard disposition for these incidents, whereas perpetrators such as Aaron Alexis, eluded preventive screening measures and went undeterred by the installation's heavy physical security presence. Instead, the Navy Yard had to summon a response force that exhausted over 69 minutes and encompassed 117 resources for police, fire, and emergency medical personnel to locate and neutralize Alexis.

Outside the NDW Police, response predominantly was facilitated by the MPD and NCIS. Despite prescriptions to provide pre-response plans and mutual aid agreements with external partners, the event was overwhelmed with fog and friction, as external agencies such as the MPD had little to no knowledge for the installation while attempting to direct critical resources. Obstructions extended from communication gaps between internal and external emergency operations centers, as well as the base's lockdown procedure that barred access from first responders. The culmination of these factors explained the uncharacteristic length for the incident, when approximately 70% of incidents conclude in five minutes or less.

Finally, incident response through the NSAW was highly scrutinized by the DON. It was determined at the operational level, NSAW did not effectively communicate and coordinate actions with the MPD until after the threat had been neutralized. Specifically, internal reviews and investigations lead by the DON highlighted deficiencies existed for the 1) Command and Control, 2) Planning, 3) Training and Exercises, and 4) Program Oversight principles for all-hazard response. As a result, many of these measures were subjected to immediate revisions to support key critical infrastructure including Military and Government Properties.

References

Department of Defense. (2017). DoDI 6055.17: DoD Emergency Management (EM) Program, February 13, 2017. Retrieved: https://www.hsdl.org/?view&did=798849

Department of Defense. (2010). DoD Independent Review Related to Fort Hood. Retrieved: https://www.defense.gov/Portals/1/Documents/pubs/DOD-ProtectingTheForce-Web_Security_HR_13Jan10.pdf

Department of the Navy. (2013). Report of the Investigation into the Fatal Shooting Incident at the Washington Navy Yard on September 16, 2013 and Associated Security, Personnel, and Contracting Policies and Practices. Retrieved: http://archive.defense.gov/pubs/Navy-Investigation-into-the-WNY-Shooting_final-report.pdf

Exec. Order No. 13526, 75 FR 705 (December 29, 2009).

Glick, Jeffrey. 2018. Course Introduction: Theoretical and Ethical Underpinnings of Emergency Response and Recovery. Lecture presentation, Alexandria VA, January 29.

Hastings, Deborah. (2013). Washington Navy Yard, nation's oldest military installation, has rich history steeped in war and lore. New York Daily News.

Interagency Security Committee. (2015). Planning and Response to an Active Shooter: An Interagency Security Committee Policy and Best Practices Guide. Retrieved: https://www.dhs.gov/sites/default/files/publications/isc-planning-response-active-shooter-guide-non-fouo-nov-2015-508.pdf

Metropolitan Police Department Washington D.C. (2013). After Action Report Washington Navy Yard September 16, 2013. Retrieved: https://www.policefoundation.org/wp-content/uploads/2015/05/Washington-Navy-Yard-After-Action-Report.pdf

National Response Framework Second Edition dated May 2013.

Navy Installation Emergency Management, OPNAVINST 3440.17A. Department of the Navy, Washington D.C. 2014

Schweit, Katherine W. (2017). Active Shooter Incidents in the United States from 2000-2016. Federal Bureau of Investigation, U.S. Department of Justice, Washington D.C. 2017.