NATIONAL TRANSPORTATION SAFETY BOARD
Investigative Hearing

Washington Metropolitan Area Transit Authority Metrorail train 302 that encountered heavy smoke in the tunnel between the L'Enfant Plaza Station and the Potomac River Bridge on January 12, 2015

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EXHIBIT	
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Agency / Organization

Title

Interview Transcript for Rafael Sa'Adah

UNITED STATES OF AMERICA

NATIONAL TRANSPORTATION SAFETY BOARD

Investigation of:	*	
	*	
WMATA INCIDENT AT L'ENFANT PLAZA	*	
STATION, WASHINGTON, D.C.	*	Docket No.: DCA-15-FR-004
JANUARY 12, 2015	*	
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Interview of: RAFAEL SA'ADAH

D.C. Fire and EMS - Fire Operations Center
500 F Street, N.W., 2nd Floor
Washington, D.C.

Monday,
February 2, 2015

The above-captioned matter convened, pursuant to notice.

BEFORE: RICHARD M. DOWNS, JR.
Survival Factors Investigator

APPEARANCES:

RICHARD DOWNS, JR., Survival Factors Investigator
Chairman, Survival Factors Technical Working Group
National Transportation Safety Board

RUBEN PAYAN, Railroad Accident Investigator
National Transportation Safety Board

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Office of Transit Safety and Oversight
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DENTON ROURKE, Operations Manager
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D.C. Fire and EMS
Homeland Security & Special Operations Division

I N D E X

I N T E R V I E W

MR. DOWNS: Today's date is February 2, 2015, and the following is an interview being conducted in reference to NTSB investigation number DCA-15-FR-004, which relates to an accident involving a heavy smoke release and train evacuations that occurred in and near the L'Enfant Plaza Station of the WMATA Metrorail System in the District of Columbia on the afternoon of January 12, 2015.

This interview is being conducted with a member of the District of Columbia Fire and Emergency Medical Services Department, as conducted by the NTSB Survival Factors Technical Working Group of the investigation.

My name is Richard Downs, Jr., and I'm a Survival Factors Investigator with the NTSB, and which I also serve in the role as the Survival Factors Technical Working Group Chairperson.

I will preside over this interview which is being recorded for the record, and which a transcript may also be compiled of the recording as a permanent docketed record of the interview.

Additionally, I'd like to mention that the purpose of the investigation is to increase safety and not to assign fault, blame or liability, and that the NTSB cannot offer any guarantee of confidentiality or immunity from legal or certificate actions.

Further, pursuant to the criteria under 49 C.F.R. 831.7, the interviewee may have one representative of the interviewee's

choice accompany him or her at this interview, in which the representative may not testify for the interviewee. It's also requested that comments of the interviewee's representative should be limited and objections expressed by the interviewee's representative are not grounds for the NTSB to refrain from asking questions.

I'll now ask that our interviewee, the witness, please identify themselves, their employment affiliation and job position title for the record.

MR. SA'ADAH: My name is Rafael Sa'adah. I'm an employee of the District of Columbia Fire and Emergency Medical Services Department. My rank is Battalion Fire Chief. I am currently assigned to the training division; however, I am detailed to the Office of the Medical Director at fire department headquarters.

MR. DOWNS: Very good. Thank you, sir. And today are you accompanied by any representative?

MR. SA'ADAH: I am not.

MR. DOWNS: Thank you. At this point, I'd like to request that the participants of the interview who will also have an opportunity to present questions to the witness, to please individually identify themselves, their employment affiliation and job position title for the record.

MR. ROURKE: Good morning, Chief. My name is Denton Rourke. I work for WMATA. I am the Operations Manager in the

Office of Emergency Management.

MR. PAYAN: My name is Ruben Payan, P-a-y-a-n, and I'm with the NTSB out of D.C. here.

MS. BURTCH: I'm Kimberly Burtch of the Federal Transit -- it's B-u-r-t-c-h -- of the Federal Transit Administration, and I'm in their Office of Transit Safety and Oversight.

MR. HAWKINS: Good morning. I'm Derron Hawkins, Deputy Fire Chief, D.C. Fire and EMS, Homeland Security Division.

MR. DOWNS: Thank you.

INTERVIEW OF RAFAEL SA'ADAH

BY MR. DOWNS:

Q. And as my first question for the witness, would you please briefly describe for us your role or involvement in this event?

A. Certainly. My involvement in this event was to assist the medical director of the D.C. Fire and EMS Department, who holds the rank of assistant fire chief, with the strategic management of the medical desk at the Fire Operations Center, which is where we are actually sitting now. So when there is a major event or an emergency mobilization of the department, the Fire Operations Center is normally stood up as it was in this instance.

Q. Activated?

A. Yes. And the -- I am the -- in this case, I happened to be the first person in the Fire Operations Center, anticipating

that it would be activated, and was already beginning to implement strategic actions, which I'll discuss in greater detail as we get further into the interview, when the second official walked in, who was Assistant Fire Chief Dave Foust, and formally activated the Fire Operations Center.

And I stood up the medical desk in advance of the arrival of the medical director, notified him of the evolving event and then worked with him staffing the medical desk past the termination of the incident. In fact, I stayed here a bit after everybody working on some patient tracking issues which I'll also discuss in greater detail as we get further into the interview.

So our focus up here is not so much the tactical management of the incident itself, but the impact of the incident on the rest of the city, serving as a point of contact for communications with the broader medical system, the hospital and so on, and then thinking about the needs of the rest of the city because obviously it's not like normal demand stops just because there's a major mass casualty event going on. And in this case, it was a very busy day in the city completely independent of this event. We had to make sure that adequate resources existed just to meet normal demands. So that's what we did.

Q. Very good. Thank you, Chief. And could you please describe for us, in your own words and to your best recollection, what occurred on the day of the event relative to your specific actions and involvement at the L'Enfant Plaza Station, commencing

at the time that you were alerted to respond to the site?

A. Sure. And I'll try to just hit the highlights and then if you want me to drill down in further detail. I like to talk, so --

Q. Quite all right. And let me correct myself. You actually didn't respond to the site, correct?

A. I did not respond to the site, yeah. I --

Q. You were actually here at the operations center?

A. I was here at the operations center.

Q. Very good. Go ahead, Chief.

A. In my current position, I don't have operational response responsibilities unless there's a contingency and I need to. So, in this case, I happened to be already at Fire Operations. I was up here just working. This is just one of the satellite office spaces that I use. And my recollection is that we keep the radios on in here, and I usually keep my own radio on as well, and I was listening to what I recall as a series of Metro type incidents or smoke type incidents that were in the close vicinity of here. They were actually sort of staggering down the street towards L'Enfant.

Q. So that was kind of a background monitoring?

A. That was the background noise, exactly, yes.

Q. Nothing jumped out at you at that point?

A. No, something -- they were, and you just sort of get a sixth sense about these things so I really can't quantify it. But

I'll put it to you this way. When Chief Foust walked in the door, I was already on the phone with the Emergency Healthcare Coalition Notification Center. So I was already pre-alerting them of an evolving event, which at this point there was no information that there were any casualties, but certainly there was the potential for there to be casualties and I wanted them in a forward leaning posture.

So -- no, so my recollection is that the background noise was significant that I shifted focus from what I was doing and put my work to the side and made the strategic decision at that point to simply stand up the desk and begin making notifications, anticipating that other department officials would begin to arrive.

We were fortunate in that there's only one EMS operational command position in the department right now. It's a position we call EMS 8, which is an operations battalion chief who is on day work, and that particular day happened to be the first day that that person was back at work after having been off for the past three months. The department had chosen not to backfill that position. So there was no operational EMS command officer to respond on incidents during that three-month gap. If he had not been back that day, I might have had to make the decision to respond to the scene, but as he was back that day and I knew that, it made my decision a lot easier. So I said, as fun as it would be to go down and get involved in this major event, where I'm

going to add the most value, and I have to think about what's best for the agency, is to get this desk stood up and start getting the hospitals geared up for what could be a mass casualty event.

Q. And, Chief, who was the operational EMS command officer that particular day?

A. That was Andre Spriggs.

Q. Spriggs?

A. Yeah.

Q. Very good. Please proceed.

A. Okay. So as Chief Foust walked in, I was -- my timestamp, and I -- you know, I've been doing this for a long time so I usually keep a little log going because my experience with mass casualty events or with major events, which I've been on many, has been that's often difficult to reconstruct timelines if you don't start tracking right away. So I kept a little log, and I still have those time points here.

I made a note at 15:45 that I pre-notified Gail Jackson at the coalition notification center, and I believe that was about 20 minutes after the original dispatch of the first fire department dispatch of resources. And that would have been about the time that Chief Foust came in because I was actually on the phone.

So let me explain what the coalition is, and if you know this, that's great, but we do need to get it on the record. So essentially the Emergency Healthcare Coalition is -- it's not a

governmental organization, at best quasi-governmental. It's a hybrid that they do get some grant funding from the government, but they are staffed and the infrastructure exists within the hospitals itself. And what it is, it's a group that takes the emergency preparedness managers and the ED directors of all the hospitals in the District and focuses them on management of emergency incidents, both whether they're incidents at the hospitals themselves or how a major citywide incident would impact the hospitals.

One of the functions that they perform is they have a coalition notification center which rotates among three sites, which serves as a single point of contact for pushing out information to the hospitals and requests from us for bed status, so that we don't have people calling all over the place or having to call individual hospitals.

So I determined that the location of the notification center for this particular rotation was at Providence Hospital, and then I identified the desk operator who was Gail Jackson. I called her, identified myself and I said, I have no information on casualties yet, we don't even know what this incident is, but I want you at your desk. I want you alert. There's a possibility we're going to have to start getting bed statuses and push out notifications, and I'm pre-alerting you.

And I made a parallel phone call to the duty officer for the coalition, Ali Abdul-Barr, and actually caught him on his cell

phone while he was driving home. Because it's a volunteer position, the duty officer position rotates and there's always a volunteer from one of the hospitals. He said thanks for the heads up, I'm going to be at my house shortly and I'll start, you know, I'll start getting my computer geared up and so on and so forth.

So I got them stood up, and I'll just hit some of the other significant time points. At 1615, based on what I was hearing over the radio, I had not heard anybody voice a concern that this was a potential terrorist event, but I was seeing enough red flags that I had significant concern based on the color of the smoke and, you know, the casualties and so on. So I wanted to make sure that the FBI was aware of the evolving event, and with events like this, redundant overlapping notifications are a good thing because one of the operational commanders may be too hands on with the incident to actually think, let me make sure that the special agents are aware. So I've got Adan Garcia on speed dial. He's our terrorist liaison with the FBI. I called him.

Q. Your normal contact?

A. My normal contact. I call him anytime I'm involved in an event that I want to make sure he's aware of or that we might need their assistance. And Chief Hawkins would make the same type of notification; other chiefs would also, and sometimes we all may make overlapping notifications. But in this case, I think I was the second person to reach him. He had -- my recollection from talking to him, he had either just jumped in his car or he was

getting ready to start heading down. So that was at 1615.

Q. Heading to the site.

A. Yeah. Yeah. So that was 1615.

At 1618, at this point, I've booted up multiple dashboards on the computers here. So I'm booting up what we call our situational awareness dashboard. What that lets me see is in real time how many transport units do we have at each hospital, what length of time have they been there.

Q. Transport units meaning ambulances?

A. Ambulances, that's correct.

Q. Okay.

A. Okay. And then how many do we have left available to respond either to this incident or to any incident.

We were working on booting up the CAD system. There's a new interface for that, and they were experiencing some technical difficulties, but we eventually got everybody logged into the iNet, what's called the iNet Viewer, so we could look at the citywide activity. And so I'm pulling up all these different dashboards.

And at 1618, I have a note that I wrote where I've let the ELOs -- the ELOs is our EMS liaison officers. That's essentially a paramedic supervisor that sits in our Office of -- at the Office of Unified Communications, and their job is the citywide management of the EMS resources from the phase of transporting from the scene to the hospital to getting them

returned into service. So they're essentially managing the interface with the hospitals. And what I told the ELOs was we have an evolving event, we have very few transport units available, you need to take all these units that are at the hospitals right now and return them to service as quickly as possible.

So essentially when we're doing that, we're -- the main thing we're concerned of has transfer of care been completed? Have we actually transferred care of the patient? And have they decon'ed and re-supplied the units? And we may have to cut some other things short. So if they're still working on their documentation, we're in a contingency situation now, let's get these units turned around.

Q. Let me --

A. Yeah.

Q. -- intercede here for a moment, Chief. Was it a particularly busy day up to the point of the event with other unrelated medical responses occurring?

A. Yes.

Q. So that would explain why all these ambulance units would be at various hospitals.

A. Yes. This time of day would normally be -- it's peak time and it would, even under normal operations, and my recollection is it was a particularly busy day independent of anything else that was going on.

Q. Would you let me interject here as a thought. Would you say that you were short of ambulance units on that day or just -- had just enough or what would you characterize availability?

A. I couldn't respond to the question framed as it is because it's too subjective.

Q. Okay.

A. What I can say is that under normal demand surge, which we experience all the time so it's about the rate of rise, if you will, as a term that some of you may be familiar with from the fire propagation curve, so -- but under rate of rise, if we start having, you know, 10 or 20 incidents within a 1-hour period -- we have 39 transport units, but you look at your cycle time for a medical call can be up to 2 hours from, you know, getting to the scene, performing care, transporting to the hospital, transferring care, you could very easily exhaust 39 transport units just based on rate of rise during normal surges and during peak demand.

So peak demand for us could be, say, 10 a.m. to 10 p.m., and it's very common for us to have no available transport units or a margin of 1 to 2 or 3 during this time period, and it's very volatile. So we could have no transport units for 5 minutes and then all of a sudden six available. So the number is very dynamic, which is one of the reasons we created the dashboard, and the deputy fire chief of operations is responsible for those operational assets at the citywide level and is constantly monitoring that. So it would be very common that we would not

have as much surge capacity as would potentially be desired during this time of day independent of a mass casualty incident.

Q. Could you -- would you say though that having extra surge capacity would be a good thing, if the city had that availability?

A. I think that the -- I can only speak for myself because I'm not --

Q. Given your experience and your position.

A. Yeah. Yes, of course. Of course.

Q. Okay. Very good.

A. And I believe that the agency has argued the same.

Q. And is there a funding issue right now with availability of units --

A. I think that --

Q. -- would you say or is that a bigger city question?

A. Yeah. I think in my current rank and position, that that question is more appropriately addressed to the people who are strategic decision makers.

Q. Very good. Okay. Thank you. We have testimony from other witnesses to the effect that there were two medical buses that responded to the event site.

A. Um-hum.

Q. Is that part of your ambulance roster, equipment roster?

A. Yeah. So the vehicles in question are a part of our mass casualty taskforce. So as I think you probably know by now

if you've done enough interviews, we have two mass casualty taskforces specific to the District and, of course, then there's additional capacity which exists in the surrounding jurisdictions which is similar.

Q. Mutual aid, mutual aid response?

A. We'll get to mutual aid in a second, but I'm actually speaking specifically about the medical ambulance bus. So the surrounding jurisdictions also have similar set-ups for their medical ambulance buses and mass casualty support units. We have a standardized inventory so that one jurisdiction's medical ambulance bus is much the same as another jurisdiction's.

Q. And you know pretty much what the other jurisdictions would have in terms of resources, and you can call at a moment's notice and get them to support?

A. That's definitely an option when one's dealing with a major incident. So -- and on this day in question, the North Mass Casualty Taskforce has two buses and South Mass Casualty Taskforce normally has one bus. It's my understanding that on the day in question, the South Mass Casualty Taskforce's bus itself was out of service for mechanical reasons but the support unit was available, and then, of course, the two buses from the North group and their support unit were available. It's my understanding that they responded. Keep in mind once again, I was not involved in requesting those resources or the actual tactical management of those resources.

Q. So to your understanding, all three of the buses responded?

A. No, my understanding is that the South Mass Casualty bus was not available to respond.

Q. Okay. So there were two buses available?

A. Two buses.

Q. Okay.

A. Okay.

Q. As well as how many -- roughly how many ambulances available to respond or whatever?

A. I would have to -- I don't have that information in front of me. The total number of transport --

Q. That would be documented someplace else; we could find that?

A. That would be very easy to reconstruct --

Q. Very good. Okay, let's continue.

A. -- from multiple data sources.

Okay. So at 1618, I'm on the phone with the ELO making sure that we're pushing the ambulances out of the hospital, pointing out hospitals where we have in particular five units at a hospital, just working with them. And at 1619, I made sure that the medical director was aware of the incident. My recollection is that I reached him at fire department headquarters at the Reef Center. He said I'll be there in 15 minutes, and he was. He got right down here.

1627, I gave an update to the coalition notification center. 1633, the coalition notification center was formally requesting the bed status update, which is where the hospitals actually go into a dashboard that they share and begin updating a matrix with their bed availability. Now, that information's not required in terms of us deciding where we take patients. It's just value added. It's just additional information.

At 1715, we called -- we're looking now at what additional resources can be activated to both create surge capacity demand for this event as well as just what was going on in the city. At this end of the Fire Ops Center and for the purposes of recording, I'm pointing to the south end of the Fire Ops Center. They were notified -- they were requesting mutual aid resources through the Office of Unified Communications, which would be normal procedure. It's my understanding that we did get transport resources from other jurisdictions, PG and Fairfax, I believe, but I don't have the specific units.

Q. We could always recover that --

A. Yeah.

Q. -- from the documentation later on.

A. That was happening down at the -- yeah.

Q. Okay, go ahead.

A. What I did was I called -- George Washington University has their own student-run ambulance service. It's called EMeRG, E-M-e-R-G, and they have two transport units. And I called their

coordinator and said we're going to activate your units for citywide use, and they said that's great, we're ready to go. Called OUC to make sure that they were loaded in the CAD system and could be deployed anywhere that they were needed.

At 2021, we forwarded the final patient distribution based on the information available at that time by unit and hospital to the coalition, and this is just a count of -- a headcount of how many patients we believe we took to each hospital by which conveyance.

Q. It's a running tally count you would keep?

A. Yeah, yeah. And then we sent the -- that was pushed out to the coalition through their notification system. It's called DCHIS. And then at 21:52, I have a note that I pushed out the patient transport log with EPCR reconciliation verified for the transport unit transport. So let me translate that into plain speak.

One of the biggest concerns with an incident of this type is having as accurate a count as possible of who were the patients we touched, where did they go, how did they get there and do we have good medical documentation for the care that was provided to them. So I just -- this is just something that's of particular concern to me having been involved in so many major incidents, and we know there's going to be many, many requests for that information -- lawsuits, NTSB.

Q. Later on.

A. Yeah, whatever, whatever. So if you don't get ahead of that on the front end, you're going to be chasing that information for a long time. So I was particularly concerned to make sure that we had an electronic patient care report for every single individual that went by transport unit.

Q. Who would connect -- who would collect that data? Would that be collected in the field by the -- by the medical command in the field?

A. Well, this is the advantage of having electronic patient care reporting system, is that actually the information goes electronically directly from the tablet that are used to input the information to a server. And so I'm going into the backend, into the Enterprise System, the server, and actually looking at the information in real time. So I'm looking at -- essentially what I'm doing is I'm cross-referencing these are the units that operations is reporting to Fire Ops who are involved in transports. Then I'm taking those unit numbers, I'm going into our server -- the system's called SafetyPAD -- and I'm looking to make sure that I see an EPCR. If they say ambulance 9 had three patients, I want to see three EPCRs for ambulance 9 and so forth.

Okay. So at 2152, I verified that an EPCR was in, and then, you know, there's a lot of back and forth with that. You have to make sure that the tablet's connected to the server, that it was successfully transmitted, that it's not hung up, and so on and so forth. So that was done and we had at that point an EPCR

for every patient.

Now the second piece, which you had started to ask, which was, well, then what about the folks on the buses? So the folks on the buses are under a different system. Okay. Sometimes you'll have the luxury if they're being few enough patients that you can actually put them in to SafetyPAD, but more commonly, and this would be the case here, you're executing disaster tags which are also known as triage tags. And in that case then what's done is the EMS command officers that were involved in the tactical management of the incident will go and collect all that information, will pull it together, and then we'll create a transport log manually and also input the information into SafetyPAD based on what the tag says. But that's done after the incident.

So at that point I also made sure that Spriggs, who's involved in the actual hands-on tactical management of the incident, had sent -- was either personally or through the supervisors, making sure that those physical tags and any other documentation specific to transports was being collected so we could then collate all the information. And then since then, I've taken those logs, made sure that our records management clerk has entered the information into SafetyPAD, and then I have a spreadsheet which contains those data sources as well as data that we got from the hospitals, and is what I would call the closest thing we have to a master transport log, and is designed --

there's actually patients on that that may not have even been transported by us, but it's designed to be the largest picture possible of patients that we either know we touched or we think we might have touched.

Q. Very good. And top of your head, were you successful in terms of getting all the data boxes in your spreadsheet correctly filled?

A. I'm confident that we have a line for every person. We still have a handful of John Does, and it's not a large number and I can actually -- I can go through. It's a living document.

Q. Right.

A. So when we have John Does -- so an example, there's very few hospitals where I have John Does left, but I'll use Howard University Hospital as an example. So for Howard at this point in time -- I'll just pull up their sheet -- I see -- no, you know what? I've got a name for everybody at Howard. I don't have dates of birth for everybody.

Q. Okay. So that's not critical information at this point.

A. I like to be as precise as possible.

Q. But you don't need it on that particular evening, the -- when you're finishing up that particular evening --

A. No, the longer you wait to get the information, the harder it is to get.

Q. Very good.

A. So I was -- I -- even after the incident had terminated,

I was working from home at 2:00 in the morning, interfacing with the hospitals just trying to make sure that they were putting their own logs together, that we were setting up mechanisms to exchange the information and --

Q. Finalizing as much data --

A. Yeah.

Q. -- as you could get.

A. So it was actually the Washington Hospital Center, which was the Metro bus. We had a Metro bus that made two stops, and it stopped at Howard and then it made a second stop at Washington Hospital Center. The patients, my understanding, were taken in through the -- there's two different number designators for the Washington Hospital Center Complex. So there's MedStar, the trauma center, which we call Hospital 4, and there's Washington Hospital Center DED, which we call Hospital 13, but it's essentially the same building. They went in through the Hospital 4 entrance -- my understanding is that the hospital center triage in there, but they were actually treated at Washington Hospital Center Hospital 13.

Q. I see.

A. And I have 1, 2, 3, 4, 5, 6 John Does that I don't have names for that got off that Metro bus and, for whatever reason, we were not able to reconstruct or capture their names. Also my understanding anecdotally from -- secondhand from a supervisor talking to Spriggs who then reported the information to me, that

at least one or two patients that were taken to that ramp may have actually left and just walked away on the ramp without ever even making it into the hospital.

Q. We've seen this before where you have people that have been transported and then when it actually gets time to treat them, they have second thoughts, they're not really injured, and they --

A. Yes.

Q. -- and they tend to walk off, and there's no way to account for them because they just basically disappear. Would that be an accurate characterization?

A. I can't say what was going through their heads, but clearly in this case there appeared to be a couple folks that just weren't interested in going through the process.

Q. And you've had this kind of occurrence before in major events where you might lose somebody like that where you can't control them if they want to walk off?

A. You certainly can't control somebody from walking off.

Q. Very good. Okay.

A. And then I also heard anecdotally that some of the patients that we transported were reluctant to surrender their disaster tags, and it was reported anecdotally to me that they wanted to make sure that they had some receipt, if you will, proving that they had actually been involved in the event, and we can understand the psychology behind that. So these are the

challenges that we faced in terms of trying to reconstruct good patient logs, but I think we have as comprehensive of a log as possible, and it's a living document and we -- if we get additional information, we update it as we go.

Q. Very good, Chief. Is there anything further you'd want to add in terms of the steps of your process you were going through there? Are you pretty much concluded as to that was your activities for the day?

A. I think that's the highlights, and then if you have specific questions, I'm happy to answer them.

Q. Very good, Chief. Thanks so much.

MR. DOWNS: I'm going to turn it over to our next questioner.

BY MR. ROURKE:

Q. Chief, Denton Rourke from Metro. I just want to ask you some basic questions about Metro training. What Metro training have you participated in, either with Metro or at the firehouse battalion level, whatever?

A. I went -- when I went through recruit school, which was 24 years ago, we went through Metro, the standard Metro orientation, and that included, you know, walking through cars and understanding the system, and that curriculum was also a part of our recruit training curriculum. Since then, I've -- you know, with a 24-year career, it's probably going to be difficult for me to reconstruct every Metro drill I've ever participated in.

Q. Um-hum.

A. I've certainly participated in many, and there have been cycles where the department was formally taking all operational members of the department back out to one of the train yards, and the site would vary depending on where the Metro liaison was and who the Metro liaison was, and doing hands-on drills. So I'm sure I've done at least four or five of those over the course of my career. And then, of course, I've been -- I've been a battalion chief since 2005.

Q. Okay.

A. So I'm not managing on the company level. So I would probably be less likely to be going out and doing hands-on Metro station inspections.

But certainly when I was a company officer, I would take my personnel down independent of any scheduled training and make sure that we were regularly visiting the Metro stations in our response area. Sometimes that was formally mandated by the department and sometimes it was just part of our normal informational inspections that we would do. Particularly if you had a newer member, you wanted to make sure they understood where the ancillary rooms were, where the E-tech cart was, what a blue light station is and so on and so forth.

Q. Okay. Thank you. Have you ever participated in a full-scale drill with Metro? It could be something that happened in the overnight hours or early on a weekend morning.

A. I know that there have been some and, you know, once again, over 24 years, it's a -- things start to blur together --

Q. Sure.

A. -- just to be frank with you. So I have some recollection of some large-scale drills. I can't, to be honest with you, remember what my role in those drills was. A lot of the work that I've done is strategic and administrative in nature so I would have been less likely than some chiefs at various points in time to actually be deployed. It was probably more focused towards the chiefs that were actually assigned to the operations division at the time. But I've certainly done a lot of large-scale drills for mass casualty incidents.

Q. Okay.

A. And one of our primary scenarios for any mass casualty incident, of course, is something involving Metro.

MR. ROURKE: That's all I've got right now. Thank you.

MR. DOWNS: Very good. Ms. Burtch.

MS. BURTCH: Yes. Kim Burtch.

BY MS. BURTCH:

Q. Were you in contact with Chief Spriggs during this activation period?

A. I did not have any -- to the best of my recollection, I didn't have any operational contact with him during the early phases of the management of the incident. But he came -- and I do believe he was communicating with the other end of the room. The

other end of the room here was much more involved in monitoring the tactical channels and getting information from the scene and communicating with incident commanders.

He was not -- my understanding, and I don't have full information so I'm just going on the information available to me, is that he was transport coordinator. So he could have been plugged in, in many places in this incident. As it turned out, my understanding is that he was ultimately plugged into the transport group as the transport coordinator working under a medical branch director, which I believe was a shared responsibility with Chief Dean and Chief -- Battalion Chief Dean and Battalion Chief Sollers, who were then in turn were reporting to the incident commander.

But I don't -- like I said, I myself have not had the opportunity to listen to the audio files or do a detailed tactical analysis of this incident. I hope to at some point because you have to use these incidents as learning experiences. They're incredible learning tools, and there's not been a single mass casualty -- and I've responded to pretty much every mass casualty incident that this agency has had, you know, over the past decade, and no matter how well they go, there's always something that you can take and learn from and you must use these as learning experiences. So my hope is that we'll do that detailed drill-down in the hotwash and the after action and so on and so forth, but at this phase, we're still in the phase where we are.

I'm sorry, just circling back around to your question, I don't recall communicating directly with him early in the incident, but he actually came up to Fire Ops once the operational component was concluded, and we had extensive communications since then including the night of the incident.

Q. Thank you.

A. Yeah.

MR. DOWNS: Chief, questions?

MR. HAWKINS: Ron Hawkins, D.C. Fire and EMS.

BY MR. HAWKINS:

Q. Chief Sa'adah, I have a question regarding Metro training, and more or less about, I guess, about the agency in terms of responding to Metro incidents. We do in-service training. There's inspections that takes place. Occasionally we participate in full-scale exercises. What do you -- how do you feel about the agency's ability to respond to Metro incidents?

A. I think due to the uniqueness of this particular target hazard, no amount of training would be too much. So unfortunate operationally, in that as a chief officer I've responded to lots of mass casualty incidents, I feel comfortable, very comfortable in the management of such, and that's experience and training together. Okay. You can train all you want, but experience comes into play as well.

Operationally I've also been assigned to the 6th Battalion, which is the area that covers downtown D.C., and that's

a chief that responds to lots and lots of Metro incidents. So I feel comfortable on my own command understanding, but where the rubber hits the road is at the tactical level. It's people that are actually going down into tunnels and can they operate safely and can they deal with communications contingencies, because there will always be challenges to communications no matter how perfectly the system is working.

So I think more training would be better, and then there's training for mass casualty incidents which is a more global issue than just Metro. And I think while we do much training for mass casualty incidents, and I think we probably do as much as anybody in the region, and I don't know if anybody else has mentioned it, but the actual -- the Mass Casualty Taskforces themselves drill on a weekly basis is my understanding with actual hands on of their -- of the support unit and the equipment and so on and so forth. I think that more would be better there as well, even though I think we probably do as much as anybody in the region. So that's a broader issue than just Metro training, which is we always need to be prepared for a mass casualty incident.

And then one of the most challenging things is the mass casualty incident that's presenting at multiple locations. Because, you know, the paradigm for a mass casualty is you assume your patients are coming in this narrow funnel and then you're triaging them and you can set up a neat casualty collection point. Reality is not like that, and we see this -- we saw this with --

well, we see this with almost any incident.

In an active shooter incident, which is another scenario I think that many of us are very concerned about, you're not necessarily going to have meat distribution of patients. You have multiple sites. You will always have patients self-evacuating, as we saw in a small scale with this incident. I've been involved in Metro responses where there was mass self-evacuation, one down by the Anacostia Metro that I remember particularly as battalion chief, and this was just in the past few years, where we had people literally popping up in the bushes and, you know, self-evacuating. And we actually had to send up a helicopter because we were concerned that there might still be people wandering around the park that were unaccounted for that had self-evacuated from this tunnel. So these aren't easy to control.

And unfortunately in the wake of this incident, I think the riding public, which includes myself -- I use Metro to commute to work -- is going to be even less likely to trust us, the government and/or Metro, and I don't know that they necessarily see those two entities as being separate entities, authority, if you will, as seeing the instructions given by authority as reliable.

So I think unfortunately one of the challenges for us, as Metro and the city working together, is people are going to be less likely to trust the emergency instructions that are given. I think we're going to see a propensity for more self-evacuation,

which is going to make the job of first responders and Metro that much harder because we're going to have people wandering through tunnels potentially and that's going to make management of the incidents really difficult. So we've got an uphill task.

So, yes, more -- that's a long-winded answer to your question. So more training would be better, yes.

Q. Next follow-up question. You stated that you had a lot of experience as 6th Battalion chief running Metro incidents. So regarding -- and you also mentioned that you have this mindset that we will always have problems with Metro, it will never be perfect. So what do we have as an agency to help with communications when we have problems in Metro system? Are there like relay systems to be set up? What do we have in place when we experience problems inside a Metro station as it relates to communications?

A. Well, we saw some of the contingency mechanisms used on this incident, which is reverting to cell phones and using runners. Okay. And the -- I think what is a big operational challenge for us is no longer having -- nothing you can do about that. What's a big operational challenge is no longer having the Metro operations center 50 feet from this building where you could walk across and have your liaison right there. So I think the most critical thing we could do is perhaps consider having that operations liaison position -- not necessarily staffed just by our agency, but I'll throw out an idea.

All of the COG jurisdictions could have a rotating duty officer with a full de-encrypted radio console on duty at all times at Metro's OCC that would be immediately plugged into our command structure. So we wouldn't need to dispatch somebody to Pennsy Drive; they would already be there and they would just answer up on the radio and be immediately involved in the management of the incident. Because Metro has the best handle on what's going on -- they've got the cameras; they've got the direct information -- and getting that information to the incident commander as quickly as possible.

I've been on the phone with Metro OCC trying to liaise and it's a nightmare. It's an absolute nightmare. It's very inefficient. And it would certainly be helpful if that person was pre-deployed and already in place.

MR. DOWNS: Anything further, Chief?

MR. HAWKINS: No, no further questions.

MR. DOWNS: Very good.

BY MR. DOWNS:

Q. Some follow-up questions that I have, Chief. Your personal work history, you mentioned you were with the fire department 24 years.

A. Yes.

Q. Can you give us the bullets, highlights of that?

A. Sure. I came up through the ranks as a firefighter, but -- not unique, but almost unique in that I've also been a

certified paramedic the entire time. So I'm the first firefighter with a paramedic credential to actually go all the way through the fire officer promotional ranks up into the chief officer ranks.

And so as a consequence of that, although I consider myself, you know, an all hazards employee and I've a lot of experience with managing fires and hazmat incidents and technical rescue and so on, by virtue of that specialization, I've often been in a role where I've either been an operational EMS chief or dealing with the strategic management of EMS. And that included 4 years as the assistant fire chief of Emergency Medical Services in the Fenty administration under Chief Rubin. But that position was eliminated by the Gray administration 4 years ago, so I reverted to my previous career service position of battalion fire chief because there was no more assistant fire chief for EMS. But as the assistant fire chief for EMS, I was responsible for overseeing the implementation of the recommendations of the Mayor's taskforce on EMS and the EMS reform effort.

So -- and other than that, as I said, particularly during those during 4 years that I was an assistant fire chief, I was integrated into the emergency mobilization plan and responded normally to the scene for every single second alarm, complex incident, mass casualty incident and so on. So I've been to most of them for a pretty long period of time. I was also the medical branch director for the first Obama inauguration, which was the largest planned special event in U.S. history, and I've served in

that role for many, many, many large special events including the inaugurations and 4th of July and so on and so forth.

Q. Very good. Thank you, Chief. And I see you brought with you some notes of the event. Would they be available to be shared with your command in terms of putting together some of the notes of our response to the event?

A. Yeah, I was not invited to the original -- the first after-action review, but since then there have been at least two after-action review sessions that I have participated in and I've, of course, provided this information in the context of informing the after-action effort. And, of course, the patient log which contains protected health information is absolutely a document that I anticipate the review board will want to look at. We just have to go through the proper protocols because of the PHI.

So this is, as I said, is a living document and I make sure that the version of record is on file with our information and privacy officer, Ms. [redacted] (ph.). Anytime I update it, I send her an updated copy. So I've already advised Chief Hawkins of the protocol for this. All you guys need to do is just format the request, explain why you need it, and she'll get that to you.

Q. Yep. And we certainly will respect the confidentiality of the personally identifiable information. I'm talking about the other notes --

A. Yeah.

Q. -- that you had compiled might be helpful in terms of

establishing our timeline, things like that.

A. Yeah. And that's essentially -- I think I gave you every single time point, but let me just see if there's anything else here. January 14, I made a note that I transmitted the patient transport log previously discussed to MTPD homicide investigators upon formal request and with the approval of the HIPAA privacy officer. Then on January 20th, was my first opportunity to participate in an after-action review.

I think it's probably these -- these time points here that you're requesting, I personally don't have any problem with just giving you this sheet but whatever works for you.

Q. Well, we can work through Chief Hawkins on that.

A. Yeah.

Q. The point is that would be helpful in terms of putting our integrated timeline together with WMATA --

A. Yeah.

Q. -- and with the fire department.

A. Yeah.

Q. That would be helpful. Okay, thank you.

A. Of course.

Q. Radios, we've had testimony from the fire department and WMATA to the effect that radios were a challenge in this event. Do you have experience firsthand on that?

A. Well, I have not managed -- just going from memory, I work fairly frequently out in operations division. I work

overtime and just go out like a, quote, "regular" battalion chief. You know, I'm in a -- currently in a day work position so my work is administrative and strategic. But I get out there in operations, so I'm fairly in touch with the ground and reality. But off the top of my head, I don't think I've been on a Metro response with the brand new radios yet. I find them difficult to understand just on structure fire incidents, but I don't have any empirical experience that I can share with you as to how well they work on Metro. And as I said, in this particular incident, I wasn't in a position to monitor the tactical traffic because I was monitoring other data sources and trying to communicate with the hospitals. This was very much a real-time communication, myself and medical director, on the phone pretty much constantly between the coalition, the individual hospitals and the ELO and the OUC liaison, Battalion Chief Pat Smith, who you should definitely make sure you interview.

Q. Pat Smith, you say?

A. Yeah, yeah. One thing that's often lost in these incidents is everybody thinks about the folks that were on the ground and nobody thinks about the folks in communications. Okay. The communications is critically involved in both the tactical and the strategic management of these incidents. So don't forget to interview the fire liaison officer, the ELOs that were on duty. I know Captain Rodney Carter; the OUC liaison, Battalion Chief Pat Smith, because they're actually trying to connect, you know, the

folks on the scene with resources, help track patients, activate additional resources. So, you know, the holistic understanding of the incident has to include that. That's not even getting into the OUC personnel that you'll probably want to interview as well.

Q. And these folks that you just mentioned are located where?

A. They're physically located at the Office of Unified Communications.

Q. Unified Communications.

A. Yeah, the 911, the call center and dispatch --

MR. DOWNS: And, Chief, you would be able to organize that if we wanted to proceed with those witnesses?

MR. HAWKINS: Yeah, I just need to get those names.

MR. DOWNS: We can do that -- we can do that after the interview here.

MR. SA'ADAH: You can go into TeleStaff to find out who was on duty. But, yeah, just Pat Smith, Rodney Carter, and the -- we'll find out who the FLO was. You can pull that up from TeleStaff as well.

BY MR. DOWNS:

Q. Very good, Chief. Next line of questioning, relationship with OCC you expressed was a bit challenging, you said, to the effect?

A. Yeah, and not challenging as in -- and we're talking Metro OCC.

Q. Right.

A. I'm just speaking like -- I'll use my -- most of my experience is really as the time period when I'm the 6th Battalion Fire Chief, as an example.

Not challenging as in they don't want to be professional or I don't want to be professional, but it's just -- it's physically almost impossible. I'm on the phone, somebody else is on the phone. I'm trying to listen to two radios and talk on the cell phone at the same time, and I'm trying to communicate something to them, but if I'm the first or second due chief -- normally it's the second due chief that establishes the liaison with OUC. And so commonly on a Metro response downtown, the 6th Battalion Chief might be only a block or two away, but the Special Operations Battalion Chief is coming from a little bit further away, is in charge of the incident. And the second due chief's responsibility is to establish the liaison with OCC and, if necessary, actually physically drive out to Pennsy Drive and assume the liaison position. But you start by getting on the phone with them. Okay?

So I might be sometimes -- you know, and the 6th Battalion Chief, as an example, might -- there's a bunch of different choices. So an argument could be made they should never actually leave the firehouse; they should actually just park on the ramp and get the phone going and then decide whether to drive out to Pennsy Drive. Sometimes if the incident's close, I prefer

to actually just go to the scene because at least it gives me some information about who's there and what they're doing, and the Special Ops Chief just responding, but -- so if you're on the phone, you're still trying to listen to at least two radio channels. You've got channel 2 and then the tactical channel for the incident. You're on the phone with OCC. You're trying to talk to them but they you just have to keep pausing because you're trying to listen to your radio to find out what's going on, and then they're dealing with the same issue on their end, which is they're trying to yell across whatever. I mean, I physically --

Q. It sounds --

A. -- yeah.

Q. It sounds like it's not a very efficient arrangement the way it's set up now.

A. Even just the physical aspects of hearing what's going on are challenging and then the physical barriers, yes, it's not very efficient.

Q. Okay. How about, how about relationship with Transit PD? No familiarity, no problems with that arrangement?

A. I've not had any particular issues interfacing with Transit PD. I think that the other major incident that I was involved with was that Anacostia response. I was not the first chief, but I came in on additional responses, and I am aware that there was some friction there about who turned off power when and a lot of finger pointing going on, but that's a separate incident

and I was not involved in the after action of that.

Q. How about your experience relationships between incident command and OCC?

A. Well, I just -- that's what I was talking about --

Q. Right. Okay, very good.

A. -- my experiences. So once again, no desire on either end to not get the job done, but it's just the physical barriers are challenging.

Q. And there could be improvements in --

A. I think there's a lot of ways they could be re-engineered.

Q. Okay. Let me touch a bit on emergency access doors on Metro cars. Is that something you would have experience with or would you have a need to know in your role? It sounds like maybe not.

A. No. No, not at the level that I'm functioning within the agency.

Q. Okay, very good.

MR. DOWNS: That concludes my questions at the moment. Let's continue on with our next line of questions.

MR. ROURKE: Denton Rourke from Metro. Just a couple more.

BY MR. ROURKE:

Q. You mentioned that you were working here on the day of L'Enfant Plaza?

A. Yeah.

Q. And you had a sense this was going to transition into something more. Can you describe that for us?

A. I wish I could. As I said, it really is more of a sixth sense than anything else. Just my intuition hearing -- as I recall, I think that there were responses on two different tactical channels and a lot of data points that each one individually may not have been hugely significant but the accretion or the accumulation of those data points was just sending up -- you know, the hairs on the back of my neck were standing up.

Q. Um-hum.

A. Okay. And then certainly at the point that I began hearing information about patients where -- and there was a lot going on obviously. So I'm literally only hearing snatches of this, but I heard the word seizure and then I heard the word CPR. Okay. So seizure, I have a patient with CPR in progress. We have yellow smoke. We have -- you know, I'm like, okay, this could easily be sarin gas again. This could be a bunch of things, but there's so many red flags here. I mean, that's the point that I'm like let me make sure that Adan's, you know, aware of this incident, that the FBI is responding. And, of course, my hope is that the tactical managers of the incident are proceeding with a high index of suspicion that this could potentially be terrorists. Fortunately they were able to rule out a nexus to terrorism very

early in this incident, but that would have been yet another challenge to the actual management.

Q. How about when you listened to the radio, do you -- when did you become aware there was a train stuck in the tunnel?

A. I couldn't tell you. My recollection is it was a really long time into this incident before any concrete information was available to me. And sitting in Fire Ops, and admittedly not -- at that point I'm not listening to the tac channels anymore to describe exactly what we had and whether there were patients. For a long time, and I'm just going from memory now, the only concrete information we had was that there were four patients who all got transported fairly quickly by ambulance and then no other information for a time period that was longer, I think, than one would have liked. So it took a really long time to actually get.

And, in fact, to be frank, it was a lot of -- the best information I got was simply from looking at the live video feed which was open source, which was the news cameras which got to the scene very quick, and I could actually look on the monitors up here and see people with soot around their faces before I had access to any of that information. Now, I'm sure the people on the scene obviously knew that, but it's not necessarily filtering up to me here. That gave me some data points. I could look at both the number of people in the presentation to make sure that once again I was communicating that to the hospitals.

The hospitals, likewise -- we've done some hotwashes

with the hospitals, the coalition has, that I participated in. They were getting some of their information about the scope of the incident from the patients that we had -- the first group of patients that we transported, asking them and then actually getting the information from them saying, yeah, I actually came off of a train and there was all these other people there and so on and so forth. So --

Q. All right. Good. Thank you.

MR. ROURKE: That's all I have.

MR. DOWNS: Ruben, any questions?

MR. PAYAN: No questions.

MR. DOWNS: Ms. Burtch --

MS. BURTCH: Yes.

MR. DOWNS: -- any questions?

MS. BURTCH: Yeah, I'd like to -- Kim Burtch.

BY MS. BURTCH:

Q. So you were saying you were hearing information on the tactical channels?

A. No, I really wasn't. I would hear snatches.

Q. Right.

A. And but I -- when Chief Foust came in, he said stand up a C13, which is the channel 4, the operations center itself, and monitor that until more people get here. So I only had that one radio there. So I'm on C13 and I'm on the phone with the hospitals, and that's about -- you can't monitor three or four

things at the same time because you're not going to do any of them effectively. So my scope, sort of focus was with that group there. I would hear snatches here and there but I wasn't actively monitoring the tactical channels. We had other people coming in to do that.

Q. Right. Now was this first or second alarm notification? I mean, when -- did you hear first alarm dispatch? Did you hear the second alarm? I mean, were you aware of those?

A. Yeah, I can't reconstruct that level of detail at this point. And normally for an incident like this, I wouldn't even rely on my memory. I would go back and look at an incident reconstruction with timelines and the actual audio files and transcripts, because memory can be unreliable. The things I have confidence in are the things that I wrote down myself because I can look at my own handwriting and say, okay, such and such. And I actually went through my phone and looked at my timestamps on my phone to cross -- yep, my times are accurate. And I try to stick to what I actually know as opposed to, you know.

Q. So other than your sixth sense --

A. Yeah.

Q. -- what would help you to initiate your function if it wasn't called out to you.

A. Yeah. Well, if I --

Q. So my point is you were not -- were you getting on-scene feedback that you needed to start initiating mass casualty

operations?

A. Yeah, that's a great question. So, first of all, let's just say I hadn't been in Fire Ops or I'd been in an office someplace else with the radio on or off or what have you. My first notification would come through the paging system of any other officer in the organization. So a page might have gone out saying whatever, whatever information was available. And I'm sure you guys will reconstruct all the Tier 1 notifications. You should actually got into what was pushed out when, and that's why it's also important for you to talk to the fire liaison officer. That's a sergeant who sits up at the Office of Unified Communications and pushes the pages out.

Okay. So I probably would have been notified by a page and/or potentially a phone call. The ELO or the FLO might call and say, hey, you know, there's an evolving incident; I just want you to be aware of it. So that would be my first information.

Now, the information about what was necessary to request the mass casualty -- keep in mind, I was not in the ICS structure for the tactical management of the information. So that would be the information that the EMS branch director for the incident themselves would need to know and obviously did since they stood up -- they requested the mass casualty taskforce very early, yes.

Q. But that works along with the hospitals' notification. That's what you do?

A. No, I'm not the only person that would make the

notification to the hospitals.

Q. Okay.

A. So I'm -- I was essentially the safety net, if you will. The actual notification to the hospitals is technically performed by the ELO and the OUC liaison at the Office of Unified Communications. And coming back to what I said where it's good to have overlapping and redundant checks and balances on that, because they're also heavily involved in tactical management potentially of the incident. So independent of whether I had ever called the coalition, Chief Smith at the OUC absolutely would have notified the coalition and that's his formal role, and if he's not there, then the ELO knows that it's her job to do it. I just happened to be doing it first --

Q. Um-hum.

A. -- and this was the advantage to being, as it just turned out, that I was essentially pre-deployed in a place where, anticipating this need, I could get them stood up a little bit quicker and then coordinate. And I coordinated what I was doing with Chief Smith so that we didn't send out conflicting information.

Q. Thank you.

MS. BURTCH: Thank you. That's all.

MR. DOWNS: Chief, any questions?

MR. HAWKINS: I have no further questions.

BY MR. DOWNS:

Q. Okay. Chief, I'd like to -- I like to give my witnesses the opportunity as we kind of wind up the interview here to offer what we call retrospective thoughts, meaning hindsight, knowing what you know now --

A. Yeah.

Q. -- to express any comments that might be helpful to the process should an event like this occur in the future that you could share with the professional firefighting community. You've already expressed a couple of thought up to now. For example, you expressed that having better full-time representative in OCC would be helpful perhaps in major events like this to get a quicker handle on the scenario that's unfolding. Would that be an accurate representation?

A. Yes.

Q. Very good. Anything else that you could offer off the top of your head? I realize you're going to do some more after-action reviews, but maybe something that jumps out at you that you'd want to offer right now.

A. Well, I think that this incident highlights the critical nature, that the EMS system is not just the Fire and EMS Department. The EMS system is the D.C. Department of Health, the hospitals, and it's made up of multiple components, the EMS system. So the management of an incident like this is not just about the fire department. It's about OUC. It's about DCDOH, and it's about the hospitals.

And there were -- the fact that DCDOH/HEPRA, Health Emergency Preparedness Response Administration, which is the state oversight agency for EMS but also has operational responsibilities to stand up the hospital emergency coordinating center, their own vector for communicating information to and from the hospitals, they also assist us with patient tracking. They have trained operators of a patient tracking device that can assist on a mass casualty incident like this. They were never notified or stood up for this incident, and certainly there could have been some areas where they added value.

So I think that's something that the city administrator will be looking at in the District's own internal review of the incident, and that notification doesn't come from us. It comes from HSEMA, the Homeland Security Emergency Management Agency. So that's certainly something that that needs to be looked at.

And then the fact that we have this robust relationship with the Emergency Healthcare Coalition, but it needs to be continually reinforced and strengthened, and much of the strength of this relationship I think right now rests on strong individual relationships between the leaders of the coalition, which is largely a volunteer effort at this point. It's my understanding, in fact, that they're not even getting grant funding through the city this year so they'll be pursuing their own funding sources just to keep that infrastructure and that network going.

And I've developed very strong relationships with them,

but this should not be dependent on me as an individual. In other words, this should be plug and play. So whatever command official -- and the medical director I think also added tremendous value on this, and I hope you'll interview Dr. MountVarner, our medical director, because he leveraged his relationships with the individual hospitals to make sure that they were aware and ready to begin receiving casualties. So we have these informal relationships that are very strong, but -- and Chief Hawkins knows that I preach this all the time -- the system should work independent of which individuals happen to be duty.

We were fortunate this incident happened during the daytime. Many of these functions that I've talked about, my function, the medical director's function and the EMS 8 function, so essentially all the -- we are the only three EMS, quote, "command" officials in the department, just the three of us. All three of those are day work positions. So what if this incident happened at 1:00 in the morning? Okay. Where are we plugged into both standing up Fire Ops and being notified and having the ability to respond off duty? You know, I would have to take Metro --

Q. Is there, is there --

A. -- to get down here, which is going to be a little difficult.

Q. Is there a provision to call in these daytime folks for an overnight event should they be needed?

A. Well, the agency can potentially call back anybody it chooses to under its emergency mobilization plan, but the only one of those three officials that's currently in the plan as it currently exists, to my understanding, is the medical director. We used to have far more EMS management positions but they were eliminated back in 2011.

Q. So it would be a shortcoming not having the capability to call up the other personnel that you were -- you mentioned --

A. Or not having them already on duty 24/7/365. We used to have a lot more EMS --

Q. -- which may not be cost efficient, but at least having the capability to bring them in. But then again, you've got the time lag if they're at home to be able to bring them in and bring them up to speed, so that might be an impediment to the overall process.

A. Absolutely.

Q. Very good. Anything else, Chief, that you can think of from the top of your head?

A. No, I think that an EMS command official should be on duty 24/7/365. That's a critical capacity, particularly in the management of a potential mass casualty incident. And I think that we were fortunate in that today was -- the day of this incident was the first day that a position was staffed in 3 months and that it happened to occur during the day when that position was staffed.

Q. Very good.

MR. DOWNS: Any further questions?

And with that, thank you very much, Chief. That concludes our interview.

(Whereupon, the interview was concluded.)

CERTIFICATE

This is to certify that the attached proceeding before the

NATIONAL TRANSPORTATION SAFETY BOARD

IN THE MATTER OF:	WMATA INCIDENT AT L'ENFANT PLAZA STATION, WASHINGTON, D.C. JANUARY 12, 2015 Interview of Rafael Sa'adah
DOCKET NUMBER:	DCA-15-FR-004
PLACE:	Washington, D.C.
DATE:	February 2, 2015

was held according to the record, and that this is the original, complete, true and accurate transcript which has been compared to the recording accomplished at the interview.

_____

Kathryn A. Mirfin
Transcriber

NTSB interview, February 2, 2015, Docket No.: DCA-15-FR-004, WMATA Incident at L'Enfant Plaza.

I have reviewed the transcript of my interview with Mr. Richard Downs and the NTSB investigative team conducted on February 2, 2015 at 500 F St. NW, Washington DC.

The transcript appears to be accurate with the exception of the following typographical or transcription errors which I am respectfully requesting be corrected:

Page 12, line 16: change "Adan" to Aidan"

Page 18, line 23, change "Reef" to "Reeves"

Page 27, line 21, change "E-tech" to "ETEC"

Page 30, line 9, change "Ron" to "Derron"

Page 32, line 4, change "meat" to "neat"

Page 43, line 21, change "Adan's" to "Aidan's"

[redacted] 2-17-05

Rafael Sa'adah, BFC, DC Fire & EMS