[Incident Name]

After-Action Report/Improvement Plan

[Date]

The After-Action Report/Improvement Plan (AAR/IP) aligns SD600 objectives with preparedness to include the National Preparedness Goal and related frameworks and guidance. Users are encouraged to add additional sections as needed to support their own organizational needs.

**Incident Overview**

|  |  |
| --- | --- |
| **Event Description** | [Insert the nature of the incident and its impact on collections] |
| **Event Dates** | [Indicate the start and end dates and times of the event. The event is considered closed when there is a return to normal access/activity.] |
| **Unit** | [Insert the name of the affected unit(s)] |
| **Threat or Hazard** | [List the threat or threats to the collection (e.g. water leak, HVAC failure, fire) |
| **Scope (location/scale/zone)** | Indicate the estimated percentage (e.g. <1%) of the collections affected and the damage caused (Consider scale and terms that will be easily understood per unit’s and/or SF-Explorer naming systems, e.g. Hall name, exhibit case #, storage room, Collections Space Survey (CSS) location; local CIS location. Remember that for follow-up mitigation actions, a unit location may not be what is reflected in Tririga-Facility Center) for SF response.  If necessary, summarize in a list with both locations. |
| **Response Area(s)** | [Prevention, Protection, Mitigation, and/or Recovery] |
| **Objectives** | Describe the primary, secondary and tertiary objectives of the response activity. (E.g. 1) Stop active leak in collection containing area 2) replace carpet, 3) reopen to visitors) |
| **Event Narrative and Analysis** | [Insert a brief overview of the event and the response, if you have a full chronology, attach as an appendix. Include a succinct analysis of whether the response operations were successful or not, and why. Further room for detailed reporting is provided below. |
| **Participating Organizations** | [Insert a brief summary of the total number of participants and participation level (i.e., Federal, State, local, Tribal, non-governmental organizations (NGOs), and/or international agencies). Consider including the full list of participating agencies in Appendix B. Delete Appendix B if not required.] |
| **Point of Contact** | [Insert the name, title, agency, address, phone number, and email address of the primary collections POC |

**Communications**

Was the Unit Emergency Operations Center activated?

Was the Smithsonian Communication Center notified of the incident?

What was the communications strategy for responding to this incident? (E.g. was the ICS system used for relaying information?)

Were the communications systems set in place by the responsible unit able to address the incident, and were these systems effectively utilized?

What were some of the strengths and weakness of the communications system or its implementation? E.g., a weakness would be that important stakeholders were not notified in a timely fashion.

In the table below, please identify areas of improvement relating to communication in the event of future incidents. If the corrective action is unknown, indicate what lessons were learned so that other responders may be aware of the potential problem.

**Communications Improvement Plan**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Issue/Area for Improvement** | **Corrective Action or Lesson Learned** | **Unit** | **Organization POC** | **Start Date** | **Completion Date** |
| 1. [Area for Improvement] | [Corrective Action 1] |  |  |  |  |
| 2. [Area for Improvement] | [Corrective Action 2] |  |  |  |  |
| 3. [Area for Improvement] | [Corrective Action 3] |  |  |  |  |
| 4. [Area for Improvement] | [Corrective Action 4] |  |  |  |  |
| 5. [Area for Improvement] | [Corrective Action 5] |  |  |  |  |
| 6. [Area for Improvement] | [Corrective Action 6] |  |  |  |  |
| 7. [Area for Improvement] | [Corrective Action 7] |  |  |  |  |

This IP has been developed specifically for [Smithsonian Unit] as a result of [Incident Name] occurring on [date of incident].

**Personnel**

Who were the personnel responding to this incident? (List organizational groups, i.e. OPS, OFMR, etc., not individuals)

Was the staffing available sufficient to address the incident? If not, was an attempt made to draw on the personnel of other Smithsonian Units?

What were some of the strengths and weakness of the staff who responded to the incident?

In the table below, please identify areas of improvement relating to the deployment of personnel in the event of future incidents. If the corrective action is unknown, indicate what lessons were learned so that other responders may be aware of the potential problem. E.g. OFMR staff was undertrained in collections handling, recommend Unit run collections-based training opportunities for our building and OPS staff.

**Personnel Improvement Plan**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Issue/Area for Improvement** | **Corrective Action or Lesson Learned** | **Unit** | **Organization POC** | **Start Date** | **Completion Date** |
| 1. [Area for Improvement] | [Corrective Action 1] |  |  |  |  |
| 2. [Area for Improvement] | [Corrective Action 2] |  |  |  |  |
| 3. [Area for Improvement] | [Corrective Action 3] |  |  |  |  |
| 4. [Area for Improvement] | [Corrective Action 4] |  |  |  |  |
| 5. [Area for Improvement] | [Corrective Action 5] |  |  |  |  |
| 6. [Area for Improvement] | [Corrective Action 6] |  |  |  |  |
| 7. [Area for Improvement] | [Corrective Action 7] |  |  |  |  |

This IP has been developed specifically for [Smithsonian Unit] as a result of [Incident Name] occurring on [date of incident].

**Materials**

Were disaster supplies available with which to respond to the incident?

Were the supplies made available by the responsible unit able to address the incident, and were these supplies readily accessible?

If the unit was unable to fully address the issue with materials on hand, how did they procure additional resources? Were other units called upon to contribute supplies?

What were some of the strengths and weakness of the materials made available for the incident response? What additional supplies would have been beneficial?

Was specialized equipment needed? If so, was it available? E.g. Dehumidifiers

In the table below, please identify areas of improvement relating to supplies and equipment in the event of future incidents. If the corrective action is unknown, indicate what lessons were learned so that other responders may be aware of the potential problem.

**Material/Supply Improvement Plan**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Issue/Area for Improvement** | **Corrective Action or Lesson Learned** | **Unit** | **Organization POC** | **Start Date** | **Completion Date** |
| 1. [Area for Improvement] | [Corrective Action 1] |  |  |  |  |
| 2. [Area for Improvement] | [Corrective Action 2] |  |  |  |  |
| 3. [Area for Improvement] | [Corrective Action 3] |  |  |  |  |
| 4. [Area for Improvement] | [Corrective Action 4] |  |  |  |  |
| 5. [Area for Improvement] | [Corrective Action 5] |  |  |  |  |
| 6. [Area for Improvement] | [Corrective Action 6] |  |  |  |  |
| 7. [Area for Improvement] | [Corrective Action 7] |  |  |  |  |

This IP has been developed specifically for [Smithsonian Unit] as a result of [Incident Name] occurring on [date of incident].